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Female control of sexuality: illusion or reality? Use of vaginal products in south west Uganda

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Abstract

This paper reports on a trial of vaginal products that were distributed and used by 131 women and 21 men in south west Uganda. It focuses specifically upon the issue of female control in heterosexual relationships and examines whether methods which are ostensibly under women's control, will in practice give women greater control of their sexual health.

Participants were invited to select two from a range of vaginal products that included the female condom, contraceptive sponge, film, tablets, foam and gel, and use each for five weeks and their favourite product for a further three months. They were interviewed up to seven times over a five-month period.

Although the women perceived that a major advantage of the products (with the exception of the female condom) was that they could be used secretly, less than 40% were using the products without their partner's knowledge after one week and this proportion declined over time with only 22% using the products secretly after ten weeks. In the main male partners were told as women felt it their duty to inform them.

In general the women were very much more positive about the products than they were about the male condom, as were the men. A contributory factor to their popularity among women was the greater control they gave them. Even though, use of these products in practice often involved negotiation with male partners, the fact that use was contingent on women's action was empowering and increased somewhat their ability to control their sexual health. © 2001 Elsevier Science Ltd. All rights reserved.

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Introduction

Women, particularly those in developing countries, occupy a position characterised by social and economic disadvantage and lack of control compared to men. Women's disadvantaged status may have repercussions on their sexual and reproductive health in that their lack of control reduces their ability to determine the spacing of their children and to protect themselves from sexually transmitted disease (STD; Okojie, 1994; Oppong, 1983; Santow, 1995). To counterbalance such disadvantage, there are a number of initiatives to increase women's empowerment in the sexual and reproductive sphere such as planned parenthood projects. There have also been a number of calls, and a growing number of research initiatives, to develop female controlled methods of protection against STDs especially HIV/AIDS.

This paper reports on a trial of vaginal products that were distributed and used by women and some men in south west Uganda. The rationale behind the project is that if and when current research efforts succeed in developing a safe and effective virucide or microbicide against HIV/AIDS the trial will inform the appropriate mode of delivery. The findings relating to product

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acceptability in general have been reported by Pool et al. (2000a). This current paper focuses upon the issues of pleasure and female control in sexual relationships associated with use of the products. It looks at the role of sexual pleasure in influencing feasibility of product use and examines whether methods which are ostensibly under women's control, will in practice give women greater control of their sexual health. In so doing, it looks beyond the rhetoric about giving women theoretical control over their sexual health towards the practical application.

The paper begins by identifying some of the issues raised in the literature about power, gender and sexual relationships, particularly in developing countries, and within the specific context of sexual relationships in south west Uganda. A brief overview is presented about studies of the female condom and the current level of development of microbicides. The data are then presented to highlight issues pertaining to female control. The overriding issue is whether use of vaginal products increases women's empowerment and if so how? This is considered in the light of the data and relevant academic debates.

Gender, sexual relationships and power inequalities

Many accounts exploring gender inequalities have focused on the relations of power and exploitation between men and women, and discuss sexual politics with reference to oppression and patriarchy (Connell, 1985). The advent of AIDS shifted the focus to the ways in which disempowered femininity could compromise the sexual health of women in subordinate roles (Holland, Ramazanoglu, Sharpe & Thomson, 1992a; Schoepf, 1992). Studies of heterosexual behaviour highlighted women's relative lack of power in sexual encounters, which prevented them from practising safer sex (with condoms) even when they would have preferred this (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1991; Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1992b).

In this model women encounter pressure from male partners ranging from mild insistence on intercourse to physical assault. Feminist writers have tended to define all male pressure (whether mild or extreme) in terms of a continuum of sexual violence of men's sexual behaviour towards subordinate women (see for example Kelly, 1988). Within this continuum, the sexual pressures women experience may often be enmeshed in loving and caring relationships.

Heterosexual women who wish to control their sexuality have to negotiate with male partners and be assertive, even unfeminine, which may threaten their sexual relationship. Using condoms, for example, may lead to problems of negotiation with a male partner, and social risks such as a sullied reputation (Hillier, Harrison & Warr, 1998). In this respect women's social status clearly affects sexual risk behaviours and the ability to take steps to reduce risk of infection (Amaro, 1995; Campbell, 1995).

Studies of African women suggest that they are particularly vulnerable to such pressures because subordination to men is a defining feature of sexual relationships. Lack of power impedes women's ability to protect their sexual health both with long term regular partners and with more short term informal sexual encounters such as in the workplace where women may be expected to provide sexual services to male employers (Obbo, 1989, 1990; Schoepf, 1992). According to Schoepf (1992, p. 276), "the subordinate position [of women] with respect to men circumscribe their options. Few are able to practice safer sex. Some do not feel able to open dialogue with sexual partners on the subject. Others who have attempted to do so have experienced rejection and retaliation."

The relationship between women and HIV is further confounded by poverty (Farmer, Lindenbaum & Delvecchio Good, 1993), because most women with HIV and those most vulnerable to infection are from poor countries, or are from poor and minority populations in more affluent countries. They generally come from a background of poor physical and mental health, malnutrition and inadequate medical care (Ward, 1993). In such environments, sexual choices of women express not only cultural values and expectations but also adaptive means of living with sexism, racism and economic disenfranchisement (Worth, 1990). It may be untenable for disempowered women living in poverty, often dependent on a male partner, to take action to reduce transmission of STDs. A number of studies of African women have shown how their survival is generally structurally linked to a dependent and subordinate relationship with a male partner and that this limits their ability to control their sexuality (Afonja, 1990; Obbo, 1989; Oppong, 1983; Schoepf, 1992). Cultural, social and economic constraints impede African women from complying with advice to limit partners and use condoms (Ulin, 1992), and they are placed at greater risk of STD infection by their ignorance of whether or not their partner is infected (Orubuloye, Caldwell & Caldwell, 1993).

Furthermore, Sobo (1993) shows that protective action, even when tenable, may be regarded as unnecessary, irrelevant and even psychologically damaging to the poor African–American women in her study, even those that see themselves as independent and self-sufficient and not financially dependent on their male partner. These women idealise monogamy and hope for loyal conjugal partners and, in this context, see condomless sex as a sign of trust, honesty and commitment. AIDS risk denial manifest in their choice to practise unsafe sex with their partners leaves these women's culturally engendered dreams of monogamy and security intact.

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