Next to Natural

A Qualitative Study of Male Acceptance of Female Condoms in Greater Harare, Zimbabwe

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Abbreviations

ABC	Abstinence, Be faithful, and use Condoms
AIDS	Acquired Immune Deficiency Syndrome
AIID	Amsterdam Institute for International Development
ARYI	African Regional Youth Initiative
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
FC	Female Condom
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
MC	Male Condom
PLHA	People Living with HIV and AIDS
PSI	Population Services International
STI	Sexually Transmitted Infection
UAFC	Universal Access to Female Condoms
ZNNP+	Zimbabwe National Network of HIV Positive Persons

Executive Summary

Rationale and objectives

This report presents the findings of a qualitative study of male acceptance of female condoms in Zimbabwe, which was part of a three country study also including Nigeria and Cameroon. The fieldwork took place in May 2011 in (semi-)urban areas of Greater Harare. This study was 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.

Zimbabwe was selected as a study country because it has had a strong female condom programme since 1997, delivered through Population Services International (PSI). The main study objective was to explore the factors influencing the acceptance of female condoms by married and single men with different types of sexual partners.

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.

[1] Fishbein (2000).

Data were mainly collected through eighteen focus group discussions (FGDs); fourteen with men (116 participants) and four with women (38 participants). Groups were divided by sex, marital status, and frequency of female condom use; 94 males and 32 females were users. Bias was towards men and frequent users; 70 men and 27 women were frequent users. Local organizations facilitated the mobilization of the FGD participants. The data collection teams consisted of local researchers and the Dutch authors. 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.

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 Zimbabwe or for all Zimbabwean men. In addition, this study should not be interpreted as an evaluation of the current policies and practices of female condom programmes in Zimbabwe. However, the views of men and women, single and married as well as the findings from the pre-FGD questionnaires were compared. We consider the study findings to be meaningful indications of male views on female condoms.

Main findings

A very positive finding was that nearly all participants were convinced of the effectiveness of female condoms for dual protection (against unintended pregnancy and STIs) compared to other methods; the precondition for effectiveness, however, was that the female condom should be well placed, that the penis should enter properly, and that only one female condom should be used per partner. The other main perceived advantages were that for men sex feels like *kurova nyoro* (natural sex), especially when the condom is inserted beforehand; that it does not constrain the penis like male condoms; that it can be used during menses; and that no erection is required to start the sex. The main disadvantages related to the control and possible abuse of female condoms by women: for example, using the same female condom with multiple sexual partners and harvesting the sperm for *muti* (medicine for black magic). Other perceived disadvantages related to the appearance and method of insertion, which made some men lose their sexual appetite, and that it is expensive (compared to male condoms).

An important finding was that female condom acceptability and acceptance differed by type of sexual partner. The types of partners men have are influenced by norms in society, which are part of the external factors. Overall men identified five types of sexual partners, differing in terms of duration, exclusivity, stability, trust, gender power relations, exchange of money or goods for sex, and purpose. These five types are: 1) marital partner; 2) stable extra-marital partner (called ‘small house’); 3) stable girlfriend (of single men); 4) casual partners; 5) and commercial sex workers (CSWs). According to tradition, men make all decisions about protection and prevention, but with their spouses they may discuss family planning methods. Male condoms are normally not used in marriage because of the association with infidelity and extra-marital affairs. With the payment of *lobola* (brideprice) the husband gains exclusive rights over his wife’s sexuality and children, and although wives are not supposed to have extra-marital affairs, it is accepted for men. About one-tenth (9%) of married men had had an extra-marital stable partner in the year preceding the study, 30% had sex with casual partner(s), and 9% with CSW(s); 77% of single men had had a stable sexual partner, 30% had sex with casual partner(s), and 19% with CSW(s).

Female condoms are generally acceptable in relationships of trust, where men can be sure that the same female condom is not used with other men and that his sperm is not used for *muti*. Since most partners outside marriage and the majority of stable girlfriends cannot be trusted, use is more problematic with them. Men (and women) generally considered female condoms

acceptable within marriage for family planning; there is no need for protection against diseases because there is trust. However, for HIV positive or discordant couples, female condoms are also acceptable against (re-)infection.

The acceptability of women *initiating* female condom use is related to the gender power relations in different relationships. In general it is not possible for a married woman to initiate female condom use with her husband for three main reasons: husbands are supposed to make all decisions; women are not supposed to talk about sex; and it would be an indication of mistrust. However, if a couple have already discussed family planning, she may propose it for this purpose. For other sexual partners it is difficult to initiate use, unless the woman has power over the man: emotional power from the 'small house' and stable girlfriend; sexual power when single (or married) men are eager for sex and will do anything the partner suggests; or financial power in the case of a 'sugar mommy' (an older woman, with whom a younger man has a relationship, who gives him money and gifts). If a man were to find a woman with a female condom already inserted without him knowing about it, this would most likely lead to serious trouble in marriage, a fight between stable partners, and the man leaving the casual sexual partner.

Generally, men non-users gave as their reasons for non-use that they did not know enough about female condoms; that condoms are not for serious relationships or marriage because of the association with CSWs; that many women abuse the control they get from using female condoms; and that women are not supposed to be in control and make decisions.

There were four major motivations why men had used a female condom for the first time: 1) curiosity about how it would feel sexually (after having heard about it in training or on an advertisement); 2) having tested HIV positive and thus using female condoms as an alternative to male condoms and/or to use the safest method; 3) because his sexual partner convinced him, or insisted; 4) because a female condom was the only method available at the time and the man was eager for sex. Some men did not have a motivation as such, because their first time had happened without them noticing that the woman had a female condom inserted – some women confirmed that they sometimes use this strategy. The main motivation for women's first use of the female condom was that they wanted to try this safe method of pregnancy prevention and protection against disease.

In general, the groups of frequent users had more positive first experiences than the one/two time users. The most often mentioned positive first experience by men was that they felt as if there was nothing there, that it felt like *kurova nyoro*. Especially if the woman already had experience with using female condoms and did not show feelings of discomfort, men enjoyed it more. Male participants' main negative first experience was mostly related to their partner not knowing how to insert the female condom well, which caused pain and unease. Some were disturbed by the sight of the female condom and feared that it might disappear into the vagina. Women overall had more negative first experiences than men, although most attributed this to incorrect insertion, which caused them pain and discomfort, even more when the man entered.

Often after a positive first experience, men said that they then became frequent users of female condoms. Most married men used female condoms with their wife and single men with their stable partner; they did not like to use them with casual partners or sex workers. The main reason given by men for continuing use of female condoms was the pleasurable sexual experience they had, along with the other advantages (which often compared favourably to the male condom): it does not have a bad smell, it gives more protection, it does not interrupt foreplay, a man does not need an erection, and the man does not have to dispose of it. For both men and women a major incentive to become a frequent condom user was if they or their partner tested HIV positive; they considered female condoms to be the safest method. Many people

living with HIV and AIDS (PLHA) said that with female condoms they had found an alternative which added variation to their sex life.

Only a few people used only and always female condoms. The common pattern was to alternate them with male condoms. People alternated because of the variation it brought to sex, and depending on the availability (in the house) of one or the other condom. Some wives still also used contraceptives concurrently because they felt that female condoms are especially for disease prevention.

Female condoms are fairly widely available for free in public clinics and through peer groups, and are for sale in pharmacies. However, participants would like to see them in more outlets such as supermarkets and offices. Most participants thought that if they were no longer available for free and people had to pay for them, the lowest current price of US$ 0.20 or 0.50 South African Rand would not be a problem. However, the price can be as high as US$ 0.60, which they considered unaffordable. A problem facing distributers who sell female condoms is the scarcity of coins, and a major external factor hindering male (and female) frequent use of female condoms is cultural inaccessibility (shame of some groups to buy them). Peer programmes were considered a culturally sensitive way to provide education about female condoms and for distribution.

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 in Zimbabwe. 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. The recommendations are:

- Realize that spreading female condom use cannot go via women only, but educate men or men and women together. Giving men a (bigger) role in introducing the female condom would be more acceptable in Zimbabwe. Promoting female condoms as a female initiated product for women's empowerment will not be conducive for uptake because in Zimbabwe a woman needs the cooperation and often approval of her male partner.
- In communication messages to men, stress the advantages and address the disadvantages of female condoms, and tailor the messages to appropriate target groups – and their sexual partners. In promotion, stress the fact that it feels like natural sex, that there is sexual pleasure in female condom use, that female condoms offer variation in protected sex, and emphasize the effectiveness of female condoms as a contraceptive. In messages address the local disadvantages and reasons why men do not (want) to use female condoms – for instance, supposed misuse by some women.
- Female condom promotion to men (as to women) should always be accompanied by a demonstration. During female condom promotion and demonstrations to women and men, participants should be invited to practice use by opening the package and doing a mock insertion.
- Visual mass promotion (on television or posters) should include *what* a female condom looks like and *how* it is used – thus not only talking about the benefits and showing the package.
- Prepare 'female condom starter packs' to give out during demonstrations with some five female condoms and information, including where to buy them.

- Address the distrust men have about using female condoms with casual partners and sex workers. Advise men to ask the woman to open the package and insert the female condom in their presence and dispose of the female condom together.
- Continue to educate women in negotiation skills appropriate to the type of sexual partner. Women can be advised to practice insertion before trying with her partner, to make his first experience more likely to be positive.
- Continue to increase sales points for female condoms and look into whether female condoms could be even more subsidized. Agree on a fixed price. Increase advertisements and sales through barber shops and hairdressers. Come up with a strategy to address the problem of scarcity of coins; for instance, give out a card for ten female condoms, or include female condoms as part of the price of a haircut.

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CHAPTER 1: INTRODUCTION

This report presents the findings of a qualitative study on male acceptance of female condoms in Zimbabwe, which was part of a three country study including also Cameroon and Nigeria.[2] Data collection in Zimbabwe took place in May 2011 through eighteen focus group discussions (FGDs) – fourteen with men and four with women. The study was 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 pregnancies.[3] Launching an effective female condom programme is not straightforward, because motivating people to engage in safer sex by using a condom is a difficult task. Literature explaining the low rates of male condom use in Sub-Saharan Africa points to socio-cultural influences including: a focus on fertility and pro-natalism; risk perceptions that differ by type of sexual partner; gender relations and related rejection of contraception use; and the association of condom use with promiscuity. When looking at female condoms, we see that the usage of female condoms in Sub-Saharan Africa is very low in most countries, including Zimbabwe, where it does not even reach 0.1%.[4] In comparison to the male condom, the female condom suffers from three additional problems: the lack of accessibility, availability, and affordability.[5]

The vast majority of research on the acceptance of female condoms has been conducted among women, with one of the main conclusions being that many men are an obstacle to women using them. 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 and why. This study aims to fill this gap in knowledge; it explored men's perspectives and whether and how they can be motivated to accept female condoms and become frequent users – taking into account the local socio-cultural and economic contexts and the perceived accessibility (of female condoms).

This introductory chapter continues with a literature review of relevant studies and reports. It starts in 1.1.1 with a brief overview of the prevalence of HIV/AIDS and unintended pregnancies in Zimbabwe, which influences risk perceptions and the felt need to use (female) condoms; then some figures on contraceptive use are provided. Section 1.1.2 addresses the socio-cultural contextual factors which may influence condom use. The following section (1.1.3) summarizes what is known about female condom use in Zimbabwe, mainly from a female point of view, and

[2] The countries of study included 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. The synthesis report *Male Views on Female Condoms* is available from the UAFC Joint Programme website.

[3] 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 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. 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.

[4] Zimbabwe Demographic and Health Surveys 2005-06 (2007).

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

the final two sections summarize the study rationale (1.2) and the study objective and questions (1.3).

1.1 Literature review

1.1.1 HIV and AIDS, unintended pregnancies, and contraceptive use

In 2009, an estimated 2.6 million people were newly infected with HIV, of which an estimated 1.8 million is living in Sub-Saharan Africa. Furthermore, the World Health Organization (2011) estimated that 200 million couples in developing countries would like to delay or stop child bearing, but are not using contraception methods. The perceived need for protection is influenced by external factors such as HIV prevalence and the availability of contraception methods. Therefore, it is important to investigate the acceptance of female condoms within the context of HIV prevalence and unintended pregnancies. This section focuses on Zimbabwe, starting with figures on HIV/AIDS.

HIV and AIDS
In 1997 the HIV epidemic in Zimbabwe reached its peak with a prevalence rate of 26.5%. Although rates have since been declining in Zimbabwe, the country is still one of the worst affected.[6] According to data from the Zimbabwean Demographic and Health Surveys 2005-06 (ZDHS 2007), the HIV prevalence among adults aged 15-49 years was 18.1%; with 21.1% HIV prevalence among women and 14.5% among men. The last UNAIDS estimates of 2009 gave an HIV prevalence of 14.3% among the adult population. In this same year, 1,187,822 adults and children in Zimbabwe – a country with a total population of 12 million – were living with HIV/AIDS.

Unintended pregnancies
Next to HIV (and STIs), unprotected sex may lead to unintended pregnancy. According to the ZDHS 2005-06, 20% of pregnancies were mistimed (wanted later) and 13% of births were unwanted. These unintended pregnancies may result in (unsafe) abortions; in 2000 and 2003 there was an annual abortion incidence of more than 30 per 1000 women.[7] The maternal mortality rate caused by unsafe abortions is estimated to be 750 per 100,000 deaths in Sub-Saharan Africa, which means that 14% of all maternal deaths are caused by unsafe abortions.[8] In Zimbabwe the maternal mortality ratio (MMR) increased from 390 per 100,000 live births in 1990 to 830 in 2005, and in 2008 it dipped marginally to 790.[9] The number of Zimbabwean maternal deaths caused by unsafe abortions was estimated to be 100 or more per 100,000 live births in 2003.[10]

Contraceptive use
The rate of contraceptive use to protect against HIV and/or prevent unintended pregnancy has increased since 1999, according to the ZDHS 2005-06. In the ZDHS 2005-06, 41% of *all* men and 40% of *all* women reported using a contraceptive method; the most commonly used method was the oral contraceptive pill (OCP), with 25% of men and 27% of women reporting use. Among the *married* respondents, 71% of men and 70% of women reported use of contraceptives; 53% of men and 43% of women reported using the OCP. Among the *single* sexually active respondents, 43% of males and 61% of females used contraceptives; the most commonly used method was the male condom, with 36.8% of single men and 26.5% of single women reporting use (with their partners). Other frequently used methods by single women were the OCP (21.3%) and

[6] UNAIDS (2010).
[7] WHO (2004); WHO (2007).
[8] WHO (2007).
[9] WHO (2008).
[10] WHO (2007).

injectables (11.1%). The ZDHS 2005-06 does not present data on concurrent multiple contraceptive use.

Overall, according to the ZDHS 2005-06 male condom use was low, with 2% of all women and 9.5% of all men using them; though this was higher among single men and women, as indicated above, compared to 4.3% of married men and 1.4% of married women.[11] In transactional sex, men reported the highest condom use, although this had shown a decrease from 82% using them in 1999 to 74% in the ZDHS 2005-06.

Different studies show that condoms are seldom used within marriage and more often used with non-marital partners.[12] Agha et al. (2002), who used data from Zimbabwe's Knowledge, Attitude and Practices Survey in 1999, show higher rates of condom use within marriage; 7% of married women aged 15-49 years and 8% of males aged 15-54 years reported using a condom during their last sexual intercourse with a marital partner. In the study of Francis-Chizaroro & Natshalaga (2003), among 700 women (though it is not clear whether or not they were married) attending health clinics in the eight Zimbabwean provinces, 76% reported having ever used a condom, of which 98.1% had used male condoms. In the same study, current reported use was 17.8% with the male condom; 52.4% were inconsistent condom users, of which 53% said that use depended on their male partners.

Overall, current female condom use is low: among both married and single men and women the ZDHS 2005-06 gives a figure of 0.0%. The figure only goes above zero for specific groups. The highest female condom use was among married women from Bulawayo province (0.3%), married men from Masvingo province (0.4%), and higher educated men (0.3%) (ZDHS 2007). From Francis-Chizaroro & Natshalaga (2003), it was found that among their study sample 71.2% had heard about the female condom, but only 0.8% had ever used one.

As the female condom is equally effective a method as the male condom, both have the potential to improve health risks related to sexual intercourse. The often mentioned advantage of the female condom over the male condom is that it gives women more power over their sexual and reproductive health, as they are the one 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 use, including the female condom.[13] The following section further discusses the different reasons for not using male or female condoms.

1.1.2 Fertility, sexual behaviour, and gender relations related to condom use

Barnett (2005) argues that programmes aimed 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 (in Sub-Saharan Africa and Nigeria) to those dealing with influences on condom use – and in particular how this prevents (consistent) condom use.

Importance of fertility

In many Sub-Saharan African cultures, maleness and femaleness is defined by fertility. In Preston-Whyte (1999)[14] it is discussed that part of a woman's (social) identity is determined by

[11] ZDHS (2005-06).
[12] Agha et al. (2002); Meekers (2001).
[13] See section 1.4 for an overview.
[14] In Barnett & Whiteside (2006).

her fertility. Women are expected to be fertile and they need to achieve this as early as possible. In addition, children ensure care in old age. This means that at a certain point in time, women have strong incentives to refrain from condom use even when they perceive a risk of contracting HIV. In addition, Barnett and Whiteside (2006) point to the importance of ancestry and descent in African cultures. Hence, childbearing is for a woman at times more important than the risk of HIV. This creates a barrier for women using condoms. Being fertile is also important for males. Barnet and Whiteside (2006) argue that producing descendants 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.

Studies conducted within the Zimbabwean context subscribe the importance of fertility. Runganga et al. (2001) describe that marriage is considered useless when no children are born, and even go a step further by explaining that being able to conceive is so highly valued by both men and women that it encourages pre-marital sex and discourages the use of condoms. The study describes how women believe that a pregnancy or having a child will increase their chances of marriage.

Types of sexual relationships and contraceptive use

Whelehan (2009) describes that, in general, emotional and psychological attachment to one's partner affects sexual decision making. She argues that for most individuals protected sex diminishes when emotional and psychological attachment occurs between two partners. Emotional attachment involves trust and trust is part of intimate relationships. Introducing a condom into such relationships suggests mistrust. This reasoning is confirmed by Mataure et al. (2002), who state that the FGD participants in their study in Harare mentioned that condom use strongly depends on the type of partner they are with. The general conclusion was that the more stable the relationship, the lower the condom use. Mataure et al. also reported that young participants mentioned using condoms in the beginning of a relationship, but that as it develops – and hence trust develops – condom use inevitably stops. On the other hand, young male FGD participants in the study also reported the belief that condoms should not be – and thus regularly are not – used when having sex with a virgin.

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 lives 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; 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 a young woman 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, for example, makes a woman submissive to his will, and she loses her bargaining power when it comes to sexual intercourse. If the man demands unsafe sex, she will go along with it because she depends on his socio-economic resources.

When setting the goals of an intervention in a certain society that aims to change sexual behaviour, these contextual factors need to be taken into account.

1.1.3 Female condom use

The Women and AIDS Support Network (WASN) in Zimbabwe began to demand access to female condoms in the country through intensive lobbying, a press campaign, and petition activities. This resulted in the approval in 1996 of female condom use by the drug regulatory agency.[15]

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); this name was chosen in order to avoid a negative 'disease prevention' image, as was attached to the male condom. Moreover, it especially targeted married women and men, who preferred the family planning message over one of disease prevention.[16] In the beginning, 'Care' was sold in selected pharmacies and clinics.[17] PSI provides 'Care' for the price of US$ 0.20 for two, through hair salons and barber shops, pharmacies, private health care institutions, support groups for people living with HIV and AIDS (PLHA), and networks of sex workers.[18]

At the same time as PSI, the Ministry of Health (MOH) launched a public sector female condom programme. Since then, the female condom has become a permanent part of the National AIDS Control Program and budget in Zimbabwe.[19] The female condom became freely available in government hospital clinics and other public health institutions in two districts of all ten provinces.[20] Since 2005, the UNFPA has supported 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.[21] Most female condom users in the ZDHS 2005-06 reported getting their condoms in supermarkets (36.2%), in provincial hospitals (12.9%), and pharmacies (10%).[22] Despite these programmes, key barriers to female condom uptake still exist, including cost, availability, and accessibility.[23]

Experiences of female condom users

In 1998 PSI conducted a study on the characteristics of female condom users, among female and male users and non-users in urban areas in Zimbabwe. This study showed that female condom users are mostly aged in their mid to late twenties, and have higher levels of education and access to household resources. Women who used the female condom 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 of the study (Kerrigan et al. 2000) showed that female condom use in general was higher among regular partners or spouses than with casual partners or commercial sexual workers.[24]

Kerrigan et al. (2000) investigated the reasons given by Zimbabwean men for starting to use female condoms. 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. In

[15] Warren & Philpott (2003).
[16] Kerrigan et al. (2000); Warren & Philpott (2003).
[17] Kerrigan et al. (2000); Meekers & Richter (2005).
[18] Meekers & Richter (2005).
[19] Warren & Philpott (2003).
[20] Meekers & Richter (2005).
[21] UNFPA (2010).
[22] ZDHS (2005-06).
[23] allAfrica.com (2010); UNFPA (2010).
[24] Kerrigan et al. (2000).

addition, it was shown that most men reported using the female condom with sexual partners outside marriage, although the study does not make a distinction between married and unmarried men.

Positive experiences

Studies in Zimbabwe reveal a number of perceived advantages of the female condom. A study from Meekers & Richter (2005) shows that some men like to use female condoms; furthermore, men who perceived the female condom as effective in pregnancy prevention, affordable, and easy to use were more likely to use them. The male FGD participants in the study of Francis-Chizaroro & Natshalaga (2003) liked the sexual pleasure which they had when using the female condom, especially because it is not too tight and the rings offer them arousal and provide a warm feeling. In addition, the men mentioned that there is no need for sexual preparedness (i.e. erection) to put it on, as with the male condom.

Female users of female condoms in the studies of Buck et al. (2005) and Ray et al. (1995; 2001) mentioned that they are easy to use, efficacious in preventing pregnancy and protecting against HIV, and make sex more pleasurable. In contrast with most participants in the study of Buck et al. (2005), who liked the male condom better than the female condom, participants in the studies of Ray et al. (1995, 2001) liked the female condom better. According to most women in these two latter studies, the lubrication was "just right", the female condom was easy to insert and remove, did not interfere with sexual pleasure, and most importantly, usage became easier with practice. The majority also said that they would use female condoms again in the future. In the study of Francis-Chizaroro & Natshalaga (2003), 93% of the women liked the female condom, mostly because of the sexual satisfaction it gave them, secondly because it offers dual protection, and thirdly they liked that they had control, choice, and power over using it. In all studies on female condoms, participants mentioned as the big advantage the dual protection which the female condom offers in protecting against STIs and HIV/AIDS and preventing unwanted pregnancy.[25]

Negative experiences

Several studies in Zimbabwe also pointed to a number of disadvantages of female condom use. Men in the Buck et al. study (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; some women said it was difficult to use; a few men and women did not like the lubrication as it made the female condom wet and slippery; and moreover it prevented 'skin-to-skin' contact. In two other studies (Francis-Chizaroro & Natshalaga 2003; 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, preferred to have 'dry' sex, and feared that the lubrication could cause cervical cancer. The other stated disadvantage was the high price, especially given that male condoms are freely available more often at health centres.[26]

Reasons for not using female condoms

The most often mentioned advantage of the female condom over the male condom is that it is female controlled.[27] This is an important feature of the female condom, as we have seen that women are more at risk of contracting HIV and unintended pregnancies and thus need a method to protect their sexual and reproductive health. However, female condom use by women is not as straightforward as it seems. Studies point out that women face difficulties when introducing the

[25] Francis-Chizaroro & Natshalaga (2003); Kerrigan et al. (2000); Napierala et al. (2008).
[26] Francis-Chizaroro & Natshalaga (2003); Kerrigan et al. (2000).
[27] Francis-Chizaroro & Natshalaga (2003); Ray et al. (2001).

female condom to their male partners. Women say that men refuse to allow them to use a female condom. In addition, studies point out that a female condom cannot be used without the partner's consent as he will notice part of it on the outside of the vagina.[28] This section summarizes the existing literature on reasons for not using the female condom.

Men refuse female condoms
Different studies among Zimbabwean women highlight that (female) condom use is difficult because of partner refusal, especially within marriage and with stable partners.[29] In a study by Feldman & Maposhere (2003) among 268 HIV positive Zimbabwean women, it was found that their partners' cooperation was crucial in condom use. In most cases co-operation was very difficult to achieve and the women received help from counsellors and support groups.

Wives seldom talk about any contraceptives with their husbands.[30] According to Agha et al. (2002), this has mostly to do with 'trust'. In their study among 15-54 year old Zimbabwean men, 73% did not use condoms with their wives because they trusted them. Within this context, trust relates to wives being faithful, and men trust that their wives do not have extra-marital affairs.

Female condoms have a negative association with promiscuity
Related to the issue of trust, the study of Ray et al. (1995) describes that some male partners of urban women in Harare were afraid that female condoms would encourage women to become casual about sex. Both Zimbabwean women and men associate condoms with extra-marital sex and sex workers.[31] In other studies, Zimbabwean men express the fear that the female condom would encourage women to be promiscuous.[32]

Other perceptions of the female condom that are a hindrance to using it
Another impediment for female condom acceptance among men is reduction of sexual pleasure.[33] Buck et al. (2005) describe that the Zimbabwean men in their study were resistant to (male) condoms because they felt that they decrease sexual pleasure; female condoms were even less preferred.

1.2 Study rationale

HIV prevalence rates as well as the number of unintended pregnancies are high in Zimbabwe. Both male and female condoms offer dual protection against HIV and unintended pregnancy. With the introduction of female condoms, couples have a dual choice in dual protection, i.e. to use either a female condom or a male condom, with widespread use having the potential to reduce rates of HIV infection 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 the female condom is not completely female controlled because a woman needs the approval and cooperation of her male partner. The studies among women referred to above showed 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,

[28] Buck et al. (2005); Ray et al. (2001).
[29] Feldman & Maposhere (2003); Francis-Chizaroro & Natshalaga (2003); Ray et al. (1995).
[30] Feldman & Maposhere (2003).
[31] Feldman & Maposhere (2003); Francis-Chizaroro & Natshalaga (2003); Ray et al. (1995).
[32] Francis-Chizaroro & Natshalaga (2003) ; Kerrigan et al. (2000).
[33] Agha et al. (2002).

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 to men and women, with the aim of increasing acceptance and use of female condoms. Before acceptance (frequent use) people have to be aware about the female condom and to have a positive attitude about using it, i.e. female condoms should be acceptable to them. This evidence on the acceptability and use of female condoms is lacking in Zimbabwe (as in other countries). This study will thus explore men's attitudes to 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 the actual availability of female condoms, which is another barrier to use (and one of the focus areas of UAFC Joint Programme and PSI). However, the availability and accessibility in the study areas as perceived by respondents was explored, because these were two factors that influenced acceptability and use.

1.3 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 on the usage of prevention methods (against STIs, HIV, and unintended pregnancy)?
2. How acceptable is the use of female condoms by 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 the female condom?
6. What are the study findings' implications for female condom programmes?

1.4 Report outline

The following Chapter 2 presents the study methodology including the theoretical framework used, the design, methods, and tools. It also describes the study populations and background of participants. Chapters 3 to 8 present the discussions during FGDs and the participants' answers to questions. Chapter 3 presents the participants' perceived advantages and disadvantages of the female condom, often in comparison to the male condom, as well as perceived effectiveness. Chapter 4 elaborates on the type of sexual partners men in Zimbabwe have and 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 acceptability as well as acceptability when different partners initiate use. This chapter also presents the reasons for not using female condoms and the motivations for 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 of female condoms. This chapter also presents findings on reasons for and patterns of frequent use. Chapter 7 shows how participants perceive the availability, accessibility, and affordability of female condoms. The last 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 them. Finally, Chapter 9 summarizes the findings regarding which factors influence male acceptability and use of female condoms, and draws the implications for future programmes. It concludes by addressing the question which was the ultimate rationale for this study – whether men are an obstacle in spreading the use of the female condom – and the implications for prevention of HIV and unplanned pregnancies.

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). The chapter ends with a reflection on the study limitations.

2.1 Theoretical framework

The UAFC Joint Programme and PSI programmes are 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).[34] 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 PSI) 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.

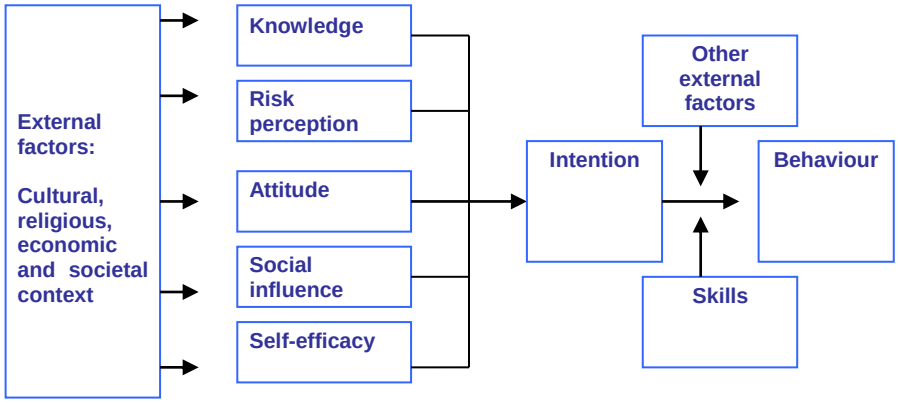

Figure 1: Theory of Planned Behaviour

[34] Fishbein, M. (2000) The role of theory in HIV prevention. *AIDS Care* 12: 273-278.

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.[35]

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 Zimbabwe – 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 a*cceptance*. 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 below presents the conceptual framework of the study.

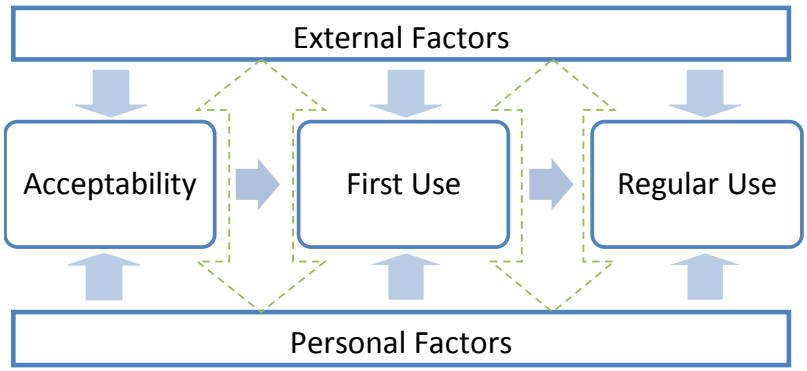

Figure 2: Factors influencing frequent female condom use by men

[35] 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) – 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 type. 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, of which 4 were with females and 12 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: Planned number of FGDs by user type, sex, and marital status

<table>
<tr><th rowspan="2">Group</th><th colspan="3">Men</th><th colspan="3">Women</th><th rowspan="2">Total</th></tr>
<tr><th>Married</th><th>Single</th><th>Total</th><th>Married</th><th>Single</th><th>Total</th></tr>
<tr><td>Frequent FC users</td><td>3</td><td>3</td><td>6</td><td>1</td><td>1</td><td>2</td><td>8</td></tr>
<tr><td>Used FC once or twice</td><td>2</td><td>2</td><td>4</td><td rowspan="2">1</td><td rowspan="2">1</td><td rowspan="2">2</td><td>6</td></tr>
<tr><td>Know FC but not used</td><td>1</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>Total</td><td>6</td><td>6</td><td>12</td><td>2</td><td>2</td><td>4</td><td>16</td></tr>
</table>

Selection of FGD participants was planned through convenience sampling; men and women who were willing to participate and were available at the proposed time for fieldwork were mobilized through gatekeepers (organized by Development Data, a research consultancy firm based in Harare). 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 objectives and considering the exploratory nature of the study, random sampling was not considered necessary.

2.2.1 Data collection tools

Two tools were developed to collect the data: topic guides for the FGDs and a structured questionnaire for the pre-FGD interview.

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 (see Annex 1). 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 condoms 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.

Questionnaire
Before the start of the FGDs the research team members interviewed the FGD participants using a short structured questionnaire (see Annex 2). 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.

2.2.3 Ethical considerations

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[36] 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 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.

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.

[36] The FGD topic guide included an introduction to the study (see Annex 1). We explained about the intention to increase the availability of the female condom. The moderators were instructed that they should not mention any further details about the female condom beyond the fact that it is a method against HIV and unintended pregnancies. This was to prevent people from thinking that the discussion groups were about the positive sides 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.

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: 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 FGDs 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.

All FGDs took place in (semi-)urban areas of Greater Harare, Zimbabwe. Participants in the two pre-test FGDs were invited to the hotel where training of the study team was taking place, and on another day participants were invited to the PSI office (where four FGDs were held). All other FGDs took place in the location where participants were residing, and were held in local clinics, a church, a school, or in the open air under a tree. Usually two FGDs took place concurrently in the same location. Annex 4 gives a description of the residences of FGDs participants; most are high to middle density suburbs, at some 10 to 20 kilometres' distance from Harare city centre.

2.3.2 Type of focus group discussions

We planned to conduct sixteen FGDs and we realized eighteen. When mobilizing the participants it appeared difficult to separate the types of users, hence several groups were mixed, with more frequent users in some and more one/two time users in others. After the pre-test, however, the FGD moderators were able to facilitate these mixed groups, and in most cases we were able to separate the non-users from the users. For both males and females the realized FGDs differed slightly from the plans. There were two FGDs with single women who were frequent users (instead of the planned one) and no FGDs with women who had used female condoms once or twice. In addition there was only one FGD with single men who had used female condoms once or twice (see Table 2).

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	5	3	8	2	1	3	7	4	11
Used FC one/two times	1	2	3	0	0	0	1	2	3
Know FC but never used	2	1	3	1	0	1	3	1	4
Total	*8*	*6*	*14*	*3*	*1*	*4*	*11*	*7*	*18*

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

In total 154 people participated in the FGDs: 116 men and 38 women. FGDs had between three (at PSI) and twelve participants, with on average nine participants. Table 3 presents the number (panel A) and percentage (panel B) of male and female participants by type of FGD. As by design, the majority of participants were frequent users (55%), while one-quarter (25%) were one/two time users, and 18% were non-users. Relatively more females were frequent users (63%) than males (53%).

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

A. Distribution of FGD participants over type of user, marital status, and sex (#)

Type of user	# Males			# Females			Total # (Males & Females)		
	Single	Married	Total	Single	Married	Total	Single	Married	Total
Frequent FC users	43	18	18	13	11	24	56	29	85
Used FC one / two times	15	16	16	5	3	8	20	19	39
Know FC but never used	11	10	10	5	1	6	16	11	27
No information	1	2	2	0	0	0	1	2	3
Total	*70*	*46*	*116*	*23*	*15*	*38*	*93*	*61*	*154*

B. Distribution of participants over type of user, marital status, and sex (%)

Type of user	% Males			% Females			Total % (Males & Females)		
	Single	Married	Total	Single	Married	Total	Single	Married	Total
Frequent FC users	61	39	53	57	73	63	60	48	55
Used FC one / two times	21	35	27	22	20	21	22	31	25
Know FC but never used	16	22	18	22	7	16	17	18	18
No information	1	4	3	0	0	0	1	3	2
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

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 times and continued use and used more than 10 times
Note: Single: singles / single – stable relationship / single – divorced / single – widowed / single – separated

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 completing the informed consent form. The actual FGD lasted between one and a half and two hours. With the written permission of the FGD participants, the discussions were audio recorded. The discussions always took place in the language preferred by the participants. FGDs were partly in Shona and partly (Pidgin) English.

The research teams consisted of local FGD facilitators and note takers from Development Data. The Dutch researchers and authors of this report were present at all FGDs.

After the FGDs had been completed, an impromptu open interview was conducted with two barbers who had taken part in one of the FGDs. They shared their personal experiences with female condoms and their work as a peer educator and a distributer of female condoms.

2.4 Data analysis

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

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

2.5 Reporting

In this report, for all themes differences between groups were explored, i.e. between married and single, 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 by FGD participants – these are mainly quotes that represent majority views. Some presented quotes give minority, original, or new ideas that may be useful for programmes, and will be indicated as such. 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 are summarized which influenced male acceptance of female condoms. Chapter 9 also draws conclusions on the implications of these study findings for female condom programmes.

2.6 Description of study population

Table 4 shows some general background characteristics of the 154 FGD participants: 116 males and 38 females. Panel A describes the marital status: 40% were married, 44% had a stable relationship, and 12% 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 makes it easier to compare the differences between single and married participants. When combining all single categories, 60% of the study population was single. The percentage of men with a stable relationship was higher than for women: 51% of the men compared to 24% of the women. More women than men indicated that they were single without any type of relationship.

Panel B shows that most participants were between 20 and 49 years old. People within this age category are expected to be most sexually active. The average age of the population of Zimbabwe is 37.2 years old. The females in our study population were on average two years

older than the males. When looking at panel C of Table 4, we see that our study population was well educated, as most participants (80%) had completed secondary education.

The last panel (D) of Table 4 shows that the majority of the study population was not formally employed. About one-third (29%) was unemployed, i.e. a full time housewife, student, or without a job. A relatively large proportion of the female study population acted as peer educators or community workers (29%), and 13% as hairdressers. People in these types of professions can be expected to have more knowledge about prevention methods as they are commonly used in prevention strategies – hairdressers and barbers are one of the pillars of the social marketing programme of PSI – hence these women are not fully representative of average Zimbabweans. Furthermore, 26% of the female study population was working as commercial sex workers. Throughout the analysis, we make reference to when particular information comes from one of these special groups. Finally, the large category 'other' represents occupations that are more or less formal employment, although we did not have information about whether this employment was full time or on a contractual basis.

Table 4: Characteristics of FGD participants

A. Marital status (%)	**Males (N=116)**	**Females (N=38)**	**Total (N=154)**
Married	40	39	40
Single	7	29	12
Single – stable relationship	51	24	44
Single – widowed/divorced/separated	3	8	4
No information	0	0	0
Total	*100*	*100*	*100*
B. Age groups (%)	**Males (N=116)**	**Females (N=38)**	**Total (N=154)**
<20	1	0	1
20-29	24	21	23
30-39	32	34	32
40-49	32	29	31
50-59	9	13	10
>60	1	3	1
No information	2	0	1
Total	*100*	*100*	*100*
Average age (in years)	*36.7*	*38.8*	*37.2*
C. Education level (%)	**Males (N=116)**	**Females (N=38)**	**Total (N=154)**
No education	1	0	1
Primary school	7	26	12
Secondary school	84	66	80
University / tertiary	3	5	3
Other	3	0	2
No information	3	3	3
Total	*100*	*100*	*100*
D. Occupation (%)	**Males (N=116)**	**Females (N=38)**	**Total (N=154)**
No job / housewife / student	33	16	29
Self-employed	14	0	10
Peer educator / community worker	3	29	10
Barber / hairdresser	9	13	10
Sex worker	0	26	6
Other / formal employment	34	13	29
No Information	6	3	5
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. The major limitation for this Zimbabwe study relates to the sampling of FGD participants. It was anticipated that finding enough male female condom users for FGDs would be difficult. Because random sampling was not possible due to very low national female condom use, we had to rely on gatekeepers. This caused a bias in the study population. ZNNP+ selected men and women from their support groups. These were mainly people living with HIV or AIDS (PLHA), although the support groups also have some members who are not HIV positive. These PLHA are sensitized and educated through their peer group and highly motivated to prevent (re-)infection by always using (male or female) condoms. From the discussions we understood that most participants mobilized by ZNNP+ were PLHA. PSI was the other gatekeeper. Most of the people they selected were from their programmes: peer educators, or barber and hairdresser distributers of female condoms. They were also knowledgeable about female condoms and most were users.

After we realized the bias, we decided to change some groups and ask passersby on the street to partake in an FGD. In the end, only these people and those selected by ARYI (African Regional Youth Initiative) – in three FGDs – can be considered representative. However, the study was not set up as a cross-sectional survey, and the findings on what makes men accept female condoms are applicable to the promotion of female condoms to groups other than PLHA and peer educators.

This study investigates male perspectives on female condoms. All respondents had heard about female condoms and had an opinion about them that they were willing to share. Thus, we missed out on people who had either no knowledge at all about female condoms or who did not want to talk about it. In addition, the participants were recruited in (semi-)urban low class to low middle class areas of Greater Harare, and thus we have no knowledge about the perceptions on female condoms of individuals of other towns, rural areas, and higher class areas.

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. 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 Zimbabwe or for all Zimbabwean men. However, the views of men and women, single and married, and the findings from the FGDs and pre-FGD questionnaires were compared. We 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 the effectiveness of female condoms compared to male condoms and other prevention and protection methods (3.2).

3.1 Perceived advantages and disadvantages of male and female condoms

This section summarizes the answers to the roughly ten minute first ice breaking session for the FGDs. Participants were asked what they considered to be the advantages and disadvantages of female and male condoms. The answers were written on a flipchart for everyone to see. Obviously the users shared more of their own experiences while non-users talked about 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, the female condom is expensive, while the male condom is cheap). Some issues were both advantages and disadvantages (for instance, pleasure from the female condom was mentioned as an advantage by some, while others mentioned discomfort or pain). Table 5 summarizes the most often mentioned answers in the discussion groups. No frequency figures are given, because it was not the intention of this question to exhaust all opinions.

Advantages of female condoms
An advantage that most groups mentioned was that when a woman inserts a female condom beforehand, it adapts to the body's temperature and adjusts to the shape of the vagina, and therefore the man feels as if there is no condom and has the sensation of *kurova nyoro* – natural, unprotected sex. The other advantage of being able to insert the female condom beforehand is that one cannot forget about protection in the heat of the moment. Men and women users said that female condoms bring more sexual pleasure – some said this was because of the inner ring which stimulates them, others said that it is psychological because they feel safe, and others that they do not notice when the woman is 'too wet' (in the vagina). For a man it is an advantage that he can rest inside the woman after ejaculation, and does not have to start all over with a new condom if the erection is lost but can wait until he is aroused again and start another round of sex. Single users mentioned the advantage that female condoms can be used during menses. It is 'inconvenient' not to have sex when you want it and contact with menstrual blood is supposed to be unhealthy for a man. Single men users said that the size of the female condom is comfortable and that they do not feel friction (as with a male condom). Married users mentioned many of the same advantages, adding that because the female condom covers a large area, the man is not in touch with the fluids of the woman, which is advantageous on two levels: some women have too much fluid, which makes sex too slippery, and it prevents infection. More married men saw it as an advantage that their wife could insert the female condom beforehand.

The sharing of responsibility for protection with their stable partner was mentioned as an advantage by single men. An interesting point was mentioned by single users that with female condoms the man cannot be accused of rape, because the insertion of a female condom by a woman implies consensual sex, and if the partner inserts it beforehand it means she is ready for sex.

Women (and some men) saw it as an advantage that women are in control with female condoms and empowered to protect themselves from STIs, HIV, and unwanted pregnancy. They also have

time to prepare for sex. Some married women said that their husband now has more sex with them and gives them sexual satisfaction because they do not have to wear anything, and because the sex feels like *kurova nyoro* – which men are entitled to with their wives. Some women also said that for women, female condom use causes more sexual pleasure.

People who always have to protect themselves – the PLHA in Zimbabwe with whom we talked were very aware of this – mentioned that an advantage of the female condom is that it brings variation from male condoms in protection. Some groups said that female condoms are easily accessible, also because not many people use them and so they are never out of stock in clinics, as sometimes male condoms are.

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

A. Advantages and disadvantages of the female condom		
	Advantages	**Disadvantages**
Effectiveness	• **Strong, does not burst** • Does not come out easily (M) • Covers big surface area	• **Penis can be inserted under the FC and not be protected**
Feeling	• **Sex feels like nyoro** • More sexual enjoyment • Makes you feel safe • Do not notice when the woman is too wet	• **Inner ring causes pain** • Associations with CSWs • Ugly shape • Fast ejaculation
Appearance and qualities		• **Package to big**
Availability	• Available	• Not widely available
Control	• **Empowers women**	• **Women misuse: use the same FC with multiple partners** • Women in control
Use	• **Can be worn in advance** • Can be used during menses • Penis can stay inside vagina after ejaculation	• **Difficult to insert** • People do not have knowledge • Takes time to put in
B: Advantages and disadvantages of the male condom		
	Advantages	**Disadvantages**
Effectiveness		• **Risk of bursting** • With removal , risk infection • Stays in vagina if man loses erection
Feeling		• **Constrains, too tight** • Reduces sexual pleasure • Causes rash
Appearance and qualities		• Bad smell
Availability	• **Readily available** • Cheap	
Control	• **Man in control** • Man disposes condom, sperm not used for *muti* • Only use once	• Men in control, and can sabotage
Use	• **Easy to put on** • Portable • Can be used for spontaneous sex	

Disadvantages of female condoms

An often mentioned disadvantage was related to the fact that women are in control – men said that women can misuse female condoms by using the same one with multiple partners (this was a particular concern with CSWs, who were generally said to insert the female condom beforehand). In that way men infect one another, but the CSW is protecting herself. Some found the association of female condoms with CSWs to be a disadvantage, because other women would not want to use them. Some single men had problems giving the responsibility over to women, especially women they cannot trust: these women could use the female condom with

multiple partners or use their sperm for *muti* (either to tie the man to her by making him impotent with other women, or to make her wealthy).

A mentioned disadvantage was also that female condoms are difficult to use, with the man having to take care that his penis is not inserted under the female condom. This would result in lack of protection for the man and the woman, and a feeling of stress about having to check all the time. Some complained about the inner ring, which can cause pain for the man or the woman or both. Some men said that the sight of the female condom, or of their partner inserting it, made them lose their appetite for sex. Other men felt that for their partner it is cumbersome or painful to insert and also said that insertion takes too much time. If they are eager for sex there is no time for it. Women users also said that it is difficult and cumbersome to insert for some, that not all women may be able to do it ("*you must have a flexible body*"), and that it may cause pain when not well inserted or if the man is too rough. A man may push it inside if his penis is not well inserted and so they are no longer protected. The best way to use female condoms for sexual pleasure is to have it inserted beforehand, but one is not always prepared for sex.

Single and married users, male and female, said that the fact that people do not know enough about female condoms is a disadvantage, because it means that not all partners are willing to use one. Another disadvantage is that female condoms are not widely available and are also expensive. This may be a contributing reason why women, and in particular CSWs, use them more than once. 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 secretly have one with them.

Advantages of male condoms

Single and married men said that they like male condoms because they are in control and cannot be tricked by a woman. They check the expiry date, put it on well, use a new one for each round of sex, and feel safe. They are also in control of disposal of the male condom and so the sperm cannot be used by the woman for *muti*. Men added that male condoms are widely available and cheap. They are used to male condoms, male condoms are easy to put on quickly, and so are good to use for spontaneous sex. Because they can only be used once and have to be put on just before sex, men and women are both protected.

Women also acknowledged the ease of use of male condoms by the man, and the fact that for every round of sex there is a new condom. Some women also considered it an advantage that the man is responsible for disposal of the condom so that she does not have to worry about it or about spillage. None of the groups talked about advantages related to effectiveness, feeling, or appearance of the male condom.

Disadvantages of male condoms

The major disadvantage of the male condom is that it can burst – all groups mentioned this. This can happen 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 if it is pierced by something sharp. Many men said that the male condom constrains the penis and is too tight, which decreases sexual pleasure. Some men and women reacted to the latex with rashes on their sexual organs. During sex it was considered a disadvantage of the male condom that if a man loses his erection the condom may stay inside the vagina, and thus he has to put on a new one if he wants to start again. Men complained of the bad strong smell of some condoms (Protector Plus). They said that everyone could smell it if they had had sex secretly, for instance during lunchtime. Married men said that they could risk infection with HIV or STIs when removing the male condom and touching the woman's vaginal fluid, or from having touched the vagina during foreplay and then touching the male condom or penis.

Women reported the same disadvantages and added that they do not always like the men to be in control because they can sabotage the male condom. Men can purposely prick it to make their partners pregnant, or at the moment just before ejaculation remove it because the condom constrains their pleasure.

3.2 Perceived effectiveness of female condoms

Generally participants considered the female condom 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 the male condom. The preconditions mentioned for a female condom to be effective were that it should be placed well, that the penis should be inserted properly (not under the outside ring), and that each one should only be used with one 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. They never had the experience or had never heard of a female condom 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. Furthermore, if the female condom is inserted beforehand, the man does not have any contact with his hands with the vaginal fluids, as is common with male condom use – many men are used to touching the woman first to get aroused, and then with the same hand putting the male condom onto his erect penis.

Participants also said that female condoms are effective because when inserted beforehand a couple cannot be overwhelmed by sexual desire and forget to use protection – as sometimes happens with the male condom. It is effective because women are in charge and they are most motivated to prevent unwanted pregnancy – a man may sabotage a male condom if he wants a pregnancy. Married men said that it is an effective female controlled method because he can check straight away if his sperm has entered the woman, whereas with other methods he can never be sure if something went wrong. As a contraceptive and compared to pills, female condoms cannot be forgotten, and compared to pills, IUCD, and injectables, female condoms do not have the risk of unexpected failure and thus an unwanted pregnancy; all participants knew stories of women who got pregnant while using these methods, while none had heard of a woman getting pregnant while properly using female condoms.

Female condoms were perceived as better for single girls for *dual* protection, because if they use a contraceptive such as contraceptive pills or injectables, they may forget to also use a male condom for protection against STIs and HIV, or their partner may refuse to use the male condom.

Men said, however, that female condoms are not effective with certain sexual partners. Casual partners and sex workers in particular may abuse the female condom by reusing a single one with several partners. In that case the woman would be protected, but protection would not be effective for the man.

CHAPTER 4: MEN'S SEXUAL PARTNERS

The second FGD ice breaker was a discussion of the categories of sexual partners men have. This was important information because it was theorized that men's acceptability and acceptance of female condoms 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 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) prostitutes or commercial sex workers (CSWs). FGD participants elaborated on each category, mentioned local names for them, and made sub-divisions. Analysis shows that types of partner differ in terms of exclusivity, 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 a sex worker and a casual girlfriend, and 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

Zimbabwean men pay *lobola* (brideprice) to the family of their spouse and with this pay for ownership of the woman, including her sexuality and offspring. After marriage the man normally makes all decisions about the number of children and use of protection and contraception. He has the right to *kurova nyoro* – Shona for unprotected and therefore pleasurable and good sex – with his wife. The term *kurova nyoro* has erotic connotations and is used to describe a condition most desired by the majority of men in Zimbabwe. A wife is not supposed to have extra-marital sexual relationships, whereas a husband's extra-marital affairs are condoned. Spouses may discuss use of the best methods of contraception to prevent unwanted pregnancy, but discussing protection against STIs and HIV is not done, because this would imply that one partner distrusts the other.

4.2 Stable extra-marital partners

Many married men have stable extra-marital relationships with a woman with whom they may also have children, and may have married traditionally and possibly intend to take as a second wife. They financially support these women, referred to as 'secret wives' or the 'small house'. Married women knew that men have these small houses (although they do not know the specific women) and said that men have them for sexual pleasure. Men also said that in the small house there is more sexual excitement. However, men have less control over the sexuality of their small house, because they have not paid *lobola* and thus do not have exclusive rights to her sexuality. Many men therefore said that they cannot trust their small house not to have other sexual relationships, and also suspect that she might try to have children with him and therefore have more power over him. The small house 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 prevention and protection.

4.3 Stable girlfriends of single men

There are different types of more or less stable girlfriends. With all these girlfriends, men cannot be sure that they are the exclusive sexual partner. Single men have their most serious stable girlfriend, also called marriage type, marriage stuff, marriage material, and *ogan* (original). With this girlfriend they are more serious, and thus more careful in their relationship, which means that

they do not want to impose too much and make all the decisions. Single men may also have older women as a stable girlfriend, called a *mbuya* friend or '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.

4.4 Casual girlfriends

Married and single men have more or less durable relationships with casual girlfriends, to whom they can go when they want sex. This can be on the basis of some form of payment, or just knowing that she likes to have sex. Importantly, with these women there are no obligations. One type of causal girlfriend is the *mai ngaa*, a woman in the community who provides sexual services for money for single and married men who want it. She usually does this because she cannot provide for herself and her children and needs extra income. However, other groups of participants said that the *mai ngaa* is a community woman who wants sex because she is not satisfied by her husband. The *mai ngaa* is not as stable as the *mbuya friend* (see 4.3 above).

Men – married and single – may also have rather stable exploitative sexual relationships with women in need of money, food, or a place to sleep, who are referred to as *tibumu* (destitute), whom they control completely. 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. The man makes all the decisions, although the girl may have emotional power over him.

Women participants described some of the single casual girlfriends which men have as *marwei* (home wrecker), as they go from one man to another and are just out to use a married man, get his money and attention, and destroy his relationship with his wife and his commitment to his family.

Men may also have a one-time stand with a woman or girl they meet in the street or another place just to have sex with. These partners are also called 'hit and run', 'time pushers', or *chikepe* (boat). With these women there are no obligations. 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 one-time women and CSWs is not always clear, because some girls men pick up from the street expect money and do this routinely – they are also called *njapisi*.

4.5 Commercial sex workers

CSWs have sex for money. Some are out on the streets, others work from bars. There is no relationship with the man with whom they have sex, and there is no obligation other than for the woman to give sex and the man to pay. The man has power over the CSW because he pays. Men had different names for them: *njapisi* – one that you pick up and have to pay for, *mahure* (whore) who work from bars, and 'vampire'. Men can be sure that the CSW will not want to have a child with him and would want to protect herself from STIs and HIV (re-)infection.

For the sake of the rest of this report, we use four categories of sexual partner: 1) spouse; 2) stable partner (for single men usually referring to the 'marriage material', for married men to the 'small house'); 3) casual partners; and 4) CSWs.

4.6 Prevalence of types of sexual partner

Table 6 indicates the number of sexual partners which men and women reported in the pre-FGD interviews to have had in the year preceding the study. The following figures should not be interpreted as representative, but still some conclusions can be drawn.

Table 6: Number of sexual partners in the last year, by sex and marital status (%)

# Sexual partners	% Males			% Females		
	Single (N=70)	Married (N=46)	Total (N=116)	Single (N=13)*	Married (N=15)	Total (N=28)
1 sexual partner	53	54	53	100	100	100
2 sexual partners	41	39	41	0	0	0
3 sexual partners or more	1	4	3	0	0	0
No sexual partner	4	0	3	0	0	0
No information	0	2	1	0	0	0
Total	*100*	*100*	*100*	*100*	*100*	*100*

Note: The 10 CSWs are excluded from this table – they all had more than 3 sexual partners

About 42% of single and 43% of married men had more than one partner in the last year. The questionnaire did not ask whether these were concurrent or not. All women reported to have had only one partner.

Concerning the types of partners participants had, 30% of married men had sex with a casual partner and 9% of the married men had a stable girlfriend besides their spouse (see Table 7). The majority of single men (77%) had a stable partner and 30% of single men had casual partners. More single men said that they had visited sex workers (19%) than married men (9%).

Several married and single men in the FGDs said that according to their culture, "*In marriage women do not express themselves sexually – and that is the reason men have outside partners to find sexual pleasure*".

As was expected, married women reported having fewer extra-marital relations than men; in our study population no females mentioned having had extra-marital affairs. Some single women did report having both stable and casual boyfriends as sexual partners (but this was not necessarily at the same time). Furthermore, a relatively large proportion of the single female study population mentioned having had sex with somebody who had been their spouse (13%); some were now single because they were divorced or separated and others had become a widow. Note here that one of the FGDs was with CSWs, who all mentioned having had casual partners; this explains the relatively large percentage of single females with casual partners (48%).

Table 7: Type of sexual partner in the last year, by sex and marital status (%)

Sexual partners	% Males		% Females	
	Single (N=70)	Married (N=46)	Single (N=23)	Married (N=15)
Spouse / spouses	14	98	13	100
Stable partner	77	9	39	0
Casual partner	30	30	48	0
Sex worker	19	9	0	0
No sexual partner	4	0	0	0
No Information	0	2	0	0

CHAPTER 5: MALE ACCEPTABILITY OF FEMALE CONDOMS

The study explored whether and why female condoms are acceptable to men – whether or not they have a positive attitude towards their use – and whether acceptability differs by type of sexual partner. This chapter presents findings on the acceptability of the female condom with different sexual partners (5.1) and the acceptability of different female partners initiating female condom use (5.2). This latter issue is particularly relevant given that female condoms are positioned by the UAFC Joint Programme as a female initiated double protection method. The last two sections discuss the reasons why men do not use female condoms (5.3) and motivations why they may start using them (5.4).

5.1 Male acceptability of female condoms with different sexual partners

Married men
Married men generally said that female condom use is acceptable within marriage as a family planning method. Since there is trust within marriage there is no need for female condoms as protection against diseases. Not all married men agreed that female condoms are acceptable within marriage, because they felt that use of any condom is associated with sex work and extra-marital sex. Generally, married men felt that female condoms are not acceptable with extra-marital partners, because they cannot be trusted. The exception to this would be if the man is present when she opens the package and puts it on (this was mentioned especially by the users).

With the 'small house' men disagreed over whether female condoms are acceptable. Some said that the small house wants to get power over the man by having his children and may sabotage the female condom, or may use it with more than one man – she may be the small house for various men. Other men accepted female condoms with their small house because they have a relationship of trust. For the very young girls and virgins with whom some married men had relationships, female condoms were not acceptable because they said that their physique makes them unable to wear one. Some thought that they are never acceptable with a CSW (or 'vampire') because their type of business makes them unable to put on new ones with each client; one participant said it would be acceptable "*…only if you have her the whole night*".

However, many men agreed that female condoms are acceptable with all sexual partners if the married man is HIV positive, because they are the safest method. They did have the condition, however, that the man would want to be present when the package is opened and the female condom inserted, because he cannot trust partners not to reuse a female condom, or use it with more than one sexual partner.

Single men
Single men could accept use of female condoms with their stable partners, as long as they trusted them. However, they could not accept it with casual partners and sex workers because they cannot be trusted; these women may reuse the female condom after washing it, or even simply leave it inside to use again. They may also use the collected sperm for *muti*, causing havoc or putting a spell on the man concerned so that he can only have sex with her. In a more or less stable relationship with an older married woman, a *mbuya* friend, female condoms would be acceptable if she was used to them. However, some single men said that this is also dangerous because some of these married women are hungry for sex and may have several young boys as lovers, using the same female condom with multiple partners.

Women

Married female *users* said that female condoms are acceptable in marriage, though it depends on the type of husband and communication about sexual issues. They were divided over men's acceptance of use with the 'small house' and with girlfriends – they said it depended on the power the man has over the woman and the trust between them. From their own experience, female condoms are acceptable in marriage if the couple is HIV positive or discordant. It was interesting that married women *non-users* thought that female condoms should be acceptable for men in all type of relationships, including with themselves, because it is a safe protection and prevention method. If their husbands used them outside, they would be protected. They noted, however, that a man has to be careful with the small house because this woman may tamper with the female condom if she wants his children and she may use his sperm for *muti* to make sure he only wants to have sex with her (and not with his wife) and make him impotent with all other women.

Single female users thought that female condoms would be acceptable in any stable relationship of married and single men because of trust and communication – they also considered the small house a stable relationship. Female condoms were not considered acceptable in casual relationships, including CSWs, because of fear of sperm harvesting and of using one with more than one man. However, the sex workers who participated in an FGD said that they experienced that young men did accept to use female condoms with them – one reason was that they do not even notice that there is a female condom inserted, and the other was that young men fear HIV more than older men. Sex workers' experience was that married men accept female condoms less and want unprotected sex – they theorized that this is because they have protected sex at home.

5.2 Male acceptability of female initiation of female condoms

The female condom is positioned as a female initiated and controlled method. Therefore in the FGDs it was discussed how men would react: first, when a sexual partner asked him to use a female condom, and second, when the sexual partner already had a female condom inserted beforehand.

Married men

Married men generally felt that their wife could not initiate female condom use for three main reasons. Firstly, in patriarchal culture the husband makes the decisions and introduces new issues, not the wife. Secondly, women are not supposed to talk about sex, let alone about condom use. Thirdly, he will suspect her of adultery and of having learned new things from an extra-marital sexual partner. If she had a condom already inserted the first time this would be a valid cause for separation. However, it would also depend on the trust and communication between the spouses. If the woman introduced it well and if the couple had discussed and agreed on the use of family planning, it would be acceptable for the wife to suggest using a female condom. After the man has accepted it, she could even insert one before the husband comes home – especially after he has informed her of his coming – but never the first time. A married non-user explained:

> My wife could only do so [introduce female condoms] by encouraging me to go with her to the clinic for advice on family planning. If she is to bring such information to me at home and not link it to a formal teaching from the clinic I am likely to take it negatively and accuse her of infidelity or having used the female condom outside the home.

Mistresses, small houses, and CSWs initiating female condoms was not acceptable to married men, mainly again because men are the decision makers and have power over women. The small house was also generally suspect because she wants children from the man and may

sabotage the female condom. A contradictory reason given by other participants for not using female condoms with the small house was that there is trust, as in marriage, and condoms are not suitable for this type of relationship. With these types of partners, having a female condom already inserted would always be unacceptable and men would not have sex with the woman. He would either ask her to remove the female condom or would just leave.

Married men living with HIV generally said that female condoms were acceptable – and advisable – with all types of sexual partners, and agreed with the woman initiating as long as they saw her taking the female condom out of the package and inserting it; some added that they would also want to see her dispose of it.

Single men

Single men disagreed about whether initiation by their stable partner would be acceptable. Some single men would accept if their stable partner initiated female condom use for the first time. However, she would have to explain how she got to know about them. Single men in another group said that they could not accept their serious girlfriend initiating use, because she is not supposed to have sex and know about issues such as condoms. They will then start to suspect that she has had other sexual relationships. Single men admitted that they have been socialized with the idea that men make all decisions and that girls and women are not supposed to talk about sex and make decisions. However, they also admitted that things are changing and that girls do get more power – mentioning that "…*even the Bible says that men have to listen to the views of women*". Single men agreed that married men have more power over their wives than over their stable girlfriends, because *lobola* has been paid; so it will be less acceptable if a wife initiates female condom use than if a girlfriend initiates.

The majority of single men would not find it acceptable if they encountered their stable partner already wearing a female condom, because he could not trust that she had not used it with someone else beforehand. However, a few men said that they would be able to accept it if he had called her to say that he was coming over; in that way, she would be better prepared with a well fitted female condom and the sex would be more enjoyable.

Initiation of female condoms by women is related to the power relations. Single men agreed that 'sugar mommies' usually have power over their young lovers, who have to accept whatever the sugar mommy initiates. Married men concurred with this, but thought that the boy had at least some say because he gives her sexual favours. A few single men also said that they would accept it if a casual sexual partner were to wear a female condom in his presence.

Women

All single and married women saw it as a problem for a married woman to initiate female condoms, because the husband will suspect her of infidelity and because he has access to her sexuality through *lobola.* If she already had a female condom inserted beforehand the wife risks big tensions and being sent away. Single women said that they had a strategy with their sexual partners: "*no condom no sex*". However, this does not always work, and women may lose their partner. Sex workers said that this strategy is difficult because they may lose customers and thus money.

5.3 Reasons why men do not use female condoms

Single and married male non-users gave various reasons why they in particular – and men in general – did not use female condoms. One often heard reason was that they just did not have enough information and knowledge about female condoms, while others did not want to use them because of their negative attributes. Generally, they thought that men did not like to use any condom, because they restrict natural sex. One young man said: "*All men have the right to*

'nyoro". Generally condoms are associated with CSWs and are not for use in serious relationships. Thus single men are reluctant to use a condom – male or female – which gives the impression that the relationship is not serious. Gender relations also come in here. Men felt that with female condoms they are not in control, because they give the control to their sexual partner. This relates to decisions about protection and control over what happens to his sperm. There are many rumours and stories about sperm being harvested and used for rituals; the sperm can also be used to make *muti* to tie a man to a specific girl, so he may end up marrying someone he does not want. Another rumour is that everything foreign should be suspect because the intentions behind them are doubtful – a story had circulated that HIV was transmitted by CSWs having sex with HIV positive dogs, and that foreign men had made them do it. There was also the rumour that the lubricant on condoms contains HIV.

Some married men said that they did not know about female condoms and were not interested to know about them. These men wanted to stay with their male condoms or did not want any condom – they wanted *nyoro*, something they are entitled to with their wife because they have paid *lobola*. Others said that they do not need condoms because they and their partner are HIV negative, and furthermore condoms are not for marriage but are associated with casual sex and prostitution – which they said they do not engage in. In addition, with casual partners female condoms are risky because these women abuse them; they insert them beforehand and use them with more than one man. Men who knew a bit more about female condoms said that the insertion is disturbing to see and kills the man's sexual appetite, therefore they do not want to use them. Married men one time users thought that men do not use them because they are not easily available and also because they lack knowledge about them. The other reason was that men, in accordance with their culture, did not like women to be in control of decisions about contraception and protection. Generally, they thought that women were not empowered to take control and to get female condoms.

Married women who had not used female condoms – or only used them once or twice – thought that men do not like to use female condoms because: with them they are not sexually satisfied; because female condoms make too much noise and disturb them; or simply because men just do not want to use condoms. A reason for not wanting to introduce condoms to the marriage may be that it would indicate mistrust between the partners – if a man introduces them he may worry that the wife will think he is HIV positive.

Table 8 presents the findings from the pre-FGD interviews from the question of why the twenty-seven respondents who had never used female condoms had never done so. Figures are too small to be conclusive, but give some indication. The most often reported reason by men for not using female condoms related to preferring another method, and by women that the partner does not want to use them (though this reason was also often mentioned among men).

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

Reasons	# Males			# Females			Total # (males & females)		
	Single (N=11)	Married (N=10)	Total (N=21)	Single (N=5)	Married (N=1)	Total (N=6)	Single (N=16)	Married (N=11)	Total (N=27)
Prefers other method	6	3	9	1	1	2	7	4	11
Partner does not want to use it	5	2	7	3	0	3	8	2	10
Does not know how to use it	0	2	2	0	0	0	0	2	2
Not available	0	1	1	0	0	0	0	1	1
No sexual pleasure	0	1	1	0	0	0	0	1	1
Not interested	0	1	1	0	0	0	0	1	1
Too expensive	0	0	0	1	0	1	1	0	1

5.4 Why men may try using female condoms

Married men who had never used female condoms said that after receiving the necessary information they may use them in the future – if they had agreed with their wife that this is the most suitable method of birth control. Some men also thought that at some point their wife might be able to convince them to use female condoms. It was also possible that they might find themselves in a situation where only female condoms were available. Some men were realistic, and talking generally said that if one or both of the partners tested HIV positive, the couple may start using female condoms.

Single men said that they might start using female condoms if they had more knowledge and heard positive stories about them. One man said that he had recently heard about the sexual pleasure with female condoms, along with other advantages, and thus he was ready to use them – also to please his girlfriend. Some said that they might start using them when they have a serious partner whom they trust and have communication with about sexuality. Some boys believed that it could be their girlfriend who would make them use them, because some girlfriends do have power over their boyfriends, especially if they earn their own money and financially support their boyfriend – which is not uncommon nowadays, they said.

It was interesting to note that the FGD participants' intentions to try female condoms became stronger after the demonstration at the end of the FGD, during which they were shown how to insert them and had heard the advantages of female condoms – in particular that they are next to natural (*nyoro*) – and were given free samples. This supports their idea that with more knowledge and supply, more men will consider using female condoms.

The large majority of the twenty-seven non-users (85%) in the pre-FGD questionnaire said that they might try using them in the future (see Table 9). Only two single men and two single women said that they did not intend to use them.

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

	# Males			# Females			Total # (males & females)		
	Single (N=11)	Married (N=10)	Total (N=21)	Single (N=5)	Married (N=1)	Total (N=6)	Single (N=16)	Married (N=11)	Total (N=27)
Yes	9	10	19	3	1	4	12	11	23
No	2	0	2	2	0	2	4	0	4
No info	0	0	0	0	0	0	0	0	0

CHAPTER 6: ACCEPTANCE OF FEMALE CONDOMS

A total of 126 FGD participants, 94 males and 32 females, shared their experiences with female condom use. Some had used a female condom just once or twice (28, 22%), others had used them up to 10 times (44, 35%), and 53 participants (42%) had used them more than 10 times – many of them were frequent users, saying: "*Do you mean more than ten in the last month?*" Table 10 below provides data on the numbers and percentages of male and female, married and single, users, by frequency of use.

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

# FC use	Males						Females						Total (males & females)					
	Single (N=59)		Married (N=35)		Total (N=94)		Single (N=18)		Married (N=14)		Total (N=32)		Single (N=77)		Married (N=49)		Total (N=126)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Once or twice	12	20	11	31	23	24	2	11	3	21	5	16	14	18	14	29	28	22
3-10 times	22	37	15	43	37	39	5	28	2	14	7	22	27	35	17	35	44	35
>10 times	24	41	9	26	33	35	11	61	9	64	20	63	35	45	18	37	53	42
No information	1	2	0	0	1	1	0	0	0	0	0	0	1	1	0	0	1	1
Total	*59*	*100*	*35*	*100*	*94*	*100*	*18*	*100*	*14*	*100*	*32*	*100*	*77*	*100*	*49*	*100*	*126*	*100*

Note: Single: singles / single – stable relationship / single – divorced / single – widowed / single - separated

This chapter follows the course of the 126 users, regarding what motivated them to use female condoms for the first time (6.1), what was their experience that first time (6.2), why they continued using them, and how some became a frequent user (6.4). A considerable number of users (31, 25%) said that they stopped using female condoms, and in section 6.3 their motivations for stopping will be presented.

6.1 Motivations for first time female condom use

Men

The main motivation to use a female condom for the first time, for both single and married men, was curiosity about how female condoms would feel and to try and experiment with something new – they mainly referred to the sexual experience. Men were curious about the difference in sexual experience with male condoms; whether it was really *next to natural* as they had heard. They were also curious about how they would feel in such a "*big shape*". Participants had heard about female condoms in advertisements, or had them explained during a workshop (in support groups, training by PSI), or had heard about them from peers. Often female condoms were given out for free during workshops and training, and so it was easy to try. A special case was the motivation of people who were trained as peer educators, who said that they wanted to have firsthand experience of the method they were going to promote among their peers.

People who tested HIV positive received counselling about positive living from the clinic, and were advised to prevent re-infection or infection of their partner if they were in a discordant couple. They were counselled about the male and female condom and made to understand that female condoms are safer. This was a strong motivation for using a female condom for the first time – also by people who had been using male condoms before. Some also said that since they were HIV positive, other contraceptives were no longer relevant, and thus they also used female condoms for prevention of pregnancy. In some cases it was in a situation where the man really wanted sex, but at that moment there was no male condom around, or the girlfriend was on her menses; this had made him try a female condom.

A few men used a female condom for the first time because their sexual partner made them or advised them to: with one young man it was with his sugar mommy; with another man because his wife insisted after she had heard about them in the clinic and was given a free sample; another man had wanted sex with a sex worker who provided it; one young man met a woman for casual sex; and a married man with erection problems was advised by his wife to try female condoms.

A few men said that it was not their conscious decision to use a female condom for the first time, but that they had not noticed that their partner had inserted one; they only found out about it after the act, or even some time later. Some married female users also shared that the first time they had used a female condom secretly and their husbands had not noticed. Only after some time did they tell their husbands about it – who were then convinced that it was next to natural.

Women
For women the main motivation was that they wanted to try this safe method of preventing pregnancy and protecting against diseases, after having heard about it in a workshop or at the clinic. However, women also reported that their motivation to try was that they or their husband had rashes from the male condom, or that their husband did not like sex with a male condom (and since they were HIV positive they *had* to use a condom), or that they thought it was a safe way to prevent pregnancy – men did not bring up these motivations. Women who were HIV positive or in a relationship with an HIV positive partner, because they always had to protect themselves, were motivated to try something new and have some variation from the male condom. Some married women said that they were not keen to try it, but that their husband had insisted because he was tired of using male condoms, with some men outright refusing to use male condoms again. A few women said that they were motivated because with female condoms they would be in control of their sex life and health. Married women gave some suggestions on how a woman could strategically introduce them and make them acceptable, for example by letting him feel that he made the decision, by explaining well where she got the information from, by making it sound exiting to use a female condom, and by explaining that it is the most suitable way to prevent pregnancy.

Motivations from sex workers were that they considered it the safest way to protect themselves against diseases. Just one participant sex worker living with HIV said that her motivation was to prevent spreading HIV to her clients.

6.2 Experience of first time female condom use

During the first time female condom use, men and women had positive and negative experiences, with some groups relating more positive and some more negative. Generally, the groups of frequent users had more positive first experiences than the one/two time users. Women usually had more negative first experiences than men.

Men
The most mentioned positive first experience by men was that they felt as if there was nothing there, that it felt like *kurova nyoro* (natural sex). They felt nothing holding their penis, unlike with male condoms. Some men had thought that they were not using anything and only later found out that their partner had a female condom inserted. Some men said that it made sex even more exciting and pleasurable; that the inner ring stimulated them; that after ejaculating they could rest their penis in the vagina and start again when aroused. Especially when the women already had experience with using female condoms, and so inserted it quickly and well and did not show discomfort, men enjoyed it more. Men said that what contributed to their positive first experience

was the psychology of feeling protected and safe by the female condom – more 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, and was fumbling around while he was ready to have sex. He then got impatient and lost momentum. When trying a female condom with a stable partner, if the woman inserted the female condom incorrectly or complained of pain or discomfort, this also made the man have a negative first experience, psychologically and/or due to pain from feeling the inner or outer ring. Men also complained of being disturbed by the noise which the female condom makes when being inserted or during intercourse – this was usually in combination with other negative experiences such as pain. Several men were put off by watching the woman insert the female condom, and seeing its disturbing big shape. Men also feared that the female condom could disappear into the vagina or 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 inserted their penis incorrectly and pushed the female condom inside, which disturbed the sex and caused pain, or said that they had used force which caused pain on their foreskin. Two men said that the female condom broke the first time they used it because it was incorrectly inserted. 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

Women overall had more negative first experiences than men – about four out of five had a negative first experience. Mostly they realized that they had not properly inserted the female condom, which then caused them pain and discomfort, even more when the man entered. They experienced pain from the inner ring or the outer ring. Some women said that it might have been psychological, that they were not ready to use female condoms, and that they were disturbed by the noise of the plastic during sex. One sex worker said that her first experience was negative because she felt too wet in the vagina and that the customer had also complained about it and refused to pay her.

Only a few women said that they enjoyed sex with their first time female condom use – because it felt natural and their partner also thought so. Most of these women had the condom already inserted when their partner came, or they were sensitized together on the female condom, including how to insert it. Women talked about a feeling of enjoyment and increased heat.

However, even with a negative sexual experience, women said that they did not mind because their motivation was really to have a safe way to prevent pregnancy and/or protect against disease and (re-)infection. Married women went as far as to secretly use the female condom for the first time without their husband knowing, because they anticipated that he would not agree or would start doubting her fidelity.

6.3 Reasons for stopping female condom use

Table 11 shows that the majority of those who indicated having stopped use of the female condom did so after one or two times (this is not a representative figure, however, because of the sampling frame).

Table 11: Participants who stopped using after number of times used, by marital status and sex (#)

# times used	# Males			# Females			Total # (males & females)		
	Single (N=13)	Married (N=12)	Total (N=25)	Single (N=4)	Married (N=2)	Total (N=6)	Single (N=17)	Married (N=14)	Total (N=31)
Once or twice	8	7	15	1	2	3	9	9	18
3-10 times	3	5	8	3	0	3	6	5	11
>10 times	2	0	2	0	0	0	2	0	2

In the FGDs the reasons for stopping use were explored. Some men reported that their first experience was not good so they stopped. Others said that their wives did not want to use them again after a negative first experience: they complained, for instance, about the inner ring being painful, or just not feeling comfortable. Some men said that they stopped because they were so disturbed by the sight of a woman putting in the female condom that they did not want to see it again. Some men had the experience that it took the woman too long to insert it, and so they had lost their appetite for sex.

Others gave as a reason that they had just wanted to try it out, but were faithful to their wife and thus did not need them – they preferred to use other methods for family planning, or just wanted their wife to get pregnant. Some married men also had reasons related to not wanting to lose control of their wives in the use of female condoms, as this would go against the gender norms within marriage of men making all decisions. Some also said that any condom is not good for marriage because it shows distrust and suspicion of adultery. Religion was also said to dictate against all condoms, and thus it felt morally wrong to use them. With other partners men feared that the same female condom had been used with multiple men.

In the pre-FGD questionnaire, people who stopped after having used female condoms were asked *why* they stopped. Figures are small, but among the participants who stopped using female condoms, men stopped because: they are too cumbersome to use; their partners did not want to use them; they did not know how to use them; or because they trust their partner and therefore have no need for protection (see Table 12).

Table 12: Participants who stopped, reasons for stopping use, by marital status and sex

Reasons for stopping use	# Males		# Females		Total # (males & females)	
	Single (N=13)	Married (N=12)	Single (N=4)	Married (N=2)	Single (N=17)	Married (N=14)
Partner doesn't want to use it	0	1	2	0	2	1
Too cumbersome to use	3	0	0	0	3	0
Prefer to use other method	2	0	0	0	2	0
Not comfortable using it	0	2	0	0	0	2
Don't know how to use it	0	2	0	0	0	2
No partner at the moment	1	0	0	1	1	1
Not available	0	1	0	0	0	1
No sexual pleasure	1	0	0	0	1	0
Wants pregnancy / is pregnant	0	1	0	0	0	1
Other	1	2	0	0	1	2
No information	1	1	2	1	3	2

Note: Other: often not specified

6.4 Frequent use of female condoms

Why become a frequent user

Men

Most men – after a positive first experience – became frequent users of female condoms (with their wife or stable girlfriend) because sex is next to natural. Many said that female condoms have advantages over male condoms, which made them embrace female condoms: for example, the female condom gives them more enjoyable sex and does not have a bad smell, it gives more protection, it does not interrupt foreplay, a man does not need an erection, and the man does not have to dispose of it.

> I like the female condom and I want to keep using it. The fact that it doesn't produce annoying smell so even you sleep after sex you are not disturbed with the smell of the condom, and the other thing that it gives you the natural sense that the male condom it doesn't give you this.
>
> 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.

For men (as for women) a major incentive to become a frequent condom user was to have tested HIV positive, or their partner to have tested positive (and thus being in a discordant relationship). Many PLHA said that with female condoms they got an alternative and variation in their sex life – being fully aware that being HIV positive means always having to use a condom.

Women

Women became frequent users when, as a couple, they and their partner had to protect themselves or needed a family planning method, and the husband preferred or dictated the use of female condoms – instead of him using male condoms. The men may have wanted her to use female condoms because he was tired of or had problems using male condoms. Married women said that even if they did not like it (at first) they had to obey their husband. All female frequent users, however, now enjoyed sex with a female condom because it felt natural – even if the first

time(s) they had experienced pain and discomfort. A married woman living with HIV explained how she and her husband became frequent users:

> When we tested positive my husband and I received counselling together. So when we were told to use either the male condom or the female condom all the time we have sex he suggested that I wear the female condom which I accepted. So we enjoyed the experience and now before sex my husband checks with me whether I am wearing the female condom.

A few single women said that they became frequent users of female condoms because they wanted to be the one in control of their sex life and protection, and female condoms give them the opportunity to do so.

Sex workers see female condoms as a weapon in their work to protect themselves and live a longer and healthier life. Some of them said that even with experiences of pain, and when customers are rough, they endure because they feel safe with the female condom. One sex worker said that with the female condom she may sometimes even enjoy sex with a customer, because she does not feel pain and she feels natural, unlike with the male condom. However, some sexual positions, such as from behind, makes it more difficult to use a female condom, because the man may easily dislocate it and she has to check it all the time.

Patterns of frequent use

Only a few people used only and always female condoms. The most common pattern of female condom use was to alternate with male condoms – especially for PLHA who use condoms mainly to prevent (re-)infection, and are convinced that they always have to use a condom. Respondents alternated for the purpose of variation in sex, or depending on the availability (in the house) of one or the other condom. Some married women still also used other contraceptives because they felt that female condoms are especially for disease prevention.

Concerning with which type of sexual partners they used them, most men used female condoms with their wife or stable partner. Single men said that they used the female condom with their stable partner whom they trust – often alternating with male condoms, so both partners take responsibility. With other sexual partners men mostly used male condoms. One single man said:

> 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.

Only a few very enthusiastic men were like the man in the quote below, and said that they used female condoms with all their sexual partners (see also Table 9).

> 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.

Most men said they (preferred to) use male condoms with sex workers, even though they knew that the female condom is safer if used properly. The reason was that the CSW may re-use the same female condom (which CSWs confirmed in the FGD that they sometimes do).

CSWs said that they preferred to use female condoms with their customers, but that customers did not always agree. Some said that they like female condoms because they can insert one before they go to the bar to meet customers and do not have to change it, and so make more money. Others added that they also do this because some customers may refuse to use a female condom; if she has already inserted it he will not notice. It is also difficult to change them and put in a new one. Insertion is not easy and/or takes too much time, and customers push them to have sex quickly. Other CSWs complained about the same issue which made men not always want to use one: "*Well with this condom it takes time so this might frustrate the customer so that's why sometimes we don't use it because he will say I am now going with my cash so he will leave me and I lose out on the customer*".

Table 13 presents findings from the pre-FGD questionnaire on use of the female condom by type of sexual partner. These seem to confirm the FGD findings that frequent use of female condoms is mainly with spouses for married men and women, and with stable partners for single men and women. Note that the high percentage of single females reporting use of female condoms with casual partners was caused by the FGD with sex workers. Some married and single men also used female condoms with sex workers. However, when we compare the figures of Table 13 with those of Table 7 (the types of partners people had in the last year), female condoms seem to be used with all partners. Thus, these quantitative findings are inconclusive, because they do not indicate how frequently they are used with these partners.

Table 13: Current use of female condoms with type of sexual partner, by marital status and sex (multiple answers)

Sexual partner FC is used with	% Men		% Women		Total % (males & females)	
	Single (N=40)	Married (N=18)	Single (N=13)	Married (N=11)	Single (N=53)	Married (N=29)
Spouse	10	89	0	100	8	93
Stable sexual partner	88	0	46	0	77	0
Casual partner	13	11	62	0	25	7
Sex worker	8	6	0	0	6	3
No information	0	0	0	0	0	0

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

CHAPTER 7: PARTICIPANTS ON ACCESSIBILITY OF FEMALE CONDOMS

This chapter describes how participants viewed the accessibility of female condoms. When somebody has accepted the female condom and theoretically is prepared to use it, external factors may prevent the person from frequently using it. Barriers to use may be easy availability and affordability. Another barrier may be that the female condom is not accessible due to, for example, shame of buying condoms. Section 6.1 describes how the FGD participants viewed the availability of the female condom, section 6.2 describes their ideas on accessibility of the female condom, and section 6.3 discusses affordability according to the participants.

7.1 Availability

The majority of the participants knew that female condoms are freely available at clinics, health centres, and hospitals, and that they can be bought at pharmacies. A few mentioned that they had seen female condoms in the beer hall they visited. Participants in five FGDs reported that female condoms are distributed at their workplace and are freely available in the women's toilet. The distribution of female condoms through hair salons was mentioned, although only in the FGDs with hairdressers as participants; in other FGDs they were not mentioned. The overall opinion was that female condoms are not available at supermarkets, local shops, nightclubs, and bars – while participants considered these locations perfect outlets to sell them. The young men from Glenorah, a high density suburb in Greater Harare, stated that they had never seen the female condom at school. No difference was found regarding knowledge of female condom availability between males and females and type of user. Only one non-user came forward and admitted that he did not know where to get female condoms.

7.2 Accessibility

Participants generally believed that buying condoms, both male and female, 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 when they are not married. 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. For men, it is generally accepted to buy condoms. Older couples are believed to have easy access to female condoms because they do not feel shame.

Another factor hampering accessibility is the placement of female condom distribution points. Although in practically all FGDs participants mentioned the availability of female condoms at clinics, some of them said that several clinics place the female condoms at the reception in front of the waiting room where many people will see that one is asking for them. This again creates shame and people would prefer a more discrete location within the clinic.

The participants who were part of support groups and who knew their way to clinics and health centres stated that they had easy access to female condoms. The general view was that at clinics, hospitals, and health centres you could get as many female condoms as you wanted, and thus one always has a female condom when the time is there to use it. This was also true for some of the support groups, where female condoms are distributed freely among the members. This finding makes sense, as we know that the majority of the participants were recruited by

ZNNP+, a network of HIV positive people. The members of this network were aware of the importance of having protected sex and also had easy access to female and male condoms.

These participants did realize their unique situation, however, and thought that for people outside of their support groups it is difficult to obtain female condoms. As they are not available in public places such as supermarkets, bars, and nightclubs, they argued that people did not have easy access to them. The lack of availability in bars and nightclubs was seen as a particular problem, because in these places the need for condoms is high.

7.3 Affordability

Concerning affordability, 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).[37] The majority of the study participants stated that the price is 1R for one female condom, and some mentioned the presence of two-packs for 2R. Compared to the male condom, the female condom was considered expensive (they can buy 4 packages with 3 or 4 male condoms for one with 2 female condoms), but many stated that they would still be affordable if they had to buy them. However, nearly all participants received their female condoms for free and thus had not been confronted with the costs of the female condom on a regular basis. Hence, we do not know if an ordinary person would be able to buy the female condom regularly. In the IDI with a barber peer educator who was supposed to sell female condoms, he brought up the issue that it is difficult for him to get money for them because of the scarcity of coins.

[37] Fraudulent behavior with regard to selling female condoms has been reported. Two respondents mentioned that vendors selling condoms in bars and beer halls take advantage of the situation and charge a high price. One mentioned a clinic selling female condoms which they are supposed to hand out for free.

CHAPTER 8: OPINIONS ON HOW TO INCREASE FEMALE CONDOM ACCEPTANCE BY MEN

This chapter first presents the participants' opinions of current female condom programmes, and then gives their suggestions on how to make men accept female condoms.

8.1 Opinions of female condom programmes

Participants mainly compared the current programmes for female condoms with those of male condoms, and sometimes with the recent campaign for male circumcision. Concerning frequency and coverage of campaigns, generally participants felt that there are not enough advertisements and promotion for female condoms compared to male condoms. Some said that they had attended road shows before where the female condom was demonstrated, but that these were no longer happening. Currently, one can only get explanations about female condoms in clinics. They believed that messages also do not reach beyond the big towns, and miss particular groups of people, for instance housewives, if promoted through companies' workplaces.

Female condoms were also reportedly not made as widely available as male condoms. A group of single men said that they noticed that in their workplaces female condoms were only displayed in female toilets, but not in male toilets. People knew that female condoms were distributed and promoted through barber shops, but not everyone was satisfied with this. Married men non-users said that most barbers were not motivated to promote them; part of the problem was because there has been inflation in the number of non-professional barbers who are too occupied in getting customers. They also believed that these barbers do not have enough knowledge and skills to explain female condoms well.

Concerning the messages and target groups, participants felt that female condom messages mainly targeted women and that men were left out; some also felt that youth are left out. The messages aim to empower women. One group said that they target prostitutes and not ordinary women – and so ordinary women do not feel that female condoms are for them. Other groups of single men said that only PLHA are targeted by female condom campaigns, to prevent re-infection. Female condom messages were felt to be mainly targeted to protect against STIs and HIV, not for prevention of unwanted pregnancy. Another complaint about the messages was that they are in English and thus not user friendly to all. They also felt that the advertisements do not address some fears that people may have – for instance, on how to dispose of them.

Many participants could (more or less) reproduce the slogan "*Care, for lovers/men and women who (chose to) care*", and could remember the picture that went with it, showing beautiful people. Some said that they liked the slogan and the picture, some not. Those who did not like it were critical of the people in the adverts, because they are always the same and do not represent people of the community, nor people of all ages (younger and older people are left out), nor actual female condom users (for instance, they are supposed to represent HIV positive people and show them living positively). Furthermore, the people in the adverts are not known people, they are just beautiful artists.

8.2 Recommendations by participants for female condom promotion among men

FGD participants had some useful recommendations for programmes to make female condoms more available and acceptable to men.

Medium and target groups

Television and radio were considered the best mediums to transmit messages and advertisements, because more people would be reached and there is limited reading culture in Zimbabwe. The adverts, using jingles, slogans, etc., should be aired more often – the media should give them more slots. It was suggested that the government could help to ask media companies to make more airtime available. In these adverts users could share their positive experiences.

However, single men said that the best way to promote female condoms was in community sensitization to men and women, where female condoms are demonstrated; this would be more convincing than adverts. During these road shows female condoms should be freely distributed, as are other regalia such as caps. Female condom demonstrations could make use of already planned gatherings, such as church or women's gatherings (for example, of married women) – where female condoms should also be distributed for free. PSI could support some major events and at the same tie promote female condoms there. A group of single men said it would be good to promote female condoms through the church:

> We can also have a breakthrough if the issue is introduced through the church. Most issues that are said through the church are not challenged. Some women have managed to convince their men to go to church. The pastor is respected in the society. If Pastor Tom [the leader of a prominent local church called Celebration International] promotes the use of the female condom we will all follow suit. … The church is very powerful. Whatever the Pastor says will probably be done. Teaching is important and more so if done through the church.

Most advised that in campaigns both women and men of all ages, regardless of HIV status, should be targeted. Furthermore, in community sensitization, special road shows, and gatherings, couples should preferably be targeted together, because they would then understand how the other had got the information (and not suspect the partner of learning about it from another sexual partner). Women commented that in these community sensitization sessions, special effort should be made to attract men, because their experience was that mainly women attended. Women also said that men should be targeted and should be taught how to insert the female condom for their wife. Groups said that these road shows should be brought to all corners of Zimbabwe, including rural areas. Some groups also said that advertisements should target women and men together; while another suggestion was to promote male and female condoms in the same advertisement or session – not separately.

Participants said that female condoms could still be promoted in clinics, but to both men and women. Especially single men suggested having youth campaigns, because youth have their own specific issues. Single non-users suggested that only creating awareness is not enough; rather, there should be demonstrations of condom insertion and explanations of use and the advantages.

A group of single users had the interesting recommendation that female condom campaigns should learn from the successful campaign on male circumcision; for instance, use singers as role models. They also recommended not placing adverts on bins but in attractive places, and having billboards high up where you can see them, because as they said: "*billboards you pass every day get to your conscience*".

Participants suggested that using volunteer peer educators (for instance, in support groups – males and young people) would be another good way to promote female condoms. These peer educators should be well skilled to demonstrate female condom insertion. However, they should

also receive some incentives, in the form of T-shirts, transport money, etc., otherwise their motivation would wane.

Better role models
Most groups recommended using other people in the adverts than those who are currently shown. Some advised using 'ordinary' (community) men and women for the adverts and not always the same glamorous people. Alternatively, groups suggested using well known or prominent people to promote them, since they can act as role 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 said that it was necessary to make sure that young people were also in the adverts – otherwise they will think that female condoms are only for adults.

Interesting was the recommendation by a group of married women – users and non-users – who suggested printing T-shirts with messages on the front and back of male and female condoms, asking community men wear them, and with the provision of transport money they could go around and promote condoms that way.

Wide availability
There should be much more promotion of female condoms, and they should be made more widely available. Some said that they should be available for free, just like male condoms. Others talked about making them available in public places other than clinics, for instance shops, beer halls, nightclubs, and churches.

Design
There were also recommendations on the size and shape. Participants felt that female condoms would be more acceptable and used if the female condom itself and the package was made smaller and more portable. Women said that they should be able to carry a female condom in their bra. They also talked about the shape – that 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 they come in different shapes, colours, and flavours. Single users suggested different flavours, a ribbed female condom for more sexual satisfaction, and improvement on the disturbing noise.

Messages
Frequent users advised that to make female condoms acceptable to men, female condom use should be well demonstrated and messages should talk about the advantages: that it feels like *kurova nyoro* (natural, unprotected sex), and that it is less stressful for the man because he does not have to wear anything. Another promotional message would be to compare female condoms with male condoms, for instance saying that female condoms are comfortable. Participants believed that married men should be targeted with messages of female condoms as a contraceptive (and so dissociating 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 they would feel normal using them and would not feel like a prostitute. Therefore, if the husband suggested female condoms to his wife, she would not feel offended. All promotional messages and materials should be translated into local languages, to reach people who are not conversant in English.

Although participants warned that just a slogan is not enough, because there should be more information and demonstrations, they came up with some slogans: "*Next to natural*", "*The female condom fits all sizes*", "*The female condom protects and benefits both partners*", "*Use care, because care cares for you*".

CHAPTER 9: IMPLICATIONS OF FINDINGS

This chapter summarizes and discusses the study findings and their implications for female condom programmes in Zimbabwe. It addresses the conditions under which men may accept female condoms, and 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. In this last chapter the personal and external factors influencing male female condom use (or non-use) are summarized (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. The chapter ends with a final note on the involvement of men.

9.1 Summary of findings and the implications for programmes

9.1.1 Knowledge of and attitudes towards female condoms

The personal factors found influencing men's acceptability and acceptance of female condoms related to the knowledge of what female condoms look like, how they are used, what the advantages are, and to belief in their positive attributes. A very positive finding was that participants were all convinced of the effectiveness of female condoms for dual protection compared to other methods. Despite seeing many advantages, they also perceived disadvantages with female condoms, related to ease of use, the appearance of both male and female condoms, sexual pleasure, effectiveness, the feeling of protectedness against HIV and pregnancy, and control.

Recommendation
In promotion programmes to men, stress the perceived advantages and address the disadvantages of female condoms. The main advantages that should be stressed in programmes (to men) are that sex feels like *kurova nyoro* (natural sex), that it does not constrain the penis like male condoms, that it is more effective than other methods and gives dual protection, that it brings variation in condom use, can be used during menses, and does not need an erection to use. The main disadvantages that should be addressed relate to the control by women and possible abuse, for example by using the same female condom with multiple sexual partners or harvesting sperm for *muti*.

9.1.2 Types of sexual partners and acceptability of female condoms

An important finding was that female condom acceptability (and acceptance) differs by type of sexual partner for the majority of men. Men differentiate between five categories of partner: 1) marital partner; 2) stable extra-marital partner (called 'small house'); 3) stable girlfriend (of single men); 4) casual partners; and 5) commercial sex workers. Relationships with these partners differ in terms of duration, exclusivity, stability, trust, gender power relations, exchange of money or goods for sex, and purpose. With spouses normally the husband decides on the use of family planning because he is the breadwinner – although this is changing, especially in situations where women are now earning an income. Condoms are normally not used in marriage – where there should be trust – because of the association with infidelity and extra-marital affairs. With all other partners men feel that they have the power to make decisions about contraception and protection, and with all partners (except for the spouse) it is easy to leave her if the woman

disagrees or wants something that he does not want (for instance, disagreeing over condom use).

Male acceptability with partners is related to trust (or lack of) in the partner. Men said that female condoms are acceptable in marriage as a family planning method, but less so as a method to prevent STIs and HIV. Outside marriage a man hardly trusts any type of partner, fully aware that he may not be her only sexual partner. There is more trust in more stable (extra-marital) relationships, such as the 'small house' for married men and the stable girlfriend of single men, and least with casual friends and CSWs. With female condoms, the woman is in control and men believe that she may possibly abuse this control.

The acceptability of women *initiating* female condom use for the first time in marriage and stable relationships is related to the gender power relations between men and women. Mainly it is not possible for a married woman to initiate use unless she can explain well where she heard the information. For other sexual partners, it is difficult to initiate female condom use, unless the woman has power over the man – emotional power from the 'small house' and stable girlfriends, sexual power when single (or married) men are eager for sex and will do anything the partner suggests, or financial power in case of a sugar mommy.

A man finding a woman with a female condom already inserted beforehand without his knowledge could lead to serious trouble in marriage, a fight between stable partners, and the man leaving the casual partner. Women can learn from the female participants' suggestions on how to make husbands accept: she can strategically introduce the female condom and make it acceptable by letting him feel that he made the decision; explain well where she got the information from; make it sound exiting to use a female condom; and explain it as the most suitable way to prevent pregnancy.

Recommendation
In designing programmes, organizations should consider the external factor of dominant gender power relations, which give more power to men, but also leave open some space for certain categories of sexual partners to apply influence or pressure. Promoting female condoms merely as a product for women's empowerment and a female initiated method will not be effective and may be counterproductive in societies where men have normative decision making power over women. Programmes should realize that spreading female condom use cannot go via women only. Educating men, or men and women together, and letting men take the lead in introducing female condoms may be more acceptable in societies like Zimbabwe. However, programmes should continue giving skills to women regarding how to convince their husbands and other partners to try female condoms.

9.1.3 First time female condom use

Curiosity was the main personal motivation for using female condoms for the first time for all groups of FGD participants. They were curious about how it would feel sexually (after having heard about it in the clinic, from training, or in peer groups). External factors that made men use one for the first time were: their sexual partner convinced him, or insisted, and because the female condom was the only method available at the time and the man was eager for sex. Some men did not have a motivation as such, because their first time happened without them noticing there was a female condom inserted – women confirmed that they sometimes used this strategy.

Men had more positive experiences if the female condom was inserted well and the woman was comfortable; after a positive first experience more men continued use. The most mentioned positive first experience by men was that they felt as if there was nothing there, that it felt like

kurova nyoro – natural sex. Male participants' negative first experiences were mostly related to their partner not knowing how to insert the female condom well, which caused pain and unease. Women overall had more negative first experiences than men. Mostly, however, they realized that they had not properly inserted the female condom, which caused them pain and discomfort, even more when the man entered.

Recommendations
In promotion stress the sexual pleasure advantage of female condoms, and the fact that it brings variation in protected sex. In addition, 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.

9.1.4 Motivations for continued female condom use

The study findings indicate that a first positive experience for men makes frequent female condom use more likely. Relatively more men with negative first experiences stopped using female condoms. However, even after negative first experiences more women continued, because they were motivated by their effectiveness as dual protection or because their husbands insisted – with husbands often having the final say. Men said that they became frequent users of female condoms (with their wife or stable girlfriend) because sex is next to natural. Most men said that they prefer female condoms over male condoms because they consider female condoms the safest method for family planning, protection against STIs, and prevention of HIV (re-)infection. For both men and women, a major incentive to become 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 got an alternative and variation in their sex life.

The common pattern of female condom use was to alternate them with male condoms – especially for PLHA who use them mainly to prevent (re-)infection and are convinced that they always have to use a condom. Some wives still used other contraceptives concurrently because they felt that female condoms are especially for disease prevention. Most married men used female condoms with their wife and single men with their stable partner – often alternating with male condoms. Female condoms were not frequently used with partners whom men did not trust, because these women were thought to abuse female condoms.

Recommendation
Programmes should be directed at making a first experience more likely to be positive. Female condom promotion to men (and women) should always be accompanied by a demonstration. During female condom promotion and demonstrations to women (and men), the 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 participants were asked to repeat the demonstration given by the promoter). Having artificial vaginas as demonstration materials makes it easier to practice than only using the hands. Women should be given an ample number of free female condoms and be advised to practice insertion before trying them with her partner. Programmes can address the distrust men have towards their other partners.

9.1.5 Accessibility

Female condoms are fairly widely available for free in public clinics and through peer groups, and are for sale in pharmacies. Participants thought that the price – if people have to pay for female condoms – would, however, be a problem. A problem for distributers is the scarcity of coins. Participants would like to see them available in more outlets such as supermarkets and offices. A

major external factor hindering male (and female) frequent use of female condoms is cultural inaccessibility – shame for some groups in buying (female) condoms. Peer programmes were considered a culturally sensitive way to provide education about female condoms and for distribution.

Recommendation
Programmes should continue spreading sales points for female condoms, look into whether female condoms can be even more subsidized, and investigate how to overcome the problem of the shortage of coins so that distributers can sell small numbers of female condoms. Education and distribution can be intensified through peer programmes.

9.1.6 Female condom promotion campaigns

Participants had useful suggestions for female condom promotion campaigns. Their main recommendations were: 1) intensify female condom promotion, in mass media and through interpersonal communication; 2) men should also be targeted and campaigns have to look for the best places to reach out to them; 3) campaigns should explain *how* female condoms are used, not only *why* they should be used; 4) female condoms should come in different designs; 5) campaigns should use appropriate role models who are real female condom users; 6) male and female condoms should be promoted together.

Recommendation
Follow the recommendations of the participants. In particular, the participants' recommendation that male and female condoms should not be treated as in opposition should be taken seriously by programmes, so as not to run the risk that male condom users shift to the female condom and thus total condom use remains unchanged. (This possible substitution effect is a serious problem when talking about reducing HIV prevalence rates. When an increase in the uptake of female condoms means substitution of male condoms, there will be no reduction in HIV prevalence. Only when total condom use increases will reduction in HIV prevalence and the number of uninteded pregnancies take place).

9.2 Summary of factors influencing female condom acceptance

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

Personal factors:

- Knowledge about female condoms – knowing the advantages, how they are used;
- Belief in the effectiveness of female condoms for family planning and in STI and HIV protection;
- Having the skills to use female condoms;
- Having a positive first experience of use of female condoms;
- Risk perception – the felt need for family planning and/or protection, depending on the type of sexual partner;
- Liking sex with female condoms – sexual pleasure, next to natural, man feels free (and protected);
- Has money to buy female condoms;
- Knows where to buy female condoms;
- Does not feel shame to buy/get female condoms.

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 against disease, only prevention of unwanted pregnancy, and any contraception with side effects is suspected of influencing fertility;
- HIV/AIDS prevalence – with a higher prevalence, as in Zimbabwe, risk perception will be higher;
- Easy accessibility of female condoms (affordable, available);
- Sexual partners agreeing / convincing / insisting on use;
- 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. These recommendations could be used to further develop female condom programmes.

- In designing programmes, consider the dominant gender power relations in different sexual relationships. Promoting female condoms as a female initiated product for women's empowerment will not be conducive for uptake because in Zimbabwe a woman needs the cooperation and often approval of her male partner.
- Realize that spreading female condom use cannot go via women only, but rather educate men, or men and women together. Giving men a role in introducing the female condom will be more acceptable in Zimbabwe.
- In communication messages, stress the advantages and address the disadvantages of female condoms, and tailor the messages to appropriate target groups – and their sexual partners. In promotion, stress that it feels like natural sex, that there is sexual pleasure in female condom use, that female condoms offer variation in protected sex, and emphasize the effectiveness of the female condom as a contraceptive without side effects. In messages, address the local disadvantages and 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. Visual mass promotion (on television or posters) should include *what* a female condom looks like and *how* it is used – thus not only talking about the benefits and showing the package.
- During female condom promotion and demonstrations to women (and men), participants should be invited to practice the skill by opening the package and doing a mock insertion. Prepare 'female condom starter packs' to give out during demonstrations with some five female condoms and information, including where to buy them. Women should be advised to practice insertion before trying with their partner – to make his first experience more likely to be positive.
- Address the distrust men have towards using female condoms with sex workers. Advise men to ask the woman to open the package and insert the female condom in their presence, and dispose of the female condom together.
- Continue educating women in negotiation skills appropriate to the type of sexual partner.
- Continue increasing sales points for female condoms and look into whether female condoms can be even more subsidized. Agree on a fixed price. Finally, increase advertisements and sales through barbers and hairdressers.

Final Note

We want to end this report by addressing the question which was the rationale for this study: *Are men a problem in spreading use of female condoms in Zimbabwe (and Sub-Saharan Africa)?* The majority of FGD participants thought that they were and would be if female condom programmes only or mainly target women – they thought that in this case men may very well resist accepting female condoms. Although this was a qualitative study and we cannot generalize findings, we agree that without more involvement of men, uptake will be slow. However, in 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 relevant knowledge and skills. 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. Female condoms do not have the association with HIV as strongly as male condoms, and this should be fostered by promoting them as a family planning method. Thus, if programmes consider the personal and external factors influencing male acceptance in their campaigns and also target men, men will not be a problem in spreading female condom use and may even be an opportunity to increase acceptance of female condoms.

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Annex 1: Focus Group Discussion – Topic Guides

Part 1: Introduction
Introduce people present / research team

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

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 would like to discuss with you your opinions on the female condom.[38]

Because you have experience with using it, you are the right persons to share with us what men like about it and do not like about it; and why and when a man would use it or not.

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

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 talking before the next person contributes. We will also respect other people's views.

We would 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 the government and the organizations working on female condoms. It will inform them on 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; prize; availability; association with modernity/style; appearance)

2. **Categories of sexual partners men in Zimbabwe have**
   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**
   Probe: For all categories of Question 2

5. **Talking with others about female condoms**
   - With whom?
   - About what? **Probe:** give advice to use female condoms?

6. **Acceptability of a woman initiating female condoms**
   A. How would a man react when**:**
      - 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 condoms / control female condom use? (by type of partner)
   C. From other research: women say that men are the problem in women using female condoms.

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

Women 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: P**robe:** to certain groups, ages, shame to ask?
- Affordability: **Probe:** price, price at different places
- How easy is it FOR YOU to get female condoms? **Probe:** where, price

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

Part 3: questions to specific types of user

A) Regular users

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

- **Experience of first time female condom use**
  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?

- **Regular use of female condoms**
  - How did you become regular 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 regular female condom use**
  - 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**
  What made YOU use a female condom for the first time?
  Probe: for curiosity, partner asked, peer influence, modernity, education programme

- **Experience of first time female condom use**
  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 a female condom once/twice?
  Probe: other methods preferred? And why?

C) Non-users

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

Annex 2: Pre-Focus Group Discussion – Questionnaire

FGD:……..
Date:……..

1. Sex	a. Male b. Female	
2. Marital Status	a. Single b. Married	c. Stable relationship d. Other….
3. Age	……Years	
4. Education level / status:	a. primary b. secondary	c. university d. Other …….
5. Present job:		
6. 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 (you are married to more than one wife) c. My stable sexual partner (single with a stable relationship, or married with a stable extra marital relationship) d. Casual partner(s) (boy friend/girlfriend) e. Sex worker	
7. 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 l. Others: antibiotics etc, probe …….. m. No method
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?	Yes ***(if yes: go to Q 12)*** No	
10. *If no*, Why not? (open question: not probing, let respondent talk, interviewer circles answer)	a. Not interested b. Looks odd c. Do not know where to get	d. Do not know how to use e. Other reason, specify ……
11. *If no:* Do you think you might use female condom in future?	Yes No ***(After this question, End interview)***	
12. *If yes (to Q 9)*, How often have you used a female condom?	a. One or two times, b. Three to 10 times,	c. More than 10 times.
13. With whom of your sexual partners did you *ever use* female condom? *(you can circle more than one answer)*	a. Spouse(s) b. Stable sexual partner c. Casual partner d. Sex worker	
14. With whom of your sexual partners do you *regularly use* female condom? (*More than one answer*) (*check Q 13*)	a. Spouse(s) b. Stable sexual partner c. Casual partner d. Sex worker	
15. Are you still using female condom?	Yes ***(If yes, End interview)*** No	
16. *If not:* What is the main reason you do not use female condom anymore?	a. Not available b. No sexual pleasure c. Too expensive d. Prefer to use other methods	e. Sexual partner does not want to use it f. Too cumbersome to use g. Other reason, specify ……

Annex 3: Consent Form for Participants of Focus Group Discussions

Consent form

Study on *Male Acceptance of Female Condoms, Zimbabwe*

My name is ....., and 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 participant 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

Date:

Do you agree: ..... YES

Annex 4: Study locations and areas of residence of FGD participants

Bronte Hotel: Participants came from Rugare. Rugare is a high density suburb, one of the oldest in Harare. It is situated in the western part of Harare and is about 25km from the city centre. Most residents in this suburb belong to the low and middle class.

Kuwaadzane: Kuwaadzana is a high density suburb located in the western part of Harare. Most of the residents in the suburb are low income earners. Some of the residents engage in urban farming to substitute their income: they mainly grow maize which is the staple food, and also sweet potatoes and pumpkins. Most people are literate and understand basic English (Zimbabwe's literacy rate is the highest in Africa at over 90%).

Mufakose: Mufakose is a high density suburb located in the western part of the city of Harare. A substantial number of the residents are young and unemployed. The residents stay in at least four-room rent to buy houses. Some families use one or two rooms and rent out the other room(s). The houses have electricity, proper sewage, and connection to the public water system.

PSI: The discussion was held in the city centre of Harare and consisted of women hairdressers and salon owners. The participants operated from different parts of the city; some operated in town whilst others worked in the high density suburbs that surround the city centre. All the participants were female condom distributers for PSI, working with PSI to market and sell the female condom to their clients. The hairdressers earned a middle class income and got cash on a daily basis.

Epworth: Epworth is a high density suburb that lies about 15km east of Harare. It was established in the colonial era as a halfway stop for immigrant workers, especially those from Malawi and Mozambique. The settlement was owned by the Methodist church. People who were homeless also found recourse there. After independence it grew as an unplanned settlement that is now under the authority of City of Harare. Most of the youths in the suburb are unemployed. The suburb is now home to some of the most wanted criminal idle youths. Political violence is rife in the area also. The unemployment rate in the suburb is very high.

Glenorah: Glenorah is a high density suburb in the western part of Harare, about 20km from the city centre. It is one of the oldest suburbs, established during the colonial time. The residents stay in small four-roomed houses, consisting of two bedrooms, a lounge/sitting room, and a kitchen. The toilet is detached from the main house. The houses all have electricity, a purified water system, and a fairly good and reliable sewage system. Most of the houses are owned by the local council and are rent to buy lease bases. Some resident now have title deeds over their homes. Most of the residents are in the low to medium earning bracket. A number of housewives in the suburb are informal traders who engage in vulnerable work such as cross-border work. Countries frequented are South Africa, Zambia, and Mozambique for second hand and food items like rice and cooking oil. Some of the women sell fish from Lake Chivero as well as fruits and vegetables. They get the vegetables from the surrounding farms. The fruits are obtained from *Mbare Musika*, a big market that is less that 10km from the city centre. Goods at the market come from subsistence farmers from rural areas that surrounds Harare.

Hopely Farm: Hopely Farm is a controversial settlement, the result of a farm invasion event. The residents are mainly young and unemployed and originally come from farms, thus most did not go to school. They were probably recruited for votes in an election and then just started living there. They are not permitted to build any permanent structures. They are very poor, and there is no electricity (except in the clinic) or water pumps.

Muvuku: Mabvuku is a high density suburb located in the eastern part of Harare. It is an old suburb that was established in the colonial time for blacks who worked in the northern suburbs and the eastern parts of the city centre. Most of the residents are foreigners because they did not have rural homes nearby to go to. At that time the local men believed in the importance of rural homes and did not want family homes in towns. Their wives and children stayed at the rural home whilst the men shared space in flats in the town and invested in building houses in their rural areas. Because of this, a good number of the residents are of the Malawi origin.

Annex 5: Advantages and Disadvantages of Female Condoms (all)

	Advantages	Disadvantages
Effectiveness	• **Strong, does not burst (9)** • Does not come out easily (2), M • Covers big surface area (2)	• **Penis can be inserted under the FC and not be protected (7)** • Fast ejaculation (2), M *Mentioned at least once:* • Can be pushed inside by man, W • Well known for bursting, M
Feeling	• **Sex feels like nyoro (12)** • More sexual enjoyment (6) • Makes you feel safe (3) • Do not notice when the woman is too wet (2) *Mentioned at least once:* • Brings variation, M	• **Inner ring causes pain (7)** • Associations with CSWs (4) • Ugly shape (2) *Mentioned at least once:* • Inserting by women makes man lose appetite for sex, M • Makes noise during intercourse, M
Appearance and qualities	*Mentioned at least once:* • No smell or irritation, M	• **Package to big (6)**
Availability / affordability	• Available (2), M	• Not widely available (2) *Mentioned at least once:* • Expensive, M
Control	• Empowers women (7)	• **Women misuse: use the same FC with multiple partners (11)** • Women in control (4)
Use	• **Can be worn in advance (11)** • Can be used during menses (3) • Penis can stay inside vagina after ejaculation (3) *Mentioned at least once:* • Fast ejaculation, M	• Difficult to insert (6) • People do not have knowledge (5) • Takes time to put in (5)

Annex 6: Advantages and Disadvantages of Male Condoms (all)

	Advantages	Disadvantages
Effectiveness		• **Risk of bursting (12)** • With removal , risk infection (3) • Stays in vagina if man loses erection (2) *Mentioned at least once:* • Does not cover whole male organ, M
Feeling		• **Constrains, too tight (5)** • Reduces sexual pleasure (4) • Causes rash (3) *Mentioned at least once:* • Association with sex workers, M
Appearance and qualities		• Bad smell (4)
Availability / affordability	• **Readily available (4)** • Cheap (2) *Mentioned at least once:* • Availability of variety, M	
Control	• **Man in control (7)** • Man disposes condom, sperm not used for juju (5) • Only use once (5)	• Men in control, and can sabotage (4)
Use	• **Easy to put on (5)** • Portable (3) • Can be used for spontaneous sex (2)	*Mentioned at least once:* • Need erection, M

Annex 7: Pictures of Focus Group Discussion Participants


can be
cured
even if you
HIV+