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A cross cultural study of vaginal practices and sexuality: Implications for sexual health☆

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ABSTRACT

Between 2005 and 2006, we investigated vaginal practices in Yogyakarta, Indonesia; Tete, Mozambique; KwaZulu-Natal, South Africa; and Bangkok and Chonburi, Thailand. We sought to understand women's practices, their motivations for use and the role vaginal practices play in women's health, sexuality and sense of wellbeing. The study was carried out among adult women and men who were identified as using, having knowledge or being involved in trade in products. Further contacts were made using snowball sampling. Across the sites, individual interviews were conducted with 229 people and 265 others participated in focus group discussions. We found that women in all four countries have a variety of reasons for carrying out vaginal practices whose aim is to not simply 'dry' the vagina but rather decrease moisture that may have other associated meanings, and that they are exclusively "intravaginal" in operation. Practices, products and frequency vary. Motivations generally relate to personal hygiene, genital health or sexuality. Hygiene practices involve external washing and intravaginal cleansing or douching and ingestion of substances. Health practices include intravaginal cleansing, traditional cutting, insertion of herbal preparations, and application of substances to soothe irritated vaginal tissue. Practices related to sexuality can involve any of these practices with specific products that warm, dry, and/or tighten the vagina to increase pleasure for the man and sometimes for the woman. Hygiene and health are expressions of femininity connected to sexuality even if not always explicitly expressed as such. We found their effects may have unexpected and even undesired consequences. This study demonstrates that women in the four countries actively use a variety of practices to achieve a desired vaginal state. The results provide the basis for a classification framework that can be used for future study of this complex topic.

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Introduction

Women's care and treatment of their vagina and genital area might affect their vulnerability to sexually transmitted infections (STI, including HIV) and other sexual and reproductive morbidities (Myer et al., 2005). The strength and consistency of this association, however, are debated as cohort studies have shown conflicting results (Martin Hilber, Chersich, Van De Wijgert, Rees, & Temmerman, 2007). Earlier studies have linked women's intravaginal practices, to an increased susceptibility to both bacterial vaginosis and HIV (McClelland, Lavreys, et al., 2006; Van De Wijgert, Morrison, Salata, & Padian, 2006), but little is known about how the potential biological vulnerability occurs (Myer, Denny, de Souza, Barone, & Wright, 2004; Myer et al., 2005).

Women are disproportionately affected by HIV, especially in Africa where in some countries as many as a third of women of reproductive age are infected (UNAIDS, 2007) despite evidence that male to female HIV transmission during vaginal intercourse is low under normal circumstances (Gray et al., 2001). "Normal circumstances" for the vaginal environment remain poorly understood. In recent years, microbicides and HIV researchers have become aware of a variety of products and practices used by women to maintain vaginal health and prepare for sexual intercourse (Braunstein & Van De Wijgert, 2003) (Woodsong & Alleman, 2008) and have speculated about how they might affect acceptability and transmission routes. These studies, however, rarely have the opportunity to explore the broader implications of the practices as they relate to hygiene, health, and notions of a preferred vaginal state for sexual intercourse, and how they may reflect women's agency and power over aspects of their sexual life.

Practices have been documented worldwide (Braunstein & Van De Wijgert, 2003) but research generally fails to distinguish culture-specific differences in practices, products, motivations and the temporality of use. Studies in the early to mid-1990s mentioned vaginal practices among risks for heterosexual transmission of STI and HIV in relation to women's sexual relationships (Awusabo-Asare, Anarfi, & Agyeman, 1993), preferences in sexual experiences (Brown & Brown, 2000; Brown, Ayowa, & Brown, 1993; Civic & Wilson, 1996; Dallabetta et al., 1995; Orubuloye, Caldwell, & Caldwell, 1995; Runganga, Pitts, & McMaster, 1992) and disturbances of vaginal flora (Karim, Karim, Soldan, & Zondi, 1995; Sandala et al., 1995). Subsequent discussions correlated vaginal practices – generally labeled "dry sex" despite evidence of diversity in motivations for the practices beyond reducing of vaginal lubrication – with other factors such as bacterial vaginosis (Atashili, Ndumbe, Adimora, & Smith, 2008), and other STI (La Ruche et al., 1999; Rottingen, Cameron, & Garnett, 2001; Tsai, Shepherd, & Vermund, 2009). Indeed, some studies in the Great Lakes region of Africa cite preference for vaginal lubrication in preparation for sex (Vincke, 1991). With the development of topical microbicides for the prevention of STI and HIV, more comprehensive reviews were undertaken on the potential effect of vaginal practices on heterosexual transmission of HIV (Brown & Brown, 2000). These focused on the underlying cultural and behavioral norms and preferences for sex which may disvalue the lubricating impact of unguents (Braunstein & van de Wijgert, 2005).

The role of gender as a significant influence limiting women's power to negotiate their own sexual lives and the added concern of intimate partner violence were increasingly documented as determinants of poor sexual and reproductive health outcomes (Blanc, 2001). Sexuality researchers have recently attempted to move beyond the characterization of women's sexual lives as a study of victimization to broader, less stigmatizing dimensions of pleasure, preferences and power. Works such as Hull (Hull, 2008), Coleman (Coleman, 2008), and Boyce (Boyce et al., 2007) have begun to bridge the gap in understanding between sexuality and positive health outcomes by calling for a holistic approach to the social construction of women's sexuality.

This paper presents qualitative results of a four-country study on gender, sexuality and vaginal practices (GSVP) conducted in two Asian and two African communities, and supported by the UNDP/UNFPA/WHO World Bank Special Programme for Research, Development and Research Training in Human Reproduction. The aim was to identify and document vaginal practices, in the process generating definitions and categorizations to facilitate the development of a standard household survey instrument for subsequent quantitative research in the study sites.

Methodology

This study was carried out in Yogyakarta, Indonesia; Bangkok and Chonburi, Thailand; Tete, Mozambique and KwaZulu-Natal, South Africa. Standard qualitative interview techniques were carried out among adult women, and some adult men. Field activities took place between 2005 and 2006 in two urban and two rural community locations in each site, selected according to: previous documentation of vaginal practices in the site; relatively high rates of STI including HIV; and the existence of a local research group with relevant previous experience.

In all countries, data collection used standardized topic guides and analytical procedures developed collaboratively. The guides were adapted to local ways of addressing sexual issues. Permission to record interviews and oral informed consent followed ethical guidelines. All data collection was carried out in local languages (Indonesian and Javanese in Indonesia; Nyanj, Nyangwe and Portuguese in Mozambique; IsiZulu and English in South Africa; and Thai in Thailand). Translations of transcripts from local languages to the national language in Mozambique and South Africa were done to facilitate analysis. In Indonesia and Thailand almost all the interviews and transcripts were in *Bahasa Indonesia* and standard Thai, respectively. Final reports were first prepared in the national language and then translated into English to share results. Commonalities and differences were identified collectively between the four country coordinators.

Vaginal practices were broadly defined to include all efforts to wash, modify, cut, cleanse, enhance, dry, tighten, lubricate or loosen the vagina, labia, clitoris, or hymen. This could include a substance or material applied, ingested, inserted, or steamed. Women were asked about their knowledge and use of any specific practice. Each practice was thus described in terms of products used, timing and frequency of use, belief systems related to the practices, as well as motivations and personal experiences with a practice. Some menstruation practices, for example, were described as insertion practices (to collect blood) or as an ingestion practice (to relieve cramps and purify) rather than as a menstruation practice per se. In addition, the study did not limit questions to practices with sexual or health motivations. The study was conducted by staff not associated with health care to create a neutral space for open discussion on a range of practices beyond those in the health domain. Research teams were trained on qualitative methods and analysis techniques, including coding and analysis.

This study sought informants who were either users of the practices (women), knowledgeable (women, men, traditional and modern health practitioners, traders) and or involved in trade in products (healers, sellers in the market, pharmacy). Further contacts were made through snowball sampling. The research teams were given some flexibility in identifying appropriate respondents as we were unsure of their willingness to speak openly about the practices. Participants were urban and rural and from different socio-economic backgrounds, marital status, and age. Each