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# Everywhere you go, everyone is saying condom, condom. But are they being used consistently? Reflections of South African male students about male and female condom use

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Received on June 16, 2010; accepted on April 28, 2011

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## Abstract

Young men in South Africa can play a critical role in preventing new human immunodeficiency virus (HIV) infections, yet are seldom targeted for HIV prevention. While reported condom use at last sex has increased considerably among young people, consistent condom use remains a challenge. In this study, 74 male higher education students gave their perspectives on male and female condoms in 10 focus group discussions. All believed that condoms should be used when wanting to prevent conception and protect against HIV, although many indicated that consistent condom use was seldom attained, if at all. Three possible situations for not using condoms were noted: (i) when sex happens in the heat of the moment and condoms are unavailable, (ii) when sexual partnerships have matured and (iii) when female partners implicitly accept unprotected sex. Men viewed it as their responsibility to have male condoms available, but attitudes about whose decision it was to initiate condom use were mixed. Almost all sexually active men

had male condom experience; however, very few had used female condoms. Prevention initiatives should challenge traditional gendered norms that underpin poor condom uptake and continued use and build on the apparent shifts in these norms that are allowing women greater sexual agency.

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## Introduction

Young men in South Africa can play a critical role in preventing new human immunodeficiency virus (HIV) infections, yet surprisingly have seldom been targeted for HIV prevention [1–2]. South Africa's mature hyper-epidemic state is complex and thought to be influenced by a number of behavioural and structural factors, including patterns of concurrent sexual partnerships [3–5], inconsistent condom use, heavy episodic alcohol use [6–8], gender inequality [9–11] and poverty [2, 9, 11–13]. HIV prevalence among South African men 20- to 24-years old is currently 5.1% and increases 3-fold to 15.7% by age 25–29 [14]. While HIV prevalence in the higher education sector is lower than in the general population,

students are still at considerable risk: nationally, 3.8% of sexually active students are living with HIV, and in KwaZulu-Natal Province, the figures rise to 6.1% overall and 8.7% among African tertiary students (We use the word ‘African’ to reflect the official racial classification system in South Africa rather than the word ‘Black’ that is used colloquially.) [15]. For many, being away from home for the first time, distant from parental monitoring and with increased independence and possibly greater access to alcohol, create conditions conducive to unprotected sex and other risky behaviours [16]. As the intellectual backbone, potential role models and future leaders of South Africa, higher education students are thus an important target for HIV risk-reduction interventions.

Reported condom use at last sex has increased considerably among youth in general, from 57.1% among men and 46.1% among women in 2002 to 87.4% and 73.1%, respectively, in 2008, according to a recent national household survey [14]. However, rates of HIV as well as teenage and unintended pregnancies remain high [8, 17–21]. Gafos *et al.* [21] conclude ‘The data we have in a province like KwaZulu-Natal consistently overestimates condom use ...’. In part, this ‘overestimation’ is likely due to reporting bias, incorrectness of condom use [22–26] and low rates of condom use in stable, committed relationships [19, 27–29]. Consistency of condom use appears to be a further factor. In a national study among South African youth aged 15–24 years, only 39.2% of young men reported consistent condom use with their most recent sex partner [24]. While achieving a higher level of education is strongly associated with more consistent use of male condoms among both women and men—possibly due in part to better access to condoms and sexual and reproductive health information and services [24, 30]—a study in higher education facilities in Durban found that only a quarter of students reported always using condoms [22].

Traditional gender norms and power imbalances between women and men have long been recognized as key drivers of the HIV epidemic in South Africa [31–33]. How these norms influence condom use—and, indeed, how they may be chan-

ging—requires closer attention. In particular, limited information exists about the perceptions and practices of higher education students, especially men, regarding male condoms. Moreover, we are unaware of any published studies that directly report on South African men’s attitudes, intentions and use of the female condom, despite their increasing availability locally, without cost, including at higher education facilities. A growing body of evidence suggests that providing male and female condoms together increases the number of protected acts of vaginal sex [34–36]. Yet female condoms remain underutilized as an HIV prevention strategy, both in South Africa (4.276 million female condoms compared with 283 million male condoms distributed by the South African government in fiscal year April 2008 through March 2009 [37] and elsewhere) [38, 39]. To address the gaps in knowledge about men’s attitudes and experience with male and female condoms, we examine male students’ views on male and female condoms and their use and explore underlying gender issues, with the goal of understanding how best to increase use of condoms overall.

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## Methods

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This focus group study with South African male students was part of a larger study designed to guide the development of a female condom intervention for female students in a higher education institution. (We use the terms ‘higher education or higher learning institution’ and ‘tertiary’ rather than ‘university/college/technikon’ to preserve anonymity of the institution.) Since we were interested in eliciting normative beliefs, attitudes, and practices regarding gender roles and condoms, we conducted focus groups, an effective strategy for ascertaining the social norms and perspectives of a group [40]. We conducted 20 focus groups (10 with women and 10 with men). In this paper, we report findings from the men’s discussions only.

## Participants

Participants were recruited from a large, urban South African higher education institution campus in 2005

(July to September). Ethnographic mapping was used to identify locations where students congregate; thereafter, direct recruitment, posters and word-of-mouth were used to recruit participants from these areas. Eligibility criteria included: (i) enrolment at the higher education institution study site, (ii) aged 18 years or older, (iii) willingness to consent and participate in the group and (iv) willingness to be audio-taped. We did not limit participation to sexually active students to protect unintended public disclosure of their sexual activity, given that recruitment took place in public spaces where students often congregated in groups. In all, 127 men were invited; of these, 74 participated in the discussions. Although times for the discussion sessions were scheduled to accommodate availability, many invited individuals were unable to participate, owing to academic time-tabling and other commitments.

### **Study procedures**

Potential participants were informed that the research was part of a larger study on female condom use and that discussions would explore topics related to sexual behaviour, vulnerability to HIV and other sexually transmitted infections (STIs), contraception, condoms and other HIV prevention tools.

The number of participants per focus group ranged between 5 and 10, and discussions lasted between 90 and 120 min. Written informed consent was given at the beginning of the discussion, and at the end, participants completed a brief demographic and sexual behaviour questionnaire and were provided with a light meal and ZAR30 (\$4) for transportation costs.

All but two of the men's focus groups were homogeneous with respect to race, since it was believed that this would facilitate discussion of sexuality. Of the 10 groups, 5 comprised only African and 3 only Indian participants, whereas 2 were African with 1 participant of mixed race in each. Focus group facilitators had at least a higher education degree and experience in collecting qualitative data on sexual and reproductive health topics. Where possible, they were matched by gender, age and language of participants to encourage more open and honest discussion. All groups were con-

ducted in English, the language of instruction on campus, but African, primarily 'isiZulu'-speaking, participants were encouraged to express themselves in isiZulu when preferred. Focus group discussions were audio-taped and transcribed verbatim, and isiZulu segments were translated into English.

### **Ethics approval**

The study was approved by the Institutional Review Board at the New York State Psychiatric Institute at Columbia University and by two Research Ethics Committees at South African institutions, including the institution where the study was conducted.

### **Focus group topics**

A semi-structured guide included questions on both male and female condoms, covering acceptability, reasons for use (e.g. Why would you want to use a condom?), experiences with use, communication and negotiation around use (e.g. How would you feel if a partner asked you to use a male condom?), men's and women's roles (e.g. Who usually determines whether or not a condom is used?), and knowledge, perceptions and misconceptions about female condoms (e.g. What have you heard about the female condom?).

### **Data analysis**

After careful reading of the transcripts, we developed first-level codes, initially guided by the broad thematic domains of the focus group guide and then informed by themes that emerged from the group discussions [41, 42]. Three investigators independently constructed a preliminary coding scheme, based on four focus groups, to develop common understanding of the data and then coded the remaining six discussions using these codes. The coding process was iterative. Interpretation of the data and coding agreement were achieved through group discussion, and new higher level and subcodes were generated and then entered into a standardized qualitative data computer program (NVIVO 2 and 7; QSR International, Doncaster, Victoria, Australia). We constructed analytical matrices to explore similarities and differences between the

African and Indian groups; however, based on these comparisons, we did not find group differences in beliefs and attitudes about male and female condoms by race. Results are thus presented for the total sample across the 10 focus groups. Quotations used throughout this paper reflect participants' typical comments unless otherwise noted.

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## Results

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### Sample characteristics

Seventy-four male university students participated in the focus group discussions. Seventy-two percent were African, 26% were Indian and 2% were of mixed race. Participants ranged in age from 18 to 34 years (mean 22 years; SD  $\pm 3.3$ ). Half were studying business and the remainder engineering, health sciences, humanities, law or science. Fifteen percent reported no sexual experience. Whereas the majority of the sexually active men (95%) reported that they had used a male condom, few (11%) said they had used the female condom. Nearly 80% of sexually experienced participants reported using a male or female condom in the past 3 months.

### Male condoms

#### *Condoms are necessary, if unpleasant*

In the current environment of HIV infection in South Africa, men accepted that condom use is a necessary part of being sexually active, even though they felt that sex without condoms was preferable.

It's easy, it's the normal thing, when you talk about sex today you don't [think] about sex separate from condoms. Even when you talk about condoms, you will find people saying I prefer flesh-to-flesh, but we have to use a condom.

The pervasive coverage of condoms in the media was noted.

Everywhere you go, everyone is saying condom, condom; the media is promoting the use of the condom everywhere.

Some participants believed that educated people, in particular, should have greater awareness of the need for condoms than the general population.

We are condomising as academics; we have that mentality that a condom must be there.

With the exception of one group, participants expressed greater concern about avoiding HIV than pregnancy. In addition, the availability of emergency contraception, also referred to as the 'morning after' pill, was viewed as something women could easily use to avoid pregnancy in the event of condom failure or non-use. Termination of pregnancy was also noted as an option in the case of an unwanted pregnancy, albeit by only one participant.

But anyway you can go around the pregnancy issue by using morning after pills .... but [to] us guys pregnancy is minor unlike females, to us, it is about protecting yourself from HIV.

I'm not scared of pregnancy coz there are morning after pills and I can convince her for abortion.

By contrast to men, women were often portrayed as 'not asking if you have a condom', 'not caring' or not being sufficiently 'worried' about the risks of HIV.

I think most girls they don't really care about using the condom you know, because if you ask them whether or not to use a condom, they will say it's up to you ... that is why I am saying most of the girls they don't care whether they get HIV or not. Of course they are scared, but they don't take precautions as much as guys do.

... girls really don't care .... I was told to take it out [penis out of condom] because she could not reach ejaculation.

#### *People do not use condoms consistently*

Despite the belief that condom use was the right thing to do, participants noted that many of their

peers were not using condoms consistently, as reflected in their statements about pregnancy rates.

No, I don't think so [using condoms] looking at the birth rate on campus.

... If people are falling pregnant, they are not using condoms. People are not scared of HIV/AIDS because more people every month are falling pregnant and that tells us that people are not practicing safe sex.

Managing to use condoms at every sexual encounter was seen as challenging, whether worried about HIV or not, especially in the heat of the moment. When a couple got carried away, unprotected sex would occur.

Sometimes you will find that you visit a girl, you spend time with her ... she is a woman and you are a man. Things get hot only to find that you don't have a condom. Both of you, you talk about it as if you will not have sex, but while you are still together it happens that you end up having sex.

... You are having a girlfriend ... maybe you are sitting together for a long time you end up touching and kissing and that leads to sex and you don't want to lose this opportunity to have sex with her. So the issue of condom and HIV you discuss it later after sex.

The issue of whether condom use could justifiably be forfeited in such situations was a contested one, however. One participant distanced himself from such statements:

It's shocking to me to see someone involving himself in sexual activities without using a condom in this time ....

But his challenge was swiftly rebuffed by others in the group, who took a more pragmatic view, emphasizing the disjuncture between expectations and reality:

We must not assume that since people are in the university that they are using condoms because things happen, things do happen!!!

#### *Initiating and communicating about condom use*

The issue of whose responsibility it was to initiate condom use generated much discussion, and a range of views emerged. Some participants said that women should initiate sex, others believed this was a man's role and still others considered it acceptable for both men and women to do so. However, with further discussion, it became clear that the issue was more complex and nuanced. The sexual script described by these men was that women expected men to acquire, carry and use the male condom, and that although women may not say anything in advance or directly verbalize a request for condom use, men expected women to resist sex without a condom.

She must resist sex without a condom until he puts on a condom. Once she resists, the guy will use it since he wants to have sex.

In the absence of such 'resistance', the outcome was clear:

You only think about the condom when you are about to penetrate honestly. So, if your girlfriend 'allows' you to penetrate without a condom, you carry on.

Communication about sex and condom use with female partners was minimal and usually not discussed within sexual relationships. There was some apprehension that talking with partners about condoms before sex might make women feel ill at ease, 'uncomfortable' or even 'scared', and that it was unnecessary, given that women supposedly assumed condoms would be used.

When asked if it was acceptable for a woman to suggest condom use, most men did not see it as inappropriate. However, a few had negative reactions, for example,

I will feel offended when she wants to use a condom when I don't want to use it. I think I am being forced to use it.

Although recognizing that such communication is dependent upon the type of relationship, participants commented that

... most of them [women] are not that open [and] won't feel comfortable; they are afraid to talk about it; we are not free to talk; it's like a taboo ....

This view contrasted sharply with a common theme in virtually all the discussions in which men spoke about their perceptions of South African women in general becoming more sexually assertive and comfortable with initiating sexual talk.

There are women who like talking about sex. They are open about sexual issues.

They have changed. Now women can ask for sex when they want it.

... eh women are powerful now.

... there are some girls who would come and say look I want this, she knows what she wants, determines the approach that she will adopt.

Women's newfound sexual assertiveness was characterized more broadly as '[women] sleeping around because of alcohol' and 'in the past men in the bedroom used to be in control or to be on top, but now women are in control'. At the same time, however, women's 'not being with a lot of guys' was considered a sign of self-respect.

#### *Condom use and length and type of partnership*

Generally men believed that condoms should be used from the outset in a new relationship and that this was an ideal time to initiate discussion around condom use. However, if the relationship started off without condom use, a woman's introduction of a condom into a more established relationship might signify that she mistrusted or had been unfaithful to her partner.

Let's say the first time I met her that she starts introducing the condom. I like it ... because it tells me that this girl cares about her life. So for her past sex life, she's been using a condom. I will think she is a safe girl. But if that girl is my girlfriend we've been having sex without a condom, but now she is introducing a condom, then I will know that ... something stupid [is] happening so she is trying to protect me.

Once a sexual relationship had run its course for a while and trust had been secured, many men said it was common for a couple to discontinue condom use. As one participant said:

Okay, for the first month, in a relationship you use a condom, second month use a condom, third month—ahh ... the relationship is fine. The relationship at first you are not familiar, but later you stop using condoms.

Some participants noted that men in stable relationships needed to be certain that their female partners were HIV negative before deciding to forgo condoms. With a casual partner, however, men believed a condom was always necessary; 'there are those that you don't trust'. But others were more cautious and thought that condoms should be used in all types of relationships—both regular and casual.

## **Female condoms**

### *Female condom benefits and barriers*

Most men had heard of the female condom, had seen the device and were willing to discuss it, but many said they did not know enough about it: only eight men had actually used the female condom. Despite its availability free of charge at the campus health centre, men cited its high cost as a reason why they had not tried it. Most men said that their limited familiarity with the method made it difficult for them to discuss their views on the female condom and even hampered their ability to try it.

The problem is that we are not used to it.

It won't be a problem, but basically we don't know how to use it. I prefer something that I know.

Many acknowledged that their perceptions of the female condom were gauged against their experience with the male condom. 'The male condom is the normal one and we are used to it. We know it'. Their concerns about the female condom mostly related to discomfort, size and loss of pleasure. These, it was felt, could be overcome with experience. As one participant noted, 'I think maybe everyone deserves a chance to try it. Maybe I was not using it properly'.

This lack of familiarity with the method provided the perfect breeding ground for misunderstandings about the female condom, expressed in all but one of the groups. These included the apparent need to wait long periods, e.g. between 2 and 8 h after female condom insertion, before having sex. This was seen as a major drawback.

I think it takes time to put it in ... 2 hours is a long period to wait.

It means I'll have to draw a timetable in order to use the female condom. I will need to get used to it because of the 8 hours .... No, I cannot use it because of these 8 hours.

Men who were aware that the female condom can be inserted up to 8 hours before intercourse, however, saw this as an advantage.

... when you are hanging the male condom, you can turn the woman off, like some other guys take like 40 seconds changing the condom. So the advantage of the female condom is that the girl can put it in 8 hours before sex.

One group saw the female condom as particularly helpful in protecting women in the event that they were inebriated.

So for example ... guys they can end up having sex when they are drunk, but for women if they

put it on before they drink, they can be better than guys in terms of protection.

The size of the female condom was a major theme that emerged in 9 of the 10 group discussions, where it was described as large relative to the male condom. However, interpretations of this differed: a few perceived the large size as an advantage because they believed it would help to prevent breakage or bursting.

Unlike the guy's, the male condom, if it's not put on correctly, having air inside, by the time you start to pump it bursts, but with the female condom there is enough space inside for you to ejaculate. You cannot fill that condom to the extent that it can burst.

Most, however, disliked the large size of the female condom.

The size of it—It's made to accommodate the whole world. It's not nice.

It's just an extra plastic all over the place that you have to fill.

... the point of entry is too big.

Some men had heard that the female condom was stronger and safer than a male condom and believed this was important for protection.

The benefit of the female condom is that it's more durable than a male condom, that's why it needs to be marketed.

I think it does not burst.

By contrast, a few men believed they might not be protected with the female condom because the device is worn by a woman, not a man, suggesting a lack of trust: 'How can you trust women with the female condom, not using your own?' Several participants expressed concern that the female condom would interfere with sexual satisfaction and the ability to determine a partner's readiness for sex.

I am worried that when the female condom is in, you cannot feel it if the woman is ready for sex because that wetness is covered by the condom.

... when we are using our own tools you can move inside the woman; so when the [female] condom is inside the woman, it's like a barrier which is sort [of] restriction.

In comments that offered revealing insights into our participants' understanding of women's experience of sexuality, some concern was expressed that women themselves would not like the female condom because of their perceived 'lack of openness' around sex and consequent embarrassment when inserting it in front of their partner:

... not all girls are comfortable and confident around sex. Girls are mostly very shy. Maybe [they] would prefer to go and put it in somewhere else rather than while you are watching, unlike the male condom.

Perhaps related to this concern, another participant attributed women's supposed discomfort with using the method to their 'having a problem to put something inside'.

#### *Control over initiation of female condom use*

Men largely believed that female condom use should be initiated by a woman, in part because she must be comfortable inserting it or may prefer using a method she could control. Emphasizing the need for stronger campaigning to promote female condoms among women, one man even expressed the view that, 'until girls are proud of the female condom, we will never use them'. Despite the limited information most participants had about the female condom—noting that it was generally not known and not well marketed—they would not be opposed to using it if a male condom were unavailable or if their partner suggested using it. When asked about their reactions to a partner initiating female condom use, one participant said: 'Cool; I don't think that will be a problem'. A few participants disagreed, with one claiming he would 'try and talk her out of the idea'.

Similar to the discourse around a woman introducing a male condom into an established relationship, men believed that if they introduced a female condom, their partner would wonder what had changed.

She would think that you are cheating.

She would think that I have tried it somewhere else. Now, I want to use it with her.

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## Discussion

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On the whole, the young men had positive attitudes about male condoms and expressed acceptance of the necessity to use them, mainly as an HIV prevention tool, especially at the start of new relationships and with casual partners. These findings concur with the most recent studies in South Africa showing high rates of male condom use at last sex among young people [14], and a belief—among nearly 90% of male and female higher education students—that condom use is now normative [22]. However, participants acknowledged that being in an academic setting (and presumably being more informed about HIV) did not preclude higher education students from using condoms inconsistently.

As noted by our participants, 'consistent' condom use has yet to be achieved, in either casual or longer term relationships. High pregnancy rates were cited as evidence of this inconsistency: 'you wonder who exactly is condomising?' That a couple would forego condom use as a relationship matured is supported by other South African studies reporting diminished condom use in a regular relationship over time and lower rates of condom use in committed compared with casual relationships [5, 17, 22, 24, 26–29, 43–45]. Once trust has been established, fidelity is expected and condom use declines [22, 24, 27]. Moreover, initial non-use followed by introduction of a condom may connote infidelity or lack of trust, while establishing an early precedent for condom use may affect willingness to sustain use [29, 46], a finding that also emerged strongly in our data.



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Open discussion of condom use with female partners was not the norm, but it was agreed that it was men's responsibility to carry condoms and have them available when sex happens. In tandem with this traditional gender script was an expectation that a woman would refuse or 'resist' unprotected sex—an act that earned women greater respect in the eyes of some men in our study. Importantly, however, without women's resistance, in practice, unprotected sex would likely occur. Just as men are expected to press for sex (and for women to resist), men are also expected to press for 'unprotected' sex, acquiescing to condom use only if the woman insists on it.

In possible violation of the traditional gender script described above, some women were described as not explicitly demanding condom use or even actively resisting [47, 48]. These women were characterized by the men as being indifferent to the need for HIV prevention. An alternative interpretation, however, would be that women are simply deferring the decision about condom use to their male partners. As one man explained, even when asked directly about condoms, most women will allegedly evade the decision by telling a partner that it was 'up to' him. This evasion ultimately places men in the position of key decision makers and may be read as the invoking of a separate—but equally problematic—traditional gender script.

Knowledge regarding male condoms was not a barrier to use—participants appreciated their role in protecting against unwanted pregnancies and HIV, which was seen as a real risk, as reported in other studies of South African youth [46]. The perception that men are more concerned about protecting themselves from HIV/STIs because, unlike women, they do not necessarily have to worry about pregnancy, reflects a traditional gender script, in particular the notion that responsibility for managing fertility rests ultimately with women. The contradiction between men's purported concern about avoiding HIV infection, alongside their inconsistent condom use, might be attributed to a disjuncture between appraisal of global HIV risk and their personal HIV risk or to their failure to consider personal risk during

a sexual encounter. Notwithstanding the admission of some participants that they would have unprotected sex in the absence of women 'resisting' it, men's assertions of their concern about HIV and responsibility for avoiding infection is a topic that could be further explored.

In contrast to widespread experience with the male condom, men lacked familiarity with the female condom, and misinformation was apparent. Encouragingly, however, most participants said they would try the female condom if their partner wished to use it. In fact, in one recent study of two types of female condoms in South Africa, men were willing to assist their partners in using the female condom [49]. Our participants believed that men should become familiar with female condoms and how to use them, but that ultimately the female condom could and should be female initiated. Their belief that carrying female condoms was a woman's responsibility whereas carrying male condoms was a man's responsibility reflects an intriguing notion of condoms as belonging to rigid, 'gender-specific' domains. Despite this, men's willingness to become more familiar with the female condom may also suggest that male students will be broadly accepting of women's initiation of female condom use for HIV/STI and pregnancy.

Our study findings suggest that dominant gender roles with respect to HIV prevention may be undergoing some important shifts, at least in this population of male higher education students, partly accounting for the heterogeneity and contradictions in their beliefs. Participants' conflicting views on whether men or women should initiate condom use, for example, appear to reflect a reshaping of existing gender norms, with some men believing that this is no longer exclusively their responsibility. Such contradictions may also signal that women's input on these issues is becoming more substantial and that men are taking notice of it. A study examining reasons for condom use among tertiary students found similar results, with women reportedly having greater influence over condom use, often forcing men to use a condom [22]. Data from our focus groups with women further indicated that women believed that they have more influence over

initiation and use of condoms [50]. That men in our study perceived some South African women as becoming more comfortable raising the subject of sex may augur well for increasing condom use. Importantly, our participants' depictions of South African women as increasingly sexually assertive is in stark contrast to much of the literature on gender and HIV prevention in southern Africa over the last two decades that has emphasized women's relative powerlessness [51–56] and constructions of masculinity that oppress women and men alike [57].

Many of our participants' views on condom use, disease and pregnancy prevention may be seen as reflecting a deeper ambivalence among men about the consequences of gender equality and women's growing independence and power in post-Apartheid South African society. In the last decade, changing gender roles and power relations between women and men have been underpinned by the formation of a national gender commission and implementation of new legal measures to promote gender equality [58–62]. All participants noted these changes and, with few exceptions, expressed some resentment for the consequent confusion generated around meanings of masculinity and femininity in South Africa today. Urban students may waiver between retaining traditionally entrenched hierarchical gender norms and adopting more progressive prevention norms, reflecting their lifetime social experience as the 'half-generation'—growing up half under Apartheid and half in the transition to democracy. Contradictory discourse reflecting retention of traditional gender roles alongside constructions of more progressive gendered power relations (e.g. men propose love relationships but women initiate sex or sex is negotiated) has been documented in other South African studies [61–64].

We acknowledge several limitations in our study. First, owing largely to scheduling difficulties, only 58% of those invited enrolled in the study. Second, the volunteer nature of our convenience sample, with its inherent self-selection bias, may mean that the men in these groups held views that differ from those of other young men in the study site as well as in other comparable institutions in South Africa.

Third, these focus group discussions are designed to elicit group norms; peer group pressure from group members may have influenced the responses of individual participants. Fourth, that 15% of participants reported they were not sexually active could have influenced the nature of responses. Finally, this study was not set up to explore views that might have emerged from cultural differences between African and Indian men.

## Recommendations

Based on our findings, we make the following recommendations:

1. HIV prevention interventions should (i) teach young people how to communicate explicitly about sex and condom use with different types of partners early in a relationship; making communication about condom use normative may help to reduce any discomfort that young women and men may have in raising condom use with their partners; (ii) stress the importance of using condoms with both steady and casual partners, to tackle the clear disjunction between recognition of the need for condom use and consistent condom use in practice; (iii) introduce the female condom to men so that men can support their female partners who wish to use it; (iv) promote correct and consistent condom use; (v) build practical skills—among both men and women—to having available and introducing condoms as soon as it becomes apparent that intercourse will take place, to overcome the 'heat of the moment' unprotected sex; (vi) integrate provision of the male and female condom for men and women, which has been shown to increase the frequency of protected acts of sexual intercourse [65], and importantly (vii) build on the increasing perceived fluidity in gender roles which allow women to have more influence over initiation and use of male and female condoms.
2. Our study indirectly suggests the need for improved assessment of condom use, e.g. observations of participants putting condoms on models, asking about slippage and breakage and sexual event-specific use [66–71], use of audio-assisted

computerized interviewing and use of biomarkers to more reliably characterize condom use [21, 72].

3. To address the larger context of gender relations, interventions such as Stepping Stones [73, 74] that engage men and women in critical consciousness and dialogue about gender (e.g. positive constructions of manhood and womanhood, perceptions of women's advancement at the expense of men, egalitarian gender relations) are needed [75]. This type of intervention could be easily incorporated into prevention programmes in South Africa's higher learning institutions. More broadly, gender transformation that engages men and women in creating positive sexual relationships, reinforcing positive, less risky forms of masculinity [76], increasing women's agency and bargaining power over their sexual lives, and ultimately achieving gender equality is an indispensable long-term goal.
4. Positive norms for condom use among higher education students in South Africa should not be seen as a pretext for HIV prevention complacency. Despite lower HIV prevalence among higher education students than other populations in South Africa, targeting prevention initiatives to this student population may help to maintain the low HIV prevalence.

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### Funding

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National Institute of Child Health and Human Development [R01-HD046351; Female Condom Use among South African College Students, principal investigator: Joanne E. Mantell, PhD; South African Site, principal investigator: Jennifer A. Smit, PhD]; the National Institute of Mental Health to the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University [P30-MH43520; principal investigator: Anke A. Ehrhardt, PhD]; the William and Flora Hewlett Foundation (grant #2008-1940 to J.A.S., M.B., Z.M., and C.M.).

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### Acknowledgements

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We appreciate the participation of the students who engaged in the focus group discussions. The authors also acknowledge the support we received from personnel at the study site.

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### Conflict of interest statement

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The views and opinions expressed in this article are solely those of the authors and do not necessarily represent the official view of the National Institute of Child Health and Human Development, the National Institutes of Health, the US Agency for International Development or the US Government.

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