From Practice to Policy: A Critical Study of the Perceptions and Use of the Female Condom by Women in Durban

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Declaration

This work is being submitted in fulfillment of the requirements for the Master's Degree in Social Sciences in Anthropology in the Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal, Howard College, Durban, South Africa.

I declare that this dissertation is my original work. All citations, references and borrowed ideas have been acknowledged.

This dissertation has not been previously submitted for any degree or examination in any other University.

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Student Signature

March 2013

Acknowledgements

This research is dedicated to the women from Chatsworth, Durban Central, Inanda, Lamontville, and Wentworth, who trusted me with this study. Thank you for opening up as you did, and sharing your views and intimate experiences with female condoms. As promised, the study findings will not only contribute to my academic achievements, but they will also be shared with the Provincial Council of AIDS, the District Municipality's Department of Health and the HIV Directorate within the KZN Premier's Office.

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Finally, I would like to acknowledge the contribution of Dr. Rozena Maart. Thank you for being willing to provide support. Yogandra Naidoo, thank you so much.

Yours in the struggle,

Nonhlanhla 'MC' Mkhize
Aluta Continua!

Abstract

The study aims to probe the perceptions and experiences of using female condoms for women living in Durban. The study probes these perceptions and experiences within the embedded socio-cultural and gendered dynamics that influence, not only the perception and understanding of the female condom, but their gendered use as well. The study was premised on the understanding that female condoms or FCs are a 'female initiated' prevention method in preventing unplanned pregnancy, and most importantly in protecting against STIs and HIV/AIDS. The study also assumed that, given the feminized face of the AIDS pandemic, FCs could potentially be an empowering contraceptive tool with which women can exercise control over their own bodies and some control within their sexual relationships; negotiating safer sex, preventing pregnancy and the transmission of STIs like HIV.

Mixed methods were used to collect data, using methodological tools such as a questionnaire, focus groups and in-depth interviews with participants from Chatsworth, Durban Central, Inanda, Lamontville, and Wentworth.

Keywords: women, female condoms, accessibility, gender dynamics

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Acronyms

ABC	Abstain, Be Faithful, Condoms Use (a government strategy)
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention
CADRE	Centre for AIDS, Development, Research and Evaluation
DISA	A Sexual and Reproductive Health Care Clinic
DOH	Department Of Health
FC (s)	Female Condom(s)
FC1/FC2	Female Condom Generation 1/ Female Condom Generation 2
FDA	Food and Drug Administration
FHI 360°	Family Health International
HIV	Human Immunodeficiency Virus
HSRC	Human Science Research Council
KZN	Kwa-Zulu Natal
LGBT	Lesbian, Gay, Bisexual or Transgender
MC(s)	Male Condom(s)
NGO	Non Governmental Organisation
NSP	National Strategic Plan (a policy framework)
PATH	Programme for Appropriate Technology in Health
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PSP	Provincial Strategic Plan
PSI	Populations Services International
RSA	Republic of South Africa

RHRU	Reproductive Health Research Unit
SANAC	South African National AIDS Council
SRPS	Sexual Relationship Power Scale
StatsSA	Statistics South Africa
STI	Sexually Transmitted Infections
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNFPA	United Nations Population Fund
USA	United States of America
USAID	US Agency for International Development
WHO	World Health Organisation

Chapter ONE: Introduction

Background and significance of the study

South Africa has what is considered to be a progressive constitutional and legislative framework regarding gender and human rights, equality, freedom, and reproductive health care. Nationally, population figures indicate that males are a minority compared to females, with females comprising 53-55% of the total population (Statistics SA, 2011). More recently we learn that the male/female population ratio in the Province of KwaZulu-Natal (KZN) is 1:1.07 (StatsSA, 2011). The disparity in population figures is, in itself, not a problem and even if it were, the legal framework in the country does not recognize it as such. However, these figures when considered from a gender equality perspective are disconcerting, especially considering that there is enough research that suggests that men have more social, political and economic power than women (Dunkle et al., 2004; Mantell et al., 2009).

These figures are also problematic considering that research has shown that women are more vulnerable to various sexually transmitted infections (STIs) including the Human Immunodeficiency Virus (HIV) (Mantell et al., 2001). Women's vulnerability is largely a result of the historical gender inequality within South African societies, e.g. the religio-cultural roles of nurturer and caretaker that have been prescribed to women in the domestic sphere and unequal power dynamics concerning sexual activity in intimate relationships. Gender inequality places women at a subordinate level to men (Lorber, 2010), who are also 'culturally' regarded as heads of household, with power over women (Gollub, 2000: 1378; Bowleg et al., 2007). Thus women's heightened sexual vulnerability to infection in South Africa is amplified through her social and 'cultural' positioning. It is this gendered vulnerability, in terms of women's sexuality and body that is of direct concern to this study, as it is believed that a significant percentage of couples around the world (both north and south, although again perhaps more so in the global south), need effective protection against STIs including HIV, despite prevention and treatment efforts improving the world over. However these do not appear to be keeping up with the actual spread of STIs, HIV

and the acquired immune deficiency syndrome (AIDS), especially amongst women and young girls. This dissertation will address this issue in the context of Durban, South Africa.

Since the world became aware of the AIDS epidemic, it can be argued that male condoms (MCs) have been perceived to be the single most efficient and easily accessible 'prevention method' in reducing the transmission of STIs (including HIV). In South Africa, condom use is one of the three elements of the ABC Strategy which was introduced by the Department of Health (DOH) in the year 2000 during the 13th International AIDS Conference. The ABC Strategy is about Abstinence, Be(ing) Faithful and Condom Use (Condomize as it is commonly known), and the majority of Government Family Planning Clinics and Life Orientation Programmes at public schools continue to promote this strategy.

Thus for a significant period of time 'condoms' have been regarded as an effective barrier or prevention method against STIs and unintended pregnancy. However, more recently a number of international studies have indicated that female condoms or FCs are one of the ways to 'put the power of prevention in women's hands' (see Shai et al., 2010), effectively promoting and initiating control for women over their sexual behaviour. Judith Lorber (2010) contends that gender inequality is something that manifests in a variety of ways. She argues that gender inequality depends on the economic structure and social organization of a particular society. She claims that when we speak of gender inequality;

> "It is usually women who are disadvantaged relative to similarly situated men. In many countries, men get priority over women in the distribution of health care services. Contraceptive use has risen in industrial countries, but in developing countries, complications in childbirth are still a leading cause of death for young women. AIDS takes an even more terrible toll on women than men globally, since women's risk of becoming infected with HIV during unprotected sex is two to four times higher than in men. Many women with HIV/AIDS have been infected through early sexual exploitation or by husbands who have multiple sexual partners but who refuse to use condoms. Sexual exploitation and violence against women are part of gender inequality

in many other ways." (Lorber, 2010:4-5).

Being mindful of these complexities and the ongoing gendered imbalance of power makes us aware that the negotiation of safe sex, in a bid to prevent contracting STIs and HIV/AIDS, is far from straightforward or simple for many women, especially for particular groups embedded within various patriarchal traditional cultures, from lower socio-economic sectors, and from so called unskilled and relatively lower educational backgrounds. Here too is a point of insertion, for the study assumes the FCs has much to offer women in these groups.

In South Africa, male condoms are, as per The National Strategic Plan (NSP) and the United Nations Joint Programme on AIDS (UNAIDS) regarded as 'key' to preventing the spread of HIV and AIDS.[1] However, FCs on which this study focuses, are arguably also an effective STI and pregnancy prevention method that is available to women, as well as enabling couples to reduce risks to which they may be vulnerable as a result of their sexual activities. Research has also shown that FCs are comparable to MCs in their effectiveness in preventing unintended pregnancy and STIs. The work by Choi et al., (2004) and Beksinska et al., (2012[2]) argue that better access to FCs may additionally increase the number of couples engaging in safe(r) sex.

However, notwithstanding such research, in South Africa the Department of Health (DOH) reveals that on average, it distributes about 3.5million FCs as compared to over 400 million MCs on an annual basis.[3] This gross numeric inequality in the procurement and distribution of condoms is highly problematic and could even be argued to be unconstitutional. This potholed and uneven distribution is symptomatic, it is believed, of the many social inequalities that are experienced by women (see Varga, 1997; Mantell et al., 2001; Dunkle et al., 2004; Chimbindi et al., 2010).

[1] http://www.genderjustice.org.za on South African National Strategic Plan, Female Condom- Needs To Play A Bigger Role. Issue 68, Article 7

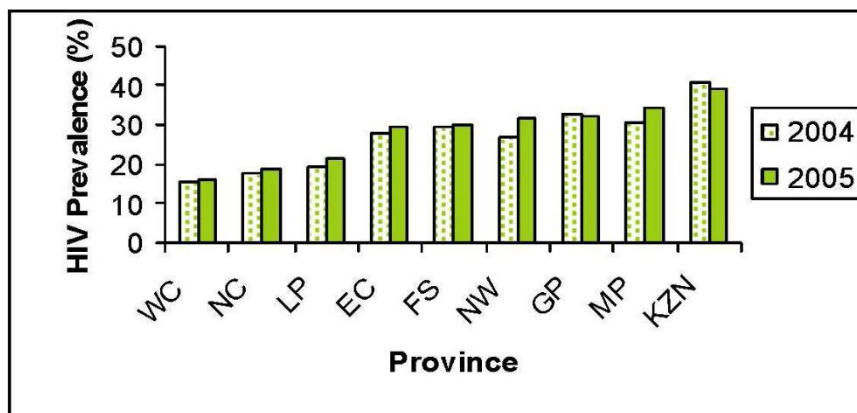
[2] Progress and challenges to male and female condom use in South Africa. Sex Health, March 2012

[3] http://www.healthlink.org.za/uploads/files/dhb0809_33.pdf

Women's Vulnerability in the Context of HIV/AIDS

Figure 1 (below) presents statistics of HIV prevalence, by province, among women attending antenatal clinics in South Africa, which indicate that between 2004 and 2005, HIV prevalence in KZN was shockingly high when compared to other provinces. According to the DOH, between 2005 and 2007, KZN accounted for approximately 21% of the country's population making it the most populous province in the country (KZN PSP, 2007-2011; NSP 2007-2011). The consistently higher than the national HIV prevalence rates reported in KZN are a cause of concern, and they have now remained the same over a long period of time. We are now in the year 2012 and this consistent prevalence has not changed since 2004.

FIGURE 1: HIV Prevalence by Province among antenatal clinic attendees in South Africa, 2004-2005 taken from the HIV & AIDS & STI Strategic Plan for South Africa 2007-2011, (November 2006, Draft8, Page 21)



KEY: KZN = KwaZulu-Natal Province; MP = Mpumalanga Province; FS = Free State Province; GP = Gauteng Province; NW = North West Province; NP = Northern Province; EC = Eastern Cape Province; NC = Northern Cape Province; WC = Western Cape Province

To elaborate further on the intensity of the problem, and what has informed this study, research by the Human Sciences Research Council (HSRC) in 2005 indicated that women were still the group most vulnerable to HIV infection. The HSRC further reported that women accounted "for 55% of people living with HIV and AIDS in South Africa (alone)" (2005: 22). The HSRC study reported that the "difference was

more pronounced in the age groups 20-24 years and 25-29 where it found HIV prevalence rates to be about 23.9% for women compared to about 6.0% for men and 33.3% for women as compared to 12.1% for men, respectively" (HSRC, 2005; National Strategic Plan 2007-2011, Draft 8, Page 22). This prevalence rate has remained unchanged, between the 2002, 2005 and the 2008 surveys by the HSRC.

The peak age for HIV infection for women was the 25-29 age group, while for men it was the 30-35 age groups (National Strategic Plan 2012-2016). More women, five to ten years younger than men, were infected which suggest that more appropriate interventions are required. It is also true that there were number of factors including, although not limited to, commercial sex work, inter-generational sex, transitional sex, and rape that might have contributed to this high prevalence rate among women.[4] In June 2009 at the launch of the 2008 Report on the South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, Dr Olive Shisana of the HSRC discussed challenges regarding the HIV prevalence in the country, pertinent to this study. Their survey found that between 2002 and 2008 the HIV prevalence levels among adults within the age group 15-49 in KZN increased by 10.1%. This survey also found that, at a national level, HIV prevention knowledge among the age groups 15-49 years had declined by 19.2% (i.e. from 64.4% in 2005 to 44.8% in 2008). The province mostly affected was KZN.[5]

In 2006, KZN HIV prevalence among pregnant women attending public health clinics alone had reached a staggering 39.1% compared to 29.1% nationally. This means that the HIV prevalence for KZN, 2003-2006, averaged at around 38.5%, while the national prevalence averaged at about 29%. While the 25-34 age group had the highest prevalence of STIs women had a much higher prevalence of STIs as compared to men ages 15-34 (taken from the HIV & AIDS & STI Strategic Plan for South Africa 2007-2011, (November 2006, Draft 8 :21).

KZN continues to be a province that is highly affected by diseases associated with

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[4] It is not within the scope of this study to probe the reasons behind this higher prevalence rate. However, the reality of the matter is a direct concern and therefore impacts on what the study is probing.

[5] Power Point Presentation: South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008, 9 June 2009, Cape Town.

underdevelopment and poverty in the country, particularly STIs, HIV and AIDS, where women and girl children remain most vulnerable to these infections. A number of other recent studies by the HSRC on HIV prevalence in South Africa have also indicated that HIV prevalence remains at about 15.8% which translates to 11.9% higher than the prevalence in the Western Cape (the province with lowest prevalence at 3.9%). Prevalence among pregnant women has been consistently higher than the national average over the years.[6] Extensive statistics regarding the context of women's vulnerability within the HIV/AIDs pandemic have been presented in this study, as this is of course such a pressing issue. The pandemic itself has been seen to have a feminized face (see Lorber 2010). Thus FCs can, arguably, potentially offer an empowering tool for the women.

Female Condoms in South Africa

There are currently five kinds of FCs now available in South Africa. There is the Female Condom generation 1 (FC1) and Female Condom generation 2 (FC2) both manufactured by the US Female Health Company (London, Malaysia and India respectively). There is the *VA w.o.w. FC* (V'Amour, L'amour) manufactured by Meditech Products Ltd (India); there is the *Woman's Condom* (WC, O'Lavie) manufactured by Shanghai Dahua Medical Apparatus Company (China); the *Phoenurse® FC* which is manufactured by Tianjin Condombao Medical Polyuthena Tech. Co. Ltd. (China), and the *Cupid™ Condom* manufactured by Cupid (India)[7].

This study focuses on the FC1 and FC2, as it is the only FC that is readily and freely available, distributed locally and nationally as part of the South African Government's Prevention Strategy. It is also important to note that all these FCs recently introduced to the South African market are not developed or manufactured locally, and would therefore have not been tested in our local context. In 1993, the United States Food and Drug Administration (FDA) approved the Reality Female Condom (FC1) based on an assumption that the *polyurethane rubber* provided better

[6] Office of the Premier (2012)- *Multi-Sectoral Provincial Strategic Plan for HIV and AIDS, STI and TB 2012-2016 for KwaZulu-Natal.*

[7] Please see APPENDIX A for some visuals and more information on these examples.

protection against STIs for women, than the more conventional MC. In 1997, the FC1 was introduced in South Africa and initially piloted in 32 sites across the country. Support Worldwide (an organisation contracted to assist the DOH to educate women across the country about FCs) reported that, FC1 distribution and education had by the end of 2010 increased to about 249 pilot sites across the country (located in both urban and rural areas) and about 31.6 million FC1 had been distributed.[8] While the efforts were not considered to be good enough, the news was welcomed as a positive step in the right direction by a number of organisations advancing women's rights and promoting the use of FCs like the Thohoyandou Victim Empowerment Programme (T.V.E.P.) and the Gender AIDS Forum (G.A.F.).

In 2004 the DOH began assessing FC distribution nationally and while that process was underway, the Global Campaign For Microbicides reported that in 2005, only 13.9 million FCs, compared to 9 billion male condoms or MCs had been distributed worldwide (2009). In response to this inequity in the manufacture and distribution of FCs against MCs, the United Nations Population Fund (UNFPA) launched the Global Female Condom Initiative to scale up FC programming, including distribution and education in at least 23 countries. In 2007, the UNFPA recorded an increase to 25.9 million FCs that were available worldwide compared to about 11 billion MCs that had been distributed. FCs now comprise about 0.2% of the world's condom supply.[9] Based on these statistics, the DOH revised its goals in the National Strategic Plan (NSP) 2000-2005 and planned to increase the distribution of both MCs and FCs through its NSP 2007-2011. [10]

A study by the Reproductive Health Research Unit (RHRU), at the University of the Witwatersrand, Johannesburg (see Edmunds 2004), demonstrated how popular the FC had become. According to the report "most users (88 percent) reported that readily available female condoms meant that they were using more protection," Mr Mmbatho Mqhayi, a researcher at the RHRU, was quoted (in the report) saying.

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[8] http://www.supportworldwide.org/country-programs/africa/south-africa

[9] Expanding Access to Female Condoms in Africa, A Fact Sheet (http://www.global-campaign.org/clientfiles/FS-EastAfricaFemaleCondom-action[E].pdf)

[10] NSP 2007-2011, Priority Area 1: Prevention; Goal 1: Promote Safe and Healthy Sexual Behaviour, Objective: Improve access to and use of male and female condoms, especially among 15-25 year olds.

“This means that FC user’s perception of FC also relied on how accessible they were (i.e. the more available and accessible they were the more people were likely to use them)”. He went further to add that, “Others said that the female condom’s structure seemed more reliable and safer. Also since it had to be inserted in advance, it allows the woman to take responsibility for her own protection. Since she inserts it herself, she knows she’s safe" (Edmunds, 2012). The last bit speaks to the perception that with frequent use, women became more confident about themselves and with the product.

Katy Pepper, the Africa Programmes Director for the Female Health Foundation (a non-governmental organisation (NGO) which aims at improving women’s protection from STI’s such as HIV and AIDS) was quoted in the report saying that, "women are desperate for FCs. I know they are. I hear it all the time in places like Crossroads, Khayelitsha, Langa, and Kwazulu-Natal; it’s the same thing, the 14-nation Southern African Development Community (SADC) countries included”. She argued that “the women in all these were saying let us give FCs a chance," that FCs as a product needed to be invested in and procured in the fight against STIs and HIV.

Prioritising Female Condoms

The DOH developed and implemented the NSP 2007-2011 and has begun implementing the NSP 2012-2016. Thus relatively recently, a paradigm and policy shift saw both national health strategies (and policy frameworks) prioritise FCs as a contraception and female initiated prevention method for access by women.

Thus since 2007 the DOH has continued to commit and budget towards increased access to FCs. However, this commitment has been put forward *without* providing much evidence as to how much women across rural and urban areas of the country know about FCs and if they are in fact using them correctly. Furthermore, there has been little, if any, consultation with South African women in any part of this strategic thinking/planning process. There has not been much evidence as to what extent FCs have been effective against STIs and unintended pregnancy. There has also not been much evidence as to whether policy around FCs, from procurement, distribution,

accessibility, strategic marketing and monitoring has positively benefited women as the target audience. This is where this study is positioned in terms of probing these issues from the women themselves and attempting to gain insights into women's lived experiences in the context of their FC use.

Research Focus and key questions

This study explores the perceptions and experiences of using female condoms among women living in Durban. The following key questions informed the conceptual framing of this study.

- **How well do women know female condoms?**
- **How do women feel about the female condoms?**
- **What are women using Female Condoms for?**
- **Are Female Condoms making it easier for women to negotiate safer sex with a sexual partner?**

Objectives of the Study

In studies of HIV/AIDS and STIs, the focus has shifted from investigating issues pertaining to the treatment and coping mechanisms of infected persons to matters concerning prevention, For a number of years prevention was male orientated by means of male condoms. Women were not fully empowered and able to protect themselves from contracting the HIV Virus when male condoms were used, as in many contexts women had to rely on the male to provide and use a condom designed for the male body! Even if women were empowered to carry condoms, ultimately they are what the man chooses to use or not on his body. The introduction of female condoms in 1997 is the first preventive mechanism aimed at women that can be used by women on their bodies. It is a female oriented prevention method, with the potential to empower women to take some measure of control over their bodies in the context of sexual behaviour and the HIV pandemic. It is for this reason that this study

investigated how well South African women, specifically Durban women choosing to use FCs, know how to use them; their knowledge and perceptions thereof, and whether they have been empowered to negotiate safer sex through using FCs.
The broader issues which this study investigated were:

1) The use of female condoms as an effective and empowering tool for women
2) Accessibility of female condoms should they emerge as an empowering tool for the women using them.

Location of the Study

The study was conducted among women in Durban, KwaZulu-Natal. It comprised women from the city (Durban Central) and from surrounding townships, specifically Inanda Township, Chatsworth, Lamontville and Wentworth (See Appendix B for a detailed synopsis of each area). The target venues were those where there may have been a FC pilot site, or the presence of a family planning clinic(s), a district municipal clinic(s) or hospital, and a local government clinic and/or hospital. The study was also conducted at and/or with women from organisations that cater for women's sexual and reproductive health care needs that had programmes educating women about FCs and distributed FCs[11].

[11] See APPENDIX C for more information on organisations where you could find FCs or be engaged on FC Awareness Programmes.

Brief Chapter Listing

- Chapter 1: Introduction
- Chapter 2: Literature review
- Chapter 3: Methodology and Theoretical Framework
- Chapter 4: Women's Perceptions and Knowledge of Female Condoms
- Chapter 5: The Many Uses and Meanings of Female Condoms
- Chapter 6: Female Condoms and Safer Sex Negotiations
- Chapter 7: Conclusions and Recommendations

Chapter TWO: Literature Review

This chapter discusses some of the literature on FCs which is available to the reader. Due to the lack of a vast number of qualitative social science based studies, as opposed to largely clinical based studies of which there are many, even in the South African context, that investigate the perceptions and challenges of women in relation to FCs in South Africa, this chapter also engages with studies that were conducted in other parts of the world. The study does, however, acknowledge that the perceptions and challenges of women in Durban may not necessarily be the same as that of other countries and cities. However, because internationally women are considered as a vulnerable group, such studies have been used as a general framework in understanding the South African context.

Female Condoms

Sixteen years after the introduction of FCs in South Africa, it is believed that women still lack substantial knowledge and understanding of this prophylactic tool. The women that have heard of or seen these condoms (see Naidu and Nzuza, 2013 forthcoming) are still not fully appreciative of them, and as this particular study argues, they are not making full use of them.

FCs can be seen as an empowering tool as they enable women to protect themselves against HIV, STIs and unwanted pregnancy. The limited literature on FCs thus serves as a valuable platform and critical rationale for this study. Through these relatively few studies, however, one is able to contextualize and begin to understand some of the challenges faced by women relating to FCs, among them accessibility to FCs seems to be a primary one. In their study amongst the sex workers in Central America Mack *et al.* (2010) found that accessibility of FCs was cited as one of the main challenges of the usage of FCs and for the continuation of female condom use. This makes sense on a very simple level; if one is unable to get hold of something as important as a contraceptive device if and when it is needed, it cannot be seen as empowering a woman or enhancing her freedom of choice.

Schoeneberger *et al.* (1999: 120) state that one solution to gender role induced power imbalance in heterosexual relationships could be the transfer of contraceptive control to women, as in FCs. This statement suggests that through FCs women can have some control when it comes to their sexual lives and their bodies in the context of infection and HIV/AIDS. The availability and distribution of FCs is said to be the major factor that can either promote or hinder this solution to induced power balance. [12]

South Africa as a country is still deeply rooted in patriarchal ideologies (see Coetzee 2001). South African women are still subordinate to men in many aspects of their lives as manifested within political, educational, social and sexual contexts (see Holland et al., 1990; Juhasz, 1990; Hollis, 1992, Deniaud, 1997, Aggleton, et al, 1999; Sippel and the Centre for Health and Gender Equality, 2007). This inequality which one can speak of as gendered inequality is also most potently and patently seen in terms of women's sexuality. Sexual inequalities among women and men have made women highly vulnerable to STIs and HIV infections, and unplanned pregnancies. It is believed that the wider introduction of FCs as female oriented strategy can contribute to redressing some of these inequalities.

Perceptions on the FC as a 'female initiated' prevention method

Since 1997, as part of the Government's (DOH) national strategy in response to HIV, South Africa has introduced and begun distributing FCs as a 'female initiated or controlled' prevention method (Department of Health 2000; Avert, 2011). However, there is not much evidence to suggest that ordinary women's voices and perceptions of FCs, whether based on knowledge of or experience with FCs, are being integrated when developing policy frameworks and strategies or recommendations for further product re-design. There is not much evidence on the extent to which women's perceptions of the FC have influenced their use or lack thereof; or effectiveness as a 'female initiated or controlled' prevention method to prevent pregnancy or to use against STIs and HIV transmission.

[12] The matter of accessibility has, to a lesser extent, been confronted in South Africa. Since 1997 FCs have been distributed, in very small quantities however, as the data collected in this study reveals, this distribution has not yet reached the majority of the general public. It has also not, to date, reached the initial target that was set out by the DOH. The general public's inability to access FCs brings about the question of whether women are being empowered to negotiate safer sex.

It is understood and acknowledged that the goals and objectives of the DOH national strategy are not the goals and objectives of this study. However, it bears noting that this forms the critical backdrop and part of the rationale of the study. It is maintained that there is a lack of critical information about women's knowledge, perceptions and experiences with FCs. This is of great concern to this study as it is almost two decades since women's lack of power to successfully control many aspects of their sexual relations was argued to be among the gender-related inequalities affecting them (Vandale-Toney and Conde-Gonzalez, 1995; Kaler, 2001; Kaler, 2004). This is even more concerning for a province like KZN and a city like Durban, which are hardest hit by the HIV epidemic, and even more so where women are one of the most at risk populations (Beksinska et al., 2001; van Loggerenberg et al., 2008; The SA DOH, 2010; KZN PDOH, 2012). The lack of qualitative work directly related to FCs) makes it difficult to cite research in the South African context, with which this study can adequately engage and we are confronted with many gaps in the literature on FC use, experience and perceptions.

However, there are broader pieces of scholarship which point out that condoms act as a shield against STDs and pregnancy. For women, particularly those who were part of this study, the main role of an FC is to prevent pregnancy and this is noted by some of the later research in this area (see Path, 2006). This is similar to the much earlier understanding of FCs providing women with an option of a prevention method over which they had total control (Gollub, 1993).

In Aggleton *et al* (1999) we learn that some women like FCs because they are 'effective for STI and pregnancy prevention, are somewhat easy to use and an alternative to using MCs'. However, much more in-depth and critical research, of which this study is a part, needs to be done regarding how informed women are of these alternatives, especially considering that the Aggleton *et al.* study was done in 1999!

(Finally!) Some Scholarship on FCs as an Empowering Tool for Women

Very recent scholarship (see Joanisa *et al.,* 2010) reveal that FCs were introduced as a

progressive and empowering prevention method that women could use to exercise control over sexual matters, control over their own bodies when it comes to choosing what to use, and some control within their sexual relationships – negotiating safer sex, preventing pregnancy and the transmission of STIs like HIV. This study revealed that providing women, especially in developing countries, with FCs to prevent pregnancy, HIV and STIs remains a high priority for a number of donor agencies (Joanisa *et al.,* 2010). At the time of this study, FCs were being piloted in over 249 sites across South Africa with about 13,6 million of them distributed by the end of the year 2010 (Support Worldwide, Online Blog).

A decade earlier, in 2000, Mqoqi *et al.*'s study investigated the progress in FC provision piloted through family planning clinics in South Africa; as did the study of Mqhayi *et al.* (2003). With a sample size of about 9,406 initial acceptors at clinics, 1,725 re-supply visits, and 1,381 initial acceptors at PPASA sites, with 300 resupply visits, they found that:

- "3 in 4 condom acceptors were also using either injectables or oral contraceptives, indicating a desire for dual protection from pregnancy and STIs;"
- "Most acceptors said they used it to protect themselves from STIs;"
- "About half of the female acceptors reported current male condom use;" and
- "About six of every 10 acceptors were ages 20 to 29." (Mqhayi *et al.,* 2003)

As part of their research Mqoyi *et al.* (2000) and the later Mqhayi *et al*. (2003) study also conducted interviews with about 18 service providers in four target provinces. While this was not the focus of this study, the findings are however, of some meaningful relevance. According to Mqoyi *et al.* (2000:1) and Mqhayi *et al*. (2003), the service providers argued that they had all found FCs a necessary addition to the prevention program, "serving as an additional choice for women who have trouble using male condoms or other family planning methods" (ibid). They went further to argue that most service providers saw FC promotion as an integral part of their job as opposed to an added burden. Half of the providers believed that FCs were more effective than MCs in preventing pregnancy and STIs because they are made of a stronger material and cover the woman's vagina giving her extra protection. The service providers reported FCs to be a safer and more reliable commodity than MCs if we consider the response (Mqhayi *et al.,* 2003).

A host of scholars point out that FCs served to complement - rather than to replace - MCs. (see Mqoqi *et al*., 2000; Mqhayi *et al*., 2003 and Warren and Philpott, 2003). Looking at how women perceived FCs in the research by Mqoyi *et al.* (2000) and Mqhayi *et al*. (2003) we are alerted to the fact that there were service providers who "reported that some women initially had a negative reaction to what FCs looked like, while others needed help in talking to their partners about using the protection to begin with."[13]

With an aim *'to assess the acceptability of the female condom among different groups of women and their partners in South Africa,'* Beksinska et al. (2001) conducted a descriptive and cross-sectional study among five sites. Here 678 women were recruited to participate in *'an acceptability trial of the female condom'*. It seems acceptability and successful use of female condoms varied. There were factors affecting successful use and willingness and intention to use female condoms again (Beksinska et al., 2001). They found 209 women had used female condoms at least once. Discontinuation rates on the other hand were high, due to partner reluctance to try them. Women with previous experience with male condoms or who had received intensive training generally found negotiating female condom use for safer sex to be much easier. The study by Beksinska et al. (2001) further highlighted the fact that 'overcoming partner opposition' was one critical step to address when introducing the use of female condoms for safer sex.

An investigation into '*gender-based violence, power relations within relationships, and the risk of HIV infection among women attending antenatal clinics in South*

[13] By way of comparison, health officials at the Toronto Public Health Department, reported that FCs were commonly accessed by women whose male sexual partner(s) could not use male condoms because they were allergic to or were sensitive to latex, and those who refused to use male condoms. A number of women who accessed their services have also reported to be using FCs so as to be able to engage in sex during a menstrual cycle. The Assistant Commissioner at the Health Department's Bureau of HIV/AIDS Prevention and Control, Dr. Monica Sweeney, in reflecting on reports in the US on how female condoms were being received said *"This is a boost for HIV and STI prevention efforts in New York City,"* and that *"It is important to find cost-effective ways to ensure access to safe and effective HIV prevention. The new FDA-approved female condom will expand access to woman-initiated HIV and STI prevention, and it will help us make continued progress in reducing New York City's HIV infection rate".* Female Health Company Newsletter Nov 16, 2010"

Africa' was conducted by Dunkle et al. (2004). Theirs was also a cross-sectional study with 1366 women who presented for antenatal care at four health centres in Soweto, and accepted routine antenatal HIV testing. Based on their engagement with the women, these authors acknowledged and concluded that *'gender-based violence and gender inequality were increasingly important determinants of women's HIV risk; and that empirical research on possible connections was limited* (Dunkle et al., 2004).

The 2004 research by Choi *et al* (2004), '*Introducing and negotiating the use of female condoms in sexual relationships: qualitative interviews with women attending a family planning clinic'* reported that safer sex skills training often taught women how to be assertive when negotiating condom use. It argued that these were crucial skills that women needed to access and acquire and recommended that this learning took place at family planning clinics and other institutions. However, Choi et al (2004) also warned against and suggested that training on how to be assertive may be inappropriate for women who lack power in their sexual relationship, especially relationships that were physically abusive and where the partner was physically stronger and bigger. Their qualitative study among 62 women, explored various communication styles that the women used to introduce and negotiate FC use in their sexual relationships.

Studies by Warren and Philpott (2003) on the introduction of female condoms into national programs indicated that in Zimbabwe, for example, women used discussions on pregnancy and disease prevention with their sexual partners as a means of introducing female condom use with their partners. This made negotiating FC use less taxing on them. By way of comparison, in Ghana, a partnership between government, the United Nations and local grassroots organizations developed a comprehensive female condom awareness program which targeted young women. This ensured a strong community focus and the development of an extensive network of women peer educators who gave clear messages to other women on female initiated prevention materials (see Warren and Philpott, 2003)[14].

[14] Prior to making female condoms available, the project partners trained more than 3,000 medical and non-medical service providers on female condoms, their dual protection from unplanned pregnancy and STIs, but also on how to negotiate and communicate the need to use female condoms (Warren and Philpott, 2003). In Ghana, female condoms are available at public clinics, NGOs, pharmacies and adult

In surveying the landscape of scholarship on FCs, we see that it is relatively uneven. The early studies, such as Gollub (1993), have not been consistently followed up, and this is problematic because we cannot look at the literature and retrospectively construct the developments in full in the field regarding female condoms. Studies such as the one by Path (2006) followed many years later, with many clinical studies on condom use and STIS and condom non-use and HIV/AIDS happening in between. It is only much more recently that there have been a host of more qualitative studies such as the ones cited above. However, there is still a need for many more qualitative studies that explore the multidimensional issues around gender/women inequalities and female condom use and non use. Just as importantly, there need to be more studies that are ethnographic, which emphasise representing the women and their stories, studies which afford a greater voice to the women. It is this gap that this study attempts to address, by adding and contributing to the intellectual conversation around women's perceptions and experiences with using female condoms.

While the mortality statistics in the wake of the HIV/AIDS epidemic rationalizes the large number of clinical scholarly works, it does not justify the lack of adequate and sustained qualitative social science research on the social aspects of FCs and FC nonuse. Such a lack of scholarship ignores the fact that sexually transmitted diseases and HIV/AIDS has a socio-cultural face and context that also needs to be studied. It is such a 'lack' and 'gap' that this study has attempted to address, as they are important to consider in the context of the FC as a 'female initiated' prevention method effective in preventing unplanned pregnancy, and most importantly in protecting against STIs and HIV/AIDS.

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shops – everywhere where male condoms could also be found.

Chapter THREE: Research Methodology and Theoretical Framework

Introduction

This chapter focuses on *where* the researcher is *situated* and the research methods used to gather data, the research setting and data collection. It will also discuss some of the socio-demographics of the participants, the research procedure and interview process and also comment on the research ethics used.

Researcher Situatedness

As indicated in Chapter 1, the aim of this study is to critically probe the perceptions of and experience with FCs among women from Durban and the surrounding townships. From where I am situated as a woman, and a human rights and AIDS activist, the urgency to conduct this research was also informed by a perceived lack of interest in paying attention to women's issues and needs that had been experienced from Provincial health departments and services, but also by civil society organisations. It was hoped that when a rights activist approach combined with an academic social science research approach to critically study women's perceptions, the resultant research findings could be integrated into provincial policy and implementation guidelines on FCs. From a 'training perspective', it is hoped that the findings would contribute immensely towards increasing the knowledge base, integrating materials development and training materials on FCs, and illuminating the perspective of ordinary women.

There is also a general concern as to whether South Africa will be able to continue to prioritize the procurement of FCs against economic changes, and women's perceptions of them in South Africa. All of this, while not part of the study itself, provides a background as to the personal interest and motivation of the researcher.

Explanation /Outline of Research Methods

This study used a mixed-methods approach and combined both qualitative and

quantitative research methods. Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry (see Creswell, 2011). It involves philosophical assumptions that guide the direction of collecting, analyzing, and mixing qualitative and quantitative approaches in many phases in the research process (ibid). The study used the random Survey Questionnaires[15]. Please See Appendix E for the template. This template was available in both English and *isi*Zulu. It was implemented in the five target study locations within Durban and surrounding townships. A list of these and more details on them is available in Appendix B.

Focus Group Discussions were used to access more qualitative data from the women participating in this study. Focus groups are useful when the researcher wishes to provoke data on the cultural norms of a particular group of people as they generate overviews of how the different group members view the topics covered in a particular study (see Creswell, 2011 and Kamberelis and Dimitriadis, 2013). To record the information that was shared during focus group discussions, a tape recorder and field notebook were used. Invitations were devised and sent out, through the persons 'in-charge' at specific public health venues. Inclusion and exclusion criteria were used to control participation in this study and was also done so that the study would attract the participation of women who knew about FCs and had used them at some point in their lifetimes. These groups were located in a manner that had only one group per area of the five target study locations[16].

Another qualitative method deployed for the purposes of this study were In-depth Interviews, which allowed for the collection of 'thick' in-depth descriptions to provide a rich analysis of any chosen social phenomenon. This methodology contains rich description and focuses on subjective meanings (see Hancock, 1998 and Sarantakos, 2005 and Babbie *et al*. 2006). Even though such interviews were lengthy in terms of time, they produced valuable data that would have not been gathered, should this study have relied only on questionnaires. Appendix G is a template of the In-Depth Interview schedule. To protect the rights of the participants, the 'informed consent' gave the participant the power to terminate the interview whenever they felt it was not what they had signed up for (See Appendix D for the relevant template).

[15] Please See Appendix E for the template.
[16] Please see Appendix F for a template of the Focus Group Discussion Questionnaire.

The only disadvantage experienced with completion of the survey was that because it was anonymous and confidential, the questionnaires had to be placed in spaces within specific sites where they would be easily accessible but at the same time where it was easy to oversee movement and 'who does what' to the drop-box where complete questionnaires could be easily and anonymously dropped. This meant it was not going to be possible to monitor that only women FC users accessed and completed the questionnaires. No members of the research team were present during questionnaire collection. It also meant that there was no way to stop the one male person who collected the form and began to complete it until he realized the nature of the questions; and still deposited it into the drop-box even though it was incomplete,

To the advantage of this study, the data collection tools were developed in consultation with and piloted among staff at the two NGOs who had already been consulted about and received permission from their management to participate in this study with them and their community of women at their premises.

Research Procedure and Interview Processes

As discussed in the section above, the survey questionnaires in both English and *isi*Zulu were distributed among the five target areas within Durban and surrounding townships. These were dropped off, checked weekly and then collected from the designated person at the various distribution venues. A female condom study drop-box had been designed and positioned on site in a private but visible space so that the participants could confidentially and anonymously deposit the completed questionnaires in it. It was kept within a space where it could not be easily tampered with.

Focus group discussions were conducted in neutral and comfortable environments, which averaged 2 hours each due to the depth of the discussion, as well as the need to respect so called 'group process' where each individual might have taken some time to acclimatize with the rest of the group on issues at hand and the level of openness it required. The in-depth interviews were also conducted in neutral and comfortable environments, which took a maximum of one hour. Most of the interviews were

conducted at a venue as per the interviewee's choice.

Sampling and the Socio Demographic Profile of Participants

SAMPLE SIZE

This study employed a random sampling technique to identify participants for the survey questionnaire, which included choosing subjects from a population through unpredictable means (see Sarantakos 2005). This yielded a total of seventy five (75) women whose age group ranged from 18-41 years. From the seventy five (75) questionnaires returned, only sixty seven (67) could be used for the purposes of the study. When it comes to qualitative data collection, a total of fifty (50) women participated in the study's five (5) Focus Group Discussions in the five target areas, with ten (10) women per group. Fifteen (15) women participated in the In-depth Interviews.

SAMPLE DEMOGRAPHICS

RACE[17]

Among the 67 survey respondents, thirty nine (39) women were Black; nine (9) women were White; eleven (11) women were Indian; and eight (8) women were Coloured. Among the 65 women participating in the focus group discussions and in-depth interviews, 33 were Black; 16 Indian; 11 Coloured; and 5 White.

AGE

About 13 of the survey respondents were in the 18-24 years age group; whereas 35 were in the 25-34 years age group; and a mere 19 were 35 years and older. The average age of the survey participants was 25 years compared to 27 in the interviews. When it comes to age the women ranged from 18-50 years. About 16 were in the 18-24 years age group; 35 were 25-34 years; and 14 were 35 years and older.

RESIDENCE

Of the overall number of women (i.e. 132) participating in this study, about 45 lived

[17] For the purposes of this study I have retained the South Africa classification system

in the city, about 10 socialized in the city but lived in suburbs, 64 were from townships and 13 lived in informal settlements. Of these some women owned homes, lived with parents, lived with siblings, stayed with or among friends, or were in temporary housing.

SEXUAL ORIENTATION

The majority of the women were attracted to men, although a small percentage indicated to be attracted to both men and women. However, unless they offered the information, no particular efforts were made to encourage them to identify themselves any further, nor to indicate whether they were intersex, lesbian or transgender as this was not a focus of the study.

EDUCATION

Regarding levels of education, the majority (56) of the women had matriculated; (49 had not completed their high schooling and only 27 had studied at a tertiary institution or were undergraduates at local Colleges and Technical Schools. Not a single woman reported to have had a post-graduate qualification.

Research setting

In-depth interviews were held primarily with women from the five communities (Inanda Township, Chatsworth, Lamontville and Wentworth) at either the women's homes, at institutions where they accessed FCs, health care or family planning services, and in other public service provider facilities. Interviews were also held with women who were (or could have been) employed by the DOH, worked with relevant organisations or institutions; and could have previously worked with or was a member of the People Living With HIV and AIDS (PLWHA), the Lesbian, Gay, Bisexual or Transgender (LGBT) and/or the Human Rights Sectors of the South African National AIDS Council (SANAC) and/or the KZN Provincial Council on AIDS. The focus group discussions were held at various safe spaces as defined by the participants and where agreed upon with the group.[18] The survey questionnaire was completed anonymously

[18] The Safe Spaces included community/church/school hall, the library, at facilities within service providing organisations and in one particular case, we used someone's car garage.

at various venues where access to enter these and/or permission to conduct this study in these locations had been previously obtained.[19]

Gaining Familiarity through Popular Media

Media has become a vital part of contemporary society serving as a powerful platform for the dissemination of information (see Treviño et al, 2000). Strebel and Lindergger (1998) note that the role of FCs in HIV prevention sparked controversy in feminist literature about the concept of choice in women's empowerment around contraception and FCs. This point informed the methodology of the study as well. In a bid to become familiar with issues around FCs, sources (aside from academic literary sources, articles and books) such as magazines and television programmes were read or watched. In South Africa there are a number of TV programmes that speak about or promote condom use within sexual relations and which promote condom use as a responsibility for all who engage in sexual activity. These programmes include Siyayinqoba Beat It, InterSexions, Soul City, 4Play and Sex Tips for Girls. These programmes were watched and revealed many issues dealt with on a popular level, and these are seen as important, albeit a secondary part of the methodological research process. Informal conversations with members of the focus groups suggested that they were also familiar with the content of these TV programmes. Some like 'Siyayinqoba Beat It', were discussed in detail at support group meetings. This study also considered transcripts on the radio programmes by Love Life & Ukhozi FM.

Data collection& Research Ethics

Correspondence and data collection were in English, since this was taken to be the most spoken language in Durban and *isi*Zulu, the second most frequently spoken. Informed consent (See Appendix D) to interview, recording of interview and the right to publish information gathered was obtained from research participants. Where necessary, this was obtained in writing. Where required the informed consent was read to research participants. During focus group discussions, it made sense to refer to

[19] These venues ranged from clinics, hospitals, female condom pilot sites, youth centres, and taxi ranks.

everyone with their given name but in sharing findings this study has refrained from referring to participants by name, but retained their age and location. There were some women participants employed by the DOH, but because they had not cleared their participation with their authorities, their identities are protected as well as the situation of the health care services where they worked.

Research Limitations

The study was limited in terms of the area and particular groups of women. The sample areas were identified according to the availability of organisations/institutions that cater for women's sexual and reproductive health care needs and distribute female barrier methods. These were based in the City, Inanda, Chatsworth, Lamontville and Wentworth. Here, the informants were primarily African, Indian and Coloured with similar socio-economic backgrounds.

This study was geographically concerned with KwaZulu-Natal (KZN) because KZN has the highest prevalence of HIV and AIDS infections among women (*NSP 2007-2011 and NSP 2012-2016*). From a personal point of view, KZN is where the research team for this study is located, where they are employed and where access to communities is possible, and where the research team has reason to believe this study would make a greater contribution or have a greater impact on women in KZN.

The greater part of this study is ethnographic, rather than theoretical and this is intentional. It is believed that positioned as the study is, from both an advocacy as well as an academic stance, the ethnographic content that is narrative driven, is valuable for advocacy and policy that seeks to learn directly from women who are perceived as the main beneficiaries of the study. The narratives suggest that women have knowledge of FCs and that they can describe them, they know what they look and feel like, and have firsthand experience with them. Their experiences and perceptions of FCs as 'a product' are based on subjective knowledge. However, such subjective narratives sharing was important, as it speaks directly to the women's experiences, and to the concerns that inform this study, namely the marginalization

and almost ‘silencing’ of women’s voices on matters that affect them the most; and on ‘products’ that claim to be ‘designed’ for their appreciation and benefit.

Theoretical Framework

Feminist Theory

Feminist approaches to research seek to ‘reduce male bias in research findings and the scholarly production of knowledge’ (see Lewin, 2006:18-22). Baym pointed out some time ago that there is guarantee to that woman will inherit their legitimate rights (Baym, 1999). Please clarify this quotation here. There is much truth that remains relevant in this quotation by Baym all these years later. Using insights of feminist theory, the study attempted to understand women’s sexuality and gendered inequalities in the context of non-use of FCs.

The study also used feminist theory to gain a better understanding of how the gendered category ‘woman’ was linked to the vulnerable/disempowered position(s) in which women found themselves, their perceptions of FCs and how FCs have impacted on women’s lives. In the questionnaire are questions about whether women like FCs or not and, how it feels to use one. These are all structured towards ensuring that women’s experiences are central to the discourse about FCs *being for women, for control and use by women, and that the perceptions that matter are those of women*. FCs are about women, deciding whether they like them enough to use them, to carry them around in their everyday hand bags, to put them on in anticipation of sexual activity, but most of all to be able to control when they want to use them and how they want them used. This is about women taking charge over their bodies and the prevention methods they want to use and /or are comfortable with (see Baym, 1995; Ritzer and Mcgraw, 2007).

The study attempted to use this information to critically analyse constructed meanings and perceptions by women of FCs as a prevention method – designed for a woman to insert in a personal and private space in her body (the vagina) so as to protect her vulnerability from a disease as in STIs and HIV, unplanned pregnancy or even sexual violence. This study therefore seeks to analyse women’s narratives on their

experience with FCs in intimate or sexual relations in order to understand the context of women's marginality in society.

Feminist Anthropology is an approach to anthropology that seeks to reduce male bias in research findings, anthropological hiring practices, and the scholarly production of knowledge (see Lewin, 2006). The study also considered feminist anthropology using for example the work of Moore, a prominent theorist who argued that 'unlike in other approaches, anthropological theory and research had included women in some way since the discipline's birth' (Moore, 1988). Her arguments were true except that women in the research and literature appeared mostly in ethnographies. This meant that they would have contributed to knowledge creation but were not referenced as the producers. In this study women are at the centre of the discourse, the production and construction of knowledge and understanding. This study engaged with women's narratives on their perceptions of and reactions to FC use, and attempts to discern the various ways in which women assert their right to decide or navigate ownership over their bodies.

Moore argues that feminist anthropology is concerned with the different ways in which different cultures constitute gender. What is interesting about her argument is "that what women may experience as oppressive is not universal" (Moore, 1988). This argument has been found relevant by this study and as a result, while the study engages with a sample of women from Durban Central, Inanda, Chatsworth, Lamontville and Wentworth; it acknowledges that they are from diverse racial groups (i.e. African, Indian and Coloured), but also that the impact of what they share is far reaching. The study also recognizes that they may have similar socio-economic backgrounds but that there may also be variations in how their cultures understand and contextualize the role of women within society; and how women are prioritized in the context of disease and prevention method procurement.

Constructionism

All meaningful accounts of the real world are mediated by the social contexts in which such accounts are constructed. Constructionism is based on the premise that categories of knowledge and of "reality" itself are actively created by and are the products of social and symbolic relationships and interactions, all within the given

temporal and spatial boundaries of a cultural context. The study attempted to engage with the idea that knowledge is constructed (Rasking, 2002) and that knowledge construction has a lot to do with the individual's perception of what is 'true',

Using this approach the study attempted to interrogate the data collected and research findings on how women's bodies and female sexuality were 'socially constructed' and as a result how the design of the female condom might have followed a particular (constructed) understanding of women's bodies. Using this theory, the study engaged women on their own understanding of how their own anatomy was designed and could work with FCs. This study focused attention on what could be gained from engaging with women's narratives towards impacting policy rather than engaging, or wrestling with theoretical issues.

Chapter FOUR: Women's Perceptions and Knowledge of Female Condoms

Introduction

This chapter is concerned with whether women's personal experiences with the female condom contribute to their knowledge and perception of it. In particular, the chapter is concerned with women's perceptions of the female condom, based on how the women think it looks, feels, and their experience using it.

The women that participated in the focus group discussions and in-depth interviews all had previous exposure to and experience and use of female condoms. Some had participated in safer sex awareness programs implemented by certain Non-Governmental Organizations (NGOs) within the city and at their own townships, and others had participated at female condom pilot sites, some at local government clinics, and/or family planning facilities. Based on this, at the time of the research they would have had, and might have still been accessing support from these institutions and programs. These women's responses would have been irrespective of whether or not they might have all been using, (or had stopped using FCs. It is important to understand the difference between these groups of women, especially the fact that those who participated in the survey questionnaire would have not all been previously exposed to FCs or FC programs or campaigns. This is considered in this study when reflecting on the women's responses to the questionnaires.

Survey Questionnaire Responses

In the Methodology Chapter it was mentioned that only 67 out of 75 survey responses completed could be used for the purposes of this study.[20] The set of questions whose responses are found below, were from the survey questionnaire. Following that, we shall shift focus to the narratives generated from the focus group discussions and in-depth interviews. Featured in the table below are quantified responses to questions in

[20] The survey questionnaire was designed in such a way that the respondent needed to only tick one answer that best represented or was the closest to what they would have wanted to communicate. There were questions that had not been completed or had double ticks.

the survey questionnaire that relate directly to the concerns of this chapter.

To test perceptions and knowledge on FCs, women were asked the following questions to which they responded:

QUESTION	YES	NO	Not Applicable
• Have you ever used a female condom with a sexual partner before?	*38*	*29*	*0*
• Have you used a female condom with a sexual partner in the past 6 months?	*25*	*42*	*0*
• Do you like female condoms?	*31*	*26*	*10*
• Do you like how the female condom feels inside your vagina?	*26*	*13*	*28*
• Would you recommend or encourage other women to use female condoms?	*30*	*29*	*8*
• Do you carry female condoms in your everyday hand bag?	*19*	*48*	*0*
• Do you have days when you wear a female condom anticipating a sexual encounter?	*9*	*30*	*28*

Data from the survey questionnaires indicate that only 38 of the 67 women questioned had used FCs. Of these, only 25 had used them as recently as 'in the past 6 months'.

The Integration of Focus Group Discussions and In-depth Interviews

Based on findings from the focus group discussions and in-depth interviews, we learn that the reasons for non use of FCs range from an individual woman's perceptions of the FC, their comfort with their own bodies, the acceptability of the use of the prevention method within a sexual relationship, and even the issue of access to the FCs. These also included issues of women who did not know how to use female condoms 'correctly', who did not like the way they look and whose sexual partner was not interested in using the FCs with them.

From the 67 survey questionnaires, a total of 31 women (of the 38 who reported to have used FCs) indicated that they liked female condoms. About 26 of the 38 women FC users participating in the survey liked how the FC feels like inside the vagina. The survey questionnaire was not designed to source more information beyond this. Data from 30 survey questionnaires indicate that women were willing to consider recommending FCs for use by other women. However, only 19 women reported that they carried female condoms in their everyday hand bags. It may seem rather unusual and strange that of the 38 FC users, 30 were willing to recommend them to other women but only 19 stated that they carried them around in their everyday hand bag.

From the survey questionnaire 32 of the FC users reported that they would recommend or encourage other women to use them. This was very interesting considering that only 38 of the women reported to have used FCs with a sexual partner before.

While the survey could have asked more in-depth questions with regards to what specifically, was it about female condoms that these women liked, at the time of developing and testing the tools, this did not happen. This was because the questionnaire was used as an early 'entry point' in the study. Being a qualitative anthropological study, the researcher was cognisant of the fact that it is qualitative data such as interviews and narratives that yield richer data and insights. This chapter therefore largely relied on the data generated from the focus group discussions and in-depth interviews.

Bowleg et al. talk about "sexual scripts" that "do not develop in a vacuum" but are "rather shaped by cultural scenarios, particularly those relevant to culture, gender, socioeconomic class, and ethnicity" (2007:7). The fact that only 9 women (of a possible 38) reported to have worn female condoms in anticipation of a sexual encounter has reference. Bowleg et al. further argued that "traditional gender norms encourage women to perceive sex as appropriate only when it occurs within the context of an emotionally committed relationship" and "to repress their own sexual needs and desires to please their male partners (Holland *et al,* 1990; Hynie *et al.,* 1998 in Bowleg *et al,* 2007, p7). Such an argument illuminates the picture presented by

survey data about the cultural and even religious backgrounds and realities of some of the women who were reached through this research. The women were from isiZulu, Xhosa, Indian, Coloured and White backgrounds. Some of their cultural contexts and socialisation did not necessarily support or promote the notion of women being sexually active, of women anticipating or feeling any desire for sex, let alone thinking about sex.

Within the focus group discussions and some in-depth interviews were women who argued that the religious beliefs or teachings which some of them subscribed to, like Christianity (especially Roman Catholic, Lutheran, and Jehovah's Witnesses), Hinduism and Islamic, had made it to seem 'dirty' and 'inappropriate' for a woman to think about sex, to be excited about it, or to even anticipate it. None of these women quoted biblical texts or referred to specific cultural expectations, myths and stereotypes about women carrying condoms or anticipating sex, but there was consensus among some that this was the norm, their reality and societal expectation. It was however, outside the limits of this study to focus exclusively or in great detail about the religious or cultural conditioning which resulted in the non-use of FCs

Perceptions on Female Condoms: Response from Focus Groups and Interviews

Women participating in focus group discussions were asked what they thought of FCs with the intention of ascertaining how well women knew their FC; and how many of them had taken time to familiarise themselves with information communicated with them about the FC through its packaging. The women were thus invited to 'play' with or study FCs, scrutinize, smell and feel the FC. The women were also invited to think back to their first encounter with FCs. Below are some of their responses:-

"When I first saw it, it looked awkward."
(A 28 year old, Indian, post graduate, attracted to men, from Chatsworth)

"When I first saw it, I thought to myself this was huge. How would it fit down there?
(A 27 year old, White, post graduate, attracted to men, from Durban Central)

"Hhayi cha bandla iqiniso lihle, khona, ngathuka. Ngasaba nokuyithinta nje indlela eyayiyiyo uma isikhishiwe kuloplasiki wayo Kodwa-ke sanikezwa ithuba lokukhuluma ngayo sihlangene kwangconywana" (Translation: Well, no, the truth is I was shocked. I was even scared to touch it the way it was outside its packaging. But we were given an opportunity to talk about it while gathered together and it got better.)
(A23 year old, Black, undergraduate student from Lamontville)

"It is big enough for all sizes? I expect my boyfriend not to refuse using it. He cannot say it is tight."
(A 24 year old mother from Wentworth)

Based on these narratives, and the background of the women discussed above, some of the women's first impressions of FCs were shock at its large size which at most times was compared with that of a male condom (MCs) and even tampons. FCs are much bigger in size compared to MCs. For some women their initial concern was whether it could fit comfortably inside the vagina. This brought attention to the concept of the size women perceived the vagina to be. It seems there were a few who saw a vagina as being too small to be inserting FCs inside it. This brought to the fore the constructed nature of women's anatomy and questioned how much women knew of their own bodies. In contrast it bears noting that men tended to be the ones fascinated about penis sizes being 'too' big and whether MCs would comfortably fit them.[21]

Women responded, "*It was pretty weird to be told that I had to insert one of the two rings inside my vagina."* This was a response shared by a woman from the Durban Central focus group. Further responses and perceptions on this question included the following:-

"Ngazibuza ukuthi unesi emtholampilo wayesanganiswa yini ukuthi acabange ukuthi mina ngizosebenzisa into enkulu kangaka ngaphakathi lapha" (Translation: I asked myself if the nurses at the clinic were mad to think I could ever use something this big inside 'down there' (i.e. the vagina).)

[21] http://rachelrabbitwhite.com/Don't Want no Short Dick Man: Our Cultural Obsession with Penis Size. By Rachel R. White; http://blogs.menshealth.com/sex-professor/

(A 31 year old from Inanda)

"Yangithusa Yangenza ngangazi noma izokwazi yini ukungena embobeni encane kangaka (Translation: It was shocking. It made me wonder if it would fit into such a small hole.)
(A 38 year old from Inanda)

Narratives such as the ones above indicate how women in this context have used their experiences to reach certain conclusions about FCs. They also reveal to what extent the context within which we live and are socialized impacts on understanding of the female body.

In order to interrogate how the design of the FC follows a particular understanding of women's bodies an important question asked during focus-group discussions and in-depth interviews was "*how does it feel to use female condoms?"* to which the responses were;-

"How it feels? …well it felt a little less than rubber, more like some kind of thick plastic, and it did not have a smell like male condoms do after sex. (She took a moment to think for a second and then continued) It feels much thicker and even the way it stretches is not the same as the male condom."
(A 29 year old married woman from Durban Central)

"It is difficult to explain but it feels different and it works great hey. I am able to insert it comfortably way before sex and I never really feel like there is something inside down there. I do not feel like I need to keep adjusting it before sex, or during sex to make sure it is fine or has not broken."
(A 26 year single woman old from Chatsworth)

"It feels great. I just put it on and that's it. However, my boyfriend seems to love it more. He says it is not so tight on his penis like the male condom and that it feels really good. I think he just enjoys the fact that he does not have to put on a condom when I am wearing this one and that, having sex feels for him more like we are doing it without a condom – more natural"

(A 27 year old from Wentworth)

There were certain women who seemed uncomfortable with the question 'how a female condom felt like inside a vagina' and provided very brief responses such as *'it felt different'* or *'great.'* There were also some women who shared that the polyurethane material used to manufacture FCs felt like they were wearing *'some kind of a thick plastic'* inside the vagina. There were women who argued that wearing a FC '*sounded like you had a shopping bag inside your vagina'*, especially in a situation where you inserted it immediately before engaging in sexual intercourse. (see Edmunds 2004) it is for these reasons that some members of the focus group discussions advised other women in the group that they ought to remember to insert FCs some time prior to sexual intercourse so that the warmth of the vagina has the opportunity '*to heat the polyurethane which enabled the FC to stick to the walls of the vagina'. 'This way it would make no noise'* (see Beksinska *et al*., 2001; Edmunds, 2004),

Further revealing responses;

"It takes some getting used to, but its good. You have to insert it into your vagina and still assist it to ensure that it is comfortably nestled inside. That is not anyone's cup of tea my dear."

(A 34 year old, somewhat shy but bluntly spoken mother from Wentworth)

"It was a bit weird at first. I am still not getting the twisting of the inner ring into an 'eight' right; it just slips in between my fingers. But I am getting used to it."

(A 37 year old from Chatsworth who had been using FCs for a few months)

"Kuyinto engajwayeleki ukuyifaka ngokuphelele, uzokhumbula ukuthi kumele usebenzise umunwe ukuyishutheka ngaphakathi." (Translation: "It is weird to insert fully, bearing in mind that you have to use your own fingers to push it further inside.")

(A 38 year old from Inanda who says she had recently stated using FCs)

"I had to get used to using them. They are a bit comfortable now."

(A 41 year old mother of three children from Inanda)

The responses by all four women quoted above did not indicate any discomfort, rather, they emphasized that FCs were a product that required some time and practice in getting used to using them t. One focus group participant from Inanda raised a very interesting concern, about the fact that with FCs, one was required the use a finger (or two) to push it into place inside the vagina.

"I have found that it is easier to slide it in if you take out the removable inner ring."
(A 35 year old from Lamontville)

"Kuba ngathi awufake lutho nje" (Translation: It's as though you don't have anything on.)
(A 21 year old from Lamontville who shared this with a laugh)

"I found female condoms feel way better during intercourse than male condoms. They are close to not wearing anything."
(A 29 year old relatively assertive informant from Durban Central)

"For me, it is somewhat uncomfortable. It's not about putting it in my vagina even though I have a problem with that, but it's the thought of having it inside me way before any sexual activity, and perhaps that I believe condoms use should be part of fore-play, where he helps me put it on or I help him put it on depending on who gets access to their kind of prevention first, or who agrees to use it during that sexual activity."
(A 25 year old from Durban Central)

What was interesting about the above responses and those discussed earlier, was how inclined women were to talk about the overall experience of FC use, size and appearance than 'feelings' about texture and the amount of lubrication found in FCs. But it could be saying something that researchers and scientists may be failing to understand women's perception of something – FCs in this case. The responses also speak to some of the innovative ways with which women have begun exploring the use of FCs, how they feel inside their vaginas, and what makes it easier for them to use the FCs.

The response *"It feels great but my boyfriend seems to love it more. He said it was not so tight and felt good"* was found to be a sentiment shared by at least 20 other women who used FCs. While it is a response that perhaps has more relevance in Chapter 7, which focuses on the use of FCs within intimate relationships, it is also included in this chapter simply because there were a number of women whose perceptions of FCs appeared to be informed or influenced by the reaction of their sexual partners. It was thus quite difficult to ascertain and separate the women's own perceptions from those of their male partners.

This may well due to the 'reality' that many women, whether they are aware of it or not, have been socialized to believe that the aim of sex is to sexually please their male partners (see Holland et al., 1990; and Hynie et al., 1998 in Bowleg et al., 2007). However, there were some women for whom sex was purely about mutual enjoyment and the use of female condoms was primarily about infection prevention.

Another interesting response requiring engagement was *"Kuba ngathi awufake lutho" ("It's as though you don't have anything on")* which was shared by only about 10 other women across focus group discussions. The FC2 is made out of nitrile, and is supposed to be a little less thick than the FC1, with a less plastic and more natural feel. With better experimentation with this new generation of FCs it would be interesting to know how women find these.

Within the Durban Central focus group, was one woman who went further to report that *"when you put it on, the FC lines the vagina and seems to assume the shape of the vagina. As a result..."* she added… *"you would know you have something inside you but still it would feel as though there was nothing there."*

This means women need to consider a different strategy in discussing, or negotiating male and female condom use with a male sexual partner. In Zimbabwe for example, FC awareness programs "stressed the advantages of the wider diameter in FC, as many men complained about the constricting nature of male condoms" (Zimbabwe National AIDS Coordination Programme, November 1998). This way there were fewer excuses to not using FCs.

There were one or two responses that indicated that FC2 were still thick and felt like thick plastic when compared to how latex condoms feel. This was a bit concerning because it is understood that the first generation of female condoms (FC1), were made from *polyurethane* sheath which was thicker compared to the recent generation (FC2) which is made of softer *nitrile* (a synthetic rubber polymer) material. It is possible that this response helps us understand that only a few women were aware that the FC2 was in circulation, and only a few had begun experimenting with it. For information purposes, FC2 has the same design and instruction for use as FC1, but the material has been changed to improve affordability, while maintaining the high quality, reliability and features of FC1.

Responses from the ten focus group discussions and in-depth interviews indicated that only about 29% of women who had used FCs would recommend them to other women. These are supposed to be women from a sample of those who have all used FCs at least once before, and are more knowledgeable about them. One woman in particular argued that,

> "It (female condom) places control of my safety in my hands and not those of my man. I can live with that reality. As a result I would happily recommend FCs to other women."

About 15% of the women shared that FCs *"did not have the nasty smell associated with latex spermicides"* normally found in male condoms. They reported to have not experienced that after sex rubber smell with FCs compared to MCs. What most did not seem to understand well was the difference in materials used to make FCs and MCs. This had bearing on how each smells. But then again this had a lot to do with the information that the pre-exposed women would have had access to on FCs. There were women within focus groups who indicated that they would recommend FC use to other women. About 13% of these argued that they would recommend female condom use primarily; "*because it could be inserted hours ahead of time, and therefore reduced the unromantic fumbling which takes the excitement away*"; as was reported by one respondent. However 43% of the women believed that "it negated arguments over my lover not wanting to wear a male condom during sex" as was

argued by another respondent. These responses are discussed in more detail in Chapter 7 which looks at 'Female Condoms and Safer Sex Negotiations'.

In the focus group discussions and among in-depth interviews women were asked "if at all there was any difference between female condom types FC1 and FC2." In Chapter 1, we had discussed that FC2 was developed to replace FC1 by providing the same safety and efficacy during use, but at a lower cost. Both are never-the-less under current circulation. As indicated earlier, not many women knew about or seemed to have experienced the difference between the two types of female condoms.

It has been difficult to find local studies that evaluated the acceptability of FC2 in many countries around the world, let alone in South Africa. However, in 2006 Smit et al. reported on a multisite, randomized, crossover trial they had conducted comparing the acceptability of Reality(R) FC1, with a new synthetic latex prototype (FC2) of similar design and appearance in Durban, South Africa. Titled 'Short-term acceptability of the Reality polyurethane female condom and a synthetic latex prototype: a randomized crossover trial among South African women': they enrolled 276 women into the study. Off these 218 used about 1,910 FC1 condoms and 216 women used 1,881 FC2 over a particular period.

They found overall experience of use reported as good for over half the participants with both condom types (FC1=50.9%, FC2=55.1%); that similar acceptability issues were reported in similar proportions for FC1 and FC2, with features such as the lubricant (FC1=36.7%, FC2=37.0%) and the material (FC1=36.2%, FC2=29.2%) most commonly viewed positively for both female condoms types. They found that the negative aspects commonly reported for both female condoms were the lubricant (FC1=30.3%, FC2=31.5%) and the appearance (FC1=29.8%, FC2=34.0%). Preference for FC1 was 29.5% and slightly higher for FC2 at 36.6%. 33.8% of the women found no real difference between the two products.

Smit et al. (2006) concluded that acceptability of FC1 and FC2 was comparable, and that women who found FC1 acceptable to use would also find FC2 acceptable. The interesting point to note here was that there were a number of similarities between what Smit et al. (2006) argued and what was uncovered in this chapter on women's

perceptions about how the female condoms felt like inside the vagina. These were specifically captured from responses by users in Smit et al. (2006) but also among women interviewed for the purposes of this study.

To determine if women perceived female condoms to be user friendly or not, they were asked at both focus groups and among in-depth interviews "how does one put on a female condom?" and "how does one use female condoms during intercourse?…" The responses flowed as though a brainstorm session was in progress - "squatting", "lying down", "sitting", "standing with one leg flat on the ground and the other slightly raised or placed on a low chair." Eventually came the responses "they can be inserted in the vagina in any position you are comfortable with" by "twisting the inner ring into an '8'; push into the vagina with a finger making sure the bigger ring remains on the outside." There was a general agreement that the penis needed to be guided into the FC during intercourse. Basically what this indicated was that women's responses on how hard it was to use it were such that it was comfortable and that the guiding of the penis was not something the majority were comfortable with doing.

Women who participated in the interviews and focus groups were asked 'where they obtained their female condoms' and 'if they were free or if they had to buy them'. 63% of the women using female condoms obtained them freely at clinics (e.g. Newtown A), at certain hospitals (e.g. Wentworth), from friends, within organisations they volunteered at; and during safer sex week or AIDS awareness campaigns. The rest either purchased them from local pharmacies, although they were not always in stock, or did not access them at all. They were asked a follow-up question, aimed at getting a sense of how they felt about having to pay for female condoms. While a minority did not really mind paying for something that would protect them from what could have lifetime repercussions, there were a number of them who felt it was the responsibility of the government to ensure that FCs were available and accessible. They all agreed that they wished female condoms could be easily accessible at supermarkets, public clinics, and recreational spaces. This was already the case with most male condom brands across the province and the country. However, it must be noted that this has been as a result of each brand having an interest in and taking responsibility for this.

When asked 'what problems if any, they might have experienced with female condoms' which contributed to continued or discontinued use, about 35% of the women who had used FCs for over ten years reported that while initially female condoms as a new concept were rather uncomfortable and awkward, with regular use within committed, and honest relationships where there was emotional sharing, their insertion inside the vagina and use during sex had become second nature. Cost and access remained two of the major concerns communicated by most women. There were long term FC users who reported that there have been numerous times where there was a problem with what was supposed to be 'a regular supply'. "You could not find FCs anywhere" argued one woman from the city focus group. "And even when you were prepared to spend your last cents to purchase them from a local pharmacy, you would learn that they were out of stock," a 32yr old woman from the Lamontville focus group had also reported.

To test women's perception and knowledge of female condoms that could impact on their choice of prevention methods they were asked 'if they had to choose one prevention method to use against pregnancy what would it be between an injection, the female condoms, a cervical cap, diaphragm or a morning after pill (male condoms were purposely left out of this list so as to focus on female initiated prevention methods). The responses were as follows - 28% said injection, 18% said female condoms, 22% said diaphragm, 27% said morning after pill and only 5% said cervical cap.

When asked how they felt about re-using female condoms, there was consensus in most group discussions that FCs should not be re-used, despite the lack of accessibility and the fact that they were pricey. What informed this decision were individual and group feelings, knowledge, perceptions and concerns about disease. The decision was also informed by the fact that some women did not have access to clean running water, but also concerns around cleanliness of the environment where women were located. The study proposed the reuse of FCs "as a way to make them more affordable and increase acceptability". Although the FC is designed as a single-use product, there have been reports of reuse. In Zimbabwe, 2.2 percent of users in a study reported reusing the FC for reasons of cost, inadequate supply, saving time, and mere experimentation" (UNFPA, PATH, 2006, 18).

There is not much extant research indicating how much re-use of the FC is currently taking place in the city, the province, the country and worldwide; and if there are any increased risks for women and/or their sexual partners in doing so. Some women did not encourage reuse based on own perceptions of hygiene. Women from informal settlements were unsure of success in washing, drying and re-lubricating FCs in their context. A joke was shared by one respondent with other women participating in the Chatsworth Focus Group discussion about how their neighbours would gossip (and perhaps even laugh) about them if there were to hang FCs on the washing line. Overall, the discussions on this concept gave a sense that the women found reusing FCs as something to consider for the future... They found washing, drying and re-lubricating FCs slightly embarrassing and unthinkable.

When asked if FCs expire and if they required any further lubrication it became clear that a number of women were aware that female condoms do have an expiry date. But there were also a few who had been misinformed that because female condoms were not made of latex, they did not expire or break. The important thing to note about this is the contribution this adds to the knowledge women construct of a product and the problem in trying to undo what has come to be believed. A number of women indicated that they were not fans of extra lubrication as they thought that between what the female condoms came with and what they were able to naturally produce, nothing more was required. There were women who had been told that the lubrication in female condoms was suspicious. There was an acknowledgment that while not many women were able to self-lubricate, there were those who found themselves forced by their sexual partners to use herbs to keep themselves dry for their sexual partners' pleasure. This subjected them to a lot of pain and suffering and exposed them to the risk of disease. They saw female condoms and the concept of extra lubrication, as a reason they could use to argue with their sexual partners as to the importance of using lubricants. There were a few women who reported to have experienced allergic reactions to certain lubricants and therefore warned others against their use, particularly with regard to Glycerin.

When asked 'how comfortable they were with the design, the cost, the accessibility and supply', about 47% of women within the focus groups argued that 'in honest

truth' female condoms were awkward in design, that they 'took some time to get used to' but were a good product "for the time being". There was a general feeling that female condoms were a little too expensive to access, though their 'health was worth it'. They also felt unequipped to recommend change. Women also argued that female condoms were not always accessible even at institutions where they should be found, such as certain pilot sites, government clinics and family planning institutions.

When members of the focus groups were asked whether female condoms were a preferred prevention method as compared to male condoms, the numbers were very close comparatively speaking. This study comprised an appreciable number of female condom users and female condom non-users. In total, the results among survey questionnaires, focus group participants and in-depth interviews were 41% self-reported users and 59% self-reported non-users. Between these discussion groups was an understanding that the responses to this question in particular depended on a variety of factors. These ranged from women's perceptions of their own bodies and their own vaginas, individual woman's comfort with intercourse, curiosity about female condoms; participant age, the sexual activities in which couples engaged and prevention methods women preferred to use with their partners and 'prevention methods women could use with their partners'. There was input from one woman from Lamontville about the inner ring. She reported that "the inner ring was uncomfortable" for her, to which another focus group participant, indicated that "If it were uncomfortable, all she needed to do was try to re-insert or re-position it so that it fit snugly right back by the cervix." Only one woman, at first, within the Wentworth focus group was brave enough to report the benefits that came with the inner ring. She reported that it added some excitement to both her and her man's sexual activity. Other participants nodded in response although no one seemed prepared to comment at this point.

In all, while it seems there may have initially been some negative reactions to the FC because of it's seemingly 'big' or 'huge' size when compared to MCs, there was consensus among the women that this feeling diminished with ongoing use. It was further advised that to avoid this misconception of FC size, it was helpful to align it with a rolled out MC and then compare length and width, and that then the user would realize that there is not much difference between the two. It is also important to note

that the female condom provides added protection because the base of the penis and the external female genitalia are partly covered during use. From this discussion and the earlier one on MCs compared to FCs, it became important to remember that societal gender roles, cultural expectations and power relations between the parties also contribute to the choice of preferred prevention method.

Once again, it is very possible that the reasons for inconsistent MC use, as discussed earlier, are linked to how gender stereotypes about men and women, when it comes to sexual activity, are at play[22]. Men can decide over sexual activity while women are not necessarily empowered to do so. Such imbalances make it easier for men to come up with excuses to not use MCs. For example if a man argues it is too small for his penis, his female sexual partner might not feel it is her place to argue with him about this let alone to question him about size. But because it is becoming accepted, that FCs provide additional protection, it would be safe to argue that FCs are primarily about bringing to the fore an incremental increase in protection (Warren and Philpott, 2003).

Conclusion

This chapter was concerned with how women's personal experiences with female condoms contribute to their perception and knowledge about them. The findings were that in contexts where women had been given the space within which to learn about FCs and to get a chance to talk to other women about them, FC use was not so awkward, and that women's perceptions of FCs were that they were not so uncomfortable and that the perceptions improve with constant exposure and regular use.

The idea that women's knowledge about female condoms is largely constructed from their individual understanding, experience and perception of them was proved through the narratives. It is also clear from the women's responses that knowledge is not

[22] By way of comparison in Zimbabwe, a study was conducted to assess the dynamics of use. The study in Zimbabwe found that 16% of all women and 28% of married women using the FC had never used MCs prior to using FCs. The reasons varied and some were common to those discussed in my study above. In addition, 20% of consistent FC users who had previously used the MC had not been consistent MC users in the past.

objective and that meaning is intimately connected with the experience(s) of an individual or group, so what a person knows has been impacted by the experiences that they have had and of those they socialize with, relate to or are influenced by on a regular basis.

Chapter FIVE: The Many Uses and Meanings of Female Condoms

Introduction

People *construct* and attach many meaning to products. Regardless of whether the product or object may have been produced for a singular purpose, people often adapt it to suit their personal needs, as the narratives in the study reveal. The construction and attachment of meanings may be due to lack of knowledge on the user's part as well as the producer's failure to create awareness.

This chapter uses ethnographic data and probes the different uses and meanings that women have construed and constructed and then attached to female condoms. This chapter works with the assumption that *'how women view their own bodies and understand and construct their vulnerability to disease'* contributes to the decisions they make about whether or not to use prevention materials such as FCs.[23]

The Many Uses of the Female Condom

In the Focus Groups women were asked "*what do you use female condoms for*" and some of the responses included the following:

"*I use female condoms because it is an effective tool to protect against STI and pregnancy prevention, especially in my line of work.*" …The respondent laughs…
(A 20 year old, matriculated, from Durban Central)

The young woman interviewed here had recently moved to Durban from the Eastern Cape and was a sex worker. She '*services'* (her words) a particular trucking

[23] In the first chapter, it is indicated that it was only in 1997 that South Africa introduced FCs as 'female initiated or controlled' prevention methods; and that about 13 years later FCs had been piloted at some 249 sites across the country with only about 13,6 million distributed since 2010. Using Statistics SA[23] population figures from 1996 and 2006, women accounted for 52% and 53.2% of the population respectively. Against this backdrop this chapter begins by assessing the uses of FCs.

community in the city. She has paid sex with a variety of men whose sexual backgrounds or HIV status she says she is not aware of. She shares that, while she was aware of female condoms,

> *"I only use them with those men who looked like bullies, so I can be in charge right…But I also use them with men who don't know about them (female condoms) but would have refused using male condoms. There is a lot of men out there who do not know about female condoms, but are happy have sex with you while you are wearing it for no reasons I know."*

The informant shares that she uses FCs in situations where she feels she needs to do so, or may need to negotiate condom use or *"be clever"* about how to introduce them into the sexual activity as safely as possible. However, female condoms are not 'violence proof', so while she might have been able to use it to protect herself from unintended pregnancy and unwanted infections, it would not protect her from customers who became violent and *"forced themselves on her"* before she had a chance to put the FC on. It is important to remember that the FC would not protect her against violence should the customer feel threatened or suspicious about her using something they do not know.

"*I don't like using the pill and my boyfriend loves for us to use female condoms to prevent pregnancy. So I am happy to use it too. It is not so bad and it does not come with side-effects like the pill does on my waist.*"
(A 33 year old, married woman, from Chatsworth) Please check on this information as in the paragraphs below she is only described as having a boyfriend.

The experience narrated above refers to a primary concern that many other respondents shared, which is falling pregnant. While we did not discuss her issues with using the pill in detail, she did however indicate that the pill made her gain a lot of weight. She seemed content that she and her boyfriend were able to use female condoms whenever available, without any issues of weight gain. She also indicated that;

> *"Sometimes we buy them from the pharmacy here by us which I am not always excited about because it is so close to home and you know people talk." And*

then she went further to say that she and her boyfriend have been "talking about having children but we are not ready yet".

She shared that *"I want to have children someday, you know, so when the time is right we would just stop using condoms."*

While there were a number of women within the focus groups who raised concerns about being vulnerable to STIs, the respondent quoted above was among the few women who believed that they were safe in monogamous relationships. Like her, these other respondents did not see the need to, and did not support the use of condoms within a long-term and/or committed relationship. These women perceived marriage as a safe-space for sexual activity. Due to the nature of the engagement being a focus group discussion with several women present, where a set of questions had been negotiated with the participant group as a whole, it was not possible to do more direct one-on-one follow-up questions with the respondent who was very much more shy in sharing personal details on a one on one basis. What was clear from the discussion was that the relevant respondents in this case believed that marriage and long-term committed relationships were safe from infectious diseases. Trusting their men or husbands, played a big role in this.

Other respondents shared that;

"It is a great option or alternative to not using male condoms. I have become used to using female condoms and male condoms alike to prevent pregnancy and HIV."

(A 31 year old single mother from Chatsworth)

For other women who shared this young woman's response, the use of FCs and MCs was about choice and exploration with a variety of prevention materials that they are comfortable with. This was quite interesting bearing in mind that the concept of women exercising their right to choice of condom use or nonuse, within a sexual context is not a common experience. Also for FCs to provide effective protection against STIs and un-planned pregnancy, they need to be used correctly and

consistently. For this to take place FCs need to be acceptable to both sexual partners (UNFPA, 2012, p 18)[24].

Within the focus groups were a number of women who were either on the pill or taking an injection and for whom pregnancy was not the main concern. In each group, there were about 3 or 4 women who reported to have been worried that condoms – female or male – might break and therefore believed in dual protection. These women used the pill or took an injection to supplement condom use.

"With gonorrhea, syphilis and all other sexually transmitted infections we get from our men, male and female condoms protect us. They also give us control over sex and safer sex negotiations when these good-for nothing husband bring diseases and don't wanna bloody use protection."

(A 37 year mother old from Wentworth)

This is a response from a woman who understands and knows her sexual risks, and was common within the City and Lamontville focus groups. It was interesting that the women who shared this sentiment were predominantly married or 'living with a long term partner'. These women felt their husbands *"did not act their age at times*" and that other respondents said that men "*believed they were God's gift to women"* – and basically led sexually care-free lives. How the women talk about using condoms articulates how they had constructed the use of FCs, in terms of their age and individual sense of responsibility. However, there was one woman who argued that she did not particularly enjoy sex with her husband and used female condoms as a deterrent. *"You see he don't want to use female condoms so I tell him female condom or nothing. He gets mad but he leaves me alone"*. So she would insist on them to put his off sexual demands towards her.

Another respondent shared;

"Preventing HIV is one but it also increases sexual pleasure."

(A 22 year old, young and vivacious looking women from Wentworth)

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[24] "On its own the FC does not change fundamental power relations within sexual relations. That is, in most cases the woman still requires the permission of her male sexual partner to use" (Patton, 1990, UNAIDS 1997, 5).

In the previous chapter it was mentioned that there was a young woman from Wentworth, who during the focus group was keen on sharing intimate details; and who shared; *"you would want to apply enough lubrication on both the inside and outside of the female condom, insert it and make sure that the inner ring is tucked comfortably at the back by the cervix".* She narrated *"you would want to assume a position sitting over your boyfriend's thighs with direct penetrative movement between the two … and the air that moves inside you from this increases pressure towards the inner ring and because it can't escape it gives you a vibrating sensation inside."*

In contrast a 41year woman from Inanda, who looked rather irritable when asked how and for what she used female condoms, and if they were readily accessible would she use more of them shared;

"Angiyithandi ngoba ingiqedela ubumnandi ngiloku ngiyigadile ukuthi ingashibiliki ingene ngaphakathi. But ke ngiyisebenzisa ocansini ukuzivikela from i-HIV"

(Translation: *I don't like it because it takes out the pleasure as I consistently need to keep watching that it doesn't slip inside. But I use it during sex to protect myself from HIV.)*

(A 41 year old mother from Inanda)

Her candid honesty was appreciated especially because the majority of her group, were ing younger, more willing to explore and more comfortable to share experience than she was. She had not had "*a great experience with female condoms".* There was also a 29 year old woman from Durban Central who similarly shared;

> "*I know female condoms and have tried to use them before but I have stopped since they can be uncomfortable during sex*"
>
> (A 29 year old shy mother from Durban Central)

One respondent shared some critical insights saying that;

"*In our STI workshop we were encouraged to have sex with lights on so that we can see what our boyfriends are bringing to bed. So if he does not want to do it with the lights on, you tell him I need to guide you and I can't do it in the dark."*

It appeared however, that for some women it was against their cultural and traditional beliefs to use FCs. It must be reiterated however, that it is outside the limited range of this study to specifically pursue religio-cultural influences. They are broadly mentioned as part of many issues that presented themselves within the focus groups. It bears noting that this focus would be critical and interesting for further and future research. It was also shared that there were women, even within the focus groups, who were using female condoms with their husbands during sex without their husband's knowledge, and felt that they were safer that way.

Among focus groups was a general perception that when engaging in vaginal sex, especially in a missionary position, FCs gave women more control over the sexual encounter. They believed that using FCs in this position meant women would be able *to control what happens, how it happens and for how long* – the setting, the position, the rhythm, lubrication and so on[25]. When asked, "*what prevention method do you prefer to use for vaginal sex*" 54% of the 67 *survey respondents* preferred male condoms. 32% preferred FC and 14% had no particular preference. This did not mean they used both types of prevention materials. Within focus groups were also some women who did not use any prevention with their steady partners or husbands.

In both the focus group discussions and the in-depth interviews there were women who used FCs to prevent pregnancy and to protect against or prevent STIs and HIV/AIDS. A few shared a concern over boyfriends and husbands "*who slept around with infected lovers"* and brought home diseases, and thus felt they needed protection. FCs users agreed that if they put aside cost and accessibility issues, FCs were a better prevention option when compared to male condoms and gloves. The risks of coming into contact with bodily fluids secreted during sex were understood to be less when handling FCs as compared to other prevention methods.

[25] At this point, there is some reference to data gathered from both, the survey questionnaire as well as the qualitative data from focus groups and in-depth one on one interviews.

Only 37 respondents listed FCs as their preferred choice of prevention method against STIs. Dental dams[26] were either unknown or not much used. However, the study did not necessarily explore in detail other sexual activities that people engaged in which put them at risk, and therefore the appropriate prevention methods that could be used.

"I have been using the injection for a long time now; I know how to regulate my body around it, my mood swings lack of appetite, libido and all. I know I can trust it and have recommended it. I use the female condom more as a deterrent to sex than a prevention method for pregnancy."
(A 41 year old from Durban central)

The problem with the injection is that if you and your partner want to get pregnant you need to have stopped using if for a particular period but with the morning after pill, it is an emergency prevention method if conceiving was not part of the plan but it means I do not have to subject my body to all the side effects that come with an injection when I am not so sexually active.
(A 38 year old from Lamontville)

"When it comes to preventing pregnancy I think the injection has been proven the best prevention method for many years now. The morning after pill is normally my plan B. I use female condoms but they only come third in my list of priorities at this point. Me and my friends have experienced a combination of difficulties with cervical caps in the past. And it did not help how many times we tried to help each other about it... so no thank you."
(A 35 year old from Wentworth)

Female condoms are worn internally by female partners and used during sexual intercourse to physically block ejaculated semen from entering their bodies. When asked *'if they had to choose one prevention method to use against pregnancy"* between an injection, FCs, a cervical cap, diaphragm or a morning after pill, the response was as follows : 28% injection, 21% FCs, 22% diaphragm, 27% morning

[26]A dental dam refers to two prevention materials. There is a kind that is used by dentists to separate teeth during a dental procedure. There is also a kind that is used by individuals upon performing cunningulus or aningulus.

after pill and 2% cervical cap. Male condoms were purposely left out of the list in this case so as to focus women's attention onto female initiated prevention methods.

The engagement with women from various backgrounds regarding their experience(s) with FCs indicates that FCs are seen as a multi-purpose prevention. According to the rich narratives from the women, FCs give them control and choice over their own bodies. The respondents shared that with FCs, women can protect themselves when their partner does not want to use a male condom, and for some women, the sexual experience was enhanced with FCs.

In the Wentworth Focus Group discussion, strong sentiments were shared about the '***certainty'*** that came with using FCs. They argued that unlike with male condoms which had to be inserted at a particular moment, when the penis is erect, otherwise its effectiveness is not experienced, and this was not the case with FCs. An FC could be inserted 8 hours prior to sexual intercourse and did not rely on the penis remaining erect for it to also remain intact.

'***Reassurance'*** was another meaning derived from the feelings women shared. FCs, it seems rarely failed due to manufacturing defects. The women reported far less chances of spillage of semen when removing a female condom from a vagina compared to removing a male condom on a penis.

'***Convenience'*** is also the word used by women in Focus Group discussions and in-depth interviews FCs can be used during menstruation or pregnancy, or after recent childbirth. They eliminate women's concern that their men will not wear a condom, and they can protect themselves from pregnancy and STIs without relying on the male condom. However, it was also argued that FCs can be an 'inconvenience' in that they are "*as good as available on prescription*" (one woman from Lamontville). "*They are primarily accessible from pilot sites, family planning clinics where one has to request for them.*" "*They are also fairly expensive,*" added another one within the same group.

Conclusion

While people are at risk from a variety of Sexually Transmitted Infections (STIs), it seems HIV is the main concern. It was also found that male condoms are by far the most accessible and widely distributed prevention materials compared to female condoms.

While FC sales have been disappointing in a number of developed countries, South Africa, like many other developing countries is increasingly using them to complement already existing family planning, STI and HIV programs. FCs are an important alternative prevention method especially for women who for a variety of reasons are not able to use MCs, or rely on their sexual partners to provide these. With women and girl children accounting for just over half of all people living with HIV worldwide, female HIV prevention initiatives are thus desperately and critically needed. The female condom is the only female-initiated HIV prevention method presently available and it has the potential to empower women to protect themselves from the risk of HIV infection (Avert, 2011).

PATH and UNFPA report that ‘women have shared that they want the means to protect themselves from unplanned pregnancy and STIs, and that they are eager to try products that offer protection’ (PATH, UNFPA. 2006). What is needed is a critical consideration and integration of the ‘meanings’ that women have constructed and attached to FCs. How women construct, construe and view their bodies and sexualities and understand their vulnerability is critical for their decisions regarding whether or not to use FCs.

Chapter SIX: Female Condoms and Safer Sex Negotiations

Introduction

In 2007, according to the UNAIDS and WHO, women accounted for half of the 40 million people living with HIV/AIDS in Sub-Saharan Africa. They argued that about 60% of the newly infected were women and girls (UNAIDS/WHO, 2008). The point that women '*lacked power*' in a world '*power dominated*' by men was identified as one of many contributing factors.

In this chapter, focus is turned towards more intimate and at times, uncomfortable relationship matters. These are regarded as more intimate in that they begin to unpack the tensions between couples or sexual partners when it comes to sexual activity, specifically around how safer sex is negotiated. These may be uncomfortable especially if they allude to or even expose power dynamics and power geometries about sexual relations that women may not necessarily want to publicly discuss.

Female Condoms and Safer Sex Negotiations

It has been widely argued that gender discourses, which generally involve differential relations of power between women and men, have significant implications for understanding the problem of HIV/AIDS for women. According to this view, women's position in society plays an important role in their ability to respond effectively to the threat of HIV/AIDS. They have been stigmatized and made to feel that they are responsible for being infected (see Sippel and the Centre for Health and Gender Equality, 2007). Women are not normally, within many contexts as the narratives in this study reveal, the initiators of sex. This illustrates that the so called traditional view of sex continues to be upheld in a heterosexual construction of sexuality and reveals that the dominant gender power is in the hands of men (see Holland et al., 1990; Juhasz, 1990; Hollis, 1992; in Bowleg et al., 2007).

Safer sex is supposed to be a shared responsibility between sexual partners irrespective of what prevention/contraceptive methods they use. Bearing in mind how

vulnerable women are to becoming infected with STIs and HIV plus a number of other issues i.e. sexual script and woman's positioning in society which makes it hard for them to negotiate safer sex or condom use, and that hinder their sexual activity, women desperately need access to contraceptives that they can control and self initiate (Aggleton, et al, 1999). Female condom use for safer sex requires partner negotiation (Sippel and the Centre for Health and Gender Equality, 2007). However, it is argued in Bowleg *et al*. (2003) that there are 'romantic' scripts which have been used to prescribe that women be sexually passive (Diekman *et al*. 2000). These preclude women from engaging in indirect HIV prevention strategies such as communicating about HIV before sex or having condoms available.

The Female Health Company's FC1 and FC2 are the only widely distributed 'female initiated or controlled' prevention method approved by the FDA and WHO. The narratives in previous chapters have shown that some women like to use female condoms because they are effective in preventing STIs and pregnancy, are easy to use, give increased sexual pleasure, and are an alternative to male condoms.

Other studies (Warren and Philpot, 2003) have shown that there are obstacles in accepting the use of female condoms among women involved in commercial sex work. There is the reaction of the woman's regular sexual partner or client that is not guaranteed to be one of 'excitement'; and then there is their attitude towards FCs (i.e. appearance, difficulty in putting it into place or uneasiness concerning its use). The moderate level of acceptance by male sexual partners may be overestimated because women whose sexual partners dislike the FC are likely to discontinue its use.

In this chapter, women were asked if they were "*able to easily and safely use female condoms with their sexual partner(s);* if their '*sexual partner(s) liked it when they use (put on) female condoms* for sex; and '*how their sexual partners communicated or showed that they like it'* when they use female condoms.

The following are some of the responses;

"I like using female condoms because I often struggle to negotiate safe sex with my partner. I hardly know what to say. I know using female condoms helps me take

control of the situation. He did not like this idea initially. But I have been feeling and displaying confidence each time we try, so he has now begun to like using female condoms too."

(A 28 year old, undergraduate, from Lamontville)

"I do not have a strategy for safer sex. I am just able to successfully 'demand' the use of a female condom (or male condom) with him the first time and then get him the morning after to admit that he liked it this time around like many times before. Since then, even if he complains and basically tries to come with every excuse to not use condoms… I simply tell him, if you won't put it on, I will put it in."

(32 year old, older student from Durban Central)

"It the beginning it was difficult to negotiate female condom use with him. I did not like them at first. So when he said he did not like it, I understood. With practice though he has begun to like it.... I suggest it and we sometimes use it or he would insist on using a male condom instead. I no longer have to negotiate using female condoms."

(A 29 year old, young mother from Wentworth)

From the narratives of the women above it is apparent that they have introduced female condoms into sexual conversations and activities with their sexual partners. Research by UNFPA has shown that condom use is not a major consideration by married heterosexual couples; that they would consider this option if they are knowledgeable about them, have spoken about them and want to prevent unplanned pregnancy.

Other responses such as;

"I am HIV+ and he does not know. I feel we have not gotten to a stage in our relationship where he needs to know. Because we have not both gone for an HIV test together I insist on using prevention. He always has stories when it comes to using male condoms. Since we discovered female condoms, he has not said he likes them but has not said he does not like them either. He does not refuse to have sex just because I have a female condom on. After first use he only said they were interesting. Sex using female condoms is so far good and safer. So I guess he likes."

(30 year old, matriculant, recently moved into new home in Durban Central)

"He has allergies to latex. Therefore, he is happy for us to use female condoms. We have begun looking for latex free male condoms."
(29 year old, matriculant, lives with partner, from Chatsworth)

From these narratives, it is clear that some women appear to be more in control when using female condoms and there are fewer feelings of disempowerment, and less need to negotiate condom use where male condoms are concerned. Some studies have shown that in most situations where male condoms are used women are subject to what the male sexual partner says (van Mens and Smith, 2009). Women, who successfully negotiate female condom use the first time, hardly feel the need to renegotiate it seems. If their partners agree the first time, they simply insert it (FC) prior to having sex the next time.

FCs can be inserted several hours before sex, and foreplay is not interrupted (Van Mens and Smith, 2009). This is something that the women shared.
The narratives show that some women experience the threat of, or actual, physical violence when attempting to negotiate safer sex using female condoms in the wake of cultural conservatism and male control over sex and female bodies!

Let us take for an example the case of the young 20 year old from Durban Central who is a commercial sex worker. She related in the previous chapter that she used female condoms without the knowledge or consent of her male sexual clients or partner(s). Through her narrative she shares that during sex the man's penis had slipped between the walls of the vagina and the female condom and therefore they needed to stop. The man however, was not aware of the existence of female condoms and assumed the young woman had bewitched him. He is reported to have hit her so severely that she could not walk or work for weeks. Her experience of violence upon introducing female condoms use is not uncommon. In South Africa the prevalence of violence experienced by women upon introducing or negotiating female condoms use is greater among commercial sex workers (Brown *et al.,* 2007).

Other women shared experiences;

"For a while now I have been using female condoms without his knowledge. The day he found out we fought and then broke up. He believed I was using some device that will trap him. He promised to see someone to heal him of my spell."
(30 year old from Wentworth)

"I felt things were getting serious with these men so I visited a family planning clinic. We spoke about a variety of prevention materials and then I was introduced to a female condom. I took it home and asked him if we could try using it sometime. Since then, he believes I have been unfaithful. We are still together but I get the feeling he does not like female condoms at all and would not even give us a chance to talk about them.
(25 year old from Wentworth)

"He does not like them at all. He does not even support the idea that women should carry condoms around in their bags or even discuss what they do with their sexual partners with strangers. He says it is not right for women to wear condoms let alone carry them around as if they are always thinking about and ready for sex." We don't use female condoms and I cannot make him change his mind anytime soon.
(29 year old from Inanda)

"It's not easy to negotiate safer sex with him, worse using female condoms. He finds them very impersonal. He says they make me feel big inside."
(30 year old mother from Chatsworth)

While some early studies have shown that some women liked female condoms because they gave them greater control over safe-sex negotiation (Aggleton et al, 1999) it is not as simple for many women. This coincides with the initial assumption in this chapter, that safer sex negotiation and female condom use may be problematic in some relationships, especially where there is a history of abuse, violence or coercion (Sippel and the Centre for Health and Gender Equality, 2007), as well as

where stereotypical gender roles are being strongly played out and enacted[27].

Nevertheless, some participants reported using female condoms without their partners' knowledge, emphasizing the point that for the majority of women, safer sex through female condom use required communication cooperation from the woman's sexual partner. The Sippel study found that "more women's partners especially husbands; opposed female condom use; and demanded unprotected sex" (Sippel and the Centre for Health and Gender Equality, 2007).

The Dunkle *et al.* study (2004) cited in the earlier literature review chapter, presents an important consideration for this study, especially since within the focus group discussions, there were women who were survivors of abuse and violence in their own relationships and were uncomfortable to openly talk about it.

The in-depth interviews in the Dunkle *et al.* (2004) study were carried out using local languages and were therefore relevant. More importantly they included an assessment of socio-demographic characteristics, experience of gender-based violence, the South African adaptation of the Sexual Relationship Power Scale (SRPS), and risk behaviours including multiple, concurrent, and casual male partners, and transactional sex. These characteristics are important in that they provide a better understanding of the women interviewed, as well as that the information they provide speaks to whether the prevention methods available really do cater to their social vulnerabilities.

The study found that women with violent or controlling male partners were at increased risk of HIV infection and a series of unplanned pregnancies. The authors (Dunkle *et al.* 2004) argued that abusive men were more likely to have HIV themselves first and imposed risky sexual behaviour on their unsuspecting wives

[27] From the interviews, only 13% of the women said they would recommend female condom use *"because of the fact that it could be inserted hours ahead of time, reducing that unromantic fumbling which takes the excitement away."* 43% believed that *"it negates arguments over my lover not wanting to wear a male condom during sex.* Studies in Zimbabwe (see Warren Philpot, 2003) indicate that women deploy other strategies such as telling their partner that sex would be more enjoyable than with a male condom or that sex would be possible during menstruation, so that they could use female condoms.

and/or sexual partner(s). They recommended that '*urgent research be conducted on the connections between social constructions of masculinity. This included the categories - intimate partner violence, male dominance in relationships, and HIV risk behaviours in men, so that effective interventions could be strategized.'* (ibid: 204).

More narratives in this study spoke to the research findings by (Dunkle *et al.* 2004) above;

"I can never negotiate female condom use with him. Ever since we got married, we do not even use male condoms. He is my husband and I have to respect his wishes. He does not like female condoms and wishes that I do not argue with him about it."
(33 year old from Inanda)

"He likes female condoms and does not mind us buying them when I do not get them from the clinic. He likes how soft and thin it feels and that it is stronger than latex and conducts heat."
(34 Year old from Durban Central)

The findings from the study by Pettifor *et al.* (2004) on *'Sexual power and HIV risk, South Africa.'* mentioned earlier, clearly indicated that while there was no direct link between STI and HIV prevalence and sexual power; there was a direct association with inconsistent condom use. This meant women who had no control over their sexual lives and those who experienced forced sex were more likely to not use condoms (2004). As a result inconsistent or no use at all of condoms, although not the fault of women, was significantly linked to STIs and HIV infection among women.

In Pettifor *et al.* (2004) it is argued that STI and HIV prevention strategies must fully consider the limitations women have in wanting to encourage a more responsible sexual behavior, as they may have little control towards making these changes. They argue that a number of factors that limit women were fundamentally entrenched within gender inequalities and power geometries. For this reason Pettifor *et al.* (2004) made a call for further research to examine sexual power and assesses the role it plays in encouraging vulnerability to HIV. They invite research that would look into issues that fuel this unequal sexual power, and recommend interventions. Interventions that would hopefully assist women towards gaining control over their sexual lives.

In the meantime women have had to identify ways, means and strategies to safely negotiate safer sex with their men. Let us consider the following experience;

"I can never negotiate female condom use with him. Ever since we got married, we do not even use male condoms. He is my husband I have to respect his wishes. He does not like female condoms and wishes that I do not argue with him about it."
(33 year old mother from Inanda)

Research by UNAIDS and WHO in Africa indicates that many women remain subordinate to men socially, politically and economically. They argue that women are therefore not able to negotiate safer sex with their men due to *negative cultural beliefs and practices embraced by many African societies*'. (UNAIDS/WHO, 2008). Women in many South African cultural contexts have no right to sex or to discuss sexual matters. How are they then expected to successfully and safely negotiate FC use? This sexual inequality renders women highly vulnerable to STIs and unplanned pregnancies. (UNAIDS/WHO, 2008 and Sonke Gender Justice, unpublished).

In this study the women were asked whether *their sexual partner(s) encouraged the purchase of female condoms.*
Some of their responses included;
"He likes female condoms and does not mind us buying them when I do not get them from the clinic. He likes how soft and thin it feels and that it is stronger than latex and conducts heat."
(A 33 year old single women from Durban Central)

"Well my man likes female condoms but they are expensive and do not have a variety like Durex male condoms do at a similar price. We are both unhappy about buying them."
(A 25 year old single mother from Lamontville)

"Well like I said before that because he has an allergy to latex he does not mind using female condoms. He is also happy to buy female condoms probably because he does not have many alternatives yet."

(A 29 year old from Chatsworth)

The above narratives introduce us to a few men who do not seem to have problems with their partners' using FCs. This is re-assuring as it indicates that some women are empowered to make healthy choices. These narratives, for me, speak to the couples' levels of awareness and how much awareness contributes to cutting down on the level of vulnerability to which the women are exposed.[28]

Conclusion

The narratives included in this chapter reveal that FC use requires different levels of negotiation with a sexual partner, however, ethical and egalitarian decision making proves problematic within gender imbalanced and skewed sexual relationships. In Sippel and the Centre for Health and Gender Equity report (2007) we learn that this problem manifests itself in relationships where there is domestic violence. The high prevalence of HIV infection among women in KZN is an indication of the reality that these women embody. If women are already finding themselves culturally and religiously in subordinate positions within society and their sexual relationships, this compounds their difficulty in not being able to negotiate safer sex.

Among the gender-related inequalities that affect women is the fact that women are not empowered to successfully control many aspects of their sexual relations. In Beksinska et al., it is argued that some of the challenges crippling STI prevention programs from being successful were inconsistent and incorrect condom use. But there was also the fact that couples in long-term relationships *did not see the need* to use condoms (Bekinska *et al.*, 2011).

It was as early as 1986, that bell hooks argued *"to understand domination, we must understand that our capacity as women and men to be either dominated or dominating is a point of connection, of commonality'* (1986, p20).

What this lesson from the past seems to suggest for current work is that as part of

[28] A comparative study by Warren and Philpott (2003) suggests that in Zimbabwe women carry the bulk of the costs of FCs in that women seem to be the ones who play a leading role in acquiring, introducing and encouraging the use of FCs.

future FC campaigning, addressing gender imbalance among the sexes is important, not just with and amongst women, but perhaps more critically amongst *both* men and women.[29]

[29] If we consider the narratives by women who were using FCs without their sexual partner's knowledge, we see that women have begun identifying the ability within themselves and opportunities within their sexual relationships to push boundaries, to foster an environment where FCs could be used, and to negotiate or demand what they want within an intimate sexual relationship.

Chapter SEVEN: Conclusions and Recommendations

Introduction

12 September 2012 marked the first ever observation of Global/World Female Condom Day. Coordinated and championed by the US-based National Female Condom Coalition, this initiative saw advocates and organizations from around the world converge to promote the use of FCs and raise awareness about their existence, use and social acceptance for safer sex. They emphasized the importance of dedicating a special day to FC awareness. They highlighted that the rates of new HIV infections around the world were alarming and were coupled with the fact that women and adolescent girls accounted for more than half of these new infections. 60% of people living with HIV and AIDS in sub-Saharan Africa were women while only 50% of women are infected globally which implies Africa needed to work harder. Thus all of this was an exciting initiative aimed at publicly drawing attention towards FCs. However, this initiative does not seem to have drawn the core beneficiaries, the women and their expectations and experiences into the discussion.

This study investigated the perceptions, assumed meanings and knowledge women have constructed about FCs based on their experience with FCs, as well as investigating these perceptions based on women's experience in accessing FCs, accessing information about FCs, and most importantly their experience actually using FCs. Additionally it also attempted to investigate the extent to which FCs may have been experienced as a form of control that women are able to exercise over their own bodies irrespective of their social living situations and diverse cultural backgrounds.

While engaging with the women from the five areas of Durban, a number of other issues surfaced. These could not all be covered within the scope of this study as its parameters were clearly delimited to probing issues around the key questions outlined in the earlier introductory chapters. However, these issues are important and are

therefore briefly discussed to consider for future FC research, programmes and campaigning.

Key Findings by Chapter

The key findings and data are engaged in the 'dissertation' body chapters of **Four, Five and Six.**

Chapter Three focused on the *knowledge and perception* women had about FCs, by engaging with women's experiences and narratives on *'what FCs look like'*. There were a number of concerns about how to insert it, and this, as was discussed in the chapter spoke volumes about women's own understanding of their bodies and sexual organs, or at least how they might have been socialized to think about their vaginas. It was assumed that the women would have been aware of the introduction of FC2 in South Africa and had perhaps begun experimenting with it. We also learned that there were women who had realised that there was a difference between the two types of FCs by the Female Health Company. According to them, we learned that while the FCs still looked the same, the FC2 'felt softer', 'had less of a smell' and was 'slightly more lubricated' when compared to FC1. With regards to the packaging, women found this to be 'too big' compared to that of MCs, as well as 'boring' and 'without colour'. They found FCs to be nothing as exciting as the variety of MCs available. Chapter Three also brought to our attention grievances or dissatisfaction with FCs by some women who participated in the study.

In hooks (1986) women are argued to be good at suppressing what they know and believe in, and in "*promoting false consciousness, inhibiting their capacity to assume responsibility for transforming themselves and society"* (1986, p.20). This was very true of the women engaged with in Chapter Four. Women have a right to express an opinion on sexual matters, but many seemed more concerned with the perceptions of their sexual partners of FCs and worked with those. Women have a right to communicate their views and perceptions publicly and privately, but still even within the focus groups were a number of women who felt uncomfortable and almost 'not empowered' to discuss their true feelings and opinions of FCs with other women. From both an activist as well as an academic and feminist background it is believed that women should be able to confidently say if they do not like a product that has

been presented to them for them! Women should be able to say they do not want FCs or what they do not want in FC design and be provided with a platform to communicate recommendations on how it can be changed or improved to suit their needs and circumstances.

In Chapter Four we learnt of the *Many Uses and Meanings of Female Condoms.* Through the women's narratives we became aware of how much women knew about risk, especially to STIs, HIV and AIDS, and prevention and the meanings that they had already attached, particularly to prevention methods such as the female condom. In this chapter we also looked at *'how women felt about their female condoms'* and found that some felt comfortable and were able to use these with their sexual partner(s), while others who liked them were not able to successfully use them with their sexual partner(s). Others did not like the fact that *"they made a noise"* during sexual activity, or that it made them feel like their vaginas were *"loose"*. In this chapter the study investigated how comfortable women were with the design, the methodology of use, the cost, the accessibility and supply of FCs.

Some women complained about how *"un-pleasurable"* and *"a mood killer"* sexual activity was when using FCs as *'one (the woman) had to constantly be aware that the penis was not slipping out of the condom'*. In this chapter, the study investigated to what extent women felt comfortable with carrying and using female condoms. Here while the women had similar background information on the need to access these, for some women their cultural and religious backgrounds made this problematic. We also learned that there were a number of women for whom FCs were a preferred prevention method compared to male condoms.

Some women shared that they were informed that FCs required practice and patience; that they needed to practice putting it in and removing it before using it for the first time during sexual activity. We learn that they were not only told to try inserting the FC inside the vagina several times, but that they had to try doing so in different body positions (i.e. standing, sitting, crouching and lying down) until they found a position most comfortable to them to use moving forward.

The picture painted by the narratives indicated that some women used FCs to prevent STIs, HIV and unintended pregnancy. There were also women who used FCs because of the pleasure derived from using them during sexual activity. The chapter thus revealed how some women were beginning to shift the gender imbalances when it came to sexual activity. It showed how some women had begun *"unlearning the 'not so obviously' oppressive socialization they have been brought up with…"* (hooks, 1986). These women had found ways to express their own opinions on sexual matters and choice of contraception, even if this meant 'tricking' their sexual partners into believing they were for example, during a period, allergic to the latex used to manufacture MC's, or even the flavorings in some MCs. However, as a prevention tool that is supposed to benefit women, it was disheartening to learn how many women used FCs *purely because their men liked them* – their men derived pleasure from FC use and thus encouraged it.

Chapter Five was about women's experiences around negotiating safer sex and if at all FCs had made, or were beginning to make, this easier for women to do *with their sexual partners in any context.* Some of the related questions in this regard probed whether women were able to easily and safely use FCs with their sexual partner(s); whether a woman's sexual partner(s) liked it when she used FCs; and if at all a woman's sexual partner(s) encouraged the purchase of FCs for use during sexual activity.

All women have sexual and reproductive health rights to choose with *whom* they want to engage in sexual activity, *how* they engage in that sexual activity and what prevention method they choose to have used on their bodies. As can be concluded based on experiences shared by women in this study, the time is long overdue for FC designers, manufacturers, educators and policy makers to listen to the voices of and engage with the experiences of 'the most at risk groups'. In this case the women. It is women who have been expected to be receptive, appreciative and active in accessing and using a prevention method procured by national policy, for her 'initiation and control' during sexual activity. In February 2010, the fourth Africa Conference on Sexual Health and Rights took place in Addis Ababa. It provided participants ample opportunity to debate diverse issues such as gender and masculinities and how these contributed to the continued undermining of efforts to combat STIs, HIV and AIDS in

Africa. What was intriguing about this meeting was the number of men who participated representing a variety of institutions. They were professionals and experts who came to make presentations and claims on women's issues, *issues that spoke about female bodily and sexual needs*. They spoke 'expertly' for women as though women did not exist to speak for themselves, to narrate their own experiences and recommendations for future research and interventions. This kind of representation is inherently flawed. It was therefore refreshing to hear that some of the men themselves advocated for more women to represent their issues. However, men such as these are the exception rather than the norm as patriarchy has been deeply entrenched in many aspects of South African and African societies. This is manifested in what Support Worldwide argues is an "ugly reality of misogyny and patriarchy ensure that the majority of decisions taken on safe sex rest with the male partner." (Support Worldwide)

The point cannot be emphasized enough that women need to be free to talk about sexual activity with other women and with their intimate sexual partners; to be empowered to raise and insist on rather than *negotiate* safer sexual activities with their sexual partners. Women need to be able to express their feelings freely and without shame or fear. They also need to be empowered so that they are able to determine when to negotiate and when to demand. hooks put it well when she referred to the "paradigm of domination" (hooks, 1986:21).

What was also interesting about their study, when compared to this study, were the different ways of introducing and negotiating FCs in a sexual relationship that they examined. When considered in the light of what was discussed in the focus groups during this study, we see that there were some commonalities. There were for example women who used very 'direct ways' to introduce FCs to their sexual partner(s). These women would just pick it up from the clinic or wherever, bring it home and engage in an open discussion on it. These were women who were likely to be in relationships where they were treated as an equal to their men, and who were allowed to share opinions on sexual matters or who felt empowered to do so for various reasons.

There were women who used semi-direct ways to introduce FCs. These for example

waited for opportune moments, such as when the FC suddenly falls from their bag, or is perhaps discussed on TV or radio. If they have high school children they discuss safer sex issues, and would use the next discussion to introduce the concept. But then there were women whose circumstance was such that they had to be indirect and almost discreet in how they introduced the concept of FC use to their sexual partner(s). Some interesting nonverbal ways of communicating about FCs included presenting it to the partner as part of a prevention method pack, surprising him by putting it on, placing it under the pillow or leaving it on the table on his side of the bed. In Choi *et al* (2004) there were women whose negotiation of FCs was so compromised that they avoided sex with their partner(s).

The outcome of the research by Choi et al (2004:88) indicated that successful introduction and negotiation of FC use was often negatively impacted upon by other factors including the characteristics of the sexual partner(s), the power dynamics within the romantic or sexual relationship, the "situational context", or the use of "additional discourse strategies" e.g. educating their sexual partner(s) about the FC. This was somewhat true for this study too. In Chapter 5 we learn of a number of women whose circumstances were such that they could not safely negotiate the use of FCs or any other prevention method. Some were in abusive relationships and others relied on their men for everything they had and would not risk upsetting them. While this is the reality for some women, it was interesting to learn that there were also women who were using FCs with their sexual partner's or husband's knowledge. These reported that this was a risk they could take because their sexual partners did not have a clue what FCs were. But because this was risky, it was for this reason that the research by Choi et al. (2004) recommended 'good FC awareness and education' to be part of effective FC programming. They recommended that this took place within family planning institutions and that these programmes encouraged the participation of both women and men. These were sentiments also shared in earlier work by Warren and Philpott (2003) among men and women in Ghana and Zimbabwe.

South Africa has a Constitutional and legislative framework regarding gender and human rights, equality, freedom, and reproductive health care and rights. This study has also shown that this did not necessarily mean any massive gain for women in the

context of FC use and the women's vulnerability to various STIs including HIV/AIDS, because of the gender inequality and imbalance of power relations among couples on sexual matters.

This study looked at FCs as a potential critical 'female initiated and controlled' prevention method effective in mitigating vulnerability to STIs and unintended pregnancy. We learned and reflected on the problematic numeric inequality in the procurement and distribution of prevention methods within the country e.g. that on an annual basis South Africa distributes about 3.5million female condoms FCs to over 400million MCs.[30] We became aware, from the women's narratives, of the frustrations that this inequality has brought when it came to accessing FCs; and the reality encountered upon trying to buy FCs, only to learn that they were not available i.e. out of stock, something not heard of among MCs.

It is important to realize that using the current legal framework in the country to change the power dynamics, and thus balance the current gender inequality in as sensitive and private a context as sexual activity, would be difficult. Advancing women's rights has always been a difficult challenge. But the work of Whipkey (2007) and Shai et al (2010), suggests that in the wake of STIs, conversations on safer sexual pleasure are become more possible to have and the introduction of prevention methods is becoming easier. But is this the experience of women outside urban contexts and those in abusive relationships? Narratives in Chapter Five indicated that negotiating safer sexual activity or the use of FCs are still difficult for a lot of women. We heard for example the experience of women in the Chatsworth focus group who did not believe their husbands or male sexual partners would be excited about the concept of using FCs., and whose religious background is such that, expressing interest in sexual matters is unacceptable. This was a sentiment shared by a number of women from Inanda too, whose cultural backgrounds did not allow for women to show interest in sexual matters. For these women even carrying MCs is taboo. Putting on an FC anticipating sex is thus 'out of line' and taboo. It is for these women that studies like those by Choi *et al* (2004) and this study suggest that FCs were one solution to put the power of prevention in women's hands, to encourage and even

[30]http://www.healthlink.org.za/uploads/files/dhb0809_33.pdf

push women to take charge of their sexual lives (see Shai et al, 2010; Whipkey, 2007).

Cross Cutting Issues

While the main focus of this study was the perception, experience and meaning for South African women on the use of FCs, there were however, a number of underlying issues which came to the surface and had to be engaged with against the background of the key questions. This also becomes critically vital in the context of this study which has positioned and indeed entitled itself 'From Practice to Policy'. While the Practice part and aspect of the title is covered by the data gained and responses around FC perception, experience and meaning making, the cross cutting issues that foreground the key questions probed are important in the context of the translation of the 'practice' to the 'policy' aspect and are thus of importance to locate the key issues within a policy framework.

Given the above, these included the following concerns:

- South Africa having committed to increasing access to FCs without providing evidence on how much women knew about the FCs;
- The lack of evidence that women were correctly using FCs across rural and urban contexts of the country;
- The extent to which FCs were effective as a 'female initiated or controlled' prevention method against STIs; and
- Lack of evidence that policy around FC distribution and education was benefiting women.

From a feminist point of view Warren and Philpott (2003) enquired, and this study supports their questioning as to why the same questions around demand and accessibility for FCs were not asked with as much intensity as when male condoms were first introduced as a prevention strategy. This says a lot about how women are viewed and prioritized when it comes to strategic interventions in which the country invests. Women have not been consulted about products they are expected to use, to have control over and to insert into their most private bodily spaces. For what is the point in procuring and making accessible a product that the target user is not aware of,

not informed about, and with whom not enough efforts are being made to engage on and around FCs?[31].

While men's perceptions of MCs were not a major reason or consideration as to whether they needed to be supplied with MCs, and have them distributed in large quantities across the country; for women it has been different, for reasons of imbalance and inequity. And because this is a reality that is not about to change anytime soon without major advocacy, it may be important or even advisable for women to understand how they are currently positioned in society in so far as accessing FCs. Women need to understand how FCs could perhaps help towards changing that perception. Furthermore, women would need to understand the role of FCs as a female initiated or controlled prevention method in mitigating this risk. Their awareness and demand of the product may in turn impact the availability and accessibility of FCs.

Referring back to the women's narratives on perceptions and how a number of women referred to how their partners felt about FCs, this reveals that there were couples that were already conversing about intimate matters such as sexual activity. The implication was that gender dynamics change. Male power was not necessarily unchanging, and women were not only passive objects. They could both show resistance to male-centered sexual discourses and actively attempt to shape their sexuality through the construction of other positions (Holland *et al.*, 1991). For the purposes of this study, the implications that gender dynamics were fluid and changing suggests the possibility that when it comes to initiatives to prevent STIs, HIV and AIDS there would always be contradictions in negotiating safer sex. As indicated earlier, this moves from women feeling disempowered to make demands, to women taking and exercising control. Argued in an article by McNeil Jr. for the New York Times titled 'Redesigning a Condom so women will use it' was the shocking reality that while *FCs were introduced in the US as early as the late 1990s, it was obviously frustrating public health services that it had not caught up as much in order to overthrow bedroom politics and become an empowerment tool for women*" (2007).

[31] The government did not necessarily require volumes of research on perception and meaning for men using MCs for them to increase availability and distribution –this also says something about the dominance of a patriarchal mindset.

Much depends on how the female condom is introduced and marketed among women, and relies quite heavily on the messaging that went with the promotion of this product (e.g. effective, female initiated or controlled', an empowerment tool, etc.). As the women indicated, it meant not only women needed to be educated about it but men (as sexual partners) too needed to be informed.

Insights and Tentative Recommendations

Based on the perceptions and experiences of women who participated in this study, the following insights are drawn:

a) Women who participate in prevention programmes have certain perceptions because they have become knowledgeable about FCs, and now pay particular attention to detail. For example there were women who were able to tell the difference between FC1 and FC2 before they were even educated about it;

b) There were women in the study who found FCs to be an empowering prevention method that they can control, can carry around in their handbag, and would recommend to other women to use;

c) There were women in the study who have experimented with FC2. These tabled concrete reasons why they like it and this information needs to be shared with other women. For example, they reported that i) it was thinner and made you feel like you were not wearing an FC; ii) that it was less lubricated and therefore made less noise; iii) that it did not smell as much; and iv) that there were those who liked the excitement that came with the inner ring;

d) There were also women in the study who felt the FC1 and its improved version, the FC2 can still be further improved, especially so that the outer ring does not slip inside. This would benefit a lot of women who worry about it slipping and never get to enjoy the intimate moment of their relationship.

Based on the perceptions and experiences of women who participated in this study, the following tentative recommendations are made, bearing in mind that much more

research needs to be carried out and that this study is an important entry point into the area of FCs:

a) There is an urgent need to listen to and pay particular attention to the detail of what women communicate when they share perceptions and experiences as FC users about FCs;

b) There is a need to integrate these women's experiences within policy and programs that attempt to 'educate' women on how to use FCs;

c) There is a need to integrate more women ambassadors within programs that help encourage safer-sex talk so that they could share their experiences with others; and

d) There is a need to encourage conversations about safer sex with FCs that is pleasurable to the women.

What is important to emphasize is the kind of qualitative social science based research that informs these recommendations, that of actually listening to the women. This in turn reminds us that there is yet much critical research still needed here.

Future Research and Conclusions

The legal framework in South Africa states clearly that everyone has the right to equality, is equal before the law and has a right to equal enjoyment of their rights to dignity. Chapter 2 of the Constitution goes further to protect individual rights to sexual and reproductive health care which is inclusive of access to prevention methods, and to deciding which methods to use on one's body. Legally and in principle women are equal to men, but the reality is that at a social level women and men are still unequal and are not treated equally as has been demonstrated in this study on the level of female condom accessibility. Cultural and religious influences on socialisation further continue to render women inferior to men in many contexts. Understanding this has been crucial for the study as it was linked to the investigation

on the position of women in the context of infections and unintended pregnancy; and that of being able to demand or negotiate sexual activity.

It is clear that multiple approaches need to be explored and considered in order to attempt to balance the power among genders and to facilitate a process through which women could enjoy that power, own their bodies, feel comfortable and free to love sex, to desire it and to be able to determine what prevention methods they want used on their bodies by or with their sexual partners. Multiple approaches are required towards assisting women to be able to demand at best, and negotiate at worst, safer sex with their sexual partner(s) without being subject to or fear being exposed to violence. We need the government, human rights activists, gender and service providing organisations to be concerned with women, what they want and believe is right for them, all sentiments that are shared in Varga (1997) and Shisana et al. (2010). As has been demonstrated by this study, when contraceptive products such as FCs are developed, designed, manufactured and produced, those targeted to benefit from these need to have been at the centre of the production process. Herein lies the possibility for women's empowerment through a product like the female condom, in potentially and powerfully changing the power geometries around bodily ownership and safe sex behaviour.

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Appendices

APPENDIX A: TYPES OF FEMALE CONDOMS AVAILABLE IN SOUTH AFRICA

FC TYPE 1. *FC2* manufactured by the Female Health Company (US)

"The Female Health Company (FHC) is the maker of the FC1 and FC2; a revolutionary option offering women dual protection against STIs, including HIV/AIDS, and unintended pregnancy. FHC was formed as a global company in February 1996 with the purchase of Chartex Resources Ltd., the holder of exclusive worldwide rights to FC1. The corporation holds exclusive product and technology patents for FC1 in the United States, Australia, Brazil, Canada, France, Germany, Italy, Spain, and the United Kingdom, the People's Republic of China, South Korea and Japan.

FHC is the sole manufacturer and marketer of the FC1 and FC2 FCs in the world. FHC and its partners currently market the FC under Female Condom®, FC2 Female Condom®, Reality®, Femidom®, Femy®, and Care® in the rest of the world.

The FC is designed for use by women to help prevent HIV and AIDS, other sexually transmitted diseases and unintended pregnancy. Currently the Female Condom is available in two materials: FC1 is made of polyurethane and is manufactured in London. FC2 is made of a nitrile polymer and manufactured in Malaysia and in India. Both versions of the Female Condom have a soft, thin sheath that lines the vagina and covers the labia during intercourse; the condom is held in place with a soft ring at each end.

Clinical studies in the United States and Japan show that FC1 is 95% to 98% efficacious in protecting

against pregnancy when used correctly and consistently. Studies have also shown FC1 to be a highly effective barrier to the viruses and bacteria that cause sexually transmitted diseases, including HIV/AIDS, and that the FC2 is functionally equivalent to FC1. FC1 is currently sold or available through various channels in 116 countries. It is commercially marketed directly to consumers in 15 countries by various country-specific partners in the United States, the United Kingdom, Canada and France. Currently, public sector female condom awareness programs in various stages are ongoing in over 90 countries. FC2 is available in 22 countries outside the United States."[32]

FC TYPE 2.*Woman's Condom* (WC, O'Lavie) manufactured by Shanghai Dahua Medical Apparatus Company (China),

IMAGE SOURCED FROM:
http://www.avert.org/apps/media_gallery/files/images/2016/the-va-wow-condom-feminine-a-type-of-female-condom-large.jpg

FC TYPE 3: *VA w.o.w. FC* (V'Amour, L'amour) manufactured by Meditech Products Ltd (India).

[32]FHC Annual Report: 2007 p 40; 2008 p 26

IMAGE SOURCED FROM:

http://www.avert.org/apps/media_gallery/files/images/2016/the-va-wow-condom-feminine-a-type-of-female-condom-large.jpg

FC TYPE 4. *Phoenurse® FC* manufactured by Tianjin Condombao Medical Polyuthena Tech. Co. Ltd. (China),

IMAGES SOURCED FROM:

http://www.flickr.com/photos/45771098@N05/4205616868/in/set-72157622923721311/

FC TYPE 5: *CupidTM Condom* manufactured by Cupid (India).

Cupid®
female Condom
1 Lubricated Latex Female Condom
Cupid®
female Condom
CE
0470

APPENDIX B: STUDY LOCATIONS

1. CHATSWORTH

Chatsworth is a large township whose population breakdown according to StatsSA (2011) is 16% Black, 80% Indian, 3% coloured, 1% White, and comprises 395,000 - 400,000 people. Languages spoken in this area of Durban are English, isiZulu and a little bit of isiXhosa, primarily as a result of job-migration and inter-racial relationships. In the history of Durban, the changes in legislation and the introduction of discriminatory and segregation laws during the apartheid era, resulted in Chatsworth being a predominantly Indian township, and it is thought to be at the centre of Indian culture. It features the famous Hindu Temple of Understanding that has been covered on numerous occasions on Eastern Mosaic.[33] South Africa has 11 official languages but to be fair to the Tamil and Telegu Indian communities found in Chatsworth, these need to be increased. The R.K. Khan Hospital is both a regional and district hospital located in Chatsworth, and was one of the official sites where the survey was implemented and where focus group discussions were held. The hospital primarily serves the communities of Chatsworth and also the surrounding areas. It is one of the few ‘well staffed’ but very ‘under-resourced’ hospitals in KZN under eThekwini Health District and as a result receives its FCs from this District Municipality. It has a HIV and AIDS unit, where education on and access to prevention methods takes place.

2. INANDA

Inanda is a name of a place originating in the Zulu term ‘ubumnandi’ nice or pleasant or ‘imnandi” something which is nice or pleasant. Inanda the place is situated about 24 km inland from Durban, with a population of about 250,000 – 300,000. Inanda’s community, according to StatsSA (2011) is about 99% Black, 1% Indian, and 2% coloured. People here speak isiZulu, a bit of isiXhosa and a little bit of English. The latter might change in the next decade if one looks at the level of urban-development taking place, and the fact that more and more black children are speaking more English. Within the tourism industry, Inanda is well marketed as the home of John Langalibalele Dube. Politically, like many other ANC stalwarts, a street and a primary

[33] Eastern Mosaic is a TV Programme that features on SABC 2, Sunday’s at 11am. It is primarily about the show-case and celebration of Indian Culture.

school in Inanda are named after Dr Dube. . Inanda is also known as the residence and base of operations of the Mahatma when he lived in South Africa, and as a result the Mahatma Gandhi Foundation, which is responsible for a lot of programmes developing women's skills and livelihoods, is located here. The Foundation also organizes the annual Salt March commemorating Gandhi's peace march in India, which begins from this informal settlement, which was another site used for one of the focus group discussions at Newtown A Clinic, where a focus group meeting was held. From a religious context, Inanda is also known as the birthplace of 'the Shembe', the Nazareth Baptist Church, which is deeply religious as well as culturally influential. The role of women within the church and the community is very clear - they are subordinate, must submit to their men, both fathers and even sons. The men in this context can easily have more than one wife, and there seems to be an unwritten belief here that more children indicate the wealth of the man. Inanda is located next to KwaMashu and Ntuzuma and together these townships are known as the INK area. They have their own radio station (Inanda FM) and a local newspaper is underway.

3. WENTWORTH

Historically, Wentworth is known as the coloured township of Durban. It is predominantly Coloured, with Black and a small number of Indians also resident there... It has a rather small population of about 115,000 – 125,000 people. English and isiZulu are the predominant languages, but you will also find a small amount of isiXhosa, Afrikaans and two of the indigenous Indian languages, i.e. Tamil and Urdu. Wentworth for the longest time has been a highly industrialized area. Through the Group Areas Act it was further divided into Black, White, Coloured and Indian areas so that 'the Bluff'A Indians were moved south and settled in what is now known as the Merebank and Merewent townships. Jacobs and Mobeni Heights have what seems a fair spread of Black and Indian communities although the business is predominantly in Indian hands. Research and campaigning by organisations such as the KZN Network on Violence Against Women and Children, have cited Wentworth and surrounds as some of the areas in Durban with the highest levels of substance abuse, violence, prevalence of HIV and AIDS and poverty. Wentworth has a Provincial Hospital, a Municipal Hospital and the colourful Keep a Child Alive Clinic (also known as the Blue Roof or Women's Centre) as the only health care facilities that are also responsible for the distribution of FCs. These were used as

sites to implement the survey questionnaire and to safely and comfortably hold focus group discussions.

4. LAMONTVILLE

Lamontville is arguably the oldest black dominated township in Durban. There is some contestation over when it was actually established – either 1930 or 1934 although a number of historians have reason to believe it was 1934. Whatever the case, most agree that it was named after its mayor for the period 1929-1932, a Reverend Lamont. On the tourist map, Lamontville is about 11km or so south of Durban on the Umlaas River and next to the small township called Mobeni. According to StatsSA (2011) it is about 95% Black, 2% Indian, 2% coloured and 1% White, and is home to about 130,000-150,000 people who predominantly speak isiZulu and isiXhosa. What is interesting about the adult population here is that the women are the majority, mostly grandmothers who stay home alone raising daughters and their children. A number of households here are headed by women mostly siblings, who live with their children, though there are some that are child-headed as a result of HIV. Religion plays a big role within this community though it is women who populate the churches while the men drink away their weekends. A lot of men live in hostels, although this reality shifts year in and year out.

5. DURBAN

Durban is commonly referred to within tourism circles as *eThekwini Metropole*, thus eThekwini Municipality. But '*itheku'* as Zulu speakers will refer to it means 'a bay'. Durban, the third largest city in South Africa, is also acclaimed as the biggest harbour and busiest port (ichweba) on the Indian Ocean. The eThekwini Municipality, which includes some of the neighbouring towns discussed above, has about 3.5 million people residing here. With a population of about 530,000 to 600,000 (HSRC Household Study 2007; StatsSA 2011) Durban Central, or the city of Durban, is about 37% Black, 27% Indian, 26% White and 10% Coloured. Languages spoken within the city centre are 59% English, 29% isiZulu, 5% isiXhosa, 4% Afrikaans, and 3% Other (StatsSA, 2011).

APPENDIX C

DURBAN AND SURROUNDS: PILOT SITES, CLINICS, HOSPITALS AND ORGANISATIONS THAT DISTRIBUTE FEMALE CONDOMS AND/OR IMPLEMENT FEMALE CONDOM USE PROGRAMS

Durban Central	**COMMERCIAL CITY CLINIC** Public Clinic, Pregnancy and Family Planning Shop 14 Commercial City Building, Dr A B Xuma Street, Durban Telephone: 031 305 5016
Durban Central	**DURBAN LESBIAN AND GAY COMMUNITY AND HEALTH CENTRE** Office 2726, Redefine Towers, 320 Dr Pixley KaSeme Street, Durban, 4001, Telephone: 031 301 2145 and 031 301 2149
Durban Central	**MATCH** Established in 2010, the Maternal, Adolescent and Child Health is based in Overport, Durban. It is a branch of the Reproductive Health and HIV Research Unit (RHRU), a division of the Wits Health Consortium (Pty) Ltd, within the Department of Obstetrics and Gynaecology, Wits. 155 Juniper Road Overport, 4091 Durban, Telephone: 031 275 1540; Email: info@match.org.za http://www.match.org.za
Durban Central	**ROSE CLINIC** Pregnancy and abortion Commercial City, Dr A B Xuma Street, Durban, 4001 Telephone: 031 307 1916
Durban Central	**SIYAYINQOBA-BEAT IT//CMT** Telephone: 021 788 9163
Umlazi	**ITHEMBALABANTU CLINIC** (AIDS Healthcare Foundation) Free Global AIDS treatment facility Group and 1st Floor, 162 Zwe Madlala Drive, W Section, Umlazi

Telephone: 031 906 0452

Wentworth **BLUE ROOF**

Keep a Child Alive Centre

74 Lubbe Road, Austerville, Wentworth, Durban, 4052

Telephone: 031 461 3101

Ethekwini Clinic List Page 2 – 11 of http://hs.ukzn.ac.za/Libraries/Post-graduate_Administrative_Procedure/DoH_KZN_Authority_CLINICS.sflb.ashx

APPENDIX D

FACULTY OF HUMANITIES, DEVELOPMENT AND SOCIAL SCIENCES

FEMALE CONDOM PERCEPTION STUDY

Name of contact person to contact with questions or in a case of an emergency:

Ms Nonhlanhla Mkhize, Telephone: 0313012145; Fax: 0313012147

INFORMED CONSENT FORM

INTRODUCTION:

Good day, my name is _________________, I shall do the interview with you. Before we continue with the interview, it is important that we go through the following information and explanations to ensure that you understand what we are going to do.

PURPOSE OF THE STUDY:

The study is about **Female Condom**s (**FCs**). It seeks to gain access to how much you know about female condoms and your perceptions of them based on your experience with them. Approved by the United States Food and Drug Administration FCs are said to provide women with better protection against sexually transmitted infections. In South Africa they are available in more than 249 sites across the country. The Department of Health (DOH) has committed to increase the distribution of female and male condoms.

PROCEDURES:

I will ask you questions about:

- You, your knowledge and perception about female condoms, if at all you use them and how;
- your sexual behaviours; and
- Your feelings about condom use.

POTENTIAL RISKS & DISCOMFORTS:

Much of the information we would like you to share with us is of a sensitive nature. Some of the interview questions about your sexual behavior may be uncomfortable.

POTENTIAL BENEFITS:

There will be no direct benefit to you from participating in this study. However, your answers will help me to better understand your perceptions and experience with female condoms. Your answers will help community organizations, researchers, and health workers in this area to provide better services.

COMPENSATION:

There is no compensation for participation in the focus group or the interview.

CONFIDENTIALITY:

Your answers will be completely anonymous, and your responses to the questionnaire will not be linked to your identity. The interviewer will not collect any personal identifying information from you other than your first name and the first initial of your last name.

RESEARCH STANDARDS AND RIGHTS OF PARTICIPANTS:

Your participation in this research project is voluntary. You may skip any question that makes you feel uncomfortable. If you decide to skip any questions you will still be allowed to complete the rest of the survey.

CONTACTS FOR QUESTIONS AND FURTHER INFORMATION:

If you want additional information regarding the study please feel free to contact Nonhlanhla Mkhize, Ms: Telephone: 031-301 2145; Fax: 031-301-2147

DOCUMENTATION OF CONSENT:

If you have read this document and given the chance to ask any questions now, or at a later time or if the document has been read and explained to you, please sign or make your mark below.

- I have been informed by ______________________ (the interviewer) about the nature, conduct, benefits and risks of this study
- I have also received, read and understood the above written information regarding the study
- I am aware that the results of the study including personal details regarding sex and relationships will be anonymously processed into a study report
- I may, at any stage during the interview, without prejudice, withdraw my consent and participation in the study
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study

I voluntary agree to participate in the research study described above.

____

Print Participant's **First Name and Initial of Last Name** Date

I have discussed the proposed research study with the participant, and in my opinion, they understand the benefits, risks and alternatives (including non-participation) and are capable to freely consent to (or refuse to) participate in this research study.

____

Print **Name of Person** Obtaining Consent Date

A signed copy of this consent form must be 1) retained on file and 2) the second one given to the participant for their records.

APPENDIX E

FACULTY OF HUMANITIES, DEVELOPMENT AND SOCIAL SCIENCES

FEMALE CONDOM PERCEPTION STUDY

Name of contact person to contact with questions or in a case of an emergency:
Nonhlanhla Mkhize, Ms: Telephone: 031-301 2145; Fax: 031-301-2147

SURVEY QUESTIONNAIRE

SECTION A: DEMOGRAPHICAL INFORMATION

AGE ________ How old were you at your last birthday?

Define Yourself (Tick the Most Appropriate)

SEX	Female	Male

GENDER	Woman	Man

ATTRACTION	Men Only	Both Men and Women	Women Only

RACE	Black	Coloured	Indian	White

I LIVE	In the City	In the Township	In an informal settlement

I HAVE LIVED HERE

Since childhood	Since I started studying	Since I got a job	Since I got married	Recently

EDUCATION	Below Matric	Matric	Under Graduate	Post Graduate

In the past **6 months**, how often have you tested for HIV?

Once	More Than Once	Never	Don't Like Testing

SEXUAL ACTIVITY

In the past **3 months**, how often have you engaged in sexual activity?

Once	More Than 5 Times	Never	Don't Like Sex

In the past **3 months**, how often have you engaged in protective sex?

Once	More Than 5 Times	Never	Don't Like Condoms

Who are you likely to have sex with?

Only Men	Mostly Men	Both Men and Women	Mostly Women	Only Women

SECTION B

QUESTION	YES	NO
1. Have you ever used a female condom with a sexual partner before?		
2. Did you use a female condom with a sexual partner in the past 6 months?		
3. Do you like female condoms?		
4. Are you able to easily use female condoms with your sexual partner?		
5. Does your sexual partner like it when you use female condoms?		
6. Do you like how the female condoms feel inside your vagina?		

7. Would you recommend or encourage other women (to use female condoms?		
8. Do you carry female condoms in your everyday hand bag?		
9. Do you have days when you wear a female condom anticipating a sexual encounter?		
10. Do you know where female condoms sites are?		
11. Do you know your nearest condoms site?		

12. What prevention method do you prefer to use for sex?	Male condom	Female Condom	Both
13. What female condom awareness media	pamphlets	adverts	Posters
14. How are female condoms advertised or promoted in Durban?			

. Where do you get your female condoms	local organisation/clinic	buy them

16. What problems have you experienced with female condoms (chose those relevant from list)

Costly	a mood killer	Accessibility	slips during sex	uncomfortable

17. If you had to choose one prevention method to use against sexually transmitted diseases or infections which one will it be:

dental dams	male condom	Gloves	female condoms	abstain

18. If you had to choose one contraceptive to prevention pregnancy what would it be:

cervical cap	morning after pill	Injection	female condom	diaphragm

APPENDIX F

FACULTY OF HUMANITIES, DEVELOPMENT AND SOCIAL SCIENCES

FEMALE CONDOM PERCEPTION STUDY

Name of contact person to contact with questions or in a case of an emergency:
Nonhlanhla Mkhize, Ms: Telephone: 031-301 2145; Fax: 031-301-2147

IN-DEPTH INTERVIEW QUESTIONNAIRE

SECTION A: DEMOGRAPHICAL INFORMATION

AGE _________ How old were you at your last birthday?

Define Yourself (Tick the Most Appropriate)

SEX	Female	Male

GENDER	Woman	Man

ATTRACTION	Men Only	Both Men and Women	Women Only

RACE	Black	Coloured	Indian	White

I LIVE	In the City	In the Township	In an informal settlement

I HAVE LIVED HERE

Since childhood	Since I started	Since I got a job	Since I got	Recently

	studying		married	

EDUCATION	Below Matric	Matric	Under Graduate	Post Graduate

In the past **6 months**, how often have you tested for HIV?

Once	More Than Once	Never	Don't Like Testing

SEXUAL ACTIVITY

In the past **3 months**, how often have you engaged in sexual activity?

Once	More Than 5 Times	Never	Don't Like Sex

In the past **3 months**, how often have you engaged in protective sex?

Once	More Than 5 Times	Never	Don't Like Condoms

Who are you likely to have sex with?

Only Men	Mostly Men	Both Men and Women	Mostly Women	Only Women

SECTION B

1) Have you ever used a female condom with a sexual partner before? If yes or no, explain why.

____

____

2) What do you use female condoms for? _____________________________________

____

____

3) What is it that you liked or like about female condoms?

____

____

4) Have you used a female condom in the past 6 months? ____________________

5) How does a female condom feel like inside the vagina? ____________________

____

6) How does it feel to use female condoms compared to male condoms for vaginal sex?

____

____

7) How does it feel to use female condoms compared to male condoms for anal sex?

____

____

8) Where do you get/buy your female condoms? ___________________________

How much do they cost you? ____

How do you feel about the treatment you receive at this place? _______________

____

____

9) Are you able to easily use female condoms with your sexual partner? _______

10) Does your sexual partner like it when you use female condoms? __________

11) How does one correctly put on a female condom? _______________________

____

____

12) If you have stopped using female condoms, why is that so? _______________

____

____

13) What problems have you experienced with female condoms (e.g. cost, accessibility, use, design, or any other) ___________________________________

____

____

14) If you had to choose one prevention method to use ***against sexually transmitted diseases or infections*** which one will it be between: a female condom, a male condom and abstinence? Please explain why? _______________

____

____

15) If you had to choose one contraceptive to prevent ***pregnancy*** which one would it be between: the injection, a female condom, a cervical cap or a diaphragm? Please explain why? ____

____

____

16) What do you prefer: female condoms or male condoms? Please explain why.

____

____

17) What would you recommend be done to female condoms so that you can use them more? ____

____

18) Would you recommend or perhaps encourage other women (or men) to use female condoms? ____

____

19) Where do you get you female condoms? _______________________________

20) Which female condom pilot site do you know? __________________________

____

21) When is the female condom an empowerment tool for prevention for women?

____

____

22) What female condom awareness media (pamphlets, posters, advertisements, etc.) do you know? ____

____

23) How are female condoms advertised or promoted in Durban? ______________

____

24) How do you think their advertising and promotion can be improved? ________

____

____

25) What language do you use at home, at school, at work or in your organization or department do you use to talk about and educate other about female condoms? How has the response been? ____________________________

____

26) In your department's / project's experience how are women responding to female condoms vs other female controlled pregnancy measures (e.g. cervical cap and diaphragm)?

____

____

27) In your department's / project's experience how are women responding to female condoms vs other female controlled sexually transmitted infection prevention measures (e.g. male condoms).

____

____

THANK YOU FOR YOUR TIME, YOUR HONESTY AND PARTICIPATION

APPENDINX G

FACULTY OF HUMANITIES, DEVELOPMENT AND SOCIAL SCIENCES

FEMALE CONDOM PERCEPTION STUDY

Name of contact person to contact with questions or in a case of an emergency:

Nonhlanhla Mkhize, Ms: Telephone: 031-301 2145; Fax: 031-301-2147

FOCUS GROUP DISCUSSION QUESTIONNAIRE

SECTION A: DEMOGRAPHICAL INFORMATION

AGE _________ How old were you at your last birthday?

Define Yourself (Tick the Most Appropriate)

SEX	Female	Male

GENDER	Woman	Man

ATTRACTION	Men Only	Both Men and Women	Women Only

RACE	Black	Coloured	Indian	White

I LIVE	In the City	In the Township	In an informal settlement

I HAVE LIVED HERE

Since childhood	Since I started studying	Since I got a job	Since I got married	Recently

EDUCATION	Below Matric	Matric	Under Graduate	Post Graduate

In the past **6 months**, how often have you tested for HIV?

Once	More Than Once	Never	Don't Like Testing

SEXUAL ACTIVITY

In the past **3 months**, how often have you engaged in sexual activity?

Once	More Than 5 Times	Never	Don't Like Sex

In the past **3 months**, how often have you engaged in protective sex?

Once	More Than 5 Times	Never	Don't Like Condoms

Who are you likely to have sex with?

Only Men	Mostly Men	Both Men and Women	Mostly Women	Only Women

SECTION B

1) Have you ever used a female condom with a sexual partner before? If yes or no, explain why.

____

____

2) What do you use female condoms for? ____________________________________

____

____

3) What is it that you liked or like about female condoms?

____

____

4) Have you used a female condom in the past 6 months? ____________________

5) How does a female condom feel like inside the vagina? ____________________

____

6) How does it feel to use female condoms compared to male condoms for vaginal sex? ____

____

7) How easy or difficult did you find it to be to get used to using female condoms for sex? ____

____

____

8) Where do you get/buy your female condoms? __________________________

How much do they cost you? ____

How do you feel about the treatment you receive at this place? _______________

____

____

9) Are you able to easily use female condoms with your sexual partner? _______

10) Does your sexual partner like it when you use female condoms? __________

11) How does one correctly put on a female condom? _______________________

____

____

12) If you have stopped using female condoms, why is that so? _______________

____

____

13) What problems have you experienced with female condoms (e.g. cost, accessibility, use, design, or any other) __________________________________

____

____

14) If you had to choose one prevention method to use ***against sexually transmitted diseases or infections*** which one will it be between: a female condom, a male condom and abstinence? Please explain why? _______________

____

____

15) If you had to choose one contraceptive to prevent ***pregnancy*** which one would it be between: the injection, a female condom, a cervical cap or a diaphragm? Please explain why? ____

____

____

16) What do you prefer: female condoms or male condoms? Please explain why.

____

____

17) What would you recommend be done to female condoms so that you can use them more? ____

____

18) Would you recommend or perhaps encourage other women to use female condoms? ____

____

19) Where do you get your female condoms?

____

20) Which female condom pilot site do you know? ___________________________

____

21) When is the female condom an empowerment tool for prevention for women?

____

____

22) What female condom awareness media (pamphlets, posters, advertisements, etc.) do you know? ____

____

23) How are female condoms advertised or promoted in Durban? ____________

____

24) How do you think their advertising and promotion can be improved? _______

____

____

25) What language do you use at home, at school, at work or in your organization or department do you use to talk about and educate other about female condoms? How has the response been? _________________________

____

26) In your department's / project's experience how are women responding to female condoms vs other female controlled pregnancy measures (e.g. cervical cap and diaphragm)?

____

____

27) In your department's / project's experience how are women responding to female condoms vs other female controlled sexually transmitted infection prevention measures (e.g. male condoms).

____

____

THANK YOU FOR YOUR TIME, YOUR HONESTY AND PARTICIPATION