

Adopting the Female Condom in Kenya and Brazil: Perspectives of Women and Men

A S Y N T H E S I S

A I D S C A P W O M E N ' S I N I T I A T I V E



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Family Health International (FHI) is a nongovernmental organization that works to improve reproductive health around the world, with an emphasis on developing nations. Since 1991, FHI has implemented the AIDS Control and Prevention (AIDSCAP) Project, which is funded by the United States Agency for International Development (USAID). FHI/AIDSCAP has conducted HIV/AIDS prevention programs in 40 countries. The AIDSCAP Women's Initiative was established in 1994 to mainstream gender issues throughout AIDSCAP and raise awareness of the impact of HIV/AIDS on women within the international community.

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Peter Lamptey, senior vice president of AIDS programs, FHI, and director of FHI's AIDS Control and Prevention (AIDSCAP) Project

Anthony Schwarzwald, deputy project director, AIDSCAP

E. Maxine Ankrah, associate director, AIDSCAP Women's Initiative

Sera Attika, Program Officer
AIDSCAP Women's Initiative

Graphic Designer: Deborah Clark

For further information, please contact:
AIDSCAP WOMEN'S INITIATIVE
Family Health International/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201 USA
Tel: (703) 516-9779
Fax: (703) 516-9781

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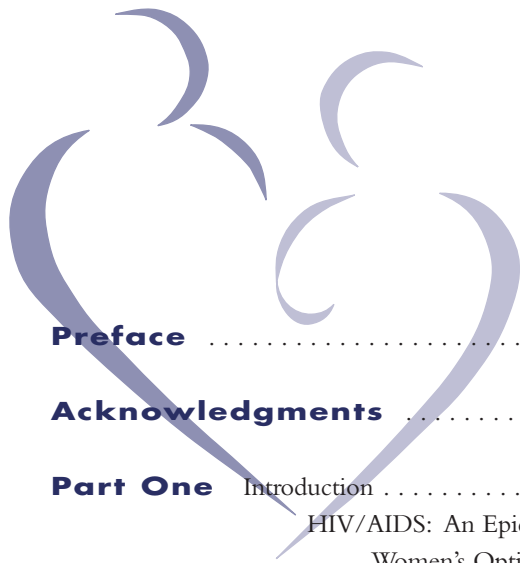
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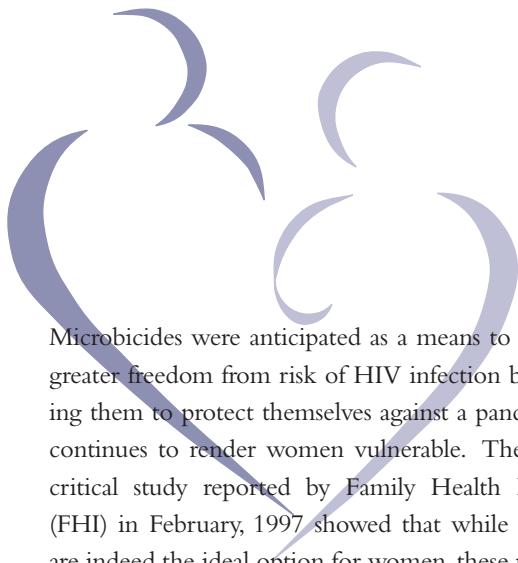
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Preface



Microbicides were anticipated as a means to give women greater freedom from risk of HIV infection by empowering them to protect themselves against a pandemic which continues to render women vulnerable. The results of a critical study reported by Family Health International (FHI) in February, 1997 showed that while microbicides are indeed the ideal option for women, these remain a distant goal not likely to be reached in the near future. JoAnn Lewis, Senior Vice President for Reproductive Health at FHI noted at the Conference on the Female Condom held in May, that currently the female condom offers women the most immediate protection against HIV/STDs.

FHI in collaboration with the United States Agency for International Development, the Centers for Disease Control and Prevention, the National Institutes of Health and others is seeking to accelerate the availability of the female condom to those who want to use it. An important challenge is to increase our understanding of its impact on the relationship between the women and men who adopt this method.

The AIDSCAP project began the process of ensuring that women's perspectives are better understood so that the female condom can be either the primary source of protection or substituted if her partner refuses to use the male condom. This will increase the power women have in being active participants in their own protection. A higher proportion of all sexual acts could be safer were the female condom more readily available and properly used.

It was with this goal in mind that in 1993 at AIDSCAP's first female condom conference that the exploratory research which is described in this synthesis was proposed. The idea was pursued in Kenya and Brazil, because of enthusiastic support from researchers, local universities, implementing agencies and the AIDSCAP country offices. Since the launching of the study in 1996, other important activities have been generated which include the international conference, "The Female Condom: From Research to the Marketplace," held May 1 and 2, 1997, in Arlington, VA, the wide dissemination of related publications and the establishment of networks advocating for enhanced accessibility of the female condom.

The researchers and their collaborators in Brazil and Kenya are to be congratulated for undertaking a study on quite a controversial subject, especially when the female condom is not readily available on the markets of either country. They are currently working on a full report which will hopefully affect local policy and other areas of influence linked to the integration of the female condom into the fight against HIV/AIDS.

In the meantime, this synthesis draws the readers attention to the rich experiences of women and men who accepted the challenge to experiment with the female condom in their partner relationships. The completed exploratory study, focused on the users as well as on the device and is not the last to be conducted. The synthesis, therefore, is an attempt to highlight potential directions for further research some of which are expected to occupy the attention of USAID's newly awarded HORIZON, IMPACT and AIDSMARK projects. Women's advocates, condom social marketers and other implementers are likely to continue a focus on the many issues raised through this study

and other work done on this protective method supported by the AIDSCAP Women's Initiative. It is certain that women and men around the world who have sought access to the female condom will benefit from this larger effort.

Anthony M. Schwarzwalder
Deputy Project Director
AIDS Control and Prevention Project
(AIDSCAP)
Family Health International

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Adopting the Female Condom in Kenya and Brazil: Perspectives of Women and Men, A Synthesis was developed through the AIDSCAP Women's Initiative (AWI) of Family Health International, in collaboration with others within and outside of the research project.

Thanks go to the research team in Brazil which was led by Principal Investigators (PIs) Suzana Kalckmann and Marina F. Rea, and the co-investigator, Wilza Villela. Similarly, we are most appreciative of the work done in Kenya, headed by PIs Wanjiku Mukabi Kabira and Joseph Ruminjo assisted by co-investigators Wangoi Njau and Wambui wa Kanyi. We acknowledge with gratitude the role played by the Advisory Committees which supported the efforts of the teams in their respective countries. We extend our appreciation to the Resident Advisors in the two countries, Maria Eugenia Fernandes in Brazil and Janet Hayman in Kenya. We acknowledge the encouragement received from the AIDSCAP Africa Regional Director, Godfrey Sikipa and AIDSCAP Latin America and Caribbean Regional Director, Ricardo Calderón. Their staff is thanked for providing logistical support for the duration of the research.

We recognize the contributions made by the directors and researchers at the HIV Center for Clinical and Behavioral Studies at Columbia University in New York for technical assistance in preparing the PIs for this innovative study. We also are grateful to Priscilla Ulin, Janet Hayman and Elisabeth Meloni Vieira for reviewing the initial drafts of this synthesis. Their comments and suggestions proved very helpful to its completion.

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Recognition is given to Deborah Clark, the graphic designer who worked often under pressure to complete this and a series of other AWI documents during the life of the Project.

Finally, we are indebted to the women and men of Brazil and Kenya who participated in the research. Some of them had to go against conventional norms to remain in a study that was somewhat controversial by virtue of its concern with sexual behavior. Hopefully, the results of their sacrifice through continuing with the research will contribute to broader awareness of the need of women and men, globally, for protection against HIV/AIDS.

Part One

INTRODUCTION

HIV/AIDS: An Epidemic Among Women

AIDS has emerged at the close of the 20th century as a global health scourge and threat to development. Initially appearing primarily among people who engaged in high-risk unprotected homosexual and commercial sex and intravenous drug use, it was assumed throughout much of the 1980s that heterosexual and monogamous women were at low risk of HIV infection. By the beginning of the 1990s, epidemiologists had begun to document the presence of differing epidemics — some old, some new, some spreading rapidly in wholly new regions, for example, in Southeast Asia where, earlier, AIDS had had little impact. A clear entrenchment of the epidemic was evident by 1995 among heterosexual monogamous women in Africa, some countries in Latin America and the Caribbean and Asia.

In parts of Africa such as Uganda, Zimbabwe, Zambia, Tanzania, Rwanda and Kenya, 20 to 40 percent of the women attending antenatal clinics were HIV infected. Of the 21.8 million people infected with HIV globally in 1996, 60 percent or 13.3 million adults were in Africa. Today women surpass men at a ratio of 6:5 and young women between the ages of 15 and 19 are twice as likely to be infected as men in the same category in that region.

As of 1996 there were an estimated 1.3 million people infected in Latin America and the Caribbean. Of these, an estimated 90 percent of the new infections occurred through heterosexual contact. Between 1990 and 1995 the percentage of women infected increased from 25 to 45 percent of the total. By 1996, AIDS had become the leading cause of death among women 25 to 40 years of age in Brazil as well as in the United States.¹

Women's Options

The escalation of HIV infection in women in developing countries and among the poor and minorities in industrialized nations is extensively documented. There is a need for responses that adequately address the unique vulnerability of these populations. An implicit question for policymakers, program planners and implementers is this: what is to be done in light of the unanticipated shift of the HIV/AIDS epidemic to women when most previous responses were designed essentially to meet the requirements of the gay and drug user male populations of the developed countries?

Except for commercial sex workers (CSWs), who have been the target of many interventions for safer sexual practices, other vulnerable women have received little attention. Programs that have addressed women's reproductive health needs, such as family planning, have only recently begun to focus on their sexual health.

Women have identified approaches to the challenge of HIV/AIDS in a number of fora, including the United Nations meetings held in Cairo² and Beijing.³ Their statements propose that to adequately counter the threat to themselves, women must have access to methods of protection that are within their power to initiate and use, with or without the compliance of male partners. Some scientists^{1,4,5} acknowledge that vaccines are still several years away, and the costs of the new protease inhibitor drugs put these out of reach of most men and women in the developing countries.

The ideal solution for protecting women against HIV infection would be microbicides.^{4,5,6} However, this ideal has not been realized despite the commitment of research and development funds.^{5,6,7,8,9,10} Several researchers^{5,7,9} call attention to the female condom as the one method currently approved by the US Food and Drug Administration that provides some protection as a contraceptive and a method for use against HIV and STIs. The research reported by FHI⁸ concerning the ineffectiveness of the nonoxynol-9 spermicide against HIV caused Lewis,⁹ among others, to conclude that for the immediate future “the female condom is all the protection that women have.”

Despite unresolved issues of price, re-use, accessibility, affordability and availability of the female condom, by the early 1990s, research was accelerating in an effort to determine the acceptability of the device for women who perceived themselves to be at risk of infection.¹¹ Yet, little was known about the women who would adopt the female condom, or whether they could move to sustained use — the ultimate goal of women’s advocates, HIV/AIDS and development specialists. Also, there was little information to predict the reactions of women’s sexual partners or the general population in countries where the device was not widely available.

In 1993 behavioral researchers at AIDSCAP made a decision to conduct exploratory research from which to derive hypotheses for future studies and interventions. A research design was developed which responded to the assumption that women would seek self-protection where there was perceived risk of HIV/AIDS infection. A second assumption was that women would need the support of other women to persist in using the female condom, which in the least could be a novel and controversial intrusion into their sexual lives.

The past three decades of this century have witnessed the unprecedented activism of women’s movements related to a variety of critical issues, including human rights, violence, health and the environment. By adopting approaches used to mobilize women around these and other issues, it was assumed that the collective energy of women also could be brought to bear on the problem of protection against HIV/AIDS. This third assumption led to the inclusion of an intervention in the research design in which women’s organizations would play a key role in the introduction of the female condom, and peer support group discussions would be a major point in data collection. The theoretical framework discussed below shows strong support in the literature for these three assumptions.

This is a synthesis of the results of the exploratory single study executed in Brazil and Kenya, *The Female Condom as a Woman-Controlled Protective Method*. The full research reports from which this synthesis is derived were prepared by the principle investigators in Kenya and Brazil, respectively.^{12,13}

The Female Condom

With the escalating HIV/AIDS epidemic, the female condom has gained increased importance as a barrier method for preventing transmission of HIV and other STIs as well as unintended pregnancy. This device is a polyurethane plastic sheath that women can insert into their vagina. It has an inner ring that helps to anchor the device in the vagina and an outer ring that covers the genitalia. Research has shown that the female condom may offer significant protection when used correctly and consistently. In a study undertaken by the Joint United Nations Programme on HIV/AIDS (UNAIDS) among female sex workers in Thailand over a six-month period, a 34 percent decline in the mean incidence of STIs was observed in the group of women using only the female condom versus the group that used the male condom only.¹⁴ The research also showed that use of the female condom also helped effect a 25 percent reduction in unprotected sex.^{15,16} The device is available currently in a few countries that include Antigua, Canada, Costa Rica, Cote D'Ivoire, Ghana, Holland, Hong Kong, South Korea, Papua New Guinea, Switzerland, South Africa, Taiwan, Uganda, United Kingdom, United States, Zambia and Zimbabwe.

Early studies on the acceptability of the female condom indicated a favorable response from women. An FHI study in Kenya among CSWs and women in the general population found that 84 percent (N=38) liked the device;¹⁷ 66 percent (N=20) of the CSWs in Thailand did;^{18,19} 94 percent (N=34) in Cameroon also accepted it;^{18,20} and 43 percent (N=106) of the women in the United Kingdom study²¹ were receptive. The responses of men were reported indirectly through the female study participants. These showed that a near equal proportion of men were both favorable and unfavorable to the device. In a study in Uganda, the partners of 74 percent (N=90) of the urban women also liked the condom, while 90 percent (N=100) of the clients of the commercial sex workers and rural women also liked it.²² In Senegal, some male partners preferred the female condom to the male condom.²³

Researchers studying the acceptability of the female condom between 1991 and 1993 found that where female participants tended to drop out of the studies before completion, it was due mainly to the partners' reactions. In a study by Bounds in the United Kingdom, many women dropped out because of their partner's rejection.²¹ Sex workers in Cameroon did the same,²⁰ as did Kenyan women in the general population and in commercial sex work.¹⁷

Other recent studies have confirmed a high level of acceptance among women.^{23,24} Moreover, where women have been offered a choice, many prefer the female condom to the male condom.^{24,25,26} Women who were at high risk of infection in the United States or who were partners of drug abusers found that the female condom was a viable method for both disease prevention and contraception.²⁷ The male acceptability of the device was high in a number of studies that surveyed the reactions of men and women. A study in New York that included women and men showed that of the 23 women who returned for the final interview, 61 percent asked for the female condom while 39 percent asked for the male condom. Of the 16 men who returned for the final interview, 31 percent asked for the male condom while 43.8 percent asked for the female condom, where both were available.²³

More critical to HIV prevention are research results showing that where the female condom is available, there is an increase in the proportion of protected sex acts.^{5,15} A study was carried out to assess the behavioral differences in those women who were offered all female-controlled barrier methods, the male condom alone or the female condom alone. Of the 233 participants, 119 women had been counseled on the use of all the female controlled methods; of those, 87 percent chose to use the female condom, 63 percent the male condom, 61 percent spermicidal foam, 57 percent spermicidal film, 33 percent spermicidal suppository, 11 percent the diaphragm and six percent the cervical cap. The self-reported reduction in unprotected sex acts was greater among women offered all methods of protection as opposed to those offered only the female or male condoms (83 percent, 54 percent and 39 percent, respectively).¹⁵

Re-use remains a critical issue in the promotion and support for the distribution of the device to women particularly in developing countries. Current results of studies on the re-use of the female condom indicate that users dispose of it after a single use.²⁸ Another contentious matter that is relevant to the question of re-use is the high cost of the device. However, in test marketing in Bolivia, Guinea, Haiti, South Africa and Zambia, CSWs, single career women and female undergraduate students continued to demand the increasingly popular device as an option, despite the difference in price between the male and female condom.²⁹

While these and other studies helped to clarify the issue of women's acceptability of the female condom, whether and how the device helped or hindered women's negotiations with their sexual partners was still unclear. Ulin³⁰ and Worth³¹ report the difficulty women have in negotiating the use of the method. The World Health Organization (WHO) and UNAIDS¹⁰ have funded a series of studies entitled, "Sexual Negotiation, Female Empowerment and the Female Condom," that assess the negotiation process and evaluate how the female condom might affect power dynamics in sexual relations between CSWs, other women and their respective sex partners. While the works of Ulin and WHO/UNAIDS have begun to highlight issues of gender disparity and empowerment, they also suggest the need for further research to show outcomes of experiences where the female condom is introduced through channels where women learn from women and support one another in efforts to influence and use the device with male partners. The intervention research reported below was thus designed to respond to such a need.

Theoretical Framework

Following on the directions set by the WHO/UNAIDS study,¹⁰ the research executed in Brazil and Kenya was designed to shift from a focus on the female condom and its acceptability to a focus on women and their partners who use the device in their sexual relationships. Several theoretical frameworks underpin that focus. These frameworks relate to gender and power, empowerment, social support and the community.

Gender Approaches and Power

Although initial efforts to combat HIV/AIDS were directed mainly towards men, particularly in Africa, women were infected nearly on par with their male partners. With international acknowledgment by 1990 that HIV/AIDS was becoming a very serious problem especially for young women, attention was turned to the gender dimensions of the epidemic. Gender refers to the social definitions of differences in the functions, roles and status of men and women in society, as opposed to their differing biological classification.³² In almost all societies women's positions have been subordinate to those of men, a fact most evident in the expression of their sexuality. Male dominance is supported by patriarchal structures that can exist even within the institution of marriage. In most cultures these structures grant decision making on sexual matters primarily to the male partner. Men also may control economic resources in the household as well as in the public domain. Thus economic and social subordination of women combine to diminish their power to influence protective measures in sexual behavior.

In many African cultures girls have been socialized into womanhood expecting *not* to take actions independently of male partners. Values imposed by the superior status of males often negate a woman's freedom to act in ways that serve her best interests. As sexual values and attitudes are deeply entrenched in social norms and expectations, neither the woman nor the man may be aware of the barriers to changing sexual attitudes and practices.

With the perception early in the 1990s that women who were not CSWs, or in a monogamous relationship, were in little danger of becoming infected, critical programs hardly targeted women specifically, such as various types of clinical trials. Most AIDS prevention efforts were largely “gender blind,” creating inherent gender contradictions that in part explain the promotion of the male condom as a device “that women can use to protect themselves.” No female can wear the male condom; Ulin maintains that most women cannot insist on its use when the male partner refuses. In Thailand, which has a policy of 100 percent male condom use in brothels, studies show that as wives and girlfriends, CSWs are unsuccessful at negotiating protection.¹⁰

An approach that is based wholly on the use of the male condom or STI treatment is inadequate for two reasons. First, such an approach minimizes — if it does not neglect altogether — the dynamics of factors such as trust, intimacy and love. Women in the United States,³³ Brazil³⁴ and Argentina³⁵ indicate that they are unable to utilize the knowledge they have about HIV/AIDS prevention, or to insist on the use of the male condom when it conveys to the partner that he is not loved or trusted, or when raising the issue challenges his power to make decisions in matters related to sex. Women in Puerto Rico³³ chose to forego protection rather than disturb the intimacy which they valued as much as protection against disease. Especially where women have invested a great deal in developing a relationship, such as in marriage, or as in the case of adolescent girls in a romantic attachment, they are reluctant to risk confrontation strategies.

Recognition that gender approaches are valid to HIV/AIDS prevention also requires a distribution of power between the sexes that permits women to lead self-directed lives. Such power can be defined operationally as the function of education, employment and relationship factors such as decision making, commitment and alternatives.³³ Where there is a power imbalance that defers power primarily to the male, for many women it is culturally impossible in a marriage or steady relationship to refuse to have sex or to compel the use of the condom. Power remains vested in the male sex even in affluent societies, unless critical levels of resources are placed at the disposal of women, strengthening their place in society politically as well as economically and socially. Except where policies insist on gender parity in, for example, parliamentary seats, voting and educational and other opportunities, most women continue to struggle for equity with regard to most resources, rights and benefits. In the realm of their sexuality and sexual choices, parity in decision making and control remains a distant goal.

In effect, if the female condom can enhance the self-efficacy of women in their gender and sexual roles, it may serve as a catalyst in changing the ways men and women relate to each other. This would require that beyond the woman’s need for a barrier method that is protective against disease and unintended pregnancies, they are also enabled to safeguard the highly valued intimacy with their partners. In addition, they also should be able to increase their power to choose and sustain actions that give them control in critical areas of their lives. Bandura^{36,37} refers to this capacity as “self-efficacy.”

Self-efficacy

According to Bandura an intervention that would enhance the self-efficacy of women would have four major components:

- ◆ information that heightens awareness and knowledge of risks and a person's belief that she or he can exercise control over behavior;
- ◆ opportunities to practice new skills in accepting situations that allow for feedback;
- ◆ social support through a network of social relations that influence and accept new adopted behavior;
- ◆ social influences within a community context and group situations achieved through community efforts and ownership.

Bandura's framework for self-efficacy is mirrored in the conceptual construct developed by Minkler³⁸ and Labonte,³⁹ who focus more specifically on empowerment. Minkler notes that a new health promotion movement has introduced new ideas, new language and new concepts about what constitutes health. The new discourse on health includes such multidimensional concepts as empowerment and community participation. This position is supported in a study by DiClemente and Wingood⁴⁰ which shows that gender empowered women were more likely to negotiate safer sex, and that female empowerment correlates with consistent condom use. They argue that a focus on HIV prevention for women with empowerment as a goal may enhance the efficacy of the intervention in reducing high risk behavior.

Empowerment

Labonte³⁹ suggests that empowerment, like self-efficacy, has four components. The first is an inter-personal encounter which facilitates dialogue.^{41,42} Because of the difficulties surrounding use of male condoms, women have been compelled to search for means of communicating with men that in most cultures necessitate a non-confrontational approach.³⁶ That they have not always met with success in this effort despite deference to the male partner is suggested by the drop-out rate for female participants from studies noted above.^{17,19,20,21} Second, Labonte³⁹ presents an "empowerment continuum" where personal empowerment is achieved because the social system facilitates efforts at the individual level. The person receives support from the group of which she/he is a member. Third, according to Labonte, the group enables men and women to "see their own experiences within a meaningful social context." Thus, the efforts of groups may lead to community organization through which people become involved in a process of change that goes beyond the particular situation, or problem, to solutions that address the real causes and point to yet more lasting solutions.

Finally, empowerment through community mobilization facilitates the building of political coalitions for overcoming limitations at the individual and community levels. Labonte notes that actions of such coalitions are "directed towards higher levels of government decision making" and are "carried out by groups that unite to exert pressure for achieving a political change or a social reform. Political action coalitions use advocacy as a means to achieve their goal." This advocacy means "taking a position on an issue" to initiate actions that influence public policy choices.³⁸

Because of awareness of the HIV/AIDS epidemic and a heightened perception of risk of infection, women must, according to Kabira¹³ “...do what they would not be expected to do within traditional cultures.” She contends they would need to create subcultures that address their basic needs and situations and develop survival mechanisms. She included among these mechanisms: “silence in times of hardship, ignoring what is happening around you [as a woman] that denigrates your dignity, getting together with other women to address your most pressing needs.”

The search for protection against HIV/AIDS has also challenged women to see how best they can maximize the resources at their disposal.⁴³ Coming together with their peers and within their own organizations has provided social support that empowers women and men to deal with the circumstances of being affected and/or infected by the disease.⁴⁴

Social Support

While group peer support and support structures⁴⁵ have proved effective, particularly for meeting the psychosocial needs of HIV-positive persons and as a vehicle for advocacy,⁴⁶ peer support groups may be inadequate⁴⁷ where the community does not respond and community leaders resist change in social norms that affect the status and power of women. In Zimbabwe,⁴⁴ while women found mutual psychological support to be of value, peer support was not enough to mitigate the pressing financial and economic problems facing group members.

Despite such limitations, women’s organizations are ubiquitous. They can serve as ready channels for efforts that include skills building through training plus psychosocial support. Sikkema⁴⁸ found that community-based intervention models could produce large and sustained changes in the behaviors of targeted communities of women. Such women’s groups can also help build community awareness around an issue and mobilize pressure for normative change.

The female condom may fail to provide the protection against HIV/AIDS that women seek, if indeed its introduction, promotion, availability and use are not buttressed by an equal concern for strengthening women’s sense of self-efficacy and empowerment, not only at the individual but also at the group and community levels. As women come together in their organizations, they can be empowered and may in turn empower their communities.

In summary, the theoretical framework discussed above supports the intervention research design adopted for introducing the female condom in Kenya and Brazil. The results of the study discussed below permit the development of rich hypotheses to test whether, indeed, the device can fit into a mix of methods for protecting women and their partners against HIV/AIDS, and at the same time empower women to take a more active role in the process of prevention.

An examination of the context, study objectives and methodology are discussed in **Part II**. **Part III** reports the major findings obtained through the synthesis of individual interviews and focus and peer support group discussions of women and men participants. The final section, **Part IV**, discusses the implications of the findings. Throughout, differences as well as similarities in the perceptions of Kenyan and Brazilian women and men are highlighted. The country research reports^{12,13} are being prepared for wide dissemination, locally and internationally.

An effort was made in data analysis and reporting to reflect the thinking of the people studied. Thus, as far as possible the text incorporates the actual words of the study participants. These are contained in the direct quotations from women and men which mirror their responses and experiences in using the female condom. To avoid breaching agreements on confidentiality, no names will be given when such quotes are used. Therefore, where a quotation is made with no specific reference, the reader can assume the comment was made by a study participant. The context of the remark will indicate whether the respondent is a Kenyan or Brazilian.

Part Two

THE STUDY

The Context

The selection of sites for the study assumed that women's adoption of the female condom and the responses of their male partners would be influenced by social cultural context. Further, it was thought that the varying status of the epidemic in the two countries would condition their perceptions of risk and the extent to which finding protective measures would be high on their list of priorities. Some similarities in the responses of women and men could also be anticipated, especially with increased awareness of the presence of the disease in Latin America and its pervasiveness in Africa.

Sites for the research were the metropolitan region of São Paulo, Brazil, one of the five largest cities in the world, with about 15 million inhabitants, and Nairobi, the capital city of Kenya, with a population of over one million people. São Paulo is located in the southeast region of Brazil where 69 percent of the national AIDS cases have been recorded. From 1982 when the first cases were reported through 1996, a surprising one-fifth of all cases were among women. The Ministry of Health reported a change in the male-female ratio from 28:1 in 1985 to 3:1 in 1996. By the mid-1990s, AIDS had become the major cause of death for women ages 15 to 49. Between 133,000 and 204,000 people are believed to be currently infected for all regions of the country. With at least five million people estimated to be at low, medium and high risk, the majority are being threatened through heterosexual intercourse.

The study in Kenya was conducted in Nairobi where the estimated HIV prevalence rate overall is 12 percent, with a rate of 24.6 percent among antenatal women. In Kenya's urban areas it is believed that one out of every eight adults could be HIV infected; 6,594 AIDS cases had been reported to the Ministry of Health by June 1996. It is estimated, however, that at least 200,000 persons have developed AIDS and currently 1.2 million people are HIV infected. Seventy-five percent of HIV cases occur between the ages of 20 to 45 with the peak ages identified as 25 to 29 years for females and 30 to 34 years for males.

These two urban cities were selected because of expected higher prevalence rates compared to rural communities, the size of the populations from which to select samples and the location of the institutions and offices from which the principal investigators could conduct the studies. Data were collected between January and July 1996 in the two countries.

Objectives

Main Objectives

The research in both Brazil and Kenya was guided by the following three objectives:

- ◆ to identify factors and rationale determining use and nonuse of the female condom;
- ◆ to determine ways in which introduction of the female condom will affect women's ability to negotiate protection against HIV and other STIs.

These first two objectives were achieved through:

- determining the range and types of women's protective strategies;
- assessing women's perceptions of the female condom as a protective device;
- exploring the impact of the female condom on partner sexual relationships;
- assessing the strategies that facilitate women's ability to negotiate its continued use.

The third objective was:

- ◆ to explore the role of peer groups in sustained use of the female condom.

Research Questions

Given these objectives, the questions guiding the research were:

- ◆ what factors are critical to adopting the female condom?
- ◆ what factors relate to sustained use?
- ◆ what are women's usual strategies for self-protection related to sexual intercourse?

These could be:

- behavioral — through avoidance, coitus interruptus, other methods;
- mechanical — through the use of barrier devices;
- verbal — through negotiation prior to and during sexual activities;
- ◆ with varying reasons for the desire to self-protect, what new strategies do women develop upon learning of the risk to themselves of HIV infection?
- ◆ which factors seem to increase women's ability to achieve self-protection?
- ◆ which factors seem to decrease women's ability to achieve self-protection?
- ◆ what is the impact of the female condom on sexual and peer relationships, that is:
 - what is its impact on partner relationships?
 - does the peer support group provide the woman with more power for self-protection?

Research Design

To achieve the research objectives, an innovative design was introduced which, although executed in the two different contexts, Kenya and Brazil, in all essential aspects was one study.

The research protocol development benefited from in-depth knowledge of the status and trends of the epidemic and AIDSCAP's program experiences in the two countries. These facilitated planning and particularly the execution of the study. Having the AIDSCAP country office resident advisors in consultation with the AWI monitor and providing logistical support to the country research teams ensured a high degree of consistency in following the research protocol. The principal investigators (PIs) were brought together in the United States to review the protocol, reach consensus on concepts and procedures and be updated particularly on qualitative data analysis. Thus, few differences occurred in the way the study was conducted. These differences were connected to timing, settings and introduction of the coital log.

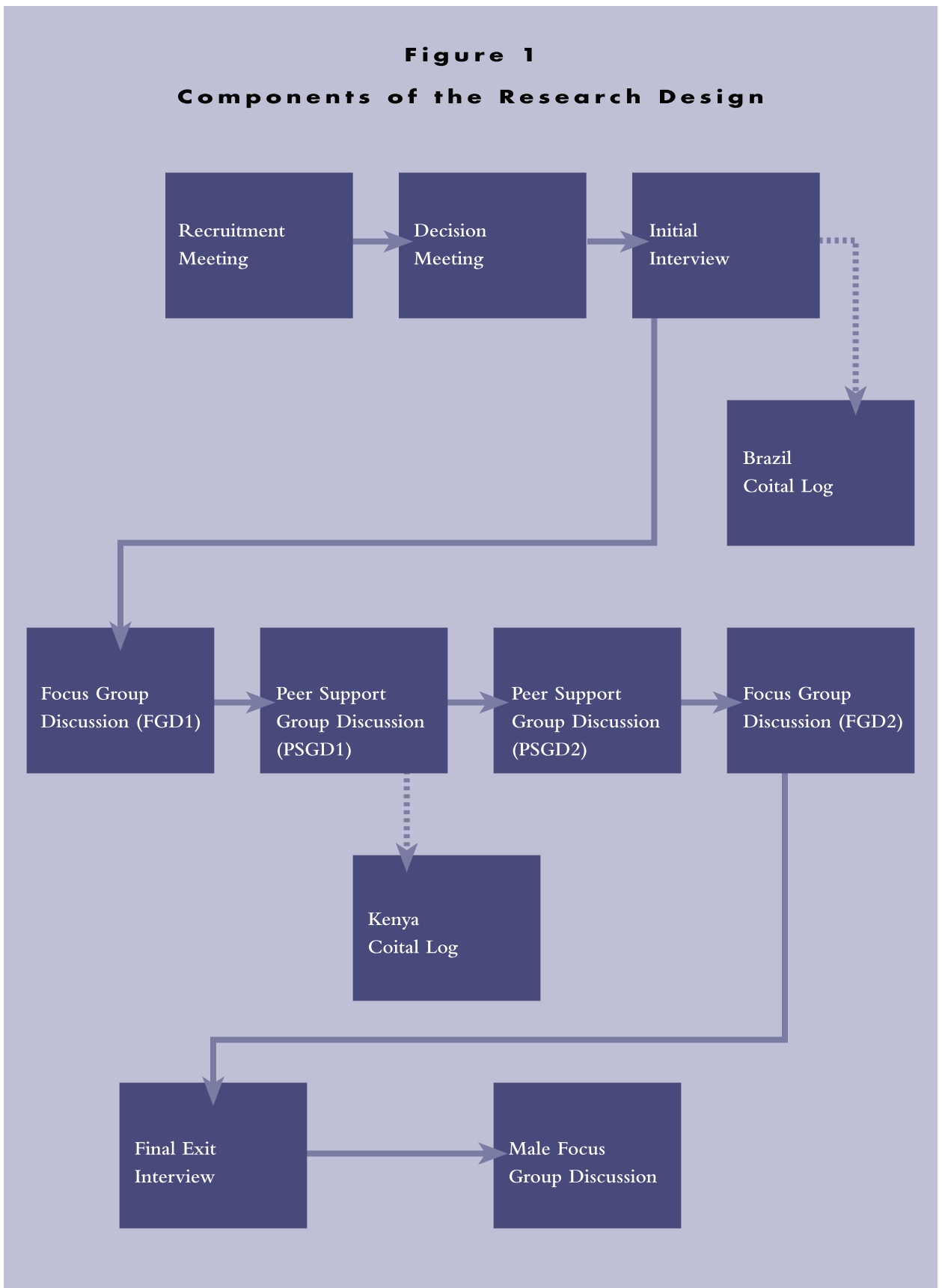
The PIs in Kenya, once the study was launched in January 1996, had no major interruptions in data collection, data analysis and drafting the report. The study in Brazil generated much media attention in January and February; however, setbacks occurred in timely recruitment of women due to need for a larger-than-expected research team. While the Kenyan women were recruited from and studied in small communities in Nairobi, women in Brazil entered the study from communities scattered over a vast city. They were less likely to come from the same women's group, as was the case with the Kenyans. In March, to accelerate the data collection, the Brazilian PI added one additional principal investigator and one co-investigator and a number of field investigators or interviewers, including two male researchers. AIDSCAP also provided the extra resources needed to reach particular communities where women were known to live in high-risk situations. Data collection intensified in April and was completed in July.

Finally, the Brazilian PIs decided that the coital log should be introduced at the end of the initial interview, while in Kenya the recordings began only after the women participated in the first peer support group discussion (PSGD). The PIs in Kenya thought that women would more accurately complete the recordings and freely share their experiences with the female condom if they were better acquainted with each other. The Brazilian women thus recorded use of the female condom over a longer period than did the Kenyans.

The Brazil and Kenya country reports separate and discuss the results of data obtained from the initial and exit interviews, focus group discussions (FGDs) and PSGDs. This synthesis integrates the findings from the seven data collection points for women. Extensive use is made of information derived from the PSGDs to address research questions about perceptions and relationships. The distinction between the FGDs and the PSGDs is this: the FGD was executed using a conventional research design, that is, the researchers guided the study participants in the examination of predetermined questions and issues and recorded responses. In contrast, the PSGDs allowed the women themselves to determine the content and guide the direction of the discussion.

Figure 1 below shows the progression of the research from initial contact with the women to the FGDs with male partners that concluded the data gathering process. In addition to the seven data collection points, a coital log or daily diary, was adopted for recording protection methods used in sexual intercourse. The selection and training of the research team, recruitment procedures and selection of study participants were dictated by the research design outlined.

Figure 1
Components of the Research Design



The Research Team

Selection

In Kenya the research team was comprised of professionals from the fields of medicine, anthropology, sociology, social work and cultural studies. The two PIs who led the team came from the University of Nairobi. One of the principal investigators is a woman with a PhD in literature who specializes in gender, and at the time of the study coordinated the Collaborative Centre for Gender and Development. The second, a man, is a medical doctor who lectures in gynecology and obstetrics and has researched and published extensively on the female condom. Three co-investigators included one university lecturer who is a gender specialist (male), one with a Master's degree in anthropology (female), and one PhD in sociology with an expertise in adolescent sexuality (female). These researchers were assisted by six field investigators, all women, who hold degrees, either at the Bachelor's or Master's level. They facilitated contact with community and women leaders and conducted individual interviews.

The research team in Brazil was headed by two female PIs. Primary responsibility for the study was undertaken by a biologist with a Master's of public health. The second PI holds MD and PhD degrees and is the director of the Women and Child Division of the Instituto de Saúde de Secretaria de Estado da Saúde São Paulo, under which the Mulher, Criança Cidadania e Saúde (MCCS), the non-governmental organization (NGO) implementing agency of the study, is situated. Their co-investigator was a psychiatrist with a PhD in public health. In Brazil, 17 women served as interviewers, observers and/or facilitators. They were recruited from the fields of psychology, health education and social work. Two men coordinators facilitated the male focus group discussions. The team was assembled and operated from the Instituto de Saúde.

Technical advice was provided in both Kenya and Brazil by the AIDSCAP country offices. In Kenya direct oversight was provided by the AIDSCAP resident advisor, an expert in communications, while in Brazil this responsibility was undertaken by an AIDSCAP senior program officer who has a doctorate in Population Studies and a background in Public Health. In both Kenya and Brazil advisory committees were convened regularly, bringing together eminent researchers, government representatives and people from universities as well as AIDS and condom distribution organizations. Funds and technical assistance were provided from AIDSCAP headquarters through the Women's Initiative.

Training

The HIV Center for Clinical and Behavioral Studies at Columbia University in New York provided a three-day training workshop for the PIs in October 1995. Thereafter, at each site the PIs organized a systematic program of training. Their objective was to ensure that the team understood the gender responsive research design in general, and the qualitative research methodology in particular. Team members were introduced to the objectives, theoretical perspectives and instruments; this included reviewing the questionnaires and focus group discussion guides. They practiced interviewing to ensure comparability in language use and uniformity in administering the questionnaire to participants as required by the protocol. Attention also was focused on the group dynamics of the study and the PIs were prepared to handle focus and peer support group discussions. The PIs of the two countries agreed on definitions of socioeconomic status (SES), partners and other terms that were influenced by the context.

In Brazil, training that lasted for about one week took place during two periods because of delays mentioned earlier. The team included nurses who in recruitment meetings and FGDs trained the women participants to use the female condom. In Kenya, a two-day training session was organized for the main research team. In addition, women who were community leaders were recruited as local facilitators to arrange for and mobilize women for meetings held in their respective communities. These leaders were fully briefed and received compensation at the close of the study. Five of the eight groups in Brazil were also recruited through the assistance of community leaders. Data analysts were included in pre-study training in both countries so that they would understand the research methodology, objectives and theoretical perspective of the study. Research teams in Kenya and Brazil met prior to and after execution of each data collection point of the study in sessions for planning and debriefing, respectively.

Once formed, each group was led by a PI who was assisted by the co-investigator. In addition, a third person was designated as an observer, who also attended each group session. The rotating function of the observer was to tape and monitor the group process, noting the groups' interaction and non-verbal communication. The observers also contributed to both the preparatory and post-evaluation sessions.

Data Collection

Recruitment of Female Study Participants

In Brazil, the effort to recruit women into the study through women's organizations started in January 1996. Forty-seven recruitment meetings were held. These meetings were conducted by the first PI with assistance from investigators and health specialists who provided basic information about contraceptives and HIV/AIDS and training in the use of the female condom.

In Kenya, women were also recruited through women's organizations, including such nationwide bodies as Maendeleo ya Wanawake – the largest women's NGO in the country, the Kenya Women's Finance Trust and the University Women's Association, among others. The large umbrella organizations contacted their branches and other smaller grass-roots groups about the study. Many women leaders also organized meetings throughout the research area and arranged for research team members to meet with local leaders such as county council administrators and women community leaders. All together 350 women were reached through seven umbrella organizations and 28 groups in Kenya, while in Brazil 394 women were contacted through eight organizations. Several meetings with women's leaders were held at the Collaborative Centre for Gender and Development, headquarters for the female PI. This site was favored because of its reputation as a credible woman's advocacy center where attending "seminars" conveyed prestige and at the same time provided privacy for women to discuss "their issues." Some of the FGDs and PSGD sessions were conducted at the Centre. Other women met at community and shopping centers, in school classrooms and in churches.

By contrast, most sessions in Brazil were held at the Instituto de Saúde, a setting outside the women's homes. This arrangement was compelled by the size of the city and distances between communities that made it difficult for most women and men to meet at a single site easily accessible to all other women. The Instituto became the central gathering point for all the participants throughout the research.

Criteria for Selection

In both countries the study used a convenience sample, that is, women self-selected to participate in the exploratory study. Criteria for the selection of participants included age, i.e., 18 to 24 and 25 to 40 years, and the SES of participants, which was defined by the PIs. Where such women at recruitment meetings did not meet the age criteria, many referred their daughters, co-wives and friends to the research team. Some were excluded as participants because they were no longer sexually active, were pregnant or not available for the specified period of data collection. Later, Kenyans who did not attend the first FGD were excluded from further participation. This is noted further in the text.

The indicators for SES in Kenya were household income, level of education and number of people in the household supported by the household income. In Brazil the research team used local standard indicators which included the level of education of the head of the family and facilities in the household, e.g., car, television, refrigerator, maids, bathroom, etc., things that were symbols of an elevated level in income and status.

In both Kenya and Brazil, eligible women received information on HIV/AIDS and a demonstration and instruction in the use of the female condom by a health care specialist. They were then offered a packet containing six female condoms and some lubricant and were invited to enroll in the study. Women chose the date, time and place for a second meeting at which they consented to participate in the study. Women who refused or who failed to meet the inclusion criteria completed a dropout form indicating reasons for not participating in the research.

In both Kenya and Brazil, consenting women were administered an individual structured interview. This occurred for most women in Kenya the week following recruitment; in Brazil, the interval was shorter, at times on the same day that the women agreed to participate. Most interviews lasted between 60 and 90 minutes. While most were administered in selected research facilities, a few took place in the privacy of women's homes.

Recruitment of Males

An earlier study cited above by Ruminjo¹⁷ indicated a low level of acceptability of the female condom by male partners. This lack of compliance by men caused women to discontinue use and was termed "lack of acceptability." In addition, reported responses from men were actually the observations made by their female partners. Thus, this research design required that the perceptions and experiences of men be reported directly by male partners rather than by the women.

The women participants were informed at the outset that they would be asked at a later stage to invite the partners with whom they had used the female condom to participate in a single male FGD. That FGD was scheduled to occur after the final exit interview had been completed by the respective female partner. Men were not interviewed separately, nor were PSGD sessions conducted for them.

The FGDs with men in both Kenya and Brazil were held in a central place, that is, The Collaborative Centre for Gender and Development in Nairobi and the Instituto de Saúde in São Paulo. In Brazil the research team consisted of two men; one coordinated/facilitated the discussions and the other served as the observer and recorder. In Kenya two male researchers were involved in the study, assisted by a female observer who taped the sessions.

Forty-six men were recruited in Kenya from which six FGDs were conducted over the life of the study. Only 24 men were recruited in Brazil due to the earlier noted delay. They were divided into three FGDs, all of which were arranged near the close of the study. In Kenya an average of seven men were recruited to each group; an average of eight men were convened in groups formed in Brazil.

Two criteria were applied to men: age and female condom use. Men were grouped into younger (<25) and older (>25) categories. The male study participant also had to have used the female condom with his female partner at least once. Most men in the study were regular partners. In Brazil among the women responding to the initial interview 78 percent (N=103) said they had only one partner and in Kenya 70 percent (N=132) gave the same report. However, some women admitted they had several others, or “casual” partners.

Qualitative data was collected using the FGD guide that elicited responses regarding the men’s perception of and levels of satisfaction with the female condom, its negative and positive aspects, its impact on the relationship with their partners and how it compared with the male condom.

Formation of Groups for Discussions

In the initial interview, participants provided data on age and SES criteria which determined assignment to an appropriate category and group. The research protocol required each country to have eight groups with women meeting together according to the following categories:

Table 1

Categories of Study Participants

SES	AGE	
	<25	>25
2 X Lower SES	24	24
2 X Higher SES	24	24

Key:
 Younger Lower SES = YLSES
 Older Lower SES = OLSES
 Younger Higher SES = YHSES
 Older Higher SES = OHSES

Focus Groups (FGDs)

A total of 96 women was required by the study protocol for each site. When eight to 12 women were recruited and interviewed, a FGD meeting was arranged. As discussed above, the FGDs were formal research sessions facilitated with a FGD guide by the PIs and co-investigators with an observer in attendance. While Brazil researchers linked the individual women to their comments during the FGDs and PSGDs, plans and preparations for data analysis in Kenya did not include this procedure.

Peer Support Groups (PSGDs)

Two PSGDs were held between the first and the last FGDs for women. These “women-directed” meetings were taped by the observer. (The PSGDs are described in greater detail in **Part III**.) When a single group of women had completed the second PSGD and FGD, each woman was asked to attend an exit interview. In Brazil some were not reached, as shown below.

Male Focus Groups

When the exit interviews were completed, the male FGD for that particular group of women was convened by the male PI and co-investigators in Brazil and Kenya with one female observer. Recruitment of men, as with women, in Brazil was less community based. Moreover, women in Brazil had less success getting their partners to participate in the male FGDs than the Kenyans did. Since some women’s groups were unable to recruit enough men to justify a separate meeting, partners of two or more women’s groups were brought together for one of the three male FGD sessions. All male FGDs in Brazil took place near the end of the study, instead of running concurrently with women’s FGDs and PSGDs, as was the case in Kenya. Data collection continued over a period of approximately three and a half months in both countries, during which period the women and their partners continued to use the female condom.

Women participants were compensated for their time, child care and transportation by a small financial reimbursement in Kenya. Each participant was given an “incentive” of Ksh. 250, or US \$4.00, while groups from which they were recruited received Ksh. 3,000, or US \$48.00, in recognition of their efforts to facilitate the research project. In Brazil women were provided with a snack during the course of the meetings, a transportation ticket and gifts, such as T-shirts.

Data Analysis

Both qualitative and quantitative data collection and analysis were used and two units of analysis were carried out, i.e., the individual and groups. The FGD and PSGD data were coded to identify individuals and in Brazil to link their responses to group data. As indicated earlier, it was not possible to identify the responses of individual women in Kenya once they became members of a group.

An assumption was made that women’s responses would reflect age and SES differences. Several sub-groups of variables for analysis were identified. These results from interviews, FGDs and PSGDs are discussed separately and fully in the country reports. The variables included demographic characteristics such as income, partner status and education that distinguished women across the four categories. Condom use, strategies used, reactions to the female condom, perceptions of risk to HIV/AIDS and partner relationships were analyzed by age, SES and, as relevant, gender.

Through comparing initial and exit interviews, the data were examined for changes in perceptions and behavior over the time of data collection. In Kenya, for example, as the synthesis shows below, a substantial increase in satisfaction with the female condom occurred in all categories between the first and last individual interviews.

The Coital Log

In both sites coital logs were collected and analyzed for indications of use of the male condom and female condom, and practice of anal sex, oral sex, masturbation and unspecified acts. As shown in **Figure 1**, in Kenya, the log was introduced to participants during PSGD1 when the researchers felt that the women were comfortable discussing sexual behavior, while in Brazil the women were instructed to complete theirs at FGD1. The content of the coital log was recorded in the local language for ease of understanding such terms as anal intercourse and masturbation, words unfamiliar to some women.

Although in both Kenya and Brazil some women at first had difficulty recording information, they quickly gained confidence and ability to use the log. By the end of the first month the reliability of data recorded in the coital log appeared to be confirmed in group discussions. In Kenya, for example, women who had said they had a single sexual partner showed they had intercourse only twice or three times within the week. The participants who indicated they had no specific times for intercourse also indicated this pattern of irregularity in their recordings. Among the few who said they feared becoming infected and, therefore, never engaged in unprotected sex (e.g., CSWs) a constant use of protection, with either the female condom or both male and female devices, was shown. Finally, some diaries in Kenya showed occasional engagement in unprotected sexual activity. No Kenyans admitted to engaging in oral and anal sex, but in discussions they indicated they knew such types of sexual activities take place. In general, the coital logs were completed adequately. However, most women in the younger age group in Brazil failed to submit their diaries for analysis. No explanation was given for their noncompliance with this aspect of the research. It was assumed to be related to the desire for privacy or the lack of conviction that the recordings would be kept secret.

Data Processing

All of the questionnaires for the individual interviews were completed and the FGD and PSGD meetings were taped. In Kenya most were transcribed from Kiswahili to English. In Brazil, all sessions were recorded in Portuguese and the full report was later translated into English. The Brazilian researchers used the Epi Info program for quantitative data analysis, while the Kenyans used the SPSS program. Qualitative data in Kenya were analyzed by use of the FolioViews package, while in Brazil, the team used thematic content analysis. In both countries the data analysts also contributed to interpretation of the results. Panels of PIs and judges in Kenya and PIs and co-investigators in Brazil, respectively, analyzed the data resulting from the open-ended questions in the individual interviews and the qualitative data of the focus group and peer support group discussions. The data analysis process was supervised by the PIs.

Whether because of the awareness of high HIV/AIDS prevalence rates, the desire to avoid unintended pregnancies or curiosity, research teams in Kenya and Brazil easily recruited participants to the study. **Part III** describes the women's and men's responses. This synthesis, under several themes, integrates the results of data derived from the individual interviews, two FGDs, two PSGDs and one male FGD to show important similarities and differences in responses between Kenya and Brazil study participants.

Part Three

W O M E N A N D M E N A D O P T - I N G T H E F E M A L E C O N D O M

Whether because of the awareness of high prevalence rates, the desire to avoid unintended pregnancies or curiosity about the female condom, research teams in Kenya and Brazil received a positive response from women and many men who were approached. **Part III** presents the major results of the study, highlighting the women's reactions to the female condom, their efforts to negotiate its use, the impact of peer support and responses of male partners. The synthesis follows these themes and subtopics to integrate the data obtained from women's individual interviews, the two FGDs and two PSGDs, as well as the male FGDs, to show the processes and outcomes of efforts to introduce the female condom in partner relationships in Brazil and Kenya. Rather than first describe each country's experience and then summarize and discuss the findings, the results derived from both sites are presented together throughout the synthesis. This format is used to show similarities and differences and is intended to facilitate comparisons where this will be useful to future research and promotion of the female condom. This part begins with a report of the women who ultimately became respondents in the study.

The Sample

In Brazil, of the 394 women who were reached, 115 women initially consented to take part in the research and were interviewed. The data analysis, however, was based on the number of women (N=103) who participated in at least one to four of the group sessions. Brazil had a modest attrition rate of ten percent which occurred over the life of the study. With an equally positive indication of interest among 350 women, 132 of them ultimately enrolled and were interviewed in Kenya. This number decreased to 100 women who continued through all seven data collection points. The reduction was a deliberate effort to bring the sample size to a level prescribed by the protocol, i.e., at least 96 women, rather than the results of a self-selected drop-out from the study. Kenya's attrition rate, therefore, was considerably higher than that of Brazil's, or 24 percent. The samples in the two countries are presented in **Table 2**.

Table 2**Demographic Characteristics of
the Samples at Initial Interviews**

	Brazil II (N=103)		Kenya II (N=132)	
	N	%	N	%
Age				
18-24	54	52	70	53
25-40	49	48	62	47
Marital Status				
Married (one steady partner)	80	78	93	70
Single	3	3	39	30
Other	20	19	–	–
Level of Education				
None			14	10
Some primary	25	24	55	42
Some secondary	21	21	45	34
Post secondary	57	55	18	14
Brazil SES				
High	45	44	54	41
Low	58	56	78	59

In Kenya, 132 women between the ages of 18 and 40 from seven locations of Nairobi participated in the initial in-depth interview. Of the 132 women who consented to the initial interview, 70 were 24 years or younger while 62 percent were 25 years and older. As previously stated SES in Kenya was measured by household income, level of education and number of people in the household supported by the household income. Of the Kenyan women (N=72) reporting actual income, overall, 59.1 percent and 40.9 percent of the respondents were from the lower and higher social economic statuses, respectively. Data not presented here show that a slight majority of the participants from each category were below 25 years of age. Forty-two percent of the women in LSES had one to eight years of formal education, while about 34 percent had nine to 13 years and 14 percent had over 13 years of schooling. However, 11 percent of the women had not attended school at all.

In Brazil, of the 103 women, 52.4 percent were 18 to 24 years, while 47.6 percent were 25 to 40 years of age. All the women were inhabitants of the metropolitan region of São Paulo. They also were classified according to their “high” or “low” socioeconomic status for the purpose of the study: 55.9 percent were grouped as HSES while 44.1 percent were grouped as LSES. All women had some level of education: 23.7 percent had attended school for three to seven years, 21.0 percent had eight to ten years and 55.3 percent had over 11 years of education.

Table 3 reveals the sample of women by SES and age who consented to be a participant.

SES	Age	Brazil		Kenya	
		No.	%	No.	%
Lower Younger	18-24	29	28.2	34	34.1
Lower Older	25-40	29	28.2	25	25
Higher Younger	18-24	25	24.2	19	18.9
Higher Older	25-40	20	19.4	22	22
Total		103	100	100	100

Perceptions of Risk

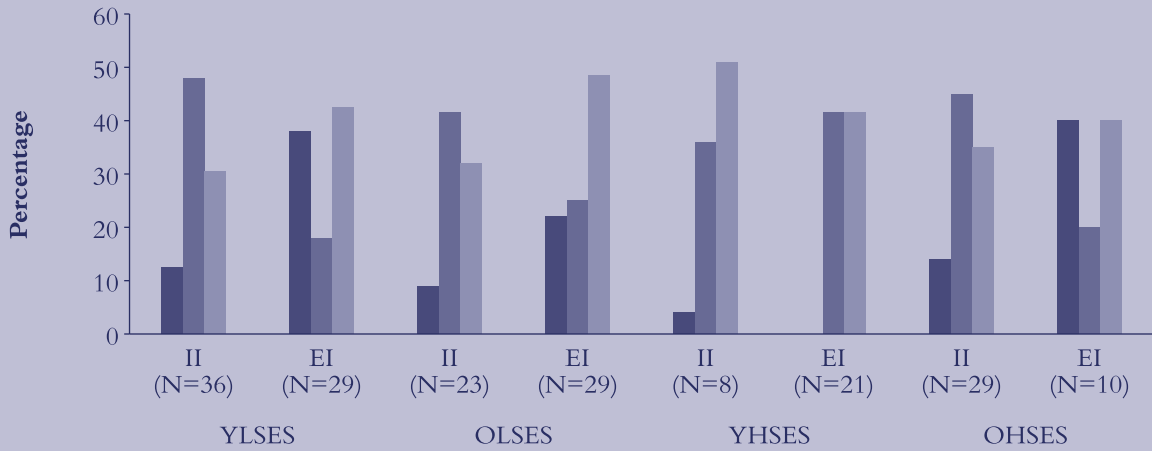
The study assumed that willingness to adopt the female condom might reflect women's perceptions of their risk of becoming HIV infected. The majority of women in the study were identified as the "general population," and thus were considered at "low risk" of HIV. Of the Brazil sample, 78 percent of the women said they had only one partner throughout the study. Of those women who thought there was a potential risk, 27 percent were partners to drug users; another 12 percent said their partners might be bisexual. In Kenya, where drug use and bisexuality are rarely acknowledged, the threat to women is almost exclusively through heterosexual intercourse. Over 75 percent of all four categories indicated that they had only one sexual partner. About 61 percent of the Kenyans believed that they were at risk; indeed, of these 48 percent said they were "very likely" to become HIV infected.

There was, however, some disparity between the four categories. Younger Kenyans in both the lower and higher SES groups perceived themselves most at risk of HIV infection. As **Figure 2** reveals, both younger (4%) and older (13 %) women in the higher SES thought they were at little risk at the initial interviews. About 13 percent and nine percent among the YLSES and OLSES, respectively, perceived themselves likely to be infected. However, by the exit interview, all except the YHSES women perceived a higher threat than when they enrolled in the study.

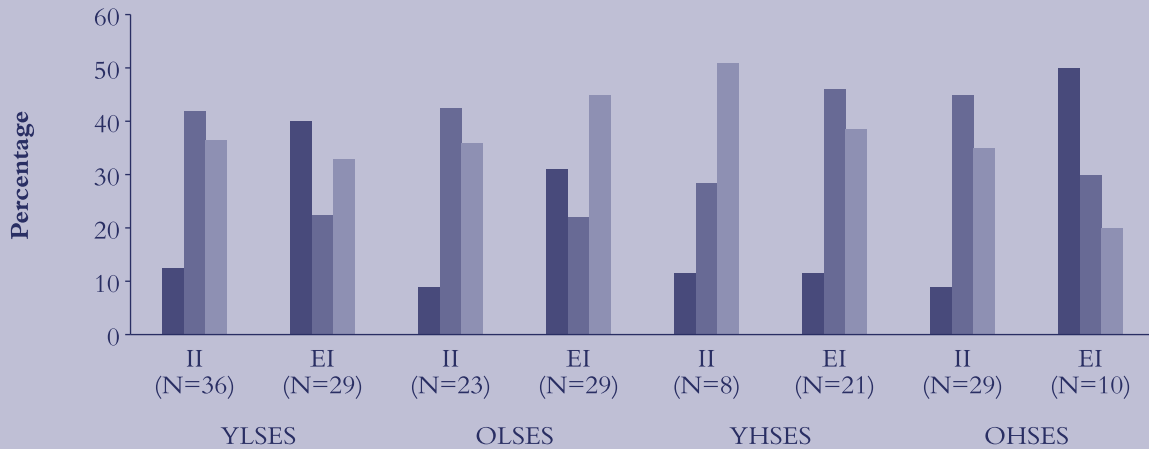
In Brazil some women also admitted that the risk of HIV/AIDS was a reason for them to suggest the use of the female condom to their partners. In contrast to women in Kenya, adopting the female condom was not predicated on a perception that they were personally at risk. For Brazilians HIV/AIDS was perceived to be a disease contracted by certain high-risk groups, e.g., CSWs, drug abusers and homosexual men. Moreover, although São Paulo has the highest percentage of AIDS cases in the country, many women in the study had little knowledge of the disease. Those who had accurate knowledge thought that AIDS was something that happened to "other" women. **Figure 3** shows that only 34 women thought they were at "some" or "great" risk. With information provided through the study, however, their perception grew that they, too, were at risk, particularly through the sexual behavior of their partners.

Figure 2

Perception of Risk of STI in Kenya by Age and SES at Initial (II) and Exit (EI) Interviews



Perception of Risk of HIV/AIDS in Kenya by Age and SES at Initial (II) and Exit (EI) Interviews



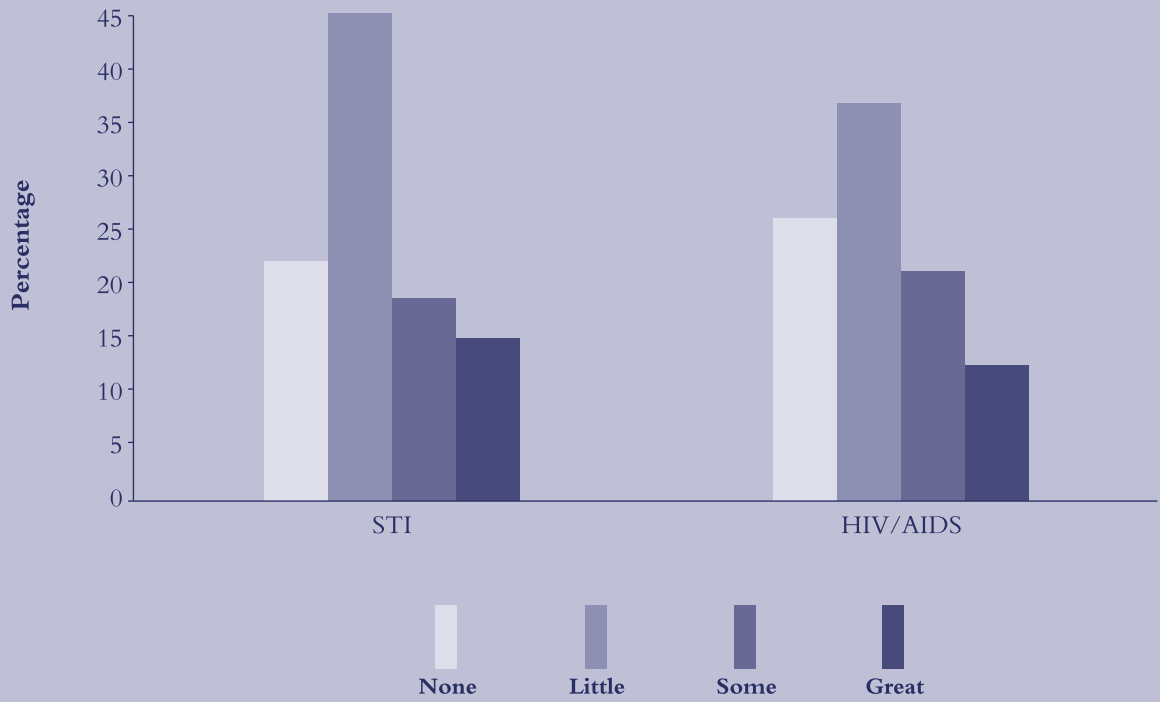
very high moderate no risk

YLSSES = Younger, Lower Socioeconomic Status
 OLSSES = Older, Lower Socioeconomic Status

YHSSES = Younger, Higher Socioeconomic Status
 OHSSES = Older, Higher Socioeconomic Status

Figure 3

Perception of Risk in Brazil (N=103)



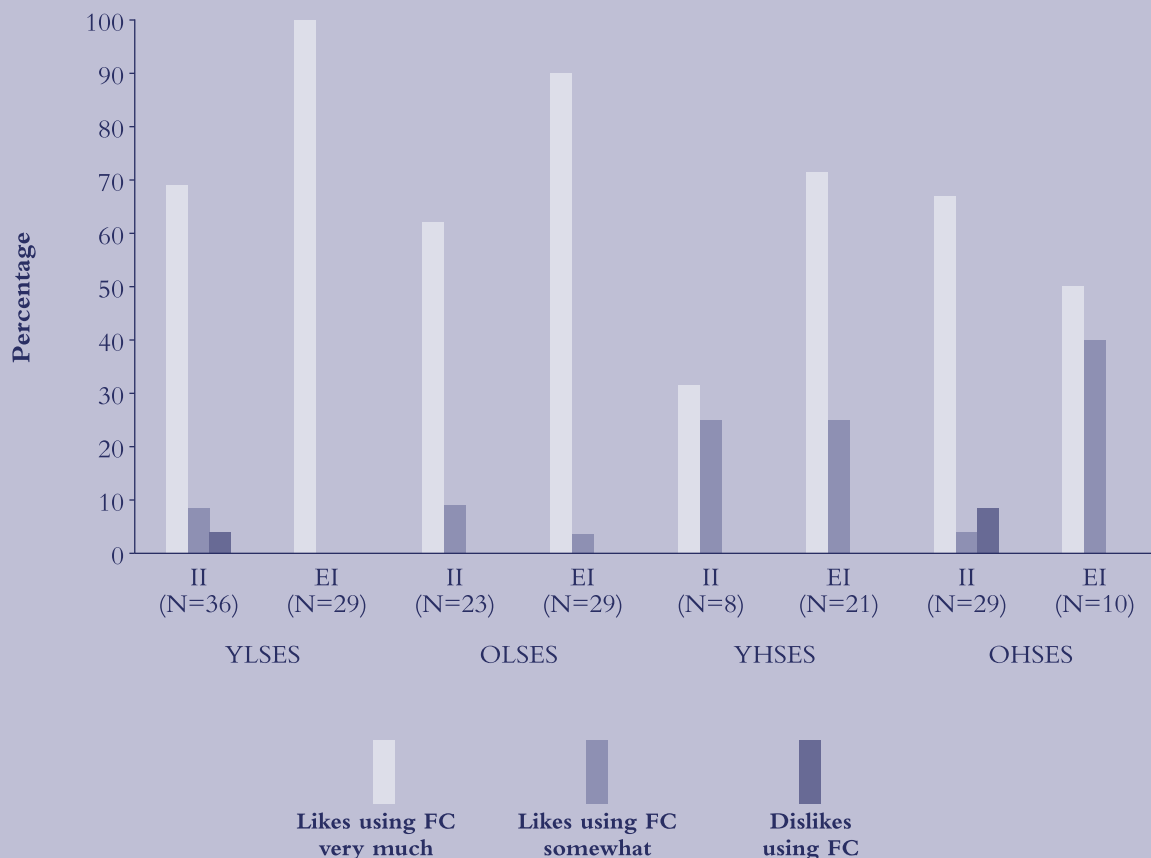
The Female Condom: Negotiating Protection

All the Kenyan women had tried the female condom by the initial interview. Over 70 percent of the women in the OLSSES category said they liked the device very much initially and just under 94 percent of these continued and still liked it at the exit interview. Among women in the YLSSES the device was extremely popular, with 80 percent

favoring it at the initial interview and 100 percent reported use at the exit interview. There was significant change reported by women of YHSES as well. While only 32 percent of the women liked it at the start of the data collection, 71 percent liked it by the close of the study. Of women in the OHSES category, 66 percent liked it initially, but only 50 percent continued use throughout the study. The reasons for this decline among high status women were not reported. It was assumed by the

Figure 4

Degree of Acceptance of the Female Condom (FC) at Initial (II) and Exit (EI) Interviews* by Age and SES in Kenya



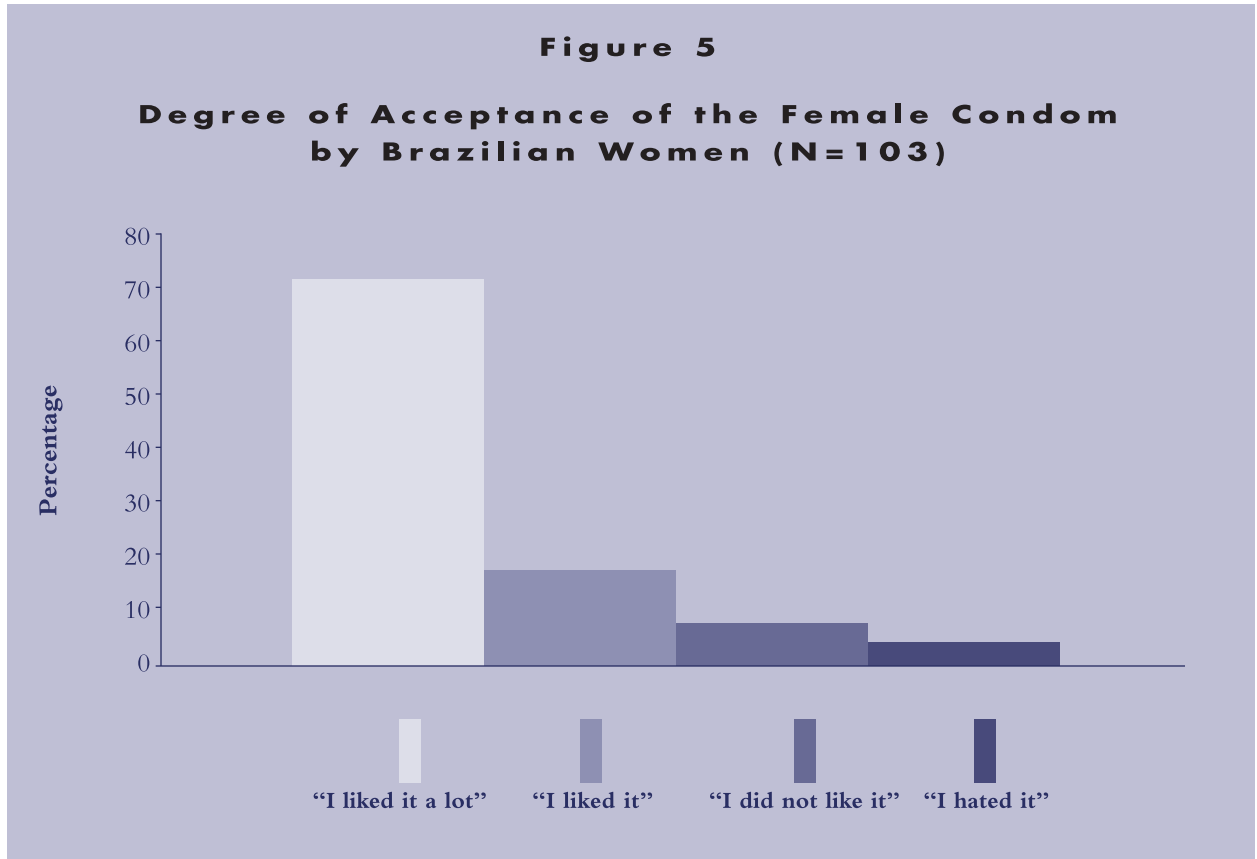
YLSSES = Younger, Lower Socioeconomic Status
 OLSSES = Older, Lower Socioeconomic Status

YHSES = Younger, Higher Socioeconomic Status
 OHSES = Older, Higher Socioeconomic Status

* Some women at the initial interview did not use the FC for reasons that included lack of familiarity, fear and uncertainty; and at the exit interview, menstruation and lack of supply were cited as reasons.

researchers that they met with difficulties in negotiating with their partners who provided them economic security, referred to later in the text.

Figures 4 and 5 indicate the levels of acceptance and satisfaction women reported. The data available from Kenya reveals that this grew substantially over the entire study period.



The acceptance rates also were high among the Brazilians, with only 45 percent of the women of all categories having liked the female condom by the time of the initial interview, but 85 percent of them saying they liked it when interviewed at the end of the study. The length of expo-

cent of sexual intercourse among this group. Among the OLSES, the disparity was less great with about a third (28%) of the women using the male condom in contrast to about two-thirds (58%) of the women using the female condom and only 14 percent using no protection at all for 491 sexual acts during the same period. As expected, sexual activity among the young was higher, with 22 YLSES reporting 560 (97%) sexual acts: 87 percent of these were protected and 13 percent were unprotected. Among the YHSESs, the male condom was used 26 percent of the time and the female condom was used 63 percent of the time. While all the participants used the female condom, 23 percent of the Kenyan women never used the male condom at all. The coital log showed that across the four categories just under 66 percent more of the sexual acts are protected when the female condom and the male condom are used than when the male condom is used alone.

The relatively greater satisfaction with the female condom over the male condom is noted in **Table 5**, where Brazilian women's preferences are stated.

Table 4

Number of Days Using The Female Condom By SES*

Category	Days
OHSES	132.5
OLSES	114.8
YLSES	112.6
YHSES	90.1
Mean Use:	112 days

* Data not available for Kenya women

sure to the female condom for Brazilian women was a mean 112 days, as **Table 4** shows. While the younger, more sexually active women used it over a shorter period, the overall response was consistently high.

The coital log or daily diary was used to record the extent to which women chose to use the female condom instead of the male condom. The log provided quantitative data that complemented the verbal reports provided by the women. While most Kenyan and Brazilian women showed ability to keep a record of use of the female and male condoms and other methods, only one report of coital log use is presented to document the results obtained.

Examining the Kenyan logs for one month only, 11 women in the OHSES reported 278 (98%) acts of vaginal intercourse. Of these, the female condom and male condom were used exclusively in 46 and 12 percent of the acts, respectively. No protection was used during 42 per-

Table 5

Preference for the Female Condom (FC) in Comparison to the Male Condom (MC) in Brazil*

	N	%
Prefers the FC	43	42
Liked as much as MC	22	21
Prefers the MC	12	12
Undecided	18	17
No response	8	8
TOTAL	103	100

* Data not available for Kenya women

Women's Strategies

Individual interviews and FGDs centered on the strategies adopted and those factors that led to the successful use of the female condom. They also focused on the reasons why some women chose not to adopt the method. What women thought were the advantages and disadvantages of using the female condom also were considered. Their responses are discussed below.

In spite of differences in the social, economic and cultural contexts and their personal situations, the strategies used by women in Brazil and Kenya to persuade partners to try the female condom were quite similar. Although differing in wording, several of these strategies showed essentially the

same action was taken in the two sites. However, in some instances the reason for the behavior was highlighted rather than the action itself. For example, in Brazil emphasis was placed on the novelty or erotic possibilities of the device while Kenyans gave more pragmatic reasons.

One possible explanation for the similarity in ways in which women introduced the female condom to their partners was that they had independently identified the same approaches and shared these through the group learning experiences. Each woman, thereafter, apparently chose the strategy that best suited her situation. **Table 6** lists these strategies; however, they are given in no particular order of priority.

Table 6

Strategies Women Used to Introduce the Female Condom to Sexual Partners

Approaches	Country	
	Brazil	Kenya
♦ use of arguments for pregnancy prevention	X	X
♦ gentle non-confrontational dialogue rather than negotiation	X	X
♦ placing the device on the bed to initiate discussion	X	X
♦ left literature/brochure out for the partner to read	X	X
♦ use of the device in secret by inserting it in advance of intercourse	X	X
♦ discussed use of the female condom as an STI/HIV prevention method	X	X
♦ participation in the female condom study as reason for use	X	
♦ used a friend to persuade partner to try the female condom		X
♦ suggested that couple experiments and then decides together	X	
♦ arguments to convince males to switch to the female condom, i.e., "it is more reliable than your male condom"	X	
♦ highlighted the novelty	X	
♦ focused on eroticism	X	

Factors Leading To Success

The favorable perceptions also were explained by various factors. The Kenyan women liked the female condom because it was supple and wide, compared to the “rough” male condom which, according to their partners, was “too tight.” They thought the device was safe and reliable because it could be checked prior to disposal and there was no evidence of rupturing unlike the male condom. The women also felt the female condom enhanced their sexual satisfaction due to its comfort. Ultimately the women valued the fact that the female condom encouraged dialogue with their partners that went beyond sex to other important issues.¹²

Further, the high level of satisfaction with the female condom was explained in part by the perception that the device offered advantages to both men and women. These were identical except for two exceptions, as **Table 7** reveals.

Table 7

Women’s Views of the Advantages of the Female Condom

	Brazil	Kenya
◆ freedom from fear of pregnancy and disease	X	X
◆ both partners found that it did not interfere with sexual pleasure	X	X
◆ couples could “stay together longer” after ejaculation	X	X
◆ more comfortable than the male condom	X	X
◆ was used as part of seduction	X	
◆ allowed body heat transmission		X

***Problems In
Using The Device***

When the use of the female condom was discussed at the PSGDs in both Kenya and Brazil, a few women said they had had initial difficulty particularly with insertion. However, 54 percent of the Kenyans considered it easy at the first attempt and only two percent were unable to insert it by the time of the first interview. Among the Brazilian women, 88 percent thought insertion was easy by the third. Only eight women continued to have problems with insertion, and only one participant in Brazil said she was unable to remove the female condom at the exit interview.

Women who experienced difficulty at first received encouragement from other women, a factor that contributed to their continued attempts to use the device. With increased effort, all the women found that they could easily insert and remove the female condom.

***Refusal to Adopt
the Female Condom***

Despite the participants' general acceptance of the female condom, not all women and men were convinced and intended to continue use. **Table 8** below compares the reasons given in both Brazil and Kenya for nonuse of the device.

Table 8
Reasons for Nonuse

	Brazil	Kenya
◆ dislike of the device because of aesthetics	X	X
◆ noncooperation from the male partner	X	X
- lack of ability to negotiate		X
- perceived unwillingness of men	X	
◆ association with prostitution		X
◆ perceived interference with pleasure		X
◆ displacement of the device	X	
◆ difficulty with the manipulation of the device	X	

In comparison, Brazilians appeared to have more difficulty than Kenyans in handling the female condom. On the other hand, the problems of women in Kenya seemed related to self-efficacy and, to some degree, to the response of the partners.

Reasons for Nonuse

Neither the Brazilian nor Kenyan women in steady relationships claimed to have detailed knowledge about the sexual practices of their partners. However, the more the women knew about HIV/AIDS the more they recognized the need for protection. Some women said they also suspected they were in danger because of their own sexual behavior. Many women in both Kenya and Brazil who were in a steady relationship were not formally married but practiced serial monogamy, having had several partners over their lifetime. Among the Brazilians 14.6 percent had had two partners over the period of the study, and four women had had three.

Despite the possibility of becoming infected by HIV, some women did not want to try the female condom. Reasons given were similar in both countries and in all categories. They included “trust” of their partners and the belief that the device would signal a suspicion of infidelity. Some women thought that faithful monogamy was protective and chose to assume their partners were monogamous and uninfected. Women also noted that having lived together for a long time gave them a “false confidence” in their partners. During initial FGDs participants indicated that they did not consider themselves to be at risk of STIs/HIV/AIDS since they had steady partners or used the male condom with them. In Kenya and Brazil, women also wanted to avoid pregnancies, and they accepted the female condom as a contraceptive.

The female condom was not available on the market in either of the countries. Few, if any, of the women had ever seen the device before the study. However, for the Kenyan women, awareness of the high prevalence rates of HIV/AIDS in the country was a reason given by most study participants to try the female condom as a protective barrier method.

When Males Refuse

Despite recognizing and attempting to overcome barriers through communication, there were some instances nevertheless when women were unable to get their partners to comply with their request. Kenyan men sometimes respected the wishes of a wife or a CSW to use a condom, but would insist on “body to body” sex with younger women.

Brazilian women in the LSES were confronted by male partners who felt disempowered. Women thought this represented “...a growing sense of insecurity when the female condom is associated with increased decision making power on the part of the woman.” As one Brazilian woman noted:

“The woman could make a choice to use the female condom when the man refused to use the male condom. The male would attempt to belittle the device through such comments as it being ‘ugly.’ Where the woman was unable to resist the put down the negotiation failed and the man refused the use of the female condom.”

Less than 30 percent of the Brazilian men were reported by women to have complained; however, the problem of compliance recorded in previous acceptability studies^{17,20,21} was diminished presumably by the increased competence and empowerment gained by the individual woman through her participation in the focus and peer support group discussions.

Partner Dialogue

Whether or not the woman was able to continue use of the female condom depended to an important degree upon the reaction of the male partner. The results shown in individual interviews, FGD and PSGD data highlighted in **Table 6** previously suggest that the Brazilian and Kenyan women adopted parallel strategies in negotiating the use of the female condom. Through interaction in the PSGDs, women said they were empowered to open up and broaden the range of topics discussed with their male partners. The aim was to convince the man to respond positively, in a situation where he could react negatively because of his cultural prerogative, to decide on sexual issues. In light of prevailing norms, women perceived that negotiations had to proceed without suspicion of infidelity or insinuations of guilt on the part of either partner. In Kenya this had to be accomplished in a context where sexual decision making is the responsibility of the men, but protection against unwanted pregnancies and HIV prevention is left largely to the women.^{13,17}

Women from both the lower and higher SES in that country confirmed that it was the man who decides when he should have sex and with whom. Kenya is typically a patriarchal society where women are not expected to express love or desire for sex. One Kenyan woman said:

“According to tradition, women are not supposed to ask for sex and that is how it has always been. Women are not expected to engage in extramarital affairs and if she is ever caught and is taken to the elders, she will pay dearly for it.”

Moreover, cultural norms in Kenya dictate that sex is for the man’s pleasure and not for the woman’s. “The nature of the society is such that women seem to accept that men are polygamous by nature and therefore cannot be trusted to be monogamous,” one woman said.

In Brazil, husbands seemed more willing to accept the female condom as a means of contraception.¹² One Brazilian woman said: “I told him I didn’t want to harm myself by taking the pill...the condom would be our best option. He agreed without raising any problem...he hesitated a bit in the beginning, he found it horrible, but now he is used to it.” In addition to being presented as a contraceptive, the additional protection from STIs/HIV made the female condom more appealing to the men. By introducing the device as a method of protection from both infection and unwanted pregnancy, the issues of unfaithfulness and infidelity were thus avoided.

For most of the Kenyan women, a major concern was whether to use any method at all. Figures taken from the Population Reference Bureau’s World Population Data Sheet⁴⁹ indicate that only 33 percent of married women in Kenya use any method of contraception, with 27 percent using modern barrier and chemical methods.

In Brazil, where 70 percent of married women have used either the male condom or other modern barrier methods with their partners, 61 percent maintained use of the male condom, while 43 percent had used it in the previous month before the study; 77 percent had used other methods also. The female condom represented a new approach to protection for the women in both countries. Many agreed to participate in the study initially out of curiosity about the device.

The Peer Support Group: Source of Information and Empowerment

While the discussions above derived primarily from data obtained through individual interviews and FGDs, this part of the synthesis focuses on the intervention component of the research which drew heavily on the women's group experiences. This choice is made in light of results showing this was a major influence on the response of women to the female condom as well as to their partners.

Based on earlier cited acceptability studies,^{17,20,21} it is concluded that women acting alone might easily discontinue use of the female condom for several reasons: noncompliant, uncooperative partners, initial difficulty with the device and lack of confidence in approaching issues of sexuality. Contrarily, in other areas of life such as development and reproductive health, women, sharing experiences with other women, have tended to be very supportive of each other and have derived a sense of solidarity and empowerment, as suggested by Bandura³⁶ and Labonte.³⁹ Through their organizations women have been able to take actions that as individuals they may not have committed to, or persisted in doing.

Women's Experiences

The use of the FGDs and group experience as a means to elicit responses are not original to the Kenya and Brazil study. Research by WHO/UNAIDS in Senegal, Mexico and Indonesia also used groups for the purpose of getting reactions to the introduction of the female condom and to identify negotiation strategies. PSGDs were introduced as the innovative intervention in this research to provide the women with a largely unstructured "open forum" or "space" to share the experience of being exposed to and introducing this new method into their partner relationships.

Unlike in FGDs, researchers offered no guidelines to participants of PSGDs. Their role, at a maximum, was to introduce start-up questions to encourage women to share their views. They also answered questions if asked directly. The researchers at the PSGDs were basically observers, there to document the process taking place between women who had their own agendas. The women had the freedom to use the space, or time together, in ways that met the needs of the individual and the group as a whole. In this situation the women learned from each other, got feedback on new ideas and began a conscious process of behavioral change.

All the participants in the PSGDs in both countries came from the same SES and age group. These factors helped to provide initial cohesion and solidarity among the women. Minimal ground rules were set: sharing between the women was to be voluntary and to evolve in a spontaneous manner. Participants were further assured that all discussions would be kept confidential. The direction of the exchanges between women therefore varied according to the interests of the different groups. In each category, women created an environment suitable to their own exploration of this new technology, the female condom.

The women noted that information about the device enabled them to discuss intimate subjects with assurance of mutual respect and support. All the participants in the PSGDs in Kenya and Brazil used the female condom regularly, based on reports in their coital logs. PSGDs enabled women to learn from each other by gaining information from the experiences of their peers as they shared attempts to use the female condom with partners. "Now I know every woman is a woman," said one Kenyan woman. Participation in the study on the female condom seemed to add a new dimension to the women's coming together: "We used to meet and discuss other things, but now we meet to discuss our sexual life." The Brazilian women saw the groups as a chance to "share secrets." They also were able to accept differences of opinion and to talk about subjects that formerly they dared not mention in public discourse.

In neither Brazil nor Kenya did situations occur which resulted in disrupting or aborting the group process or compelling some women to leave the group, with but one exception in Kenya. For the most part, PSGDs were thought provoking and serious, though “fun times,” said a Brazilian. However, some groups required careful facilitation to promote such cohesion, especially the younger higher socioeconomic status (YHSES) women in both countries.

Among Brazilian women, the most difficult groups to engage in discussion were of the YHSES category. The most common reason they gave for their reluctance was lack of time. Since the majority of the YHSES were either students or single working women, they lived busy scheduled lives. They also put a high premium on privacy and were less willing to discuss their sexual behavior with “strangers.” More importantly, they believed they had already acquired “equal rights” with men and believed that both sexes shared the same sexual values. Ideologically, like younger high-status men, they felt no pressure to conform to traditional sexual norms.

The Kenyan team observed a similar reluctance among YHSES women. Some of the resistance of this group sprang from their preoccupation with academic studies, their careers and their individualized private life. But in addition, the researchers found that the directors in some educational institutions were unwilling to cooperate with the research team. Many were afraid that if parents learned of the participation of their daughters in a study related to sex, they would blame the institution for encouraging promiscuous practices among the students.

Kenyan OHSES women also showed some initial resistance to the group aspects of the study and its focus on sexual behavior. Researchers believed the reluctance among these women was due to their greater economic dependence on the support and status of their men, with less freedom of choice in sexual matters when their welfare was seen to be jeopardized. These women nevertheless felt they needed to discuss sexual issues and to introduce the female condom into the relationship because the husband’s economic resources could as well support extramarital affairs which could thus increase the risk of HIV transmission.

The greater loss to FGD and PSGD meetings that occurred in Brazil was reportedly due to the difficulty women had in traveling to the Instituto. These meetings were held in the early evening hours and required child care. By contrast, in Kenya where the women showed consistent attendance from the initial through the final interviews, they met relatively close to their homes, brought their babies along and usually met during the day. Moreover, the community leader facilitators in Kenya took responsibility for both contacting women and arranging sites for the meetings.

Among the YLSES in both Brazil and Kenya, younger women’s life experiences were similar to the older lower socioeconomic status (OLSES) women, i.e., some YLSES were already married with children. Like the older women, the young ones felt they lacked power to change the sexual behavior of their partners.

Both YLSES and OLSES participants in the two countries stated that the study presented an opportunity to meet and discuss issues of concern “intimately and privately” with other women. An environment for networking was apparently created especially for the women in the LSES who had few options in disadvantaged communities. This contrasted with women of the HSES who had many other avenues for interaction by virtue of higher levels of education, work and financial resources.

In Kenya the overall high level of participation was attributed to the rapport and very supportive climate created by the researchers and facilitators, which gave the women a sense that they could trust the research team with confidential information. In effect, the women enjoyed the peer support group experience, which was evident in the sustained contacts noted later. Moreover, the women were aware of the high HIV-prevalence rates in Kenya. They were apparently responding positively to information that, though not perfect, the female condom would provide some protection for them with less difficulty than trying to get partners to use the male condom.

The Brazilian women thought it a privilege to be included in the study and to have their ideas accepted by other women. They believed they contributed to society by helping to make the female condom available and by providing information about it to other women.

Empowerment

Having information through the FGDs and the support of other women within the PSGDs the majority of women were empowered to talk to their partners about the female condom. “The Kenyan women counseled and encouraged each other, and in other ways assisted women in the group who had initial difficulty with the use of the device,” noted Kabira.¹³ The increased levels of proficiency of some women in use of the device was due largely to the support they received from women who were not having difficulties. In Kenya, one participant said:

“I was afraid to use the female condom, because after the first attempt I noticed blood stains and thought the female condom had injured me in the vagina.”

The other participants tried to assure her that the female condom could cause no such harm, suggesting that “maybe you were still menstruating.”

Although the women of the LSES in Brazil had fewer options in their partner relationships than women in the HSES, they perceived they had added power and control over their sexuality through the use of the female condom. Having the device increased their sense of ownership over their bodies and their sexuality. However, they acknowledged that the use of the female condom would depend on the partners’ agreement. The YHSES group said it was indeed the responsibility of women to seek information about their own sexuality. The women also believed women to be “vehicles of information about sexual health matters and protection for the men.” The YLSES group indicated that the women therefore should develop their own strategies for self-protection, rather than depend on the desires of the male partner. And the women in the OLSSES indicated that lack of power was the reason self-protection was necessary and that the female condom provided that protection.

A majority of the women participants felt that the introduction of the female condom had a positive impact on the relationship with their partners. For some, this was the response to increased knowledge about HIV/AIDS and a fear of being vulnerable. Other women received support and encouragement to use the device. One woman expressed the need “to be close” to her partner before initiating discussion on the use of the female condom, i.e., creating the right atmosphere to talk about such a sensitive issue.

Stories of the individual attempts of women to introduce the female condom to their partners were brought to the PSGD interaction. A number of common themes surfaced in both countries, including issues related to the woman’s body and her sexuality.

Women in both countries felt that their knowledge about their bodies had increased and that sex had become an issue they could discuss. Kenyan women discovered that their new found freedom to discuss intimate subjects allowed them to talk openly about issues of sexuality that were formerly cultural taboos outside the bedroom and except with partners. The women observed that they became more open about enjoyment of sex, claiming that with the female condom it was more pleasurable.

In both Kenya and Brazil, women learned from each other how to use the female condom while having sex in different positions. Suggestions were made to each other on ways to deal with problems of insertion and lubricating the device.

Kenyan women also noted that the group sessions helped by allowing the women to exchange information on how to deal with difficult partners. In using the information gained, women said they were overcoming cultural barriers that had prohibited effective communication in the past. Both women and men had been reluctant to talk directly about sex. Women revealed that before participating in the research they could not tell their partners when they wanted sex and how they wanted it, nor whether or not they were sexually satisfied. “Even the Kenyan men recognize a change has taken place in the attitudes of their partners,” one man in a Kenya male FGD claimed. Some women reported that the men felt a greater sense of responsibility for protecting their partners against getting infected with HIV/AIDS and were less worried when they knew the women would have “their condom too,” one Kenyan male remarked.

Male Perspectives: Compliance and/or Cooperation

As reported earlier, 24 men participated in three FGDs in Brazil and 46 were reached in six FGDs in Kenya, with an average of eight men and seven men, respectively, in each group in Brazil and Kenya. Initial male experiences and perceptions of the female condom were overwhelmingly positive, and the men’s stated reactions were in agreement and closely resembled those of the women participants. The partners were curious about the method and inclined to try it. They saw the female condom as an alternative to the male condom that many of them did not like. Men in both study sites also were motivated to participate in the FGDs largely because of perceived risk of HIV/STIs, since in both countries having multiple female sexual partners is condoned.

The reactions of men to the device once introduced varied according to whether it was being used by a wife or by a girlfriend. In Kenya, the men were reported to be first “shocked and suspicious.”¹³ The suspicion was due to the possibility of a woman using the same device with several men, thus “the risk of her spreading the disease by using one female condom.”¹³ Such suspicion, however, was more the exception than the rule, reports Kabira.

A few men were only moderately enthusiastic, but almost none totally rejected the female condom in either of the settings. Their initial resistance was abated by a dialogue with the female partners and with the repeated attempts of women to get them to agree to use the female condom. In Brazil, some men were reported to be “curious and ambivalent.” They were surprised that the female condom had been introduced into Brazilian society and excited by the prospect of sharing information about it with friends as well as with sexual partners.

A number of Kenyan men admitted taking their female condoms with them for casual sex. Some also acknowledged getting female condoms from other men to take home for use by their wives. The Kenyan study was community based, thus, male partners, like women participants, could have known each other and shared the supply of female condoms as well as information brought home by their wives from the study.

Reasons for Acceptance by Males

Men in Kenya were reported to be receptive to the female condom primarily because of its protective quality. The fears of HIV/AIDS/STIs and/or unintended pregnancies were alleviated by the availability of this protective method. In addition, the men in both studies expressed satisfaction that they could have prolonged erections when they used the female condom, and that it did not require a complete erection as in the case of the male condom. Men also agreed with the women's report that couples could stay together longer and thus have several sexual acts. The men felt that the female condom was comfortable, as it did not "squeeze" the penis.

The female condom reportedly did not alter sexual satisfaction or pleasure as it allowed the men "to feel the women's body heat," according to a report from the Kenya FGDs. Since the female condom could be inserted in advance as women had agreed earlier, there was no interruption to intercourse. Brazilian men found the device "erotic," as did their female partners. Unless informed by the women, some men did not know that the partner was wearing the device. A few Kenyan women acknowledged that when drunk the male partner was unaware that the female condom was being used. However, very few women adopted the use of alcohol as a strategy for getting male compliance to use the female condom.

Some men said they assisted with insertion of the female condom. This practice was part of the eroticism of the sexual encounters reported by the Brazilian women as one of the advantages of its use. Male partners of Kenyan women also found this practice pleasurable.

According to reports from the male FGDs, a surprising majority of men liked the female condom as well as, or better than, the male condom. They were attracted by the fact that the polyurethane from which the female condom was made was strong and did not tear even during vigorous sexual acts, unlike the latex male condom. They noted that it was also less permeable to STI agents than their condoms.

In addition, the female condom was appealing to Kenyan men because they were able to have sex with their partners during the women's menses. Because it is customary to avoid foreplay during sexual intercourse, the female condom rarely needed to be touched by the man. Women thus could guide the penis and avoid misrouting or pushing the outer ring of the female condom into the vagina. Kenyan and Brazilian men felt that since the use of the female condom was a "woman's responsibility," the burden of protection was no longer theirs alone. On the other hand, some men also felt "empowered" by the added protection against HIV/AIDS when they were not using the male condom.

Reasons for Nonacceptance

Men from both sites nevertheless commented on the aesthetics of the female condom, i.e., its smell, noise and the slippery feeling during intercourse. There also was the concern in Kenya that the device might tear or become dislodged and retained in the woman's "stomach." The added fear of leakage existed where the amount of ejaculation was large. Although the female condom allowed men to feel the woman's body heat, the fact that there was still a barrier between the two human bodies made the device less "attractive." Some Kenyan men still wanted "skin to skin" contact.¹³

Some men were sensitive to the reputation of the male condom, that it is often associated with promiscuity and extramarital sex. The same kind of suspicion could be projected onto the female condom some men said. In Kenya, some men also worried that their partners would be able to have other partners in secret.

Comparisons of the Female Condom with the Male Condom

In Kenya, the verdict overwhelmingly was that the male condom, such as the brand name “Trust,” could not be trusted.¹³ Male condoms available in that country, FGD participants said, “tore far too easily during coitus; with the male condom, bursting is normal.” Unreliability of the male condom was perceived to be responsible for unintended pregnancies and STIs. For many in the FGDs in both Brazil and Kenya, sustained periods of intimacy and added protection made the female condom more attractive than the male condom. Others liked the fact that the female condom did not have to be removed immediately even after ejaculation. Whereas the male condom could be displaced and retained in the vagina, the female condom was never displaced during coitus, they noted. Although some male participants reported irritations and allergic reactions to the latex male condom, there were no such reports in the case of the female condom. In addition, the female condom could cover a larger surface area than the male condom and therefore was perceived by some men as offering greater protection for both men and women against HIV and STIs. In developing country situations where crowding may be a hindrance to privacy, the female condom was seen as an ideal device, as it could be inserted by the woman hours before actual sexual intercourse.

Women could check the female condom after use and then dispose of it to ensure that there was no rupturing. This was not the case with the male condom where the men were in control of disposing of the device. In Kenya women were sometimes suspicious that the men punctured the male condom deliberately. With the female condom, this suspicion was reduced. Because women could decide when to wear the female condom, they could feel a sense of ownership and enhanced ability to protect themselves against STIs and HIV, whatever the attitude of the male partner. Some men also expressed satisfaction that their wives would be afforded protection.

Reuse of the Device

Some men expressed concern about cost. Despite the advice and strict prior instructions about the single use of a female condom, a few men in Kenya admitted having used the female condom for up to five acts of coitus. These men were conscious of the high price of the device and wanted to economize by repeated use of a single female condom. Others were concerned by the lack of availability of the method which they had come to accept and therefore were reluctant to discard. A man from one of the six FGDs in Kenya said: “Because the female condom, you can use it twice, thrice, but the male condom you can only use it once...”

Empowerment Of Men

Surprisingly, some males in Kenya felt that the female condom was empowering for men as well as for women. Some thought that the device was a good thing because the woman could initiate its use for her own protection. In both countries, some men used the term “responsibility,” stating it was “lifted from them (men) and placed on women.” Men said they felt affronted, insulted, belittled and under suspicion when women insisted that they wear male condoms. They indicated that now men could carry the female condom and insist that women use it. It was felt this reversal would help to equal scores with both men and women retaining their self-respect.

Where the woman was tactful in introducing the female condom and explained its advantages, acceptance by male partners to use it generally followed in both countries. One Kenyan man said he had no problem with his wife bringing the female condom into the relationship; he was willing to use the device to protect her, since he traveled a great deal. Men in both Kenya and Brazil are known to have extramarital affairs; however, some men noted in the FGDs that they could take responsibility for introducing the device into their homes. They believed they could bring the female condom home and their wives would not question this because they, too, wanted to be protected from STIs/HIV. Moreover, the men said that having the female condom reduced suspicions of infidelity that is normally associated with use of the male condom.

Men in Partnership for Prevention

The FGDs evoked some unexpected proposals from the men that could help to ensure the availability and sustained interest in the female condom. The Kenyan men said that they should not be viewed by their partners and others in healthcare and HIV prevention as irresponsible and indifferent sexual partners. Some suggested that the response to the introduction of the female condom into the sexual relationship proved that men are sensitive to the feelings of their women and want to protect them. They urged that the women be better informed and supported in their attempts to use the device.

In addition to revealing a very positive attitude, the male FGDs showed that most men were willing to promote the female condom for use within regular partner relationships. Despite the high cost of the device, the Kenyan and Brazilian men said they were willing to buy the female condom at a price comparable to the male condom.

Kenyan men also urged that they be involved in promoting the female condom from the time it is introduced into the country. They felt they could make a contribution as advocates since they wanted its availability and accessibility to be increased for use with all categories of partners. Most felt that the device should be accessible not only through family planning clinics but in all the places in Kenya where male condoms are available. Finally, the many men who participated in the six FGDs recommended that they be used to recruit, counsel, educate and support other men in the use of the female condom.

Beyond the Study: Sustainability

That the research, and particularly its peer support group process, had a significant impact on the lives of women and their male partners is evident from statements about female condom use that followed the study. In Brazil during the exit interview, 97 percent of the women indicated willingness to purchase the device as a means to “guarantee” lasting protection. Eighty-two percent of them believed that the female condom would be well accepted when available on the market. Kenyan women and men were equally committed to purchasing the device when available. One man said “...if available I would buy nothing else.” The Kenyan men, as indicated above, proposed that they be used as advocates, promoting the device among other men.

Price was an issue in the decision of some to reuse the device. During the study male partners in Kenya indicated that cost would be a factor in continued use. Significantly, however, when comparing the price of the male condom with the female condom, they indicated that the advantages of the female condom would compel them to accept the extra cost. The majority said they would be willing to buy the female condom at the same price range as the male condom; a minority would buy it, unconditionally.

A further significant development was the group cohesion among women that persisted in both Kenya and Brazil. Groups that developed during the PSGD intervention continued to meet in homes and community settings even after the research was completed.

Part Four

CONCLUSIONS

Global mobilization of women around issues of reproductive health has exposed the pervasive gender power imbalance, awareness of which has become a springboard for interventions initiated and controlled by and for women. The development of the female condom may prove to be one such intervention. The intervention research conducted in Brazil and Kenya sought to determine its impact; the results highlighted above, suggest that this device is acceptable to, and can be mutually empowering to men and women.

This synthesis of individual interviews, FGDs and PSGDs brings into focus many issues that women agree are important in protecting themselves against HIV/AIDS and unintended pregnancy. No result was more revealing than that peer support groups can be an important and effective channel for preparing women to introduce the female condom into sexual relationships. Analysis of the qualitative and quantitative data shows that women developed their own strategies at the individual level. The FGDs and PSGDs provided an opportunity for sharing information for reflection, exploring feelings and articulating fears. An outcome of use of the PSGD in particular was that groups of women learned and developed strategies for protecting themselves as a result of the availability of the female condom.

The following conclusions therefore are suggested by the synthesis. First, increasing the woman's sense of empowerment may be an important precursor for success in introducing, negotiating and sustaining the use of the female condom. If it is, then it is important to determine whether support groups such as PSGDs are a critical factor to the empowerment process. Programs for introducing the female condom could integrate women's support groups into their strategies rather than depending exclusively on targeting women, individually. Reaching women through their organizations has several important advantages: use can be made of existing group structures; the female condom can be promoted by women's advocates and networks; and women leaders can be used to promote favorable policies that ensure the availability, affordability and accessibility of the device within their respective communities. Women encouraging other women can contribute to sustained dissemination of information about the use of the female condom for health and well-being and, thus, concomitantly increase protection against STIs/HIV/AIDS.

Second, Kenyan and Brazilian women adopted strategies that reflect efforts to initiate rather than control sexual relationships with partners. Even attempts to convince men to accept the female condom should contribute positively to men's as well as women's sense of empowerment in the relationship. In the case of Kenya, where considerable attention was paid to the cultural barriers, including the "patriarchal traditions,"¹³ women recognized that it was more effective to be gently than confrontationally persuasive. Women in Brazil and Kenya also recognized that male cooperation rather than compliance was essential for repeated use of the female condom. Women cannot succeed in concealing use of the device from their partners indefinitely. The strategies adopted seem both to inform and change male attitudes, instead of compel and control the use of the female condom. Therefore, a distinction needs to be made, by virtue of the approaches the women actually took, between a woman's initiation of use of the device and her control over the use of the device.

Third, women in Kenya admitted at the beginning of the study that they felt vulnerable to HIV infection, even without adequate knowledge of their HIV status. The availability of the female condom, although through a research project, was a sufficient stimulus to empower women to aggressively seek to use the device for self-protection. An opportunity was created to talk not only about contraception and sex, but also about sexual desire and pleasure, subjects not openly discussed previously. Women could introduce the sexual act by inserting the device hours before intercourse and actually tell the partners they wanted to have sex. The increased capacity to initiate sexual encounters was empowering for many women. "We can talk with our partners without fear, previously we used to be afraid."¹³ The act of bringing a female condom into the household in itself showed enhanced power to call attention to the risks of HIV/AIDS to the entire family as well as to the male and female partners. Previously, the discussion of the male condom presupposed infidelity and suspicion which sometimes resulted in violence against the woman. Whether consciously or unconsciously, the female condom appears to serve as a catalyst that permits men and women to develop an effective means of communicating that is necessary for successful negotiation.

Fourth and finally, while in Kenya the women participants complained about oppressive cultural norms and sexual attitudes, they managed to confront culture in a way that showed, in effect, that many norms governing partner sexual relationships might be already in a transition. Although they verbalized adherence to male dominated patriarchal ideology, where female subordination is taken for granted, at the same time they were capable of taking action that defied the very ideology to which they claimed to acquiesce. There appeared to be little relationship between their complaints and the use of the female condom. A paradox was seen where the female participants articulated a condition of powerlessness, yet were quietly involved in strategies to deal with their need for protection in an increasingly powerful manner.

The Brazilians also expressed this dilemma: "...in the same woman coexists traditional standards of roles and positions in the love relationship and the need to control her body, her sexuality."¹² "And now the problem is mine because I am the one who has to stop. Up to now, my husband controlled the moment of penetration." Nevertheless "...for the majority, it is the partner's opinion that is going to determine whether it is used..."

What is in the future in Kenya, Brazil and elsewhere for women and men who seek to protect themselves? The synthesis suggests that the female condom may provide part of the answer.

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Appendix One

THE STUDY PARTICIPANTS

AT DATA COLLECTION POINTS*



	KENYA	BRAZIL
INITIAL IN-DEPTH INTERVIEW	132	115
FOCUS GROUP DISCUSSION 1	106	75
PEER SUPPORT GROUP DISCUSSION 1	100	65
PEER SUPPORT GROUP DISCUSSION 2	100	72
FOCUS GROUP DISCUSSION 2	100	73
FINAL INTERVIEW	100	96
FINAL SAMPLE*	100	103
MALE FOCUS GROUP DISCUSSION	46	24
NUMBER OF WOMEN REACHED	350	394
WOMEN'S ORGANIZATIONS CONTACTED	28	8

* In Kenya, the number of participants remained the same from PSGD1. Brazil included in the analysis all women who were interviewed and who attended one of the four group sessions, which numbered 103. Only 96 were administered the exit interview.

