THE international call for women-controlled methods of contraception and protection against sexually transmitted infection (STI) has come from women from all walks of life, ranging from rural peasant to professional women.1,2,3 Women-controlled methods are those that women can use for themselves without necessarily needing the cooperation of their male partners. The demand for these methods arises from the frustration many women feel, that they are unable to protect their own health and well-being. For the majority of women living in the Third World, decisions about their reproductive health are made by their male partners, their families, or health workers.4 That a similar powerlessness is felt by women in Western societies, despite their general social and economic advancement, has also been argued.5,6 Inherent in women’s demand for more control over their own health and sexuality is that it should be accessible to women of all classes and regions. Socially disadvantaged women all over the world face more barriers to effective health care, while economic dependence on their male partners gives them less power to insist on sexual health protection. Rich women in poor countries, on the other hand, have commonly had better means of buying contraception, infertility and abortion services, at the same time as having greater resources to break out of deleterious relationships.

In many situations men are supportive of their women partners and cooperative in preventing pregnancy as well as STIs. However, while the most effective methods of pregnancy prevention are methods used by women:

‘...the HIV epidemic (has) restored to men the locus of control over the consequences of sexual behaviour.’1

The hope invested in women-controlled methods is that women might be able to regain some of that independence in relation to protection against STIs. The question that has to be asked is: To what extent are methods that women use women-controlled, in that they are independent of the need for male partner cooperation?

The pandemic of HIV/AIDS in the world today has led to a frantic rethink on issues to do with
sexuality and reproductive health. Although sexually transmitted infections have caused major problems in deprived areas for generations, the emphasis has often been on treatment rather than prevention. Family planning programmes have had a narrow contraception remit, rather than promoting improvement in overall reproductive health, and emphasis has been on research and provision of the most efficacious methods for prevention of pregnancy, such as hormonal contraception and sterilisation, which do not protect against STIs.

Attention has now turned to dual protection measures which protect women and men against both STIs and unwanted pregnancy. As a barrier method, condoms provide protection against both. Use of condoms is more likely to be consistent when they are being used as a dual purpose method rather than in combination with another contraceptive. Contraceptive methods do not usually bear the same stigma as methods for STI prevention, and can carry more social approval, thereby legitimising their use. Family planning is much more often championed openly by key celebrities and influential figures than AIDS prevention, with notable exceptions. Promotion of condoms for STI protection, on the other hand, has the effect of labelling people who use them as candidates for infection. Protection against unwanted pregnancy can therefore be used to justify gaining protection against infection. Condom use as the primary dual purpose method, backed up by emergency hormonal contraception in cases of method failure as regards pregnancy, is emerging as the most practical and cost effective method of dual protection in locations with high HIV prevalence.

Condoms most widely available to date are the conventional male variety, but recently there have been increased efforts to improve women’s access to female condoms in the Third World.

Development of female condoms
Female condoms became commercially available in some European countries in 1992. By 1996, they were being marketed in more than ten countries, including Korea, South Africa, Thailand, and the USA. Acceptability studies have been done on female condoms in such countries as Britain, Thailand, Cameroon, USA, Papua New Guinea, Zambia, South Africa and Zimbabwe. In the West, these have primarily looked at their acceptability as a contraceptive method. In the developing world, where the HIV/AIDS epidemic is predominantly heterosexual, acceptability studies have focused on use of female condoms to prevent infection. These studies have shown high levels of satisfaction with female condoms among users, although a general limitation of the studies has been the short duration of follow-up.

There is an increasing demand being expressed for female condoms, so long as they are at a highly subsidised, affordable price, eg. in Zimbabwe. The private sector price of female condoms (approximately US $2.50 each) has been a major obstacle to access even for many middle-class people in the West. Although it has taken a long time for international agencies to negotiate an appropriate public sector price, there are now various initiatives underway to subsidise provision of female condoms in developing countries. However, there has been little work done to date on whether better access to female condoms has reduced the extent of unprotected sex or negative outcomes.

Analysis of two female condom studies in Zimbabwe
This paper discusses some of the issues arising from two studies carried out by us in Zimbabwe on user perspectives of female condoms, as part of the Zimbabwe AIDS Prevention Project, in 1993 and 1995. In both studies the participants were provided with male and female condoms to use and information was collected from questionnaires, interviews and focus group discussions. The details of the first study have been reported elsewhere. Papers describing the second study have been submitted for publication.

Zimbabwe has been particularly affected by the HIV epidemic. Anonymous testing at antenatal clinics shows that between 15 and 45 per cent of pregnant women have HIV. In countries such as Thailand and India, HIV seroprevalence rates in sex workers are as high as 36 to 45 per cent. In the two groups of sex workers we studied, in two different towns in Zimbabwe, the prevalence of HIV was over 80 per cent. Studies in Nairobi ten years earlier showed similar rates. Acutely aware of the risks they face, women in many diverse circum-

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stances were asking for female condoms even before they had seen one. Acceptability studies were considered important to establish whether women who perceived themselves to be at risk of infection would be willing to use this method, and to identify the benefits and disadvantages.

The first study was carried out in three areas of Zimbabwe in 1993 with three groups of women: urban sex workers who were also peer educators, urban family planning clinic attenders and a group of rural women who were not sex workers. The women’s main motivation for using or trying male and female condoms was to prevent STIs, even though some appreciated the contraceptive benefits as well. More than 80 per cent of women in all three groups in this study liked the female condom fairly well or very much, over 65 per cent liked it better than the male condom and more than 70 per cent reported that their partners liked it also. The women reported that their partners liked female condoms more than male ones because they were not constricting, did not need a full erection for application, did not require removal immediately after ejaculation (as with male condoms) and because the men did not have to take responsibility for protection.

The second study focused on sex workers in Harare in 1995, who were considered to be at high risk of STIs. Given that sex workers who were peer educators had succeeded in negotiating with their clients to use female condoms, we were interested to find out if the same were true for sex workers who were not peer educators. We found acceptability levels similar to those of the women in our first study, both among the sex workers and in the responses they reported from their partners. The main reasons given for preferring female to male condoms were that they seemed stronger and safer. The majority said they would recommend female condoms to their friends and would continue to use them if they were available. This study also investigated whether easy access to female as well as male condoms would reduce the risk of STI transmission or the number of unprotected sexual episodes. Comparisons were made between two groups of sex workers, randomly allocated to a group that was offered male condoms only and a group offered both male and female condoms, over a total study period of 10 months. Outcome measures investigated were STI incidence and unprotected sexual episodes, recorded on coital logs. There was no significant difference in STI incidence in the two groups, though the time interval between infections was longer in the group offered both types of condom. Over a longer period of follow-up, this lengthened interval between infection may convert to reduced incidence of STIs and needs further investigation. Our conclusion was that access to female condoms in addition to male condoms did not offer additional protection in this particular group of women over a short period of time.

Despite considerable need and demand for women-controlled methods, and despite enthusiasm for female condoms when they have been tried, easy access in this group of women, did not appear to give them extra protection. These findings cannot be generalised to the overall population of women at risk, since the study group was made up of sex workers and undertaken over a relatively short period of time, when female condoms had not been promoted or made available to the public. However, there are lessons to be learnt from this work which were anticipated by du Guerny and Sjoberg, who stated that:

‘Female condoms are only likely to reach women who are already in a position to control their sexual relations and thus probably already in a position to insist on their partners’ use of condoms.’

These authors recommend that programmes focus on ‘why people have unprotected sex instead of concentrating on how to practise safer sex’. This paper is about the obstacles experienced by women in using condoms in both of our studies, which resulted in their having unprotected sex in spite of condoms being an ‘acceptable method’ to them. Many, though not all, of these would hold true for contraceptive use of these methods as well.

**Obstacles to using barrier methods**

There are two kinds of obstacles to using barrier methods. The first is the nature of relationships between sexual partners. The symbolism of condom use in relationships has been widely discussed. In particular, the different interpretations of men versus women introducing condoms into a sexual encounter reflect a
whole range of complex gender, power, and societal value statements.

The second area of obstacles is mechanical, due to problems arising from the barrier methods themselves, side effects experienced or difficulties in using the method correctly and consistently. A vital concern in this arena is that unfortunate experiences with any method undermine the success of future attempts with that method. Browne and Minichello describe these as ‘condom memories’ which, if negative due to unpleasant or embarrassing sexual experiences or unfortunate partner reactions, will put users off trying condoms. Memories can have protective consequences as well, for instance if failure to use condoms results in an infection, users may feel more determined to use them next time.

With any method, use becomes easier with practice, and this is particularly true of barrier methods, and true for both partners. We asked participants in our studies not to make a decision about using female condoms based on their first attempts. This was obviously problematic for sex workers who were trying them with first-time customers. Similar situations arise with male condoms even though there are assumptions that men know how to use them intuitively. One writer has pointed out that to put on male condoms according to some instructions, the user would need three hands. About two thirds of the men in that study group sometimes or often lost their erection while putting a condom on. Nearly as many lost their erection during intercourse. Since such problems could discourage men and their partners from using condoms, health promoters have to find ways of advising their clients on how to deal with them.

Our second study showed a high rate of male condom breakage, which may indicate that male condoms are not being used or stored appropriately. The resulting fear of breakage led to several men wearing double condoms, an activity which has not been adequately evaluated either for comfort or safety. Sex workers in Zimbabwe have also reported concerns over frequent condom breakage in other settings, especially when condoms were used with vaginal drying agents.

### Commercial sex, relationships and condom use

The economic basis of the sexual relationships described by sex workers in these studies was varied, ranging from clients on a casual, one-off basis to regular clients with whom the women had more steady relationships, but still for money. Some steadier relationships may have started off on a commercial basis but moved to a non-paying relationship in which the women would still expect gifts and help with rent and food. Even though these relationships predominantly applied to sex workers, many aspects of such relationships also apply with ‘other’ women. Women in different parts of Africa have described how they expect money or presents in extra-marital and premarital affairs as a sign of appreciation or out of economic necessity, yet the women did not consider themselves to be sex workers. Although there would be an unspoken awareness that there may have been other partners, safer sex protection would not be seen to be needed because the women would not be regarded as sex workers.

Most of the women had become sex workers after being divorced or widowed, sometimes as a result of infertility, or because their husbands had taken second wives and stopped giving them money for themselves and their children. Their main hope for getting off the streets was to find men who would look after them financially on a long-term basis, even marriage. They often did not have skills or training to be able to get alternative employment other than vending. There were therefore different economic bases for their relationships with clients versus boyfriends.

In both our studies there were marked differences in the pattern of condom usage by sex workers with clients and boyfriends. In the second group, nearly 70 per cent of the women were using male condoms frequently (more than half the time) with clients, while about 60 per cent rarely or never used them with boyfriends. Use, or otherwise, of condoms was an expression of this difference in relationship. Not using a condom was an expression of trust and friendship. Regular clients who treated a woman nicely, paid well and did not show signs of infection were more likely to get sex without condoms if they wanted it, as a sign of appreciation. Clients were clearly also aware of the advantages of being a
regular customer and the difference in condom use. Some clients would insist on sex without condoms after they had visited the same woman for some time, since they felt they were now like boyfriends (and deserved the same rights).

As an extension of this, most of the sex workers reported that their boyfriends refused to use condoms with them, and they themselves often did not want to use condoms with their boyfriends. Partly this was because some were hoping to get pregnant with their boyfriends as a seal to their commitment. Partly it was a way of separating what they did to earn a living from what they did for love, and to show their lovers that they were special. This phenomenon has been witnessed internationally, where use of condoms is seen as creating the separation between commercial and noncommercial (romantic) sex.6,30,36,37,38 Problems arose for the sex workers when their boyfriends were the source of infections (since their boyfriends were rarely monogamous) or if their boyfriends would not take responsibility for the children that were born to them. Since over 80 per cent of the sex workers in both these studies were already HIV positive, infection was shared not only with their boyfriends and clients, but also with the other partners of these men.

Power and trust

McKeganey and Barnard describe in a study in Glasgow how a strong motivation for some men to buy sex was to have power over women.6 That power was sometimes expressed as abuse or violence, but more commonly paying for sex with sex workers gave men the right to ask for whatever form of sex they wanted. The more vulnerable the sex worker, i.e. if she was a newcomer to prostitution, young or a drug addict, the more likely she was to give in to his demands.

In our studies, the transient nature of the relationships between sex workers and most of their clients undermined their ability to use female condoms effectively. The sex workers often gave up trying to introduce the female condom because they were afraid of losing business. In our second study, nearly half the women had some clients who refused to use female condoms because they did not trust these new condoms or they were put off by their appearance. Many sex workers had been using male condoms for several years, their clients were now used to them and distrusted something new. If the clients were satisfied with using male condoms, then they said they did not see the need for female condoms. Once a few men had refused to use them, the sex workers were afraid to try with others in case they lost interest.

The men’s distrust of female condoms, as reported by the sex workers, was also a reflection of the distrust and contradictions in these particular relationships. Men buying sex in Harare expressed their power by sometimes withholding payment or by using violence. Both the men and the women were suspicious that the other wanted to infect them. The women often expressed this by accusing clients of wanting to make holes or tears in male condoms with their nails, so that the woman would get infected or pregnant (described as ‘leaving their mark on them’). Making holes in condoms, if in fact it happens, may be another way of expressing power over the women, and is certainly perceived as such and feared by sex workers. This was one reason why the sex workers liked the fact that female condoms seemed stronger, along with the fact that the woman puts the condom in herself.

Deven and Meredith describe how unprotected intercourse is seen as:

‘...a consequence of the male-female power distribution, the training of men to be aggressive and the persistence of gender roles that define the male as the sexual initiator, and the female role as establishing the sexual pace and limits.’39

Other writers have also commented on the traditional role of women as the gatekeepers of morality,5 and the contradictions between male expectations of power, authority and control, with women trying to assert themselves to ensure safer sex and male compliance with this.5,6 In this context, a sex worker trying to negotiate for use of a female condom would be perceived as too assertive, too threatening. The search for power in relationships by men who may be socio-economically powerless in other ways is an issue that must be faced in order to understand the spread of the HIV epidemic in poor communities. Campbell, in describing the sexual identities of South African miners, refers to the irony that:

‘The very sense of masculinity that assists men in
their day-to-day survival also serves to heighten their exposure to the risks of HIV infection.40

There was more opportunity for negotiation with those regular clients with whom the women were able to communicate and persuade to try female condoms. Some women reported that when they persisted, their clients were more willing to try female condoms and with experience, the men sometimes expressed a preference of female to male condoms.

**Differences between sex workers in the two study groups**

The sex workers who formed one of the three groups in our first study were much more able to introduce female condoms to their clients than those in the second study. The former were part of a peer educator programme which included promotion of condom use and negotiating skills. They were therefore already part of a support group, had more confidence about refusing unsafe sex, and tended to rely on more regular customers for their income. Their clients were more likely to trust that they were not trying to infect them. The latter group were not organised in the same way. Though some had support from other women in the same brothel, they were very vulnerable to exploitation. In our focus group discussions with the women, several who had been long-standing sex workers mentioned that fewer men were coming to buy sex than in the past, because of fear of AIDS. They thought that clients who were still coming possibly had HIV infection already, and that this could explain their adamant refusal to be protected.

The women felt that the responsibility to initiate safer sex was their own, since they were the ones with many partners, but although some said they would refuse sex without condoms, many recalled times they had had unprotected sex because they were desperate for money and were offered more for sex without a condom.

The Glasgow study shows that although clients believed HIV to be very widespread amongst the sex workers they frequented (higher than it actually was), hardly any of them felt at personal risk of infection. The basis for their optimism was the belief that they could identify which women were likely to be infected, by their appearance or where they were working.6 In Singapore investigators found that sex workers were only successful in persuading half the clients they negotiated with to use condoms.31 In separate work that we did in Harare with the clients of sex workers, we found a high level of denial about risk from unprotected sex; the men did not make realistic assessments of the level of risk in the situations they were in. For instance, the association of youth with being free from infection led one man to have sex with a 17-year-old sex worker without a condom. Several men also spoke of ‘trusting’ their partners (including women they paid for sex) to be infection-free, without taking the precautions necessary to ensure this (unpublished data).

**Negotiation for safer sex**

Dowsett describes the ability to have safer sex as being about making decisions and sticking to them when feelings for another and the heat of the moment challenge resolve.42 This description conjures up images of sex characterised by passion and abandonment. In the context of sex work in Zimbabwe, safer sex usually depends more on the ability to convince partners that it is in their mutual best interests to use a condom, without changing the basis of the relationship. Yet the very act of proposing condom use by women introduces an assertiveness and confidence that sex partners may not welcome. Programmes which focus on encouraging men to take more responsibility in ensuring safer sex, sometimes inadvertently reinforce the desire for women to be passive in these relationships.

In both our studies, we found that the same barriers that prevented women from negotiating for male condom use existed for female condoms also. Even though female condoms are thought of as ‘woman-controlled’ because women put them in themselves, clearly the willingness of partners is needed in most instances.

One sex worker (in our second study) vividly described being told to take her condom out and to get a male condom, which her partner trusted more. Insofar as she was economically dependent on that transaction taking place, it was difficult to refuse. If she had the support of the other sex workers in the block, so that the man knew he could not get what he wanted elsewhere, she would have more power to assert herself; peer support for safer sex is a powerful lever for change.6 If this woman’s clients did not
know that she was using female condoms, such as when they were too drunk to notice, she could get away with it. If, however, she got a reputation amongst the clientele for using female condoms, she might only get customers who liked them, which may have been safer for her, but might also mean less money coming in.

This woman was still protected since her partner used a male condom. Yet our research showed, and her example is indicative of why, access to female condoms along with male condoms did not seem to offer extra protection for this group of sex workers. Those who could negotiate for condom use may already have been maximising their opportunities with male condoms. Those who could not negotiate for male condoms may not have been able to negotiate for female condoms either. Circumstances mentioned in which they could use female condoms without their partners consent were mainly when their partners were too drunk to use male condoms or too drunk to notice, in other words, situations in which there was no need to negotiate use. These were also situations in which it would not have been possible to use male condoms, so female condoms would have had additional benefit, as the only possible source of protection.

Many of the women in both studies perceived as a benefit of female condoms that they could be used when men refused to use male condoms. However, whether or not they could actually use them depended on why their clients were refusing male condoms. If the man found male condoms uncomfortable, he might appreciate the benefits of female condoms as an alternative. If he had other motivations, for instance if he was paying for sex to escape from the need to use protection, it would not matter whether an alternative was offered.

**Promotion of female condoms in certain relationships**

The issue is not whether to target female condoms at sex workers because they are involved in cycles of high risk of HIV/STI transmission, or to target them at non-sex workers who may be in longer-term relationships. Women in general have differing types and levels of negotiation with their sexual partners, and their partners are at various stages of willingness to comply with the need for safer sex. It may be more appropriate for sex workers to use male condoms for first-line protection, with female condoms as a back-up with men who refuse or are unable to use a male condom. Further, different negotiation skills are needed for clients versus boyfriends. Women may be better able to negotiate using female condoms in less casual relationships, where there is more trust between partners. At the same time, the commercial basis of a sex worker’s relationships with her clients may allow introducing condoms, while her romantic relationship with a lover prevents discussion of protection.

Authors writing about condom use in Western societies describe how partners negotiate for safer sex, and that consistent and correct condom use is related to the quality of communication between them. Browne and Minichello describe safe sex occasions as those in which condom dialogues are supportive of condom use and involve partners reassuring each other that condom use is expected. Some exploration of alternatives and shared concern about consequences also seems to be needed. Partners who are able to eroticise condom use as well are more likely to be successful. Most of the brief, non-explicit, often non-verbal communication that precedes the purchase of sex does not constitute negotiation or communication.

*The new age has given more freedom of sexual action but has not led to experimental sexual discussion which paves the way for true sexual freedom and autonomous relations.*

**Mechanical and technical obstacles to female condom use**

Female condoms do not need to be prescribed or fitted by health workers, and are sold in the First World over the counter in pharmacies and supermarkets. This may have implications for lack of consistency and correctness of use, as it has with male condoms. Many of the technical reasons for discomfort during use of female condoms need to be sorted out by sensitive and sympathetic guidance by health workers introducing the device. For example, pain caused by the inner ring was reduced when women were shown how to remove the inner ring after insertion of the condom. Comments made about the size of the female condom being off-putting...
can be countered by showing that male and female condoms are in fact the same length, though different widths. It is the extra space that makes the female condom feel less constricting, which is a feature that women have reported their partners liked.

Less than 20 per cent of participants in both our studies had problems using this method. Despite this, reports on female condoms often focus on the problems faced. Many women are willing to tolerate some discomfort if they feel that a method is better for them than the alternatives. Although no method is perfect, and different side effects have varying importance at different times in people’s lives, it is sometimes easier for people to focus on side effects of a method rather than express uneasiness about other aspects of their use, such as the effect on the power balance in their sexual relationship. Women in our first study would sometimes say to us that their husbands would not allow them to do something, when probing revealed that they themselves did not want to do it, but thought it was more acceptable to use partner refusal as an excuse.

It may be that when female condoms are more available in non-research settings, with people more used to them, there will be less distrust attached to them. Female condoms need practice before men and women feel confident using them and they require better conditions for having sex than some sex workers can arrange. In the focus groups, the women mentioned that it was difficult to use female condoms when having sex in the street, in alleys or doorways, since there was nowhere to wash their hands, or to insert the condoms comfortably.

Unfortunately, the negative propaganda given female condoms, such as that they are noisy or that they feel like shopping bags, adversely influences women and men who may benefit from using them. The effects mentioned can usually be resolved by using extra lubrication and making sure the condom is inserted properly. Similar negative comments are common for male condoms, eg. it’s like showering with a raincoat, eating sweets with a wrapper, and so on. Health promotion workers have had to work hard to combat this propaganda. The affectionate name of gumboots has been used with a protective connotation, ie. ‘Don’t go out without your gumboots’ or ‘A raincoat is useful to protect you against the rain’.

**Consistency of use: negotiating skills as part of the package**

Because of the association with HIV, condom use has been very stigmatised, but this is changing. Surveys show that more people are using condoms nowadays.22,44 However, protection from infection is dependent on consistency of condom use; occasional unprotected episodes still leave individuals at risk.8,45,46,47,48 These are international dilemmas. First World studies have also shown that sex workers are exposed to infection through their boyfriends rather than clients because of selective condom use, and women are more likely to use condoms in short-term rather than long-term relationships regardless of the number of partners either have had.36,38,49

As a result, barrier methods for contraceptive and HIV/STI protection cannot be seen as ‘products’ only. Successful use depends on a whole package of care. This includes the attitudes of the health workers providing the methods, and the promotion and publicity given to the methods, as well as the involvement of both men and women partners as users of the method. Acceptability studies have shown the areas where problems need to be sorted out and where negotiation skills for both partners can be improved. Programmes for sex workers which include skills training as part of their method promotion have established that their clients became more able as a result to negotiate for condom use, but also to establish relationships with men who were willing to use condoms.41,50,51

The knowledge and training of health workers who are providing counselling and services to the women using these methods are vital to successful use. Health workers have to learn to anticipate and respond to the problems which arise, in reassuring and imaginative ways. Several of our research nurses had used female condoms themselves and in finding solutions to their own problems with them, were more able to support the sex workers with theirs.

**Support from peers**

Use of female condoms became a campaigning issue with the Women and AIDS Support Network in Zimbabwe starting several years ago. Some of the members of the group had used female condoms and they too were able to advise other women on how to overcome problems and
what strategies to use in negotiating with partners for their use. Without this support, women acting on their own may have given up. Women have demonstrated a need for encouragement to persist despite difficulties. They may also be more willing to discuss intimate matters with their own peers than when confronted by the professional (and often class) barriers presented by health workers. Groups like these play a similar role to those in Europe and the USA in the seventies who encouraged women to learn about their bodies, and who acted as advocates to improve the attitudes of health workers towards providing information in accessible and non-judgemental ways. They also serve a crucial role in redefining the roles and status of women, providing a social network within which women can get support to change their lives.

Interestingly, there is little written about whether men compare notes or support each other on how to use male condoms. Men would probably benefit from learning from each others’ experiences, but there appears to be less of a culture of ‘bodytalk’ amongst heterosexual men. This is another area which is changing in the West with the advent of men’s magazines which focus on health issues. Peer educator programmes in Africa and elsewhere have included demonstrating condom application using wooden models. Our impression from observing these groups is that they rarely get into the kind of intimate discussion about the mechanics of condom activities that women in support groups do. However, men (like women) spend a lot of time talking about sex and comparing notes so peer educators have a crucial role to play in introducing safer sex and responsibility issues into the discussions.

Conclusions

Users of barrier methods are both the men and women involved in the sexual partnership, whether they are using a male-controlled or female-controlled method. In countries where condoms are already distributed for family planning purposes, it may be easier to emphasise their dual protection benefits. However, although acceptability studies have shown high levels of satisfaction with female condoms among both men and women, there is no evidence that female
condoms will increase protection of women from HIV/STIs or unwanted pregnancy if women are not empowered to use them. Advances in contraceptive and HIV/STI prevention technology have to be matched by advances in the social and economic standing of women, their sense of self-efficacy and value, and enhancement of their status as equal decision makers in reproductive and sexual health matters.

Our research shows that despite some change in practices, many women still have problems negotiating to protect themselves from infection. Similar barriers also exist if women want protection from pregnancy but their partners do not. Use of barrier methods for either purpose requires the willingness of men to be successful users. The search for the ideal ‘invisible’ barrier method that women can use, without their partners necessarily knowing, has led to renewed interest in microbicides. Du Guerny and Sjoberg suggest these methods may come up against similar obstacles as female condoms do, for example, if men expect their partners to get pregnant, they will still question why this is not happening. However, until there are new products (and one line of research is non-spermicidal microbicides) this cannot be determined in practice.

If the real barriers to women’s health are male attitudes and behaviour, these have to be challenged. In the long run, it is no use avoiding the real issues in trying not to threaten the status quo. It is harder for men to change as individuals, in isolation. Like women, they need to be supported to make changes. New group norms need to be developed through the activities and influence of role models and opinion leaders within social networks. Gender relationships and societal values that prevent women from protecting themselves from infection and unwanted pregnancy have to be questioned and solutions found. Research and policies which take the social context of female and male sexuality into account have a better chance of being successful in leading to long-term change.

Countries that have been the worst affected by AIDS are countries that were already struggling with major problems in relation to other reproductive health issues, in particular high maternal morbidity and mortality, sexually transmitted diseases and their consequences, such as infertility. Together with HIV/AIDS, these have shown up ways in which women have little power to insist on safer sex for themselves. This powerlessness includes not having access to health services and condom supplies, as well as not being able to use condoms when they have access to them. Policymakers, health care providers and other prominent figures have also been blamed for creating obstacles to the development of interventions for high risk groups. The problems described are of bureaucratic delays, lack of interest and commitment, and obstruction in the name of religion.

In particular, failure to recognise that impoverishment of women plays a major part in perpetuating the HIV epidemic has led to short-sighted approaches to prevention. Failure to make provision for the needs of sex workers, in the way of health services and advice centres, has delayed possible interventions which could have supported them in trying to protect themselves, all their partners and therefore their boyfriends’ and clients’ partners. This too is an international problem. In Britain, for example, health services have been intensified for sex workers mainly out of fear of HIV transmission to ‘innocent victims’ rather than concern for the well-being of the women themselves.

There have to be significant shifts in ideology and value systems to support men and women in changing the power basis in their relationships. It is necessary actively to seek and advertise models of effective change. Peer education programmes have made a significant contribution to changing community attitudes and to acceptance of the urgent need for both prevention of HIV transmission and support for those living with HIV. Lobbying policymakers through public demonstrations and petitions for female condoms to be made accessible in Zimbabwe have also made a difference. A social marketing initiative was launched recently in Zimbabwe which sold 24,000 female condoms through the private sector in the first two weeks. Global programmes such as the Safe Motherhood initiative, UNAIDS and family planning programmes can influence government policies, by focusing on the status of women and how this status can be enhanced. The fundamental principle that has to be accepted in order to have a significant and sustainable impact is the value given to women’s lives.

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Acknowledgements
The authors are grateful to Professor Peter Mason and the staff of the Zimbabwe AIDS Prevention Project, University of Zimbabwe, for their support, and to Chartex UK for supplying the female condoms.

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