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Women's views on and experiences of condom use: An exploration
of how this impacts on women's sexual satisfaction and male
condom use among women

Mini-dissertation submitted to the University of Cape Town

in partial fulfillment of the requirements for the Degree Master of Public Health

By

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DECLARATION

I, Vuyelwa Eullicia Mehlomakulu, declare that the work presented in this thesis document is my own original work, and that I have not previously, either in its entirety or in part, submitted it to any university for degree purposes.

University of Cape Town

ABSTRACT

Women are most vulnerable when it comes to HIV infections. This has been linked to their biological makeup, gender, and their social status in the communities. Consistent condom use amongst women and men is one of the important safer sexual practices in combating the spread of HIV/AIDS. This dissertation examines factors which hinder or facilitate consistent male condom use, particularly as it relates to women's sexual satisfaction. This qualitative study was conducted amongst 25 women between the ages of 18-36 years, living in Masiphumelele, in the Western Cape. In-depth interviews were conducted with women irrespective of their HIV status, to obtain their views and experiences on male condom use, in particular with respect to male condoms' impact on women's sexual satisfaction. Purposive sampling was used in recruiting women for the study. Findings indicated that women felt that it was important to use condoms during sexual intercourse in order to obtain protection against HIV, STIs and pregnancy. Though the importance of condom use during sexual intercourse was acknowledged, as found elsewhere, this did not necessarily translate to consistent condom use. Just over half of these women reported condom use at last sexual intercourse. Women's own sexual dissatisfaction was regarded as one of the main reasons why condoms were not consistently used by women. Some women reported that they do not reach orgasm when they used condoms, so this hindered their sexual satisfaction. The results of this study suggest that while it is important for HIV/AIDS interventions to focus on gender-based related issues such as gender power relations, women's negotiation skills on condom use, it is also important to better understand a less investigated issue of women's own possible resistance to male condom use. The interventions need to include addressing women's own issues on sexual satisfaction and how these can be taken into account in facilitating safer sexual practices.

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PART A: PROTOCOL

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I. TITLE

Women's views on and experiences of condom use: An exploration of how this impacts on women's sexual satisfaction and male condom use among women.

II. INTRODUCTION

Background

It is estimated that 5.7 million people are living with HIV in South Africa (UNAIDS, 2008). Approximately six out of ten men, five out of ten women, and nine out of ten children living with HIV in the world, live in Sub-Saharan Africa (Shisana et al., 2005). The HIV prevalence rate in the Western Cape is 3.8% (Shisana et al., 2009), which is considerably lower than the national average of 10.9%. However, despite the overall lower level of HIV prevalence in the Western Cape, some urban areas within the province have HIV prevalence rates of almost 30 percent, higher than the national prevalence. A district survey done at 374 facilities, involving the testing of 5 964 people, revealed that Gugulethu/Nyanga had a prevalence rate of 28,1%, Khayelitsha 27,2%, Helderberg 19,1%, Oostenberg 16,1%, Knysna/Plettenberg Bay 15,6% and Caledon/Hermanus 14,2% (Thom, 2004)

Women are the most vulnerable to new HIV infections. The Nelson Mandela/HSRC study of HIV/AIDS, found that 12.8% of South African women are HIV positive compared with 9.5% of men (Shisana & Simbayi, 2002). In 2005 these numbers increased for women, to 13.3% and decreased for men to 8.2% (Shisana et al., 2005). In South Africa, 16.9% of 15 – 24 year olds living with HIV are female compared to 4.4% of males in the same age group (Shisana et al., 2005). These high prevalence rates reflect a significant crisis for South Africans' health, particularly for women's health status.

Literature review

At a time when AIDS has become a devastating public health issue, the use of barrier methods, like condoms, to prevent transmission of HIV is critical. In this study women's attitudes and preferences towards condom use was explored with respect to male condoms only, the most condom type used. Female condoms despite their importance fell outside of the scope of this study. In a recent South African study, about 45% of females and 30% of males reported not using a male condom at last sex (Burgard & Lee-Rife, 2009).

This study builds on a growing body of literature in Southern Africa, which examines factors that influence condom use. Most research has focused on an association between low condom use and gender inequalities, gender power imbalances, and cultural norms that discourage women from talking about sexual matters, including contraception (Kaaya et al., 2002; Mba, 2003; Ackermann & de Klerk, 2002). Attention has also centred on the economic context in which women navigate their sexuality. The message has been that because of their economic dependence on men, women are less able to suggest condoms or refuse sex if condoms are not used (Ackermann & de Klerk, 2002) and contribute to their unsuccessful attempts at ensuring safer sexual behaviour (Campbell, 2000; Jewkes, Levin & Penn-Kekana, 2003).

In addition, investigations emphasize the context of intimate partner violence in which many women operate. Women report fearing asking a partner to wear a condom as it may result in violence. This too weakens their power to negotiate condom use (MacPhail & Campbell, 2001). Hence, most research conducted suggests that women have limited power to negotiate sexual matters and are often not in a position to leave sexual relationships that they perceive to be risky (Jewkes & Morrell, 2010).

The focus on the social context in which women struggle to combat men's resistance to condom use implies that women themselves are eager to use condoms, but that gender inequalities leave them powerless to do so. However, if they are to prove successful, strategies for promoting male condom use need to take into account women's attitudes and preferences with respect to male condom use and its impact on sexual decision-

making. There is a need to explore whether women's own attitudes and preferences influence their use of male condoms. This will assist in adding an additional dimension to the factors promoting or hindering male condom use among heterosexual couples that can influence sexual decision-making and safer sex practices.

The Desmond Tutu HIV Centre (DTHC), based at the UCT Medical School, has a long history of HIV-related clinical trials and care and regularly undertakes various forms of HIV-focused research and campaigns. In work carried out by the DTHC, a series of focus groups were conducted in Masiphumelele in 2003 that explored issues around HIV knowledge, attitudes and practices. This qualitative investigation found that some women experienced sex with condoms as painful, and therefore chose not to use them. In June 2004 the DTHC did a Deep Democracy Training session for their counsellors. The training took place at Sizophela in Nyanga, an organisation linked to the Desmond Tutu HIV Centre.

During this training, once again some of these women described their dislike of condoms. They reported that they were frequently sexually dissatisfied and that their partners were seldom concerned with their sexual needs. Group members reported experiencing very little foreplay during sex with their partners. As a result, most women stated that they did not experience sufficient vaginal lubrication and as a result sex was often very painful. Women felt that the use of unlubricated condoms added to this problem and led to even greater sexual dissatisfaction. Hence some women appeared to have actively chosen not to use condoms, due to their own lack of sexual pleasure experiences when using condoms. This highlighted the need to explore the issue of condom use, women's preferences and attitudes and their relationship particularly to women's sexual pleasure.

Many studies have emphasized the divide between HIV knowledge and sexual risk behaviour, yet the primary intervention in HIV work remains educational. Prevention initiatives have had limited success in restricting continued HIV transmission. It would be of practical benefit for researchers to develop a broader understanding of the impulses driving women's decisions regarding condom use and non-use, and in so doing provide

the framework for relevant and effective intervention programs, tailored to specific factors affecting women.

This study will use Wojcicki and Malala's conception of power, which takes cognizance of the micro decision-making that occurs in daily life (Wojcicki & Malala, 2001). This highlights the difficulties women face in their intimate relationships in negotiating safer sex but also explores the choices women make in this regard within the context of these relationships and circumstances and own individual views.

III. AIM

The aim of this study will be to examine women's experiences of male condoms in particular in relation to their own sexual pleasure and how this influences their attitudes towards using condoms in protecting themselves from HIV infection.

IV. STUDY OBJECTIVES and STUDY QUESTIONS

This study aims to:

1. Gain insights on women's sexual practices.
2. Assess the impact of male condom use or non-use in relation to sexual satisfaction and how this affects their safer sexual practices.
3. Identify the most important factors affecting women's male condom use in protecting them from HIV infection.

The key research question:

What factors impact on male condom use and particularly how women's sexual satisfaction could influence their willingness to use condoms?

Sub-questions:

1. What kind of sexual practices do women at Masiphumelele engage in?
2. What kind of sexual protection do women at Masiphulele use?

V. METHODOLOGY

Study Site

Masiphumelele (“we will overcome”) is a peri-urban settlement found 40 km South of Cape Town in the South Peninsula Municipality (Middelkoop, 2008). It was established in 1992, after a struggle for land rights and it is divided into three areas, which are the formal/serviced area, the old site area and the wetlands. Masiphumelele has a population of approximately 14000 people (Middelkoop, 2008).

The Masiphumelele Census (2008) reports that the community has a single primary care clinic which is largely run by primary health care nurses with a provincial doctor who attends twice weekly, mostly to review TB patients. The clinic provides voluntary counselling and testing (VCT) services, family planning and treatment of sexually transmitted diseases (STIs) and TB as well as providing an infant care and an immunisation service (Middelkoop, 2008).

In 2000, the Desmond Tutu HIV Foundation (DTHF) began assisting with the HIV clinic at this facility. This service has expanded to become an antiretroviral (ARV) rollout site, and the Foundation has built an additional wing onto the clinic to house this service, as well as the many other research projects the Foundation conducts in this community. Importantly, however, the DTHF engages in HIV prevention work among members of this community. Hence participants in their programs will include HIV-positive individuals as well as those who are HIV-negative or of unknown HIV status. This study will form part of DTHF program of work in this community.

Study design

The study design was qualitative, best suited for probing experiences, ideas, beliefs and factors underlying behaviour (Creswell, 2003).

Study Population

As the study wanted to explore how condoms impact on the sexual satisfaction and continued condom use amongst women, sexually active women, living in the

Masiphumelele area constituted the study population. Women were included in the study if they met the following inclusion criteria.

a) *Inclusion Criteria:*

Individuals needed to be:

- Between 18 and 40 years of age
- Female
- A Masiphumelele resident
- Acknowledge voluntary participation in the study by signing a consent document
- Have been sexually active in the last 6 months

b) *Exclusion Criteria:*

Participants were ineligible for the study if they met any of the following criteria:

- Any mental health condition, which in the opinion of the investigator, would preclude comprehension of informed consent, or study participation.
- Refusal to acknowledge voluntary participation in the study by signing a consent document
- Have not been sexually active in the last 6 months.

The criteria for women's inclusion in the study was not based on their HIV status. The study sought to explore women's attitudes and preferences with respect to male condom use irrespective of their HIV status. Some women voluntarily disclosed their HIV-positive status during interviews for the study in order to explain their sexual practices. However, others may not have disclosed their status.

Study Sample

This study set out to enrol a sample of 25 purposively selected women from the Masiphumelele area according to the study eligibility criteria.

Study duration

The total duration of the study was 5 months. One month for recruitment; two months of data collection; one month of data analysis; and one month for study report writing.

Recruitment

In terms of recruitment, DTHF had been addressing the topic of women's health within the community for the past year. DTHF has trained outreach workers who move through the community on a daily basis interfacing with women regarding their health issues. DTHF also runs two women's discussion groups on a weekly basis with women who are HIV positive as well as those who are negative or of unknown status. The first discussion group introduces women to DTHF and the research that they are currently undertaking in the community and the second focuses on various women's health related topics (such as basic women's health, family planning, STIs, HIV prevention, domestic violence and women's health related research that is being conducted in the community). In addition, DTHF's Community Liaison Officer has also established links with various women's groups in the community. The DTHF has also established a Community Advisory Board (CAB) as part of their ongoing dialogue with the community. An awareness campaign for this study was launched in the community with the aid of the CAB and through the centres and clinics with which the DTHF is associated.

Information about the study was disseminated through the following groups/individuals:

- Women were informed about the study by the outreach workers in the field or by the research team at either of the discussion group sessions.
- DTHF's Community Liaison Officer gave a short presentation of the study to the women's groups with whom links exist.
- The CAB was informed about the study and asked to disseminate information within the community. However, CAB members were not responsible for any study participant recruitment.

After a period of advertising and awareness campaigning, the Principal Investigator (PI) began recruiting participants. Recruitment was done in the following procedure:

- The PI was at the DTHF centre 2 to 3 times a week.
- During the study information dissemination, the DTHF outreach workers and the Community Liaison Officer distributed cards to those women who expressed interest in

participating in the study. They were then invited to visit the DTHF centre on the days that the PI would be at the centre with their cards to find out more about the study.

- Women who attend the DTHF women's discussion groups on a weekly basis were also informed about this study and if they were interested they were then referred to the study PI who was at the centre at that particular time.
- Interested participants who were referred to the PI by the outreach workers, community liaison officer or from the women's group discussion sessions went through a recruitment session, conducted by the PI.
- During the recruitment sessions, an information sheet was given to the potential participants, explaining the research study, describing possible risks and benefits of participation, issues of confidentiality and outlining the proposed use of results and the right not to participate or withdraw from the study at any stage without any impact on their health care. Respondents were provided with comprehensive, understandable information with which they could make an informed choice.
- If they were still interested, consent to enrol in the study was then solicited from those participants who met the eligibility criteria requirements and they were asked to sign an "Informed Consent Form". The informed consent was available in English and Xhosa. Those participants who were unable to read the form had it read to them in their home language by an independent witness. Consent procedures included permission to record the interview. A copy of the signed informed consent was given to the participant and a signed copy remained with the researchers.

After consent to participate has been obtained, a time was arranged for the participant to go through an in-depth face-to-face interview with the PI taking approximately 45 minutes to one hour in duration.

Instruments

A quantitative data sheet was used to collect background demographic data on participants. This data was also tape-recorded. In-depth qualitative interviews using a semi-structured interview guide were held with individual participants (see PART D for

the interview schedule). The interview guide was available in English and Xhosa. Interviews were audio taped and transcribed verbatim for the purposes of qualitative data analysis. Permission to tape the interviews were obtained from the participants. All interview transcriptions were anonymous, with no personal identifiers. In addition, the researcher kept a field diary of her own thoughts, impressions and views.

VI. DATA MANAGEMENT

The quantitative data sheets and interview transcripts were securely locked away at the investigator site. Participants were identified by an ID number rather than a name, to protect patient confidentiality. The data was transferred to Atlas.ti., where the participant's number was used on the databases to further ensure confidentiality.

VII. DATA ANALYSIS

Data analysis and data collection occurred concurrently in this study. Completed interview audiotapes were transcribed by the researcher as further new interviews were taking place. This gave the researcher insights into how to improve the data collection and allowed the researcher to stay closer to the research process (Creswell, 2003). The researcher made sure that transcription of all interviews was complete. If interviews or transcriptions were incomplete, additional participants were interviewed in order to replace the incomplete interviews/transcripts. The researcher kept memos tracking her thoughts, views and impressions during the analysis.

Data was analysed inductively, i.e. the researcher built meaning (concepts or hypotheses) from the collected data. Themes were identified from the data throughout the duration of the study. Emerging themes were compared with existing themes so that 1) major themes and sub-themes could be identified 2) essential data could be separated from the non-essential data. Data interpretation involved the identification and explanation of the data's core meaning.

Coding involved the attachment of labels to sections in the data on the basis of meanings that the researcher deduced from the data (Creswell, 2003). Themes emerging from the

coding were documented by the interviewer. A sample of transcripts was given to another researcher to cross-code for validity purposes. In order to reach a consensus in the coding, a process was developed to negotiate or reconcile coding differences between the researchers. Atlas Ti, a computer program that aids in the sorting and management of data, was used to manage the data and hence facilitate analysis.

VIII. ETHICAL CONSIDERATIONS

a. Participant Withdrawal

Study participation would have been discontinued for either of the following reasons:

- The participant withdrew her consent. Participants were permitted to withdraw from study participation at any time, for any reason.
- The study researcher determined it to be in the best interest of the subject for a non-medical reason.

b. Informed Consent

Written informed consent was obtained from all study participants by the researcher. The rationale for the study, procedural details and investigational goals were explained to each participant together with potential risks and benefits via the informed consent form.

c. Risks and Discomforts

The risks of taking part in the study were small. Some questions may have made the participant uncomfortable or shy. It was explained to participants that if this is the case they could refuse to answer any of the questions and could leave the interview at any time.

d. Benefits

There was no direct benefit to the participant for taking part in this study. An indirect benefit would be the opportunity to help researchers gain insights into women's experiences of condoms and sexual satisfaction or dissatisfaction and how this impacts on their willingness to use condoms as a means of practicing safer sex.

e. Confidentiality

The information on individual participants arising from this study was considered confidential and transmitted only in a form that did not permit identification of the individual. All records were kept in a secure storage area with limited access.

f. *Study permission*

Permission to conduct this study was granted by the DTHF. The site staff was informed about the study well in advance and additional permission to use Masiphumelele as a study site was requested from the relevant stakeholders, by the researcher. The study proposal was also submitted to the University of Cape Town Ethics Committee for approval before the study commenced. A study reference number (REC REF: 407/2009) was given by the University of Cape Town Ethics Committee as proof of approval.

IX. LOGISTICS

Timeline

It was estimated that the study would be conducted over a maximum period of 5 months following protocol development. Below is a provisional timeline of planned research activities:

Activity	Month				
	1	2	3	4	5
Revision of research instruments	■				
Data Collection and Data entry		■	■		
Data Cleaning and Analysis			■	■	
Report writing, dissemination and feedback to stakeholders					■

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PART B:

**STRUCTURED LITERATURE
REVIEW**

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1. OBJECTIVES OF LITERATURE REVIEW

As the study is looking specifically at women's views and experiences on male condom use and sexual satisfaction this review is restricted to a focus on the role of gender and sex and the impact of male condom use on women's sexual pleasure within the context of the HIV epidemic. The literature review below covers research done in the intersection between gender, women's sexual behaviour, social context and the HIV/AIDS pandemic as well as the literature on male sexual pleasure and condom use and the little literature that exists on women's sexual pleasure and condom use.

2. LITERATURE SEARCH STRATEGY and LITERATURE

The Human Sciences Research Council Virtual library was used to search for relevant literature. Data bases such as ABI/INFORM Global, Academic Search Complete , Africa-Wide: NiPAD, African Journals Online (AJOL), African Journals Online (AJOL), African Studies Journals , Business Source Complete , Child Development & Adolescent Studies Database , Cochrane Library, CSIR Research Space , Directory of Open Access Journals (DOAJ) , EBSCO databases, PubMed, ScienceDirect, SCOPUS, SpringerLink EBSCOhost Web , Econlit , Electronic Journal Service (EJS), ERIC , ERIC via EBSCO , Family and society studies worldwide , Health Source: Nursing/Academic Edition , MEDLINE , Oxford Journals , ProQuest databases , PsycARTICLES and were used to retrieve literature related to the topic in question. Keywords such as HIV/AIDS, condoms, sexual satisfaction, sexual dissatisfaction, women and gender relations were used for the search. The search included research work written in English and published between 1995 and 2010. Research work including published papers, journal articles, and academic abstracts were viewed to select appropriate and relevant literature.

A. Women's greater vulnerability to HIV infection

South Africa is currently experiencing the world's largest and fastest growing HIV/AIDS pandemic, with an estimated 5 500 000 people living with HIV and 320 000 people having died of AIDS (UNAIDS, 2006). The number of new infections is high, estimated at more than 800 per day (UNAIDS, 2006). HIV/AIDS is a gendered disease. In the early years of discovering HIV, men, specifically men who were having sex with men were seen as the group to be concerned about in terms of getting infected with HIV. However, in the early 90's research found that women are more vulnerable to HIV infection. This was in part due to women's biological susceptibility and social vulnerability to exposure (Higgins, Hoffman & Dworkin, 2010). For example a national household survey done by Health Sciences Research Council (HSRC) in South Africa found that HIV prevalence among women was 13.3% as compared with 8.2% among men (Shisana et al., 2005).

Young women in particular are the most vulnerable to new HIV infections, with 16.9% of 15 – 24 year olds living with HIV being female compared to 4.4% of males in the same age group (Shisana, et al., 2005). The highest prevalence rate is amongst women at the peak of their reproductive years, with 32.7% of women in the age group 25-29 years being HIV-positive compared to 15.7% of males in the same age group (Shisana et al., 2009).

Women's biological make up makes them more vulnerable to HIV infection. Women have a greater mucus area exposed to infections including HIV during sexual intercourse (Lin, McElmurry, & Christiansen, 2007). Turmen (2003) also indicates that women's biological makeup is one of the determinants which put women at higher risk of HIV infection. He further explains women's susceptibility to HIV as caused by hormonal changes, vaginal microbial ecology and physiology as well as higher prevalence of Sexually transmitted diseases (STIs) (Turmen, 2003).

While biological factors play a role in increasing women's vulnerability to contracting the HIV, there is also an increasing emphasis in the literature on the role played by societal patterns of gendered behaviours and the intra- and inter-gender power-relations that underlie and fuel such behaviours. In particular, the dynamics of patriarchal social structure have been implicated in increasing women's vulnerability to HIV infection (Kaaya et al, 2002; Jewkes & Morrell, 2010; Jewkes, 2010). The patriarchal nature, in particular of the South African society and what are perceived to be the dominant conceptions of masculinity translate into risky sexual behaviours such as men having multiple sexual partners (Jewkes, Dunkle, Nduna, & Shai, 2010). These behaviours fuel HIV infections.

Increasingly research is focusing on the gendered aspects of HIV/AIDS, such as gender inequality, economic inequalities, gender based violence and socio-cultural practices. It has been noted that the incidence of HIV infection is highest in women aged 15 to 24 (Rehle, et al., 2010). Above that 29.4% of pregnant women aged 15-49 years are infected with HIV nationwide (Department of Health, 2010). Researchers cite "gender inequality, a lack of power in decision-making and sexual coercion" as primary reasons for the high risk of infection amongst women (Kaaya et al., 2002; Mba, 2003; Jewkes & Morrell, 2010; Jewkes, 2010). Other research work has also pointed to this trend, emphasising that women in the 20-29 year cohort are at greatest risk (Ackermann & de Klerk, 2002).

Most research found gender inequalities, gender power imbalances, and cultural norms discourage women from talking about sexual matters, including protection against sexual infections (Kaaya et al., 2002; Mba, 2003; Ackermann & de Klerk, 2002). An economic imbalance between men and women has also contributed to high infection rates amongst women. It is suggested that because of their economic dependence on men and social norms women tend to be less active in sexual decision-making and are less able to suggest

protection or refuse sex without protection (Ackermann & de Klerk, 2002). This has therefore contributed to their often unsuccessful attempts at ensuring safe sexual behaviour (Campbell, 2000; Jewkes, Levin & Penn-Kekana, 2003). Hence, most research conducted suggests that women have limited power to negotiate sexual matters and are often not in a position to leave sexual relationships that they perceive to be risky.

Other literature has argued that there is a relationship between gender-based violence and HIV. According to Jewkes and Morrell (2010), women who experience gender-based violence are more likely to be at a higher risk of HIV infection. Data collected from the Eastern Cape province of South Africa showed that women who have experienced gender based violence had a high HIV incidence (Jewkes et al., 2010). It was argued that, both dominant normative masculinity and femininity in gender relations play a role in driving the HIV epidemic (Jewkes et al., 2010). It is further argued that male violence towards women and male risky sexual behaviours are results of dominant ideals of masculinity, while on the other hand women's tolerance towards men's gendered violence behaviour is understood by the adoption of dominant feminine gender roles into which they are socialised (Jewkes & Morrell, 2010).

B. Women and Condom Use

At a time when AIDS has become a devastating public health issue, the use of barrier methods, like male or female condoms, to prevent transmission of HIV is critical. While the 2008 National Household Survey showed that condom use in general has increased, specifically for women increasing from 32.8% in 2005 to 60.4% in 2008 (Shisana et al., 2009), in a recent South African study about 45% of females and 30% of males reported not using a condom at last sex (Burgard & Lee-Rife, 2009).

There is a growing body of literature in Southern Africa, which examines factors that influence male condom use. Low male condom use amongst women has been generally associated with gender inequalities, gender power imbalances, economic inequalities as well as societal expectation and cultural norms (Hoosen & Collins, 2004; Kaaya et al., 2002; Mba, 2003; Ackermann & de Klerk, 2002; East et al., 2007). It is also underpinned by women's feeling that they need to make sure that their male counter partners enjoy sexual pleasure as well as condom use militating against trust built up in "steady" sexual partnerships. Substance abuse and gender based violence has also been seen as having an influence on unprotected sex.

Hoosen and Collins (2004), state that, due to traditional cultural practices women normally do not have the power to negotiate condom use. In their study done in kwaZulu Natal, they found that women are generally seen as subordinate, submissive and passive subjects, while men are perceived to be figures of authority whose sexual and other needs have to be satisfied. This includes sexual needs (Hoosen & Collins, 2004). Other researchers have argued that traditional cultural practices which see men in charge of making decisions, including sexual related decisions hinder male condom use (Macheke & Campbell, 1998; Pettifor et al., 2004).

These research findings therefore suggest that gender roles put women in a position in which they are less able to suggest condom use or refuse sex if condoms are not used. It is argued that gender power inequalities put women in a powerless position to control the circumstances of sex particularly when faced with risky encounters (Jewkes & Morrell, 2010). Furthermore, the social and cultural norms which promote male dominance and female passivity in sexual relations lead to difficulties in negotiating safer sex for women (Jewkes et al., 2010; Jewkes & Morrell, 2010; East et al., 2007). Mba (2003) argues that, in patriarchal cultures where women are expected to be passive and subservient to men, female adolescents in particular, have very little or no control over sexual decisions, nor

can they control the sexual behaviour of their male partners, or even play an equal role in the negotiation of condom use for the prevention of HIV or pregnancy.

Some research has shown a desire to prove fertility as another barrier to condom use (Heise & Elias, 1995; Preston-White, 1999). According to Heise & Elias (1995) many South African women are expected to prove their childbearing ability even before marriage and that childbearing ability gives women a positive social status, particularly in marriage (Heise & Elias, 1995). This social expectation of fertility in women contributes to condoms non-use as they prevent one from falling pregnant. A recent study done at the Cape Town Metropolitan reinforces this suggestion as the results showed that married women in particular were under pressure from their partners, family and community at large to give birth (Cooper, Harries, Myer, Orner, & Bracken, 2007). Being married and have no children was seen as disgrace, hence condom use was perceived as less of a priority amongst these women in this context (Cooper et al., 2007). A later study showed that 24% of women indicated that their decisions in having children were influenced by their partners, and 44% indicated being influenced by their families in decision-making regarding childbearing (Cooper et al., 2009)

Attention has also centered on the economic context in which women navigate their sexuality. The message has been that because of their economic dependence on men, women are less able to suggest condoms or refuse sex if condoms are not used (Ackermann & de Klerk, 2002) and contribute to their unsuccessful attempts at ensuring safe sexual behaviour (Campbell, 2000; Jewkes et al., 2003). In another study, amongst 19 500 participants in Burkina Faso, Ghana, Malawi and Uganda, economic status was associated with non use of condoms (Madise, Zulu & Ciera, 2007). Their findings showed that in Malawi and in Uganda, male and female participants from poor households were more likely not to use condoms compared to those from the wealthier households (Madise et al., 2007).

Recent research has revealed that there is a correlation between alcohol use and high risk sexual behaviours such as practicing unsafe sex and engaging in multiple sexual partners. A review of 33 studies showed that there was an association between quantities of alcohol consumed, attending alcohol serving places and sexual risks (Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007). Their results showed that those who drink heavier are more likely to have greater sex alcohol expectancies, multiple sex partners and less condom use, though this was more prevalent to men than in women (Kalichman et al., 2008).

Besides other barriers to male condom use as discussed in the above literature review, recent research has shown that sexual dissatisfaction also contributes in the decision to use condoms or not to use condoms in a relationship (Crawford, Gardner, & McGrowder, 2008; Sunmola, 2005; Chakrapani, Newman, Shunmugam & Dubrow, 2010). The results of a study done by Sunmola (2005), investigating sexual practices, barriers to condom use and its consistent use among long distance truck drivers in Nigeria, showed that their main barrier to condom use was that condoms interfered with men's sexual satisfaction. This is reiterated in another study, where female participants stated that condom use interfered with their men's sexual satisfaction, making condom use more difficult for them to insist on (Chakrapani et al., 2010).

Little literature also exists which shows that some women do not consistently use condoms as they interfere with their own personal sexual satisfaction rather than interfering with their partners' sexual satisfaction. Results from a study conducted by Crawford, Gardner & McGrowder (2008), showed that 69.3% of women generally could not reach sexual satisfaction. Sunmola's study (2005), revealed similar results where one of the barriers to condom use for women was that condoms interfered with their sexual satisfaction. In another qualitative study done by Williamson, Buston & Sweeting (2009),

many women reported that they disliked condoms as they hindered their sexual satisfaction.

There is also evidence that condoms are more used with casual sex partners and not consistently used with steady sexual partners (Foulkes, Pettigrew, Livingston & Niccolai, 2009). In a study done by Williamson, Buston, & Sweeting (2009), most women reported they were most likely to use condoms with casual and new partners in order to protect themselves against STIs.

3. SUMMARY OF LITERATURE

The literature tells us that women are more vulnerable to HIV infection when compared with men. The literature further shows that despite the fact that more women are infected with HIV compared to men, a large number of women are still engaging in sexual risk behaviour such as non use of male condoms. In general the literature focuses on gender inequalities which leave women powerless to use or initiate condom use. The literature also suggests that because of their economic status which is mostly lower compared to males, women feel like they don't have any other choice but to comply with men's sexual needs, even if it means non use of condoms. Furthermore the literature indicates that women frequently need to comply with social expectations, such as proving their fertility even before marriage. This kind of pressure is said to influence non use of condoms as they prevent one from becoming pregnant. Substance abuse such as alcohol use is also seen as one of the barriers to condom use. Some literature also refers to sexual partner characteristics such as, main partner vs. casual partner, as a hindrance to condom use. There is also evidence that condoms are not used due to male partners' sexual dissatisfaction when using condoms during sex. Some literature does reveal that some women themselves do not use condoms due to their own sexual dissatisfaction when using condoms.

4. GAPS IN LITERATURE AND NEEDS FOR FURTHER RESEARCH

The focus on the social context in which women struggle to combat men's resistance to condom use implies that women themselves are eager to use condoms, but that gender inequalities, gender power imbalances, economic inequalities, male partner sexual fulfilment and substance abuse, leave them powerless to do so. However, some literature does suggest that some women's own negative attitudes towards condom use may influence their safer sex decision-making (Kline, Kline, & Oken, 2002).

The literature has focused mostly on male sexual dissatisfaction as one of the barriers to male condom use (Measor, 2006; Crosby et al., 2005). But recent literature shows that sexual satisfaction might be more of concern for women themselves than was previously believed. In work carried out by the Desmond Tutu HIV Centre (DTHC), a series of focus groups were conducted in Masiphumelele in 2003 that explored issues around HIV knowledge, attitudes and practises. This qualitative investigation found that some women experienced sex with condoms as painful, and therefore chose not to use them. In June 2004 the DTHC did a 'Deep Democracy' Training session for their counsellors. The training took place at Sizophela in Nyanga, an organisation linked to the Desmond Tutu HIV Centre. During this training, once again some of the women described their dislike of condoms. They reported that they were frequently sexually dissatisfied and that their partners were seldom concerned with their sexual needs. Women felt that the use of unlubricated condoms led to even greater sexual dissatisfaction. Hence some women appeared to have actively chosen not to use condoms, due to their own lack of sexual pleasure experiences when using condoms.

These studies collectively show that women may have their own dislikes related to sexual dissatisfaction experience when using male condoms. Women's frequent inability to negotiate male condom use with men is an important factor hindering condom use. However, women might not always be in a position where they cannot negotiate condom

use, as most literature suggest but sometimes they may choose not to use condoms due to their own feelings of dissatisfaction.

This study wanted to investigate what women's own attitudes and preferences are on male condom use and to what extent these may influence their actual use of male condoms. This is underpinned by the notion that some women may be able to exercise some degree of influence over sexual decision-making and safer sex practices. This study uses the Wojcicki and Malala's framework that takes cognizance of the micro decision-making that occurs in daily life. In their study of sex workers and condom use, Wojcicki and Malala (2001) highlight the micro decision making in the sex worker's lives and see this as a 'cry for agency' (Wojcicki & Malala, 2001). Wojcicki and Malala (2001) focus on female sex worker's daily circumstances and difficulties as representing efforts at exercising their own desires, will or 'agency' in influencing safer sexual practices (Wojcicki & Malala, 2001). In this study the framework will be used to highlight both difficulties women face in their intimate relationships in negotiating safer sex as well as how male condom use impacts on women's sexual satisfaction and influences their choices and possibly their actions in this regard.

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University of Cape Town

Women's views on and experiences of condom use: An exploration of how this impacts on women's sexual satisfaction and male condom use among women

V. Mehlomakulu

Women are most vulnerable when it comes to HIV infection. This has been linked to their biological makeup, gender, and their social status in the communities. Consistent condom use amongst women and men is one of the important safer sexual practices in combating the spread of HIV/AIDS. This paper examines factors which hinder or facilitate consistent male condom use, particularly as it relates to women's sexual satisfaction. The study was conducted amongst 25 women between the ages of 18-36 years, living in Masiphumelele, in the Western Cape. In-depth interviews were conducted with women irrespective of their HIV status, to obtain their views and experiences on male condom use, in particular with respect to male condoms' impact on women's sexual satisfaction. Purposive sampling was used in recruiting women for the study. Findings indicated that women felt it was important to use condoms during sexual intercourse in order to obtain protection against HIV, STIs and pregnancy. Though the importance of condom use during sexual intercourse was acknowledged, as found elsewhere, this did not translate to consistent condom use. Just over half of women reported condom use at last sexual intercourse. Women's own sexual dissatisfaction was regarded as one of the main reasons why condoms were not consistently used by women. Some women reported that they do not reach orgasm when they used condoms, so this hindered their sexual satisfaction. The results of this study suggest that while it is important for HIV/AIDS interventions to focus on gender based related issues such as women's negotiation skills on condom use, it is also important to better understand a less investigated issue of women's own resistance to male condom use. The interventions need to include addressing women's own issues on sexual satisfaction and how these can be taken into account in facilitating safer sexual practices.

Introduction

In South Africa young women in particular are the most vulnerable to new HIV infections, with 16.9% of 15 – 24 year olds living with HIV being female compared to 4.4% of males in the same age group (Shisana, et al., 2005). The highest prevalence rate is amongst women at the peak of their reproductive years, with 32.7% of women in the age group 25-29 years being HIV-positive compared to 15.7% of males in the same age group (Shisana et al., 2009).

It has been reported that women's biological make up as well as the role played by societal patterns of gendered behaviours and the intra- and inter-gender power-relations that underlie and fuel such behaviours makes them more vulnerable to HIV infection (Lin, McElmurry, & Christiansen, 2007; Kaaya et al., 2002; Jewkes, Dunkle, Nduna, & Shai, 2010).

At a time when AIDS has become a devastating public health issue, the use of barrier methods, like male or female condoms, to prevent transmission of HIV is critical. While the 2008 National Household Survey showed that condom use in general has increased, specifically for women increasing from 32.8% in 2005 to 60.4% in 2008 (Shisana et al., 2009), in a recent South African study about 45% of females and 30% of males reported not using a condom at last sex (Burgard & Lee-Rife, 2009).

The relatively low condom use amongst women, particularly given the heightened HIV epidemic in South Africa, has been generally associated with gender inequalities, gender power imbalances, economic inequalities as well as societal expectation and cultural

norms (Hoosen & Collins, 2004; Kaaya et al., 2002; Mba, 2003; Ackermann & de Klerk, 2002; East, Jackson, O'Brien, & Peters, 2007). It is also underpinned by women's need to make sure that their male counter partners enjoy sexual pleasure, as well as male condom use militating against trust built up towards "steady" sexual partners (Williamson, Buston, & Sweeting, 2009). Apart from this substance abuse has also been seen as having an influence on unprotected sex (Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007)

Many studies have emphasized the gap between HIV knowledge and sexual risk behaviour, and prevention initiatives have thus far had limited success in controlling continued HIV transmission. This paper aims to broaden our understanding of specific factors that affect women's use of male condoms in relation to women's own preferences and choices. It is hoped that this will provide greater insight and contribute to relevant and effective safer sex interventions, tailored at addressing these additional specific factors affecting women.

Methods

Participants

The target population was adult women between the ages of 18 and 40 years, who had been sexually active in the previous 6 months, resident in Masiphumelele Township in the Western Cape. Women's HIV status was unknown, meaning that women were not recruited based on their HIV status. However, some women disclosed their HIV positive status during the interviews. Masiphumelele ("we will overcome") is a peri-urban settlement found 40 km South of Cape Town in the South Peninsula Municipality. This

study enrolled a sample of 25 Coloured and Black women between the ages of 18 and 36 years who consented to take part in the study. Purposive sampling was used for recruitment to ensure that a heterogeneous group of women was recruited. Recruitment was done in May 2010 with the assistance of DTHF fieldwork recruiters. Four women spoke English and 21 spoke Xhosa. Interviews were audio-taped and took approximately 45min.

Data collected

Participants were interviewed using an interview guide which documented demographics and explored sexual partnerships, sexual satisfaction, male condom use and sexual satisfaction and condom use.

A quantitative data sheet was used to collect background demographic data on participants which included race, age, education level, employment status, intimate relationship status, and whether women had multiple sexual partnerships.

Participants were asked to indicate their understanding of the terms “sexual partner” and “steady sexual partner”. For the participants who indicated having more than 1 sexual partner they were asked to report on the factors that lead them to have more than one sexual partner. Participants reported on the nature of their sexual relationships as well as the roles their sexual partners played in their lives. Those who reported having more than one sexual partner were asked to explain how their intimate relationships differed.

Participants were asked to report on what they understood by sexual satisfaction. They were further asked to indicate if they felt they experienced sexual satisfaction with their steady sexual partner and any other sexual partners. Participants were asked to talk about sexual practices that lead to them experiencing sexual satisfaction or dissatisfaction.

Participants were also asked what they understood orgasm to be; whether they felt they had experienced this and whether it was important to reach or not to them to reach orgasm during sexual intercourse.

Only male¹ condom use was assessed, by asking the participants if they had used sexual protection during their last sexual intercourse. Participants were also asked to report on the circumstances in which condoms were used and not used. Sexual decision making around male condom use was also explored in terms of who in the relationship takes the decision to use or not to use condoms. Whether differences were experienced in women's own experiences of sexual satisfaction when using or not using a male condom were explored.

Ethics

Ethical approval for the study procedures, instruments and consent forms was granted by the University of Cape Town Health Sciences Faculty's Human Research and Ethics Committee. This study formed part of Desmond Tutu HIV Foundation (DTHF) work in the community of Masiphumelele. All interviews were conducted at the DTHF fieldworker's offices, where privacy and confidentiality were maintained all the time.

¹ . All references to condoms in this paper are to male condoms as female condom use was not probed in this study.

Interviews were conducted by the first author who is fluent in the language mostly spoken by the participants, isiXhosa. The consent to participate in the study was obtained from all the participants.

Data analysis

Interviews were transcribed verbatim for the purposes of qualitative data analysis. Atlas Ti, a computer program that aids in the sorting and management of data, was used to manage the data and hence facilitated analysis. Coding involved the attachment of labels to sections in the data on the basis of meanings that the researcher deduced from the data (Creswell, 2003). Data was analysed inductively, using grounded theory, i.e. the researcher built meaning (concepts or hypotheses) from the collected data. Themes were identified from the data throughout the duration of the study. Data interpretation involved the identification and explanation of the data's core meaning.

Results

Participant demographics

Twenty-one enrolled women were African, Xhosa speakers, and 4 were Coloured, English speakers. The women ranged between 18 and 36 years of age. Fourteen women in total reported that they were employed and 11 were unemployed. More than half of the women had completed grade 12, while 12 of them finished grades between 8 and 11. None of the participants had a tertiary level qualification.

Safer sex practices

Fourteen out of 25 women reported using male condoms during their last sexual intercourse, while eleven did not use condoms during their last sexual intercourse. Of the 11 women who reported being unemployed most (n= 7) reported using condoms at their last sex act. Most women reported to be in steady relationships of more than 24 months (n=18). A minority of women (n=4) reported that they had multiple sexual partners and all of these women reported using condoms in their last sex act. Women's reasons for engaging in multiple sexual partnerships included wanting intimacy from another male partner when they felt they did not experience this in their primary relationship; wanting someone to talk to when they were not on good terms with their primary partner; and having additional sexual relationships when they suspected that their main partners were unfaithful or they were not sexually satisfied by their main partners.

Reasons for male condom use

Women acknowledged the need to use condoms in order to prevent sexually transmitted infections (STIs), pregnancy and HIV transmission and re-infection. Most women saw condom use as essential if a person was HIV-positive regardless of whether the couple was discordant or concordant. Condom use depended heavily on the stage of their relationship. Most women reported that when the relationship was new they would use a condom, but not as the relationship progressed, due to issues of trust that arose. Trust militated strongly against condom use. Use of condoms was seen as indicating a lack of trust in one's partner. Condom use was linked to trust between the partners. So many

women reported that while they and their partner would use condoms when the relationship was new, it became difficult as the relationship became a steady one.

“I don’t like condoms and because he is my only partner and I don’t like condoms” P19

“Because when I first meet a person and have a relationship with I use it (condom) in that process, maybe in the first month and then after not use it” P22

“And when I just met him, obviously there is no total trust there” P11

A few commented on a partner’s unknown HIV status for using condoms or suspicions that their partner was having an affair as reasons to use condoms.

“It is important sometimes because you can’t sleep with someone you don’t know his status, you must do some tests first, you can’t risk because your boyfriend maybe he is seeing someone that’s why it is important” P15

“It depends like last week we went to test because two months back I suspected that he is having an affair so wrong or right I have to be safe so I used a condom” P11

“Ok the reason why we constantly use condoms is because we are on HIV treatment” P6 [HIV-positive couple]

“Ok, at the beginning I was the one on HIV treatment and not him, so I had to sit him down although I know he does not like condoms, I told him that we must always use condoms.” P6
[HIV-positive couple]

Reasons for discontinuing or not using condoms

Sexual dissatisfaction. Women’s own sexual dissatisfaction emerged as an important reason for discontinuing or not using condoms. More than half of the women reported that condoms interfered with sexual satisfaction. Sexual satisfaction was understood as when a person experiences sexual pleasure, sexual enjoyment, flesh to flesh sex and reaching orgasm. Women singled lack of ‘flesh to flesh’ sex as something that they did not enjoy. Two participants used the commonly used metaphor of eating sweets with a plastic on to describe sex with a condom:

“That is a plastic so you can’t eat a sweet with a plastic” P14

“Like if you didn’t use condoms you feel good when you have sex, that’s why they say you cant eat a sweet with its paper and a condom hurts” P15

“Its (sex) lousy because there is always the thought that there is something inside, it’s not flesh to flesh” P20

Participants reported greater pleasure when not using condoms.

“There is a difference; you enjoy sex more without a condom, ...” P11

“For my side when I use it (condom) I don’t get satisfied” P22

Reiterating the same view point the, another participant said:

“I didn’t focus that much but for me I did remember there was times I said to him take it off” P19

And when asked why, she responded:

“I couldn’t feel it [the sex experience, when using a condom]” P19

One participant strongly believed that when using condoms it was difficult to reach orgasm and that this diminished sexual satisfaction. She explained that this was because sometimes men reached a sexual climax first and when using a condom it was necessary to withdraw the penis and that as a result the woman was left dissatisfied. In cases where condoms are not used when the male partner reached climax he did not have to withdraw his penis and this gave time for the female partner to also reach orgasm.

“ It dependsif we use a condom then there is nothing else because the condom, when he is finished, it will slip off if he does not take the penis out, when we are not using a condom if he does not take out the penis then there is still that pressure [prolonging a woman’s sexual pleasure]” P11

A participant who nevertheless reported using condoms consistently reiterated this view:

“The difference is that you do no get that pleasurable feeling when you use condoms” P13

Physical complications. Other issues related to women’s own dissatisfaction with condom use included reported physical problems. Some women reported experiencing pain when

using male condoms, possibly related to lack of lubrication or stimulation or perceptions of negative side effects:

“What I have experienced is that when I use a condom it hurts more than when I am not using a condom” P11

“.....and a condom hurts” P15

“They make me to develop rash” P20

Gender related dynamics. While reporting on their feelings on sexual satisfaction and male condom use, other factors, already reported on in research were also mentioned as additional factors hindering condom use. For example, one participant reported on her partner’s refusal to use condoms:

“It would be easy if your male partner was in it as well, but its not easy because you tell him this and he will tell you that, you ask to do a certain thing then he will ask you questions like why must a certain thing be done, then you end up letting him take the decision [to use or not use condoms] putting yourself at risk sometimes.” P14

She further stated:

“I don’t know I want to use condoms but it’s my boyfriend who has a problem with condoms” P14

In a similar vein another said:

“He himself never liked condoms from the beginning” P20

One other participant seemed to believe that using a condom can ‘break’ a marriage, even if the person was HIV-positive.

“Yes it is important because men...its worse for people like us who are HIV its important when the man knows that both of you are like that and he still doesn’t want it then you decide that you can’t break your marriage just because of the condom, for me anyway it causes problems.” P20

One participant also mentioned a commonly raised issue that partner’s also did not like condoms because of diminished sexual pleasure.

“Like even him, he becomes more satisfied when we are not using a condom.” P11

Non-use when there is unplanned sex. Spontaneous sex also led to inconsistent condom use, as condoms interrupted spontaneous sex, impacting on sexual desire. One of the women reported:

“Sometimes you have not planned that you are going to have sex then you get caught up in the moment then you think special that there is something called a condom then you must stop, then the feelings go down.”P11

A participant who used condoms in her last sexual intercourse reported that on some occasions she did not use condoms:

“No I do not want to lie on that day we were in a hurry hungry for each other and we knew that using a condom will take time, so let’s do this thing” P16

Decision-making on condom use

There were varying responses to the question of who took the decisions to use condoms in a relationship. More than half of the women reported being those making decisions in this regard. Others reported that both partners made the decision. Some of them indicated that they made it their responsibility to always make sure that they have condoms with them or they made sure that there were always condoms at their boyfriend's place. Over time, joint decision-makings seemed to be more likely.

"Ok at the beginning it was me but now when he is ready he would take it also" P6

Discussion

An important outcome of this study is the fact that women generally emphasized the importance of condom use for protection against STIs, HIV and pregnancy. Nevertheless, as has been shown elsewhere, having knowledge on the importance of condom use didn't necessarily translate to consistent condom use among the women. This is borne out by the fact that 11 women out of the 25 interviewed reported that they did not use condoms in their last sexual act.

Literature on safer sex generally focuses on non-condom use amongst women as mainly fuelled by the unequal gender relations and gender power imbalances between men and women, with men refusing condom use (Macheke & Campbell, 1998; Pettifor et al., 2004). It has also focused on women's dependent economic status on their male partners as a reason why they found it difficult to take safe sex decisions such as using condoms

(Hoosen & Collins, 2004; Kaaya et al., 2002; Mba, 2003; Ackermann & de Klerk, 2002).

Some researchers further point out that social and cultural norms which promote male dominance and female passivity in sexual relations lead to difficulties in negotiating safe sex for females (Jewkes et al., 2010; Jewkes & Morrell, 2010; Jewkes, 2010; East et al., 2007).

While gender relations, gender power imbalances and women's economic status are important constraints in women engaging in safer sex, women's own preferences also impacted on the sexual practices and choices among this group of women. While economic dependence can play a role in safer sex decision-making, eleven women in this study were unemployed but still reported consistent condom use. However, it is unclear whether this was due to their own decision-making, their partner's or both.

While this study is a qualitative one and therefore the sample is not a representative one, women were purposively chosen as 'typical' women in that community. Some women reported that condom use was often seen as more imperative when they had a new sexual partner rather than a steady sexual partner. This corresponds with other studies also showing evidence that condoms are more used with casual sex partners and inconsistently used with steady sexual partners (Foulkes, Pettigrew, Livingston & Niccolai, 2009). In this study, as in others, condom use was linked with trust between the partners.

Women pointed to many reasons why they did not consistently use condoms. These included: partner refusing to use condoms; when sex was unplanned therefore often no

time to think about condom use; condoms were sometimes perceived to cause physical complications such as rashes and bleeding; they militated against trust in the sexual partner; use was dependent on known HIV status; and that condoms caused sexual dissatisfaction among some women. These reasons are in line with many other study findings on the reasons why women do not use condoms (Crawford, Gardner & McGrowder, 2008; Sunmola, 2005; Chakrapani, Newman, Shunmugam & Dubrow, 2010; Measor, 2006; Crosby et al., 2005). Factors promoting condoms use were reported as, when the women suspected that a male partner was having affairs and that condom use was also dependent on going for HIV and STIs tests – knowing one's HIV status.

In addition to non-condom use due to reported male sexual dissatisfaction (Crawford et al., 2008; Sunmola, 2005; Chakrapani et al., 2010; Measor, 2006; Crosby et al., 2005), this study adds new insights on women's non use of condoms related to their own personal sexual dissatisfaction, shedding light on condom use or non-use connected with their own personal experiences of sexual dissatisfaction. This adds an additional dimension to the factors promoting or hindering male condom use among heterosexual couples that can influence sexual decision-making and safer sex practices.

This study uses the Wojcicki and Malala's conception of power, which takes cognisance of the micro decision-making that occurs in daily life (Wojcicki & Malala, 2001). In their study of sex workers and condom use, they conceptualise empowerment as not just an ability to make safer sex decisions all the time, but rather highlight the micro decision making in the sex worker's lives and see this as a 'cry for agency' (Wojcicki & Malala,

2001). They do not conceptualise sex workers as “victims” or “powerless”, instead they follow Foucault’s understanding of power relations in which he couples this with resistance. Wojcicki and Malala (2001) move beyond understanding the sex workers as “victims” and “powerless” as the ‘agency’, but also focus on their daily circumstances and difficulties as representing efforts at ‘agency’ (Wojcicki & Malala, 2001). This study uses a similar framework to that of Wojcicki and Malala, in that while not detracting from some women’s difficulties in negotiating safer sex in heterosexual relationships and gender power problems that women face, it posits them as also having personal issues in practicing safer sex related to their own sexual satisfaction experiences. It suggests that women could be able to influence condom use, through their own attitudes and preferences.

Limitations of this study include the fact that as a qualitative study it is designed to look in depth at an issue and therefore is not designed to generalize these findings to the study population. Further quantitative research would be needed to determine how widespread these views are. In addition, this study was conducted in a peri-urban area of the Western Cape. Similar research would be valuable in other urban settings and in rural areas. Nevertheless, these findings are important in informing HIV/AIDS interventions for women. Interventions need to focus, in addition to gender based empowerment related issues such as women’s negotiation skills on condom use, also on the difficulties women face in their intimate relationships related to their own sexual satisfaction. Interventions need to be more tailored to facilitate women in making safer sexual choices within the

context of their own personal situations and the diverse circumstances of women's experiences of sexual satisfaction.

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PART D: APPENDICES

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Second citation:

(MADD, 2000)

When the author and publisher are identical, use the word Author as the name of the publisher.

Chapter in edited book

Author, A.A., & Author, B.B. (Year of publication). Title of chapter. In A. Editor & B. Editor (Eds.), *Title of book* (pages of chapter). Location: Publisher.

Author, A.A., & Author, B.B. (Year of publication). Title of chapter. In A. Editor & B. Editor (Eds.), *Title of book* (pages of chapter). Retrieved from <http://www.xxxxx>

Author, A.A., & Author, B.B. (Year of publication). Title of chapter. In A. Editor & B. Editor (Eds.), *Title of book* (pages of chapter). Location: Publisher. doi:xxxxxxxxxx

O'Neil, J.M., & Egan, J. (1992). Men's and women's gender role journeys: Metaphor for healing, transition, and transformation. In B.R. Wainrib (Ed.), *Gender issues across the life cycle* (pp. 107–123). New York, NY: Springer.

Give initials and surnames for all editors. With two names use '&' between names and no comma to separate. With three or more, separate names by commas. For a book with no editor, simply include the word 'In' before the book title.

Book chapter, English translation, reprinted from another source

Author, M.N. (1987). Title of chapter (T. Translator, Trans.). In E. Editor & E.E. Editor (Eds.), *Title of book* (pp. xx–xx). Location: Publisher. (Reprinted from *Title of book*, pp. xx–xx, by A.N. Editor, Ed., 1979, Location: Publisher)

In text, use (Author, 1979/1987)

Edited book

Duncan, G.J., & Brooks-Gunn, J. (Eds.). (1997). *Consequences of growing up poor*. New York, NY: Russell Sage Foundation.

Plath, S. (2000). *The unabridged journals* (K.V. Kukil, Ed.). New York, NY: Anchor.

Multiple editions

Helfer, M.E., Keme, R.S., & Drugman, R.D. (1997). *The battered child* (5th ed.). Chicago, IL: University of Chicago Press.

Revised edition

Helfer, M.E., Keme, R.S., & Drugman, R.D. (1997). *The battered child* (Rev. ed.). Chicago, IL: University of Chicago Press.

Multivolume work

Wiener, P. (Ed.). (1973). *Dictionary of the history of ideas* (Vols. 1–4). New York, NY: Scribner's.

Merriam-Webster's collegiate dictionary (10th ed.). (1993). Springfield, MA: Merriam-Webster.

Multivolume work published over more than one year

Koch, S. (Ed.). (1959–1963). *Psychology: a study of science* (Vols. 1–6). New York, NY: McGraw-Hill.

In text, use (Koch, 1959–1963).

Non-English book

Piaget, J., & Inhelder, B. (1951). *La genèse de l'idée de hasard chez l'enfant* [The origin of the idea of chance in the child]. Paris: Presses Universitaires de France.

If the original version is used as the source, cite the original version. Give the original title, and, in brackets, the translation.

Non-English reference work, title translated

Real Academia Española. (2001). *Diccionario de la lengua española* [Dictionary of the Spanish language]. Madrid: Author.

Translated book

Laplace, P.S. (1951). *A philosophical essay on probabilities*. (F.W. Truscott & F.L. Emory, Trans.). New York, NY: Dover. (Original work published 1814)

If the English translation is used as the source, cite the English translation. In the text, cite the original publication date and the date of translation (Laplace, 1814/1951).

Republished work

When you cite a republished work in your text, it should appear with both dates:

Laplace (1814/1951).

Republished book (electronic version)

Author, G.H. (1942). *Title of book: Subtitle*. Retrieved from <http://books.google.com/books> (Original work published 1900)

Place of publication

For location, you should always list the city, but you should also include the two-letter state abbreviation for US publishers. There is no need to include the country name.

If the publisher is a university and the name of the state is included in the name of the university, do not repeat the state in the publisher location (e.g. Lincoln: University of Nebraska Press).

New York, NY: McGraw-Hill

Washington, DC: Author

Newbury Park, CA: Sage

Pretoria: Unisa

Chicago, IL: University of Chicago Press

Cambridge: Cambridge University Press

Cambridge, MA: Harvard University Press

Abingdon: Routledge

Publisher name

Give the name in as brief a form as possible. Omit terms such as 'Publishers', 'Co.', 'Inc.', but retain the words 'Books' and 'Press'. If two or more publishers are given, give the location listed first or the location of the publisher's home office.

When the author and publisher are identical, use the word Author as the name of the publisher.

7. Conference proceedings, paper, poster session.

Deci, E.L., & Ryan, R.M. (1991). A motivational approach to self. In R. Dienstbier (Ed.), *Nebraska Symposium on Motivation: Vol. 38. Perspectives on motivation* (pp. 237–288). Lincoln: University of Nebraska Press. doi:xxxxxxxxxx

Treat regularly published proceedings (including those published online) as periodicals.

Paper presented at meeting

Lanktree, C. (1991, February). *Early data on the Trauma Symptom Checklist for Children (TSC-C)*. Paper presented at the meeting of the American Professional Society on the Abuse of Children, San Diego, CA.

Poster session

Ruby, J., & Fulton, C. (1993, June). *Beyond redlining: Editing software that works*. Poster

session presented at the annual meeting of the Society for Scholarly Publishing, Washington, DC.

Symposium

Contributor, C. (Year, Month). Title of contribution. In C. Chairperson (Chair), *Title of symposium*. Symposium conducted at the meeting of Organization Name, Location.

Conference paper abstract retrieved online

Author, A. (2007, June). *Title of article*. Paper presented at the Conference Name, Location. Abstract retrieved from http://www.conference.org/abstracts_2007.htm

8. Database.

When you are referencing material obtained from an online database, provide the appropriate print citation information (formatted as a normal print citation would be). Then give the date of retrieval and the proper name of the database, so that people can retrieve the print version if they do not have access to the database. (For more about citing articles retrieved from electronic databases, see page 278 of the Publication Manual.)

Smyth, A.M., Parker, A.L., & Pease, D.L. (2002). A study of enjoyment of peas. *Journal of Abnormal Eating*, 8(3). Retrieved February 20, 2003, from the PsycARTICLES database.

9. Dissertation or thesis.

Available from a database service

Author, A. (2009). *Title of dissertation* (Doctoral dissertation/Master's thesis). Retrieved from Database Name. (Accession/Order No.)

Author, A. (2009). *Title of dissertation* (Doctoral dissertation/Master's thesis). Available from Proquest database. (Accession/Order No.)

Doctoral dissertation from an institutional database

Author, A.M. (2009). *Title of dissertation* (Doctoral dissertation). Retrieved from <http://www.university/etd/>

Doctoral dissertation from the Web

Author, A.M. (2009). *Title of dissertation* (Doctoral dissertation, University Name, Country). Retrieved from <http://www.xxxxxxxx/thesis/>

Doctoral dissertation abstracted in Dissertation Abstracts International

Bower, D.L. (1993). Employee assistant programs supervisory referrals. *Dissertation Abstracts International*, 54(01), 534B.

Unpublished

Wilfley, D.E. (1989). *Interpersonal analyses of bulimia* (Unpublished doctoral dissertation). University of Missouri, Columbia.

Almeida, D.M. (1990). *Fathers' participation in family work: Consequences for fathers' stress* (Unpublished master's thesis). University of Victoria, Victoria, British Columbia, Canada.

10. Electronic sources.

Provide the DOI if one has been assigned. Copy and paste this where possible, and do not change it. The DOI can usually be found on the first page of an article at the top or bottom of the page.

If no DOI has been assigned, give the home page URL of the journal, book, or report publisher. Do not insert a hyphen into a URL, and do not add a full stop after it.

Authors should test URLs in their references at each stage of publication, updating the URL if necessary. If the content is no longer available, substitute another source (i.e. the final version if you have cited a draft version) or remove it altogether.

Do not include retrieval dates unless the source material may change, e.g. wikis.

11. Email, mailing list, blog.

No personal communication (email, interview, letter, etc.) should be included in the reference list. In the text, cite the communicator's name, the fact that it was personal

communication, and the date of the communication.

(E. Robbins, personal communication, January 4, 2001).

A.P. Smith also claimed that many of her students had difficulties with APA style (personal communication, November 3, 2002).

Online forum or discussion board posting

Include the title of the message and the URL of the newsgroup or discussion board.

Frook, B.D. (1999, July 23). New inventions in the cyberworld of toylandia [Online forum comment]. Retrieved from <http://groups.earthlink.com/forum/messages/00025.html>

If the author provides a real name, use their real name, but if only the screen name is available, then use that. Provide the exact date of the posting. Follow the date with the subject line, the thread of the message (not in italics). Provide any identifiers in brackets after the title. Include the retrieval information and the name of the list to which the message was posted if this is not part of the URL. Provide the address for the archived version of the message.

Blog post

Screen name. (2007, January 23). Re: Title of message [Web log message]. Retrieved from <http://xxxxxxxxxxxxx.php>

Video blog post

Jennings, A. (2009, February 8). How to knit [Video file]. Retrieved from <http://www.youtube.com/xxxxxx>

12. Film.

Producer, P.P. (Producer), & Director, D.D. (Director). (Date of publication). *Title of motion picture* [Motion picture]. Country of origin: Studio or distributor.

Smith, J.D. (Producer), & Smithee, A.F. (Director). (2001). *Really big disaster movie* [Motion picture]. United States: Paramount Pictures.

If a movie or video tape is not available in wide distribution, add the following to your citation after the country of origin: (Available from Distributor name, full address).

Harris, M. (Producer), & Turley, M.J. (Director). (2002). *Writing labs: A history* [Motion picture]. (Available from Purdue University Pictures, 500 Oval Drive, West Lafayette, IN 47907)

13. Interview.

No personal communication (email, interview, letter, etc.) should be included in the reference list. In the text, cite the communicator's name, the fact that it was personal communication, and the date of the communication.

(E. Robbins, personal communication, January 4, 2001).

A.P. Smith also claimed that many of her students had difficulties with APA style (personal communication, November 3, 2002).

14. Journal article.

Author, A.A., Author, B.B., & Author, C.C. (Year). Title of article. *Title of Periodical, volume number*, pp–pp. doi:xx.xxxxxxxxxx

Harlow, H.F. (1983). Fundamentals for preparing psychology journal articles. *Journal of Comparative and Physiological Psychology*, 55, 893–896. doi: xx.xxxxxxxxxx

Scruton, R. (1996). The eclipse of listening. *The New Criterion*, 15, 5–13. doi: xx.xxxxxxxxxx

Authors are named by last name followed by initials (closed up); publication year goes between parentheses, followed by a full stop (period). Only the first word and proper nouns in the title and subtitle are capitalized. The periodical title has main words capitalized, and is followed by the volume number which, with the title, is also italicized and then the DOI. Provide the issue number ONLY if each issue of the journal begins on page 1. In such cases it goes in parentheses: *Journal*, 8(1), pp–pp.

If the DOI is not available and the reference was retrieved online, give the URL of the journal home page. No retrieval date is needed.

Harlow, H.F. (1983). Fundamentals for preparing psychology journal articles. *Journal of Comparative and Physiological Psychology*, 55, 893–896. Retrieved from <http://xxxxxx>

If you are citing a version which is not the Version of Record, insert ‘Advance online publication’ before the retrieval statement.

Von Ledebur, S.C. (2007). Optimizing knowledge transfer. *Knowledge Management Research and Practice*. Advance online publication. doi: xx.xxxxxxxx

If you are citing supplementary material which is only available online, include a description of the contents in brackets following the title.

[Audio podcast]

One author

Green, T.J. (2002). Friendship quality and social development. *Current Directions in Psychological Science*, 11, 7–10.

Multiple authors

Wegener, D.T., & Petty, R.E. (1994). Mood management across affective states: The hedonic contingency hypothesis. *Journal of Personality & Social Psychology*, 66, 1034–1048. doi: xx.xxxxxxxx

Kernis, M.H., Cornell, D.P., Sun, C.R., Berry, A., & Harlow, T. (1993). There’s more to self-esteem than whether it is high or low: The importance of stability of self-esteem. *Journal of Personality and Social Psychology*, 65, 1190–1204. doi: xx.xxxxxxxx

If there are more than seven authors, list the first six with an ellipsis before the last.

Harris, M., Graham, B., Karper, E., Stacks, G., Hoffman, D., DeNiro, R., ... Cruz, P. (2001). Writing labs and the Hollywood connection. *Journal of Film and Writing*, 44, 213–245. doi: xx.xxxxxxxx

If there are seven authors, all of them can be listed.

Two or more works by the same author

Use the author’s name for all entries and list the entries by the year (earliest first).

Green, T.J. (1981).

Green, T.J. (1999).

When an author appears both as a sole author and, in another citation, as the first author of a group, list the one-author entries first.

Green, T.J. (1999). Friends’ influence on students’ adjustment to school. *Educational Psychologist*, 34, 15–28. doi: xx.xxxxxxxx

Green, T.J., & Keefe, K. (1995). Friends’ influence on adolescents’ adjustment to school. *Child Development*, 66, 1312–1329. doi: xx.xxxxxxxx

References that have the same first author and different second and/or third authors are arranged alphabetically by the last name of the second author, or the last name of the third if the first and second authors are the same.

Wegener, D.T., Kerr, N.L., Fleming, M.A., & Petty, R.E. (2000). Flexible corrections of juror judgments: Implications for jury instructions. *Psychology, Public Policy, & Law*, 6, 629–654. doi: xx.xxxxxxxx

Wegener, D.T., Petty, R.E., & Klein, D.J. (1994). Effects of mood on high elaboration attitude change: The mediating role of likelihood judgments. *European Journal of Social Psychology*, 24, 25–43. doi: xx.xxxxxxxx

Two or more works by the same author in the same year

If you are using more than one reference by the same author (or the same group of authors listed in the same order) published in the same year, organize them in the reference list alphabetically by the title of the article or chapter. Then assign letter suffixes to the year. Refer to these sources in your text as they appear in your reference list, e.g.: ‘Green (1981a) makes similar claims...’

Green, T.J. (1981a). Age changes and changes over time in prosocial intentions and behavior between friends. *Developmental Psychology*, 17, 408–416. doi: xx.xxxxxxxx
Green, T.J. (1981b). Effects of friendship on prosocial intentions and behavior. *Child Development*, 52, 636–643. doi: xx.xxxxxxxx

Editorial without signature

Editorial: Title of editorial: Subtitle. [Editorial]. (2009). *Journal Title*, 13, 1–2. doi: xx.xxxxxxxx

Special issue or section

Barlow, D.H. (Ed.). (1991). Diagnoses, dimensions, and *DSM-IV* [Special issue]. *Journal of Abnormal Psychology*, 100(3). doi: xx.xxxxxxxx

Barlow, D.H. (Ed.). (1991). Diagnoses, dimensions, and *DSM-IV* [Special section]. *Journal of Abnormal Psychology*, 100, 300–453. doi: xx.xxxxxxxx

To cite an entire issue, give the editors of the issue and the title of the issue.

Monograph as part of a journal issue

Barlow, D.H. (Ed.). (1991). Diagnoses, dimensions, and *DSM-IV* [Monograph]. *Journal of Abnormal Psychology*, 100, 25–89. doi:xx.xxxxxxxx

Supplement

Regier, A.A. (1990). The epidemiology of anxiety disorders. *Journal of Psychiatric Research*, 24(Suppl. 2), 3–14. doi: xx.xxxxxxxx

Translated title

Ising, M. (2000). Intensitätsabhängigkeit evozierter Potenzial in EEG: Sind impulsive Personen Augmenter oder Reducer? [Intensity dependence in event-related EEG potentials: Are impulsive individuals augmenters or reducers?]. *Zeitschrift für Differentielle und Diagnostische Psychologie*, 21, 208–217. doi: xx.xxxxxxxx

If the original version is used as the source, cite the original version. Use diacritical marks and capital letters for the original language if needed. If the English translation is used as the source, cite the English translation.

Journal article with DOI, advance online publication

VandenBos, G., Knapp, S., & Doe, J. (2001). Role of reference elements in the selection of resources by psychology undergraduates. *Journal of Bibliographic Research*. Advance online publication. doi:xx.xxxxxxxx

Advance online publication refers to a version which is not the Version of Record. It may be a proof or the author's original version, so it has normally been peer reviewed but not necessarily copy-edited or formatted correctly.

In-press article posted in a preprint archive

Author, B.K. (in press). Title of article. *Title of Journal*. Retrieved from <http://cogprints.org/xxxx/xxx.pdf>

15. Legal materials

Case

Name v. Name, Volume Source Page (Court Date).
Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972).

Statute

Name of Act, Volume Source § section number (year).
Mental Health Systems Act, 41 U.S.C. § 9403 (1988).

Testimony at federal hearing

Title, xxx Cong. (date).

Federal regulation

Title/Number, Volume Source § xxx (year).

Patent

Smith, I.M. (2009). *U.S. Patent No. 12345*. Washington, DC: U.S. Patent and Trademark Office.

16. Newspaper, magazine, or newsletter article.

Henry, W.A., III. (1990, April 9). Making the grade in today's schools. *Time*, 135, 28–31.
Schultz, S. (2005, December 28). Calls made to strengthen state energy policies. *The Country Today*, pp. 1A, 2A.

Give the month for monthly publications and the day for weeklies. Unlike other periodicals, p. or pp. precedes page numbers for a newspaper reference.

Online newspaper article

Schultz, S. (2005, December 28). Calls made to strengthen state energy policies. *The Country Today*. Retrieved from <http://xxx.xxx.com>

Give the URL of the home page when the online version is available by search.

Online magazine or newsletter article

Author, K.M. (2009, August). Title of article: Subtitle. *Title of Magazine*, 22. Retrieved from <http://xxx.xxx.com>

No author

Title of newsletter. (2009, January). *Title of Newsletter*. Retrieved from <http://xxx.xxx.org>
New drug appears to cut risk of death from heart failure. (1993, July 15). *The Washington Post*, p. A12. Retrieved from <http://xxx.xxx.com>

In text, use a short title:

('New drug', 1993)

Letter to the Editor

Moller, G. (2002, August). Ripples versus rumbles [Letter to the editor]. *Scientific American*, 287(2), 12.

17. Personal communication.

No personal communication (email, interview, letter, etc.) should be included in the reference list. In the text, cite the communicator's name, the fact that it was personal communication, and the date of the communication.

(E. Robbins, personal communication, January 4, 2001).

18. Reference work.

Sadie, S. (Ed.). (1980). *The new Grove dictionary of music and musicians* (6th ed., Vols. 1–20). London: Macmillan.

Bergmann, P.G. (1993). Relativity. In *The new encyclopaedia Britannica* (Vol. 26, pp. 501–508). Chicago, IL: Encyclopaedia Britannica.

Bergmann, P.G. (1993). Relativity. In *The new encyclopaedia Britannica* (Vol. 26, pp. 501–508). Retrieved from <http://www.xxxxx>

Title of entry. (2009). In A. Editor (Ed.), *Title of reference work* (xx ed., Vol. xx, pp. xx–xx). Location: Publisher.

Word. (n.d.). In *Online dictionary* (11th ed.). Retrieved from <http://www.xxxxx/word>

19. Report.

Technical report

Author, A. (1988). *Title of work* (Report No. xxx). Location: Publisher.

Mazzeo, J. (1991) *Comparability of computer and paper-and-pencil scores* (College Board Rep. No. 91). Princeton, NJ: Educational Testing Service.

Report from a private organization

American Psychiatric Association. (2000). *Practice guidelines for the treatment of patients with eating disorders* (2nd ed.). Washington, DC: Author.

Report from non-governmental organization

Author, A. (2009). *Title of report* (Research Report No. xx). Retrieved from NGO website: <http://www.ngo.xxxxxx.pdf>

Government report

National Institute of Mental Health. (1990). *Clinical training in serious mental illnesses* (DHHS Publication No. ADM 90-1679). Washington, DC: US Government Printing Office.

National Institute of Mental Health. (1990). *Clinical training in serious mental illnesses* (DHHS Publication No. ADM 90-1679). Retrieved from <http://www.xxxxxx.pdf>

University report

Shuker, R., Openshaw, R., & Soler, J. (Eds.). (1990). *Youth, media, and moral panic* (Delta Research Monograph No. 11). Palmerston North, New Zealand: Massey University, Department of Education.

Report from institutional archive

Shuker, R., Openshaw, R., & Soler, J. (Eds.). (1990). *Youth, media, and moral panic* (Delta Research Monograph No. 11). Retrieved from Massey University, Department of Education website: <http://www.university/reports/xxxxxx.pdf>

Issue brief or working paper

Name of Institute. (2009, March). *Title of document* (Issue Brief No. xx). Location: Publisher.

20. Review.

Baumeister, R.F. (1993). Exposing the self-knowledge myth [Review of the book *The selfknower: A hero under control* by A.A. Author]. *Contemporary Psychology*, 38, 466–467.

doi:xxxxxxx

Kraus, S.J. (1992). Visions of psychology: A videotext of classic studies [Review of the motion picture *Discovering Psychology*]. *Contemporary Psychology*, 37, 1146–1147. doi:xxxxxxx

Peer commentary on an article

Author, S.K. (2009). Title of commentary. [Peer commentary on the paper 'Title of original paper' by A. Author]. Retrieved from <http://www.xxxxxxxxxx>

21. Software, data set, measurement instrument, apparatus.

Provide reference entries for specialized software or computer programs with limited distribution.

Rightsholder, A.A. (Year). Title of program (Version number) [Description of form]. Location: Name of producer.

Rightsholder, A.A. (Year). Title of program (Version number) [Description of form]. Retrieved from <http://xxxxxxx>

Miller, M.E. (1993). The Interactive Tester (Version 4.0) [Computer software]. Westminster, CA: Psytek Services.

Name of software (Version Number) [Computer software]. Location: Publisher.

Data set

Author, A. (2009). *Title of data set* [Description]. Retrieved from <http://xxxxxxxxxxx>

Measurement instrument

Author, A. (2009). Title [Description]. Unpublished instrument. Retrieved from <http://xxxxxxxxx>

Apparatus

Name [Apparatus]. (2009). Location: Publisher.

22. TV or radio.

Broadcast

Crystal, L. (Executive Producer). (1993, October 11). *The MacNeil/Lehrer news hour* [Television broadcast]. Washington, DC: Public Broadcasting Service.

Episode

Smith, A. (Writer), & Miller, R. (Director). (1989). Title of episode [Television series episode]. In A. Green (Executive Producer), *Series*. New York, NY: WNET.

Series

Miller, R. (Producer). (1989). *The mind* [Television series]. New York, NY: WNET.

23. Unpublished work.

This includes work that is available on a personal or institutional website, electronic archive or preprint archive.

Zuckerman, M., & Kieffer, S.C. (2009). *Race differences in face-ism: Does facial prominence imply dominance?* Unpublished manuscript / Manuscript submitted for publication / Manuscript in preparation.

If the work is available on an electronic archive, provide the information at the end.

Unpublished manuscript with university cited

Zuckerman, M., & Kieffer, S.C. (2009). *Race differences in face-ism: Does facial prominence imply dominance?* Unpublished manuscript, Department of Psychology, University of Oxford.

Manuscript in progress or submitted

Zuckerman, M., & Kieffer, S.C. (2009). *Race differences in face-ism: Does facial prominence imply dominance?* Manuscript submitted for publication.

Do not give the name of the journal or the publisher.

Accepted manuscript

Treat as an in-press reference.

Draft manuscript

Zuckerman, M., & Kieffer, S.C. (2009). *Race differences in face-ism: Does facial prominence imply dominance?* Manuscript in preparation.

In the text, give the year of the draft.

Unpublished raw data from study, untitled work

Zuckerman, M., & Kieffer, S.C. (2009). [Race differences in face-ism: Does facial prominence imply dominance?] Unpublished raw data.

Informally published or self-archived work

Zuckerman, M., & Kieffer, S.C. (2009). *Race differences in face-ism*. Retrieved from <http://xxxxxxx/archive/000003456/>

Informally published or self-archived work, from ERIC

Zuckerman, M., & Kieffer, S.C. (2009). *Race differences in face-ism*. Retrieved from ERIC database. (ED12345)

Book in press

Auerbach, J.S. (in press). The origins of narcissism. In J.M. Masling & R.F. Bornstein (Eds.), *Empirical studies of psychoanalytic theories: Vol. 4. Psychoanalytic perspectives on psychopathology*. Washington, DC: American Psychological Association.

In text, use (Auerbach, in press).

Unpublished raw data

Bordi, F. (1992). [Auditory response latencies in rat auditory cortex]. Unpublished raw data.

STUDY INTERVIEW GUIDE

Women's views on and experiences of condom use: An exploration of how this impacts on sexual satisfaction.

Visit Date: _____ Site: _____

Interviewer Initials _____ Interview Language: _____

Participant ID: _____

DEMOGRAPHIC INFORMATION:

Firstly I would like to ask you background questions about yourself.

1. Race (*do not ask, record by observation*)
 - a. African
 - b. Indian
 - c. Coloured
 - d. White
 - e. Other (specify)
2. How old are you? (*In years*)
3. What is the highest grade you completed at school?
 - Below grade 7
 - Grade 7
 - Grade 8
 - Grade 9
 - Grade 10
 - Grade 11
 - Grade 12
 - Above grade 12
4. What is your employment status?
 - a. Employed

- b. Unemployed
- c. Working for self
- d. Seeking work
- e. On grant

5. Are you in an intimate relationship?

- Yes, I am in a relationship of more than 24 months
- Yes, I am in a relationship of less than 24 months and more than 12 months
- Yes, I am in a relationship of less than 12 months and more than 6 months
 - Yes, I am in a relationship of less than 6 months
 - No, I am not in a relationship

6. If yes, how would you describe your main intimate relationship?

- a. Husband
- b. Living together stable partnership
- c. Boyfriend
- d. Casual relationship

7. Do you have any other intimate relationships besides the one you have mentioned?
(Yes/No)

8. If yes, how many other intimate relationships do you have?

SEXUAL PARTNERS:

1. Please tell me what do you understand by “sexual partner”?
2. What do you understand about “steady” sexual partner?
3. If you have more than one sexual partner, can you tell me more about the factors that lead you to having other sexual partners besides your steady sexual partner?
4. Can you explain the role your steady sexual partner plays in your life?
5. If you have more than one sexual partner can you please tell me about the role/s they play in your life?

6. Can you please tell me more about the kind of sexual relationship you have with your steady sexual partner? (NB: **PROMPT**, is it a caring and loving relationship, is it equal in terms of making sexual decisions? Etc.)
7. Please explain in what way your sexual relationship with your other sexual partner/s is/are different from the kind of sexual relationship you have with you steady sexual partner? (NB: **PROMPT**, is/are they different in terms of a caring and loving relationship; in terms of equality in making sexual decisions? Etc.)

SEXUAL SATISFACTION:

8. Please tell me what you understand by “sexual satisfaction”/being satisfied sexually.
9. Have you ever felt sexually satisfied in a relationship and if so with whom and when?
10. Can you tell me about whether your steady sexual partner may enable you to feel sexual satisfaction and if so more about the ways in which he does so?
11. Can you tell me about whether your other sexual partner/s may enable you to feel sexual satisfaction and if so more about the ways in which he/they do so?
12. Can you talk to me about any sexual things that your steady sexual partner does, which may make you feel dissatisfied during sexual intercourse?
13. If there are any sexual things, which cause sexual dissatisfaction to you, can you explain how you would prefer your steady sexual partner to do them differently?
14. Now can you talk to me about any sexual things that your other sexual partner/s does/do, which may make you feel dissatisfied during sexual intercourse?
15. If there are any sexual things, which cause sexual dissatisfaction to you, can you explain how you would prefer your sexual partner/s to do them differently?
16. Please tell me what you understand by the word orgasm/coming/climaxing.
17. Can you talk about whether you feel it is important or not to reach orgasm during sexual intercourse and the reasons?
18. Can you also talk about how your partner feels about you coming or doesn't it matter to him?
19. If you have experienced organism, can you tell me your experience of this.

20. If you haven't reached orgasm, can you tell me if there are things that prevent you from reaching orgasm or not – whether it doesn't matter to you. Are there any things that your steady partner or other sexual partner/s do/does which make it difficult for you to reach orgasm? (NB: DEAL WITH EACH SEPARATELY)
21. Please talk to me about whether you have had any difficulties that you might be experiencing during sex?

CONDOM USE:

22. Can you explain to me what kind of sexual protection, if any, you used during your last sexual intercourse?
23. Can you discuss how you feel about the importance of using condoms or not.
24. If no protection was used, can you talk about the reason/s either that it may have been difficult to use protection or why you felt no need for it?
25. Can you please tell me more about the reasons why you think people use condoms?
26. If you have used condoms can you tell me in what kind of instances/situations and with whom do you use condoms?
27. If you haven't used condoms, can you tell me in what kind of instances/situations and with whom you wouldn't use condoms?
28. If you have used condoms in your steady relationship, how and by whom in the sexual partnership was the decision of condom use taken?
29. If you have used condoms in your other relationship/s, how and by whom in the sexual partnership was the decision of condom use taken?

SEXUAL SATISFACTION AND CONDOM USE:

30. If you have used condoms, can you please tell me about your experiences when using condoms during sexual intercourse? (NB: PROMPT: Was it easy to use?, were you comfortable with it?, Did you feel good about using it?)
31. Can you please discuss with me whether you feel there is any difference in sexual satisfaction when you use a condom and when you are not using a condom during sexual intercourse? (*Probe as to what exactly causes satisfaction or dissatisfaction*)

when she uses condoms, i.e. is it how it feels inside the vagina, is it putting it on lubrication, etc.)

32. . If you would be given a choice between using condoms during sex and NOT using condoms during sex, what would you prefer? And can you talk about your reasons
33. What advice, if any, would you give to others about the pleasure or lack of pleasure when using condoms and about dealing with this?

THANK YOU FOR THE INTERVIEW. I VERY MUCH APPRECIATE YOU GIVING UP THE TIME TO HAVE THIS DISCUSSION WITH ME.

University of Cape Town

Women's views on and experiences of condom use: An exploration of how this impacts on women's sexual satisfaction and male condom use among women

Patient Information and Informed Consent Form

Why are we doing this study?

The UCT School of Public Health and Family Medicine and the Desmond Tutu HIV Centre are doing a study to learn more about condom use and sexuality. This is with the intention of assisting in the design of programmes that better take into account women's likes and dislikes in practising safer sex.

Who can take part in the study?

This study will include 25 women (between 18 and 40 years old) who live in Masiphumelele, and who understand the study and give their consent to participate, through signing a consent form.

What will women who take part need to do on the study?

Women who take part in the study will do an interview with the study staff. The interview will take approximately 45min – 1 hour and will be tape-recorded.

What types of questions will the women be asked?

The questions we will ask will be about how they feel about the quality of their sex lives; and what kind of sexual practices they engage in; if and how often the women use condoms; whether they get to decide themselves on whether or not to use condoms; what things make women keen to use or not use a condom.

What about confidentiality?

Everything that women tell us during the study will be CONFIDENTIAL. In other words, we will not tell anyone else any of their personal details that they have told the research team.

The interview transcripts will not have the woman's name on it. Instead it will have the woman's initials and a secret research identity number, so that no woman can be identified individually.

While we undertake to keep the individual information you give us confidential, there are certain situations in which we have an ethical duty to pass on information to appropriate other people. This includes, if you tell us that you plan in any way to physically or sexually harm an identifiable person including a partner. The researchers will need to take steps to ensure that person is protected. Also, if you state that you believe an identifiable person is going to physically or sexually harm you, steps will need to be taken to ensure your protection. If you reveal to us suicidal feelings or homicidal feelings or that a child or elderly person is the victim of abuse, actions may be taken to protect others and you. If this any of these situations occur, I will let you know that I need to report this further.

What are the possible risks of this study?

The risks of taking part in the study are small, if any. Some questions can make you uncomfortable or shy. If this is the case, you can refuse to answer any of the questions. You are also able leave the interview at any time without any impact or future possible impact on your care at the clinic.

What are the benefits of the study?

There is no direct benefit to you for taking part in this study. But we honestly believe that by taking part in this study, the information gathered from you will assist in developing effective strategies and campaigns to safer sex so as to combat the HIV/AIDS epidemic in South Africa.

Cost and Compensation

There will be no cost to you for taking part in this research. Participants will be compensated with an amount of R50, 00 for transport expenses and time spent at the study site doing the interviews.

Voluntary participation

Your participation in the study is voluntary. It is optional to be part of this study, and your decision will in no way affect any current or future treatment you may require at the clinic.

Women can decide at any point to withdraw from the study after agreeing to take part.

Who do I call if I have questions?

If you have any questions about the study, you can call Vuyelwa Mehlomakulu on telephone number 021 466 7916. If you have a question about rights as a research volunteer you should contact Professor Marc Blockman, Telephone: 021-406 6496. He is the head of the University of Cape Town Research Ethics Committee that has approved this study.

University of Cape Town

Participant Consent

The researcher at this centre from the University of Cape Town has explained to me that there is a research study on male condom use in my community. They are wanting to know how women in my community feel about the quality of their sex lives; if and how often women in my community use condoms, whether women in my community get to decide themselves whether they use condoms or not, and why women do or do not use condoms. This is with the intention of assisting in the design of programmes that better take into account women's likes and dislikes in practising safer sex.

I understand that I am being asked to participate in an interview with a study staff member, which will take about 45 minutes to an hour. I have been told that the interview will be audio taped for the purposes of quality control and transcription.

I understand that certain information will be gathered by the research team. My personal details (including my age, sex, employment and financial standing, as well as information of my condom use and sex life) will be collected as background information and other information in order to increase the understanding of condom use. All this information will be kept CONFIDENTIAL and will not have my name attached. I will not be able to be identified individually in this study.

I understand that I may decide whether or not to take part in this programme and my decision will not in any way affect my treatment and care at the centre. If I change my mind at any time I may withdraw from this programme and this will also not affect my treatment.

I understand the risks and benefits of joining this program, and hereby give my consent to be a part of the study.

Participant name: Date

Participant signature:

Researcher name Date

Researcher signature

For those who are unwilling or unable to sign ONLY:

I have witnessed the discussion of consent and am satisfied that the participant understands the nature of the study:

Witness name: Date

Witness signature:

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