Traditional Practices and Uptake of Female Condoms in Zimbabwe

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Abstract

This paper examines the imbalances between the consumption of male and female condoms in Zimbabwe. Though HIV prevalence rates are reported to be declining in Zimbabwe, it is the position of this paper that women's prevention methods are being compromised by traditional beliefs and practices. Patriarchy and male domination in decision making negatively impacts the women's capacity to make sexual and reproductive decisions. The female condom, a barrier device intended to protect women from contracting sexually transmitted infections lags behind the male condom in terms of uptake. Subordination of women, definition of womanhood and control issues in sexual matters are some of the factors compromising acceptance of women centered HIV prevention devices. Sex is controlled by men and women are stripped of their capacity to make sexual decisions. Results of this study can be used in reproductive and HIV and AIDS programming in Zimbabwe. They can also help women's organizations to strengthen their efforts in fighting cultural barriers to women empowerment.

Keywords: HIV and AIDS, women, tradition, culture, female condom, Zimbabwe.

INTRODUCTION

This paper is informed by the radical feminist theory which believes that women’s oppression is caused by patriarchy, which is a system of male authority that is especially exhibited in sexuality, personal relationships, and the family and as well tumbles into the rest of the male-dominated world. It is the position of this paper that consumption of the female condom in Zimbabwe is negatively affected by patriarchy, this is so because the word condom has become synonymous with the male condom. The female condom was introduced in Zimbabwe in July 1997 as a family planning device under the brand name Care1. This was after a non-governmental organisation Women and AIDS Support Network (WASN) had mobilised 30 000 women to petition the government to introduce the female condom (The Herald, 24 August 2011). The female condom, however, remains unpopular despite being in the market for more than a decade apart from its distinguished advantages (Newsday 26 June 2011, Newsday 13 May 2011). This paper seeks to highlight the imbalances in the consumption of female condoms in Zimbabwe due to traditional barriers. The paper ends by giving possible remedies to fight the assumed barriers. A snapshot of Fig. 1 below shows that the female condom is way below the male condom in terms of consumption.

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1 Brand name for the female condom distributed by Population Service International.
The female condom is a polyurethane sheath with a flexible inner ring which secures the condom against the cervix and an outer ring which prevents the condom from entering the vaginal carnal. It can be inserted up to eight hours before intercourse. Studies have established that the female condom is impermeable to the HIV virus (Beksińska et al., 2011). It provides more protection from sexually transmitted diseases since it covers both the internal and external genitalia and it has less risk of rupture than the male condom. It also protects from infections from pre-ejaculation fluids. The female condom has a multiple function of prevention of HIV, STIs and unwanted pregnancy. Perfect use of the female condom reduces chances of being infected with HIV by 90 percent among women who have intercourse twice every week with infected men (UNIFEM, 2011).

Zimbabwe was the first country in Africa to advocate and successfully bring female condom supplies to the people. The female condom was introduced through social marketing and public sector distribution. Upon its preliminary introduction, there was a peak in demand, which dropped hastily but steadily improved over the years. Zimbabwe is regularly cited as a female condom success story and has the highest distribution and sales in the world (Herald, 24 August 2011). Currently Population Service International (PSI) markets more than 45 million male condoms and just over one million female condoms (PSI, 2011). PSI markets the Care female condom whilst a government parastatal, Zimbabwe National Family Planning Council (ZNFPC) also markets the female condom under the brand name FC22. The female condom is the only available technology for HIV in Zimbabwe that women can initiate and control (Herald, 24 August 2011).

Though Zimbabwe is cited as a success story in female condom programming, the statistics available seem to be fragmented and based on distribution rather than actual consumption. Awareness of the female condom is very low especially in rural areas. Some women report that it is painful on insertion, too noisy and too big. The perception that the female condom is too big is sometimes due to the fact that some people have poor understanding of female anatomy (Chizoro and Natshalaya, 2011). It is slightly larger than the male condom so that it covers a woman’s vagina more comfortably. Though the female condom is meant to give women power over their sexual rights, for the majority of women in third world countries, reproductive decisions are made by their male partners. This is mainly due to traditional power imbalances between men and women as shall be alluded in this paper.

### Traditional Barriers to Uptake of Female Condoms in Zimbabwe

Women vulnerability to HIV infection is increased by cultural and behavioral factors such as gender stereotypes which reduce the leverage women have in negotiating protection with their sexual partners (Jackson, 2002). In the Shona culture a woman is not expected to initiate intimate relationships or readily accept any request for sex by a man. The culturally accepted behaviour in an intimate sexual relationship is that a woman is supposed to show some degree of resistance otherwise she is labeled a whore or a loose woman (Jackson, 2002). Thus in most situations, the foundation of intimate relationships among women and men are in principle perennially the cause of subjugation of women and the basis of their vulnerability. Sometimes young Shona women are taught by their aunts and of late parents or religious leaders to be passive sexual partners and this affects their ability to assert themselves.

Men have control over their spouses’ sexual and reproductive decisions. The definition of a good wife then is underpinned by virtues of submissiveness with men taking the most active role. Patriarchal society philosophy that condones wayward behaviour as part of what defines the Shona men puts some women to a disadvantage. Married women may be unable to refuse unprotected sex with husbands because culturally protected sex is looked down upon and is not acceptable among most couples in Zimbabwe (Herald, 16 June 2011). Traditionally, men have control over their wives and women have no right to resist or refuse sexual advances from their husbands. This complicates the women’s capacity to negotiate for the female condom use. Married women whose behaviors violate this cardinal law of a good wife are often subjected to varying forms of reprimands or worse still violence in the home. Men who are accustomed to this false resistance hypothesis usually impose sexual desires on their wives and the women have no right to assert their needs in the sexual encounters that occur even if they have justifiable suspicion that they may be at risk of getting infected with HIV. Culture expects a woman to say no to sex when she means yes (Motsi and Mabvurira, 2011). Sex is usually coerced. It is almost impossible for women to negotiate condom use where sex is coerced.

Given this set up which is deeply entrenched in men’s minds from the time they are adolescents engaged in dating and courtship until they marry, men are imbued with values that later on in life shape their relationships with women both inside and outside marriage which put women in danger in the era of HIV and AIDS. Married women are in this regard not only vulnerable to the sexual whims of their husbands but may also suffer the same fate from their male employers and bosses. This perception is a

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2 Brand name for the female condom distributed by Zimbabwe National Family Planning Council
very enduring mode of thought which has persisted and has been entrenched by the various administrative regimes since colonialism.

Marriage in most Zimbabwean ethnic groups is basically a contract between two families involving the elders of each family. A bride price or lobola is paid to the bride’s family by the groom’s family, in some cases the dissolution of the marriage follows the same pattern, upon death of one party, the surviving spouse can be inherited by a family member with the sanction of the respective families (Tichangwa, 1998). In the Zimbabwean society, payment of bride price gives the marriage validity and strength; it provides the woman with dignity and worth. Commercialized bride prices have given the wrong signal in some cases that women are just like any other piece of property to men (Armstrong, 1998). This practice can have negative implications on women married customarily in light of the current HIV and AIDS epidemic facing Zimbabwean society today. If a woman is seen as any other piece of property owned by a husband, then she has no right to make any decisions including the decision to or not to use the female condom. Customary law marriages are clear on multiple marriages, they allow up to four wives per man but not vice versa. But even in these customary law marriages some men continue to be promiscuous. This is maybe because in most setups, marriages give the husband exclusive sexual rights over the wife and her reproductive capacities. This right continues as long as this woman is married to the man, and even after death in a Zimbabwean Shona setting. The extended family may continue to control the widow’s sexuality long after the demise of the legal husband through proxies from the partrilinity.

Another Shona cultural element to married women’s sexuality is control. Culturally men should have total control over women’s spheres of life. Boys and men are socialized to think that sex is their right and they are entitled to it whenever they want it, masculinity is culturally constructed (Bourdillon, 1987). Most relationships have men taking the lead in the when and how aspects of sex. It is difficult for women to initiate sex or discussion of sexually related topics. The woman, in her role as wife is not allowed to challenge the husband on any issues. Sexual matters occupy the highest position in the hierarchy of issues that women should not assert their will. Women in most cases are not supposed to ask questions on where men sometimes spend time or at times sleep. The normal scheme of relations is that men should ask questions and women should account for their time to the satisfaction of their husbands. Women who insist on accountability from their husbands may face various forms of sanctions including but not limited to physical assault and or battering and this compromises their ability to negotiate condom use.

Dry sex is a significant sexual practice in Zimbabwe. It is believed that a dry vagina indicates that no man has been there recently (Van de Wijgert, 2001). In turn, in a bid to sexually please their husbands, some women use herbs to dry their vaginas. Women in Zimbabwe and elsewhere have been found to use a variety of drying agents to achieve these effects (Motsi and Mabvurira, 2011). Drying agents have physical and psychological consequences. That is, agents are said to dry and tighten a woman’s vagina, and also to serve as ‘love potions’. Friction which results from dry sex can promote the chances of women acquiring HIV and complicates condom use as it can easily break (Civic and Wilson, 2009). It seems that some men are beginning to admit that they do not like it, but the symbolic value of a dry vagina exists (Motsi and Mabvurira, 2011). Another way a woman can demonstrate her fidelity is by having a dry vagina. The female condom is lubricated and is thus incompatible with dry sex.

All this boils down to the fact that women are supposed to tolerate any sexual behavior by men irrespective of the consequences. Refusing or talking against the husband’s views or position on sex is not tolerated in traditional Zimbabwean Shona culture, worse still if someone were to do it in public or in the presence of other people. Hence most Zimbabwean men are supposed to behave like a loud speaker to women and whatever they say on issues of sexuality is to be respected. In other words the man determines and dictates the terms of conjugal agreements and relatives enforce the contract. If a woman refuses the husband or men’s terms the matter can be referred to elders, on the women’s and/or on the husbands’ side, and the woman is often ostracized for denying her conjugal obligations. Consent is nonexistent on the part of the woman but mandatory on the husband’s side. The only thing that can allow abstinence on the part of the woman is probably the menstrual cycle, childbirth or illness, otherwise the game must go on the husband’s terms and conditions, and anything to the contrary results in some form of punishment. Wearing a female condom in advance can easily be misinterpreted negatively as a woman stepping outside of her gender roles.

Among the Shona people of Zimbabwe, girls are taught from a very early age to be submissive and obedient to males. It is un-African for a woman to refuse her husband sex even if there is danger of infection. Safer sex negotiation is almost non-negotiable in most marital relations since this can be considered by the husbands as being accusatory. Most men refuse condom use when having sexual intercourse with their wives arguing that the payment of lobola gives them unlimited access to their...
conjugal rights (Motsi and Mabvurira, 2011). Some HIV positive men demand unprotected sex from their wives on the grounds that they want to leave their wives pregnant before they die (Motsi and Mabvurira, 2011). The number of children can be used to determine a man’s virility among the Shona of Zimbabwe. As a result, some men demand more children regardless of their wives or their own HIV positive status. In focus group discussions conducted by Zimbabwe Women’s Resource Centre Network (ZWRCN) with women in Zimbabwe, some women reported that both the male and the female condoms are associated with prostitution and extramarital sex and as a result they were not willing to accept it. Gender dynamics, cultural practices and self esteem can affect the negotiation power between men and women. Traditional practices in most societies disadvantage women. Culturally, men think sex acts are not complete unless fluid is deposited into a woman, thus some men tear their condoms or force women to pull out the female condom so that they ejaculate into the vagina.

Intimate partner violence is frequently associated with increased HIV risk in women, often because men who abuse their wives also exhibit riskier sexual behaviors (Motsi and Mabvurira, 2011). These findings confirm prior clinical studies that indicate that intimate partner violence is a correlate of HIV and STIs (Silverman et al, 2008). UNAIDS identifies pervasive gender inequalities, including imbalances in social, economic, and sexual power, as increasing a woman’s risk of contracting HIV or another STI as she may have reduced ability to negotiate when; with whom, and under what conditions she will have sex (Dude, 2009). One particular source of gender-based power differentials is the physical, emotional, and sexual violence men perpetrate against women. These violent behaviors can include rape, sexual assault, and coercing a woman into unwanted sexual acts; physically abusive acts such as hitting, kicking, slapping, or threatening a woman with a knife or other weapon; or emotionally demeaning and coercive acts such as verbal abuse, threats of harm to the woman or to others close to her, or arbitrary deprivation of food, liberty, or other necessities, among other acts (United Nations, 2004). In most cases, the husband’s family condones the behavior and often turns a blind eye to the plight of the battered woman. Women in abusive relationships are at higher risk of infection regardless of their own sexual behaviors and they are stripped of their capacity to negotiate for protected sex (Dunkle et al, 2006). The nature of partner abuse itself can increase viral transmissibility, as forced sexual activity, including sexual assault within marriage, is traumatic to the vaginal canal, leaving microscopic tears that allow the virus to invade the vaginal epithelium (Van Der Straten, 1998). The threat of violence also often impedes open communication regarding disease risk and condom use (Dude, 2009). Women avoid HIV testing or disclosing their sero-status to their partners because of fear of violence or economic abandonment, especially as women are often punished when other family members are subsequently found to be HIV positive. Abused women have shown a decreased ability to negotiate condom use with abusive partners (Santelli, 1996).

Considering the body of literature on the links between intimate partner violence, sexual risk-taking, HIV, and other STIs, there is a gap in terms of large-scale, population-based studies conducted in sub-Saharan Africa, particularly outside of South Africa. Younger wives facing abuse could be less prone to asking their husbands about their other previous or current sexual partners and HIV status, leaving them more vulnerable to infection. The reality of intimate partner violence might also hamper future HIV/STI prevention efforts (Dude, 2009). Condom use among abused married women is quite rare (Allen et al, 2007). Encouraging condom use among women facing abuse, however, might prove more difficult (Dude, 2009). Avoiding sex with an infected partner might be difficult for women in abusive marriages, as women are often forced to have sex even if they know their husbands’ HIV status (Lary et al, 2004).

The economic subjugation of women has also contributed to promiscuity and in times of hardships such as droughts, some married women can embark on sex for work or food if their husbands do not provide enough for the family. Economic dependence of women on their male partners gives them less power to negotiate safer sex. Traditional patriarchal values reinterpreted in European law resulted in further subjugation of women as even limited rights to ownership were withdrawn. For many women, sexual relations with men, either within marriage (for the majority) or outside, become inextricably linked to economic and social survival. In this setting, all sexually transmitted diseases become rampant, including genital ulcer, which facilitates transmission of the human immunodeficiency virus (Mhlonyi and Bassett, 1991). In Zimbabwe, patriarchy and colonialism appear to be the most significant social legacies responsible for the family structure and sexual behavior associated with HIV infection.

Among the Shona people of Zimbabwe, a married man can play with her wife’s unmarried sister, fondling her and sometimes rape her under a practice called chiramu. This is an acceptable behavior and it is very difficult for the young lady to negotiate for condom use under such impromptu sexual encounters. Furthermore it has been noted that the first sexual experience for many girls happens with little or no knowledge of how to deal with relationships or protect themselves hence the use of the female condom is very rare. Virginity of girls is still valued among some ethnic groups like the Tonga...
in Zimbabwe. It is shown by the intactness of the hymen though this is not always the case. This complicates the ability of young girls to use the female condom since the use of such a device can be used as evidence that they are not virgins. In the Shona culture, a newly married man used to and sometimes pays a she piece of cattle called chimandaas appreciation of finding her wife virgin. Some young ladies have gone to the extent of having sex whilst on monthly period so that blood can act as evidence of the broken hymen. All these practices compromise the capacity of women to use the female condom. The most unfortunate part is that these cultural practices have been nurtured for a very long time that they are now the norm and talking against them is anomalous.

RECOMMENDATIONS AND CONCLUSIONS

Though Zimbabwe boasts of a success story in the implementation of the female condom, a number of questions remain unanswered and there is variance in statistics available. Some private reporters indicate that female condom uptake is poor while some organizations report the opposite. Most statistics in Zimbabwe are based on distribution rather than consumption collection from the delivery points. It is very misleading to conclude that there is an improvement in uptake of the female condom based on the increment in volumes distributed since distribution in new areas automatically increases national volumes. It is, therefore, safe for conclusions to be made after a national survey assessing the acceptance and actual use of the device by women. Such a survey must be led by one organization for example PSI or ZNFPC to avoid duplication of efforts and contradicting results. A national survey will bring near authentic results since Zimbabwe is not a homogeneous society with; educated and uneducated, rural and urban women as well as multiple religious and ethnic groups. Assertiveness training is very important to women of low economic status since this can help them to negotiate the female condom. Negotiation skills are very important if the female condom is to be successful.

Awareness of the device should include women in rural areas as well as very remote parts of the country. Such awareness campaigns should as well target rural leadership structures like chiefs, village heads and local political leaders since they are believed to have influence on their people. PSI has been advertising the Care contraceptive sheath using billboards, radio and television channels as well as posters and flyers. All these methods are problematic and leave out rural women given that there are no radio or television transmission waves in some rural areas of Zimbabwe and that most illiterate women are based in rural areas as well billboards are an urban thing in Zimbabwe. It will be wise to use National AIDS Council grass-root structures like the District AIDS Action Committee, Ward AIDS Action Committee and the Village AIDS Action Committee to reach rural women. PSI has been using saloons and barber shops to distribute the Care female condom. This is problematic since most of these are urban based. Another interesting thing is that these distributors were getting a commission, this means that they can be tempted to distort information so that they get more money.

Men need to be seriously targeted and men’s organizations like the Padare, Young Men Christian’s Association can be used to disseminate information on the female condom. Men should understand everything about the female condom especially how it works, how it is inserted and justification for its size. This can help in demystifying most grey areas surrounding the female condom and is also in tandem with expectation of patriarch that men are the head of the family. This way, they feel involved and are likely to accept use of the device. Continual empowerment of women in all spheres of life is of supreme importance. From this discourse it can, therefore, be seen that quite a number of cultural aspects are still impinging on the uptake of the female condom in Zimbabwe. Players in the promotion of the device should, therefore, carryout proper surveys and watch out for some cultural barriers especially in rural areas.

This discourse has shown that there are a number of cultural factors militating against the female condom in Zimbabwe. Efforts to promote women initiated methods in sexual issues should not therefore ignore cultural beliefs and practices. Uptake of the female condom can be increased if men are conscientised to accept it and own it together with their women counterparts.

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