

**CONDOM USE IN MARRIAGE AMONG
FAMILY PLANNING PROVIDERS IN THE
CITIES OF BLANTYRE, LILONGWE AND
MZUZU**



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**CONDOM USE IN MARRIAGE AMONG FAMILY
PLANNING PROVIDERS IN THE CITIES OF
BLANTYRE, LILONGWE AND MZUZU**

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EXECUTIVE SUMMARY

Background

HIV/AIDS infection is currently one of Malawi's major public health problem. This problem is compounded by the fact that the main mode of transmission is through sexual activity, a very private activity involving individuals or families. In Malawi, the condom to date has been seen more as a disease protection device for sexually transmitted disease (STD) and used those individuals engaging in extra-marital affairs, or those working as commercial sex workers. Currently there is considerable evidence that a significant proportion of HIV/AIDS infection in Malawi is contracted within marriage. Any efforts, therefore, to combat the spread of HIV/AIDS infection through behavioural change needs to target individuals or families sexual attitudes, beliefs and practices. In 1995, the Condom initiative Committee was formed and the study on condom use in marriage was one of the many initiatives of this Committee. The overall objective of the study on condom use in marriage was to ascertain married couples' sexual attitudes, beliefs, and practices, and their readiness to adopt self-protective behaviour.

Methodology

The participants to the study were drawn from 11 parastatal and 7 private organizations in the cities of Blantyre, Lilongwe and Mzuzu. All the organizations had employees in both management position, and skilled and unskilled workers. A total of twenty-eight focus group discussions were conducted.

A focus group discussion guide was used to obtain data on sexual attitudes, beliefs and practices related to condom use in marriage. Questions on the guide focused on areas concerning matters related to sex and sexual practices in marriage, and about condom use in particular. Data was collected by two teams, a male team and a female team, comprising one facilitator and one note-taker, from October to December, 1995. Discussions were conducted in English, Chichewa and Chitumbuka, depending on which language the group of participants felt most comfortable to use.

Data were analysed manually by group and organized into concurrent themes related to couple's attitudes, beliefs and practices pertaining to sex and condom use in marriage.

Findings

Results of the study showed there was no distinct difference in views expressed by participants by city, ethnic background, religious affiliation, or educational level.

A. Discussion of sex in marriage

Discussing sex in marriage among couples was viewed as difficult by the majority of the participants. This difficulty was attributed to the upbringing of females in the "Malawian

culture", superiority accorded to husbands over sexual issues in marriage, fear of the husband, shyness of the wife and fear of the intent being misinterpreted as a sign that the wife was having extra-marital affairs or that she was not sexually satisfied with her husband.

The few participants who had no difficulty attributed the lack of difficulty to the fact that they had family life lessons given to them at the time of their marriage by their church. The Seventh Day Adventist church and the Roman Catholic church were said to prepare newly weds for marriage by providing family life lessons.

B. Attitude and belief on condom use in marriage

1. Condoms brought by the husband into the home for the first time

A man who brought condoms into the home for the first time without prior discussion, was said to have done so because he had extra-marital sex and that he suspected that he possibly infected with STD which he did not wish to pass on to his wife.

2. Thoughts or feelings of wife whose husband has brought condoms

Participants used the following words to describe the thoughts or feelings of a wife whose husband had brought home condoms: pained, hurt, bitter, doubtful, disappointed, and worried. The participants further stated that the wife would present this problem to *Ankhoswe* (marriage counsellor).

3. Thoughts or feelings of husband whose wife suggested condom use in marriage

Participants used the following words to describe thoughts of a husband whose wife suggested condom use in marriage: suspicious, surprised, and angry. Participants further indicated that the issue will be taken to *Ankhoswe* (marriage counsellor).

4. Discussing the condom issue with spouse

The majority of the participants indicated that they would discuss the issue with their spouse and the discussion would be centered on why the condom had been introduced. The participants observed that they would have to be very tactful in bringing up the subject of condoms in order to have a useful discussion with their spouse.

5. Using condoms in marriage

- (a) Condoms were mainly used as a contraceptive in combination with other hormonal contraceptives, and just for a short period while waiting for the hormonal contraceptive to take effect.
- (b) Condoms were used because the wife had persistent menses and or irregular menstrual cycle as a result of the contraceptive depo-provera.
- (c) Condoms could be used in marriage if there was a very good reason, for example, if a spouse has STD, if a couple is HIV sero-positive or if a spouse is suspected of infidelity.

6. **Who ought to suggest condom use in marriage?**

- (a) Husband ought to suggest because he is the head of the family and he is the one who uses the condoms.
- (b) Wife ought to suggest because she is the one who attends the family planning clinic and was likely to have information on condoms.

C. Experience of using condoms

- (a) The positive experience given was that there was no difference in sexual satisfaction.
- (b) The negative experiences given included husband not being able to ejaculate, husband's penis not being able to erect and the couple missing the natural friction in sexual intercourse.

CONCLUSION

The perception that condoms interfere with sexual pleasure, as well as the strong association with extra-marital sex is suggestive that change to using condoms will be slow even among some health care professionals as family planning providers. Some recommendations to help family planning providers have been given.

INTRODUCTION

Background and Brief literature review

HIV/AIDS is currently one of Malawi's major health problems. This problem is compounded by the fact that it is transmitted through sexual activity, a very private activity involving individuals or families. The number of AIDS cases and the HIV prevalence is highest in the age bracket of 15- 49 years, the reproductive age. Any efforts, therefore, to combat the spread of HIV/AIDS needs to target these individuals or families sexual attitudes, beliefs and practices. It is important to furnish them with information geared at: (a) helping them change their sexual attitudes, beliefs, and practices, and (b) guiding them to adopt self-protective behaviour.

Currently there is considerable evidence that a significant proportion of HIV/AIDS in Malawi is contracted within marriage. A survey conducted at the Queen Elizabeth Central Hospital (QECH) in Blantyre revealed that of the women who attended the ante-natal clinic, 31% were HIV positive, although 95% of these were married and 70% reported having had only one sexual partner. In 1995, an analysis of new AIDS cases by occupation revealed that 26.4% were housewives, 18.5% were farmers, 18.5% were unskilled workers, 15% were skilled workers and 9.6% were educated workers (AIDS Secretariat, 1995).

Several studies done in Malawi have shown that the condom to date has been seen mainly as a protective device against sexually transmitted diseases (STD) and used by those individuals engaging in extra-marital affairs, or working as commercial sex workers. Several misconceptions also exist about the condom. These include the condom: (a) reducing the man's ability to express his manhood fully, (b) causing male sterility, (c) diminishing sexual satisfaction, and (d) causing physical discomfort (Kornfield, 1995; Namate and Kornfield, 1997). Kornfield's (1995) study on condoms also revealed that although condoms were often linked with promiscuity among both men and women, there were some married couples who used condoms within marriage for various reasons. Previous studies in other countries have cited several barriers to condom use in marriage and these include reduced sexual pleasure, preference for other contraceptives, suspicion between the couple aroused through use of condoms, preference for abstinence in STD prevention, and lack of perceived need to use condoms (Knodel & Pramualratana, 1996).

A study on assessment of attitudes of family planning providers (Tavrow, Namate and Mpemba, 1995) revealed that condoms were not promoted as a family planning method. The condom was rather more often given as a back-up method after starting on oral contraceptives. The study also revealed that family planning providers had very

limited trust in condoms. The major disadvantages cited included possible allergy from the rubber, delayed male partner excitement, the spread of infection from improperly disposed condoms and the high chance of pregnancy. This finding supports findings from other studies which indicate that the attitude of family planning providers towards contraceptive methods influences the contraceptive choice of the family planning clients.

In Malawi condoms have been available to people through various means, each targeting a specific group of individuals. Through social marketing, the target has been mostly males and commercial sex workers. Through family planning clinics, the target has been mostly family planning clients and some clients with STDs. Through private clinics and out-patient clinic facilities, the target has been mostly clients with STDs.

Family planning providers in Malawi are therefore in a strategic position to promote condom use as they interact with clients who are in their reproductive years, who are sexually very active, and who form the largest percentage of the high risk group for HIV infection (AIDS Secretariat, 1995). Secondly, condoms distributed by family planning providers or other health care providers are better accepted for use in marriage than when condoms are obtained elsewhere (Namate and Kornfield, 1997). However, if family planning providers are to appropriately guide people to adopt self-protective behaviour in marriage, their own sexual attitudes, beliefs and practices towards the use of condoms in marriage needs to be ascertained. Further, considering that HIV/AIDS epidemic remains a major health problem in Malawi and still having no cure in sight, the extent to which family planning providers promote condom use could have an impact on behaviour change and the AIDS epidemic as a whole.

Study objective

The objective of the study on condom use in marriage was to ascertain family planning providers' sexual attitudes, beliefs, and practices, and their readiness to adopt self-protective behaviour.

Specifically, the study sought to answer the following questions:

- (a) What are the attitudes and beliefs of family planning providers towards discussing sex in marriage?
- (b) What are the attitudes and beliefs of family planning providers about the use of condoms in marriage?
- (c) What are the family planning providers' experiences with using condoms?

METHODOLOGY

Sample and sampling

Family planning providers (FPPs) were randomly selected from a list of FPPs working in governmental and non-governmental health institutions in the cities of Blantyre, Lilongwe and Mzuzu. The list was obtained from the district health office in each of the three cities. According to FPPs randomly selected were informed of the purpose of the study and requested for their willingness to participate in the study. A date, time, and place for the conduct of the focus group discussions was communicated to the potential participants. Attendance at the focus group discussions was taken as their consent to participate in the study.

A total of three focus group discussions were conducted, one in each city. The focus group discussions had between 10 to 17 participants.

Data collection tool

A focus group discussion guide was used to obtain data on sexual attitudes, beliefs and practices related to condom use in the family (Appendix 1.). The focus group discussion guide was translated into Chichewa and Tumbuka. The topics for discussion followed the outlined study questions. The focus group discussion guide had a total of 28 questions which focused on areas concerning matters related to sex and sexual practices in marriage, and about the use of the condom in particular. The focus group discussion guide was pre-tested in one of the districts in the Southern Region. It was noted from this pre-testing that people responded freely and openly to the questions in the focus group discussion guide although the questions addressed an issue which was not normally discussed in marriage.

Data collection procedure

Data collection was done from October to December, 1995. A two-day training was conducted for the facilitators and note-takers of the focus group discussions. The focus group discussions were conducted in either English, Chichewa or Tumbuka, depending on which language the group of participants felt most comfortable to use. Conducting the focus group discussions in Chichewa or Tumbuka allowed the participants to express themselves more freely and fully than they would have done had the discussions been conducted in English only.

Data collection was carried out by a female team, comprising one facilitator and one note-taker. A tape recorder was used during the focus group discussions to compliment the note-taker. The data were then transcribed and translated into English.

FINDINGS

Data were analysed manually by group and were organized into concurrent themes related to family planning providers' attitudes, beliefs and practices pertaining to sex and condom use in marriage. The study findings will be presented under the following headings: (a) discussion of sex in marriage, (b) attitudes and beliefs about use of condoms, (c) experiences in condom use, and (d) readiness to use condoms.

There were no distinct differences in the views expressed by participants by city, ethnic background, religious affiliation, or educational level.

Demographic data

A total of 42 participants were involved in this study, 17 from the city of Blantyre, 15 from the city of Lilongwe and 10 from the city of Mzuzu. All participants were female.

The age of participants ranged from 30 to 55 years, with 47.6% (n= 20) in the age range of 30-39 years, 45.2% (n= 19) in the age range of 40-49 years and 7.2% (n= 3) were between 50 and 55 years of age. The majority were in the age range which is sexually active and most vulnerable to HIV/AIDS infection.

The educational level ranged from primary to secondary school level of education, with 4.8% (n= 2) having senior primary level education, 59.5% (n= 25) having junior secondary school level education and 35.7% (n= 15) having senior secondary school level education. The majority of the family planning providers were enrolled nurses.

The participants belonged to one of several religious groups including 42.9% (n= 18) of the Church of Central Africa Presbyterian (CCAP), 23.8% (n= 10) Roman Catholic, 16.7% (n= 7) Seventh Day Adventist and the remaining 16.6% (= 7) belonged to one of the following religions: Anglican, Baptist, Assemblies of God, New Revival Church and World Wide Church of God.

The participants belonged to a range of ethnic groups. The majority were Ngoni (33.3%), 21.4% (n= 9) were Tumbuka, 16.6% (n= 7) were Chewa, 9.5% (n= 4) were Nyanja and the remaining 19.2% (n= 8) belonged to one of the following ethnic groups: Lomwe, Tonga, Nkhonde, Sena, and Msukwa.

All except 19% (n= 8) of the participants were using one form of contraceptive or another. Thirty-eight (n= 16) percent had tubal ligation, 19% (n= 8) were using depo-provera, 9.5% (n= 4) were using the natural method, 7.2% (n= 3) had a Lippes' loop or Copper T, 4.8% (n= 2) were using pills and only 2.4% (n= 1) was using male condoms.

A . Discussion of sex in marriage

All participants shared similar views on the subject of discussing sex in marriage. The majority of the participants were of the view that it was difficult to discuss sex in marriage while a smaller percentage indicated that it was not difficult.

1. Discussing sex in marriage is not difficult

The few participants who were of the view that discussing sex in marriage is not difficult based this on the preparation the couple had for marriage. Some participants indicated that at the time of their marriage they were given family life lessons by some designated individuals at their church. Two churches were cited as being actively involved in this activity, the Seventh Day Adventist Church and the Roman Catholic Church. Further family life lessons were also given to the couple during their marriage, providing a mechanism for sustaining what had been taught.

Participants reported that those individuals who had read books on communication in marriage, or had watched movies on sex or had been exposed to 'western culture' or are copying 'western culture', tend to discuss the subject of sex with their spouse more freely. Even those few individuals who indicated that they discuss sex with their husband stated that in the true 'Malawian culture' there is no discussion on sex in marriage, only actions.

2. Discussing sex in marriage is difficult

The participants who were of the view that it was difficult to discuss sex in marriage attributed this mainly to culture. The explanation was given that in the traditional 'Malawian culture', women are inhibited from communicating verbally with their spouse on sex-related matters. Participants reported that in their upbringing girls were encouraged to be shy and not to discuss sex issues with men. One participant reported at puberty she was instructed that if she had sex with a man her mother would die. The participants reported that the result of this teaching was that the man they were married to was usually the first man they ever had sex with. It follows then that even as grown ups, it was difficult for women to be very free with their husbands, let alone to verbally discuss the subject of sex with them. The participants stated that this may be changing slightly for those who have been through some kind of formal education but they still were of the view that educational differences between husband and wife in some cases accounted for the communication problems. For example, a husband having higher educational level than the wife.

While "Malawian culture" does not encourage women to verbally communication on sexual matters with their spouse, non-verbal communication is strongly advocated,

through signs and symbols. For example, use of touch or gestures to indicate sexual desire, placing red beads or red piece of cloth on the bed to indicate that the wife was menstruating, and white beads or a white piece of cloth to indicate that she is finished. The participants indicated that while they had been instructed on this as they were growing up and at the time of their marriage, they did not indicate whether they themselves were currently still practicing these behaviours.

The participants also stated that at the time of their wedding, when the couple is given special advice about marriage, the counsellors and advisors place a lot of emphasis on the husband as the head of the family and his superiority in marriage and provide him with the freedom to initiate discussions in that marriage. For the wife, the submissive role in marriage was emphasized, including the requirement to always listen to her husband. At this time emphasis is placed on the responsibility of the husband as the initiator of sexual activity and not the wife. The counsellors and advisors also inform the couple that sex is secret and it should not be discussed at all. Some participants reported being told not to undress in front of their husband. Participants indicated that it was only after the couple had stayed together for sometime and were used to each other that they could have a discussion on the subject of sex with each other. One participant candidly put her feelings as given in this quote:

"Let me say something about myself. I am not free to discuss sex issues with my husband but my husband is free. Maybe it is because of what they have already said that you only deliver children but do not enjoy sex. And because of this you may think your husband is bothering you. And in a family I feel as if I am a slave. You know, I have responsibility of which I feel it is too much, for example, I have to welcome him when he comes from work, wash his clothes, prepare food for him and then have sex with him even if I have no feelings. I deliver children but I do not enjoy sex. I really feel as if I am a slave."

An observation was made by the participants that it was very hard for them to initiate a discussion on sex because of shyness, fear of the husband, and fear of the intent being misinterpreted as a sign that the wife was having extra-marital affairs, that she may not be sexually satisfied by her husband. There was also a state of powerlessness or hopelessness on the part of the wife as indicated by one participant in this quote "....if you have a cruel husband you are afraid of telling him your feelings for fear that he may beat you or chase you out of the house so you keep quiet. If you have a drunkard for a husband, you have no opportunity to discuss much, so you just keep quiet." One participant stated that initially she was not free to discuss sex with her husband but changed after going through the family planning programme and living together for years.

3. Time for discussing about sex

In relation to the time when sex is discussed between spouses, the majority of the participants indicated night or early morning, while a few stated that the couple could talk any time they had the opportunity to do so. Night or early morning was preferred because there were minimal disturbances, the children if any, were asleep, there were no interruptions from visitors, and it was the best time for the majority of couples, time when they had peace and quiet. According to participants, shyness may also be the reason for choosing to discuss sex at night. Day time or any time was mostly applicable to those who did not have children, like young couples, or those who worked shift jobs, or those who had spacious homes which provided the couple enough privacy to discuss sexual issues with minimal disturbances.

Some participants indicated that although there may be a discussion it was never direct, it usually came about in a round about way. What was said to be discussed varied a lot. Some of the discussion centered around the dangers of extra-marital sex in the wake of the deadly disease AIDS, problems associated with their sex life, number of children to have, whether or not they satisfied each other sexually, being faithful to each other so that they did not contract diseases such as STDs, family planning and other problems at home which affect ones' response to sex such as money or food shortage and poverty.

B. Attitude and beliefs on condom use in marriage

To determine the attitude and beliefs of family planning providers on condom use in marriage, a hypothetical situation was presented to which participants reacted and several related questions were asked, some of which were personalized to the participants.

1. Condoms brought by the husband into the home for the first time

A hypothetical situation was provided to solicit participants' views on a man who had been away from home and introduced condoms in marriage to be used for the first time without any prior discussions with the spouse. The man's action was associated with his having had extra-marital sex and that he suspects he might be infected with an STD which he does not wish to pass on to his wife. The action of bringing a condom home was also interpreted as love for his wife.

2. Thoughts or feelings of a wife whose husband had brought condoms.

Participants were asked to describe feelings or thoughts of the wife whose husband had brought home condoms for the first time. Participants used the following words to describe their feelings: bitter, hurt, pained, disappointed, doubtful, and worried. They stated that the wife will think of taking the issue to their Ankhoswe (marriage counsellor), not having sex without condoms from that point on, asking that they both have an HIV test and based on the results, using condoms forever or having no sex at all. One participant stated that "when a man brings condoms home he is telling you that he is having sex with other women. After this you worry about AIDS and attribute any illness to the condom issue".

These responses demonstrate that participants recognize that if a husband brought condoms home for the first time without prior discussion, such an action would create emotional pain and turmoil for the wife.

3. Perceived thoughts or feelings of a husband whose wife suggested condom use in marriage.

Participants were also asked to describe what they thought would be the feelings or thoughts of the husband whose wife had suggested using condom with them for the first time. The following words were used to describe the husband's feelings: suspicious, surprised and angry. The participants stated that the husband would also demand to know where the wife got the condoms and an explanation as to why condom. Further, the husband would think of taking the issue to their Ankhoswe (marriage counsellor), of divorcing the wife and would think that the wife was being unfaithful.

4. Discussing condoms with spouse.

Participants were asked whether they would discuss condoms with their husbands. The majority of the participants stated that they would discuss this with him. The discussion would center on why the condom has been introduced and a plausible explanation would be required. The participants stated that they would have to be very tactful in bringing up the subject of condoms in order to have a useful discussion with their spouse. Many questions would be asked focusing on behaviour of the spouse, whether this was an indication of lack of trust for the spouse, what transpired for the spouse to think of bringing home condoms, whether this was admitting to infidelity and possible STD infection. All participants agreed that it was critical for a very good explanation to be given otherwise the issue would be brought to their Ankhoswe (marriage counselor).

Participants were also asked to indicate whether they had ever discussed condoms in their own marriage. The participants were equally divided between those who had discussed condoms with their husbands and those who never had. Those participants who discussed condoms did so as a follow up to radio advertisements on Chishango condoms, or condoms as a protective device against STDs and as a device to be used to maintain sexual relations despite prolonged menses resulting from use of Depo-provera. Those participants who had never discussed condoms in their marriage stated that it was shameful to talk about condoms with their husbands and the discussion on condoms was embarrassing to men because it signaled that they were involved in extra-marital sex.

5. Using condoms in marriage

Participants were asked whether they themselves had ever used condoms in their own marriage. Seventy-one percent of the participants had used condoms with their husbands. The condoms were used mainly as a back-up while waiting for hormonal contraceptives to take effect and for a few participants, in situations where they had persistent menses or an irregular menstrual cycle as a result of the contraceptive Depo-provera.

The participants were also asked if they would use condoms in their marriage. The majority of participants indicated that they would use condoms in their marriage if there was a very good reason. The reasons included condom used as a family planning method, as part of STD treatment package, if a couple was HIV sero-positive and if spouse is suspected of infidelity. Those participants who stated that they would not use condoms did so because they believed condoms brought disharmony and mistrust in marriage, and increased promiscuity.

6. Who ought to suggest condom use in marriage?

The majority of the participants stated that either the wife or husband may suggest condom use in marriage depending on who had the information or reasons for introducing the condoms. Those who indicated that the husband should suggest condom use gave the husband's superior status in marriage as the head of the family and the fact that he is the one to use the condom, as their reasons. An example was given of a husband who was very angry with his wife for suggesting condom use with him. The husband took the condom, blew it up and tied it to a bed and told the wife to have sex with the blown condom. Those participants who indicated that the wife should suggest condom use stated that the wife was the one who attended the family planning clinics and was likely to have the information on condom use.

C. Experience of using condoms

The participants who had ever used condoms were asked to share their experiences. The experiences of the participants were more negative than positive. The only positive experience given by the participants was that no difference was experienced in sexual satisfaction with or without a condom and that it took the husband longer to ejaculate and that made the sexual activity enjoyable. The negative experiences included (a) husband not being able to ejaculate, (b) husband's penis not being able to erect and (c) missing natural friction during sexual intercourse hence having no satisfaction from the sexual activity, (d) missed the feeling of sperms inside the vagina.

DISCUSSION

The study findings show that promotion of condom use in general and in marriage in particular, is a formidable task even among family planning providers. The thoughts of family planning providers on condom use were not any different from those of wives who were not family planning providers. Discussion of sex among married couples demonstrates that women are not socialized into language which enables them to discuss their sexual experiences with their spouse because for Malawian women, it was more acceptable socially to communicate about sex with their spouse in a non-verbal manner. Sexual intercourse was viewed as intimate, private and therefore it was impolite to include this subject in everyday conversation, even with own husband. In most instances the participants just commented that in the "Malawian marriage", there is no discussion between the spouses about sex, only actions associated with sex. While one would suppose that having knowledge of sexuality and discussing family planning issues with clients would ease the family planning provider's ability to carry out such discussion in her own marriage, this study has demonstrated that it does not.

The data suggests that the family planning providers must have internalized the notion that in the "Malawian culture", men are accorded a superior status in marriage and are in control of matters related to sex. Women, on the other hand, are provided with limited control on their sex life in marriage. Underlying values inculcated and internalized as girls grow up have a powerful grip on the grown woman such that formal education or specialized education in health matters, does not necessarily manage to break these. Examples of such values include, cultural norms which allow men to have extra-marital sex with the result that women have resigned to it, the difference in status accorded men and women in marriage, the inhibition of girls to being open in their sexuality and that a man is the head of the family and that the woman's role is to listen and obey. All these contribute to the difficulty experienced by women in discussing sex in marriage and being a family planning provider did not make it any easier.

Family planning providers expressed the same fears of their husbands and of being subjected to suspicions of unfaithfulness once the subject of sex was brought up with the spouse, as expressed by other married women who had no special training in family planning and STD prevention (Namate and Kornfield, 1997). The discussions of the family planning providers suggest that male dominance over sexual issues in "Malawian marriages" is indeed very strong and it creates a state of powerlessness or hopelessness on the part of the wife. This finding could have major clinical significance. If a family planning provider herself does not feel free to discuss sexuality with her husband despite her educational background, she may not encourage or be able to convince another woman who comes as a client to the family planning clinic to discuss sexuality with her spouse.

Participants strongly believed that if a husband brought home condoms for the first time without prior discussion, or if a wife suggested condom use, such an action would bring emotional pain and turmoil to both spouses. Although the majority of the participants were willing to discuss the subject of condom use with their spouse, they demonstrated some degree of uncertainty and indicated that tact was essential in order to have a useful discussion. The fear of hurting the other person or being misinterpreted or having the issue brought before their *Ankhoswe* (marriage counsellor) are some of the underlying factors which contribute to the failure of the family planning providers to introduce condoms in their marriages. These same fears were also expressed by husbands and their wives, in three cities where a similar study was conducted (Namate and Kornfield, 1997). These reactions demonstrate that although the family planning providers are in a strategic position for promotion of condom use in marriage, the majority of the family planning providers may not advise clients on condom use for fear of being a party to potential disharmony which may ensue in marriages as a result of condom introduction. Secondly, the family planning providers themselves may not be equipped with appropriate negotiation skills befitting such a situation. This again may have clinical significance in that knowledge of marriage disharmony caused by introduction of condoms in marriage may make the family planning providers reluctant to actively encourage other women to use condoms in their own marriages.

Condoms are associated with infidelity and are described by the majority of the family planning providers as something which would not be brought into marriage unless there was a very good reason. Since condoms are ordinarily seen as a means to prevent the spread of disease, the suggestion by a spouse to start using condoms during marital sex is likely to raise suspicion. Bringing condoms into marriage was viewed as a sign that one was having extra-marital sex. Consequently, family planning providers, as women, were even more reluctant to open discussion on condom use in marriage for fear of having their fidelity questioned, a moral double standard in this country where it is widely accepted that men often have more than one sexual partner.

Family planning providers have been known to have negative attitudes towards condoms (Tavrow, Namate and Mpemba, 1995). The findings from this study suggest that these negative attitudes could be rooted in some aspects of their upbringing and cultural values inculcated in them in their youth. While various factors could affect how a family planning provider carries out her work, their negative attitudes, coupled with their reluctance to discuss about condoms, could negatively impact the process of counseling clients on condom use in the family planning clinics.

The majority of the participants had used condoms in their marriages although only one participant indicated that she was currently using condoms. Their experiences confirm the barriers to condom use in marriage as cited in other previous studies (Komfield, 1995; Knodel and Pramualratana, 1996; Namate and Komfield, 1997). From the responses it can be inferred that condoms are viewed negatively even by family planning providers. As a family planning device, the condom is the least preferred because of the stated negative effects on sexual pleasure. The condom was only used as a back-up while awaiting the hormonal contraceptives to take effect. As an STD protective device it could not be used in marriage because of the negative social association of condoms with extra-marital affairs. It is apparent that the stigma of condoms as associated with extra-marital sex and promiscuity is so strong that even with knowledge in the health discipline, the family planning providers perceive the same stigma.

Family planning providers in Malawi are in a strategic position to promote condom use because they deal with a sexually active clientele which is also at high risk for HIV/AIDS infection. However, if they are to appropriately guide other people to adopt self-protective behaviour in marriage, their own sexual attitude, beliefs and practices towards the use of condoms in marriage has to change first. Family planning providers need to move beyond using condoms just for back-up or as an occasional necessity. Family planning providers need to change their association of condoms with marriage disharmony and increased promiscuity by partners if they, in turn, are to encourage others to use condoms.

It was reassuring to note that although the majority of the family planning providers did not favour the condom, there were circumstances under which they found the condoms acceptable to use in marriage. The situations given included (a) as part of STD treatment package, (b) if a couple was HIV sero-positive and (c) if a spouse was suspected of infidelity. As STD and HIV/AIDS are among the major health threats in Malawi, this positive thinking should be promoted.

CONCLUSION

The perception that condoms interfere with sexual pleasure, as well as the strong association with extra-marital sex is suggestive that change to using condoms will be slow even among some health care professional as family planning providers. Family planning providers need to change from using or advising others to use condoms as a back-up to using condoms for STD/HIV protection between husband and wife.

RECOMMENDATIONS

1. Cultural values such as the dominance of husbands over sexual issues in marriage influences the family planning provider's ability to use condoms in their own marriage and to encourage other women to use them in their marriage.

Through in-service education programmes, provide knowledge of negotiation skills to the family planning providers as women, to use in their own marriages as well as to teach the family planning clients they counsel in the clinics.

2. Family planning providers are in a strategic position to promote condom use among the public.

Seminars should be conducted for the family planning providers to help them clarify their values and roles in the wake of the AIDS epidemic. Husbands of the family planning providers should also be included in these seminars to assist the spouses clarify their values on condom use.

3. There is recognition of circumstances under which condoms could be used in marriage, that is, as part of STD treatment; by HIV sero-positive couples; and in cases of suspected infidelity.

Such positive thinking should be encouraged through in-service education and should be included in family planning curriculum.

4. Open verbal communication about sex and sex related issues among family planning providers and their spouses is difficult. Some cultural values inculcated in girls as they grow up, and in some cases, internalized, attribute to this difficulty.

Churches and community groups could help promote open dialogue between couples in marriage through family life programmes which could help couples explore their sexual lives and relationships with their partners, and assist them to openly recognize and acknowledge high risk sexual behaviours and implications of such behaviours.

FOCUS GROUP DISCUSSION GUIDE

Condom use in marriage

1. Many of us married people have trouble discussing freely about sex in the family. What comments do you have on this statement.

Kugonana m'banja ndi nkhani yomwe anthu okwatirafe imakhala yotibvuta kuti tikambilane. Maganizo anu ndi otani pa nkhani imeneyi.

Tawanthu wanandi nkhwakusuzga kudumbiskana mwakufwaska pa nkhani zakukhwaskana na kugonana pa nthengwa. Maghanoghano ghinu ngakuti uli pa nkhani iyi.

2. Why do you think this is like this?

Mukuganiza zimakhala choncho chifukwa chiani?

Mukughanaghana kuti vikuwa ntheura chifukwa?

3. When do people talk about sex?

Kodi ndi nthawi yiti yomwe anthu m'banja timakambirana zakugonana?

Kasi ni nyengo uli iyo wanthu wakudumbiskana vya kuchipinda?

4. Give examples.

Pelekani zitsanzo.

Mungatipako viyelezgelo.

5. In your own experience, when do you talk to your spouse about sex?

Inuyo m'banja mwanu, ndi nthawi yiti yomwe mumakambirana zakugonana?

Imwe munyumba yinu, ni nyengo uli iyo mukudumbiskana na wawoli winu vya kuchipinda?

6. The husband comes home from work which took him out of town for two weeks. He has thought of using a condom with his wife.

Bambo atangofika kuchokera ku ntchito komwe anakhalako sabata ziwiri, anaganiza zogwiritsa ntchito kondomu kwa akazi awo.

Mwanalume wawelako ku ntchito uko wakhalako sabata ziwiri, waghanaghana kwamba kugwiriska ntchito kondomu na muwoli wake.

7. Why is the man doing this?

Kodi mukuganiza kuti bambo amenewa akuchita izi chifukwa chiani?

Nchifukwa uli mwanalume uyu waghanaghana kuchita iyi?

8. What kind of thoughts will the wife of this man have?
What kind of feelings would this wife experience?

*Kodi akazi abambo amenewa angakhale ndi maganizo otani?
Kodi akazi abambo amenewa angamve bwanji m'mtima ?*

*Kasi muwoli wake waghaneghanenge vichi?
Kasi mumtima mwake mupulikenge uli?*

9. Does this happen?

Kodi zimenezi zimachitika?

Kasi vyantheura vikuchitika?

10. Give examples.

Perekani zitsanzo.

Mungatipako viyelezgelo.

11. If you were the wife of this man, how would you react?

Kodi inuyo mukanakhala mkazi wa bambo amenewa, mukanatani?

Kasi imwe muwenge muwoli wa dada uyu, mungachitachi?

12. If you were this wife, could you discuss this issue with your husband?

Mukanakhala mkazi wa bambowa, mukanakambirana nawo nkhaninyi?

Kasi imwe muwenge muwoli wa dada uyu, mungadumbiskana nawo nkhaninyi?

13. If you could discuss it, how would you discuss it?

Ngati mukanakambirana, mukanakambirana nawo bwanji?

Usange mungadumbiskana nawo, mungadumbiskana nawo uli nkhaninyi?

14. If a wife suggested condom use in the family, what would the husband think?

Kodi amayi atayambitsa nkhaninyi yogwiritsa ntchito makondomu m'banja, abambo angawaganizire zotani?

Usange mwanakazi wangambayambiska nkhaninyi ya makondomu pa nthengwa, kasi mwanalume wangaghanaghanachi?

15. Does this happen?

Kodi zimenezi zimachitika?

Kasi vyantheura vikuchitika?

16. Give examples.
Perekani zitsanzo.
Mungatipako viyelezgelo.
17. What do you think about this?
Nanga inu maganizo anu ndi otani?
Imwe maghanoghano ghinu ngakuti uli pa nkhani ya mwanakazi kwambiska vya makondomu?
18. Have discussed such issues before?
Munayamba mwakambapo nkhani zoterezi?
Muli kudumbiskanapo makani nga ndi agha?
19. Do you discuss condoms in your family?
If no, why not?
Under what circumstances would you discuss condom use?
Kodi mumakambirana za makondomu m'banja mwanu?
Ngati ayi, chifukwa chiani simutero?
Ndichiani chingakupangitseni kuti mukambirane?

Mukudumbiskanapo za makondomu na wawoli winu?
Usange yayi, nchifukwa uli?
Ni vichi ivyo vingamupangiskani kuti mudumbe vya makondomu?
20. If yes, what is it like when you discuss about condoms?
What do you talk about?
What do you feel like when you talk about condoms? Easy, difficult, hard, sensitive (under what circumstances)

Ngati mumakambirana za makondomu, mumamva bwanji? Ndichobvuta? Nchapafupi?

Pala mukudumbiskana vya makondomu, mukupulika uli? Mukumasuka? Nchinonono?
Nchipusu?
21. What problems do you face?
Kodi ndi mabvuto anji omwe mumakomana nawo?
Ndimasuzgo uli agho mukukumana nagho?
22. How can you solve them?
Nanga mungawathetse bwanji?
Kasi masuzgo agha ghangamala uli?

23. What do you think about using the condom in the family?
Kodi mukuganiza bwanji zogwiritsa ntchito makondomu m'banja?
Mukughanaghanapo uli na vyakugwiriska ntchito kondomu pa nthengwa?
24. Can you yourself use a condom in your family?
Kodi inuyo mungangwiritse ntchito makondomu m'banja mwanu?
Kasi imwe mungagwiriska ntchito makondomu na wawoli winu?
25. Have you ever used condoms?
Kodi munagwiritsapo ntchito makondomu?
Kasi mulikugwiriskapo ntchito makondomu?
26. If yes, how often do you use condoms?
Ngati munagwiritsilapo ntchito makondomu, kodi mumagwitsira ntchito kawiri-kawiri kapena mwa kamodzi-kamodzi?
Usange muli kugwiriskapo ntchito makondomu, mukagwiriskanga ntchito kamoza-kamoza panyake kawiri-kawiri?
27. Please describe your opinion of the experience you had using the male condom.
Tatifotokozeraniponi maganizo anu okhuza nkhani ya m'mene munawonera mutagwiritsira ntchito makondomu.
Maghanoghano ghinu ghakawa ghakuti wuli mukati mwagwiriska ntchito makondomu, mukapulika uli?
28. Who ought to start (suggest) the subject of condoms in the family? Why?
Kodi oyenera kuyambitsa nkhani ya makondomu m'banja ndani? Chifukwa?
Ninjani uyo wakwenera kwambiska nkhani ya makondomu pakati pa imwe na wawoli/ wafumu winu? Chifukwa?

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