MALE VIEWS ON FEMALE CONDOMS

A Study of Male Acceptance of Female Condoms in Zimbabwe, Cameroon, and Nigeria

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Abbreviations

ABC	Abstinence, Be faithful and use Condoms
ACMS	Association Camerounaise pour le Marketing Social
AIDS	Acquired Immune Deficiency Syndrome
AIID	Amsterdam Institute for International Development
AIGHD	Amsterdam School for Global Health and Development
ARYI	African Regional Youth Initiative
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
FC	Female Condom
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IUCD	Intra-Uterine Contraceptive Device
KAPB	Knowledge, Attitude, Practice, Behaviour
LGA	Local Government Area
MC	Male Condom
MMR	Maternal Mortality Ratio
N	Naira
NACC	National AIDS Control Committee (Cameroon)
OCP	Oral Contraceptive Pill
PLHA	People Living with HIV and AIDS
PSI	Populations Services International
SFH	Society for Family Health
STI	Sexually Transmitted Infection
UAFC	Universal Access to Female Condoms
UNFPA	United Nations Population Fund
ZDHS	Zimbabwe Demographic and Health Survey
ZNNP+	Zimbabwe National Network of HIV Positive Persons

Executive Summary

Rationale and objectives

This report presents the findings of a three country qualitative study on male acceptance of female condoms in Zimbabwe, Cameroon, and Nigeria. The fieldwork took place between May and August 2011, with seven days allocated per country. This study is part of a larger research project commissioned by the Universal Access to Female Condoms (UAFC) Joint Programme; this programme aims at increasing the uptake of female condoms with the ultimate goal of reducing HIV prevalence and the rate of unintended (mistimed and unwanted) pregnancies. The UAFC Joint Programme aimed to explore the role of men in the acceptance and use of female condoms. The vast majority of research on acceptance of female condoms has been conducted among women – with one of the conclusions being that men may be an obstacle to women using them. However, very little evidence exists about men's opinions of the female condom and whether indeed they actually do *not* want their partners to use them and why. This study aims to fill this gap in knowledge by exploring men's perspectives on female condom use, and whether and how they can be motivated to accept them and become frequent users – set in the contexts of local socio-cultural and economic conditions, and perceived accessibility (of female condoms). The main study objective was to explore the factors influencing acceptance of female condoms by married and single men with different types of sexual partners, with the aim of providing recommendations to programmes for education and promotion of the female condom in order to increase acceptance among men.

Methodology

Data collection and analysis was guided by use of the theory of planned behaviour, as presented by Fishbein.[1] This model distinguishes two categories of factors that may influence behaviour and behaviour change: personal factors and environmental factors. Personal factors include knowledge, skills, attitudes, self-efficacy, and risk perception. Environmental factors include the social and cultural context, social influence, and other external factors, depending on the type of behaviour under study. This study therefore explored the influence of men's knowledge, skills, and attitudes towards female condoms, and the environmental factors such as the gender power relations in different types of sexual relationships, set in the context of dominant societal norms. Other external factors studied were social influence by partners, and the availability, accessibility, and affordability of female condoms.

Key study concepts and their definitions are: 1) *acceptability*, which is the positive attitude towards using female condoms; and 2) *acceptance*, which is the actual use of female condoms. Acceptance may amount to just one time use or more frequent usage. Frequent use in this study was defined as someone who had used female condoms between three and ten times and at the time of the study was still using, or someone who had used female condoms more than ten times.

The main data collection method was through focus group discussions (FGDs), which is the most appropriate study method to explore topics on which not much is yet known. The groups for FGDs were divided into men and women, married and single, and non-users, one or two time users, and frequent users. Bias was towards men and frequent users. We conducted a total of 52 FGDs in the three countries: 37 with men and 15 with women. Local organizations mobilized the participants for the FGDs. The data collection teams consisted of local researchers and the

[1] Fishbein (2000).

Dutch authors. The local research teams of five to six people were appointed by the local research partner organizations: Development Data in Harare, Zimbabwe; Society for Family Health (SFH) in Lagos, Nigeria; and the Association Camerounaise pour le Marketing Social (ACMS) in Yaoundé, Douala, and Bamenda in Cameroon. Before the start of the FGDs the research team members interviewed the FGD participants using a short structured questionnaire with the aim of gathering background information and ascertaining whether the person was in the right FGD. In addition to FGDs, in-depth interviews were conducted with single and married male frequent users in both Nigeria (4) and Cameroon (2).

This was a small explorative study of persons in (semi-)urban settings, who were selected by convenience sampling. The findings, therefore, cannot be said to be representative for the whole of the three countries or for all men. In addition, this study should not be interpreted as an evaluation of the current policies and practices of female condom programmes in Zimbabwe, Cameroon and Nigeria. However, through the methodology and population triangulation the validity was increased. Findings from the three countries are compared, as are the views of men and women, single and married, and the findings from the FGDs and pre-FGD questionnaires. We thus consider the study findings to be meaningful indications of male views on female condoms.

Main findings

Personal factors influencing male acceptability and acceptance of female condoms relate to knowledge of what they look like, how they are used, what their advantages are, and to belief in their positive attributes. Participants reported knowing many advantages of female condoms, but also disadvantages. A positive finding was that nearly all participants believed in the superior effectiveness of the female condom for prevention of pregnancy and protection against HIV and STIs in comparison to other contraception methods and male condoms. The other main advantages (for men) of female condoms are that sex feels natural, that they increase sexual pleasure, do not constrain the penis, do not have side effects, bring variation in condom use, and can be used during menses. The main disadvantages relate to the control and possible misuse by women (for example, by using the same female condom with multiple sexual partners), and that they are difficult to insert, too big, not widely available, and expensive. Especially with the disadvantages, there were some slight differences between countries, mainly related to rumours about misuse by women.

An important finding was that male acceptability and acceptance of female condoms differ by type of sexual partner. The type of partners men have is influenced by the norms in society, which are part of the external factors influencing behaviour. Generally speaking, men differentiate between four categories of sexual partners: 1) spouse; 2) stable partner (for married and single men); 3) casual partners; and 4) commercial sex workers (CSWs). Categories of sexual partners differ in terms of duration, exclusivity, stability, trust, power relations, exchange of money or goods for sex, and purpose. With all these partners, men feel and women concur that men have the power to make decisions about contraception and protection.

Male acceptability of female condom use with different types of partners is related to trust (or lack of) in the partner. Female condoms are generally more acceptable in relationships where there is trust – in marriage (as a family planning method only) and in other stable relationships (for dual protection). Outside marriage and serious stable relationships, a man hardly trusts any type of sexual partner – since there is no guarantee of exclusivity – and therefore female condom use is less acceptable. There were subtle differences between countries in terms of male acceptability of female condoms with different categories of partner, with relatively greater acceptability, including with casual partners, in Cameroon. Generally, however, it is not acceptable to men

when women initiate female condom use, in particular if she has inserted a female condom beforehand in anticipation of sexual intercourse.

Men gave various reasons for why they do not use and do not intend to use female condoms. The two main reasons were lack of knowledge about them (including how they are used and how they would affect sexual pleasure) and lack of availability. Other mentioned reasons related to dominant gender power relations (not wanting to give control to the female partner), mistrusting certain type of sexual partners (who are thought to misuse the female condom), the association of female condoms (like male condoms) with casual sex and CSWs, and preference for other methods, for example the male condom.

Men had four major motivations for using female condoms for the first time. Personal factors were: 1) curiosity about how it would feel sexually (after having heard about them in training or in an advertisement); and 2) having an alternative for male condoms (for couples who always use protection, such as HIV positive or discordant couples, but also single men). External factors that made men use a female condom for the first time were: 3) that their sexual partner had convinced them, or insisted (mainly with casual partners); and 4) that female condoms were the only method available at the time and the man was eager for sex.

Study findings indicate that the personal factor of a positive first experience for men makes frequent female condom use more likely. Men with negative first experiences more often stopped using female condoms. The most mentioned positive first experience of female condoms by men was that it felt like natural and thus pleasurable sex. Male participants' negative first experiences were mostly related to the fact that their partner did not know how to insert the female condom well, which caused pain and unease. Two main factors can be identified which make a positive first experience for men more likely: 1) if men have knowledge on what a female condom looks like, how it is inserted, and how to enter the penis, they know what to expect and will feel more at ease the first time; and 2) if their partner is an experienced female condom user, or at least when she knows how to insert the female condom well and how to direct the man's penis into the female condom.

Only very few frequent users said that they always use female condoms every time they have sex. Rather, the common pattern of frequent female condom use is to alternate with the male condom – either for sex with different partners or with the same partner depending on the mood and availability of either condom. Frequent use is most common with spouses for married men and with stable partners for single men. Female condoms are not frequently used with other types of partners for two main reasons: 1) men do not trust them, because these women are thought to misuse female condoms (with the exception of Cameroon, where female condom use with casual partners is relatively more accepted); and 2) with casual partners and sex workers, where there is not much time for sex and no intimacy.

Major external factors hindering male frequent use of female condoms – for persons who want to use protection or prevention – according to FGD participants were scarce availability and the high price (relative to male condoms).

Recommendations

The conclusion of the study is that female condom programmes should consider men to be an opportunity rather than a hindrance in increasing female condom uptake, because most of them like sex with a female condom and believe in its effectiveness as a contraceptive and for STI and HIV protection. To make female condoms more accepted by men and to spread use of the female condom, personal as well as external factors influencing acceptance and use should be

considered, including local dominant gender power relations in different sexual relationships. Following are the main recommendations for female condom programmes based on the findings in the three countries studied. The recommendations are a direct result from the study and are not based on the current policies and practices of female condom programmes in Zimbabwe, Cameroon or Nigeria. Most of these recommendations will be applicable to programmes in other countries with similar gender power relations and patterns of sexual relationships. The recommendations are:

- Do not promote female condoms solely as a product for women's empowerment in contexts where decision making power is mostly with men, because a woman needs the cooperation and often approval of her male partner to use female condoms. Giving men a role in introducing the female condom may be more acceptable in some societies, like those of the present study. Programmes should also educate men, or men and women together, on female condoms.
- Target men with interpersonal communication in places they frequent, such as motor parks, bars, and clubs. In messages to men, stress the advantages and address the disadvantages of female condoms, and tailor the messages to local ideas and appropriate target groups (single men, married men, young men). In promotion to men, peer educators should stress the positive aspects of female condoms: that they make sex feel natural, that there is sexual pleasure, and that they offer variation in protected sex. To married men they can be promoted as an effective family planning method without side effects. They should also address the local reasons why men do not (want) to use female condoms.
- Female condom promotion to men (as to women) should always be accompanied by a demonstration. During female condom promotion and demonstrations, participants should be invited to practice the skill by opening the package and doing a mock insertion, using either their hands or a pelvic demonstration model.
- Prepare 'female condom starter packs' to give out during demonstrations with some five female condoms, information about insertion, when to consult a health professional (e.g. if there is pain during insertion or use), and where female condoms can be bought (and for what price).
- Visual mass promotion (on television or posters) should include what a female condom looks like and how it is used (possibly using drawings), thus not only talking about the benefits and showing the package.
- Increase sales points for female condoms, make them available day and night in some outlets, and look into whether female condoms can be even more subsidized in order to increase availability and affordability.
- Try to develop a smaller package for the female condom.
- Do not put male condoms and female condoms forward as an either-or choice, but promote them together, for both men *and* women (currently the male condom is seen as a men's issue and female condoms as a women's issue).
- In peer education to different groups of women (single, married, youth) female condom negotiation skills should be taught – adjusted to local gender power relations in different types of sexual partnerships. Women should be advised to practice insertion before trying with their partner – to make his first experience with the female condom more likely to be positive.

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CHAPTER 1: INTRODUCTION

This report presents the findings of a qualitative study on male acceptance of female condoms in Nigeria, Cameroon, and Zimbabwe. Between May and August 2011 a total of fifty-two focus group discussions (FGDs) were conducted: 37 with men and 15 with women. Most of the groups consisted of users of female condoms. The study was commissioned by the Universal Access to Female Condoms (UAFC) Joint Programme; this programme aims to increase the availability, affordability, and accessibility of female condoms. Launching an effective female condom programme is not straightforward, because motivating people to engage in safer sex by using a condom appears to be a difficult task. Literature explaining the low rates of male condom use in Sub-Saharan Africa point to socio-cultural influences including: a focus on fertility and pro-natalism; risk perceptions that differ by type of sexual partner; gender power relations and related rejection of contraception use; and the association of condom use with promiscuity. When looking at female condoms, we see that usage is very low – in most countries not reaching 0.1%. In comparison to the male condom, the female condom suffers from three additional problems: lack of accessibility, availability, and affordability.[2]

The vast majority of research on the acceptance of female condoms has been conducted among women – with men being frequently mentioned by women as an obstacle to use (see section 1.2.3). However, very little evidence exists about men's opinions of the female condom and whether indeed they do *not* want their partners to use them. This study aimed to fill this gap in existing knowledge. Through qualitative methods men's perspectives were explored, including whether and how they can be motivated to accept female condoms and become frequent users – set in the contexts of local socio-cultural and economic conditions, and accessibility. The chosen countries of study were Nigeria and Cameroon, because they are part of the UAFC Joint Programme, and Zimbabwe, because it has a large and well known female condom programme and is often mentioned as a success story.[3]

This introduction chapter continues with a brief overview of the UAFC Joint Programme (1.1). Section 1.2 then presents a literature review of relevant studies and reports; the review starts with a brief overview of the prevalence of HIV/AIDS and unintended pregnancies in the three countries – which influence the risk perception and felt need to use (female) condoms – and then some figures on contraceptive use are provided (1.2.1). Section 1.2.2 addresses the socio-cultural contextual factors which may influence condom use. The following section (1.2.3) summarizes what is known about female condom use in the three countries, while the final two sections summarize the study rationale (1.3) and the study objective and questions (1.4).

1.1 Universal Access to Female Condoms (UAFC) Joint Programme

The UAFC Joint Programme began in 2008 and is a joint initiative of the Dutch Ministry of Foreign Affairs, Oxfam Novib, I+ solutions, and Rutgers WPF. The UAFC Joint Programme dedicates its activities to three components. First, the *Support to Manufacturers and Regulatory Issues* component focuses on decreasing the price of female condoms and increasing variety. Second, the *International Advocacy, Linking & Learning, and Communication* component focuses on increasing financial and political support as well as gathering good practices and lessons learnt to render implementation of large scale female condom programmes more effective. The third component aims at creating sustainable demand for and access to female condoms by

[2] Several studies point to these issues, examples are: Cecil et al. (1998); Ray et al. (2001); Welsh et al. (2001); Hoffman et al. (2003); Gollub (2004); Peters et al. (2010).

[3] The programme in Zimbabwe was launched in 1997 by Population Services International (PSI) as a social marketing project.

introducing two large scale programmes in Nigeria and Cameroon. These country programmes are executed by local partner social marketing organizations, namely the Society for Family Health (SFH) in Nigeria and the Association Camerounaise pour le Marketing Social (ACMS) in Cameroon. The objectives of these programmes are to create female condom demand by increasing public awareness, to ensure availability of female condoms by effective supply chain management, and to include female condoms in existing programmes and health services (see Annex 3 for more on the UAFC Joint Programme country projects in Nigeria and Cameroon).

The ultimate goal of the UAFC Joint Programme is to reduce the number of unintended pregnancies – and subsequently reduce maternal deaths – as well as to reduce the prevalence of sexually transmitted infections (STIs), including HIV. In addition, the UAFC Joint Programme intends to promote gender equality and the empowerment of women.

1.2 Literature review

1.2.1 HIV/AIDS, unintended pregnancies, and contraceptive use

HIV and AIDS

The latest statistics on HIV prevalence rates in the three countries reveal that the situations differ per country: in Nigeria HIV prevalence was measured at 3.6% (in 2007[4]), in Cameroon 5.3% (measured in 2008[5]), and 14.3% in Zimbabwe (measured in 2009[6]). From Barnett & Whiteside (2006) we learn that in Sub-Saharan Africa women are disproportionately affected by HIV; on average there are thirteen women living with HIV for every ten infected men. Moreover, Barnett & Whiteside mention that this gap between men and women is increasing. In the three countries under study we see a similar pattern, with women more affected by HIV than men. In Nigeria, 4% of females aged 15-49 are infected with HIV, which is higher than the male infection rate of 3.2%.[7] In Cameroon the HIV prevalence rate is 6.8% for women and 4.1% for men.[8] Zimbabwe shows the largest difference in prevalence rates between men and women, where 21.1% of the female population between 15-49 years is infected compared to 14.5% of the male population.[9]

Although the HIV prevalence rates in many Sub-Saharan African countries, including the three countries under study, are decreasing (in Nigeria from 5.8% in 2001, in Zimbabwe from 26.5% in 1997, and in Cameroon from 11.8% in 2003)[10], this is no reason to sit back. To further decrease the prevalence rates and to prevent renewed increase, continued attention to prevention is crucial.[11] In addition, it remains important to gain better insights into what influences condom use, so as to improve prevention interventions.

Unintended pregnancies

In addition to STIs and HIV, unprotected sex can lead to unintended pregnancy, which is a major cause of induced abortions and possible maternal mortality if abortions are unsafe. It is estimated that mistimed or unwanted pregnancies in Nigeria account for 10% of births and 11% of induced abortions.[12] In Cameroon, according to the CDHS 2004, around 5% of the 9,176 pregnancy

[4] FMOH [Nigeria] (2009).
[5] For adults aged 15-49 years (UNAIDS 2009).
[6] UNAIDS (2010).
[7] FMOH [Nigeria] (2009).
[8] Country Situation, UNAIDS (2009).
[9] ZDHS (2005-06).
[10] UNAIDS Annual Report 2010.
[11] Barnett & Whiteside (2006).
[12] Guttmacher Institute (2006).

cases studied were unwanted and more than 17% were mistimed.[13] And in Zimbabwe it is estimated that 20% of all pregnancies are mistimed and 13% are unwanted.[14] These unintended pregnancies may lead to unsafe abortions, as abortion is illegal in Nigeria and Cameroon and only partly legal in Zimbabwe.[15] Unsafe abortions in Nigeria cause 11% of all maternal deaths.[16] According to Schuster (2005), in 2000 the number of maternal deaths caused by unsafe abortions in Cameroon was estimated to be 90 per 100,000 live births, which would mean that 14% of maternal deaths in Cameroon are due to abortion.[17] These figures, as well as those on HIV, emphasize the importance of continued attention to information and education about contraception.

Contraceptive use

Contraceptive use rates, especially among married people, differ considerably between the three countries, with the highest rate in Zimbabwe and the lowest in Nigeria. Statistics from the Zimbabwe Demographic and Health Survey (ZDHS) 2005-2006 (2007) show that 71% of married men and 70% of married women reported that they were currently using contraception. The main method among married individuals was the oral contraceptive pill (mentioned by 53% of men and 43% of women); male condoms were used by 4.3% of married men and 1.4% of married women. Among the sexually active singles, 43% of the males and 61% of the females reported using contraception methods. Their favourite method was the male condom, as reported by 36.8% of single men and 26.5% of single women. In transactional sex, men reported the highest male condom use, although the percentage has decreased: in 1999 82% reported use, while in the ZDHS 2005-2006 it was 74%. Overall, female condom use was almost non-existent: among both married and single men and women the reported use of female condoms did not reach 0.1%.[18]

In Cameroon, figures from 2004 reveal that 26.0% of married women reported using a contraceptive method, though only 13% used a modern method, of which 7.8% used male condoms. The main reported contraception method among married women was periodic abstinence. Of the sexually active single population, 68.5% used any contraception method and 42.8% used a male condom.[19] The Demographic and Health Survey (DHS) does not report figures on contraceptive use by males.[20] The baseline study for the UAFC Joint Programme project by ACMS (2010) shows that 4.4% of the study population reported having used a female condom at least once. During the last sex encounter, 31.9% had used (any) condom, but only 1.2% had used a female condom. An even lower percentage of 0.2% systematically used female condoms.

In Nigeria, 14.6% of married women reported current contraception use, of which 9.7% used a modern method; only 2.6% used male condoms.[21] The rate of current contraception use among married men is 13.4%. Male condoms are the most often reported contraception method: 5.5% of married men reported currently using male condoms for contraception.[22] When looking at singles, 61% of sexually active single women reported ever having used a contraception method; for

[13] EDSC-III (2004: 134).
[14] ZDHS 2005-2006 (2007).
[15] Abortion is allowed when physical health or the life of the woman is in danger, when the pregnancy is caused by rape or incest, or when there are foetal impairments (UN).
[16] FMOH (2011).
[17] Schuster (2005: 131).
[18] ZDHS 2005–2006 (2007).
[19] EDSC-III (2004).
[20] In the report on risk profiles – which is forthcoming 2012 and an addition to this report – we will be able to say more about condom use by males in Cameroon.
[21] DHS Nigeria (2008).
[22] DHS Nigeria (2008 – author's calculations).

35.5% this was a male condom.[23] Current contraception use among sexually active single men is as high as 59.4%. Male condom use among sexually active single men is also much higher than among married men; 51.8% of the single population reported that they currently use male condoms for contraception.[24]

Female condom use was very low. Nigerian DHS 2008 statistics show that although 14.7% of all women had heard about the female condom and 13.9% had heard a specific family planning message on the female condom, only 0.2% had ever used one.[25] In the baseline study conducted in 2011 by the Society for Family Health (SFH) Nigeria, 38.9% of respondents had heard about female condoms, but only 3.5% of these had ever used one. Thus 1.4% of all respondents had ever used a female condom; with relatively higher use reported among men (1.7%) than women (1.0%).[26]

The female and male condoms are the sole methods that offer protection against both STIs, including HIV, and unintended (mistimed or unwanted) pregnancy. Although relatively high male condom use among single men and women appears promising, it is important to note that reported condom use should be interpreted with caution as reported use does not mean consistent use. Studies on male condom use point to the often inconsistent use of male condoms, meaning that high rates of condom use do not per se contribute to lower HIV prevalence and unintended pregnancy rates.[27] Statistics show that usage of condoms, and all other contraception methods, varies by marital status and sex. Different qualitative studies show that male condoms are seldom used within marriage and more often with non-marital partners,[28] as will be discussed in more detail in section 1.2.2. The substitution effect of female for male condoms is seldom researched, although some studies show that female condoms do increase the total number of protected sex acts.[29]

Both male and female condoms have the potential to improve health risks associated with sexual intercourse. The often mentioned advantage of female condoms over male condoms is that they give women more power over their sexual and reproductive health, as they are the ones who insert the condom. However, female condom use is not completely female controlled because a woman needs the approval and cooperation of her male partner. Studies point out that men may have different reasons for refusing contraception, including the female condom.[30] The following section further discusses the different reasons which men may have for not using condoms.

1.2.2 Cultural barriers to condom use

Barnett (2005) argues that programmes which aim at changing sexual behaviour – such as accepting contraceptives for protected sex – should integrate the fact that values and norms around sexuality form people's sexual desires and practices. The focus in this section is on male to female sexuality, and in addition we limit the extensive literature on cultural values and norms in sexual behaviour and gender relations to that dealing with influences on condom use, and in particular how this can prevent (consistent) condom use.

[23] DHS Nigeria (2008).
[24] DHS Nigeria (2008 – author's calculations).
[25] NPC [Nigeria] & ICF Macro (2009).
[26] SFH (2011a).
[27] See for example: Okafor & Obi (2005); Sunmola et al. (2007); Audu et al. (2008); Abdulraheem & Fawole (2009); Francis-Chizaroro & Natshalaga (2003); Mosoko et al. (2009); Agha et al. (2002); Lagarde et al. (2001).
[28] See for example: Agha et al. (2002); Meekers (2001); Meekers & Klein (2002).
[29] Vijakumar et al. (2006).
[30] See section 1.2.3 for an overview.

Importance of fertility

In many cultures, maleness and femaleness is defined by fertility. Preston-Whyte (1999)[31] argues that a main part of an African woman's identity is determined by her fertility. Women are expected to have children and infertile women face stigma (see also Koster 2003). Children also ensure care in old age. In addition, Barnett & Whiteside (2006) point to the importance of ancestry and descent in African cultures. Hence, at a certain point in time, women have strong incentives to refrain from contraception and condom use even when they perceive a risk of exposure to HIV. These factors thus create a barrier for women to using condoms.

Being fertile is also important for males. Barnet & Whiteside (2006) argue that producing descendants (and thus being able to become an ancestor) is seen as a greater virtue than having a long term monogamous relationship. Thus males also have strong motives to refrain from condom use when the urge for a child is higher than the perceived risk of contracting an STI, including HIV.

Economic circumstances and sexual power

Women might also use their bodies as a part of their survival strategy. Especially in Sub-Saharan Africa, where the majority of the population live below the poverty line, women use their bodies as a resource to make a living or pursue an education. This does not necessarily mean that these women are commercial sex workers (CSWs). Receiving gifts from a boyfriend is well accepted and occurs often. Barnett & Whiteside (2006) illustrate this by referring to a study in Nigeria among female students. This study by Edet (1997) suggests that pursuing a university degree might result in having three sexual partners at the same time: her teacher (for good grades), her sugar daddy (to pay her fees and living expenses), and her boyfriend. Being dependent on a man for financial resources or good grades makes a woman submissive to his will, and she loses her bargaining power when it comes to sexual intercourse. Hence, when the man demands unsafe sex, she will go along with it because she is dependent on his socio-economic resources.

Types of sexual relationships and sexual power

Whelehan (2009) points to the fact that emotional and psychological attachment to one's partner affects sexual decision making. She argues that protected sex diminishes when emotional and psychological attachment occurs between two partners. Whelehan explains that emotional attachment involves trust and trust is part of intimate relationships. Introducing a condom into such relationships, for example marriage, suggests mistrust. This idea is strengthened by research focusing on condom use, which points to the fact that condoms are associated with extra-marital affairs, promiscuity, and commercial sex workers.[32] It is estimated that 60-80% of African women who are infected with HIV were infected by their partner; while most of these women only had one sexual partner.[33] Hence, women have several reasons to negotiate safe sex within their sexual relationships. However, they do not have the power to do so when they are in a marriage or a stable relationship that is expected to end in marriage. With the payment of brideprice in many African societies – as in the three countries under study – the husband acquires ownership of the sexuality and children of his wife.[34] Whelehan (2009) explains that women balance the risk of contracting HIV or becoming pregnant against the possible rejection of her husband and the need to produce descendants.

[31] In Barnett & Whiteside (2006).

[32] Agha et al. (2002); Abdulraheem & Fawole (2009); Adebayo et al. (2010); Iwuagwu et al. (2000); Munoz et al. (2010); Saddiq et al. (2010); Smith (2007); Sunmola et al. (2007); Okonkwo (2010).

[33] Barnett & Whiteside (2006).

[34] Koster (2003).

1.2.3 Female condom use

Influence of female condoms on STIs and HIV incidence

A few studies have analysed the use of female condoms as a protection method against STIs.[35] In one study by Fontanet et al. (1998), sex workers in Thailand received either a 'male condom only' intervention or a 'male and female condom' intervention. The rate of unprotected sex reduced significantly more in the latter group compared to the former.[36] A study in the US with a similar intervention set-up among female patients at an STI clinic found a (non-significant) reduction in STIs among women who were also provided with female condoms, in comparison to women provided with male condoms only (French et al. 2003). Similarly, Choi et al. (2002) found that in the US the rate of unprotected sex decreased among females who used both male and female condoms.[37] However, a study in Kenya found no effects on STI prevalence in the areas where female condoms were introduced (Welsh et al. 2001). In sum, the current literature generally indicates that a combination of female and male condom use increases the rate of protected sex. This in turn is expected to reduce the rate of STIs/HIV and unintended pregnancies. However, evidence from Sub-Saharan Africa remains scarce.

The following paragraphs show what we currently know about female condom users: what they see as advantages and disadvantages of female condoms and what are the barriers to use. Current knowledge is mostly based on information from female respondents and is very limited.

Experiences of female condom users

Users of female condoms

To find out more about the determinants of female condom use, a study was conducted by PSI in 1998 among users and non-users of both female and male condoms in urban areas in Zimbabwe. This study showed that users of female condoms were mostly in their mid-to-late twenties, and had higher levels of education and access to household resources. The women who used female condoms instead of male condoms were more often the primary breadwinners and unmarried, in contrast with men who were more often married. In addition, the authors show that female condom use in general was higher among regular partners or spouses than within casual or commercial sexual relations.[38]

A study from Meekers & Richter (2005) shows that some men like to use (female) condoms, and furthermore, men who perceive the female condom as effective in pregnancy prevention, affordable, and easy to use are more likely to use them. In addition, it was shown that most men reported using the female condom with sexual partners outside marriage, which seems to contradict the PSI study; however, the study did not make a distinction between married and unmarried men. According to Kerrigan et al. (2000), 50% of Zimbabwean men in their study used the female condom because of it novelty or as experimentation, while 45.8% said that they used it to prevent pregnancy, and 36% used it as a prevention method against STIs or HIV.

Positive experiences

Studies in Zimbabwe show a number of perceived advantages of the female condom. Female users of female condoms mention that female condoms are easy to use, efficacious in preventing pregnancy and protecting against HIV, and make sex more pleasurable.[39] In contrast with most participants in the study of Buck et al. (2005), who liked the male condom better than the female

[35] See for example: Fontanet et al. (1998); Latka et al. (2000); Ray et al. (2001); Choi et al. (2002); French et al. (2003); Vijayakumar et al. (2006).
[36] This finding is supported by a study among sex workers in Zimbabwe conducted by Ray et al. (2001).
[37] Latka et al. (2000) found similar results for another, comparable US study.
[38] Kerrigan et al. (2000).
[39] Buck et al. (2005); Ray et al. (1995, 2001).

condom, participants in the studies of Ray et al. (1995 and 2001) liked the female condom better. According to most women in these studies, the lubrication is 'just right', the female condom is easy to insert and remove, does not interfere with sexual pleasure, and most importantly they stated that usage becomes easier with practice. Furthermore, the majority said that they would use a female condom again in future. Moreover, the FGD participants in the study of Francis-Chizaroro & Natshalaga (2003) liked the sexual pleasure which they derive from use of the female condom, especially because it is not too tight and the rings offer them arousal and provide a warm feeling. In addition, there is no need for sexual preparedness (i.e. an erection) to put it on, as with the male condom. In this study, 93% of the women liked the female condom, mostly because of the sexual satisfaction it gives them, but also because it offers dual protection, and they liked that they had control, choice, and power when using the female condom. In all studies on female condoms, participants mentioned dual protection – protection against STIs/HIV and prevention of unwanted pregnancy – as a big advantage.[40]

An action study by Simons (2009) of female condom use in Nigeria shows that even after difficulties with first time use, the majority of the participants and their partners preferred the female condom over their currently used method and stated that they would like to switch to using it in the future. They experienced the female condom as safer and more natural and comfortable than the male condom. In the mid-term evaluation of SFH in Nigeria, where thirty FGDs with men and women were organized, current users revealed that they all had issues with initial insertion but that after persistent usage they had few complaints. Some men perceived use of the female condom as "freedom from having to use a condom themselves", and stated that it "increases male enjoyment" and provides "maximum pleasure and protection".[41]

Negative experiences

The studies in Zimbabwe also pointed to a number of disadvantages of female condom use. Men in the study of Buck et al. (2005) reported that female condoms were uncomfortable and made their partner's outer genitalia inaccessible. The women in this study did not like the female condom because it moved and made a disturbing noise during sexual intercourse, while some women said it was difficult to use, and a few men and women did not like the lubrication that made the female condom wet and slippery or the fact that it prevents 'skin-to-skin' contact. In two other studies, one by Francis-Chizaroro & Natshalaga (2003) and the other by Kerrigan et al. (2000), men and women reported these same disadvantages. Moreover, women and men feared the size and shape of the female condom, experienced that the ring caused pain and discomfort during sexual intercourse, found it difficult to insert, stated a preference for 'dry' sex, and feared that the lubrication could cause cervical cancer. An additional disadvantage was the high price of female condoms, especially given that male condoms are more often freely available at health centres.[42]

Simons' study (2009) in Nigeria showed that participants had negative experiences during first time use because of the clumsiness of inserting it. No studies were found in Cameroon except for the ACMS baseline study, in which participants recounted similar experiences to those in the Zimbabwean and Nigerian studies.

Reasons for not using female condoms

When talking about female condoms, the most often mentioned advantage is that it is female controlled.[43] This is an important feature of the female condom, as we have seen that women are more at risk of contracting HIV and suffering the consequences of unintended pregnancies, and thus need a method to protect their sexual and reproductive health. However, female condom

[40] Francis-Chizaroro & Natshalaga (2003); Kerrigan et al. (2000); Napierala et al. (2008).
[41] SFH (2011b).
[42] Francis-Chizaroro & Natshalaga (2003); Kerrigan et al. (2000).
[43] Francis-Chizaroro & Natshalaga (2003); Ray et al. (2001).

use by women is not as straightforward as it seems. Studies point out that women face difficulties when introducing the female condom to their male partners. Women say that men refuse to allow use of female condoms. In addition, studies point out that a female condom cannot be used without the partner's consent, as he will notice the ring on the outside of the vagina.[44] This section summarizes the existing literature on the reasons for not using the female condom.

Men refuse female condoms
Studies conducted among women in Zimbabwe, Cameroon, and Nigeria all point to the same thing: men are the problem when it comes to low rates of female condom use.[45] Different studies among Zimbabwean women highlight that female condom use is difficult because of partner refusal, especially within marriage and with stable partners.[46] There are several reasons why men may not want to use female condoms with their wives. First, men trust their wives and thus consider (female) condoms unnecessary.[47] Second, men are afraid that the female condom will encourage women to become promiscuous.[48]

However, a study among women in Zimbabwe pointed out that women seldom talk with their husband about contraception.[49] A study in Nigeria by Audu et al. (2008) among 417 women in hospital clinics shows that only 33% reported having ever asked their partner to use a condom. Unfortunately, only 18.5% of men always agreed to use one. A qualitative study by SFH in Nigeria (2011b) concluded that female condom use is low largely because of partner refusal and the subservient nature of African women. Some women in this study who intended to use the female condom confirmed that they were scared of talking to their husbands and boyfriends about it because they feared the resultant negative perceptions about them, for example of being viewed as possibly promiscuous or infected with an STI/HIV.

Female condoms have a negative association with promiscuity
A major problem with the acceptance of female condoms is the association of condoms in general with distrust in ones partner, no real love, extra-marital relationships, and sex work.[50] These associations exists in Zimbabwe, Cameroon, and Nigeria and lead many people to the conclusion that (female) condoms are not fit for use in marriage.

Other perceptions of female condoms that are a hindrance to use
The study of Simons (2009) on female condom use in Nigeria reveals several beliefs about the female condom that prevent people from using it. The study indicates that before using a female condom, people may be afraid that it will not fit, it is difficult to insert, it will get stuck in the vagina, it will cause pain or discomfort, and/or is too expensive.

1.3 Study rationale

To summarize, HIV prevalence rates as well as the number of unintended pregnancies are high in all three countries. Both male and female condoms offer dual protection against STIs/HIV and unintended pregnancy. With the introduction of female condoms, couples have a dual choice in

[44] Buck et al. (2005); Ray et al. (2001).
[45] EDSC-III (2004); Agha et al. (2002); Ekani-Bessala et al. (1998); Feldman & Maposhere (2003); Francis-Chizaroro & Natshalaga (2003); Ray et al. (1995); Abiodun & Balogun (2009); Audu et al. (2008); Daniyam et al. (2010); Iwuagwu et al. (2000); Omokhodion et al. (2007); NPC [Nigeria] & ICF Macro (2009); UNFPA (2010).
[46] Feldman & Maposhere (2003); Francis-Chizaroro & Natshalaga (2003); Ray et al. (1995).
[47] Agha et al. (2002).
[48] Francis-Chizaroro & Natshalaga (2003).
[49] Feldman & Maposhere (2003).
[50] Agha et al. (2002); Abdulraheem & Fawole (2009); Adebayo et al. (2010); Iwuagwu et al. (2000); Munoz et al. (2010); Saddiq et al. (2010); Smith (2007); Sunmola et al. (2007); Okonkwo (2010).

dual protection, i.e. to use either a female or a male condom. Their widespread use would thus have the potential to reduce rates of HIV and unplanned pregnancy at the same time.

One of the perceived advantages of female condoms over male condoms is that women have more say and control over their use. As women are more often infected with HIV and also bear the burden of unintended pregnancies, there is a strong rationale for focusing on a method for women. It seems straightforward to solve female sexual health problems with a female controlled method. However, studies show that female condoms are not completely female controlled, because a woman needs the approval and cooperation of her male partner. The studies among women referred to above show that men may refuse to allow a woman to use contraception and female condoms for various reasons. This partly depends on the type of sexual relationship, which is taken into account in this study. Thus female condom programmes have to consider the socio-cultural contexts, including gender power relations, in different sexual relationships.

Since men are key to female condom acceptance and use by couples, in-depth qualitative information on males' perspectives is needed to inform education and promotion messages targeted at men, with the aim of increasing their acceptance and use of female condoms. Before acceptance (frequent use) people have to be aware about female condoms and have a positive attitude towards using them. Evidence on male acceptability and use of female condoms is lacking in the three countries focused on in this study (as in other countries). This study will thus explore the attitudes of men in Zimbabwe, Cameroon, and Nigeria regarding female condom use with different sexual partners, and what can make men have a positive attitude and then become an actual frequent user of female condoms – possibly in combination with other prevention and protection methods. The study will not focus on actual availability of female condoms, which is another barrier to use – and one of the focus areas of the UAFC Joint Programme. However, the availability and accessibility in the study areas, as perceived by respondents, will be explored because they are factors that influence acceptability.

1.4 Study objective and study questions

The main study objective is to explore the factors influencing the acceptance of female condoms by married and single men with different types of sexual partners. The contribution of the study to female condom programmes is to provide recommendations for approach, content, and channels for education and promotion in order to increase acceptance among men.

The questions answered in this study are:

1. What kind of sexual relationships do single and married men have? And within these relationships, how do gender power relations affect the decision making process regarding the use of prevention methods (both against STIs and HIV and unintended pregnancy)?
2. How acceptable is the use of female condoms for single and married men with their different categories of sexual partners, and why do they not want to use them (with certain partners)?
3. What motivates men to use female condoms for the first time and what are their experiences?
4. What motivates men to become frequent users of female condoms and what are the patterns of use?
5. What recommendations do study participants give to female condom programmes to increase male acceptance of female condoms?
6. What are the study findings' implications for female condom programmes?

1.5 Report outline

The following Chapter 2 presents the study methodology, including the theoretical framework used, and the study design, methods, and tools. It also describes the study populations and background of the participants. Chapter 3 presents the participants' perceived advantages and disadvantages of the female condom, often in comparison to the male condom, as well as the perceived effectiveness of the female condom. Chapter 4 elaborates on the type of sexual partners which men in the three countries have and the gender power relations within these sexual relationships. Chapter 5 continues by presenting the findings on the acceptability of female condoms with different types of sexual partners; it describes general male acceptability, as well as acceptability when different partners initiate use. This chapter also presents the reasons for not using female condoms and the motivations why men may try the female condom. Chapter 6 discusses the facets of female condom acceptance by men. Motivations for first time use and experiences are described, as well as reasons for stopping use. This chapter also presents findings on the reasons for and patterns of frequent use. Chapter 7 shows how participants perceived the availability, accessibility, and affordability of female condoms. The final two chapters discuss how female condom acceptance can be increased among men. Chapter 8 discusses this topic from the viewpoint of the FGD participants. They gave their opinion on current female condom programmes and how these can be improved, and how women can motivate men to use female condoms. Finally, Chapter 9 summarizes the findings about the factors influencing male acceptability and use of female condoms, and discusses the implications of the study findings for female condom programmes. It concludes by addressing the question which was the ultimate rationale for this study: are men are a problem in spreading the use of female condoms?

CHAPTER 2: METHODOLOGY

This methodology chapter starts with the theoretical orientations which guided data collection and analysis (2.1). Then the study design is presented in 2.2, including study methods, tools, themes, planned groups of participants, and ethical considerations. Section 2.3 describes data collection procedures. The following sections are on data analysis (2.4), reporting (2.5), and a description of the study populations (2.6). This chapter ends with a reflection on the study limitations.

2.1 Theoretical framework

The UAFC Joint Programme is a typical example of a Knowledge, Attitudes, Practices and Behaviour (KAPB) intervention – the type of intervention that seeks to alter (sexual) behaviour. Such interventions are based on the idea that a change in behaviour starts with an individual having the right knowledge about a certain issue, in this case the female condom. Second, an individual needs to change his or her attitude towards the issue, and finally alter his or her practices and behaviour. The main difficulty for many such behavioural change programmes related to sexual behaviour is that increased knowledge does not necessarily change behaviour, as people might not have the incentives or the power to change it, might not have the resources (no condoms available), and because sexual behaviour and gender relations (which might not favour the behaviour) are deeply rooted in culture, which is not easily changed. Therefore, in this study we looked beyond knowledge and attitudes as influencing factors for behaviour (in terms of female condom use).

The study's data collection and analysis are based on the theory of planned behaviour as presented by Fishbein (see Figure 1).[51] This theory distinguishes between two categories of mutually related factors that may influence intentions, behaviour, and behaviour change: personal factors and external factors. Personal factors include knowledge, risk perception, attitudes, skills, and self-efficacy. External factors include the social, religious, economic, and cultural contexts (including gender relations), social influence, and other external factors depending on the type of behaviour under study. A certain programme (like the UAFC Joint Programme) trying to influence behaviour also constitutes an external factor. External factors influence the personal factors that may lead to intentions for certain behaviour, and also influence whether a person can realize the intention by executing the behaviour. Economic factors are external, but also personal when a person has economic power to realize his or her intentions.

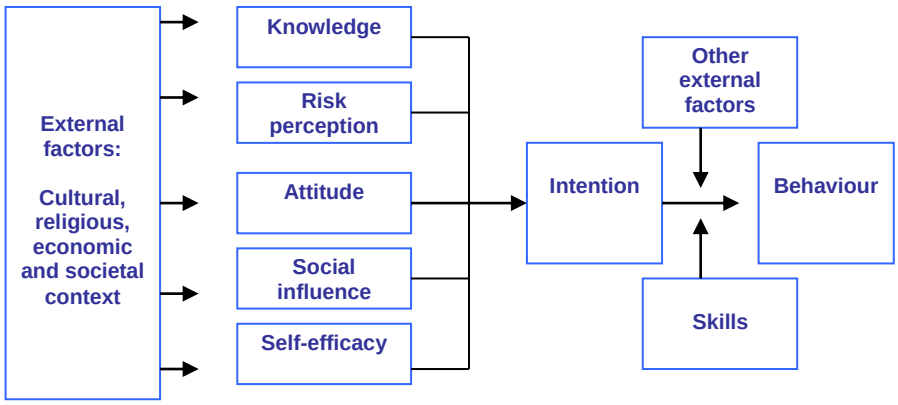

Figure 1: Theory of Planned Behaviour

[51] Fishbein (2000).

When relating this model to sexual behaviour and condom use in general, the reasoning is as follows. External factors such as cultural and religious beliefs, prevalence of HIV, as well as societal roles and values influence an individual's perception of their risk of contracting STIs and/or HIV as well as unintended pregnancies. Determining one's risk means having knowledge about the existence of these risks as well as perceiving them as risks. Whether a person is able to do something about their situation when they realize they are at risk depends on a person's knowledge, self-efficacy, and skills. Once the individual has the intention to use condoms, this can again be disturbed by external factors such as the availability and affordability of the condoms, and by the refusal of a partner. In programming it is often assumed that changing the determinants (such as knowledge and risk perception), after establishing the link between the health problem (for instance HIV infection), behaviour, and its determinants, will result in behaviour change and improved health. However, Boler and Aggleton (2004), commenting on this theory, note that in the end external factors may be more influential in determining people's behaviour and behaviour change than knowledge, attitudes, and skills.[52]

In this report we study the behaviour and behaviour change related to the use of female condoms by men – as a protection against HIV and STIs and prevention of unintended pregnancies. Various personal and environmental determinants possibly influencing the use of female condoms are explored. We theorize that having a positive attitude towards the female condom (*acceptability* of the female condom) is influenced by personal knowledge of the female condom (what it is, how it is used) and by one's belief in its effectiveness. These personal factors may be influenced by female condom programmes (external factor). Another factor influencing acceptability is the type of sexual partner and normative gender relations. From the literature (see 1.2) it is known that men in the three countries – as elsewhere in the world – have different types of sexual partners, with different gender power relations. It is theorized that female condom acceptability and use will differ by type of sexual relationship. In this study, we define actual use of the female condom as female condom *acceptance*. Moving from acceptability – the positive attitude – to actual use by men for the first time is again influenced by various personal and external factors. Personal factors may be, for instance, self-efficacy (that the man thinks he will be able to use it, influenced by knowledge of the female condom), perception of need, and having the economic resources. External factors include female condom availability and accessibility, willingness or insistence of the partner, and the influence of peers. These same external factors may influence him to become a frequent user, with an additional influence from his first experience; if positive, he might be more willing to continue using. Figure 2 presents the conceptual framework of the study.

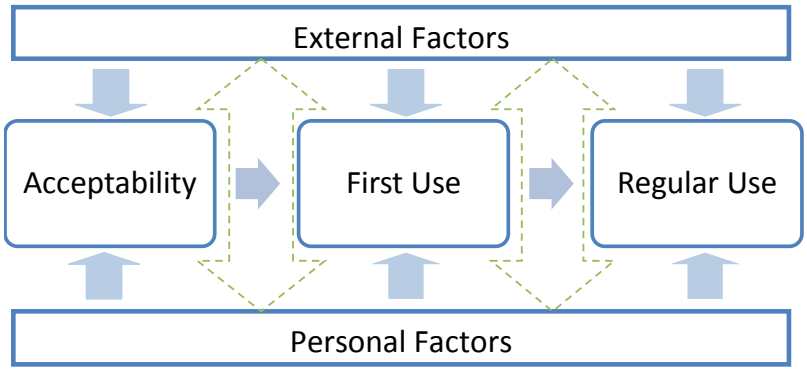

Figure 2: Factors influencing frequent female condom use by men

[52] Boler & Aggleton (2004).

2.2 Study design

The study was explorative because very little is known about the topic of this research, as has become clear from the literature review in Chapter 1. The study therefore used mainly qualitative data collection methods – focus group discussions (FGDs) and in-depth interviews (IDIs) – because these methods are more appropriate than quantitative methods for explorative studies. Before the FGDs quantitative background information was collected about the FGD participants.

When designing the study it was clear from the literature that the rationale behind (female) condom use or non-use differed among males and females, married people and singles. To give every individual the opportunity to speak freely in the discussion, we made separate groups at three levels. The first level of distinction was made between males and females. Although the emphasis of the study was on male acceptance of female condoms, we believed it was important to also have FGDs with women, to see what they thought about female condom acceptance by men. The second level of distinction was between married people and singles. As Chapter 1 points out, contraception use and gender relations are different within and outside marriage. Singles were defined as all men and women who were not formally married (thus among singles were also persons who were in a stable relationship and living together). The third level of distinction was between user types. Participants (who had all heard about the female condom) were divided into three groups: 1) frequent users; 2) one/two time users; and 3) non-users. The reason for dividing the one/two time users from those who used female condoms more often was that from the literature it is known that the first time that female condoms are used they may be cumbersome and people may be put off from further use, but that afterwards people get used to them and start enjoying them. Thus, there were six different groups for FGDs (see Table 1).

We aimed to hold sixteen FGDs in each country, of which four would be with females and twelve with males (see Table 1). More FGDs were planned with male frequent users because this group could give us the most insightful information about what may make men routinely accept female condoms. The twelve male groups were evenly divided between single and married men. For women, the groups of those who had used once or twice and non-users were combined into one group (thus cells are merged in Table 1).

Table 1: Number of FGDs with men and women, by user type group

Group	Men			Women			Total (males & females)
	Married	Single	Total	Married	Single	Total	
Frequent FC users	3	3	6	1	1	2	8
Used FC once or twice	2	2	4	1	1	2	6
Know FC but not used	1	1	2				2
Total	*6*	*6*	*12*	*2*	*2*	*4*	*16*

Selection of FGD participants was planned through convenience sampling: men and women who were willing to participate and who were available at the proposed time for fieldwork. They were to be mobilized through gatekeepers from ACMS in Cameroon, SFH in Nigeria, and PSI and other organizations in Zimbabwe. We opted for this sampling method because female condom uptake is low and it would have been difficult to find enough eligible people to participate in a random sample. Moreover, for the study objective, and considering the type of study, random sampling was not considered necessary.

In addition to the FGDs, we planned to conduct two in-depth interviews (IDIs) with frequent users in each country: a married man and a single man. These interviews would provide deeper insight

into the motivations for and experiences of first time female condom use, how these individuals experienced their first time, and what obstacles individuals faced (for example, convincing their partner, insertion, etc.) that could have prevented them from becoming a frequent user, as well as how they handled these obstacles.

2.2.1 Data collection tools

Three tools were developed to collect the data: topic guides for the FGDs, a topic guide for the IDIs, and a structured questionnaire for the pre-FGD interviews (see Annex 2).

FGD topic guides
For each of three groups of users – frequent users, one or two time users, and non-users – we developed a different topic guide. Two sets were made, one for males and one for females, thus making six different tools. The facilitator and the note taker were trained in the topic guides and received explanation about the kind of questions that were important for married and single persons.

The main themes in the discussions were: type of sexual partner(s); perceived advantages and disadvantages of female and male condoms; perceptions of the effectiveness of female condoms as dual protection; acceptability of female condoms compared to other prevention and protection methods, in particular the male condom, in different types of sexual relationships; experience with female condom use, first time and frequent use; decision making on use of contraception/protection methods, in particular on male and female condoms, by type of partner(s); patterns of female condom use with different sexual partners; availability, affordability, and accessibility of female condoms; recommendations for increased uptake and use of female condoms.

IDI topic guides
The topics in the IDIs were similar to the FGD topic guides for frequent male users. During the IDIs it was possible to explore the respondents' experiences in more depth.

Questionnaire
Before the start of the FGDs the research team members interviewed the FGD participants using a short structured questionnaire. The aim was to get background information on the participants' marital status, sexual relationships, education, and use of female condoms. Moreover, the questionnaire was used to find out in which FGD the participant should participate.

2.2.2 Ethical considerations

ACMS and SFH assisted in obtaining ethical clearance for the studies in their respective countries – which they deemed necessary. Ethical clearance for the study in Cameroon was requested and granted from the *Cameroon National Ethics Committee* presided over by Professor Lazare Kaptue. In Nigeria approval was granted by the National Health Research Ethics Committee (NHREC) of Nigeria, chaired by Clement Adebamowo BMChB Hons (Jos), FWACS, FACS, DSc (Harvard), Honorary Consultant Surgeon, Director of the West African Centre for Bioethics, and Chairman of the National Health Research Ethics Committee of Nigeria (NHREC). In Zimbabwe such official clearance was not deemed necessary by local partners considering the topic of study; written informed consent by participants was considered sufficient.

Ethical considerations during design of the study related to guaranteeing informed consent by FGD participants and diminishing the possible 'harm' for participants related to sensitivity of questions and time required for involvement in the study.

After arriving at the venue, facilitators explained the purpose of the study to potential participants[53] and asked for their consent to participate, after which a written informed consent form was given to complete before starting the interview or FGD (see Annex 2; A2.3). Before starting the FGD the facilitator introduced the research team and procedures of the FGD. (S)he again asked for permission to proceed and audiotape, and assured the participants that they were free to leave at any time during the discussion. Participants did not have to give their real names but were asked to provide a nickname for the sake of the discussion. Some participants were very creative in their chosen nicknames for themselves, for example in Nigeria they included *World Best, Young Money, Wise One, Too Handsome,* and *H2O*.

The consent forms – with the real names – are stored securely in the office of AIID. The group pictures and those taken during the FGDs in this report were taken with the permission of the participants. Many participants asked for pictures and to be acknowledged in the report and possible presentations on the study.

Participants were not pressured to share their personal experiences, but most willingly did so. Participants always had the option not to answer a question or not to participate when a certain topic was discussed. To accommodate possible loss of productive time, interview and FGD hours were set at a time, place, and day convenient for participants. They were informed beforehand that the FGD would take 1.5 to 2 hours. No information on incentives was given to participants before the FGDs, so as not to attract participants who may forge answers to fit the criteria for participation, or raise expectations regarding awards. However, FGD participants were provided with standard compensation for transport costs and received snacks and drinks during the FGD.

2.3 Data collection

Before data collection the local research team of FGD facilitators, note takers, and interpreters met for a day with the Dutch researchers to discuss the developed tools, get familiar with them, and adjust wording to the local context if necessary. During this day a pre-test was done (which was mostly already useful for analysis).

2.3.1 Mobilization of participants

Mobilization of FGD participants was done through local organizations through convenience sampling. In Zimbabwe, the mobilizing organizations were: ZNNP+ (Zimbabwe National Network of HIV Positive Persons), PSI (Populations Services International) Zimbabwe, and ARYI (African Regional Youth Initiative). Staff members from these organizations mobilized men and women for the specific groups who were willing to participate and who were available at the proposed time for fieldwork. One group of men and one group of women were mobilized from the street at the location where the research team was at the time. One consequence of the mobilization methods used was that people living with HIV/AIDS (PLHA) were highly represented in the Zimbabwe FGDs. In Nigeria and Cameroon the participants were mobilized through SFH and ACMS networks.

In all three countries mobilization took place in (semi-)urban areas: Harare in Zimbabwe, Lagos in Nigeria, and Yaoundé, Douala, and Bamenda in Cameroon. In Zimbabwe and Nigeria the FGDs were organized in different communities in the suburbs of Greater Harare (in eight areas)

[53] The FGD topic guide included an introduction to the study (see Annex 2). We explained about the intention to increase the availability of the female condom. The moderators were instructed, however, that they should not mention any further details about the female condom beyond the fact that it is a method to prevent HIV infection and unintended pregnancies. This was to prevent people from thinking that the discussion groups were about the positive aspects of female condoms instead of their honest opinion. Emphasizing the fact that all answers are correct, and that right or wrong answers do not exist, stressed this point even more.

and Lagos (in 4 areas). In Cameroon the FGDs took place in three different cities. Although not fully representative, the FGDs were held in diverse environments, thereby increasing the validity of the data.

2.3.2 Type of focus group discussion

As explained in section 2.2, we had planned to conduct sixteen FGDs in each country, totalling forty-eight for all three countries. Table 2 shows that in the end we conducted more FGDs than planned, totalling fifty-two in all three countries (see Annex 1, Table A1, for number and type of FGDs by country). More FGDs were conducted with frequent users because it was assumed that this group would be able give us the most insightful information about what may make men accept female condoms.

Table 2: Realized total number of FGDs, by user type category, sex, and marital status

Type of user	Males			Females			Total (Males & Females)		
	Single	Married	Total	Single	Married	Total	Single	Married	Total
Frequent FC users	13	8	21	7	5	12	20	13	33
Used FC one/two times	3	6	9	-	-	-	3	6	9
Know FC but never used	4	3	7	2	1	3	6	4	10
Total	*20*	*17*	*37*	*9*	*6*	*15*	*29*	*23*	*52*

Note: Used one/two times: used FC one/two times and used FC 3-10 times but stopped
Note: Frequent users: used FC 3-10 and continued use and used more than 10 times
Note: Single: singles / single – stable relationship / single – divorced/widowed/separated

In total, 478 people participated in the FGDs: 350 men and 138 women. FGDs had between 8 and 11 participants, with on average 9.2 participants. Table 3 presents the number (panel A) and percentages (panel B) of male and female participants in the three countries, by type of FGD. As by design, the majority of participants were frequent users (57%), while about one-quarter (23%) were one/two time users, and one-fifth (19%) were non-users. Relatively more females were frequent users (67%) than males (53%), and more single participants (60%) than married (53%) were frequent users. Annex 1 (Table A2) presents the data separated for the three countries.

Table 3: Distribution of FGD participants over user type groups, by sex and marital status

A. Distribution of FGD participants over user type, by sex and marital status (#)									
Type of user	**# Males**			**# Females**			**Total # (Males & Females)**		
	Single	**Married**	**Total**	**Single**	**Married**	**Total**	**Single**	**Married**	**Total**
Frequent FC users	112	68	180	48	45	93	160	113	273
Used FC one/two time	45	46	91	9	11	20	54	57	111
Know FC but never used	36	29	65	16	9	25	52	38	90
No information	2	2	4	-	-	-	2	2	4
Total	*195*	*145*	*340*	*73*	*65*	*138*	*268*	*210*	*478*
B. Distribution of participants over user type, by sex and marital status (%)									
Type of user	**% Males**			**% Females**			**Total % (Males & Females)**		
	Single	**Married**	**Total**	**Single**	**Married**	**Total**	**Single**	**Married**	**Total**
Frequent FC users	57	47	53	66	69	67	60	54	57
Used FC one/two times	23	32	27	12	17	14	20	27	23
Know FC but never used	18	20	19	22	14	18	19	18	19
No information	1	1	1	-	-	-	1	1	1
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Note: Frequent users: used FC 3-10 and continued use and used more than 10 times

2.3.3 Data collection procedure

Each FGD session lasted about two and a half hours. The first half hour was for introductions, administering the questionnaires, and filling in the informed consent form. The actual FGD lasted between one and a half and two hours. With the written permission of the FGD participants, FGDs were audio recorded. The discussions always took place in the language preferred by the participants. In Zimbabwe, FGDs were partly in Shona and partly in English. In Cameroon, FGDs were partly in French and partly (Pidgin) English. In Nigeria, most FGDs were in (Pidgin) English mixed with Yoruba.

The research teams in all countries consisted of local FGD facilitators, note takes, and translators (in Nigeria). In Zimbabwe the research was organized by Development Data, a consultancy firm based in Harare. In Cameroon and Nigeria we worked with the UAFC Joint Programme organizations, respectively ACMS and SFH. The Dutch researchers and authors of this report were present at all FGDs.

In-depth interviews (IDIs) in each country (six in total) were conducted by the two Dutch researchers with selected FGD participants: all male frequent users, who were willing to share their personal experiences. They were invited for an IDI after the FGD they participated in had finished.

2.4 Data analysis

The local research team members transcribed the FGD and IDI discussions verbatim in digital Word documents – the discussions in Pidgin English, Shona, French, and (part) Yoruba were literally translated into English. The FGD information from the digital Word documents was transferred by theme into spreadsheets by an AIID research assistant. For each FGD category (by user type, sex, and marital status) a set of spreadsheets was made, then manual content analysis was done by theme and by group, and similarities and differences were explored. Since the number of FGDs were small, no qualitative computer analysis programmes were deemed necessary.

IDI information was analysed by theme. The pre-FGD questionnaire data (quantitative) were entered and analysed in Stata. In the analysis and reporting, the three different single groups were taken together: 1) single with stable relationship; 2) single (without stable relationship); and 3) single widowed/divorced/separated.

2.5 Reporting

In this report, for all themes differences between groups were explored, i.e. between married and singles, women and men, users and non-users of female condoms. Where differences were found these are presented in the report. Findings are sometimes illustrated by quotes from FGD participants or IDI respondents – these are mainly quotes that represent majority views. Some quotes are presented that give minority, original, or new ideas that may be useful for programmes – these will be indicated as such. Quotes have been mildly edited from the direct verbal transcripts for ease of reading. Further illustrations and additions to the FGD findings come from the quantitative information from the pre-FGD questionnaires (in tables).

Chapters 3 to 8 present a summary of what participants discussed and answered (most) during the FGDs. We use the literal translations. In Chapter 9 their answers are analysed using the theoretical framework, and personal and external factors which influence male acceptance of female condoms are summarized. Chapter 9 also draws conclusions on the implications of these study findings for female condom programmes.

This is a synthesis report of the studies in the three countries and cannot reflect all relevant country specific information. Therefore, three separate country reports have also been written; these give more detailed findings and literature reviews, with specific implications for country programmes. These reports will be available from the UAFC Joint Programme website.

In the main text synthesis tables are presented, while the country specific statistics are presented in the tables of Annex 1.

2.6 Description of study population

As mentioned we had a total of 478 study participants: 340 males and 138 females. Table 4 shows some general background statistics of the FGD participants. Panel A describes the marital status of the participants: 44% were married, 39% had a stable relationship, and 14% were single without a stable relationship. In the tables in the remainder of the document we have combined the multiple categories of singles: single, single with stable relationship, and single widowed/divorced/separated. This made it easier to see the differences between single and married respondents. When combining all single categories, the majority of our study population (56%) was single. The percentage of men that had a stable relationship was higher at 46% than for women at 20%. In turn, more women than men indicated that they were single without any type of relationship.

Panel B of Table 4 shows that most participants were between the ages of 20 and 39 years. People within this age category are expected to be most sexually active. The average age of the study population was 32.8, and the women were on average one year older than the men. When looking at panel C of Table 4 we see that our study population was relatively well educated, as most of the participants had completed secondary education (57%), and 29% had even pursued higher education. This could have influenced our study results, as educated people are expected to be more aware of the risks of engaging in unprotected sex.

The last panel (D) of Table 4 shows that although educated, the majority of the study population did not have an official job. Most males and females mentioned having no job at all or were self-employed. Two important characteristics of the female population should be highlighted here. First of all, it is important to note that a relatively large percentage of the females in the FGDs were peer educators or community workers. These women can be expected to have knowledge about the female condom, be educated about its use, and be exposed to other tools of empowerment. This could have had implications for the results. In the analysis, when necessary we point to instances where the answers mainly came from peer educators. In addition, we organized several FGDs with commercial sex workers, who comprised a relatively large proportion of the female study population (14%). We analysed the findings for this group of women separately and thus take their exceptional background and possible different perceptions of female condom use into account.

Table 4: Characteristics of FGD participants

A. Marital status (%)	**Males (N=340)**	**Females (N=138)**	**Total (N=478)**
Married	42	47	44
Single	10	25	14
Single - stable relationship	47	20	39
Single - widowed/divorced/separated	1	8	3
No information	-	-	-
Total	*100*	*100*	*100*
B. Age groups (%)	**Males (N=340)**	**Females (N=138)**	**Total (N=478)**
<20	1	3	1
20-29	45	36	42
30-39	30	36	31
40-49	17	17	17
50-59	5	7	6
>60	1	2	1
No information	2	-	2
Total	*100*	*100*	*100*
Average age (in years)	*32.2*	*33.6*	*32.6*
C. Education level (%)	**Males (N=340)**	**Females (N=138)**	**Total (N=478)**
No education	-	2	1
Primary school	6	14	9
Secondary school	58	55	57
University / tertiary	31	25	30
Other	3	1	2
No information	2	2	2
Total	*100*	*100*	*100*
D. Occupation (%)	**Males (N=340)**	**Females (N=138)**	**Total (N=478)**
No job / housewife / student	30	26	29
Self-employed	28	22	26
Peer-educator / community worker	2	14	6
Barber / hairdresser	5	7	5
Sex worker	1	14	5
Other	30	15	26
No Information	4	1	3
Total	*100*	*100*	*100*

2.7 Study limitations

Focus group discussions cannot be used for quantitative purposes such as testing hypotheses or to generalize findings to larger populations. Therefore, the results presented in this report need to be interpreted as explorations about the perceptions of men towards female condoms. For a

generalization of the findings for broader areas, it would be necessary to conduct large scale surveys.

The participants in the FGDs were men and women who knew about the female condom. Hence, we do not know how people who have no knowledge about the female condom might perceive it. In addition, the participants were recruited in (semi-)urban areas, thus we do not know anything about rural populations. These two limitations of the study are general limitations in all three countries.

Because random sampling was not possible due to the very low national rates of female condom use, we had to rely on gatekeepers for participant recruitment. This resulted in an additional limitation in the study for Zimbabwe, as recruitment of participants was biased towards PLHA and peer educators. First, ZNNP+ selected men and women from their support groups. From the discussions we understood that most participants mobilized by ZNNP+ were PLHA. They can be expected to be sensitized and educated through their peer group and highly motivated to prevent (re-)infection by always using (male or female) condoms. After this finding, we added a question on HIV status in the questionnaires, where we explicitly asked for the participants' HIV status (however, in this report we do not analyse by HIV status). PSI was the second gatekeeper in Zimbabwe. Most of the people they selected were peer educators and barber and hairdresser distributers of female condoms from their programmes. This group is also knowledgeable about female condoms and most are users. After we learned about the profile of our participants, we decided to change some groups and ask passersby on the street to participate in an FGD. In the end only these people and those selected by ARYI – in three FGDs – can be considered representative.

It is also important to emphasize that this study is not an evaluation of the current policies and practices of female condom programmes in Zimbabwe, Cameroon and Nigeria. We did not ask the participants to what extent they were exposed to female condom programmes. Hence, this research should not be interpreted as an evaluation but as an explorative study on male acceptance of female condoms.

In conclusion: this was a small explorative study of persons in (semi-)urban settings, who were selected by convenience sampling. The findings, therefore, cannot be said to be representative for the whole of the three countries or for all men. However, through the methodology and population triangulation the validity was increased. Findings from the three countries are compared, as are the views of men and women, single and married, and the findings from the FGDs and pre-FGD questionnaires. We thus consider the study findings to be meaningful indications of male views on female condoms.

CHAPTER 3: OPINIONS ON FEMALE CONDOMS

For female condoms to be acceptable people need to have knowledge and positive opinions about them. This chapter presents findings on participants' knowledge of and opinions about the advantages and disadvantages of female condoms (3.1), and specifically on their perceptions of their effectiveness in protection against diseases and prevention of unintended pregnancy (3.2). Effectiveness is compared to male condoms and other prevention methods.

3.1 Perceived advantages and disadvantages of male and female condoms

This paragraph summarizes the answers to the roughly ten minute long ice breaking session for the FGDs, about what participants considered the advantages and disadvantages of female and male condoms. Obviously, female condom users shared more of their own experiences while non-users shared what they had heard. In the analysis, advantages and disadvantages were categorized into: (ease of) use, appearance, feeling, effectiveness, accessibility, and control. Often the two condoms were compared to one another, with the advantage of one being related to a disadvantage of the other (for instance, male condoms burst easily, female condoms are strong; female condoms are expensive, male condoms are cheap). Table 5 summarizes the answers mentioned most in all countries, which are further elaborated on in the report below. No frequency figures are given because it was not the intention of this question to exhaust all opinions. Annex 4 and 5 give an overview of the answers given in each of the three countries.

Advantages of female condoms

The two most mentioned advantages of the female condom is a) the effectiveness to prevent unwanted pregnancy and protect against STIs and HIV and b) female condom does not burst. Men and women users often said that using female condoms feels like natural, unprotected sex, and brings more sexual pleasure: some men said that this was because they felt free as the female condom is not tight around their penis (Cameroon), others said it was psychological because they felt safe (Zimbabwe), while others said that with female condoms they do not notice when the woman is 'too wet' (in the vagina) (Zimbabwe). For a man it was considered an advantage that he can rest inside the woman after ejaculation; he does not have to start all over with a new condom, but can wait until he is aroused again to start another round of sex (Cameroon and Zimbabwe). Many mentioned the advantage that female condoms can be used during menses. It is 'inconvenient' not to have sex when you want, and contact with menstrual blood is supposed to be unhealthy for a man. Men liked that because the female condom covers a big area, the man does not come into contact with the woman's vaginal fluids, which is advantageous for two reasons: some women have too much fluid (which makes sex too slippery) and it prevents infection. Many men and women, but mostly married men, mentioned the advantage that their wife could insert the female condom beforehand, which makes sex feel even more like it is unprotected (because the female condom adapts to the shape and temperature of the vagina). Women (and some men) saw it as an advantage that women are in control with female condoms and empowered to protect themselves against STIs, HIV, and unwanted pregnancy as well as rape (Cameroon).

Disadvantages of female condoms

The most mentioned disadvantage of female condom is related to insertion of the female condom. Both male and female, users and non-users said the female condom is difficult to insert. In addition, men said that it takes too much time to insert; if they are eager for sex there is no time for it. Another major disadvantage, is the possibility of the penis pushing the female condom aside, which would result in a lack of protection for both partners; they feared the stress of having

to constantly check this and hold the condom in place during intercourse. Women and men complained about the inner ring, which can cause pain for the man or the woman, or both. Another reported disadvantage is that female condoms are not widely available and are too expensive. Concerning the packaging of the female condom, generally it was considered too big. People – and especially women – usually do not want others to know that they are carrying a condom, but like to have one with them secretly.

Table 5: Summary of perceived advantages and disadvantages of female and male condoms

A. Advantages and disadvantages of the female condom		
	Advantages	**Disadvantages**
Effectiveness	• Protects against STIs / pregnancy • Strong does not burst	• Penis inserted under female condom
Feeling	• Sex feels natural • More sexual enjoyment	• Inner ring causes pain
Appearance and qualities	• No smell • No side effects	• Package too big
Accessibility		• Too expensive • Not widely available
Control	• Empowers women • Women in control of their sex lives	
Use	• Can be worn in advance • Can be used during menstruation • Penis can rest in vagina after sex	• Insertion is difficult • Insertion takes too much time • Needs to be held in place during sex
A. Advantages and disadvantages of the male condom		
	Advantages	**Disadvantages**
Effectiveness	• Protects against STIs / pregnancy	• Risk of bursting • Not 100% reliable
Feeling		• Constrains, tight on penis • Decreases sexual pleasure • Causes rashes
Appearance and qualities	• Portable	• Bad smell
Availability	• Cheap • Readily available	
Control		
Use	• Easy to put on / use	• Can get stuck in vagina

Advantages of male condoms

The two most mentioned advantages of male condoms are a) they are cheap and b) easy to use. Men and women are used to male condoms, which are available everywhere and easy to put on quickly, hence are good to use for spontaneous sex. In addition, male condoms are easy to carry around. Also the majority of men and women mention that male condoms offer them protection against STIs and pregnancies.

Disadvantages of male condoms

The major perceived disadvantage of male condoms is that they can burst – all groups mentioned this – either when the sex is rough, the condom is not put on properly ("*sometimes, if you are turned on and eager for sex, you do not take enough time for it*"), or is pierced by something sharp. And thus the male condom is not always 100% reliable. Many men said that the male condom constrains the penis and is too tight, which decreases sexual pleasure. Some men and women react to the latex with rashes on their sexual organs. Another complaint is that the male condom can slip off or stay in the vagina during intercourse or when the men looses his erection. Men in Cameroon and Zimbabwe complained of the bad strong smell of some

condoms. They said that everyone could smell it if they had had secret sex, for instance during lunchtime.

3.2 Perceived effectiveness of female condoms

We probed into the perceived effectiveness of female condoms compared to other methods. Generally participants considered the female condom to be very reliable, safe, and effective for prevention of unwanted pregnancy and protection against STIs and HIV, and compared it favourably with other methods, in particular with male condoms. The precondition mentioned for female condoms to be effective was that they should be placed well, that the penis should be inserted properly (not under the outer ring), and that only one female condom should be used per partner. Respondents mostly mentioned that the female condom is so effective because the material it is made of is very strong and does not burst, unlike male condoms. Very few had the experience or had heard of female condoms bursting. People also thought that because the outer ring covers the outer genitalia, there would not be any exchange of fluids between the partners and so no risk of infection that way. Additionally, when the female condom is inserted beforehand, the man would not have any contact with his hands and the vaginal fluids, as is common with male condom use; for example, some men are used to touching the woman first to get aroused, and with the same hand put the male condom onto his erect penis.

Some people said that female condoms are also effective because when inserted beforehand a couple cannot be overwhelmed by sexual desire and forget to use protection – as sometimes happens with male condoms. As a contraceptive and compared to pills, female condoms cannot be forgotten, and compared to pills, the intra-uterine contraceptive device (IUCD), and injectables, female condoms do not have a risk of unwanted pregnancy – all participants knew stories of women who got pregnant using these other methods, while none had heard of a woman getting pregnant while properly using female condoms.

CHAPTER 4: MEN'S SEXUAL PARTNERS

The second of the FGD ice breakers was to discuss the categories of sexual partners which men have. This was important information because it was theorized that the acceptability and acceptance of female condoms by men differ by type of sexual partners. The answers were written on a flipchart for everyone to see and referred back to during the remainder of the FGD. Participants in the three countries agreed that overall these partners can be divided into five categories: 1) marital partner; 2) stable extra-marital partner; 3) stable girlfriend (of single men); 4) casual partners; and 5) commercial sex workers (CSWs). FGD participants elaborated on each category, mentioned local names for them, and made sub-divisions. Types of partners differ in terms of duration, exclusivity, stability, trust, gender power relations, exchange of money or goods for sex, and purpose. From the elaboration in the following sections it is clear that there was also overlap between categories; for instance, it was not always easy to differentiate between sex workers and casual girlfriends, or even between a casual and a stable girlfriend. It will be indicated where participants disagreed, for instance on trust and power relations.

4.1 Marital partner

Men in the three countries, as in most African societies, reported that they pay brideprice to the family of their wife, and with this pay for ownership of the woman, including her sexuality and offspring. Once brideprice is paid the bond is official, and the man has more power over his wife; the wife has to submit to the gender norms for a married woman, including being submissive to the wishes of her husband and having sex with him whenever he wants and only with him. Traditionally men in these societies can marry more than one wife if they have the money to pay brideprice. In Cameroon polygamy is legal.

After marriage the man normally makes all decisions regarding the number of children, and the use of protection and contraception. He also has the 'right' to unprotected sex with his wife, which is considered pleasurable and good sex. A wife is not supposed to have sexual relationships with any man other than her husband, whereas a husband's extra-marital affairs are expected and condoned. Spouses may discuss the best use of contraception to prevent unwanted pregnancy, but discussing protection against STIs and HIV is taboo, because this would imply distrust. The main purpose of marriage for men and women is to have children, although intimacy and sexual pleasure may help a good relationship.

The normative power which men hold in relationships does not mean that women are powerless. They have their tactics and subtle ways to (try to) get what they want within the dominant gender norms, and make their own decisions – as will be illustrated in the course of this report.

4.2 Stable extra-marital partners

Many married men have stable extra-marital relationships with one or more women, with whom they may also have children, and whom they possibly intend to take as a second wife. Men have many names for them, but the most important are 'small house' in Zimbabwe; '*deuxième bureau*', or '*njumba*' in Cameroon; and 'outside wife', 'concubine', or just 'my girlfriend' in Nigeria. Men financially support these 'secret wives'. Wives know that men have these extra-marital affairs (although they often do not know the specific women), and said that men have them for sexual pleasure and for when their wife cannot have sex – for instance, when nursing a small baby or menstruating. Men also said that with these partners there is more sexual excitement. Men have less control over the sexuality of these women than over their wife, however, because they have not paid brideprice and therefore do not have exclusive rights to her sexuality. Thus many men

said that they cannot trust their stable extra-marital partner completely not to have other sexual relationships. They also mistrust these women in that they may try to get pregnant by him – even if he does not want it – and so gain more power over him. The woman often has emotional power over the man because he derives pleasure and intimacy from this stable sexual relationship, but the man wants to be in control of pregnancy prevention and protection.

Married men may have other stable relationships with girlfriends, whom they can go to when they want sex. This can be on the basis of paying her, or just knowing that she likes to have sex (though in the latter case she might still expect something more). Men realize that these girls and women will probably have other boyfriends. Some married men have a stable younger girlfriend, a 'sweet sixteen', to whom they are a 'sugar daddy'. They give the girl money, materials, pay school fees, or take her to restaurants and hotels, in exchange for sex. He makes all the decisions, although the girl may have emotional power over him.

4.3 Stable girlfriends

Single men have different types of stable girlfriends. They usually have one special stable girlfriend, called: the 'marriage type' in Zimbabwe, '*la titulaire*' in Cameroon, and 'fiancée' in Nigeria. With this girlfriend they are more serious, and may be living together.[54] She could be someone young, possibly still in school, whom he intends to marry after she has finished. A man will want to be careful with her and will not want to make her pregnant or risk an STI or HIV infection. He also does not want to impose too much and make all decisions, including regarding use of and type of contraception and protection. There is more intimacy and time for sexual encounters and discussion in these relationships than with casual sexual partners.

Aside from their special serious girlfriend, many single men have more or less stable relationships with other girls. As they say, it is never good to rely on just one woman, because one never knows what the future will bring. Some single men also had older women as a stable girlfriend, which in all countries was called a 'sugar mommy'. These women may be married but sexually unsatisfied by their husband, or they may be separated or widowed. In this case the woman may pay in money or kind for sex with the young man. Sugar mommies have economic power over their young partners, who will have to agree with any type of protection or prevention she wants to use.

With all these different partners, men cannot be completely sure and have trust that they are the exclusive sexual partner, although with the serious girlfriend this is more expected.

4.4 Casual partners

Married and single men may have sex just once or a few times with a woman or girl they meet on the street or elsewhere, where the sole purpose of the encounter is to have sex. Some men have their regular casual partners: 'spare tires' as they call them in Cameroon. Men have these casual partners for sex, excitement, and fun. The man may pay her something, or buy her food or drink, but this is not always the case. It also depends on the woman. Some women, married and single, are eager for sex and are easily tempted by men. The difference between these casual partners and CSWs is not always clear, because some girls which men pick up from the street expect money and do this routinely. Some casual partners may become more regular after a while, if the partners start to like one another. Nicknames for casual partners are many and within towns even area-bound. In Nigeria some names are: *shasha,* 'come and go', 'chop [eat] and go', *sarewa*, *aristo*; in Cameroon they are called *bois blanc* in Francophone and 'white wood' in Anglophone

[54] In the Cameroon DHS there is a marital category 'living with sexual partner' (besides 'currently married' and 'never married'), which would be the category we are referring to here.

areas (this refers to a type of wood that burns very fast and is thus good to use when one is feeling cold), free wheel, *roue de secour*, *rococo*. In Zimbabwe some nicknames were: 'hit and run', 'time pusher', *chikepe* (boat).

Between casual partners there are no obligations and there is no trust. Men (and women) know that they are not the only sexual partner. Men have the power to make decisions, but the women and girls may have sexual power over the man because he is so eager for sex at that moment.

4.5 Commercial sex workers

CSWs have sex for money. Some sex workers have their regular areas or streets which they work from, or bars they frequent, while others walk around and visit different places to pick up customers. In Lagos, more CSWs worked from brothels than was found in the other two countries. Some women live in these brothels, while others come during the evening and go home in the morning after work. Men had different names for CSWs: *njapisi*, *mahure* (whore), or 'vampire' in Zimbabwe; *ashewo* in Nigeria; and *waka* in Cameroon.

There is no relationship with the man they have sex with, and there is no obligation other than for the woman to give sex and the man to pay. Men can be sure that the CSW will not want to have a child from him and would want to protect herself from STIs and HIV (re-)infection. The man has power over the CSW, including over use of protection and prevention methods, because he pays.

4.6 Prevalence of type of sexual partners

For the sake of the rest of this report, instead of five categories of sexual partner we use four: 1) spouse; 2) stable partner (for single men usually referring to the serious girlfriend he may marry, for married men to the most stable extra-marital partner); 3) casual partners; and 4) CSWs.

Table 6 presents the number of sexual partners which men and women reported in the pre-FGD interviews to have had in the year preceding the study. Respondents from the three countries are taken together and findings differentiated by sex and marital status. Annex 1 (Table A4) presents the same table differentiated by country. The following figures should not be interpreted as representative, but still some conclusions can be drawn.

Table 6: Reported number of sexual partners of FGD participants in the year before the study, by sex and marital status

# sexual partners	% Males			% Females			Total % (males & females)		
	Single (N=195)	Married (N=145)	Total (N=340)	Single (N=73)	Married (N=65)	Total (N=138)	Single (N=268)	Married (N=210)	Total (N=478)
1 sexual partner	53	46	50	86	91	88	62	60	61
2 sexual partners	37	43	40	10	8	9	29	32	31
3 sexual partners or more	7	9	8	-	-	-	5	6	6
No sexual partner	3	-	1	3	-	1	3	-	2
No information	-	2	1	1	2	1	-	2	1
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Note: Not all totals add up to 100% due to rounding

About half of the married and single men (48%) had had more than one partner (relatively more so in Nigeria and Cameroon) in the year prior to the study (see Annex 1; Table A4). Married and

single women reported fewer sexual partners than men; most had had one sexual partner. Interestingly, 8% of the married women reported having had more than one sexual partner in the past year; however, this could indicate sex with the man whom they later married that year, and not necessarily an extra-marital affair.

Table 7 shows the type of sexual partners which men and women reported in the pre-FGD interviews to have had in the year preceding the study. A majority of single men had a stable partner (84%), but additionally about half of the single men also had a casual partner (more so in Cameroon and Nigeria). About one quarter of married men had a stable extra-marital partner (more so in Cameroon and Nigeria), and about one-third had casual partners (more so in Zimbabwe and Cameroon). Generally more single men visited sex workers (14%) than married men (6%) (more so in Zimbabwe and Cameroon).

Married and single women had fewer sexual partners than men and very few married women reported a stable extra-marital relationship; with those women who did, this could have been the fiancée whom they married in the same year. More single women did report having had stable and casual boyfriends as sexual partners (but this was not necessarily at the same time).

Table 7: Reported type of sexual partners in the year before the study, by sex and marital status (multiple answers possible)

Type of sexual partner	% Males			% Females			Total % (males & females)		
	Single (N=195)	Married (N=145)	Total (N=340)	Single (N=73)	Married (N=65)	Total (N=138)	Single (N=195)	Married (N=145)	Total (N=340)
Spouse / spouses	5	96	44	7	91	46	6	94	45
Stable partner	84	24	58	52	9	32	75	20	51
Casual partner	46	33	40	34	5	20	43	24	35
Sex worker	14	6	11	-	-	-	10	4	8
Other (clients)	-	-	-	12	2	7	3	-	2
No sexual partner	3	-	1	3	-	1	3	-	1
No Information	-	2	1	1	2	1	-	2	1

Note: multiple answers possible hence totals do not add up to 100%

CHAPTER 5: MALE ACCEPTABILITY OF FEMALE CONDOMS

The study explored whether and why female condoms are acceptable to men – i.e. whether or not they have a positive attitude towards their use – and whether acceptability differs by type of sexual partner. Section 5.1 presents the general findings related to the acceptability of female condoms to men with different sexual partners. Section 5.2 then zooms in on the acceptability of different female partners *initiating* female condom use. This information is important because often – also by the UAFC Joint Programme – female condoms are positioned as a female initiated and controlled dual protection method. The last two sections discuss the reasons why men do not use female condoms (5.3), and the motivations for why they may start using them (5.4).

5.1 Male acceptability of female condoms with different sexual partners

Only a few men said that female condoms are acceptable with all partners; most men differentiated by type of partner. In Nigeria and Zimbabwe men overall said that female condoms are more acceptable with their wife and stable partners, but less so with casual partners and sex workers. In Cameroon opinions were divided, with some men saying that it is more acceptable with casual partners than with stable partners, and others that it is more acceptable with stable partners.

Men who said that female condoms more acceptable within marriage and with stable partners referred to the trust between partners, including men trusting that the female condom will not be misused by these women. Men fear that casual partners and sex workers may misuse the female condom by using the same one with more than one partner or using it as a means for sperm harvesting for spiritual black medicine. Aside from referring to trust, men also referred to having more time for sex, and more intimacy and love with stable partners, which make female condoms more acceptable. In Nigeria, this greater intimacy which the female condom entails was more often mentioned – with relatively more men than in the other countries saying that they insert it for their wives, which they could not imagine doing for other women.

Men who considered female condoms unacceptable with their wives and stable partners feared that it would give the woman license for promiscuity, while others said that they do not want to give the power over prevention and protection to the woman. Married men who did not find it acceptable with their spouse said that any condom – male or female – is not acceptable because it is associated with promiscuity and HIV and other STIs; such are not relevant in marriage. Many married men said that it is only acceptable for family planning, in combination with observing the safe/unsafe period. For single men, female condoms are also most acceptable with their stable partner, for pregnancy prevention and for protection against HIV and other STIs. Most single men realize that they cannot fully trust their stable partner not to have other sexual partners; they can only require this from their spouse after brideprice has been paid.

Generally women also thought that female condoms would be most acceptable to men within marriage for family planning, and that is how the woman should try to convince him to use one. However, other women said that they thought that female condoms should be acceptable in all relationships, also outside marriage, because female condoms are the most effective method and if used outside the marriage would ensure protection.

The reason why a minority of men (more so in Cameroon) felt that female condoms are more acceptable with casual partners and sex workers is because they are the most effective

protection method, if used well. A precondition for acceptability with these partners is that the man is present when she opens the package and inserts the female condom, and that the female condom is disposed of in his presence (either by him or together) after sex.

The discussion between participants in the FGD with married men users in Douala illustrates well the different positions:

> **Participant 1:** I think it should be used on someone we esteem, someone we love. The male condom on the other hand is used to protect oneself against another. You put it on yourself except the lady in question refuses.
>
> **Participant 2:** I think that the female condom should be used within the marital setting rather than the male condom. For about two or three years now, I have been using the male condom out of my home each time I am on mission. So I esteem the female condom in my home, given all that which I have already explained.
>
> **Participant 3:** I do not agree with him on the fact that the female condom should be used only at home. I prefer using it outside because it protects the man more since there are more possibilities of contacting infections from outside to transmit them to your wife. One has only one wife, you know. ... One could meet about fifty women before dying, so there is need of an assurance of protection from all of that.

A special case was the acceptability of female condoms for men living with HIV/AIDS in a stable relationship, or for those in a discordant couple – for them female condoms would always be acceptable in any sexual relationship because they always have to protect themselves (and others).

5.2 Male acceptability of female initiation of female condoms

The FGDs explored men's opinions on the acceptability of a woman initiating female condom use. First it was discussed what their views were when different partners asked them to use female condoms, and after what their reaction would be if they were to find a woman with a female condom already inserted.

A sexual partner proposing female condoms

Generally men did not like women, and more so within marriage and stable relationships, to initiate female condom use, especially when the men do not already have knowledge of female condoms. There were three main reasons mentioned for this. Firstly, within marriage in patriarchal societies the husband makes all decisions and introduces new issues, not the wife. Secondly, women are not supposed to talk about sex, let alone about condom use. Thirdly, the husband will suspect her of adultery and of having learned new things from an extra-marital sexual partner.

Initiation by the wife is even less acceptable than by stable partners. This is related to the dominant gender power relations, with married men having more power over their wives than single men over their stable girlfriends. More single men said that it would be an ambiguous issue: on the one hand they would want to please a serious girlfriend whom they may possibly marry in the future, and would thus accept what she proposed; on the other hand, it would make them doubt her fidelity, because possibly she had learned about female condoms from another partner.

In Nigeria, men were more adamant that wives and stable girlfriend could not initiate. In general, women are not to carry around condoms or initiate use because this would indicate that she is loose and a prostitute. A married man reacted to this question saying that: "*She does not have*

the right to do such a thing". A single man said about his stable girlfriend: "*The day she does that she will have to go back to her parents' house*".

Just a few men, more so in Cameroon and Zimbabwe, said that under some conditions it would be acceptable for a wife or serious stable partner to initiate female condoms. This would be when there is general trust and communication between the partners, when the man is aware of female condoms, and when the woman explains well how she got to know about them and why she wants to use them, mainly explaining that it is for family planning. Most participants said that single men will have to accept initiation by a 'sugar mommy' because she has (economic) power over her lover.

Initiation by casual partners was also not very acceptable, but more so than by wives or stable girlfriends. This is related to the motivation for the casual encounter, which is mainly to have sex. If a casual partner or sex worker initiates female condom use, men would find it more acceptable because they are keen to have sex and it means the woman is ready for it. A single man in Cameroon said: "*I cannot refuse because the desire is there*". They also believed that this casual partner would be experienced in using them; the men know (and do not mind) that she has other partners besides them. Most men said that they would first try to convince her to use male condoms, but would agree to female condoms if the woman insisted. However, they stated that they would prefer to see her open the package and insert it in front of them before they would accept. It was interesting that in Nigeria, initiation by a casual partner or sex worker was acceptable for relatively more men than in the other countries – though this was less so for sex workers than for casual partners.

Sexual partner with a female condom already inserted

Men said that they could never accept it if for the first initiation of female condom use their wife or serious girlfriend had a female condom already inserted. However, if they were frequent female condom users, it would be more acceptable, because they would both know that sex is more pleasurable when the female condom has been inserted beforehand. Some men also said that they like their women to be in the mood and think about sex. However, and especially in Nigeria, frequent users said that there would still be doubt if the woman had inserted it without their knowledge or without informing him beforehand. For this reason some said that they would never accept it if they were to find their wife or stable girlfriend with the female condom inserted beforehand.

Men said that it would never be acceptable when a casual partner or sex worker already had the female condom inserted. They would refuse sex and either walk away or ask her to take it out and put in a new one in their presence. However, men accepted that especially with CSWs, men who are eager for sex and drunk might not always recognize that she is wearing a female condom. CSWs in Zimbabwe and Cameroon confirmed that they sometimes go to work with a female condom already inserted and that most men do not notice.

All single and married women saw it as a problem for a married woman to initiate female condoms, because the husband would suspect her of infidelity. If she already had the female condom inserted, the wife would risk big tensions and being sent away. Single women said that they have a strategy with their sexual partners: "*no condom no sex*". However, it does not always work, and women may lose a partner if he considers female condom initiation by his stable partner unacceptable. CSWs were also aware that initiation by them is difficult and that they may lose customers and thus money. Concerning inserting the female condom beforehand, CSWs said that it involves a weighing of risks: on the one hand they will be protected against men unwilling to use female or male condoms, though on the other they risk violence or refusal if the customer finds out. They know that for clients it is never acceptable if they insert it beforehand.

5.3 Why men do not use female condoms

Two major reasons why men reported not using female condoms were that they do not know (enough) about them and that they are not easily and widely available. The lack of knowledge is on different levels. Firstly, some men are not even aware of their existence. If they are aware of them, however, they may not know the benefits, and many do not know what they look like (have only seen the package from outside), let alone know how to use them. Because of this lack of knowledge, many men believe the negative stories about female condoms, including: that they are only for women and give them too much power over decision making; that women will become promiscuous; that female condoms can disappear inside the woman; that female condoms, just like male condoms, reduce sexual pleasure; and that they are very difficult to insert and then cause loss of erection or appetite for sex. Some single non-users in Nigeria thought that female condoms are only for sophisticated men and women, thus not for them. The fact that female condoms are not widely available (like male condoms are) meant that men do not see them around and are thus not inclined to use them. They said that they are confident with male condoms and do not see a reason to have to try to find female condoms.

Some men do not use female condoms because, as they said, they only have sex with their wife or stable girlfriend, and in such relationships female condoms are not appropriate. If they would propose use to these stable partners these women would feel offended, and to the stable partner of the single men it would indicate to her that he does not consider the relationship to be serious. Some married men who do not use female condoms said that in marriage they have the ‘right’ to unprotected sex, which is believed to be the best, most pleasurable kind of sex, so there was no reason for them to use female condoms.

In the pre-FGD questionnaire, non-users answered the question about why they had never used female condoms. A considerable proportion (33%) of married female participants reported that they did not use them because their partner did not want to (see Table 8). The major reasons reported by all groups for not using were not being interested, not knowing how to use them, and not knowing where to get them.

Table 8: Reasons for not using female condoms (frequencies, multiple answers possible)

Reasons	# Males			# Females			Total # (males & females)		
	Single (N=36)	Married (N=29)	Total (N=65)	Single (N=16)	Married (N=9)	Total (N=25)	Single (N=52)	Married (N=38)	Total (N=90)
Does not know how to use	7	5	12	1	-	1	8	5	13
Partner does not want to use	5	2	7	3	3	6	8	5	13
Prefers other method	6	3	9	1	1	2	7	4	11
Uses other method	-	5	5	-	2	2	-	7	7
Not interested*	2	1	3	3	1	4	5	2	7
Never seen it, but knows it	5	-	5	1	-	1	6	-	6
Do not know where to get	3	2	5	-	1	1	3	3	6
Didn't know it existed	1	2	3	1	-	1	2	2	4
Looks odd	2	-	2	1	-	1	3	-	3
Not available	-	1	1	-	-	-	-	1	1
No sexual pleasure	-	1	1	-	-	-	-	1	1
Too expensive	-	-	-	1	-	1	1	-	1
Other**	5	6	11	-	-	-	5	6	11
No information	1	2	3	4	-	4	5	2	7

Note: Percentage non-users in study population, per country: Zimbabwe 18%; Cameroon 18%; Nigeria 23%
Note: Multiple answers possible, hence percentages do not add up to 100
** Uses other method: mainly MC use and respondents see no reason to change*
** * Other reasons are: FC is not common as MC, doesn't have sexual relationship, never had the opportunity to use it*

5.4 Why men may try using female condoms

The majority of non-users (87%) in the pre-FGD questionnaire answered that they might try using a female condom in the future (see Table 9), while 11% of all non-users said that they did not want to use the female condom.

Table 9: Non-users about their future female condom use (frequencies)

Use	# Males			# Females			Total # (males & females)		
	Single (N=36)	Married (N=29)	Total (N=65)	Single (N=16)	Married (N=9)	Total (N=25)	Single (N=52)	Married (N=38)	Total (N=90)
Yes	30	27	57	12	9	21	42	36	78
No	5	-	5	4	-	4	9	-	9
No info	1	2	3	-	-	-	1	2	3

Note: Percentage of non-users in study population, per country: Zimbabwe 18%; Cameroon 18%; Nigeria 23%

In the FGD we discussed with the non-users and the one/two time users what could make men accept using female condoms. Most said that if they had more information about them and heard about the benefits, this would trigger their curiosity to try them and feel the difference with male condoms. Some men also thought that at one point their wife or girlfriend may be able to convince them to use female condoms. Single men in particular thought that this might happen, because their girlfriends have more power over them than a wife over her husband. It would also be possible that they could find themselves in a situation where only a female condom was available – this relates especially to situations where a man really wants to have sex with a casual partner. Some men were realistic and speaking generally said that in a couple, if one or both would test HIV positive, the couple may start using female condoms.

A single man in Zimbabwe said that he had recently heard about the sexual pleasure with female condoms, and other advantages, and that he was ready to use them, also to please his girlfriend. Some singles said that they may start using when they have a serious partner that they trust and have communication with about sexuality. A few participants in Nigeria said that they would only start using them when female condoms become cheaper than they are now.

It was interesting to notice that the FGD participants' intentions became stronger after having the female condom demonstration at the end of the FGD, during which they heard about the benefits, were shown how to insert them, and were given free samples. This supports the idea that with more knowledge and supply more men would start using female condoms.

CHAPTER 6: ACCEPTANCE OF FEMALE CONDOMS

A total of 387 FGD participants, 274 males and 113 females, shared their experiences with female condom use. Table 10 shows that some had just used a female condom once or twice (21%), 36% had used them between three and ten times, and 42% had used them more than ten times. Many of this latter group were frequent users, saying: "*Do you mean more than ten in the last month?*" The sampling strategy was biased towards more frequent use.

Table 10: Frequency of female condom use, by sex and marital status

# FC use	Males						Females						Total					
	Single (N=159)		Married (N=115)		Total (N=274)		Single (N=57)		Married (N=56)		Total (N=113)		Single (N=216)		Married (N=171)		Total (N=387)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Once or twice	39	25	31	27	70	26	4	7	8	14	12	11	43	20	39	23	82	21
3-10 times	62	39	45	39	107	39	21	37	13	23	34	30	83	38	58	34	141	36
>10 times	57	36	39	34	96	35	32	56	35	63	67	59	89	41	74	43	163	42
No info	1	1	-	-	1	-	-	-	-	-	-	-	1	-	-	-	1	-
Total	*159*	*100*	*115*	*100*	*274*	*100*	*57*	*100*	*56*	*100*	*113*	*100*	*216*	*100*	*171*	*100*	*387*	*100*

Note: Not all totals add up to 100% due to rounding

This chapter follows the course of users regarding what motivated them to use female condoms for the first time, what was their experience that first time, why they continued use, and how some became a frequent user. A considerable number (90 participants) said that they stopped using female condoms, and in section 5.3 their motivations for stopping will be presented. First, the general experiences will be presented, and then, if applicable, differences between countries and sub-groups (men, women, single, married) will be presented.

6.1 Motivations for first time female condom use

Curiosity was the main reason why men and women used a female condom for the first time. They became interested after hearing about female condoms in advertisements on TV, in workshops or training sessions, or by peer educators such as barbers or friends. Only in Nigeria did people report that chemists and pharmacists had informed them. Men and women said that they were told about the existence of female condoms, what they are used for, that sex is pleasurable with them, and that they are effective. Some received a demonstration of use. They were curious about how they would feel, and mainly wanted to experience the difference with male condoms. A married man in Cameroon said: "*It was a comparative study*. *I am someone who loves adventures, so when I heard about the female condom, I decided to use it*". Many were curious about whether it is true that sex with a female condom is as pleasurable as they had heard. Men were more explicit about their curiosity regarding the sexual experience with female condoms than women; they wanted to try if it is really 'next to natural', and also know how it would feel inside "*such a big shape*".

Another main reason why participants were motivated to use female condoms for the first time was that they had heard that they are a very effective method for pregnancy prevention and protection against disease. Within marriage people need effective contraceptive. With other partners, or when HIV positive or in a discordant couple, they need effective protection. Relatively more women and participants in Nigeria gave effectiveness as their major reason for trying female condoms. This is understandable in the context of gender relations, with women feeling more vulnerable because they know that their male partners have more sexual partners

besides them. Especially Nigerian married men and women reported that they wanted to try female condoms as an effective family planning method. In Nigeria, modern contraceptive use is very low, with one of the major reasons being that they are believed to have many negative side effects on the menstrual cycle and fertility. Female condoms do not have such side effects, so are potentially a good method of family planning. Male condoms also do not have side effects, but they are associated with HIV and STI protection, sex work, and promiscuity, and not considered appropriate in marriage.

Being HIV positive was another major reason for people to try female condoms. Upon hearing the HIV test results, people are educated about positive living and protection against re-infection, and in the case of discordant couples against infecting their partner. Female condoms are one of the two methods they could use, so they tried them. This reason was given more often by HIV positive people in Zimbabwe than those we talked to in other countries.

Trying out the item they were going to promote was the main reason given by peer educators and distributors of female condoms, who took part in the FGDs in all countries, as to why they had used female condoms for the first time. With firsthand experience they considered themselves better able to educate others.

A facilitating external factor for first time use was when people were given free samples of female condoms during workshops or sensitization campaigns. In this way the first step towards trying them out was made easier than for someone who had to buy a female condom after hearing about them on television, radio, or elsewhere.

Some men and women said that it was not really their motivation to use them, but that their partner had insisted on use (for married men this was mostly *not* their spouse). Female partners had successfully tried to convince men by referring to the female condom's greater sexual pleasure and safety. Sometimes the partner insisted because a female condom was the only method available. This happened especially to single men, whose regular or casual partner insisted and/or there was no other method available. In some cases, it was in a situation where the man really wanted sex at that moment and the women was on her menses, and she explained that female condoms make protected sex still possible.

In a few cases the man had no say at all in using female condoms for the first time, as their sexual partner had one already inserted without their knowledge. Some said that only later did they become aware that they had used a female condom. Some married female users in Zimbabwe shared that they had secretly used female condoms and their husbands had not noticed. Only after some time did they tell their husbands about it, who were then convinced that it feels like unprotected sex. Sex workers also reported that they sometimes do not inform their customers that a female condom is inserted.

In the FGDs married men said that their first time was mainly with their wife or stable girlfriend, while single men's first time was with their stable girlfriend or a casual friend. Relatively more married men introduced the female condom when they used it the first time, while with single men relatively more often was it the partner who introduced it.

Only in Cameroon and Nigeria did we ask in the pre-FGD questionnaire with which partner a female condom was used for the first time (see Table 11). The findings confirm those of the FGDs, that first time use was mostly with a spouse for married men and a stable partner for single men and women. CSWs (most of them single) had often used female condoms for the first time with their clients.

Table 11: First time female condom use with type of sexual partner

Sexual partner	% Males		% Females		Total % (males & females)	
	Single (N=100)	Married (N=80)	Single (N=39)	Married (N=42)	Single (N=139)	Married (N=122)
Spouse	-	71	8	86	2	76
Stable sexual partner	73	10	59	10	69	10
Casual partner	19	14	15	2	18	10
Sex worker	-	1	-	-	-	1
Clients	-	-	18	2	5	1
No information	8	4	-	-	6	2
Total	*100*	*100*	*100*	*100*	*100*	*100*

6.2 Experience of first time female condom use

During first time female condom use men and women had positive and negative experiences, with some groups relating more positive and others more negative. Generally the groups of frequent users had more positive first experiences than the once or twice users, and women usually had more negative first experiences than men.

The most mentioned positive first experience by men was that they felt as if there was nothing there, that it felt like natural, pleasurable, unprotected sex. In Zimbabwe they call this *nyoro*, in Nigeria they referred to it as *skin-to-skin* or *flesh-to-flesh*. They felt that nothing was holding their penis, unlike with male condoms when they feel tightness. Some men said that it made sex even more exiting and pleasurable; that the inner ring stimulated them; that ejaculation was easy and without pain; and that after ejaculating they could rest their penis in the vagina and start another round of sex when aroused. Overall a relatively larger proportion of the FGD groups in Nigeria had a positive first experience. Most men reported that their sexual partners enjoyed it equally, though some said that their partners did not, in particular they complained about the inner ring. Men said that what contributed to their positive first experience was the psychology of feeling protected and safe by the female condom – more so than with the male condom which can burst.

Men also shared negative first experiences. These were mainly the result of a badly inserted female condom, if insertion took too much time, and/or when the man did not insert his penis well into the female condom. Men complained that the woman was fumbling around while he was ready to have sex, and so he became impatient and lost momentum. "*Before she was able to put it on, I was already dead*", said a single man in Douala. Especially when trying it with a stable partner, and the woman inserted the female condom incorrectly and/or complained of pain or discomfort, this made men have a negative first experience, psychologically and/or with pain because of feeling the inner or outer ring. Some men inserted their penis incorrectly and pushed the female condom inside the vagina, which disturbed the sex and caused pain, or said that they had used force which caused pain on their foreskin. Two men in Zimbabwe said that the female condom broke the first time they used it because it was not inserted correctly.

Some negative experiences were related to the attributes of the female condom. Men were disturbed by the big shape (like a plastic bag), the oily lubrication, and the noise during insertion and when it moves inside during intercourse (they said that this was more of a problem with the first female condom (FC1) – the present female condom (FC2) is not noisy). Some said that they were put off by watching the woman insert the female condom. Men also complained that they could not change positions during intercourse, or have sex in the position they wanted (for example, taking the woman from behind).

Other negative experiences were psychological. Some men feared that the female condom may disappear into the vagina and even further into the womb, which put them at unease during sex and made them check continuously whether the outer ring was still there, which disturbed their sexual pleasure. Some men said that they were psychologically disturbed when they thought about the fact that the women could have used the same female condom with other men.

Women had similar positive and negative first experiences, but overall relatively more women reported negative rather than positive experiences, even in the frequent user groups (about 8 out of 10). With women, nearly all negative experiences were related to the difficult insertion and to not feeling at ease; and as a result of incorrect insertion feeling pain and/or having the man insert his penis under the outer ring or pushing the female condom inside the vagina.

A few conditions stood out from these first experiences which made an overall positive experience more likely. When the women is experienced in using female condoms and/or had inserted it quickly and well, and did not show feelings of discomfort or pain – this made men enjoy the experience more. Single men in Cameroon who had their first experience with a woman who was used to the female condom all had pleasurable experiences. These men explained this by saying that the woman was obviously in the mood for sex, and made them feel at ease. Some men inserted the female condom for their stable partner or wife, and this created a feeling of intimacy. Finally, some men had a positive experience because the woman had inserted the female condom before sex, so that it had adapted to the shape and temperature of the vagina, which made them feel as if nothing was there.

6.3 Reasons for stopping female condom use

A total of 89 participants had stopped using female condoms, and most did so after one or two uses (see Table 12). The major reason for stopping, as reported in the FGDs, was a negative first or second experience and this de-motivated them to use them another time. They reported that it took too much time to insert the female condom, that it came out during intercourse, that the woman was not able to insert it properly, that they did not have the same emotions as with natural sex, and that it caused pain and unease. "*During intercourse the time to come out, enter again...it takes too much time. And it discourages, frankly... You do not find yourself making love but sports instead*", said a single man in Nigeria. Some men in Zimbabwe were so disturbed by the sight of the woman inserting the female condom that they did not want to see it again. The men compared them with male condoms and just thought that male condoms are faster to use and not so messy (with one man the sperm flowed out of the female condom).

Another reason why some men and women stopped using them was because their partner refused to use them again. Some men said that they had just wanted to try it out with a casual partner (who introduced it to him); but that since they are faithful to their wife they do not need female condoms. Some married men also had reasons related to not wanting to lose control to their wives through the use of female condoms. This would go against the gender norms within marriage of men making all decisions. Some added that any condom is not good for marriage because it shows distrust, with spouses suspecting adultery. Zimbabwean men said that religion is also against condoms, and thus it feels morally wrong to use female condoms.

An often mentioned reason for stopping was that female condoms were not easily available, and there were no sales point close by. Especially when one wants casual sex, a male condom is easier to get. Some participants who had received some (free) female condoms, and had used them, did not buy new ones when the samples ran out. Aside from not being available, a few men in Nigeria and Cameroon said that female condoms are too expensive. One married man in Cameroon also explained that if storekeepers have trouble selling the female condoms, after exhausting their stock they will not get new ones, but will go back to only selling male condoms.

Even with a good first experience, some men went back to the male condom because they considered the trial with the female condoms just an experience, and preferred to return to what they are used to. A single man in Zimbabwe said: "*We stay loyal to our male condom*".

Table 12: Participants who stopped using after number of times used, by sex and marital status

# times used	# Males			# Females			Total # (males & females)		
	Single (N=33)	Married (N=38)	Total (N=71)	Single (N=8)	Married (N=10)	Total (N=18)	Single (N=41)	Married (N=48)	Total (N=89)
Once or twice	24	22	46	1	6	7	25	28	53
3-10 times	6	15	21	5	3	8	11	18	29
>10 times	3	1	4	2	1	3	5	2	7

In the pre-FGD questionnaire participants were also asked why they stopped using female condoms. Relatively more married men and women stopped because their partner did not want to use them, and more women relative to men temporarily stopped because they currently had no partner. Relatively more married men complained that they are too cumbersome to use (see Table 13).

Table 13: Participants who stopped, reasons for stopping use, by sex and marital status

Reasons for stopping use	# Males		# Females		Total # (males & females)	
	Single (N=33)	Married (N=38)	Single (N=8)	Married (N=10)	Single (N=41)	Married (N=48)
Partner doesn't want to use	2	7	-	4	2	11
Too cumbersome to use	4	5	1	1	5	6
Prefer to use other method	3	2	1	2	4	4
Not available	3	4	-	-	3	4
No partner at the moment	3	1	2	2	5	3
No sexual pleasure	3	3	1	-	4	3
Not comfortable using it	2	2	-	-	2	2
Don't know how to use	1	2	-	-	1	2
Wants pregnancy / is pregnant	1	1	-	1	1	2
Other*	7	10	3	-	10	10
No information	4	1	-	-	4	1

** Other: often not specified*

6.4 Frequent use of female condoms

Why become a frequent user?

A major reason given by single and married men for becoming a frequent user was that they get sexual pleasure and satisfaction out of it – often when compared to male condoms. They also considered female condoms to have more advantages compared to male condoms: mainly that they are more effective, but also that they do not have a bad smell, do not interrupt foreplay, a man does not need an erection, and that the man does not have to dispose of them or do anything but can leave it to the woman.

A first bad experience was not always a reason to stop use. A married man in Yaoundé explained that he did not like the female condom the first times he used it, but that he persisted

after hearing from others that it was nice, and so he and his wife started enjoying the sex after continuous use:

> The first time it left me with a bitter taste. I asked why it was like that and some people told me they did not have the same problem as me. The second time I tried, I changed tactics and we took our time. The third time, I think we each used our condoms just to see what it was like. As time went by, I realized that the more we tried to use the condom, the more we liked it because we discovered various positions that can permit the easy use of female condoms.

Married men, more so in Nigeria where female condoms are mainly used with regular partners, gave as a reason for having become frequent users that they considered female condoms the best contraceptive method due to their effectiveness and lack of side effects, unlike other contraceptive methods including pills and injectables. Men also became frequent users because with female condoms they can always have sex with their wife or stable girlfriend when they feel like it, since it can be used during menstruation. Some older men and women mentioned that it makes sex after menopause more pleasurable because of the lubrication.

Some married men became frequent users because their wife or stable girlfriend insisted on it for family planning. Their wives were also in favour of using female condoms because, according to the men, they feel safe and enjoy the sex.

Single men more often talked about female condoms' effectiveness as dual protection as a reason for frequent use. Single men in Yaoundé, Cameroon, explained that they became frequent users because their girlfriend insisted and they liked that with female condoms the girl is fully involved. They reasoned that women who use them derive pleasure from them and want to have sex, and it is not the man who always has to ask for it. Women's involvement creates sexual excitement and pleasure for both.

> It changes the whole set up of things. Under normal circumstances it is the man who wears the condom. With the female condom the female has to put it on prior to the act. So seeing it on her basically makes it nicer. So I can say it is exciting to watch her put it on and the fact that I am not wearing anything whilst she is in charge of the protection is exciting. (single man in Zimbabwe)

For both men and women a major incentive for becoming a frequent condom user was to be tested HIV positive, or if their partner tested positive (and thus being in a discordant relationship). Many PLHA said that with female condoms they had found an alternative and variation in their sex life – they are fully aware that being HIV positive means always having to use a condom. For people with HIV in Zimbabwe, female condoms can be obtained for free from clinics or support groups.

An external factor that facilitated frequent condom use reported by some men was that they have a supplier, or are a supplier themselves, and so have easy and sometimes free access.

Patterns of frequent use

Frequent users in the three countries used female condoms more with their stable partners than with casual partners or sex workers (see also Table 14). However, in Cameroon female condoms were used relatively more often, also with casual partners. Married men used them with their wives and stable extra-marital girlfriends, and single men with their serious girlfriend. Within marriage, female condoms are mainly used for pregnancy prevention, and thus often only in the 'unsafe' period, and additionally during menstruation. With the stable partner of married or single men, female condoms are, in addition to pregnancy prevention, also used for protection against disease and often alternated with male condoms. Female condoms provide variation and can be used during menstruation. One of the reasons why frequent female condom use occurs more

with stable partners is due to trust and intimacy between partners; another reason is that sex is less hurried than with a casual partner.

Only a few frequent users said that they also use female condoms with casual partners (though this was more so in Cameroon) or CSWs, and this is related to lack of trust in these partners. Men explained that they fear that these women misuse the female condom and they do not like to give control to them. They felt that with male condoms they protect themselves best, even though they still believed that female condoms are more effective and pleasurable if used properly. Some men found a solution to this dilemma by making sure that they see their partner open the package, insert the fresh female condom, and dispose of it afterwards.

The common pattern of frequent female condom use – except in marriage – was to alternate with male condoms. Men alternate because: 1) they want variation in sex; 2) it depends on availability of one or the other condom; and 3) they do not use them with every sexual partner. A single frequent user in Zimbabwe explained his pattern of use as follows:

> Myself I am torn in between the two condoms in that I will rather use the female condom on my trusted partner because I trust that she is going to insert it properly and that she is not going to cheat on me, but the male one I trust to use it with casual sex partners and proper commercial sex workers.

Many men complained that female condoms restrict the positions one can take during intercourse and therefore alternate use with the male condom. Others alternate because their stable partner prefers one or the other. Some single men in Cameroon reported that with their stable girlfriend they agree to use female condoms if they themselves want more sexual pleasure and the male condom when she wants to have more. However, others were of the opposite opinion, that women enjoy sex more with female condoms. HIV positive or discordant couples also alternate between male and female condoms mainly for variation in their sex life – being aware that they always need to use a condom.

Participants in Cameroon and Nigeria in particular said that they cannot frequently use female condoms because they are not available or are too expensive. They can get male condoms everywhere, whenever they want sex, and they are cheaper. Talking about the relative proportions of female and male condom use, they gave percentages like 25% female condoms, 50% male condoms, and 25% free (without a condom).

Only a few men reported that they always use female condoms with all sexual partners – like the married Zimbabwean man in the following quote.

> My first experience with a casual partner who had used female condom before made me want to continue using it. Even when I introduced it at home I then knew what to do and we followed that. My wife also enjoyed her first experience with me and afterwards she would barge me for the female condom. We used to use the male condom but now my wife also insists on the female condom. She even buys it and often I find her already wearing it and ready for me!! If worn properly and used correctly it is really nice to use during sex. For me it's like I use them with my wife as well as when I engage in extra-marital affairs. I sometimes work out of town and the places we go to can be boring after work as there is limited forms of entertainment. So sometimes I engage in casual sex. I have been to Banket [a small farming/mining town 80km out of Harare towards Zambia] where I slept with CSW and I instructed her to put on the female condom. … I instruct my extra-marital sexual partners to use the female condom. They initially refuse but succumb. Of course I do carry my own condom, both the male and the female ones. I don't want to be caught with my pants down. Even the workmates I travel with also carry the male condom and female condom. The CSWs sometimes refuse to use the female condom and if they insist I use the male condom. The male condom is cheap and easily accessible and one can easily get them for R5 in pubs and the like, even when under pressure to get one and even late at night.

Table 14, which presents findings from the pre-FGD questionnaire, confirms the FGD findings that frequent use of female condoms is most common with spouses for married men and women, and with stable partners for single men and women.

Table 14: Use of female condoms by frequent users, with type of sexual partners, by sex and marital status (multiple answers possible)

Type of sexual partner	% Males		% Females		Total % (males & females)	
	Single (N=112)	Married (N=68)	Single (N=48)	Married (N=45)	Single (N=160)	Married (N=113)
Spouse	4	94	-	93	3	94
Stable sexual partner	87	13	57	9	78	12
Casual partner	37	21	39*	5	38	14
Sex worker	9	3	-	-	6	2
Clients	-	-	15	-	5	-

Note: Frequent users: used FC 3-10 times and continued use and used more than 10 times
*Note: * Two groups of single women were sex workers with many casual partners*

CHAPTER 7: PARTICIPANTS ON ACCESSIBILITY OF FEMALE CONDOMS

This chapter describes how participants viewed the accessibility of female condoms. When female condoms are acceptable to a person, then theoretically he or she would be prepared to use them. However, external factors may prevent a person from starting to use them or from frequent use. Barriers to use may be easy availability and affordability, or that the female condom is not accessible due to, for example, the shame of buying female condoms. These factors are explored in this chapter. Section 7.1 describes how the FGD participants viewed the availability of the female condom, section 7.2 describes their ideas on accessibility, and section 7.3 discusses how affordable the female condom is according to participants.

7.1 Availability

The FGD participants, males and females, non-users and frequent users, in Nigeria, Cameroon, and Zimbabwe, all agreed that the female condom is not easily available. Especially when comparing the female condom to the male condom, people said that the female condom is scarce. In all three countries, there seemed to be specific areas around or close to the bigger cities and/or certain neighbourhoods within the cities where female condoms are more available compared to other places. Some participants have to travel to a different neighbourhood or area to get female condoms. In addition, according to the FGD participants the female condom is not available outside the bigger cities and towns.

When talking about where to buy the female condom, the majority of participants in Nigeria mentioned that they can be bought at the chemist, though some also find them in hospitals, health centres, and at pharmacies. In Cameroon, the majority of participants also find female condoms at pharmacies and some get them at the hospital or health centre. In Zimbabwe, the majority of participants knew that female condoms are freely available at clinics, health centres, and hospitals, and that they can be bought at pharmacies. Participants in five FGDs in Zimbabwe reported that female condoms are distributed at their workplace and freely available, though only in the women's toilet.

Despite the fact that hair salons, barbershops, and beauty parlours have been made official sales points for female condom programmes, in Zimbabwe and Cameroon these locations were not often mentioned as places of accessibility for female condoms. In Zimbabwe, the distribution of female condoms through hair salons was only reported by the female hairdressers who participated in one of the FGDs. In Cameroon, barbershops and salons were only mentioned in three female FGDs and two male FGDs.

In Zimbabwe, the lack of availability particularly in bars and nightclubs was seen as a problem, because in these places the need for condoms is high, according to participants.

7.2 Accessibility

It is generally believed that buying condoms, both the male and female variety, is difficult for women and young people. Women are considered "loose" when they are seen buying condoms, and young people of school going age are not supposed to have sex. This creates an environment of shame, as women do not want others to think badly about them and young people do not want to expose themselves as sexually active. Ultimately, this prevents women and young people from buying condoms. In Nigeria, the problem for women and young people to

buy condoms was not as often mentioned as in the other two countries. For men it is generally accepted to buy condoms.

Discretion in obtaining the female condom in all three countries was said to be very important. In Zimbabwe, where practically all FGD participants mentioned the availability of female condoms at health clinics, it was discussed that their placement can be an obstacle to obtaining them. Apparently, several health clinics place the female condoms at the reception in front of the waiting room, where many people can see that one is asking for them. This creates shame and people would prefer a more discrete location within the clinic. In Cameroon some men were of the opinion that it is difficult to buy a female condom because of their association with *women*, and because they have their own *male* condom; hence women should buy the female condom and men should buy the male condom. Although some Nigerian male non-users agreed with this sentiment of the Cameroonian men, there were also some Nigerian male frequent users who had a different opinion; they said that if men are comfortable using something, they should not be ashamed to buy it, and they would not care if others talked about it.

7.3 Affordability

In all three countries, the female condom was considered expensive in comparison to the male condom. In general, the female condom is at least double the price of the male condom. In Nigeria and Zimbabwe, the female condom does not have a fixed price. According to participants in Nigeria the prices differ between neighbourhoods and communities, from 30N to 100N (0.19 – 0.63 USD) for one female condom. In Zimbabwe, the female condom in PSI networks costs US$ 0.20 for a pack of two, though after hours in some outlets or with some vendors there is no fixed price; the price ranges from free to 0.50R to 5R for one female condom (US$ 0.06 to 0.60). In Cameroon, one female condom costs 100CFA (0.20 USD).

In Zimbabwe, nearly all frequent users obtained their female condoms for free and thus had not been confronted with the costs of use on a regular basis. Hence, we do not know if an ordinary person in Zimbabwe would be able to regularly buy female condoms. The participants in Cameroon and Nigeria stated that it all depends on how wealthy a person is; in general, they thought that the female condom is not affordable for everybody.

Conclusion

We can conclude that the three obstacles to female condom use – lack of accessibility, availability, and affordability – are still present, despite the efforts of female condom programmes. From the above stories we learn that participants in the FGDs in Zimbabwe, Cameroon, and Nigeria considered the female condom to be not easily available and expensive (especially in comparison to the male condom), and reported that females and youth have difficulty in accessing female condoms, as buying condoms in general is shameful due to their associations with promiscuity and sex work.

CHAPTER 8: OPINIONS ON INCREASING FEMALE CONDOM ACCEPTANCE BY MEN

This chapter presents participants' suggestions on what could make men accept female condoms and become frequent users. The first section (8.1) presents their opinions on current programmes and their recommendations for increasing acceptance among men. Then findings are presented regarding whether men or women were considered by participants to be the biggest obstacle in spreading the use of female condoms, followed by section 8.2, which outlines participants' suggestions on how women could convince their male partners to use female condoms.

8.1 Opinions of female condom programmes and recommendations

8.1.1 Knowledge of current programmes

Overall participants in the three countries felt that there are not enough advertisements and promotion of female condoms. Many compared the situation to campaigns for male condoms, which are more prominent; and in Zimbabwe they compared it with the recent prominent campaign around male circumcision. In Cameroon, especially in Bamenda, more participants had seen advertisements on television, but were worried that these did not reach many people because not many have televisions. In Nigeria, only a few had seen female condoms being promoted on television (just once or twice), and some had heard about female condoms on the radio. Other mass media promotion spots included billboards in the streets, but these were very few, and some had disappeared. In Zimbabwe participants did not refer to television and radio promotion, and most participants got to know about female condoms when attending road shows where they were demonstrated; they said, however, that these were no longer happening. Furthermore, in Nigeria and Cameroon participants got to know about female condoms through peer education programmes in the community or in hotels and schools, or through seminars and sessions organized by the local government or clinics. In Zimbabwe, participants said that one can now only receive explanation about female condoms in clinics.

Concerning the messages and target groups, male and female participants felt that female condom messages mainly target women and that men are left out; some also felt that youth are left out. The messages aim to empower women. Some commented that messages that are only directed at women will discourage men from accepting. Married male users in Yaoundé, Cameroon, said that sensitization made it seem as if male and female condoms are in opposition, which is not good.

The three countries differed in terms of their main opinions and critiques of present campaigns. In Zimbabwe, one group said that campaigns target prostitutes and not ordinary women, and so ordinary women do not feel that female condoms are for them. Other groups of single men in Zimbabwe said that only PLHA are targeted by female condom campaigns, to prevent (re-)infection. Others felt that female condom messages are mainly targeted for protection against STIs and HIV, and not for prevention of unwanted pregnancy. Another complaint about the messages in Zimbabwe was that they are in English and thus not user friendly to all. Many Zimbabwean participants could (just about) reproduce the slogan "*Care, for lovers/men and women who (chose to) care*", and remembered the picture showing beautiful people. Some said that they liked the slogan and the picture, while others were critical about the people in the adverts, because they are always the same models and do not represent people of the community, nor people of all ages (younger and older are left out), nor female condom users (for

instance, they are supposed to represent HIV positive people and show them living positively). Finally, the people in the adverts are not known people, just beautiful artists.

In Cameroon people also had positive and negative opinions about current campaigns. The positive comments were made by young men in Bamenda, some of whom had read about female condoms in the *100% Jeune* magazine, some had seen a smooth negotiation over female condom use between a woman and man on television, and some a poster with a woman and man on a bed discussing female condom use. Some liked the advert with celebrities on the television, while others thought that the attention went more to the celebrities than to the condom. Another objection to some television adverts was that they only show the package of the female condom and explain why it should be used, but do not show how to use them.

> The advert is good in colour and speech – but in action it is not. In the 'Protectiv' advert a girl is shown holding the condom. There is nothing concrete. Something like that could motivate people to use it. Advert only shows why you should use it, not how we should use it.

Very few knew about the programmes in barbershops and hairdressing salons. Some people in Zimbabwe knew that female condoms are distributed and promoted through barbershops, but not everyone was satisfied with this. Married male non-users said that most barbers are not motivated to promote them, especially because there has been inflation in the number of non-professional barbers who are too preoccupied in getting customers. They also believed that these barbers do not have enough knowledge and skills to explain female condom use well. In Nigeria, more people referred to community sensitization and interpersonal communication on female condoms in diverse places like beer halls, brothels, schools, communities, health centres, bus terminals, and even parties. They thought that these were good ways to make people aware of female condoms, educate them about use, and distribute them.

8.1.2 Recommendations by participants for female condom promotion among men

The general recommendation by male and female FGD participants in the three countries was that there should be much more sensitization and promotion of female condoms than there is now, and that men should be targeted more in campaigns. Men should be made aware of the existence of female condoms, know the advantages, what they look like, and how they are used. Without men having good knowledge of female condoms, women who want to use them face challenges in introducing them to their partner. The other main recommendation was to make female condoms widely available. Following are their more concrete recommendations on how to do this.

Channel and target groups

Most advised that in campaigns, both women and men of all ages, and living with HIV or not, should be targeted. Furthermore, if this occurs in community sensitization, in special road shows, or in gatherings, it is preferable for couples to be targeted together because they would then both understand how the other had gotten the information, and not suspect that their partner had learned about it from another sexual partner. There were concerns in all countries that men usually do not attend these sessions and so special effort should be made to target them in places they frequent, such as bars, club houses, sports fields, and offices (barbershops were not mentioned).

Television and radio were considered the best channels to promote female condoms, because more people would be reached and there is limited reading culture. However, the adverts – using jingles, talk, etc. – should be aired more often, and the media companies should give them mores slots. Participants recommended that television and radio should target men and air the advertisements in between programmes that men watch or listen to, including the news and

sports. In Nigeria, a group suggested putting adverts on *molue* buses (commuter vans), and in all countries they recommended billboards. "*Billboards you pass every day get to your conscience*", said a single man in Zimbabwe.

Interpersonal communication was, however, still considered important for reaching men with messages about female condom use. Participants suggested that using volunteer peer educators (for instance in support groups, communities, beer parlours, offices) is a good way to promote female condoms. Participants said that these peer educators should be well skilled and equipped (with enough female condoms, posters, and possibly pelvic demonstration models for insertion practice) to demonstrate female condom insertion and address all fears related to female condom use.

What is important is that people hear about female condoms everywhere and all the time – then they will start requesting them, believed Nigerian male participants.

Messages

Frequent users advised that to make female condoms accepted by men, female condom use should be well demonstrated and messages should talk about the advantages: that it feels like unprotected sex, and that it is less stressful for the man because he does not have to wear anything. Another suggested promotional message could be to compare female with male condoms, and say for instance that female condoms are more comfortable. However, other participants warned that female and male condoms should not be presented as antagonists, but should be promoted together in the same advert or session.

Participants believed that married men should be targeted with messages of female condoms as a contraceptive (and so dissociate them from HIV and extra-marital sex). They also had the advice that female condoms should be promoted to appeal to ordinary women, so that it would feel normal for them to use them and they would not feel like a prostitute. Thus if the husband suggests female condoms, the wife will not feel offended. All messages should be translated into local languages to reach people who are not conversant in English.

Participants recommended that messages about *why* one should use female condoms are not enough; they should be accompanied by explanations on *how* to use female condoms. Even on television, people should be explained about usage.

Although participants warned that simply using a slogan is not enough for effective promotion (there should be more information and demonstrations), they nonetheless came up with some possibly useful slogans. In Zimbabwe: 'Next to natural', 'The female condom fits all sizes', 'The female condom protects and benefits both partners', 'Use Care, because Care cares for you'. In Cameroon: 'Greater protection', 'Greater sex', 'You are safe with me', 'Female condoms for women and men', 'Operation gender equality', 'Pinch/tear and insert'. In Nigeria: 'Elephant skin, it *no dey* burst' (The female condom is like elephant skin, it never bursts), 'Female bullet proof', 'Female condoms, enjoyment'.

Better role models

Most groups recommended using role models for men in the adverts. Some in Zimbabwe advised using ordinary (community) men and women for the adverts, and not always the same glamorous models. Some suggested using people from support groups, or real female condom users, because as was mentioned, "*they will promote female condoms from the heart, unlike the artist*". Others recommended making sure that young people are also in the adverts, otherwise they may think that female condoms are only for older adults.

Wide availability
Female condoms should be made more widely available. Some (though not the majority) said that they should be available for free, just like male condoms. Others talked about making them available in more public places beyond clinics, for instance shops, beer halls, nightclubs, churches, and workplaces (in both male and female toilets).

Improve size and shape of the female condom
Only in Zimbabwe were there many recommendations regarding the size and shape of female condoms. Participants felt that female condoms would be more acceptable and used if the female condom itself and the package was made smaller and thus more portable. Women said that they should be able to carry a female condom in their bra, and men in their pocket. They also talked about the shape: the appearance should be made more attractive and the shape more convenient. A group of married male frequent users suggested making a wider variety of female condoms, just like with male condoms, where there are different shapes, colours, and flavours. Single users suggested different flavours and a ribbed female condom for more sexual satisfaction. Participants in Nigeria and Cameroon also preferred to have a smaller package for female condoms.

8.2 How women can convince men to use female condoms

Men and women gave their suggestions on how a woman can try to convince a man to use a female condom, and also how it should not be done. The opinion of most participants was that women have to be careful in how they introduce them. As one Nigerian man stated: "*First approach matters most. A woman to bring out the condom and say, 'Oga* [address for a man showing respect] *we use this', then I cannot accept it*". A woman should introduce the female condom in a culturally sensitive way, and tailor it to the character of the man. A married woman may start by talking to her husband when he is in the right mood, saying that they really have to prevent having a mistimed child (maybe just after having a baby), and bring up a discussion about what methods to use. She can talk about the side effects of many methods and say that she has heard from the clinic about a female condom which is very effective and is without side effects. She can then say that she will find out more about it, or ask him to do so. The next time – again when he is in a good mood – she can talk about the advantages of the female condom and explain how it is used. Another approach would be for a woman to talk to her husband and tell him that she has been to a seminar or was in the clinic where female condoms were explained; she can suggest that it might be a good method of family planning for them, and then mention the benefits and use.

Single girls can convince their stable boyfriend in a similar way, but can go further to also talk about their effectiveness for protection against diseases and place more stress on the sexual pleasure and advantages compared to the male condom (this is more relevant to single women, since condoms in general are not used within marriage). A Nigerian single man said: "*She needs to study his mood. When he is happy she should talk to him. Tell about female condoms and that she wants to use it with him and only with him*".

Wives and stable girlfriends can also try to motivate their partner to get information on female condoms from a clinic or other promoter, as a single woman in Nigeria did: "*I was introduced to female condoms by the chemist and I asked him to introduce it to my boyfriend as well because I do not want him to think I'm up to something. After that my boyfriend could accept*".

Casual partners can try to convince the man by first romancing him and talking sweetly. When he is in the right mood for sex she can try to insist that she will use a female condom or not have sex. She can explain about the benefits, especially that it brings sexual pleasure to the man and feels like skin-to-skin sex. She can make jokes about it so that the man becomes curious to use it

and compare it to male condoms. Single men in Cameroon said: "*Some women use drastic methods – like going through the preliminaries and when it is time to start she said it is female condoms or nothing!*"

Sex workers can also stress the effectiveness, sexual pleasure, and feeling of natural sex when trying to convince clients to use female condoms. However, for them it is difficult to insist and they may also accept male condom use. In a Lagos brothel, sex workers explained that male and female condoms are exhibited in the brothel and that there is no option to have sex without a condom. Particularly important with casual partners and sex workers is to open the package in the man's presence and also dispose of the used female condom together.

CHAPTER 9: IMPLICATIONS OF FINDINGS FOR FEMALE CONDOM PROGRAMMES

This chapter summarizes and discusses the study findings and their implications for female condom programmes. Although this was an exploratory study with a small study population in a few locations, by triangulating the findings from the three countries some general conditions can be identified under which men may be more likely to accept female condoms. Based on these, suggestions can be given for possible programme strategies and activities to facilitate acceptance by men. The discussion is based on the 'theory of planned behaviour', as explained in Chapter 2. This theory distinguishes two categories of factors which possibly influence behaviour and behaviour change: personal factors and external factors. The personal and external factors influencing male use (or non-use) of female condoms are summarized in 9.2. The chapter continues with a summary of the recommendations for female condom programmes (9.3). The recommendations are a direct result from the study and are not based on the current policies and practices of female condom programmes in Zimbabwe, Cameroon and Nigeria. The chapter ends with a final note on the involvement of men.

9.1 Summary of findings and their implications for programmes

9.1.1 Knowledge of and attitudes towards female condoms

Personal factors found to influence the acceptability and acceptance of female condoms by men are related to knowledge about what female condoms look like, how they are used, and what the advantages are, and to belief in their positive attributes. Participants reported many perceived advantages of female condoms, but also disadvantages related to effectiveness, use, appearance, sexual feeling, availability, and control. The very positive finding was that nearly all participants were convinced of the superior effectiveness of female condoms for prevention of pregnancy and protection against HIV and STIs in comparison with other contraceptive methods and male condoms. The other main female condom advantages (to men) were that sex with female condoms feels natural, they increase sexual pleasure, female condoms do not constrain the penis, they do not have side effects, they bring variation in condom use, they can be used during menses, they are hygienic, you do not feel if the woman's vagina is 'too wet', and they do not require an erection for use. The main disadvantages were related to the control and possible misuse by women (for example, using the same female condom with multiple sexual partners or harvesting sperm for black magic), difficult insertion which makes men lose their sexual appetite, the 'ugly' appearance, and that they are not widely available and are expensive. Especially with the disadvantages, there were some slight differences between countries, mainly related to rumours about misuse by women (there was no mention of harvesting sperm in Cameroon).

Recommendation
Programmes that aim to increase knowledge of and positive attitudes towards female condoms should stress the advantages and address the disadvantages, tailored to local ideas and appropriate target groups. For instance, in Nigeria the main advantage of the female condom in marriage is considered to be its effectiveness as contraception without side effects. For relationships where condoms are acceptable and used, such as in casual relationships and in HIV positive or discordant couples, female condoms can be promoted as an effective means of protection and as adding variation to one's sex life. In all countries and all groups, female condoms can be promoted as making protected sex next to natural. The fear of misuse by sex workers can be addressed by advising men to ask the woman to open the package, insert the female condom, and dispose of it in his presence.

9.1.2 Male acceptability by types of sexual partners

An important finding was that female condom acceptability and acceptance differ by type of sexual partner. The types of partners men have are influenced by the norms in society, which are part of the external factors. Men generally differentiate between five categories of sexual partners: 1) marital partner; 2) stable extra-marital partner; 3) stable girlfriend (of single men); 4) casual partners; and 5) commercial sex workers; (with categories 2 and 3 combined for the purpose of analysis in this report). Categories of sexual partners were found to differ in terms of duration, exclusivity, stability, trust, power relations, exchange of money or goods for sex, and purpose. With all these partners, men feel and women concur that men have the power to make decisions on contraception and protection; this is according to dominant gender power norms. With all sexual partners, with the exception of the spouse and the most serious stable girlfriend, it is easy for the man to leave her if she disagrees with him or wants something he does not want, for instance regarding condom use. However, women in male dominated societies are not powerless; they have their own, often secret, tactics to get what they want within the dominant gender norms.

Male acceptability of female condoms with different types of partners is related to trust. Female condoms are generally more acceptable in relationships of trust – in marriage as a family planning method only and in other stable relationships for dual protection. Condoms in general are normally not acceptable in marriage because this is a relationship where there should be trust, and condoms are associated with infidelity and extra-marital affairs. Outside marriage and the serious stable relationship, a man barely trusts any type of partner, since he knows that he cannot expect the relationship to be sexually exclusive. Perhaps surprisingly, we found that female condoms are thus less acceptable with less stable partners. Since they put the woman in control, men believe that she may possibly misuse the female condom by using a single one with multiple partners. This is a particular concern if she has inserted one before meeting the man; this may be because either she had no time to insert a new one in between sexual partners (for CSWs), or because she wants to re-use the female condom because they are expensive. There were subtle differences between countries in terms of the acceptability of female condoms with different categories of partner. Female condoms were relatively more acceptable with casual partners in Cameroon compared to the other two countries (however, they were still less acceptable than with spouses for married men or stable partners for single men). Generally, it is not acceptable to men when women initiate female condom use, let alone when they have one already inserted beforehand in anticipation of having sexual intercourse, because this goes against the gender norms where men make decisions and introduce new issues. Men who are knowledgeable about female condoms are slightly more inclined to accept female initiation.

Recommendation
In designing programmes organizations should consider the dominant gender power relations which give more power to men but also leave open some space for female negotiation, and should take into account differences between categories of sexual partners. Female condom programmes should explore the reasons why female condoms are acceptable or not with certain partners and address the objections. Promoting the product merely in terms of women's empowerment may in fact be counterproductive in societies where men have normative decision making power over women. Educating men, or men and women together, and letting men take the lead in introducing female condoms may be more acceptable in societies like Cameroon, Nigeria, and Zimbabwe.

9.1.3 Experience of first time female condom use

Various reasons were given why men do not use and do not want to use female condoms. The two main reasons were lack of knowledge about them (including how they are used and how they would affect sexual pleasure) and lack of availability. Many men do not see female condoms around and so they do not think about using them. Other important reasons for not using them were related to the dominant gender power relations (of not wanting to give control to the female partner), to mistrusting certain types of sexual partners (who are suspected of misusing the female condom), because of the association of female condoms (like male condoms) with casual sex and CSWs, and because of female condoms not being readily available.

Men had four major motivations for using a female condom for the first time. Personal factors were: 1) curiosity about how it would feel sexually (after having heard about this in training or on advertisements); and 2) having an alternative to male condoms (for couples who always use protection, such as HIV positive or discordant couples, but also single men). External factors that made men use a female condom for the first time were: 3) that their sexual partner had convinced them, or insisted; and 4) that a female condom was the only method available at the time and the man was eager for sex.

Recommendation
Programmes can learn from these motivations that it will be effective to promote female condoms with information about sexual pleasure and variation in protected sex. Furthermore, programmes can continue to target women with negotiation skills and female condoms should be made more widely available.

9.1.4 Continued female condom use

Study findings indicate that a first positive experience for men makes frequent female condom use more likely. Men with negative first experiences more often stopped using female condoms. The most mentioned positive first experiences by men were that they felt as if there was nothing there, that it felt like natural and thus pleasurable sex. Men said that what contributed to their positive first experience was the psychology of feeling protected and safe with the female condom, more so than with the male condom which can burst. Male participants' negative first experiences were mostly related to the fact that their partner did not know how to insert the female condom well, which caused pain and unease. Women overall had more negative first experiences than men, though mostly they realized that this was because they had not properly inserted the female condom, which caused them pain and discomfort, even more so when the man entered. However, even after negative first experiences more women continued use because they were motivated by female condoms' effectiveness as dual protection or because their husbands insisted (with husbands often having the final say). Two main factors can be identified which make a positive first experience for men more likely: 1) if men have knowledge about what female condoms look like, how they are inserted, and how to enter the penis they will know what to expect and will feel more at ease the first time; and 2) a first experience is more likely to be positive for men when their partner is an experienced female condom user, or at least when she knows how to insert the female condom well and how to direct the man's penis into it.

Only a few people said that they used only and always female condoms. Rather, the common pattern of female condom use was to alternate them with male condoms, either for sex with different partners or with the same partner depending on the mood and availability of either condom. Most married men used female condoms with their wife, and very few used any other methods. Most single men used them with their stable partners, and often alternated them with male condoms. Female condoms were seldom used with other types of partners where there is

little to no trust in the relationship, because these women are thought to misuse female condoms. Only in Cameroon did men also report using female condoms with casual partners.

The underlying reason for men to become frequent users of female condoms (with their wife or stable girlfriend) is that they like the fact that (protected) sex with female condoms is next to natural, and they derive sexual pleasure from it. Another major reason for frequent use in marriage is that it is considered the best contraceptive, because it is very effective and most importantly it does not have side effects – in Nigeria this was the major reason given by married men. Single men have the additional motivation that they are a very effective protection against STIs and HIV, and that they bring variation to male condom use. This variation motive was also pertinent for HIV positive or discordant couples who always have to engage in protected sex. Many said that female condoms have advantages over male condoms, which made them embrace female condoms: they enable more enjoyable sex, do not have a bad smell, give more protection, do not interrupt foreplay, a man does not need an erection, and the man does not have to dispose of them.

Recommendation
Programmes should be directed to making the first experience more likely to be positive. Female condom promotion to men (as to women) should always be accompanied by a demonstration. Visual mass promotion (on television or posters) should include what a female condom looks like and explain how it is used, for instance using drawings, thus not only talking about the benefits and showing the package. During female condom promotions and demonstrations to women (and men), participants should be invited to practice the skill by opening the package and doing a mock insertion (during fieldwork we saw some good examples of demonstrations, where men were asked to repeat the demonstration given by the promoter). Having pelvic demonstration models makes it easier to practice than only using the hands. Women should be given ample number of free female condoms and be advised to practice insertion before trying with her partner. In promotion it should be explained that female condom insertion and sex with female condoms should not induce pain; if this is the case, the woman should see a doctor.

Although it is good that men like using female condoms with their stable partners, programmes can still address the distrust they have towards other sexual partners, because with these partners they either use male condoms – which, as they reported, regularly burst – or they do not use condoms at all. Especially with more stable casual partners, with whom men spend more time than just for quick sex, they can ask the woman to open the package and insert the female condom in their presence, wait for some time for it to adjust to the shape and temperature of the vagina, and so enjoy next to natural sex.

Programmes should use the local motivations of frequent male users in their promotion campaigns and target messages to different groups

9.1.5 Accessibility and female condom promotion campaigns

Major external factors hindering male (and female) frequent use of female condoms are the scarce availability, high price (relative to male condoms), and cultural inaccessibility (shame for some groups to buy (female) condoms). Some participants in the FGDs did not necessarily have these experiences personally, but were referring to other people. Peer programmes were considered an effective and culturally sensitive way to provide education about female condoms and distribution.

Participants had useful suggestions for female condom promotion campaigns. Their main recommendations were: 1) to intensify female condom promotion, in mass media, on billboards, and through interpersonal communication; 2) that men should also be targeted and campaigns should look for the best places to reach out to them; 3) that campaigns should explain *how* female condoms are used, not only *why* they should be used; 4) to make female condoms more widely available; 5) to ensure that male and female condoms are not treated as in opposition, but are promoted together; and 6) that people shown in the advertisements and on billboards should be varied and should include those who look more 'normal' (from the community), instead of only celebrities or models.

Recommendation
Programmes should continue to increase sales points for female condoms and look into whether they can be even more subsidized. They can intensify education and distribution through peer programmes. The participants' recommendation that male and female condoms should not be treated as opposing should be taken seriously by programmes, so as not to run the risk that male condom users shift to female condoms and so total condom use remains unchanged. Only when total condom use increases will a reduction in HIV prevalence and the number of unintended pregnancies take place.

9.1.7 Female condom negotiation skills for women

Participants gave suggestions on how a woman could try to strategically introduce female condoms to a man and make him accept using them. The first thing is that in a stable relationship she cannot just bluntly say that she wants to use them; rather, she has to carefully plan her strategy. She should introduce them when he is (or when she has put him) in a good mood, explain well where she got the information from, stress the advantages, make it sound exiting to use female condoms, and let him feel that he made the final decision. Single women in particular can promote them by also stressing the sexual pleasure for the man.

Recommendation
Programmes should continue to teach negotiation skills to women and make them culturally relevant.

9.2 Summary of factors influencing female condom acceptance

From the above we can extract several (inter-related) personal and external factors which influence acceptability and acceptance of female condoms by men in Cameroon, Nigeria, and Zimbabwe. Men will be more likely to become (more) frequent users of female condoms with the following personal factors:

- Knowledge about female condoms – knowing the advantages, how they are used;
- Belief in the effectiveness of female condoms for family planning and STI and HIV protection;
- Having the skills to use female condoms;
- Having a positive first experience of use of female condoms;
- Feeling the need for family planning and/or protection, depending on the type of sexual partner (related to risk perception of unwanted pregnancy and/or STIs and HIV); in Nigeria there was a felt need for a contraceptive without side effects;
- Liking sex with female condoms – feeling sexual pleasure, next to natural, free (and protected);
- Having money to buy female condoms;
- Knowing where to buy female condoms.

These personal factors are influenced by the following external factors:

- Dominant gender power relations – that give decision making power to men, and give women tactics to convince men;
- Norms about contraception and protection use – in marriage there is no need for protection, only prevention; any contraception with side effects is suspected of influencing fertility;
- HIV/AIDS prevalence – with a higher prevalence, the risk perception of contracting HIV will be higher;
- Easy accessibility to female condoms (affordable, available);
- Sexual partners agreeing / convincing / insisting;
- Influence of peers / role models.

9.3 Summary of recommendations

The following is a summary of the recommendations on how to make female condoms more acceptable to and accepted by men. This summary is directed at organizations with female condom programmes. This report presents general recommendations for female condom programmes in the three African countries where the study took place, but most of the recommendations will be applicable to programmes in other countries with similar gender power relations and patterns of sexual relationships. More detailed country reports have been written, which include more case studies and country specific recommendations.[55]

The conclusion of the study is that female condom programmes should consider men as an opportunity in increasing female condom uptake, because most of them like sex with a female condom and believe in their effectiveness as a contraceptive and in protection against STIs and HIV. To make female condoms more accepted by men and to increase usage, personal as well as external factors influencing acceptance and use should be considered, including local dominant gender power relations in different sexual relationships. Following are the main recommendations for female condom programmes.

- Do not only promote female condoms as a product for women's empowerment in contexts where decision making power is with men, because a woman needs the cooperation and often approval of the male partner to use female condoms. Giving men a role in introducing the female condom may be more acceptable in some societies, like those of the present study. Programmes should also educate men on female condoms, or men and women together.
- Target men with interpersonal communication in places they frequent, such as motor parks, bars, and clubs. In messages to men, stress the advantages and address the disadvantages of female condoms, and tailor the messages to local ideas and appropriate target groups (single men, married men, young men). In promotion to men, peer educators should stress that with female condoms it feels like natural sex, and thus there is sexual pleasure, and that female condoms offer variation in protected sex. To married men they can promote them as an effective family planning method without side effects. They should address the local reasons why men do not (want) to use female condoms.
- Female condom promotion to men (as to women) should always be accompanied by a demonstration. During female condom promotions and demonstrations to men (and women), participants should be invited to practice the skill by opening the package and doing mock insertions, by using either the hands or a pelvic demonstration model.

[55] These country specific reports can be obtained from the UAFC website.

- Prepare ‘female condom starter packs’ to give out during demonstrations with some five female condoms, information about insertion, when to consult a health professional (because of pain during insertion or use), and about where female condoms can be bought and for what price.
- Visual mass promotion (on television or posters) should include what a female condom looks like and how it is used (possibly using drawings) – thus not only talking about the benefits and showing the package.
- Increase sales points for female condoms, making them available day and night in some outlets, and look into whether female condoms can be even more subsidized in order to increase availability and affordability.
- Try to develop a smaller package for female condoms.
- Do not put male and female condoms forward as an either-or choice, but promote them together, both for men *and* women (currently the male condom is seen as a men’s issue and the female condom as a women’s issue).
- In peer education to different groups of women (single, married, youth) female condom negotiation skills should be taught – adjusted to local gender power relations in different types of sexual relationships. Women should be advised to practice insertion before trying with their partner, to make his first experience with the female condom more likely to be positive.

Final note

We want to end this report with an answer to the question which was the rationale for this study: *What is the role of men in the acceptance and use of female condoms in Nigeria, Cameroon, and Zimbabwe?* The majority of FGD participants thought that men would be a problem when it comes to spreading the use of female condoms in the countries studied, if female condom programmes only or mainly target women. However, with the presence of facilitating external factors, including wide availability of affordable female condoms, and if promotion takes into account the dominant gender power norms within different sexual relationships, men may accept female condoms if they are targeted in promotion campaigns and are given the knowledge and skills to use them. The fact that female condoms are not as associated with HIV/STIs and extra-marital sex as male condoms, but rather more with family planning, is a facilitating factor for female condom use in marriage. Personal factors such as positive sexual experiences with female condoms and the conviction of their effectiveness for pregnancy prevention without side effects and protection against STIs and HIV will facilitate female condom acceptance by men. Thus, if programmes consider the personal and external factors influencing male acceptance in their campaigns, and also target men specifically, men will not be a problem in spreading female condom use and may even be an opportunity.

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Annex 1: Supporting Tables

Table A1: Number and type of focus group discussions by country (actual figures, is not equal to what was planned)

Group	Zimbabwe					Cameroon					Nigeria				
	Males		Females		Total	Males		Females		Total	Males		Females		Total
	Single	Married	Single	Married		Single	Married	Single	Married		Single	Married	Single	Married	
Frequent FC users	5	3	2	1	11	4	3	4	2	13	3	3	1	2	9
Used FC one/two times	1	2	-	-	3	1	2	-	-	3	2	1	-	-	3
Know FC but never used it	2	1	1	-	4	1	1	1	-	3	1	1	-	1	4
Total	*8*	*6*	*3*	*1*	*18*	*6*	*6*	*5*	*2*	*19*	*6*	*5*	*1*	*3*	*15*

Table A2: FGD participants – type of female condom user, by sex, country, and marital status

A. Males

Type of FC user	Single						Married						Total (single & married)					
	Zimbabwe		Cameroon		Nigeria		Zimbabwe		Cameroon		Nigeria		Zimbabwe		Cameroon		Nigeria	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Frequent FC users	43	61	34	55	35	56	18	39	23	48	27	53	18	53	57	52	62	54
Used FC one/two times	15	21	16	26	14	22	16	35	14	29	16	31	16	27	30	27	30	26
Know FC but never used it	11	16	11	18	14	22	10	22	11	23	8	16	10	18	22	20	22	19
No information	1	1	1	2	-	-	2	4	-	-	-	-	2	3	1	1	-	-
Total	*70*	*100*	*62*	*100*	*63*	*100*	*46*	*100*	*48*	*100*	*51*	*100*	*116*	*100*	*110*	*100*	*114*	*100*

B. Females

Type of FC user	Single						Married						Total (single & married)					
	Zimbabwe		Cameroon		Nigeria		Zimbabwe		Cameroon		Nigeria		Zimbabwe		Cameroon		Nigeria	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Frequent FC users	13	57	26	68	9	75	11	73	15	65	19	70	24	63	41	67	28	72
Used FC one/two times	5	22	4	11	-	-	3	20	8	35	-	-	8	21	12	20	-	-
Know FC but never used it	5	22	8	21	3	25	1	7	-	-	8	30	6	16	8	13	11	28
No information	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	*23*	*100*	*38*	*100*	*12*	*100*	*15*	*100*	*23*	*100*	*27*	*100*	*38*	*100*	*61*	*100*	*39*	*100*

C. Total (males & females)

Type of FC user	Single						Married						Total (single & married)					
	Zimbabwe		Cameroon		Nigeria		Zimbabwe		Cameroon		Nigeria		Zimbabwe		Cameroon		Nigeria	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Frequent FC users	56	60	60	60	44	59	29	48	38	54	46	59	85	55	98	57	90	59
Used FC one/two times	20	22	20	20	14	19	19	31	22	31	16	21	39	25	42	25	30	20
Know FC but never used it	16	17	19	19	17	23	11	18	11	15	16	21	27	18	30	18	33	22
No information	1	1	1	1	-	-	2	3	-	-	-	-	3	2	1	1	-	-
Total	*93*	*100*	*100*	*100*	*75*	*100*	*61*	*100*	*71*	*100*	*78*	*100*	*154*	*100*	*171*	*100*	*153*	*100*

Table A3: Socio-Demographic information of FGD participants, by sex and country

	% Males			% Females			Total % (males & females)		
A. Marital status (%)	**Zimbabwe (N=116)**	**Cameroon (N=110)**	**Nigeria (N=114)**	**Zimbabwe (N=38)**	**Cameroon (N=61)**	**Nigeria (N=39)**	**Zimbabwe (N=154)**	**Cameroon (N=171)**	**Nigeria (N=153)**
Married	40	44	45	39	38	69	40	42	51
Single	7	8	14	29	26	21	12	15	16
Single – stable relationship	51	48	41	24	26	5	44	40	32
Single – widowed/divorced/separated	3	-	-	8	10	5	4	4	1
No information	-	-	-	-	-	-	-	-	-
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
B. Age groups (%)	**Zimbabwe (N=116)**	**Cameroon (N=110)**	**Nigeria (N=114)**	**Zimbabwe (N=38)**	**Cameroon (N=61)**	**Nigeria (N=39)**	**Zimbabwe (N=154)**	**Cameroon (N=171)**	**Nigeria (N=153)**
<20	1	1	1	-	7	7	1	3	1
20-29	24	59	52	21	54	21	23	57	44
30-39	32	25	32	34	33	41	32	27	35
40-49	32	11	7	29	7	21	31	9	10
50-59	9	2	4	13	7	13	10	1	7
>60	1	-	1	3	-	-	1	-	1
No information	2	3	3	-	-	5	1	2	3
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Average age (in years)	*36.7*	*29.4*	*30.4*	*38.8*	*32.5*	*36.6*	*37.2*	*29.1*	*31.9*
C. Education level (%)	**Zimbabwe (N=116)**	**Cameroon (N=110)**	**Nigeria (N=114)**	**Zimbabwe (N=38)**	**Cameroon (N=61)**	**Nigeria (N=39)**	**Zimbabwe (N=154)**	**Cameroon (N=171)**	**Nigeria (N=153)**
No education	1	-	-	-	-	8	1	-	2
Primary School	7	4	8	26	7	15	12	5	10
Secondary School	84	35	53	66	51	51	80	40	52
University / Tertiary	3	54	39	5	39	21	3	49	35
Other	3	5	-	-	3	-	2	5	-
No information	3	3	-	3	-	5	3	2	1
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
D. Occupation (%)	**Zimbabwe (N=116)**	**Cameroon (N=110)**	**Nigeria (N=114)**	**Zimbabwe (N=38)**	**Cameroon (N=61)**	**Nigeria (N=39)**	**Zimbabwe (N=154)**	**Cameroon (N=171)**	**Nigeria (N=153)**
No job / housewife / student	33	39	18	16	43	10	29	40	16
Self-employed	14	27	44	-	10	62	10	21	48
Peer-educator / community worker	3	3	1	29	13	3	10	6	1
Barber / hairdresser	9	-	5	13	5	3	10	2	5
Sex worker	-	-	-	26	16	-	6	6	-
Other / formal employment	34	27	29	13	13	21	29	22	27
No Information	6	4	3	3	-	3	5	2	3
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Table A4: Number of sexual partners in the last year, by sex and marital status (%)

	% Single			% Married			Total % (single & married)		
A: Males	**Zimbabwe (N=70)**	**Cameroon (N=62)**	**Nigeria (N=63)**	**Zimbabwe (N=46)**	**Cameroon (N=48)**	**Nigeria (N=51)**	**Zimbabwe (N=116)**	**Cameroon (N=110)**	**Nigeria (N=114)**
1 sexual partner	53	58	49	54	42	43	53	51	46
2 sexual partners	41	37	33	39	35	53	41	36	42
3 sexual partners or more	1	3	16	4	19	4	3	10	11
No sexual partner	4	2	2	-	-	-	3	1	1
No information	-	-	-	2	4	-	1	2	-
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
B: Females	**Zimbabwe (N=13)**	**Cameroon (N=38)**	**Nigeria (N=12)**	**Zimbabwe (N=15)**	**Cameroon (N=23)**	**Nigeria (N=27)**	**Zimbabwe (N=28)**	**Cameroon (N=61)**	**Nigeria (N=39)**
1 sexual partner	100	84	67	100	83	93	100	84	85
2 sexual partners	-	13	17	-	17	4	-	15	8
3 sexual partners or more	-	-	-	-	-	-	-	-	-
No sexual partner	-	-	17	-	-	-	-	-	5
No information	-	3	-	-	-	4	-	2	3
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Table A5: Type of sexual partner in the last year, by sex and marital status

A: Males									
Sexual partners	**% Single**			**% Married**			**Total % (single & married)**		
	Zimbabwe (N=70)	**Cameroon (N=62)**	**Nigeria (N=63)**	**Zimbabwe (N=46)**	**Cameroon (N=48)**	**Nigeria (N=51)**	**Zimbabwe (N=116)**	**Cameroon (N=110)**	**Nigeria (N=114)**
Spouse / spouses	14	-	-	98	90	100	47	39	45
Stable partner	77	94	81	9	33	29	50	67	58
Casual partner	30	45	63	30	42	27	30	44	47
Sex worker	19	3	19	9	6	4	15	5	12
No sexual partner	4	-	2	-	-	-	-	-	1
No information	-	2	-	2	-	-	3	1	-
B: Females									
Sexual partners	**% Single**			**% Married**			**Total % (single & married)**		
	Zimbabwe (N=13)	**Cameroon (N=38)**	**Nigeria (N=12)**	**Zimbabwe (N=15)**	**Cameroon (N=23)**	**Nigeria (N=27)**	**Zimbabwe (N=28)**	**Cameroon (N=61)**	**Nigeria (N=39)**
Spouse / spouses	13	3	8	100	87	89	47	34	64
Stable partner	39	63	42	-	17	7	24	46	18
Casual partner	48	21	50	-	9	4	29	16	18
Sex worker	-	-	-	-	-	-	-	-	-
No sexual partner	-	24	17	-	4	-	-	16	5
No information	-	-	-	-	-	4	-	-	3

Table A6: Reasons for not using female condoms (frequencies, multiple answers possible)

	# Single			# Married			Total # (single & married)		
A: Males	**Zimbabwe (N=11)**	**Cameroon (N=11)**	**Nigeria (N=14)**	**Zimbabwe (N=10)**	**Cameroon (N=11)**	**Nigeria (N=8)**	**Zimbabwe (N=21)**	**Cameroon (N=22)**	**Nigeria (N=22)**
Uses other method	-	-	-	-	1	4	-	1	4
Never seen it, but knows it	-	1	4	-	-	-	-	1	4
Do not know where to get it	-	1	2	-	1	1	-	2	3
Didn't know it existed	-	-	1	-	1	1	-	1	2
Prefers other method	6	-	-	3	-	-	9	-	-
Partner does not want to use it	5	-	-	2	-	-	7	-	-
Does not know how to use it	-	6	1	2	2	1	2	8	2
Partner does not know how to use it	-	-	-	-	-	-	-	-	-
Not available	-	-	-	1	-	-	1	-	-
No sexual pleasure	-	-	-	1	-	-	1	-	-
Not interested	-	1	1	1	-	-	1	1	1
Too expensive	-	-	-	-	-	-	-	-	-
Looks odd	-	2	-	-	-	-	-	2	-
Other	-	2	3	-	5	1	-	7	4
No information	-	-	1	-	2	-	-	-	1
Panel B: Females	**Zimbabwe (N=5)**	**Cameroon (N=8)**	**Nigeria (N=3)**	**Zimbabwe (N=1)**	**Cameroon (N=0)**	**Nigeria (N=8)**	**Zimbabwe (N=6)**	**Cameroon (N=8)**	**Nigeria (N=11)**
Uses other method	-	-	-	-	-	2	-	-	2
Never seen it, but knows it	-	-	1	-	-	-	-	-	1
Do not know where to get it	-	-	-	-	-	1	-	-	1
Didn't know it existed	-	-	1	-	-	-	-	-	1
Prefers other method	1	-	-	1	-	-	2	-	-
Partner does not want to use it	3	-	-	-	-	3	3	-	3
Does not know how to use it	-	1	-	-	-	-	-	1	-
Partner does not know how to use it	-	-	-	-	-	-	-	-	-
Not available	-	-	-	-	-	-	-	-	-
No sexual pleasure	-	-	-	-	-	-	-	-	-
Not interested	-	3	-	-	-	1	-	3	1
Too expensive	1	-	-	-	-	-	1	-	-
Looks odd	-	1	-	-	-	-	-	1	-
Other	-	-	-	-	-	-	-	-	-
No information	-	4	-	-	-	-	-	4	-

Table A7: Non-users about their future female condom use (frequencies)

	# Single			# Married			Total # (single & married)		
A: Males	**Zimbabwe (N=11)**	**Cameroon (N=11)**	**Nigeria (N=14)**	**Zimbabwe (N=10)**	**Cameroon (N=11)**	**Nigeria (N=8)**	**Zimbabwe (N=21)**	**Cameroon (N=22)**	**Nigeria (N=22)**
Yes	9	8	13	10	9	8	19	17	21
No	2	2	1	-	-	-	2	2	1
No information	-	1	-	-	2	-	-	3	-
B: Females	**Zimbabwe (N=5)**	**Cameroon (N=8)**	**Nigeria (N=3)**	**Zimbabwe (N=1)**	**Cameroon (N=0)**	**Nigeria (N=8)**	**Zimbabwe (N=6)**	**Cameroon (N=8)**	**Nigeria (N=11)**
Yes	3	2	3	1	-	8	4	2	11
No	2	6	-	-	-	-	2	6	-
No information	-	-	-	-	-	-	-	-	-
C: Total (males and females)	**Zimbabwe (N=16)**	**Cameroon (N=19)**	**Nigeria (N=17)**	**Zimbabwe (N=11)**	**Cameroon (N=11)**	**Nigeria (N=16)**	**Zimbabwe (N=27)**	**Cameroon (N=30)**	**Nigeria (N=33)**
Yes	12	14	16	11	9	16	23	23	32
No	4	4	1	-	-	-	4	4	1
No information	-	1	-	-	2	-	-	3	-

Table A8: Frequency of female condom use, by sex and marital status

A. Males

Type of FC user	Single						Married						Total					
	Zimbabwe (N=59)		Cameroon (N=51)		Nigeria (N=49)		Zimbabwe (N=35)		Cameroon (N=37)		Nigeria (N=43)		Zimbabwe (N=94)		Cameroon (N=88)		Nigeria (N=92)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Once or twice	12	20	16	31	11	22	11	31	9	24	11	26	23	24	25	28	22	24
3-10 times	22	37	19	37	21	43	15	43	17	46	13	30	37	39	36	41	34	37
>10 times	24	41	16	31	17	33	9	26	11	30	19	44	33	35	27	31	36	39
Missing	1	2	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-
Total	*59*	*100*	*51*	*100*	*49*	*100*	*35*	*100*	*37*	*100*	*43*	*100*	*94*	*100*	*88*	*100*	*92*	*100*

B. Females

Type of FC user	Single						Married						Total					
	Zimbabwe (N=18)		Cameroon (N=30)		Nigeria (N=9)		Zimbabwe (N=14)		Cameroon (N=23)		Nigeria (N=19)		Zimbabwe (N=32)		Cameroon (N=53)		Nigeria (N=28)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Once or twice	2	11	2	7	-	-	3	21	5	22	-	-	5	16	7	13	-	-
3-10 times	5	28	15	50	1	11	2	14	7	30	4	21	7	22	22	42	5	18
>10 times	11	61	13	43	8	89	9	64	11	48	15	79	20	63	24	45	23	82
Missing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	*18*	*100*	*30*	*100*	*9*	*100*	*14*	*100*	*23*	*100*	*19*	*100*	*32*	*100*	*53*	*100*	*28*	*100*

C. Total (males and females)

Type of FC user	Single						Married						Total					
	Zimbabwe (N=77)		Cameroon (N=81)		Nigeria (N=58)		Zimbabwe (N=49)		Cameroon (N=60)		Nigeria (N=62)		Zimbabwe (N=126)		Cameroon (N=141)		Nigeria (N=120)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Once or twice	14	18	18	22	11	19	14	29	14	23	11	18	28	22	32	23	22	18
3-10 times	27	35	34	42	22	38	17	35	24	40	17	27	44	35	58	41	39	33
>10 times	35	45	29	36	25	43	18	37	22	37	34	55	53	42	51	36	59	49
Missing	1	1	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-
Total	*77*	*100*	*81*	*100*	*58*	*100*	*49*	*100*	*60*	*100*	*62*	*100*	*126*	*100*	*141*	*100*	*120*	*100*

Table A9: First time female condom use with type of sexual partner, by sex and marital status

	% Single			% Married		
A: Males	**Zimbabwe (N=n/a)**	**Cameroon (N=51)**	**Nigeria (N=49)**	**Zimbabwe (N=n/a)**	**Cameroon (N=37)**	**Nigeria (N=43)**
Spouse	-	-	-	-	68	74
Stable sexual partner	-	84	61	-	5	14
Casual partner	-	14	24	-	24	5
Sex worker	-	-	-	-	3	-
Client	-	-	-	-	-	-
No information	-	2	14	-	-	7
Total	-	*100*	*100*	-	*100*	*100*
B: Females	**Zimbabwe (N=n/a)**	**Cameroon (N=30)**	**Nigeria (N=9)**	**Zimbabwe (N=n/a)**	**Cameroon (N=23)**	**Nigeria (N=19)**
Spouse	-	7	11	-	83	89
Stable sexual partner	-	57	67	-	9	11
Casual partner	-	13	22	-	4	-
Sex worker	-	-	-	-	-	-
Client	-	23	-	-	4	-
No information	-	-	-	-	-	-
Total	-	*100*	*100*	-	*100*	*100*
C: Total (males and females)	**Zimbabwe (N=n/a)**	**Cameroon (N=81)**	**Nigeria (N=58)**	**Zimbabwe (N=n/a)**	**Cameroon (N=60)**	**Nigeria (N=62)**
Spouse	-	2	2	-	73	79
Stable sexual partner	-	74	62	-	7	13
Casual partner	-	14	24	-	17	3
Sex worker	-	-	-	-	2	-
Client	-	9	-	-	2	-
No information	-	1	12	-	-	5
Total	-	*100*	*100*	-	*100*	*100*

Table A10: Participants who stopped using after number of times used, by sex and marital status (#)

	# Single			# Married			Total # (single & married)		
A: Males	**Zimbabwe (N=13)**	**Cameroon (N=7)**	**Nigeria (N=13)**	**Zimbabwe (N=12)**	**Cameroon (N=10)**	**Nigeria (N=16)**	**Zimbabwe (N=25)**	**Cameroon (N=17)**	**Nigeria (N=29)**
Once or twice	8	7	9	7	5	10	15	12	19
3-10 times	3	-	3	5	5	5	8	5	8
>10 times	2	-	1	-	-	1	2	-	2
B: Females	**Zimbabwe (N=4)**	**Cameroon (N=3)**	**Nigeria (N=1)**	**Zimbabwe (N=2)**	**Cameroon (N=7)**	**Nigeria (N=1)**	**Zimbabwe (N=6)**	**Cameroon (N=10)**	**Nigeria (N=2)**
Once or twice	1	-	-	2	4	-	3	4	-
3-10 times	3	2	-	-	3	-	3	5	-
>10 times	-	1	1	-	-	1	-	1	2
C: Total (males & females)	**Zimbabwe (N=17)**	**Cameroon (N=10)**	**Nigeria (N=14)**	**Zimbabwe (N=14)**	**Cameroon (N=17)**	**Nigeria (N=17)**	**Zimbabwe (N=31)**	**Cameroon (N=27)**	**Nigeria (N=21)**
Once or twice	9	7	9	9	9	10	18	16	19
3-10 times	6	2	3	5	8	5	11	10	8
>10 times	2	1	2	-	-	2	2	1	4

Table A11: Participants who stopped, reasons for stopping use, by sex and marital status

	# Single			# Married		
A: Males	**Zimbabwe (N=13)**	**Cameroon (N=7)**	**Nigeria (N=13)**	**Zimbabwe (N=12)**	**Cameroon (N=10)**	**Nigeria (N=16)**
No partner at the moment	3	-	2	-	-	1
Partner refuses to use it	1	-	1	2	2	3
Too cumbersome to use	-	1	2	1	3	2
Do not trust partner / wants control	3	-	-	-	-	-
Not available	2	-	1	-	-	3
Does not know how to use it	-	1	-	2	2	-
Trust in partner: no need for protection	-	-	-	2	-	-
Prefer other methods	1	1	2	-	1	1
Not accessible	-	-	-	1	-	-
No sexual pleasure	1	-	1	-	-	3
Wants children	-	-	1	1	-	1
Not comfortable using it	-	2	-	-	1	1
Other, not specified	1	1	-	2	-	1
Missing	1	1	3	1	-	-
B: Females	**Zimbabwe (N=4)**	**Cameroon (N=3)**	**Nigeria (N=1)**	**Zimbabwe (N=2)**	**Cameroon (N=7)**	**Nigeria (N=1)**
No partner at the moment	2	1	1	-	1	1
Partner refuses to use it	-	-	-	-	3	-
Too cumbersome to use	2	-	-	1	1	-
Do not trust partner / wants control	-	-	-	-	-	-
Not available	-	1	-	-	1	-
Does not know how to use it	-	-	-	1	-	-
Trust in partner: no need for protection	-	-	-	-	-	-
Prefer other methods	-	1	-	-	1	-
Not accessible	-	-	-	-	-	-
No sexual pleasure	-	1	-	-	-	-
Wants children	-	-	-	-	1	-
Not comfortable using it	-	-	-	-	-	-
Other, not specified	-	-	-	-	-	-
Missing	-	-	-	-	-	-
C: Total (males & females)	**Zimbabwe (N=17)**	**Cameroon (N=10)**	**Nigeria (N=14)**	**Zimbabwe (N=14)**	**Cameroon (N=17)**	**Nigeria (N=17)**
No partner at the moment	5	1	3	-	1	2
Partner refuses to use it	1	-	1	3	5	3
Too cumbersome to use	2	1	2	1	4	2
Do not trust partner / wants control	3	-	-	-	-	-
Not available	2	-	1	-	-	3
Does not know how to use it	-	1	-	2	2	-
Trust in partner: no need for protection	-	-	-	2	-	-
Prefer other methods	1	2	2	1	2	1
Not accessible	-	-	-	1	-	-
No sexual pleasure	1	1	1	-	-	3
Wants children	-	-	1	1	-	1
Not comfortable using it	-	2	-	-	-	1
Other, not specified	1	1	-	2	-	1
Missing	1	1	3	1	-	-

Table A12: Current use of female condoms with type of sexual partner, by sex and marital status (multiple answers)

	% Single			% Married		
A. Males	**Zimbabwe (N=40)**	**Cameroon (N=34)**	**Nigeria (N=36)**	**Zimbabwe (N=18)**	**Cameroon (N=23)**	**Nigeria (N=27)**
Spouse	10	-	-	89	96	96
Stable sexual partner	88	91	82	-	9	27
Casual partner	13	35	68	11	22	27
Sex worker	8	3	18	6	4	-
No information	-	-	-	-	-	-
B. Females	**Zimbabwe (N=13)**	**Cameroon (N=26)**	**Nigeria (N=8)**	**Zimbabwe (N=11)**	**Cameroon (N=15)**	**Nigeria (N=18)**
Spouse	-	4	-	100	93	89
Stable sexual partner	46	54	75	-	13	11
Casual partner	62	27	38	-	7	6
Sex worker	-	-	-	-	-	-
No information	-	27	-	-	-	-
C. Total (males & females)	**Zimbabwe (N=53)**	**Cameroon (N=60)**	**Nigeria (N=44)**	**Zimbabwe (N=29)**	**Cameroon (N=38)**	**Nigeria (N=45)**
Spouse	8	2	-	93	95	93
Stable sexual partner	77	75	81	-	11	20
Casual partner	25	32	62	7	16	18
Sex worker	6	2	14	3	3	-
No information	-	12	-	-	-	-

Note: Includes only frequent users and excludes users who stopped using
Note: Multiple answers possible, hence percentages do not add up to 100%

Annex 2: Data collection tools

A2.1: Focus Group Discussion Topic Guides

(Slightly different for each country – presented is the Nigeria guide)

Part 1: Introduction

Introduce people present / research team

We are representatives from SFH and a researcher from the Netherlands who were asked to conduct this study. Some organizations, like SFH and government intend to make female condoms wider available besides the male condom as dual protection against unwanted pregnancy and sexually transmitted infections and HIV which are all health problems in Nigeria.

You are in the FGD because you know about female condoms and are a frequent user. With this study we want to explore the acceptability and acceptance of female condoms among men. We like to discuss with you your opinions on the female condom.[56]

Also we would like to have your views on whether and how you think female condoms could be made more acceptable and accepted in Nigeria.

There are no right and wrong answers in this discussion. Everyone's opinion, views and experiences are valuable to us. So please, feel free to contribute to the discussion. As a rule we will keep a central discussion and let a person finish his talking before the next person contributes. We will also respect other people's views.

We like to ask your permission to audio record this discussion, to be better able to grasp all your contributions in the report. Be assured that we will keep your names private and there will be no referral to your names. However, if you like to you can give your name and you will be acknowledged in the report. This report will be presented to government and the organizations working on female condoms. It will inform them how they can improve their operations.

Introduce informed consent form
Introduce questionnaire

Part 2: General questions

1. ***Ice breaker:*** **Advantages and disadvantages of female and male condoms**
   [*Fill a spread sheet – for all to see]*
   Probe: sexual pleasure of man/woman; effectiveness; side effects; male/female controlled; price; availability; association with modernity/style; appearance)

2. **Categories of sexual partners men in Nigeria have – (GENERAL, NOT ONLY PARTICIPANTS)**
   Probe: Specific names for the categories

3. **Effectiveness of female condoms**
   1. For prevention of unwanted pregnancy
   2. For protection against diseases

   Probe: For comparison with other methods, and male condoms

4. **Acceptability of female condoms by type of sexual relationship (GENERAL, NOT ONLY PARTICIPANTS)**
   Probe: For all categories of Question 2

5. **Talking with others about female condoms (PARTICIPANTS' PERSONAL EXPERIENCE)**
   - With whom?
   - About what?

   Probe: Give advice on how to use female condoms?

6. **Acceptability of a woman initiating female condoms (GENERAL, FOR MEN IN NIGERIA)**
   A. How would a man reacts when**:**

[56] Each topic guide was adjusted to the participants. Hence, the introduction for males and females differed as did the introduction of users and non-users. At this point in the introduction we adjusted it to users by saying: *Because you have experience with using it, you are the right persons to share with us what men like about it and not like about it; and why and when a man would use it or not.* And we adjusted it to women thus: *We like to discuss with you your opinions on the female condom as it relates to men.*

- A woman asks a man to use a female condom (by type of partner)
- A woman has already inserted a female condom (by type of partner)

B. How can a woman convince a man to use female condom / control female condom use? (by type of partner)

C. From other research: women say that men are the problem in using female condoms, and say that men do not allow them and do not want women to use female condoms: Do you agree, disagree, explain.

Probe: decision making (power, economic, gender relations)

7. Three A's for female condoms (GENERAL)

- Availability: **probe**: always available, places?
- Accessibility: **probe**: to certain groups, ages, shame to ask?
- Affordability: **probe**: price, price at different places
- Who normally buys female condoms **(PARTICIPANT EXPERIENCE)**
- How easy is it FOR YOU to get female condoms? **Probe:** where, price **(PARTICIPANT EXPERIENCE)**

8. Female condom programmes

- What are current programmes / messages on female condoms? **Probe**: target groups? Also men?
- Opinions of current communication campaigns about female condoms
- Suggestions how organizations or government can promote female condoms among men:
  Probe: Channels, messages, target groups
- Can you think of a slogan to make men accept female condoms more?

Part 3: Questions to specific type of user

A) Frequent users

- **Reason for first female condom use (PARTICIPANT PERSONAL EXPERIENCE)**
  What made YOU use a female condom for the first time?
  Probe: curiosity, partner asked, peer influence, modernity, education programme

- **Experience first time female condom use (PARTICIPANT PERSONAL EXPERIENCE)**
  Indicate by raising your hand whether first time use was mainly positive or negative?
  Probe: (to each group) what was positive, what was negative about female condom first use experience?

- **Frequent use of female condoms –(PARTICIPANT PERSONAL EXPERIENCE)**
  - How did you become frequent users? (Many couples stop using female condoms after once or twice use)
  - What and who can motivate men to use female condoms more often? (Probe for differences by type of partners)

- **Patterns of frequent female condom use (PARTICIPANT PERSONAL EXPERIENCE)**
  - Frequency (always, sometimes)
  - With certain partners
  - With other contraceptive and protection methods
  - Why this pattern?

B) One/two time users

- **Reason for first female condom use (PARTICIPANT PERSONAL EXPERIENCE)**
  What made YOU use female condoms for the first time?
  Probe: curiosity, partner asked, peer influence, modernity, education programme

- **Experience first time female condom use (PARTICIPANT PERSONAL EXPERIENCE)**
  Indicate by raising your hand whether first time use was mainly positive or negative?
  Probe: (to each group) what was positive, what was negative about female condom first use experience?

- **Stopping female condom use**
  Why do some men / did you stop using after using female condoms once/twice?
  Probe: other methods preferred? why?

C) Non-Users

- **Reasons why men do not use female condoms**
- **Reasons why a man may *try* using female condoms**
  Probe: curiosity, partner asks, peer influence, modernity, education programme

A2.2 Pre-FGD Questionnaire

Type of Discussion group: Male / Female; Single / Married Regular / One time / Non-users
Date: **Location:** **Interviewer:**

1. Sex	a. Male b. Female		
2. Marital Status	a. Married b. Single	c. Single - Widowed d. Single - Divorced	e. Single - Stable relationship f. Other:…
3. Age	……Years		
4. Education level / status:	a. No school b. Primary	c. secondary d. university / tertiary education	e. Other …….
5. Present job:	a. Formal employment, describe:…… b. Volunteer, self-employed, describe…… c. No Job / full time housewife / Student		
6. Last year, who were your sexual partners in the last year? **(you can circle more than one option)**	a. My spouse (the one man/woman you are married to) b. My spouses (married to more than one wife) c. My stable sexual partner (single, or married extra marital relationship) d. Casual partner(s) (boy friend / girlfriend) e. Sex worker f. No sexual relationships past year		
7. Last year, what methods to prevent pregnancy / protect against STIs have you (your sexual partner) used in the LAST YEAR? **(you can circle more than one option)**	a. Contraceptive pill b. Injectables c. IUCD d. Withdrawal e. Male condom f. Female condom	g. Emergency contraception h. Diaphragm i. Breast feeding post partum j. Abstinence k. Rhythm / Calendar / Safety	l. No method m. Other:
8. *If male condom:* Please indicate the frequency: whether this is *Note: b and d can happen at the same time*	a. Always when you have sex with any partner, b. Always with certain sexual partner: (indicate partner) spouse / stable sexual partner / casual partner / sex worker c. Sometimes independent of partner d. Sometimes with certain partners (indicate partner) spouse / stable sexual partner / casual partner / sex worker		
9. Have you EVER used a female condom?	a. Yes ***(if yes: go to question 12)*** b. No		
10. *If no*, Why not? (open question: **not probing**, let respondent talk, interviewer circles answers – **multiple response possible)**	a. Not interested b. Looks odd c. Do not know where to get d. Do not know how to use e. Protection is not necessary	f. Partner does not want to g. Partner doesn't know how to use h. Other reason, specify ……	
11. *If no:* Do you think you might use female condom in future?	a. Yes b. No ***(After this question, Go to question 18)***		
12. How many times did you use a female condom?	a. One or two times, b. Three to 10 times,	c. More than 10 times.	
13. With whom did you use female condom for the **first time**?	a. Spouse b. Stable sexual partner	c. Casual partner d. Sex worker	
14. After that first time with whom did you use female condom? **(multiple answer possible)**	a. Spouse(s) b. Stable sexual partner	c. Casual partner d. Sex worker	
15. Are you still using F condom?	Yes ***(If yes, next question)***	No ***(If no, question 17)***	
16. With whom are you now using the female condom? **(multiple)**	a. Spouse(s) b. Stable sexual partner	c. Casual partner d. Sex worker	
17. *If not:* What is the main reason you do not use female condom anymore? (not probing)	a. Not available b. No sexual pleasure c. Too expensive d. Prefer to use other methods e. No sex: widow. / divorc. / single	f. Sexual partner doesn't want to use it g. Too cumbersome to use h. Not comfortable using it i. Other reason, specify ……	
18. Have you ever been tested on HIV?	a. Yes b. No **(end of interview)**		
19. Did you get the results of that test?	a. Yes b. No **(end of interview)**		
20. What is your HIV-status?	a. Positive	b. Negative	c. No answers

A2.3 Consent Form

Consent Form
Study on Men Acceptance of Female Condoms, Nigeria

I agree to participate in the study on male acceptance of female condoms. I will participate in the Focus Group Discussion. From the explanations by the facilitator I understand that the discussion is about my experiences and opinions about female condoms. I had a chance to ask questions, which were answered to my satisfaction and the following was explained to me:

- An anonymous questionnaire is filled out to make sure I'm in the right discussion group;
- Participation is voluntary; there is no particular reward or benefit for me;
- The discussion is tape recorded;
- My opinion and experiences with female condoms, that I shared in the discussion, will be treated with confidentiality:
  - The recordings will be deleted after writing of the report;
  - All participants as well as the facilitator, note taker, and Dutch researcher will not talk about me and the things I shared outside the discussion groups;
  - My name will remain anonymous in the report and cannot be traced back to the findings.
- I will be confidential about the experiences and opinions of the other participants.

If you have questions about this study you may wish to call any of the following numbers for confirmation, ***Dr. Samson Adebayo 07033979837 and Dr. Jennifer Anyanti 08055095603*** *of Research & Evaluation Division, Society for Family Health, Abuja.*

This study has been approved by the National Health Research Ethics Committee (NHREC) of Nigeria. If you have concerns about your rights as a participant in this study, please contact the Committee as follows: via e-mail: chairman@nhrec.net; deskofficer@nhrec.net; or by telephone: 08065479926 or 08033520571.

Name _____ *Signature* _____ *Date* _____

A2.4 In-depth Interview Guide

(For frequent users only)

Since you were very open during the FGDs and wanted to share your experiences and opinions we would like to ask you more of your personal experiences to get a more in-depth idea about frequent users of female condoms. We like to ask your permission to audio record this discussion, to be better able to grasp all your contributions in the report.

FIRST TIME

1. When did you hear for the first time about female condoms? Elaborate, where, from whom?
2. When did you use female condoms for the first time? How long after you heard about it – explain.
3. What was the reason for you using the female condom for the first time?
4. With whom did you use the female condom for the first time (type of sexual partner)?
5. Who initiated – yourself or your partner?
6. How and what did you discuss with your partner about using the female condom for the first time?
7. Did you use it that time mainly for pregnancy prevention or protection against STIs and HIV?
8. That time were you using other contraceptives / protection against diseases before? Explain.
9. How was your experience that first time?

REGULAR USE

10. You are a regular user now – how/why did you become a regular user while many men stop after once or twice?
11. Do you always use female condoms? Every time you have sex?
12. Do you use female condoms with all your sexual partners? **PROBE:** Who were your sexual partners (types) since the time you used female condoms?
13. Can you explain why you use female condoms with some sexual partners and not with others?
14. Do you use female condoms mainly for pregnancy prevention or protection against STIs and HIV? Different for different partners?
15. Does your stable partner agree to / like the use of female condoms?
16. How do you communicate with your stable partner / casual partner about female condoms? Were there at any time disagreements / problems with your partner(s) about using female condoms? Explain the discussions.
17. Together with female condoms, do you / your sexual partner also use other contraceptives / protection for STIs and HIV? Can you explain the pattern?

AVAILABILITY

18. From where do you usually get female condoms?
19. Are female condoms always available when you want them?
20. Who buys the female condoms? You or your partner? Explain.
21. Can you afford to pay for female condoms? How many do you get in a week / month?

Background respondent:

Name …… Age …… Marital status …….
Peer educator? Yes / No HIV positive: Yes / No

Annex 3: Female Condom Programmes

This annex presents a short summary of the past or existing female condom programmes in Zimbabwe, Cameroon, and Nigeria.

A3.1 Zimbabwe

In 1997 Population Services International (PSI) launched an extensive female condom social marketing project. The female condom was promoted under the brand name 'Care contraceptive sheath' ('Care' for short), in order to avoid a negative 'disease prevention' image, as was attached to the male condom. Moreover, it targeted especially married women and men who preferred the family planning message over that of disease prevention.[57] According to an interview in the Global Post (2010) with Mrs. Patience Kunaka, the communication manager for PSI Zimbabwe, the key to success is education and outreach. According to the UNFPA, Zimbabwe's success in promoting female condoms was also due to highly creative tactics: not only by training female condom promoters, working with community-based organizations and institutions, and using face-to-face communication, but also in terms of overcoming stigma by using billboards, radio spots, and TV commercials.[58] In the beginning, 'Care' was sold in selected pharmacies and clinics, but distribution has since expanded.[59] PSI provides 'Care' for a price of US$ 0.20 for two through hair salons and barbershops, pharmacies, private health care institutions, support groups of people living with HIV/AIDS, and networks of sex workers. Additionally, 'Care' is available in large supermarkets and convenience stores.[60]

At the same time as PSI, the Ministry of Health launched a public sector female condom programme. The female condom has since become a permanent part of the National AIDS Control Program and budget in Zimbabwe.[61] The female condom became freely available in government hospital clinics and other public health institutions in two districts in each of the ten provinces.[62] According to an article posted on allAfrica.com by the government of Zimbabwe, female condoms are still free of charge through local clinics, and a new, cheaper, and more user friendly female condom (FC2) will soon be launched (allAfrica.com 2010). Since 2005, the UNFPA has been supporting the Zimbabwean Ministry of Health and Child Welfare, The National Family Planning Council, the National AIDS Council, and PSI in promoting male and female condoms through the public sector.[63]

Despite these programmes, the uptake of female condoms is still low, which was shown in the figure of 0% overall reported female condom use in 2005 (see section 1.2.1 of this report). The main obstacles in Zimbabwe to increasing female condom uptake are still acceptability, affordability, and accessibility. The success story of Zimbabwe comes from the progressive and innovative approach adopted in the promotion of family planning methods. Warren & Philpott (2003) argue, however, that social marketing and the public sector do not reach all communities. Their recommendation is to include more women support groups in the programme to increase knowledge and use of female condoms.

A3.2 Cameroon

Since the diagnosis of the first AIDS case in Cameroon in 1985, the government of Cameroon expressed a strong commitment to fight HIV/AIDS.[64] A programme with the focus of reducing unintended pregnancies and HIV infections was implemented by the *Association Camerounaise pour le Marketing Social* (ACMS) with the support of PSI in 1989, with the title *Programme de Marketing Social au Cameroun* (PMSC). The initial programme aimed at selling subsidized high quality condoms and hormonal contraceptives through private sector channels.[65] In 2003, the government formulated its 2000-2005 AIDS Strategy that consisted of three focus points: 1) development of communication and outreach campaigns, targeted at youths, women, and people from rural areas; 2) creating partnerships with

[57] Kerrigan et al. (2000); Warren & Philpott (2003).
[58] UNFPA (2010); Warren & Philpott (2003).
[59] Kerrigan et al. (2000); Meekers & Richter (2005).
[60] Meekers & Richter (2005).
[61] Warren & Philpott (2003).
[62] Meekers & Richter (2005).
[63] UNFPA (2010).
[64] WHO (2005).
[65] Niebuhr et al. (2004).

different groups within society; and 3) promoting male *and* female condoms. The last point in particular is relevant today, since as part of the 2000-2005 AIDS Strategy PMSC introduced (amongst other methods) subsidized branded condoms: 'Prudence Plus' male condoms and 'Protectiv' female condoms.[66] Despite all efforts, however, female condoms were rarely available if at all in 2004.[67] In reality, female condoms were not included in the standard prevention packages during most clinical trials.[68]

Since 2009 the female condom has received more attention due to the launch of the UAFC Joint Programme in Cameroon. ACMS has increased social marketing for 'Protectiv' (the branded female condom).[69] In 2009, female condoms were promoted through TV, radio, billboards, leaflets, and posters.[70] Figures show that female condoms became more available over the years: in 2007, 14,822 female condoms were distributed, in 2008 distribution increased significantly to 143,593, and even more in 2009 when 382,276 female condoms were distributed.[71] In September 2010, 862,217 female condoms had been sold and 244,157 distributed for free since January 2009.[72] The female condom is available for 100 CFA (approximately €0.15) at pharmacies[73]. Part of the UAFC Joint Programme is to train grocery and hair salon owners and their staff on the use of female condoms. In addition, the UAFC Joint Programme makes female condoms available through different types of outlets. In September 2010, 1,522 points of sale of female condoms had been set up or created since January 2009, and peer educators from 145 hair salons had been trained to introduce the female condom.[74] However, according to the National AIDS Control Committee (NACC 2010) communities in semi-urban and rural communities are still not (sufficiently) reached and more condoms still need to become available to people at risk of HIV infection or unintended pregnancy, such as sex workers, truck drivers, migrant populations, fishermen, men who have sex with men (MSM), and men in uniform.

Other programmes that have been implemented by the government to reduce unintended pregnancies and the prevalence of HIV have proved to have had a limited reach.[75] One relatively successful youth program is the *100% Jeune* program in Yaoundé and Douala, which started in 2000 and has been integrated into the nationwide social marketing program by PMSC. Its goal is to motivate at-risk urban adolescents to practice safe sexual behaviour.[76] The program promotes one hundred percent condom use, especially with regular partners, through a mass media campaign and interpersonal communication. Examples of communication channels are radio dramas and call-in shows, newspapers, a monthly magazine, and use of peer educators. Condom use increased among both sexes through the *100% Jeune* program, but it was more effective among males than females; this is probably due to the limited focus on women's perceived ability to negotiate condom use and young women's low risk perception.[77]

A3.3 Nigeria

Female condoms were first distributed in Nigeria in the late 1990s. At the time distribution was limited, the female condoms were too expensive, and were targeted mostly at sex workers and women at government family planning clinics. General awareness of the benefits and skills in using female condoms was low.[78] In 2008, the UAFC Joint Programme in Nigeria began in three pilot states in Southern Nigeria – Lagos, Edo, and Delta – with the Society for Family Health (SFH) as the leading partner. The actual selling of female condoms started in November 2009. SFH distributes the female condom under the brand name 'Elegance' (FC2). Programmes target men and women with the basic message of dual protection against unintended pregnancies and STIs, such as HIV.[79] Female condoms

[66] Meekers et al. (2005b).
[67] Niebuhr et al. (2004).
[68] USAID (2009).
[69] PSI Cameroon (2011).
[70] UAFC Integrated narrative and financial report (2009).
[71] UNGASS report (2008); NACC (2010).
[72] UAFC (2010: 5).
[73] Source: http://www.pressedelanation.com/news/1748.html; http://wwp.greenwichmeantime.nl/time-zone/africa/cameroon/currency.htm
[74] UAFC Q3 (2010).
[75] Meekers et al. (2005b); Meekers & Klein (2002).
[76] Meekers & Klein (2002).
[77] Plautz & Meekers (2007); Meekers et al. (2005b).
[78] SFH (2009a).
[79] UAFC (2009).

are mostly provided, for a price of €0.13 for a package of two, in the private sector, including pharmacies, hair salons, and beauty parlours. At the same time, the government and UNFPA work within the public sector, such as family planning clinics.[80]

In 2009, female condoms were still not widely available or easy to access. In the SFH baseline study among 811 men between 15-64 years old and 795 women of reproductive age, nearly 40% had heard about female condoms, but only 6.1% of respondents thought that female condoms were easy to obtain.[81] According to the 2009 year report of the UAFC Joint Programme, the availability of female condoms increased fast. In 2010, 756,516 female condoms had been sold in the three pilot states, and 187,917 in other parts of the country. SFH has also intensified messages through mass media such as public billboards and advertisements on television.[82]

[80] Mybody (2011); UAFC (2011).
[81] SFH (2011a).
[82] Q4 (2009).

Annex 4: Advantages and Disadvantages of Female Condoms per country

Advantages of Female Condoms

	Cameroon	Nigeria	Zimbabwe
Effect	• **Protects against STIs and HIV (10)** • **Protects against pregnancies (9)** • Does not burst (easily) – better material (5) • Double protection – prevention STIs & pregnancy • Protects / reduces risks • More reassuring / protection (than male condoms	• **Prevents pregnancies (6)** • **Prevents diseases (6)** • Protects against unwanted pregnancies and diseases (M) • FC is better than MC because it does not tear (M)	• **Strong, does not burst (9)** • Does not come out easily (M) • Covers big surface area
Feeling	• **Feels natural (5)** • **Feel free during intercourse – not tight around penis (4)** • More sexual pleasure • Feel comfortable • No vaginal dryness (so no wounds) • Easy to ejaculate (M) • Women get more sex drive • Well lubricated	• **It is like natural sex (2)** (M) • **It is like flesh-to-flesh / skin-to-skin (3)** (M)	• **Sex feels like nyoro (12)** • More sexual enjoyment (6) • Makes you feel safe • Do not notice when the woman is too wet
Appearance and quality	• Fits male organ	• **Does not tear like MC – puts mind at rest (5)** (M) • Stronger than MC (M)	
Availability/affordability			• Available (M)
Control	• **Women can put it in before – protects against sexual violence / rape (8)** • Woman control her sex life (6) • Woman can protect herself • Can be put on without man noticing	*Mentioned one time:* • Method to protect myself – husband does not want to use condoms, not even outside (F) • Women can now protect themselves (M) • Women are wise when using the female condom (M) • With FC women can be sure men did not put a hole in the condom – mind at rest (F)	• Empowers women (7)
Use	• **Can be put in before sexual act (3-8 hours) (6)** • Easy to remove • No need for erection Hygiene increases because women have to look at their private parts • Can use it for a second round	• Can be worn during menstruation	• **Can be worn in advance (11)** • Can be used during menses • Penis can stay inside vagina after ejaculation

Disadvantages of Female Condoms

	Cameroon	Nigeria	Zimbabwe
Effectiveness	Not 100% reliable		• **Penis can be inserted under the FC and not be protected (7)** • Fast ejaculation (M)
Feeling	• **Reduces pleasure, does not excite you (8)** • Inner ring causes pain (6) • Do not feel the heat of the woman / walls of vagina (2)	• **Inner ring causes women pain (4)** (M) • Not like skin-to-skin (M)	• **Inner ring causes pain (7)** • Associations with CSWs (4) • Ugly shape
Appearance and quality	• **Makes noise (6)** • **Too big (5)** • Having to keep female condom in place reduces pleasure (2) • Can go inside (2) • Too oily / lubrication is messy / slippery • It comes out (2) • Not stable in vagina – can move (2) • Can go inside (2)	• Too big (M)	**Package to big (6)**
Availability/affordability	• **Too expensive (14)** • Scarce – not easy to find (8)	• **Costly (3)** • More expensive than MC (F) • Less available than MC (F)	• Not widely available
Control	• Leads young girls to prostitution / sexual acts (2)	*Mentioned one time:* • Men spread rumours about female condom: it can enter and destroy the womb (F) • Some women might refuse to use it because you bring out something that she needs to use (M)	• **Women misuse: use the same FC with multiple partners (11)** • Women in control (4)
Use	• **Insertion takes too much time (9)** • Difficult to insert (5) • Cannot do different sex positions (4) • Women do not know how to use them • You need to know how to insert them very well • Too much work: have to direct the penis all the time	• **Inserting is difficult – takes too much time (M)** • **Inserting is difficult (M)** • Can be pushed aside by penis • Can enter when you don't hold it • Inserting can be difficult – women get discouraged / prefer to use MC (M)	• Difficult to insert (6) • People do not have knowledge (5) • Takes time to put in (5)

Annex 5: Advantages and Disadvantages of Male Condoms per Country

Advantages of Male Condoms

	Cameroon	Nigeria	Zimbabwe
Effect	• **Prevents unwanted pregnancy and STIs (7)** • **Protection against pregnancies / family planning (6)** • **Protects against STIs (6)** • Protects	• **Prevents pregnancies (5)** • **Prevents diseases (3)** (M) • Protects against unwanted pregnancies and diseases (M)	
Feeling	• Almost body-to-body contact • Man can stay long on the woman – prolongs sexual act which is beneficial to women and increases sexual pleasure • Intense pleasure	*Mentioned one time:* • You ejaculate on time (M)	
Appearance and quality	• Easy to transport • Package is attractive • Small	• **Easy to carry around (3)**	
Availability/affordability	• **Good price / cheaper (8)** • Available everywhere (4)		• **Readily available (4)** • Cheap
Control	Mentioned once: • Accepted by most women (M) • Man does not bother me when I suggest it (CSW) • Men in control: can use it without partner's opinion (MN)		• **Man in control (7)** • Man disposes condom, sperm not used for juju (5) • Only use once (5)
Use	• **Easy to use (9)** • Man can stay long on the woman – prolongs sexual act which is beneficial to women and increases sexual pleasure • Well lubricated	• **Easy to wear (4)** (M) • Easy to use (M)	• **Easy to put on (5)** • Portable • Can be used for spontaneous sex

Disadvantages of Male Condoms

	Cameroon	Nigeria	Zimbabwe
Effect	• **Can burst easily (12)** • Can slip from penis (5) • Not 100% reliable (4) • Tears if partner is too violent	• **Breaks / tears / leaks (11)**	• **Risk of bursting (12)** • With removal , risk infection • Stays in vagina if man loses erection
Feeling	• **Tightens penis (5)** • Slows ejaculation • Reduces sexual pleasure	• Men do not derive maximum sexual pleasure • Not like flesh-to-flesh (M)	• **Constrains, too tight (5)** • Reduces sexual pleasure (4) • Causes rash
Appearance and quality	• **Not well lubricated – facilitation of penetrations decreases after time (4)** • **No good lubrication causes infection, stomach pain, itches (4)** • Very fragile • Bad smell of lubrication / male condom has perfume • Can cause wounds	**Breaks / tears / leaks (11)**	• Bad smell (4)
Availability/affordability			
Control	• Leads young girls into prostitution / sexual acts (2)		• Men in control, and can sabotage (4)
Use	• Can get stuck inside • Needs full erection		