

# Understanding Female Condom Use and Negotiation Among Young Women in Cape Town, South Africa

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**CONTEXT:** In most countries, female condoms are not widely available and uptake has been slow. More information is needed on how women and men successfully negotiate female condom use.

**METHODS:** In-depth interviews were conducted at two sites in Cape Town, South Africa, with 14 women and 13 men who had used female condoms. A structured interview guide was used to elicit information on how women negotiate female condom use, and how male partners negotiate or respond to negotiations of female condom use. Thematic analysis was used to identify key patterns in the data.

**RESULTS:** Participants reported that female condoms are easier for women to negotiate than male condoms, largely because the method is understood to be under a woman's control. The main barrier to use was lack of familiarity with the method; strong negative reactions from partners were not a major barrier. Personal comfort and tensions with partners usually improved after first use. Some male respondents preferred the method because it shifts responsibility for condom use from men to women.

**CONCLUSIONS:** Findings suggest that female condoms empower women to initiate barrier method use, and that programs designed to educate potential users about female condoms and familiarize them with the method may be useful. That some men preferred female condoms because they wanted women to take responsibility for condom use is cause for concern, and suggests that counseling efforts should be directed toward men as well as women, and should include a discussion of gender dynamics and responsibility that emphasizes condom use as a choice that couples make together.

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The female condom is a female-initiated barrier method that offers potential for reducing the incidence of HIV, other STIs and unintended pregnancy. In many countries, female condoms are not widely available and use rates have remained low. Brazil and South Africa stand out as exceptions, as women in both countries have greater knowledge of the female condom and higher levels of use than do their counterparts in other countries, largely because of promotion and distribution campaigns.<sup>1</sup> South Africa was deemed an appropriate site for this study because of its low levels of male condom use<sup>2,3</sup> and its strong female condom program.

Female condoms are the only alternative barrier method to male condoms for HIV prevention and, like male condoms, are highly effective for preventing other STIs. Use of female condoms is likely to reduce the prevalence of negative health outcomes, such as STIs and unintended pregnancy, and to reduce the rates of unplanned childbearing and morbidity and mortality due to unsafe abortion.

Understanding barriers to female condom use in long-term relationships is essential to improving reproductive health outcomes. The barriers specific to use in South Africa have not been adequately explored and include taboos about the female body and reproductive anatomy, gender-based violence and gender disparities in power.<sup>4–7</sup> In particular, it is essential to examine the feasibility of

women's using the female condom to gain control of sexual encounters. In a 2012 study, Beksinska et al. noted concerns that abuse and violence could increase if women attempted to initiate use of the female condom; however, no evidence supporting or refuting this claim exists.<sup>8</sup>

## HIV in South Africa

The prevalence of HIV in the general population of South Africa is 18%—the fourth-highest prevalence in the world<sup>9</sup>—which indicates a hyperendemic.<sup>8</sup> Around 6.1 million South Africans are living with HIV, and 240,000 die yearly from AIDS-related illnesses. As in other countries, large disparities exist by province and demographic characteristics.<sup>10</sup> For example, HIV prevalence is around 40% in KwaZulu-Natal, compared with 18% in both the Northern and Western Cape provinces. Women are disproportionately affected, and on average are infected earlier in life than men: Female prevalence peaks at 33% between ages 25 and 29, whereas for men the peak is at 26% between ages 30 and 34.<sup>8,11</sup> Further, incidence among 15–24-year-old women is four times that among their male counterparts (2.5% vs. 0.6%).<sup>11</sup>

The country spends more than a billion dollars annually on its well-developed HIV/AIDS program. Programs have specifically targeted youth for more than a decade

and have slowed the epidemic in that population; HIV prevalence among youth aged 15–19 decreased from 10.3% to 8.6% between 2005 and 2008, according to a national survey.<sup>8</sup> The epidemic's toll has been somewhat smaller among students in higher education; nonetheless, 3.7% of sexually active tertiary students nationally are living with HIV, and the prevalence among such students is even higher in KwaZulu-Natal (6.1%) and among those of black African ethnicity (8.7%).<sup>12</sup>

Outside of youth populations, however, HIV prevalence has continued to rise, despite a simultaneous increase in HIV/AIDS-related knowledge. This rise is due in part to increased access to antiretroviral medication, which allows HIV-positive people to live longer. Another contributing factor may be that increased awareness of HIV risk has not translated into behavioral change, particularly among high-risk women.<sup>8</sup> As in many other Sub-Saharan African countries, the bulk of HIV transmission in South Africa occurs within heterosexual relationships. The lack of behavioral change is consistent with the possibility that gendered barriers regarding condom negotiation exist for South African women, though evidence for this hypothesis is lacking.

Overall, evidence suggests that the major contributors to the continuing severity of the HIV epidemic in South Africa are patterns of sexual partnership (e.g., concurrency), heavy alcohol abuse, significant gender power inequities, violence and poverty<sup>8,13</sup>—all of which are associated with lack of barrier method use. Moreover, frequent condom failure (incorrect use and breakage) is generally acknowledged as a problem in South Africa; a history of condom failure has been reported by one-third to two-fifths of patients receiving care for STIs.<sup>14,15</sup>

### Condom Distribution and Uptake

Multiple types of male condoms are distributed by the South African government, and a variety of private brands are also available. Promotional campaigns have had significant impact on awareness that condoms are an effective method for HIV prevention, and three comprehensive HIV surveys (conducted in 2002, 2005 and 2008) have documented increases in condom use at last sex.<sup>8</sup> Among youth, in particular, the proportion who reported condom use at last sex rose from 57% to 87% for males and from 46% to 73% for females between 2002 and 2008.<sup>6</sup> A lack of consistent use, however, has been documented in multiple studies, including one in Durban showing that although condom use is considered normal and is accepted among students in higher education, only a quarter reported using condoms for every act of intercourse.<sup>3</sup>

In other countries, women often prefer the female condom to the male condom once they become familiar with it, because it empowers them to improve their sexual health and is capable of reducing STI incidence.<sup>16–18</sup> South Africa introduced the female condom in 1998 through public-sector clinics and community-based programs<sup>19</sup> and now has one of the world's largest female condom promotion and distribution programs, comprising more than 300

designated public-sector distribution sites.<sup>8</sup> Distribution of the female condom has increased steadily since its introduction, and increased from 4.2 million condoms in 2008 to 5.1 million in 2010 and 12 million in 2013.<sup>6,20</sup> Although the FC2 is currently the most widely used female condom in South Africa, most studies have focused on the FC1, which had significant deterrents to use (e.g., noise) that were resolved with the FC2.

A national, population-level survey conducted in 2013 found that while 78% of women knew about the female condom, only 7% were using it.<sup>5</sup> Usage was higher among women aged 25 and older than among those aged 15–24 and varied substantially by province. A usage rate of more than 10% was reported in three provinces (Northern Cape, Free State and Limpopo), compared with one of only 3% in KwaZulu-Natal, where HIV prevalence is highest.

Studies suggest that barriers to female condom use include a steep learning curve, limited familiarity with the device, taboos about condom use in long-term relationships, gender power disparities, cost and stock-outs.<sup>6,7,11,17,21</sup> To date, only one qualitative study has elicited in-depth data regarding some of these barriers. The study's focus group participants, who were male students at higher-education institutions, explained that lack of familiarity with female condoms was the greatest barrier to use. Many falsely believed that female condoms are expensive; in reality, the condoms are distributed free of cost nationally. Another misconception was that female condoms must be inserted 2–8 hours before initiating sex. Many participants also found the large appearance of the female condom to be a deterrent, and a few voiced concerns about possible lessening of sexual pleasure.

A randomized trial conducted in 2012 found that female condom interventions increased use; however, the study did not explore specific barriers to use.<sup>11</sup> Another randomized controlled trial, conducted in South Africa's Eastern Cape Province, found that gender power inequities and intimate partner violence were positively associated with HIV incidence;<sup>13</sup> this study did not involve female condoms, but the findings highlight the importance of gender power disparity and gender-based violence in HIV outcomes in South Africa. These realities, in turn, underscore the importance of female condom promotion and availability.

It is noteworthy that many studies of female condom use have been conducted among sex workers, and that there is a relative paucity of data on female condom use among general populations.<sup>17</sup> Studies of sex workers have shown that the female condom is an empowering device. However, the degree to which this might translate to the general population, and particularly to women in long-term relationships, has not been explored. The purpose of the present study was to fill this gap in the literature.

## METHODS

### Study Design

To explore how women experience female condom use and navigate decision making, we conducted 27 in-depth, semi-structured interviews in two sections of Cape Town:

Khayelitsha and Kraaifontein. The study was conducted in 2014 in collaboration with Partners in Sexual Health (PSH), a nongovernmental organization founded in 2008 that operates throughout South Africa and whose work focuses on sexual and reproductive health, especially HIV and AIDS in vulnerable, high-risk populations.

Khayalitsha and Kraaifontein were selected for this study at the request of PSH, which has field offices in those areas. Although both areas can be considered suburbs of Cape Town, they are quite different from each other. Khayelitsha, located in the southern Cape Flats, is one of the largest townships in South Africa and is well known as a site of forced relocation during apartheid. Roughly nine-tenths of residents are blacks of Xhosa ethnicity, and poverty is widespread. The area is thus a popular place for nongovernmental organizations and foreigners to target development projects or recruit research participants. Kraaifontein, on the other hand, is a more diverse suburb: Around 33% of residents are Xhosa, 40% are colored, 15% are white and most of the rest are non-Xhosa blacks. Kraaifontein is technically part of the Northern Suburbs, whose residents, unlike those of the Southern Suburbs, are largely middle class.

### **Participants**

Community members were eligible for the study if they spoke English well, were 18 or older and had used a female condom at least once (preferably with a long-term partner). They were recruited for the study by two male PSH field workers who were familiar with the organization's clientele and the community. Because the fieldworkers were local residents, they knew community members who had come to PSH to obtain free female condoms, and visited them at their houses or elsewhere in the neighborhood to invite them to participate. Potential participants then came immediately to the study site for an interview; they were excluded from participating if they did not appear to be sober or cognitively capable of consenting to an interview.

All 27 participants were aged 19–41. They were almost evenly divided between women (14) and men (13); none were married to each other (i.e., partners were not interviewed). Data collection began in Khayelitsha, where 10 women and nine men were interviewed. In Kraaifontein, recruitment was stopped after four women and four men had been interviewed, because no differences had emerged between the experiences of participants from this site and those from Khayelitsha.

We used an in-depth interview guide to explore use of female condoms with various partners. It began with an open-ended question concerning participants' thoughts about condoms (both male and female) in general, followed by prompts designed to elicit reports of specific instances of female condom use with each partner with whom the method had been used. The bulk of each interview focused on how participants initiated use of female condoms and how their partners responded to initial

and continued use. Specifically, for each relationship, the guide asked participants about how they and their partners came to use female condoms and about the couple's experiences with them. Because only one partner was interviewed, responses reflected participants' own perceptions and their reports of what their partners had said to them.

The first author conducted all interviews in private rooms in the PSH field offices. In Khayelitsha, a separate empty building with comfortable chairs was available, assuring auditory privacy. In Kraaifontein, a private room was used; however, participants were aware that at times, depending on noise levels, others might be able to hear parts of the conversation. Some of the 27 interviews were very brief (seven minutes) and others relatively long (49 minutes); they averaged 25 minutes. Prior to data collection, approval for the study was obtained from the Emory University institutional review board and from the South African Research Ethics Committee. Before each interview, study team members obtained written consent from the participant and explained the compensation provided. After the interview, each participant received 50 rand (about US\$5) for their time, in accordance with standard reimbursement rates at the Human Sciences Research Council in Cape Town.

### **Analysis**

All interviews were digitally recorded with participants' consent and transcribed verbatim. Prior to analysis, all identifying information was removed from transcripts. We used a thematic approach to analyze the data, beginning with an initial code list that was developed deductively from the research questions. Additional codes were developed from numerous readings of the data and represented themes that participants discussed frequently. Six transcripts were selected for initial coding; to capture the variation present in the data set, this initial sample included at least one male and at least one female from each site. To further refine the code list, the six transcripts were coded three times; after the third round of coding, we felt that all relevant data had been indexed by the 13 codes we had devised. We subsequently coded all 27 transcripts and analyzed them using MAXQDA 11 software.

Analysis began with the retrieval of text coded with commonly used, multidimensional codes that applied to many, often large, segments of text (e.g., "negotiation and discussion") and that co-occurred with less common and more concrete codes (e.g., "access and variety"). We brought coded segments of text into MAXMAPS, a virtual whiteboard in MAXQDA, and arranged the segments in groups to determine properties and dimensions of themes discussed by participants. Code summaries were then written for each code, beginning with the more complex codes and proceeding to the remaining ones. Finally, we reviewed all code summaries to conceptualize the interrelationships between themes and how they were related to the research question.

## RESULTS

### Condom Use

Participants described a variety of condom use patterns. About a quarter of participants reported consistent condom use with all partners for every act of intercourse, while slightly fewer than a quarter reported that they had used condoms consistently with a partner for a period of time prior to testing for HIV or other STIs, or until they trusted their partner to be monogamous. The remaining participants—just over half—described using condoms inconsistently: They either used condoms consistently with secondary partners but not with their primary partner, or they used condoms with their main or only partner, but not for every act of intercourse. Several reasons were cited for inconsistent use. One was a preference for unprotected sex, despite its known risks. Another was that in some cases, suspicions that a partner had recently cheated triggered occasional condom use in monogamous relationships. Inconsistent condom use was never said to be due solely to not having a condom available in the moment.

### Motivations for Female Condom Use

Participants cited a wide range of reasons for wanting to try female condoms. Men and women alike described general discontent with male condoms and were particularly concerned about condom failure. At least eight participants had experienced this, and a few more mentioned it as a common problem with male condoms. One young woman described the issue as follows:

“[The condom] might break when we’re having sex. Like, your boyfriend breaks it when he ejaculates and then you will fall [become] pregnant. [And] you will not understand, [because] ‘we use a condom, why [do] I fall pregnant?’ ... When we use that female condom, I don’t [worry that] I will fall pregnant.” —*Nobantu, female, aged 23, Khayelitsha*

Participants also mentioned trying the female condom because they were curious about it or because they wanted a different method or to have some variety in their contraceptive choices, and they noted that free access to the female condom made them more willing to try it. All participants except one had used the method more than once; most had used it at least three or four times. One-third of participants reported having used the female condom with only one partner, almost always their primary partner.

Around half of participants, in a range of relationship types, discussed the possibility that their partner was cheating, noting that they did not assume that their partners, even in their primary relationships, were monogamous and that it was common sense to not trust anyone absolutely. Some said that they used condoms (male or female) when they were aware that their partner had additional partners, while others reinitiated condom use even if they only suspected that their partner was cheating. For example, Maudisa, a 25-year-old woman in Khayelitsha, said that she used condoms “when I fight with my boyfriend or when I think my boyfriend has gone with another

girlfriend.” Kenna, a 39-year-old woman in Kraaifontein, noted that infidelity is not restricted to males: “[My partner] goes outside, and he’s cheating; even me, maybe I’m cheating, that’s why I use condoms.” No male participants, however, reported concern that their female partners cheated. Instead, when men discussed nonmonogamy, they described outside partners they themselves had, typically without the knowledge of their primary partner.

### Introducing the Female Condom

None of the female participants reported that using the female condom had been their partner’s idea. Two women described discussing female condoms with their partner and mutually deciding to use them; otherwise, all female participants introduced the idea of using female condoms to all of the partners with whom they had used the method. A different pattern emerged among male participants. About half of the men said they had introduced the female condom to their partners, while slightly more than a third said a partner had suggested using the method. Two men reported that using the female condom had been a mutual decision with their partner.

Lack of familiarity with female condoms and discomfort with trying a new barrier method were common among men and women alike at the time of first use. Moreover, women commonly reported that partners responded negatively, or at least hesitantly, at first:

“Ah, he didn’t want me to use it. He said, ‘The female condom, I don’t want it.’ I said, ‘If you don’t want to use it, no sex. No [male] condom. Because I don’t feel comfortable with the male condom.’ And when I told him about these troubles, I convinced him.... He decided, ‘Okay, it’s fine. If you want it, it’s fine.’” —*Sarah, female, aged 30, Khayelitsha*

Participants described partners’ reactions as ranging from immediate acceptance to curiosity and even shock. Of the six male participants who had a female condom introduced to them, four described their own reaction as accepting; they wanted to use a condom and it did not matter what type. For instance, Madala, a 24-year-old man in Khayelitsha, responded to a nonexclusive partner’s suggestion to use a female condom by saying, “It’s fine. As long as I know that at the end of the day both of us are not going to infect each other with STIs or [get] pregnant.” In contrast, Thomas, a 26-year-old man in Khayelitsha, described being shocked and put off by the condom’s large size before accepting its use. Nineteen-year-old Mpepho from Kraaifontein was already familiar with the method; he had introduced it to a previous partner because he wanted to try something new. About a third of male participants stated that they would not encourage a partner to try the female condom, either because it was “hers to use” or because they were afraid it might make her uncomfortable.

Three men, but no women, described women as being shy about their bodies. They suggested that such feelings inhibit women’s use of the female condom, and that for this reason they would not initiate female condom use

with a casual partner. For instance, Richard, a 37-year-old male in Kraaifontein, said, “Females, they tend to be shy with their bodies, and so I expect that. So I don’t want to ask a person, ‘Can you use this?’” About half of female participants mentioned initially feeling fear with the female condom, but none suggested that this fear was due to discomfort with their own bodies. For Louisa, the condom’s size was an obstacle:

“It was difficult because ... it was difficult for me to even insert it. I just saw this big thing. How am I going to use it? And I was scared! I was crying because I want to try this, but it’s too big.” —*Lovisa, female, aged 22, Kraaifontein*

In addition, three male and two female participants expressed concerns that female condoms might fail. Samuel, a 19-year-old male in Khayelitsha, was worried that his penis could enter the vagina to the side of the female condom instead of within it. His concern was due to the “openness” of the female condom outside the vagina: “You don’t trust [it], the female condom, ‘cause two sides are open.” Concerns about invagination, when the entire female condom, including the outer ring, is pushed inside the vagina during intercourse, were voiced by three participants, including Samuel:

“[Women] don’t bother with [female condoms] always. They’re scared. And men are also scared of that thing. But, if it can go inside of her vagina, she’s also scared, that’s why I don’t think they trust those condoms.”

For three-quarters of women, these issues resolved with their first use of the female condom, which was subsequently accepted as a regular method in their relationship. Ultimately, almost all participants described a change in comfort level or acceptance of the female condom over time and with increased use. Women who stopped using the method attributed the decision more to their partner’s preference than to their own. A number of women said that a partner’s dislike of the female condom discouraged use; one said it had resulted in discontinuation. Another participant said that she herself did not like using the female condom and chose not to use it because her husband was willing to use a male condom. Three women said that their partner periodically resisted female condom use, although serious issues did not persist.

About one in five participants reported alternating between female and male condoms. Others also may have alternated use, but their discussion focused on their preferred method, usually female condoms. Reasons cited for alternating use were the partner’s desire to share responsibility for condom use, a preference for a variety of condom types and the immediate availability of one type but not the other. As one woman explained:

“Why do I mix [male and female condoms]? You see, ‘cause we’re not staying in the same places. When he comes over to my house, then I have a female condom. Maybe he doesn’t want to use a condom, [so] he’s gonna say ‘I don’t have a condom.’ Then I say, ‘No, fine, I do have mine, so let’s use mine.’” —*Bukiwe, female, aged 19*

Three male participants talked about regularly doubling up—using both a male condom and a female condom. All three discussed this as a risk reduction method, but two also said that they enjoyed sex this way. It was unclear whether the enjoyment was due to a greater feeling of safety, increased physical pleasure or a combination of both. Madala noted that he liked to use both a male condom and a female condom “to protect her, and then to protect myself,” suggesting a belief that the male condom protects only men and the female condom protects only women.\*

### Negotiating Female Condom Use

Women described use of female condoms as easier to negotiate than use of male condoms, noting that the female condom was “for a woman to use” and that a woman could refuse to have sex if her partner would not accept it. For example, Lovisa reported that condom negotiations with her partner were easier with the female condom than with the male condom, saying, “He don’t want his, but he doesn’t have a problem with mine.” In essence, participants said that because the female condom is “hers to use,” the male partner is unlikely to say no in the end, although the female may encounter some resistance. Of course, this is true only in relationships in which a woman feels she can refuse sex. Around half of the women in this study either did exactly that (said “no sex if you don’t accept the female condom”), or said they would do so if their partner ever resisted use. Male participants’ comments paralleled this dynamic. Although some men initially were hesitant regarding female condom use, they said that they had decided to accept the device because of the possibility of being denied sex.

When men said that they preferred female condoms to male condoms, they cited greater pleasure as a primary reason. Women, on the other hand, appreciated having a method that they could control, so that they did not have to rely on men’s willingness to wear a condom. For example, one noted:

“Some of the men, they say, ‘I’m gonna use this male condom.’ [But] they don’t use it. They switch off the light, he says, ‘I used it.’ So you find out after having sex that they [didn’t] use it. It’s very horrible. So I’m gonna convince the women that if you use the female condom, you are the one gonna put it in your vagina, no one’s gonna lie to you [that] ‘I used it’ but not use it.” —*Sarah, female, aged 30, Khayelitsha*

Men also perceived this shift in control, but for them it translated to a reduction of their own responsibility to provide and use a condom, as the following illustrates:

“It wasn’t different, it was like, okay, yeah, it’s a condom, right?... It didn’t surprise me that much. Everything just went normal[ly] ... I told her she should protect her[self] more so I don’t have to care after condoms all the time.” —*Joe, male, aged 26, Khayelitsha*

\*Upon completing their interview, participants were informed that neither male nor female condoms are approved for this type of use.

When asked what they thought might make men more willing to accept the female condom, women and men had similar responses. They generally discussed the importance of providing information and empowering women to communicate with male partners:

“It’s more of empowering women so they can be able to speak for themselves, I think. Because there’s not much marketing or trainings that are being done for people. The people actually have an attitude towards the female condoms themselves. This one girl, she was issuing them out, and I asked her, ‘Would you actually feel comfortable using them yourself?’ And she was like, ‘No way!’ So I think it intimidates.” —James, male, aged 32, *Khayelitsha*

Participants said that to feel comfortable with female condoms, women first needed to have information about them, and then needed to be empowered to discuss them with their partners.

### Condom Responsibility

Both men and women said that female condoms shift the responsibility for condom use from men toward women. About half of male participants suggested that it is a woman’s responsibility to acquire female condoms and to suggest their use in a particular relationship. Some men appreciated the shift in responsibility, while others accepted it despite feeling discomfort with the idea. Three of the seven men who discussed the notion of female responsibility also described nuances in how they felt. Joe, for instance, reported frequently choosing to not use female condoms: “The responsibility to have the condom is with the man, you know? So you go back again to get your own condoms.” Other men seemed to embrace a more mutual approach:

“Maybe it’s a part of the foreplay that I insert [the female condom]. Because I think I’d be more comfortable with it if we’re both into it, more than giving the responsibility to somebody else.” —James, male, aged 32, *Khayelitsha*

For men who liked the female condom, a preference for female responsibility was a driver of both general preference for and use of the female condom. They described the responsibility of condom use being lifted from them and assigned to their female partners. James described his perception of other men’s appreciation of the female condom:

“One of the [things] I hear is the female condom, it takes away the responsibility from you. It’s not my thing. It’s her thing. It’s a female condom.”

Women also discussed issues of barrier method responsibility in some sense; however, for women, these discussions were centered specifically on control. They appreciated being able to gain control in contexts in which men were hesitant to assume responsibility for barrier method use by wearing male condoms.

### DISCUSSION

This study is innovative in two key ways. First, it is one of the first studies in South Africa to include men in its consideration of female condom negotiation. Notably, we

found more similarities than differences in the experiences of men and women. For both, partner reactions to female condom negotiation tended to be more positive than negative, perhaps because both men and women express a certain discontent with male condoms, especially concerning condom breakage, and because both men and women said that they do not assume that their partners, including main or serious partners, will be monogamous. Both also reported that in most cases, any initial hesitancy toward using the female condom resolved after the first use. The fact that both sexes further reported that later they sometimes alternated between male and female condoms, and that it is often easier for women to negotiate female condom use than male condom use, suggests that having both barrier methods available may lead to more consistent protection for some couples.

Our findings on female condom use and nonuse echo previous research. Educating people about the female condom and familiarizing them with it are key to facilitating its use; the challenges of acquiring and learning to use the condoms are barriers to use. Education on the female condom and first-time use itself provide familiarity, which in turn further promotes use. Most participants who were initially uncomfortable with the method felt that way only during the first use. Women were often afraid of having insertion difficulties or experiencing condom failure, but they did not actually experience either type of problem.

In addition, men and women both noted that the female condom is “hers to use,” and said that for this reason men were less likely to refuse to use the method than they were with the male condom. This finding informs an important gap in the literature regarding female agency and barrier method use. Beksinska and colleagues questioned whether violence might increase if women attempted to initiate use of female condoms, but this study paints a more favorable picture. Only one female participant recounted a partner’s negative reaction that resulted in nonuse of female condoms and a return to male condoms; the more common narrative was one of initial acceptance, and ongoing negotiation around sexual health decision making. This suggests an alternative perspective on partner dynamics than the commonly cited disempowerment experienced by Xhosa women.<sup>5,6</sup>

At the same time, participants’ understanding that female condoms belonged to women was accompanied by the assumption that women were responsible for acquisition and use. Our findings suggest that the availability of female condoms empowers women to initiate barrier method use with various partner types. Moreover, previous research suggests that female condoms can be more pleasurable than male condoms for both partners—for men because the penis is not constricted, and for women because the outer ring may stimulate the clitoris during sex.<sup>6</sup> Some men, however, also prefer using female condoms because the method shifts the responsibility of barrier method use to women. This is of some concern,

because gender inequalities could be reinforced by men's viewing barrier method use as a woman's responsibility. Yet, the benefits seem to outweigh the risks, particularly given South Africa's high burden of HIV and other STIs.

The second key innovation is that this study focused on men and women who had already introduced the female condom to one or more partners. This provides a better understanding of barriers to use among individuals who have already reached the "preparation" and "action" stages of the transtheoretical model of behavior change.<sup>22</sup> Among these individuals, who are perhaps more likely than those in the earlier ("precontemplation" and "contemplation") stages to have experienced other sexual health concerns or to be at particularly high risk for HIV and other STIs, this study revealed few highly negative reactions to female condom introduction. In fact, the study shows that introduction rarely led to a significant need to negotiate female condom use.

For men and women who are prepared to introduce female condoms, familiarity may be key to facilitating use. For almost all of the women in this study, familiarity with the device meant comfort with it and trust in its efficacy. Familiarity prior to use could be enhanced by encouraging women at the preparation stage to practice inserting the female condom before actually introducing it to a partner. In clinical settings, assisted initial insertion may be particularly helpful. For men in this stage, it may be helpful for providers to convey educational messages on women's comfort with the device to counter the notion that women are uncomfortable with their bodies.

For men and women in earlier phases of the transtheoretical model—particularly those in the precontemplation phase, in which the cons of changing behavior outweigh the pros—educational messaging might focus on sharing positive accounts of female condom use, such as the ones presented here. We found very limited evidence that negative partner reactions to the introduction of female condoms hinder use. On the contrary, few participants described negative reactions that persisted after initial use. This message is perhaps of particular importance for men, given their expressed reluctance to introduce the female condom to women, and especially to casual partners. The fact that none of the female participants in this study had female condoms introduced to them by male partners reinforces this point, and suggests that future studies might focus more squarely on male introduction of the female condom, from the perspectives of both men and women.

The specific nature of our study population raises questions about whether use might be as easily negotiated among other women in this community, or in other Xhosa communities in South Africa. The nature of qualitative research means that our findings cannot be generalized. However, when asked what they thought about the capacity of other women in the community to negotiate female condom use, participant responses were either positive or neutral. Some participants thought that other women

might face greater challenges with female condom negotiation than they had. Yet, they still felt that such women might be successful, and certainly were more likely to successfully negotiate female condom use than male condom use. Further research in a more varied population would provide important insight into this issue.

Programming efforts may address the concerns raised here by making changes to the way female condom education is conducted. Programming should focus on overcoming barriers to initial use, should be directed toward men as well as women and should include a discussion on gender dynamics and responsibility. Clearly, more comprehensive female condom education is as important as increased availability, given our finding that experience with the female condom was more important than knowledge. Private, individual counseling may also be beneficial, because educational experiences in clinics may be perceived as too public. Comprehensive training for providers and educators seem to be a critical first step in the process.

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## RESUMEN

**Contexto:** En la mayoría de los países, la disponibilidad de condones femeninos no es amplia y su aceptación ha sido lenta. Se necesita más información acerca de cómo las mujeres y los hombres negocian exitosamente el uso del condón femenino.

**Métodos:** Se condujeron entrevistas en profundidad en dos zonas de Ciudad del Cabo, Sudáfrica, con 14 mujeres y 13 hombres que habían usado condones femeninos. Se utilizó una guía de entrevista estructurada para obtener información acerca de cómo las mujeres negocian el uso del condón femenino y cómo las parejas masculinas negocian o responden a las negociaciones relativas al uso del condón femenino. Se usó análisis temático para identificar patrones claves en los datos.

**Resultados:** Los participantes informaron que para las mujeres es más fácil negociar el uso de condones femeninos en lugar de los masculinos, en gran medida debido a que se entiende que dicho método está bajo el control de la mujer. La principal barrera para su uso fue la falta de familiaridad con el método, mientras que las reacciones negativas fuertes de las parejas no fueron una barrera importante. La comodidad personal y las situaciones de tensión con la pareja usualmente mejoraron después del primer uso. Algunos hombres entrevistados prefirieron el método porque transfiere la responsabilidad de los hombres a las mujeres.

**Conclusiones:** Los hallazgos sugieren que los condones femeninos empoderan a las mujeres para iniciar el uso de métodos de barrera, y que son importantes los programas diseñados para educar a usuarios potenciales sobre los condones femeninos y familiarizarlos con el método. El hecho de que algunos

hombres prefirieran los condones femeninos porque querían que las mujeres se responsabilizaran del uso del condón es causa de preocupación y sugiere que se deben realizar esfuerzos de consejería dirigidos tanto a hombres como a mujeres, y que estos deben incluir una discusión sobre dinámica de género y responsabilidad, que ponga énfasis en el uso del condón en tanto una decisión que las parejas toman de forma conjunta.

## RÉSUMÉ

**Contexte:** Dans la plupart des pays, le préservatif féminin n'est pas largement disponible et son adoption est lente. Il serait utile de documenter davantage la manière dont les femmes et les hommes négocient avec succès l'usage du préservatif féminin.

**Méthodes:** Des entretiens en profondeur ont été menés sur deux sites de Cape Town, en Afrique du Sud, avec 14 femmes et 13 hommes qui avaient utilisé le préservatif féminin. Un guide d'entretien structuré a permis d'obtenir une information sur la façon dont les femmes négocient l'usage du préservatif féminin et sur celle dont les partenaires masculins négocient cet usage ou répondent aux négociations le concernant. Les tendances clés des données ont été identifiées par analyse thématique.

**Résultats:** Les déclarations des participants révèlent qu'il est plus facile pour les femmes de négocier le préservatif féminin, plutôt que le masculin, largement parce que la méthode est comprise comme relevant du contrôle de la femme. L'obstacle principal à son usage est le manque de familiarité avec la méthode. Les fortes réactions négatives des partenaires ne représentent pas un obstacle majeur. Le confort personnel et les tensions avec les partenaires s'améliorent généralement après le premier usage. Certains répondants masculins préfèrent la méthode car elle fait passer la responsabilité de l'homme à la femme.

**Conclusions:** Les observations laissent entendre que le préservatif féminin permet aux femmes de prendre l'initiative d'une méthode barrière et que les programmes conçus pour informer les utilisateurs potentiels et les familiariser avec la méthode peuvent être utiles. La préférence exprimée par certains hommes à l'égard du préservatif féminin parce qu'ils attendent des femmes qu'elles assument la responsabilité de l'usage du préservatif est préoccupante. Elle donne à penser que les efforts de counseling doivent viser les hommes aussi bien que les femmes et inclure une discussion sur la dynamique de genre et la responsabilité, qui souligne l'importance de l'utilisation du préservatif en tant que choix mutuel des partenaires.

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