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Female control of sexuality: illusion or reality? Use of vaginal products in south west Uganda

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Abstract

This paper reports on a trial of vaginal products that were distributed and used by 131 women and 21 men in south west Uganda. It focuses specifically upon the issue of female control in heterosexual relationships and examines whether methods which are ostensibly under women's control, will in practice give women greater control of their sexual health.

Participants were invited to select two from a range of vaginal products that included the female condom, contraceptive sponge, film, tablets, foam and gel, and use each for five weeks and their favourite product for a further three months. They were interviewed up to seven times over a five-month period.

Although the women perceived that a major advantage of the products (with the exception of the female condom) was that they could be used secretly, less than 40% were using the products without their partner's knowledge after one week and this proportion declined over time with only 22% using the products secretly after ten weeks. In the main male partners were told as women felt it their duty to inform them.

In general the women were very much more positive about the products than they were about the male condom, as were the men. A contributory factor to their popularity among women was the greater control they gave them. Even though, use of these products in practice often involved negotiation with male partners, the fact that use was contingent on women's action was empowering and increased somewhat their ability to control their sexual health.

Keywords: Female control; HIV; Contraceptives; Uganda

Introduction

Women, particularly those in developing countries, occupy a position characterised by social and economic disadvantage and lack of control compared to men. Women's disadvantaged status may have repercussions on their sexual and reproductive health in that their lack of control reduces their ability to determine the spacing of their children and to protect themselves from sexually transmitted disease (STD; Okojie, 1994; Oppong, 1983; Santow, 1995). To counterbalance such disadvantage, there are a number of initiatives to increase women's empowerment in the sexual and reproductive sphere such as planned parenthood projects. There have also been a number of calls, and a growing number of research initiatives, to develop female controlled methods of protection against STDs especially HIV/AIDS.

This paper reports on a trial of vaginal products that were distributed and used by women and some men in south west Uganda. The rationale behind the project is that if and when current research efforts succeed in developing a safe and effective virucide or microbicide against HIV/AIDS the trial will inform the appropriate mode of delivery. The findings relating to product

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acceptability in general have been reported by Pool et al. (2000a). This current paper focuses upon the issues of pleasure and female control in sexual relationships associated with use of the products. It looks at the role of sexual pleasure in influencing feasibility of product use and examines whether methods which are ostensibly under women's control, will in practice give women greater control of their sexual health. In so doing, it looks beyond the rhetoric about giving women theoretical control over their sexual health towards the practical application.

The paper begins by identifying some of the issues raised in the literature about power, gender and sexual relationships, particularly in developing countries, and within the specific context of sexual relationships in south west Uganda. A brief overview is presented about studies of the female condom and the current level of development of microbicides. The data are then presented to highlight issues pertaining to female control. The overriding issue is whether use of vaginal products increases women's empowerment and if so how? This is considered in the light of the data and relevant academic debates.

Gender, sexual relationships and power inequalities

Many accounts exploring gender inequalities have focused on the relations of power and exploitation between men and women, and discuss sexual politics with reference to oppression and patriarchy (Connell, 1985). The advent of AIDS shifted the focus to the ways in which disempowered femininity could compromise the sexual health of women in subordinate roles (Holland, Ramazanoglu, Sharpe & Thomson, 1992a; Schoepf, 1992). Studies of heterosexual behaviour highlighted women's relative lack of power in sexual encounters, which prevented them from practising safer sex (with condoms) even when they would have preferred this (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1991; Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1992b).

In this model women encounter pressure from male partners ranging from mild insistence on intercourse to physical assault. Feminist writers have tended to define all male pressure (whether mild or extreme) in terms of a continuum of sexual violence of men's sexual behaviour towards subordinate women (see for example Kelly, 1988). Within this continuum, the sexual pressures women experience may often be enmeshed in loving and caring relationships.

Heterosexual women who wish to control their sexuality have to negotiate with male partners and be assertive, even unfeminine, which may threaten their sexual relationship. Using condoms, for example, may lead to problems of negotiation with a male partner, and social risks such as a sullied reputation (Hillier, Harrison & Warr, 1998). In this respect women's social status clearly affects sexual risk behaviours and the ability to take steps to reduce risk of infection (Amaro, 1995; Campbell, 1995).

Studies of African women suggest that they are particularly vulnerable to such pressures because subordination to men is a defining feature of sexual relationships. Lack of power impedes women's ability to protect their sexual health both with long term regular partners and with more short term informal sexual encounters such as in the workplace where women may be expected to provide sexual services to male employers (Obbo, 1989, 1990; Schoepf, 1992). According to Schoepf (1992, p. 276), "the subordinate position [of women] with respect to men circumscribe their options. Few are able to practice safer sex. Some do not feel able to open dialogue with sexual partners on the subject. Others who have attempted to do so have experienced rejection and retaliation."

The relationship between women and HIV is further confounded by poverty (Farmer, Lindenbaum & Delvecchio Good, 1993), because most women with HIV and those most vulnerable to infection are from poor countries, or are from poor and minority populations in more affluent countries. They generally come from a background of poor physical and mental health, malnutrition and inadequate medical care (Ward, 1993). In such environments, sexual choices of women express not only cultural values and expectations but also adaptive means of living with sexism, racism and economic disenfranchisement (Worth, 1990). It may be untenable for disempowered women living in poverty, often dependent on a male partner, to take action to reduce transmission of STDs. A number of studies of African women have shown how their survival is generally structurally linked to a dependent and subordinate relationship with a male partner and that this limits their ability to control their sexuality (Afonja, 1990; Obbo, 1989; Oppong, 1983; Schoepf, 1992). Cultural, social and economic constraints impede African women from complying with advice to limit partners and use condoms (Ulin, 1992), and they are placed at greater risk of STD infection by their ignorance of whether or not their partner is infected (Orubuloye, Caldwell & Caldwell, 1993).

Furthermore, Sobo (1993) shows that protective action, even when tenable, may be regarded as unnecessary, irrelevant and even psychologically damaging to the poor African–American women in her study, even those that see themselves as independent and self-sufficient and not financially dependent on their male partner. These women idealise monogamy and hope for loyal conjugal partners and, in this context, see condomless sex as a sign of trust, honesty and commitment. AIDS risk denial manifest in their choice to practise unsafe sex with their partners leaves these women's culturally engendered dreams of monogamy and security intact.

Insistence on safe sex, would amount to admission of partner's potential faithlessness thus reducing their self-esteem and social status among their peers.

Urbanisation in Africa has resulted in some women acquiring paid work and a degree of economic independence. A study by Dinan (1983) of white-collar single women in Accra, for example, shows how, despite moral and legal pressure on women to find husbands, they often prefer affairs with "sugar-daddies" (older married men). These "affairs" enable them to augment their wages to enjoy a comfortable standard of living and to buy furniture, property or land to secure their future. And a more recent study by Stambach (1998) provides evidence that for some women education is enhancing their independence and challenging traditional gender relations. Stambach's study of the Chagga in northern Tanzania shows how education is increasingly used by women to gain access to resources as an alternative to marriage. "Education is my husband" comments one Chagga women, by which she means that schooling has given her access to a job in a boarding school that provides her with a house, a garden and an income, benefits that she would otherwise obtain through marriage. At least in some regions, it appears that professionally oriented women are emerging and asserting political and economic autonomy in arenas traditionally controlled by men.

Notwithstanding subtle changes that may foster women's empowerment, the vast majority of women in developing countries have lower socio-economic status and less power than men (de Bruyn, 1992), and a lack of independence that disempowers them from taking sexual health protective action (Campbell, 1995). Husbands may be threatened by women's use of contraception, fearing it will allow them an unacceptable degree of sexual freedom. Condoms, in particular, tend to be associated with premarital or extramarital sex. Indeed, in many countries a husband's approval is legally required for his wife to use family planning services (Cook & Maine, 1987). Other factors identified as threatening women's sexual health are men's premarital and extramarital activity during work related absences, polygyny, post-partum sexual abstinence for wives but not for husbands, and for some the necessity to supplement income through prostitution (Santow, 1995). A key issue, in any of the above scenarios is whether women have either the power to refuse sex or insist on a condom being used. In Uganda, it is reported that many women who suggest using a condom risk accusations of promiscuity, of being infected, or that they are accusing partners of infidelity (de Bruyn, 1992).

Methods controlled by women

The constraints on women that limit their ability to protect their sexual health are of particular concern for those living in countries where the prevalence of STDs and HIV is high such as Uganda. Women's vulnerability to HIV is further accentuated by the nature of HIV transmission whereby the virus is more easily transmitted from men to women than women to men (European Study Group on Heterosexual Transmission of HIV, 1992; Carpenter, Kamali, Ruberantwari, Malamba & Whitworth, 1999). A major barrier for many women wishing to control their sexual health is that use of prevention measures, such as the condom, is controlled by men. This situation has prompted repeated calls at international conferences from women living in countries with high levels of HIV, and in the literature (Stein, 1990, 1993) for the development of methods of protection that can be controlled by women.

To date the female condom is the only safe and effective method of STD and HIV prevention controlled by women. There is evidence from Britain (Bounds, Guillebaud & Newman, 1992; Ford & Mathie, 1993) and the United States (Farr, Gabelnick, Sturgen & Dorflinger, 1994) that many women are reluctant to try it, including "high risk" women on an HIV prevention programme (Sly, Quadagno, Harrison, Eberstein, Riehman & Bailey, 1997).

In Africa, perhaps as a result of the very high prevalence of HIV in some areas and lower availability of other protective methods, the female condom appears to be more acceptable to women, and to a lesser extent their partners, in a number of settings (Ankrah & Attika, 1997; Ray et al., 1995; Sapire, 1995). An analysis of ten studies conducted in sub-Saharan Africa between 1990 and 1996 suggest that the female condom is acceptable to women who participate in trials of it (Deniaud, 1997). For example, two-thirds of a sample of low-risk women in Kenya said they liked the female condom as much or more than a male condom and 55% said that they would use the device in the future if it were available (Ruminjo, Steiner, Joanis, Mwathe & Thagana, 1996). Although few studies provide the numbers of women who are asked to participate and refuse to take part, and perhaps find the concept of the female condom unacceptable, it would appear that the female condom is acceptable to over one-half of the African women who are prepared to try it.

Whilst the female condom is a method controlled by women it is visible when inserted and cannot be used covertly. A vaginally inserted microbicide is likely to be far less obtrusive and perhaps have potential for covert use, which would in theory enable women to protect themselves from STDs without their partner's knowledge. The development of vaginal microbicides is ongoing but studies have so far been mainly biomedical and concerned with safety and efficacy. It is estimated that novel preventative measures which women control are highly unlikely to be developed for widespread use in the immediate future (Elias & Coggins, 1996), but the

development of such products has high priority, and it is probable that in time a safe and effective vaginal microbicide will be developed. Given that its success will depend upon cultural acceptability, it is important to conduct studies to provide information about the appropriate formulation and distribution of such products to ensure rapid uptake and widespread use, and to assess the potential of such vaginal products to increase women's control of their sexual health and sexuality.

Sexual relations in the study area

The study was carried out in three areas (a town, a roadside settlement and rural area) in the Masaka District in south west Uganda where the Medical Research Council (MRC) programme on AIDS in Uganda has been conducting community-based studies since 1988. The prevalence of HIV among the adult population in the three areas is estimated to be 20–25% in the town, and in 1991 was reported to be 40% in the roadside settlement (Nunn et al., 1996), although has probably declined somewhat since. The reported rate in the rural area is considerably lower at about 8% (Nunn, Mulder, Kamali, Ruberantwari, Kengeya-Kayondo & Whitworth, 1997).

The Baganda are the predominant ethnic group. There is little recent literature on sexual practices among the Baganda, although it is clear that many men in the area have concurrent sexual relationships with more than one woman (McGrath et al., 1993). Traders and lorry drivers often have a history of multiple and commercial sexual contacts (Carswell, Lloyd & Howells, 1989), casual sex with local sex workers along the trans-African highway is routine for many, and they were among the first groups identified as being at risk of HIV infection (McGrath et al., 1993; Pickering, Okongo, Nnalusiba, Bwanika & Whitworth, 1997).

A measure of the divergent norms for the sexual behaviour of men and women is that whilst it is expected in most of Uganda that wives will be faithful to their partners, the same rule does not generally apply to men. Findings reported in the early 1970s that it is acceptable, even expected, for men to have more than one partner (Kisekka, 1973), whereas women risk domestic violence from, and abandonment by, their partners if they are not faithful (Southwold, 1973), are still relevant in the late 1990s. It has been reported that male teachers may sexually coerce female students (Onyango, 1991 cited in Olowo-Freers & Barton, 1992; Kinsman, Harrison, Kengeya-Kayondo, Kanyesigye, Musoke & Whitworth, 1999), male bosses may offer advancement to female workers in return for sex (Obbo, 1990), and a study in the central Baganda region reports that 22% of women say that they had been forced to have sex against their will at some point in their adult lives (Okongo, 1991 cited in Olowo-Freers & Barton, 1992). Whilst fertility is highly valued by both sexes, men in particular gain status from fathering numerous offspring (Blanc, Wolff, Gage, Ezeh, Neema & Ssekamatte-Ssebuliba, 1996). Although sexual norms are more restrictive for women than men, movement between sexual partners is not uncommon for women who may sometimes take other partners to exact revenge, or for greater sexual satisfaction, or for economic assistance (McGrath et al., 1993).

Despite diverse gender norms, sexual satisfaction is deemed important for both sexes (see annotated bibliography by Olowo-Freers & Barton, 1992). Sexual norms emphasise mutual pleasure, foreplay, female sensuality and active participation by both partners (Kisekka, 1989). Girls are taught about sexuality and how to please their partner by their paternal aunt (Southwold, 1973) and, traditionally, female genital modification through labial elongation is practised to promote sexual pleasure (Kilbride & Kilbride, 1990). Premarital sex is common and marriage only occurs if sexual compatibility has been established (Kisekka, 1989). Whilst virginity and faithfulness are promoted by the evangelical churches which have increasing influence in the area, and as part of many AIDS health promotion endeavours, on-going studies in the area suggest that these qualities are not becoming more highly valued (see Kinsman, Nyanzi & Pool, 2000; Nyanzi, Pool & Kinsman, 2000). Divorce and marital separation are not uncommon and both men and women may leave their partner if they are no longer satisfied with the union (Mandeville, 1975; Nabaitu, Bachengana & Seeley, 1994). Infertility and impotence are sometimes cited as reasons for separation (Nabaitu et al., 1994), which has also been noted in neighbouring African countries (Boerma & Mgalla, 2000).

Overview of the study

In this paper we report on data collected in 1997–98 from a trial of vaginal products among women (and some of their partners) in south west Uganda. The products include the female condom (Femidom, Chartex International, London, UK), foaming tablets (Neo Sampoon, Eisai Co. Ltd., Tokyo, Japan), contraceptive sponge (Protectaid, Axcan Ltd., Laval, Canada), Delfen foam (Ortho Pharmaceutical Corp., Raritan, NJ, USA), film (VCF, Apothecus Pharmaceutical Corp., Oyster Bay, NY, USA) and gel (Rameses, Schmid Laboratories, Sarasota, FL, USA). All the products are used by insertion into the vagina a few minutes before intercourse although the sponge may be inserted many hours beforehand. The female condom should be removed immediately after intercourse while the sponge should be left in situ for several hours and can be left in place for multiple episodes of intercourse. All the other products dissolve and do not require removal and new products

should be inserted prior to each episode of intercourse. All the products, with the exception of the female condom and the foaming tablets (which contain menfegol) contain the spermicide nonoxynol 9 as the active ingredient.

All these formulations would be suitable for the delivery of novel and more effective microbicides. Whilst they are mainly used in the west in conjunction with other contraceptive methods such as the diaphragm, used on their own they do offer some protection against pregnancy and some cervical infections and chlamydia (Elias & Coggins, 1996).

The first part of the study involved focus group discussions (FGDs) with women and men to determine the acceptability of these products in theory, the findings of which are reported in earlier papers (Hart, Pool, Green, Harrison, Nyanzi & Whitworth, 1999; Pool, Hart, Green, Harrison, Nyanzi & Whitworth, 2000b). Three themes emerged in the FGDs with the women: (i) problems of men's control over the male condom; (ii) the importance of control over and secrecy about protective measures; (iii) sexual pleasure associated with the different methods (Hart et al., 1999). Women reported male resistance to condom use and that men sometimes tampered with condoms (e.g. by putting holes in them) to make them less effective and men in their FGDs actually reported doing this (Pool et al., 2000b). The women stressed the importance of vaginal products that could be used without a male partner's knowledge. In general they were very positive about the products although the female condom was recognised as having limited value because of the need to agree its use prior to sex taking place.

A central theme in FGDs with the men was their anxiety about retaining control over the means of protection. Men were ambivalent about female controlled methods; they wanted their women to be protected from STDs including HIV but the threat of infection was seen as ensuring that women remained faithful (Pool et al., 2000b).

Whilst the FGDs provided evidence of cultural consensus that the concept of vaginal products was acceptable to women in south west Uganda, group attitudes are not necessarily related to individual behaviour. A comparison between what people say about vaginal products in a group setting and how they report actually using them will help determine whether rhetoric about female methods of control can be translated into individual practice.

This paper is based on data gathered during the second stage of the study — a trial of the products. Repeated face-to-face interviews with women and a small number of their male partners who were using the products were used to gather data on use of the products and advantages and disadvantages associated with use. Following the trial FGDs were again conducted with participants.

Methods

Participants were recruited to the second stage of the trial from the FGDs in which three groups of women (aged 17–54) were recruited from Masaka District. The first group were recruited in a rural village 25 km from the nearest large town. The second group were recruited in Masaka town, the district's administrative and commercial centre. A further group of women who worked in bars in a roadside settlement and truck stop on the trans-African highway were also recruited. Some male partners of the women from the rural village and the roadside settlement were recruited too. In the rural village and the urban area subjects were recruited by counsellors working in family planning clinics and health centres. In the roadside settlement local residents employed as interviewers recruited from a pre-existing cohort of men and women. During the FGDs the female condom and the vaginal products described above were passed around for comment and participants were invited to use their two preferred products.

The study was longitudinal with up to seven interviews with participants over a five-month period. The interviews were all conducted by local fieldworkers in Luganda the native language. In the rural area participants (who were widely dispersed) were interviewed in their homes, in Masaka they were interviewed in the family planning clinics and in the roadside settlement interviews took place in a clinic or in their homes. This was due to convenience. At each contact respondents were asked about their use of the products: whether they informed their partner, whether the product increased or decreased their and their partner's enjoyment of sex. In addition in the early interviews women were asked about ease of insertion, and in the later interviews, whether they noticed any vaginal discharge or irritation. The questions generally took the format of fixed choice responses followed by open questions to gather textual qualitative data, e.g. (i) Did you inform your partner you were using the product? If yes, why? If no, why not? (ii) Did the product increase or decrease your enjoyment of sex? If so, how?

Whilst data from interviews about sexual behaviour is sometimes seen as unreliable given the sensitive nature of the topic, in the context of the AIDS epidemic in Uganda, people are becoming accustomed to talking about sex. Data quality was ensured by extensive training of interviewers, pre-testing questionnaires, comparing results from different rounds of interviews and cross-checking results in discussions with both interviewers and participants.

Table 1 shows the number who took part at each stage. In total 146 women and 35 men agreed to participate in the trial and of these 131 women and 21 men completed one interview. Each participant was asked to select two products to try as we were unsure at

Table 1
Project timetable and numbers of women and men interviewed at each contact

Interview	Number of women	Number of men
Recruited into trial	146	35
First product after one week	131	21
First product after five weeks	116	21
Second product after one week	108	17
Second product after five weeks	104	19[a]
Favourite product after at least one further months use	101	15
Completed five months of trial	65	12

[a] Two men were not available for the weekly interview of the second product but were available for the following interview about monthly use.

the outset whether we would be able to recruit a sufficient number to ensure all six products were used if each participant used one product only. They were interviewed about product one and then product two after one and five weeks use. If a couple was participating the woman chose the products. They were then asked to use their favourite product for a further three months and interviewed one, two or three times during this period according to availability. The rationale behind this design was that product use might vary over time. We hypothesised that women may use the products, and even find them exciting, in the short term following the FGDs but may not sustain use in the longer term. We also wanted to know if women who wanted to use the products secretly were able to sustain secrecy in the long term.

Participants were aware that they could withdraw from the study at any time and, apart from those in the town, were offered medical treatment in return for their participation. They were screened for symptomatic STDs and offered syndromic treatment if any were detected. Participation in the study was delayed until the STD had been treated. Whilst only 44% (65/146) of the women completed all interviews over the five- month period, 90% (131/146) completed at least one interview after use with one product, 74% (108/146) after use with two products and 69% (101/146) completed at least one interview about longer-term use of the product. Only 34% (12/35) of the men completed all interviews over the five-month period, but 60% (21/35) completed at least one interview after use with one product, 54% (19/35) after use with two products and 43% (15/35) completed at least one interview about longer-term use of the product.

After the completion of the trial a further nine FGDs were held (six groups with 40 women and four groups with 21 men), in order to evaluate in a group setting subjects' experience with the product.

Results

Table 2 gives details of the women and men who completed the first trial interview. Over 90% of men and women had some education although this did not extend beyond primary education for most of the men. The religious affiliation of most of the women was Catholicism although a greater proportion of the men were Protestant or Muslim. Just under one-half of the women were using some form of contraception at the start of the study, the most common methods being depo-provera (19%), the pill (15%) and male condom (10%). Three women used an intrauterine device and one woman had used foaming tablets. The social characteristics of both the male and female samples were virtually unchanged in subsequent interviews.

Product choice and impact on enjoyment

Despite the fact that, with the exception of the female condom, the vaginal products offered only very limited protection against pregnancy and STDs including HIV (a fact made clear and constantly reiterated by the interviewers) in general the products were extremely popular and we had no problem recruiting study participants.

Table 3 presents data on which products the women selected (as product 1 and 2) and the ease of insertion, presence of vaginal discharge and impact on enjoyment for self and partner after five weeks use. All women were asked to try two products and their choices reflected the preferences that were expressed in the FGDs in that the tablet and the sponge were the most popular, then the foam and the female condom and then the film and the gel. The patterning of, and rationale for, product preference are discussed in detail by Pool et al. (2000a).

The women reported few problems with insertion of any of the products after one month's use. In the post-trial FGDs, however, women expressed concern that the delay required to insert the product could interrupt the sexual act. According to a woman from the roadside settlement: "A person can lose the desire when you delay him [by going out to insert the product]. When a man is stimulated and you delay him the desire goes away." This was seen to be particularly problematic when using the foaming tablet as it takes a few minutes to dissolve following insertion. Delay not only impeded sexual enjoyment for some, but could also lead to partner suspicion about the union. Said a woman from the urban area: "The husband may say that, 'I'm confused about my wife. Whenever I want her, she first goes out. She takes time to think about it. We are no longer united.'" Thus insertion clearly jeopardised covert use of the products as, "there is no way of asking him to wait when he doesn't know why he should". No such

Table 2
Social characteristics of study sample

	Women who completed first interview ($N=131$) (valid % and number)	Men who completed first interview ($N=21$) (valid % and number)
Location:		
Rural village	47.3 (62/131)	76.2 (16/21)
Roadside	21.4 (28/131)	23.8 (5/21)
Town	31.3 (41/131)	–
Education:		
None	7 (9/129)	9.5 (2/21)
Primary	47.3 (61/129)	76.2 (16/21)
Secondary	38 (49/129)	14.3 (3/21)
Further	7.7 (10/129)	–
Religion:		
Catholic	64.6 (84/130)	23.8 (5/21)
Protestant	13.8 (18/130)	42.9 (9/21)
Muslim	19.2 (25/130)	33.3 (7/21)
Born again[a]	2.3 (3/130)	–
Contraception:		
Currently using some method of contraception	46.6 (61/131)	N/A
Mean age	29.4 (S.D. 7.2) range 17–54	35 (S.D. 7.6) range 20–59

[a] "Born again" is a widely-used term referring to the converts of the (mostly American) Pentecostal churches that have swept through Africa in recent decades. Although strictly speaking, they could be grouped with the Protestants, they tend to distinguish themselves from the more traditional Protestant denominations by referring to themselves as "born again" (see Gifford, 1998).

problems were reported with use of the sponge that can be inserted a few hours before intercourse.

The women were also asked about vaginal irritation and discharge. Although, nonoxynol 9 is effective against a variety of sexually transmitted bacterial and viral pathogens, including HIV in vitro, in vivo studies have shown that more genital ulcers and vulvitis occur with high dosage use of nonoxynol 9 and HIV infection is not reduced (Kreiss et al., 1992). In our study just over 10% in the medium term and 8% of the sample in the longer term reported vaginal irritation or discharge. Although this figure is high, it is comparable to the proportion of women (9%) who reported such symptoms at the beginning of the trial during the STD screening interview, suggesting that use of these products over a three- to five-month period does not result in increased vaginal irritation or discharge. It should, however, be noted that self-report figures for discharge are very imprecise, and that as the women were screened for symptomatic STDs and given treatment before entering the trial one might have expected a decrease in the proportion reporting discharge. The data on vaginal discharge by product shows that a higher proportion of women (18%) using the film than other products reported discharge but the numbers are very small and none of the nine women who used the film in the longer term reported discharge.

Vaginal products are only likely to be used widely over time if use does not diminish pleasure. Pool et al. (2000a) report that use did not generally interfere with sex, and for some was associated with increased enjoyment. Table 3 shows that almost one-quarter of the women reported increased enjoyment after five weeks use (a figure which was sustained with longer term use), and 18% of the women reported use of products also increased enjoyment for their partners. Products most often associated with enjoyment were the foam, the tablets and the sponge with users of the film least likely to report enjoyment.

The main reason cited for increased enjoyment of both men and women was the increased lubrication resulting from use of most of the products. Said one woman from the roadside settlement who was using the sponge without telling her partner: "[W]ith that sponge...it even has that oily substance which is really nice. It is very nice (laughs). Wonderful (more laughter). He can even say, 'This is wonderful. I have never enjoyed it like this'. He continues, 'I have never had such a moment'. But you really know your secret." In this case covert use appears to enhance the woman's enjoyment by giving her control (in that her partner is unaware of product use) to enhance the sexual experience. Other reasons stated for increased enjoyment are: feeling somewhat better protected; liking the heat generated by the foaming tablets; finding sex more exciting particularly in the short term; and that the male partner took longer which women said was important to their partner's enjoyment.

Table 3
Women's use and enjoyment (for self and partner) of all products after five weeks use[a]

	% who used product 1 for five weeks ($N=116$)	% who used product 2 for five weeks ($N=104$)	% who report it easy to insert after five weeks use	% who report vaginal discharge after five weeks use	% who report increased enjoyment of sex after five weeks use	% who report increased enjoyment for partner after five weeks use
All products	100	100	96.3	10.6	22.7	17.7
Female condom	17.2	16.3	97.2	8.7	17.1	12.5
Sponge	28.4	14.4	95.8	6.3	20.8	22.9
Foam	16.4	21.2	95.1	7.7	32.5	24.1
Gel	–	16.3	90.0	9.1	18.2	11.1
Film	10.3	10.6	93.1	17.9	13.8	10
Tablet	27.6	21.2	100	13	26.4	16.7

[a] Percentages are based on valid percents, i.e. missing values are not included.

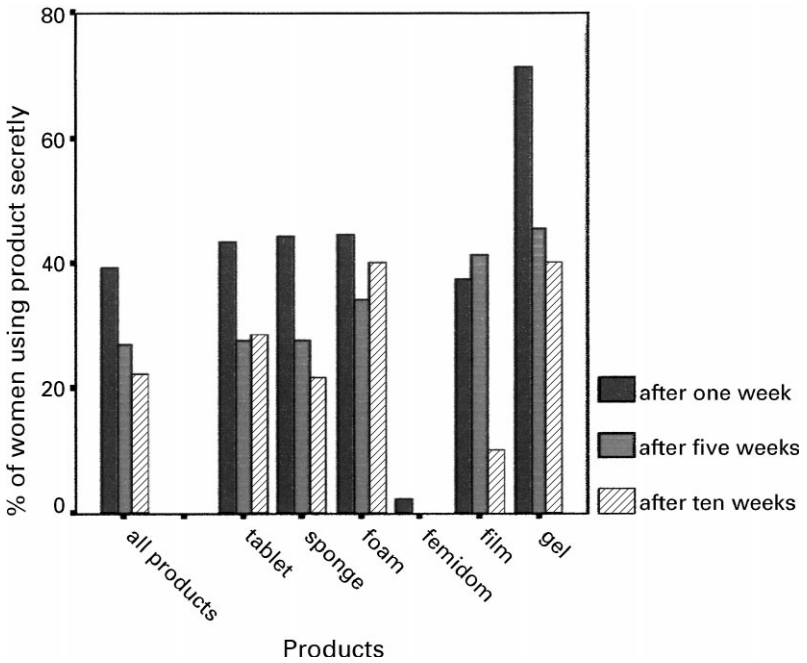

Fig. 1. Percentage of women using the products secretly after one, five and ten weeks.

Secrecy

Despite the fact that women in the pre-trial FGDs stated that one of the perceived advantages of these products was that they could be used secretly, after the first week of using the products only 40% were using them secretly and this figure had declined to 27% after five weeks use and 22% after ten weeks. By the end of the trial, among those interviewed after five months use, only 13% were using the product secretly.

There were few differences by product except for the female condom, which only one woman reported using for one week without telling her partner. As a woman from the rural area commented: "We tried it [female condom] madam. What we found out is there is no secrecy in it." Whilst Fig. 1 suggests that at least for one week the gel had greater potential than the other products for secret use, the numbers actually using the gel were very small, so this finding needs to be interpreted with great caution.

Table 4 shows the main reason women gave for informing their partner after one and ten weeks in the trial. Most of the reasons cited for informing the partner suggest that the women anticipated little if any partner resistance. The most common reasons for informing the partner were that the women wanted to tell him or that their partner already knew they were participating in the study or they felt sure their partner would agree to use as neither wanted more children. Twelve percent told their partner as they felt he would have noticed had they not

Table 4
Main reason for informing partner after one and ten weeks (%)[a]

	After one week in trial	After ten weeks in trial
Wanted him to know	31.3	40.8
He already knew of study	25.4	30.2
We both don't want more children	11.9	13.2
He would have noticed/found out	11.9	10.5
Protects us both	6.0	3.9
Had to decide together	6.0	–
He noticed	4.5	1.3
He liked them	3.0	–

[a] Percentages are based on valid percents, i.e. missing values are not included.

Table 5
Main reason for not informing partner after one and ten weeks (%)[a]

	After one week in trial	After ten weeks in trial
He wouldn't agree	39.5	54.5
My secret	30.2	22.7
Partner wants children	16.3	9.1
He would suspect me	9.3	9.1
Wanted him to discover it himself	4.7	4.5

[a] Percentages are based on valid percents, i.e. missing values are not included.

and that this may have led to suspicion or disharmony. In the post-trial FGDs many women echoed the sentiment voiced by a woman from the urban area who said: "It is good to tell the partner first because when he finds out he will wonder why you kept it from him."

Table 5 shows the main reason women gave for not informing their partner. The main reasons for not informing the partner were fear of partner opposition and his subsequent refusal to use the product or because they enjoyed having "their secret". Other reasons for not telling was that the male partner wanted to have (more) children and that he may have become suspicious about his partner's faithfulness.

It is not entirely clear from these responses whether or not women voluntarily informed their partners, an issue we return to in the discussion below. It also remains unclear whether these women would have been able to use the product secretly if they had wanted to. Of those male partners who were not informed initially, five actually noticed the product within one week of product use and two in the longer term. In addition, one-third of women (including both those who were and were not using the product covertly) reported that their partners felt the product during intercourse suggesting that secret use may not be possible for all women. One woman reported that the wetness of the gel may make partners "suspect that you have been with another man, because once for me when I inserted it, he was suspicious".

Also, with regard to informing the partners, telling did not always follow the sequence of: did not inform the partner at all or did not inform him initially but did in the course of the study. There were 12 women who did not inform their partner at first, but then alternated between reporting that they informed him and that they did not. These inconsistent patterns illustrate the complexity of the issue. For example, one woman initially did not inform her partner because he wanted to have children and she did not. After five weeks in the trial she told him as he had noticed the product. Then with her second choice of product she again did not inform him as she was worried he would not agree. Informing the partner was thus often a process subject to change and fluctuation.

It is interesting that most women in this sample clearly did not use the products secretly and the possibility of doing so and thus ceding women more control was only cited as the best thing about the products by 12 women in the face to face interviews. However, in the post-trial FGDs, it became apparent that women's use of these products (whether they informed their partners or not) was frequently part of sexual negotiation. Said one woman "It is better to negotiate, but if he refuses, you do so [insert vaginal product] secretly". And another "Even if he refuses to put it [male condom] on, you just say OK. Then you use your own method".

Discussion

Will use affect enjoyment?

Though inserting a device like the female condom, which needs positioning properly, might require training, women generally found the products easy to insert. This may be related to the sexual culture in south west Uganda in which foreplay and vaginal stimulation are expected during sex and intercourse tends to be vaginal rather than oral or anal. In addition, the practice of labial elongation, which is still common in the study area except perhaps among the very small urban elite, means that many women are accustomed to manipulating and touching their vaginas. There is of course a distinction between finding the products acceptable and using them properly — willingness to use vaginal products does not necessarily mean that they are inserted correctly. Nonetheless, vaginally inserted products appear to be culturally acceptable in this area (for an illustration of the impact of culture on sexual risk see Taylor, 1990). Some participants, however, found insertion of all products resulted in an unwelcome interruption to sex. Disquiet was also expressed by women using the products secretly, who feared their partner may notice them.

In general the products were popular and did not interfere with enjoyment of sex. The products most and least associated with enjoyment reflected those found most and least acceptable in general (see Pool et al., 2000a). The sponge and the tablet were those that participants most enjoyed and the film the least. The popularity of the products is in marked contrast to participants' expressed dislike of the male condom. Male condoms are generally considered unacceptable in regular relationships as they imply distrust and unfaithfulness. They also directly challenge men's desire to father many children. All these reasons apply equally to the female condom, and to a lesser extent to the other products, and this begs the question as to why they were so popular among participants in this study. Of relevance here is the issue of female control. In the FGDs women articulated that male condoms could never guarantee safety as men put holes in them, a practice confirmed by the men. Opportunities for men to insert holes in the female condom are reduced as the woman generally inserts them. There is even less possibility of tampering with the other vaginal products and they will also tend to be inserted by the woman. In this sense these products are in practice very much more under women's control than the male condom.

Studies of the female condom in Britain suggest that use may have a negative impact on sexual pleasure for both women and men and may result in discontinuation of use (Ford & Mathie, 1993). This highlights the difference between use in a country where the prevalence of HIV is comparatively low and everyone has free access to a range of contraceptives to use in a country with high prevalence of HIV and limited accessibility at an affordable price to methods of protection. The very high prevalence of HIV may also explain the popularity of the foam products at this time even though they were unpopular when introduced as contraceptives to parts of sub-Saharan Africa long before the onset of HIV/AIDS. Both men and women may now be more tolerant about using protective products as concern about HIV transmission may outweigh the negative connotations of protective measures.

Another possible explanation for the popularity of these products, particularly for men, was the increased lubrication, which was linked with heightened sexual enjoyment for a proportion of women and men in the trial. That many valued the increased lubrication associated with use of most of these products is largely explained by the culture of wet sex that is the norm in this area. In many other parts of Africa, however, dry sex is preferred (e.g. parts of Zambia, Zaire, Zimbabwe and Malawi; Dallabetta, Miotti, Chiphangwi, Liomba, Canner & Saah, 1995). In Zimbabwe, for example, use of intravaginal herbs and other agents to heat, dry and tighten the vagina to enhance sexual pleasure is common (Runganga, Pitts & McMaster, 1992). In this situation, lubrication is clearly not an integral part of "satisfactory" sex and there may be problems of cultural acceptability.

The novelty of the products may also have added to their attractiveness. With one exception (a woman who had used the foaming tablets) women in this study had not had the opportunity to use these products before. Products that enhance lubrication have also not been widely available. This novelty factor seems to have contributed both to the women's inclination to inform their partners and to the men's accepting their use. Also the fact that some women did not tell their partners as they wanted him to "notice it himself" suggests that they derived pleasure from this teasing.

Can the products be used secretly?

Despite the fact that the women said in the FGDs that one of the things they most liked about the products was that they could be used secretly (with the exception of the female condom), only 40% of women successfully used the products without their partner's knowledge for one week and only 22% maintained secrecy over ten weeks. Interestingly, in the post-trial FGDs with women who had used the products, secrecy and control were again central themes, and among the most highly valued properties of these products. We can see here quite clearly a discrepancy between theory and practice, which suggests the importance of multiple methods and triangulation in studies of this kind.

One explanation for the discrepancy is the translation of the concept of secrecy. It is possible that by "secretly" the women meant that they used the products "privately" or "discreetly", rather than without their partner's knowledge. Keeping products related to sex and menstruation "secret" from men is culturally appropriate (in a culture in which male and female domains are generally separate) and in the FGDs women made reference to "safe places" where they kept cloths to use during menstruation. It seems clear from the language used in the interviews, however, that the women generally referred to secrecy rather than discretion using words such as *bubba* (stealth) and *kyama* (secret). One woman from the rural area, for example, made it quite clear that "with one who resists [to use any protection] then you are forced to use it secretly".

In seeking to explain the discrepancy between stated value of secrecy and its actual frequency, let us then examine the possibility that the women in the FGDs exaggerated the distrust between men and women. The large number of studies of sexual behaviour which have employed diverse methods suggest that information about sex varies considerably depending on the research method used. A structured questionnaire elicits different data to self-completed sexual diaries, which in turn produce different findings to in-depth qualitative face to face interviews (Boulton, 1994). It is also clear that sex talk is very context-specific, and language and content will vary accordingly. Much group talk about sex is characterised by laughter, ribaldry and exaggeration and the FGDs in our study with both the men and the women were jocular and ribald.

Single sex groupings are also often associated with criticism of the opposite sex who may be discussed in a less than favourable light. It is quite possible that women in the FGDs focused upon the conflictual nature of gender relations. In each of the female FGDs, for example, the issue about men putting holes in condoms emerged, but when asked to cite specific examples of this in the post-trial FGDs none of the women were able to mention a single case that they had heard about directly. The women in the FGDs also talked about male infidelity, male desire to father numerous offspring and male mistrust of women using measures to protect themselves against STDs. Whilst these criticisms are partially substantiated by the men themselves in the male FGDs (Pool et al., 2000b), and in the literature cited above, it is of note that the women did not talk about more positive male roles in sexual relationships.

Notwithstanding that distrust between men and women in regular sexual relationships may be exaggerated in a group discussion setting, the literature described earlier suggests that the norm for regular heterosexual relationships is one of a pragmatic gender division of labour combined with sexual conflict and mutual distrust. Why then did a greater proportion of women not use these products secretly? It would seem that telling male partners was not always volitional. A lot of men knew about the study before the trial began and, at least in the roadside settlement and rural area, it was no secret in the community who was participating. In addition, the women often seemed to think that their male partners should be told. Although only a minority of women told their partner as they were scared he would found out, many women seemed to feel that they had a duty to tell their partner. The precise nature of this perceived duty is not known but is worth exploring in further studies in order to gain better understanding of the nature of "secrecy" and "women's control".

The notion of duty would appear to link in with the literature cited earlier about sexual pressures on women often being exerted within the context of loving and caring relationships. Thus even though some telling may have taken place in the context of a caring, sexual relationship, underpinning the relationship is women's lack of empowerment which propels them to divulge information to their male partners. It is also noteworthy that some women who did not inform their partners kept the product secret not because they wanted control but because letting the partner discover it himself made things more exciting.

It is also worth considering the issue of the attractiveness of secret use as something women value for women in general versus the role of secrecy in individual relationships. Consider the work by Sobo cited above which highlights the supposedly contradictory stance of women who think that condoms should be used by women in general to protect themselves from infection by men but think that they do not need to use them with their partner because he is faithful. Perhaps in the context of this study the women felt that these products should be used secretly by women in general because other women's partners would not accept them but that they could tell their partner because he would. This may perhaps explain the high stated value for secret use in the FGDs when talking about women in general compared to low frequency of secret use reported in the individual interviews.

A further explanation for the discrepancy between theory and practice with regard to secrecy is that many women may have felt that they would not be able to use the products covertly. Whilst it may be possible to use them secretly for casual sex it may be very difficult to sustain secrecy in the long term with a resident partner, particularly in the context of this fairly public study. The products have to be collected from a distribution centre, kept somewhere in the home, inserted a few minutes prior to sexual intercourse, some have to be removed, and they alter the vaginal environment. It is quite likely that a regular partner will notice them at some stage unless the woman is prepared to go to some lengths to keep them hidden. It is possible that women told their

partners as they were not able, or did not have the energy or guile, to keep them hidden. In a post-trial FGD in the urban area, some of the women said that the products were noticeable and could not be kept secretly. Interestingly few felt that this was a problem.

Many women told their partner as they felt that if they did not do so and then he found out, he would suspect them of being unfaithful. One woman observed that the wetness of the products would be noticed by men "which means you can't alone take control of it. You must inform him first". They often likened this to the use of contraceptives and as a woman from the rural area said "[T]hey [men] are saying that contraceptives are helping women to misbehave".

The potential to use the products (except for the female condom) covertly is much greater in casual relationships although we have very limited data on this. In the face to face interviews no women reported having casual partners, not even the most notorious sex workers, one of whom could not be followed up because she was always in bed with a client. We do not know whether the participants used the products with casual partners or not, nor whether they only talked about use with regular partners in the interviews nor whether they conflated their experiences with both when answering the questions. However, outside the formal interview setting, many of the women from the roadside settlement spoke of having a number of casual partners and they in particular stressed the possibility of secret use of the products as a great advantage in the post-trial FGDs. With the exception of the female condom, these products would be easiest to use secretly in casual relationships, which would give women greater control over their sexual health with casual partners.

Conclusion: is female control an illusion or a reality?

Female control can have several interpretations with regard to use of vaginal products. Does "control" mean that women own the products but need to get permission/persuade partners to accept use, or that they own them and inform partners of use, or that they have access to products and use them secretly? This study shows that each of these scenarios resulted from women's use of vaginal products and that each was associated with giving women greater (albeit still often very restricted) control.

Although the women generally did not use the products covertly there was a sense in which the products seemed to give them a sense of control, an issue that was reiterated in the post-trial FGDs. Female ownership facilitates women's use of the products, as there is little a man can do once his partner has inserted a product even if he disapproves of its use. This puts the woman in a stronger position than one who is trying to persuade a man to use a condom if he does not want to. It should, however, be noted that women in this study might have been given more empowerment to use these products as they were supported by the authority of the MRC, the interviewers and the other women with whom they participated in the FGDs. It is possible that women buying the products through individual initiative would meet more partner resistance and thus have less control (see Pool et al., 2000a). The study area has also been the site for a lot of research for over a decade and this may have predisposed the population to be more willing to try new products than they would have been in other areas.

Within the context of this study though, there is evidence that use of products did enhance women's control. They had the advantage of physically possessing the means of protection and there was the possibility, at least for some, of using the products secretly. In addition, the very existence of products that women could use gave them a useful bargaining stake in their negotiations with male partners. A number of women used them when male partners refused to use a male condom. As one woman from the roadside settlement asserted "Personally I tell him. 'If you are not equipped, I have mine'". Used in this manner they greatly strengthen a woman's ability to control her sexual health.

Thus the evidence would suggest that female controlled methods have the potential to give women more control over their sexual health in practice as well as in theory, and if the trend towards greater independence for some African women noted among for the Chagga in Tanzania (Stambach, 1998) becomes more widespread, then the potential of vaginal products to protect women's sexual health will be yet further enhanced. However, in the main female control will be mitigated by the gender imbalanced relationships in which these products will be used. Women's relative lack of power may limit their access to these products and inhibit their secret use of them. Additionally, the fact that use may imply faithlessness and distrust may make women as well as men less willing to use them.

Whilst use of these products will often involve negotiation with partners (at least with long term use with regular partners), some women are able to use them covertly. In either case, vaginal products appear to give women more control, as the use of the product is contingent on her action (inserting the product into her) rather than the action of a male partner (putting a condom onto him). There is every reason to suppose that once a safe and effective vaginal microbicide has been developed, it will play an important women-led role in reducing the transmission of HIV in some countries, thus increasing women's ability to control their sexual and reproductive health.

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