THE ACCEPTABILITY OF THE FEMALE CONDOM AMONG LOW-INCOME AFRICAN-AMERICAN WOMEN

Denese O. Shervington, MD
New Orleans, Louisiana

Among women, African Americans are at the highest risk for contracting the human immunodeficiency virus (HIV). Unfortunately, the majority of African-American women do not perceive themselves to be at risk nor perceive the need to engage in safe-sex practices. Given the alarming rate of increase of HIV disease among African-American women, more in-depth information about the sociocultural factors influencing these nonhealth-promoting beliefs and behaviors is needed immediately in order to design effective Information, Education, Communication campaigns. As part of such an effort, a premarketing study of the recently developed female condom, Reality (Wisconsin Pharmacal, Jackson, Wisconsin), was used as an opportunity to assess not only acceptance and relevance of the product, but also knowledge, attitudes, and practices among a group of African-American women in New Orleans.

The methodology chosen was focus group discussions. The main finding from these discussions is that the previously reported low-risk perception of HIV disease among African-American females is also true among this focus group. The discussions suggest that cultural norms of female submission and passivity in sexual negotiation is a major barrier to preventive actions among these African-American women, ie, insistence on condom use during sexual intercourse. The second important finding from these focus group discussions is that the women enthusiasitically endorsed the female condom because they felt this condom allowed them control over safe-sex practices without having to challenge the power of their male partners.

This study also demonstrates that the dynamics of universality and interpersonal learning inherent to insight-oriented or support groups can also be present. When occurring in the nonthreatening environment of the focus group, such processes can be extremely helpful in encouraging and motivating participants to adopt more positive health actions. (*J Natl Med Assoc.* 1993;85:341-347.)

Key words • female condom • human immunodeficiency virus • safe sex •African-American women

The 1991 report of the National Commission on Acquired Immune Deficiency Syndrome, *America Living With AIDS,* states, "The number of women and children infected with HIV—particularly within communities of color, continues to grow dramatically. In fact, AIDS cases among women are growing faster than AIDS cases among men. As of June 1991, women accounted for 10% of all AIDS cases. In 1991, AIDS is projected to be one of the top five causes of death for young women."[1]

From the Department of Psychiatry, Louisiana State University Medical Center, New Orleans, Louisiana. Requests for reprints should be addressed to Dr Denese O. Shervington, Dept of Psychiatry, Louisiana State University Medical Ctr, 1542 Tulane Ave, New Orleans, LA 70112-2822.

Similarly, the April 1992 human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) surveillance report from the Centers for Disease Control and Prevention[2] shows that:

- African Americans account for 63 941 of the 218 301 cases of AIDS, ie, 29% of total AIDS cases (African Americans comprise only 12% of the total US population).
- African-American women account for 12 896 of the 24 307 cases of AIDS in women, ie, 53% of the cases.
- African-American children account for 1971 of the 3692 cases of AIDS in children, ie, 53% of the cases.

Among women, African Americans of lower socioeconomic status have been the hardest hit by the disease—these women are the most at risk for unprotected sex with an HIV-positive, intravenous drug-using partner, or for being intravenous drug users themselves. Eventually, all sexually active African-American women are going to be at equal risk, given the complex web of sexual relationships permeating all socioeconomic boundaries.

However, the majority of African-American women do not perceive themselves to be at risk for infection with HIV. A 1991 nationwide Women of Color Reproductive Health Poll conducted by the National Council of Negro Women found that 6 of 10 respondents did not believe they were at risk for contracting AIDS.[3] In the 1992 follow-up poll on contraception, approximately 40% of the sexually active African-American women surveyed between the ages of 18 and 44 used no method of contraception. Of the 60% of women who did use contraception, only approximately 25% used condoms.[4] Similarly, a study on sexuality done by Gail Wyatt in Los Angeles found that 69% of the African-American women interviewed (compared with 31% of the white women) did not use any contraception.[5]

Known mechanisms of HIV transmission are contact with HIV-infected body fluids through sexual intercourse, sharing intravenous drug paraphernalia, blood transfusion, placental transfer, and breast feeding. For African-American women, unprotected sexual contact is the major risk factor for HIV infection. The studies cited above suggest that the contributing sociocultural factors are low levels of any contraceptive use, a preference for contraceptive methods that do not prevent transmission of body fluids,[5] and low perception of susceptibility.

The most effective method of decreasing the spread of HIV disease has been educational programs on safe-sex practices, stressing the use of barrier protection. In San Francisco, such approaches were noted to have resulted in "dramatic and sustained reduction in risk behavior."[1] Similarly, in Kinshasa, Zaire, there was a significant difference in the rate of HIV infection among female prostitutes reporting condom use by 50% or more of their partners compared with women reporting less frequent condom use among their partners.[6]

Until recently, the only condom available to women in the United States has been the male condom, the use of which requires the cooperation of the male partner. The assumption of female responsibility for condom use during sex has been very difficult, given the usually passive female role in sex. As stated in the 1991 National Commission on AIDS report, "Perhaps the most unrealistic prevention message for women is the nearly exclusive focus on the use of condoms, advice that is naive regarding anatomy, gender roles, and power."[1] The report recommended, "Increased efforts are necessary to develop a wide array of chemical and physical barriers to block vaginal HIV transmission that do not depend entirely on the male partner's cooperation."[1]

A female condom, the Reality Vaginal Pouch, recently developed by Wisconsin Pharmacal (Jackson, Wisconsin), is one such potential physical barrier. Given the alarming rate of the increase of HIV disease among African-American women, it is of utmost urgency that extensive efforts be directed at Information, Education, Communication (IEC) campaigns within this community, based on a sound understanding of the sociocultural determinants of sexuality and reproductive health behaviors among African-American women.

Given the low level of awareness among African-American women of their susceptibility to AIDS, compounded by their powerlessness in sexual negotiation, it is important that any such intervention:

- capture the attention of African-American women and realistically appraise them of their risks and susceptibility to HIV infection,
- empower African-American women in the sexual decision-making process, and
- allow for interactive participation to maximize the potential for learning and mastery of risk-reducing behaviors.

The focus group was chosen because its format lends itself to all the above-stated communication objectives. Focus groups are specialized groups that are used to "gain insight into the dynamic relationships of atti-

tudes, opinions, motivations, concerns, and problems related to current and projected human activity."[7] Focus groups can be used for both phenomenologic and clinical purposes; in this study it could therefore be used simultaneously to both gather data and assess the determinants of general reproductive health knowledge and practices, and to communicate information about HIV disease and the female condom.

When gathering information considered taboo or embarrassing, focus groups have been found to be very effective. Zimmerman et al successfully used focus groups in assessing the acceptability of Norplant in four countries.[8] Likewise, Michielutte et al found focus groups to be very effective in the development of community-based public health education designed to reduce mortality from cervical cancer among black women in Forsyth County, North Carolina.[9] The use of focus groups for social marketing programs has increased markedly in recent years.[10]

METHOD

Group Formation

Three groups consisting of 12 African-American women were recruited in June 1992. Within groups, educational and socioeconomic status were homogeneous; age and degree of sexual exposure varied.

Group 1. Participants in this group were medical students recruited from a major university medical center. This group was chosen to serve as a comparison for the effects of higher social and educational status. The average income was under $15 000 annually. The average age of Group 1 participants was 23 years old (range: 21 to 26 years). Ten women were present.

Group 2. This group was comprised of low- to middle-income women, with the majority being high school graduates. The women were recruited from a self-help, community-based, health-improvement group. The average age was 31 years old (range: 14 to 65 years). Initially, 12 women were recruited for this group; however, several women brought friends and asked that they be allowed to observe. The recruits felt that this was important information that needed to be shared. Twenty women were present. (It is recognized that the generally recommended number for focus group participants is from 6 to 12 and that ideally members should not be acquainted with each other. However, given the health urgency and immediacy of combating HIV disease within the African-American community, the women were allowed to stay.)

Group 3. Group 3 was comprised of low-income women. The majority of the women in this group had high school backgrounds and were recruited from a housing project health clinic. The average age was 31 years old (range: 17 to 53 years). Initially, 12 women were recruited, but as with Group 2, a few women also brought friends along to observe. Fifteen women were present.

Location of Group Meeting

Group 1 was conducted in a hotel conference room, during which breakfast was served. Group 2 was conducted in the home of a community member, during which lunch was served. Group 3 was conducted in a community center, during which an afternoon snack was served. Meals were served at the beginning of each group.

Group Process and Format

All groups were moderated by the author, an African-American female psychiatrist experienced in group process and dynamics, and the modified focus group. A female assistant was present at all three meetings, her primary task being record-keeping. All groups were audiotaped with the prior permission of the participants. All groups followed the same protocol and covered the same topics.

The group format was divided into two segments. The first segment was for gathering information on the reproductive knowledge, attitudes, and practices among these women. Data was collected from guided discussions on the following topics:

- general attitudes regarding sex and sexuality,
- knowledge of sexually transmitted diseases (STDs),
- knowledge regarding contraception,
- knowledge regarding barrier protection devices,
- acceptability of the female condom, and
- readability and comprehension of the proposed instruction guide.

The second segment was experiential and educational. The participants were each given a female condom and oriented to it by the moderator. They were then asked to report their feelings about the meaning of such a device. Then each group member took turns reading a portion of the instruction guide and demonstrating their comprehension.

In all three groups, it was observed that the women were very open and uninhibited in discussing highly personal subject matters. This is similar to the observations of other focus group leaders. Folch-Lyon and Trost hypothesized, "The group situation may also encourage participants to disclose behaviors and attitudes that they might not consciously reveal in an

individual interview situation. This occurs because participants often feel more comfortable and secure in the company of people who share similar opinions, attitudes, and behavior or simply because they become carried away by the discussions."[7]

The meetings lasted approximately 90 minutes. Participants were paid $35. At the conclusion of the groups, all participants were invited to sign up to receive a free Reality condom when it became available; they all did.

RESULTS

The results of the discussions are summarized by topic for each group.

Sexuality

Group 1. Most participants in Group 1 expressed frustration at the culturally sanctioned dominant roles of males in sexual relationships. Many resented that women were taught to rely on male approval for their self-worth. As a result, they were not assertive in their relationships. A majority of these women concluded that despite their intellectual and professional achievements, they too looked to relationships for validation. They expressed concern about the growing trend of early exposure of African-American youth to sexually explicit language and behaviors in the media (TV and music), which were often degrading to women. Several women expressed anger at the then-popular song, "Baby Got Back," which they felt exploited the sexulaity of African-American women.

Group 2. Initially, most participants in this group expressed satisfaction with their roles in sexual relationships; toward the end of the group, however, many admitted to being frustrated by the infidelity of their spouses. They worried about their exposure to STDs. Despite these fears, these women felt that they had to accept these relationships because this was "the way things were." They also discussed concerns about the early exposure of children to sex, which they felt was responsible for the high rate of teenage pregnancy. Several women gave examples of 10- and 12-year-old sexually active youth who either became pregnant, developed STDs, or both.

Group 3. The topic of sexuality immediately triggered a discussion of HIV transmission in this group. An adolescent discussed being saddened by the knowledge that a 19-year-old former classmate was dying of AIDS. These women, too, expressed fears of the health hazards resulting from their partners' infidelity. Some women were concerned about the denial of homosexual acts by some men, in particular, those that had been incarcerated; they felt this placed them more at risk. These women also felt powerless to make any changes in their relationships with their spouses; like the Group 2 participants, these women felt that they had to accept their spouses' behaviors.

Sexually Transmitted Diseases

Group 1. Participants were highly informed about STDs and were extremely knowledgeable about the etiology and modes of transmission of the various diseases. Participants did not perceive themselves at risk, and no one discussed any personal experiences. Most of these women got their health information from reading and also from their involvement in medical education.

Group 2. Participants generally were very misinformed about STDs; however, their information about HIV was the most accurate. Several participants shared many myths regarding sources of STDs and recounted humorous stories of being blamed by their spouses for being the source of these diseases. Most of the women relied on friends for their primary source of information (especially those friends who worked in the health field).

Group 3. Participants had some knowledge about the causes and transmission of STDs; they were very curious to get more information about such diseases, particularly HIV. Many of the women were very knowledgeable about community resources for the treatment of STDs. Most of these women relied on physicians and the media (TV) for health information.

Contraception

Group 1. The majority of these women expressed anger at the lack of male responsibility in matters of contraception. They felt that women were unfairly burdened with the responsibility for contraception. They questioned why more effort was not being put into the development of male contraception. One woman asked, "Why isn't there a male birth control pill?"

Group 2. The women discussed their concerns about the low rate of contraceptive use among women in their communities. They felt that this was responsible for the high rates of pregnancy, especially among teenagers. A majority blamed low contraceptive use on poor communication about sexuality between mothers and their children.

Group 3. These women also discussed concerns about low contraceptive use among their peers. One woman stated, "It's free, and women are still not using

it." Many of these women felt that women were having babies in their search for someone to love them. As one woman stated, "They expect love from the baby or the baby's father."

Barrier-Method Contraception

Group 1. These women liked the idea of the protection of condoms, but reported that male partners were resistant to condom use. However, they felt strongly that women who respected themselves and hence expected respect from their mates would not engage in unprotected sex. As one woman stated, "Turn down that man who refuses to use a condom." Only half of these women reported use of the male condom during most acts of sexual intercourse. All of the women liked the idea of a female condom because they felt that it gave women more control over their protection from diseases. A few of these women raised the concern that some women may not be comfortable with touching themselves in intimate ways and therefore may not like inserting a condom.

Group 2. Most of these women reported that it was difficult to get their partners to consider condom use. The majority did not use condoms (only 4 of the 18 sexually active women used condoms), even though they would have preferred to do so. These women were unwilling and afraid to insist that their partners use condoms, and did not feel that they could refuse to engage in unprotected sexual intercourse. All of these women were excited about the female condom because it offered them more control in protecting themselves from diseases and pregnancies. One woman stated that she found the condom preferable to taking pills or other medication for contraception.

Group 3. The majority of these women discussed their frustration trying to get their partners to use condoms. "They say sex doesn't feel the same; they say condoms are not big enough," were some of the reasons their partners gave for refusing to use condoms. These women also felt powerless to insist on condom use or to refuse sex if it was not used. These women also were very excited about the female condom, as they felt it put them in control. As one woman stated, "you know it's on because you put it on." Several women stated that since they were in control of its actual insertion, they would use the female condom, with or without partner approval.

Feedback Regarding the Reality Condom and Ability to Understand the Proposed Instruction Guide

Group 1. The reactions to the feel of Reality by the women in this group were quite neutral. As one stated, "It feels like an exam glove." Several women expressed concerns about the appearance of the outer ring outside of the vagina. Most felt that the instruction guide was too cluttered, making it difficult to follow. They recommended that the instructions be simplified by using less words and bigger and brighter illustrations. Many questions were asked about the physical aspects of the condom, such as its durability, ability to stay in place after insertion, and possible harmful effects. Despite some hesitancy and skepticism about Reality, the group felt that they would use Reality if it became available and that they would definitely recommend it to acquaintances. They also felt that men should be informed regarding Reality and also be expected to participate in its use.

Group 2. This group liked the feel of Reality. One woman said that it felt like a "safe shield," and another woman said it felt "like a Ziploc." The group expressed no dissatisfaction with Reality. They demonstrated no difficulty in their ability to understand the instruction guide. The majority felt that it was good to have a lot of information in the instruction guide to ensure proper usage. The group did not express much concern about the appearance of Reality and did not perceive that they would have much difficulty in using it. The group strongly endorsed using Reality for themselves and felt that they would definitely recommend its use to acquaintances. Some women asked that similar meetings be held for other women in the community.

Group 3. These women also liked the feel of Reality, the majority opinion being that it felt strong, and hence made them feel safe. A few women did not like the appearance of the outer ring hanging from the vagina. Some women had questions about possible movement of the condom during intercourse that could result in the loss of protection. This group felt that the instruction guide was easy to understand and did not think that it was cluttered. Like the women in Group 2, they felt that it was better to have too much than too little information. This group overwhelmingly endorsed Reality. One woman said that she was anxiously awaiting the opportunity to use the condom. The group felt that the information on this condom was very important and needed to be shared with other women. Several women asked that similar meetings be conducted for other women in the clinics and that younger children should be included.

DISCUSSION

The discussions of the women in all three focus

TABLE. RECOMMENDATIONS FOR MARKETING REALITY CONDOM TO AFRICAN-AMERICAN WOMEN

- Testimonials on television by popular female African-American celebrities, encouraging women to be more assertive in protecting themselves, eg, using variations on the theme "PUT YOUR HEALTH FIRST"
- Rap poetry on large print media such as billboards, posters, and flyers, with images and messages encouraging women to take control; such themes could be put to music and broadcast on radio: "Ladies, protection no longer is random; for guess what, Reality is now your condom"
- Interactive small-group condom theme parties (modeled after the Avon party concept)
- Mail order through popular African-American magazines, such as *Essence* and *Jet*
- Availability of Reality in nontraditional markets such as beauty salons and nightclubs, in addition to traditional health markets

groups indicated that they were aware of the transmission of the HIV virus and knowledgeable about mechanisms to protect themselves from HIV disease by the use of condoms. They were also aware of the increasing threat of the AIDS epidemic within the heterosexual African-American community.

The majority of these sexually active women, however, did not perceive themselves to be personally at high risk. They therefore engaged in unprotected sex without much conscious fear of becoming infected with HIV. The majority indicated they would prefer that their partners use condoms during sexual intercourse because of some doubt about the fidelity of their partners. However, they do not insist on condom use because they feel powerless in negotiating the real or perceived refusal to do so by their partners.

The discussions indicated that the fear of relationship loss is more operant in the health beliefs and actions of the majority of these African-American women than fear of infection with the deadly virus. The majority placed more value on being in a relationship than on wellness and disease prevention. In fact, for some women, wellness was equated with being in a relationship. Only the few women who seemed to have an internal sense of self-worth were willing to value their health above and beyond being in a relationship.

It appears that this cognitive dissonance between knowledge and risk appraisal results from the extremely high value placed on male-female relationships within the African-American culture. A major source of self-validation and esteem for many African-American women is "being in a relationship." To prevent the perception of self-disintegration and preserve self-cohesion, many African-American women appear to use strong denial defenses to prevent relationship loss. One might hypothesize that for many such women, the death instinct (self-nothingness) is driven more by the fear of relationship loss than by the fear of physical disease.

Such a maladaptive schema results in behavioral submission and passivity. As one woman in the group stated, "A bad relationship is better than no relationship." This could explain why the majority of the women in the focus groups avoided asserting the need for condom use by their partners. Such behavior is viewed as a challenge to the authority and dominance of the male partner.

A very positive and encouraging finding of this qualitative study is that the majority of the women participating in the focus groups were able to confront their nonhealth-promoting behaviors wihtin the context of the group. This is similar to Basch's observations that, "Group based intervention programs appear to be useful in assisting individuals to modify or maintain many health behaviors, for example, compliance with therapeutic regimens, cessation of cigarette smoking, maintaining exercise, and weight control programs, improving appropriate utilization of health services, and managing and mediating adverse effects of stressful life events."[10]

The inherent group dynamics of universality and interpersonal learning is present in these focus groups, albeit that they are not insight-oriented. Group participation seems to have afforded the women the opportunity to clarify for themselves and each other the value of good health. It also allowed them to help each other recognize their own power in assuming more responsibility for protecting themselves from disease. This resulted in the women becoming highly motivated to reduce their risk of exposure to HIV by the use of barrier protection. The women positively endorsed the female condom. They particularly liked that it afforded them control over its use and enabled them to overcome the obstacle to use of the previously only available mechanical barrier, ie, the male condom. The liking of the female condom was particularly pronounced in those women who had friends or family members who were dying or had died of AIDS.

The previously cited reasons for not liking Reality—that it is cumbersome or that the appearance of the ring

outside the vagina was not aesthetically pleasing—was not a major barrier among these women. In fact, many took ownership of Reality, referring to it as a "safe shield."

CONCLUSION

Recommendations for marketing the female condom to African-American women are summarized in the Table. That men play a dominant role in the sexual decision-making process presents a major obstacle to the use of male condoms among African-American women. The majority of African-American men do not like using condoms. Given that the female condom allows women the ability to assume responsibility without having to challenge their male partners' need to dominate the negotiation of sexual matters and given that the female condom has been enthusiastically accepted by the women in this study, much potential lies in the use of this product in the battle to decrease the spread of HIV within African-American communities.

Literature Cited

1. *The 1991 Report of the National Commission on Acquired Immune Deficiency Syndrome. Living With AIDS.* Washington, DC: US Government Printing Office; 1991.

2. Centers for Disease Control and Prevention. *The 1992 HIV/AIDS Surveillance Report.* Atlanta, Ga: Centers for Disease Control and Prevention; 1992.

3. The National Council of Negro Women and Communications Consortium Media Center. *The 1991-1992 Women of Color Reproductive Health Opinion Poll.* Washington, DC: Consortium Media Center; 1991.

4. National Council on Negro Women and Communications Consortium Media Center. *The Follow-Up Birth Control Survey Summary Report.* Washington, DC: Consortium Media Center; 1992.

5. Wyatt GE, Blumenthal S, Eichler A, Weissman G. Ethnic and cultural differences in women's sexual behavior. In: *Women and AIDS: Promoting Health Behavior.* Washington, DC: US Dept of Health and Human Services; 1991:174-182.

6. Devita V, Hellman S, Rosenberg S. *AIDS, Etiology, Diagnosis, Treatment and Prevention.* 2nd ed. Philadelphia, Pa: JB Lippincott Co; 1988.

7. Folch-Lyon E, Tost JF. Conducting focus group sessions. *Stud Fam Plann.* 1981;12:443-449.

8. Zimmermann M, Haffey J, Crane E, Szumowski D, Alvarez F, Bhiromrut P, et al. Assessing the acceptability of NORPLANT implants in four countries: findings from focus group research. *Stud Fam Plann.* 21:21-22, 92-103.

9. Dignan M, Michielutte R, Sharp P, Bahnson J, Young L, Beal P. The role of focus groups in health education for cervical cancer among minority women. *J Community Health.* 1990;15:369-375.

10. Basch CE. Focus group interview: an underutilized research technique for improving theory and practice in health education. *Health Educ Q.* 1987;14:411-448.

Help as much as you can.

Together, we can change things.