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[Morbidity and Mortality Weekly Report] [loose]

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Abstracts of articles on HIV/AIDS to which we could refer during Oct. 2 training session.

Seibt, AC et al. "Condom Use and Sexual Identity Among Men Who Have Sex With Men--Dallas, 1991." MMWR. Morbidity and Mortality Weekly Report. 42(1). January 15, 1993. pg. 7, 13-14.

Between January and June 1991, staff at a Dallas County Health Department clinic in Texas, interviewed 540 men who had anal intercourse with other men and came to the clinic for anonymous HIV counseling and testing to learn the relationship between using safer sex practices and these men's sexual self-identity. 25 men considered themselves to be heterosexual. Men who reported to be homosexual or bisexual had a higher mean score of frequency of condom use than men who did not perceive themselves to be homosexual or bisexual (2.7 = most of the time vs. 0.9 = almost never; $p < .0001$). A significantly higher percentage of men who considered themselves to be heterosexuals never used condom than that of those who considered themselves to homosexual or bisexual (64% vs. 16%; $p < .001$). Men who studied HIV/AIDS information in newspapers, brochures, or leaflets had a higher score of frequency of condom use than did those who did not study these materials (2.8 vs 2.3; $p < .01$). Men who felt uncomfortable about telling their family about having had anal sex with men were less likely to use condoms consistently than men who felt comfortable ($p < .02$). Respondents who reported reading materials addressing homosexual issues had a higher score of frequency of condom use than those who did not such materials (2.8 vs. 2.1; $p < .001$). These results indicated that men who had anal sex with other men but did not perceive themselves to be homosexual or bisexual tended not to adopt risk reduction behaviors. Therefore, they were at greater risk for HIV infection and AIDS than those who were honest about their homosexuality or bisexuality.

Salem, A. "A Condom Sense Approach to AIDS Prevention: A Historical Perspective." South Dakota Journal of Medicine. 45(10). October 1992. pp. 294-296.

Condoms have been used for 1000s of years to prevent transmission of sexually transmitted diseases (STDs) and to prevent pregnancy. They have been made of various materials including oiled silk paper (in China) and muscle sheaths of enemies (in Rome). In the 1840s, vulcanization of rubber led to mass production of reliable and inexpensive condoms which made them available to the common folk. In 1873, the US Congress passed the Comstock bill outlawing any information on contraception including condoms. Rather than issue condoms to troops during World War I, the Army lost about 7 million days of active duty due to STDs. In the 1930s, condoms began to be made with latex and the Food and Drug Administration (FDA) released its first quality control standards for condoms. The Army distributed condoms during World War II despite objections by church groups. Oral contraceptives and changing mores in the 1960s hurt the condom market even though the STD incidence

increased. AIDS brought condoms back to the forefront during the 1980s. In 1987, FDA began to test latex condoms for leaks which resulted in improved quality condoms. Nevertheless, condom use does not equal protection from STDs, HIV, and pregnancy and largely depends on correct and consistent use. Some people are allergic to the latex, lubricants, and perfumes, however. A female condom is expected to reach the market soon. In many countries, groups are promoting condoms by using colorful and humorous marketing gimmicks. For example, an animated condom donning a soccer jersey entertained audiences at the world cup games. Sweden and Thailand use Proud Pete, a condom clad penis, to promote condom use. In the US, schools, AIDS activists, and clergy distribute condoms to prevent HIV transmission. Today there are at least 108 different condom brands in the US with catchy names such as Blacky, Skin Less Skin Crown, and Rough Rider.

Doppenberg, H. "Contraception and Sexually Transmitted Diseases: What Can Be Done? Experiences and Thoughts from the Netherlands." British Journal of Family Planning. 18(4). January 1993. pp. 123-125.

The Netherlands has the lowest adolescent pregnancy rate and abortion rate (5.3/1000 women vs. 7-111.9) in the world. Further, the percentage of people using condoms is increasing steadily (e.g., among sexually active teenagers, 20% in 1980 and 55% in 1989). Women's and teenage magazines in the Netherlands continually reinforce contraceptive knowledge so that contraception is now part of the Dutch culture. The culture has not yet assimilated knowledge of means to prevent STDs, however. Even though there is no legal obligation to report AIDS cases in the Netherlands, the numbers are quite reliable (386 in 1990). On the other hand, health professionals are required to report cases of gonorrhea and syphilis, but the numbers are 5 to 10 times lower than the assumed actual numbers. The number of AIDS cases is relatively low in the Netherlands and the likelihood of having sex with a partner who is not infected with HIV is greater than 99%. Still condom use is encouraged. In fact, the Netherlands has a double Dutch campaign which promotes use of both oral contraceptives and condoms to avoid pregnancy and STD and/or HIV infection. Yet, some Dutch people still assume that if they are using the condom they do not to use other contraception. Some Dutch physicians believe the lower than expected growth of people with HIV and AIDS cases is attributed to increased condom use and decreased numbers of multiple or serial sexual partners. The Netherlands encourages dissemination of information about contraceptives, sex, and STD prevention via the mass media; widespread availability of contraceptives and condoms; comprehensive sex education; training in social behavior (skills in decision making, communication and to improve self esteem); and people to not be ashamed about sexual thoughts or sexual activity. Thus, the Netherlands could serve as a model for improving contraceptive use and control of sexually transmitted

diseases (STDs) for other countries.

Haffner, DW. "Toward A New Paradigm On Paradigm Adolescent Sexual Health." SIECUS Report. 21(2). January 1993. pp. 26-30. [SIECUS = Sex Information and Education Council of the US]

Society often sends strong inconsistent messages about sexuality to teenagers. Few existing educational strategies, including those based on fear, consider adolescents to be responsible sexual persons or promote healthy sexual development. Yet, sex education programs must emphasize decreasing the risk of unprotected intercourse (delay of first intercourse and increasing the number of acts of protected intercourse). Family planning and sexuality specialists need a new definition of adolescent sexual health which can help them better deal with healthy adolescent sexual development. During the 1980s, public policies in the US revolved around sexual abstinence. Yet, normative adolescent sexual behavior was and continues to be sexual intercourse. The US Centers for Disease Control reports 54.2% of students in grades 9 through 12 have had in sexual intercourse during the last 3 months and, by 12th grade, 71.9% have had sexual intercourse. 16.1 years is the median age of first intercourse for males and 16.9 years for females. Further, adolescents are practicing more preventive sexual behaviors. For example, between 1979 and 1988, adolescents were more likely to use a contraceptive at first intercourse (48% vs. 65%). Males were more likely to use a condom during their last intercourse (almost 60% vs. almost 30%). Nevertheless, many adolescents are still becoming pregnant and acquiring sexually transmitted diseases, including HIV/AIDS. Most adolescents have positive attitudes about sexual experiences. For example, 1 study shows that 87% of males and 64% did not feel pressured in having their first intercourse. Further, sexually experienced teenagers, except less than 15 year old females, tend to have higher self esteem than the unexperienced. The Sex Information and Education Council of the US (SIECUS) promotes a comprehensive sexuality education program with a positive approach which helps adolescents develop a sexual identity. Such a program needs to affirm adolescents' sexual rights and advocate easy acces to sexual health care services without parental consent. These programs must support virgins as well as adolescents who have sexual intercourse.

Parris, J. "Learning through Experience." AIDS Action. 19. p. 2.

After the first AIDS patients were diagnosed in 1983 in Trinidad and Tobago, every nurse attended a large group lecture on HIV/AIDS which lasted 1 or 2 days. Even though the information acquired helped them greatly in infection control, the lectures did not prepare them adequately for caring for AIDS patients. The nurses did not want to treat AIDS patients and would not make home visits. They feared infection with HIV and stigmatization

through their contact with AIDS patients. They often believed God was punishing AIDS patients. They were intolerant of homosexual men. They were more willing to care for HIV/AIDS patients who were children or infected by a blood transfusion. In 1990, these attitudes and beliefs prompted a modification of the design of the training program. The program now involves all participants and uses role play to simulate reality. Each training course has only 10 to 15 people and is informal and relaxed. It is held 1 day a week for 8 weeks. The subject matter depends on participants' needs identified through a questionnaire they complete before the course. Group discussions often include HIV positive people, family members, and experienced nurses. The nurses leave the course with a better understanding of the feelings and needs of people with AIDS, human sexuality, and the diversity of sexual behaviors. They are also better able to separate illness from sexual practice, recognize the value of each patient, communicate with and encourage families to accept the patient, support the patient, spread the word about prevention of HIV and sexually transmitted diseases, and understand issues of HIV positive homosexual and bisexual men. The primary health care system in Trinidad and Tobago serves HIV/AIDS patients. The nurses visit them in their homes and make sure they receive the care they need at hospitals and outpatient clinics.

Reid, E. "Why Women and HIV? It Takes Two to Tango, Safely [Editorial]." AIDS Health Promotion Exchange. 3. 1992. pp. 1-3.

We know that great inequalities and injustices adversely affect the length and quality of women's lives, especially in light of the HIV epidemic, yet, we still acquiesce to them. Talking and listening to women motivate us to question why we stress the information and education strategy about HIV, AIDS, and sexually transmitted diseases which does not acknowledge their reality; more women than men are becoming infected with HIV; and why women bear the burden of care. Further, we must no longer condone women not seeking treatment because family or culture prohibits them from seeking help at health clinics, because the treatment is often impersonal, immodest, or threatening, and because it is financially and physically inaccessible. Moreover, we must deal with how societies and communities value women; we rear children; and aspirations we have about the behavior of our sons and daughters, husbands and wives, and fathers and mothers. Women's dependency is a key factor placing them at risk of HIV. To expect women to bear the all the burdens of HIV/AIDS only reinforces the certainty of failure. The nature of HIV transmission calls for both men and women to respond equally to the epidemic. New patterns of communication and of sharing current responsibilities (including the burdens of sadness, pain, care, and support brought about HIV/AIDS) and joys of women's lives can stem the tide and form the basis for men's love for their partners, children, and

families. The family is the key for social change. Specifically, it must love and nurture boys and girls so they become independent, confident adults, able to form respectful and nonviolent relationships, regardless of sexual orientation. Parents and children must talk openly about sexuality and the care of their bodies, ideally supported by community norms and moral values. Gender paradigms should stress compassion, concern for others, and love of family in men, and for women, recognition of their value and worth.

Samuel, MC et al. "Factors Associated with Human Immunodeficiency Virus Seroconversion in Homosexual Men in Three San Francisco Cohort Studies, 1984-1989." Journal of Acquired Immune Deficiency Syndromes. 6(3). 1993. pp. 303-312.

AIDS specialists compared data on 83 homosexual or bisexual men who experienced HIV seroconversion between January 1984 and December 1989 with data on 246 controls (matched for seroconverter's first HIV seropositive visit and number of months between that visit and the previous visit) to determine the risk of seroconversion linked to sexual practices. All the men lived in San Francisco, California. The rate of seroconversion decreased with time (40%-22% between 1984-1985 and 1988-1989). 53% of the seroconverters took part in all 4 practices (receptive anal intercourse, insertive anal intercourse, receptive oral intercourse, and insertive oral intercourse) compared to 30.5% of controls. The univariate analysis indicated that all 4 practices were significantly related to HIV seroconversion ($p < .0001$, $p = .006$, $p < .0001$, and $p = .002$, respectively). The number of sexual partners was also significantly associated with HIV seroconversion ($p < .0001$). None of the seroconverters had no partners while 13% (33) of the controls had no sexual partners during the study period. The odds ratios (ORs) of HIV seroconversion for men with 1, 2 to 4, and at least 5 partners were 6.5, 11.5, and 18.3, respectively. Among men who did not take part in receptive anal intercourse, receptive oral intercourse (OR = 3; $p = .01$) and insertive oral intercourse (OR = 8.4; $p = .001$) were both associated with HIV seroconversion. Among men engaging in receptive anal intercourse, condom use by some partners had a high OR (5.4), presumedly because of the higher median number of partners for converters (8 vs. 5). Nevertheless, the association remained significant in multivariate analyses. Few men used condoms during oral intercourse. These findings revealed an unmeasured risk linked to condom use, perhaps it is more HIV seropositive partners.

Baulieu, EE et al. "Sexual Behavior, Contraception and the Risk of Contracting HIV." International Journal of Gynecology and Obstetrics. 40(2). February 1993. pp. 101-103.

The people at greatest risk of contracting HIV are hemophiliacs, intravenous drug users, those who have anal

intercourse including homo- and heterosexual, and those with multiple sex partners. To reduce the risk of sexual transmission of HIV, the International Committee for Research in Reproduction recommends people to only have sexual intercourse in a monogamous relationship and to use condoms any time one has sexual intercourse outside of a monogamous relationship. More and more women in the world are becoming infected with HIV or are developing AIDS. Some people are concerned that oral contraceptive (OC) use increases the risk of acquiring HIV. Yet, there is no evidence that OC use prevents women from using the condom. Further, OCs do not appear to contribute to a rapid spread of HIV infection and AIDS. The condom best protects women against an HIV infection while OCs are the best way to prevent unwanted pregnancy. It is important for women in nonmonogamous relationships to use both. The likelihood that an infant born to an HIV infected mother of also becoming infected with HIV is 30% thereby making it all the more crucial to use OCs and condoms. In addition, OCs offer noncontraceptive health benefits including regulation of the menstrual cycle; diminished risk of ovarian cysts and of ectopic pregnancies; and decreased incidence of endometrial and ovarian cancers, of fibroadenomas and fibrocystic disease of the breast, and of acute pelvic inflammatory disease.

Van Griensvan, GJP et al. "The Success and Failure of Condom Use by Homosexual Men in San Francisco [letter]." Journal of Acquired Immune Deficiency Syndromes. 6(4). 1993. pp. 430-431.

In California, the San Francisco Men's Health Study has followed at least 807 homosexual and bisexual men since 1984. (49%) tested HIV seropositive in 1984 and 11% have since seroconverted. After researchers identified anogenital intercourse as the primary risk factor of HIV transmission among homosexual men in San Francisco, health education messages have promoted condom use. The researchers have followed the practice of anogenital insertive and receptive intercourse and condom use for at least 13 examination cycles (each cycle = 6 months). During cycle 1 (1984), 68% either ejaculated or received ejaculate during anogenital intercourse, but by cycle 7 (1987), this figure had fallen to and stabilized at 30% throughout the remaining cycles. At cycle 1, 33% of HIV seropositive men used a condom at least once during anogenital insertive intercourse with ejaculation compared to 18% of HIV seronegatives. By cycle 7, these percentages climbed to 90% and 77%, respectively. After cycle 7, the percentages neither decreased nor increased. Regardless of the cycle, a higher percentage of HIV seropositive men used condoms than did HIV seronegative men. 13% of men who used condoms experienced condom breakage during 1 cycle. This percentage increased consistently to 59% among men who used condoms during 8 cycles. Further, 5% of men who used condoms during 1 cycle began anogenital intercourse before putting on a condom. This figure was 44% for 8 cycles. This study indicated that men responded quickly and appropriately to health education

messages about the primary risk of HIV transmission in their population group. It also showed that HIV seropositive men were more likely to use condoms than were HIV seronegative men. On the other hand, it also showed a deficient response to properly putting on or use of a condom to reduce condom breakage and to initiating intercourse prior to putting on a condom.

Gollub, EL and Stein, ZA. "Commentary: The New Female Condom--Item 1 on a Women's AIDS Prevention Agenda." American Journal of Public Health. 83(4). April 1993. pp. 498-500.

An advisory panel recommended in late 1992 that the US Food and Drug Administration (FDA) approve the female condom, Reality, for use as a contraceptive and for prevention of HIV/AIDS and other sexually transmitted diseases (STDs). It is the 1st woman-controlled barrier method to prevent STDs which, in effect, removes the ambiguities in sexual negotiations. It also eliminates the double bind of the usual hierarchical AIDS education messages: get your partner to use a condom; if he refuses, use a diaphragm or cervical cap and spermicide; and if you cannot do this, at least use a spermicide. Nevertheless, the availability of the female condom should not diminish efforts to address the effects of gender imbalances in sexual relationships or the responsibility of men to protect themselves and their partners. Advantages of the polyurethane female condom include insertion before intercourse to not interrupt sexual intercourse and to protect against HIV transmission from pre-ejaculate seminal fluid and does not need an erect penis to position it, a common sources of male anxiety. Disadvantages are it is cumbersome, is relatively costly ($2.25/Reality vs. < $1/condom), and comes in 1 size. In the past, FDA delayed and deferred devices and drugs to protect women from AIDS and STDs. In fact, the number of AIDS cases among women rose 10 times since Reality was 1st developed. Yet it requested male condoms' possible role in preventing HIV and STDs on labels in 1987, even though the data on HIV did not consistently support FDA's claim. Further, it approved Norplant and Depo-Provera without examining the likelihood that their use might replace condoms and increase the risk of HIV/STDs infection. Development of surreptitious methods to prevent HIV infection (e.g., virucide) is next on a women's agenda, but progress has been slow.

Alary, M. "HIV Infection in European Female Sex Workers: Epidemiological Link with Use of Petroleum-Based Lubricants. European Working Group on HIV Infection in Female Prostitutes." AIDS. 7(3). March 1993. pp. 401-408.

Between September 1990 and November 1991, the European Working Group on HIV Infection in Female Prostitutes collected data on 945 15 to 75 year old prostitutes working in Amsterdam, the Netherlands; Antwerp, Belgium; Athens, Greece; Copenhagen, Denmark; Lisbon, Portugal; London, England; Spain; Paris, France;

and Vienna, Austria to determine risk factors for HIV infection. Overall HIV seroprevalence was 5.3% (46 of 866). Only 2 women had HIV-2 infection and these women did not use intravenous (IV) drugs. IV drug users (IVDUs) were 31.8 times more likely to have HIV infection than non-IVDUs (31.8% vs. 1.5%; $p < .0001$). Other significant risk factors for both IVDUs and non-IVDUs included non-condom use ($p = .002$) and prior genital ulcer (odds ratio [OR] = 3.6; $p = .06$). Among IVDUs, previous hepatitis B (OR = 13.8; $p = .02$) and needle sharing (OR = 4.1; $p = .04$) were risk factors. Both IVDUs and non-IVDUs from Spain had a higher HIV seroprevalence than did women from the other countries (IVDU: 78.4% vs. 56.5% total for the other 5 countries, OR = 40.5, and $p < .0001$; non-IVDU: 6.3% vs. 2.6% total for the other 5 countries, OR = 5.8 and $p = .028$). No IVDU and non-IVDU from Antwerp, Athens, Copenhagen, and London tested positive for HIV-1 or HIV-2. More than 80% of all prostitutes always used condoms with clients. Use of petroleum based lubricants was significantly associated with HIV infection in non-IVDUs (OR = 15.2; $p = .001$). In fact, women using these lubricants (10% of all women) experienced condom breakage considerably more often than those not using these lubricants (58.2% vs. 45.7%; $p = .023$). Other significant risk factors for non-IVDUs were low educational status ($p = .02$), prior blood transfusion (OR = 9.1; $p = .003$), and being from sub-Saharan Africa (OR = 5.4; $p = .05$). This was the first epidemiological study to establish an association between petroleum based lubricants and HIV infection.

Humphery-Smith, I et al. "Evaluation of Mechanical Transmission of HIV by the African Soft Tick, Ornithodoros moubata." AIDS. 7(3). March 1993. pp. 341-347.

In an in vitro feeding chamber, many African Hut Tampan ticks (Ornithodoros moubata) fed on a CEM lymphoblast-rich human blood meal containing a copious amount of HIV-1 BRU so researchers in France could examine the ability of the tick to transmit HIV-1 at 28 and 35 degrees Celsius--ambient temperatures in some parts of Africa. They also used Aedes albopictus mosquito cells and HIV-1 BRU and HIV-1 NDK to reexamine HIV-1 infectivity in an arthropod cell line at 28 and 35 degrees Celsius. Some adult female ticks ingested as much as 240 mcl of blood meal (about 70 times the amount ingested by mosquitoes) (mean, 106.3 mcl). On the other hand, the fourth and fifth stage nymphs which are the most likely mechanical vectors of HIV consumed a mean of 39 mcl (maximum, 73 mcl). The shortest interval between feeds for nymphs which had not yet molted was 14 days. But, other studies suggested that ticks often refeed sooner than 14 days. The ticks regurgitated part of their previous blood meal into the feeding lesion when they later fed on a suckling mouse. Adult ticks harbored viable HIV-1 BRU for as long as 10 days, the longest recorded survival of HIV in an arthropod. Yet, other evidence indicated that HIV survival in O. moubata under natural conditions could actually be 14 days. 4.5% and 1.3% of human CEM lymphoblasts remained viable up to 7 days in the ticks' digestive

tract at 28 and 35 degrees Celsius, respectively. Neither HIV-1 BRU or HIV-1 NDK could replicate in CD4-A. albopictus C6/36 mosquito cells, but the researchers did find some evidence of retrotranscription of HIV-1 NDK. These results indicated that mechanical transmission of HIV-1 is probably not possible in vitro, but, it could contribute somewhat to HIV-1 transmission in areas of Central Africa where HIV prevalence is high.

Kettering, J. "Efficacy of Thermoplastic Elastomer and Latex Condoms as Viral Barriers." Contraception. 47(6). June 1993. pp. 559-567.

A microbiologist at Loma Linda University in California used T7 (100 nm), a virulent bacteriophage of Escherichia coli, and the poliovirus type 1 (PV-1) (27 nm) to compare the efficacy of the viral barrier of latex and new thermoplastic elastomer (TPE) condoms. The scientist used a passive test and a simulated intercourse model to compare the 2 condom types. The simulation consisted of a condom-covered disposable centrifuge tube with 4 ml of virus which was inserted into an outer condom with 2 ml of virus-free medium. This apparatus was withdrawn and inserted 30 times within 30 seconds into a commercially produced latex vagina. The tests with T7 used 15 condoms of each brand. The tests with PV-1 used 14 condoms of each brand. The only TPE condom brand was Tactylon. Latex condom brands were Shiek, Trojan-Enz, and Lifestyles. No virus passed through the barrier during the passive test. T7 leaked through 2 latex condoms (13.3%) of the same brand (Trojan-Enz) during the simulated intercourse test. On the other hand, PV-1 did not leak through any of the condoms. Tactylon effectively prevented the passage of both T7 and PV-1. These findings confirmed that latex condoms tend to block passage of both small and large viruses. They indicated that TPE condoms also block passage of small and large viruses. Thus, the effective maximum pore size in all of the TPE condoms and in all but 2 of the latex condoms was too small to let HIV (80-120 nm) and hepatitis B virus (about 42 nm) filter through the condoms. Clinical trials have indicated the breakage rate of TPE condoms is not significantly different than that of latex condoms. Advantages of the TPE condom are its ability to resist environmental effects, e.g., ultraviolet light and heat, which deteriorate latex condom and it does not have antioxidants and accelerators the latex condom has which cause allergic reactions, e.g., dermatitis.

Fullilove, MT et al. "Crack Cocaine Use and High-Risk Behaviors Among Sexually Active Black Adolescents." Journal of Adolescent Health. 14(4). June 1993. pp. 295-300.

Researchers combined data from 2 surveys conducted in the summer of 1988 to examine the association between sexually transmitted disease (STD)/HIV risk behaviors and crack cocaine use among sexually active, black teenage crack users and

nonusers. Everyone lived in an inner city neighborhood in the San Francisco Bay Area in California. The Centers for Disease Control had earlier found a large increase in gonorrhea among black teenagers in San Francisco. Crack users were more likely to have sexual intercourse under the influence of drugs or alcohol (43% vs. 11% for boys and 46% vs. 14% for girls; $p < .001$), take part in sexual acts placing them at risk for STD/HIV in exchange for money or drugs (29% vs. 4% for boys and 25% vs. 0 for girls; $p < .001$), and have more sexual partners in the last year (11.1 vs. 5.3 partners for boys; $p < .01$ and 4.5 vs. 2.5 partners for girls; insignificant) than nonusers. Female nonusers were more likely to have had used a condom during last sexual intercourse than were female crack users (39% vs. 18%; $p < .01$). Both groups of boys used a condom during the last sexual act at the same low rate (about 25%). About 63% of all adolescents admitted to having at least 1 sexual risk behavior. Crack cocaine use and having at least 1 relative who used drugs were the greatest predictors of STD/HIV risk behaviors (odds ratios, 2.2 and 1.97; $p < .001$ and $< .01$; respectively). An urban anthropology study in the same neighborhoods showed that the teenagers lived in an area conducive to high risk behaviors. The ecological risk factors in these areas included drug use common among friends and relatives, more than 1 sexual partner/year, high prevalence of STDs, and low condom use. The findings from these studies indicated that public health workers planning to implement interventions to prevent or reduce the risk of teenage drug use and/or HIV infection must consider both individual and environmental influences.

Folmar, S et al. "Condom Use in Bangladesh." Presented at the Annual Meeting of the Population Association of America. Cincinnati, OH. April 1993. 8, [11] pgs.

Interviews with 402 condom users greater Khulna, Bangladesh are used to learn how men use condoms and to better understand use-effectiveness of condoms. The researchers want to see whether the results would challenge the official belief that Bangladeshis do not engage in risky sexual behavior, thereby justifying an official nonresponse to HIV/AIDS. 29% of all men have engaged in premarital sexual intercourse. Almost 7% have extramarital sexual encounters. In both cases, rural men are the most promiscuous (43.6% vs. 20.6% for urban and 22.6% for semi-urban and 9.4% vs. 5.3% and 7.9%, respectively). Despite this relatively high level of unsafe sex behavior, the men do not publicly discuss their sex behavior. This is consistent with the fact that, in Bangladeshi-Islamic society, the more specific and personal a topic, the smaller the social circle in which it is addressed. In fact, these estimates are probably low because of the rebuke they would face if they reveal such behavior. Just 30% of men who have engaged in premarital sex have ever used a condom compared to 68% of men who engage in extramarital sex. Still, 129 men engaging in extramarital sex are unprotected. In Bangladesh, condom use is low, reflecting the risks involved with purchasing condoms which can result in exposing specific and personal information about

sexual activity in the public arena. Indeed 91% of the subject buy condoms at dusk or night, usually from several stores outside of their neighborhood. Further, 15% even have the shopkeeper choose the brand, despite the wide range in costs. Leading sources of knowledge about condoms are the mass media and friends. Yet correct instructions on condom use either do not exist or are written in English. 97% of the men consider contraception to be the main reason for using condoms. Just 8% say it is to prevent sexually transmitted diseases, even though 62% have heard of AIDS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

JAN 18 1994

NOTE TO: PHS Executive Secretariat
Through: Acting Director, NAPO

Subject: Review and Clear
Response from Dr. Lee to Dr. Denese Shervington objecting to Dr. Shalala's statements on condom usage

I have reviewed closely the attached CDC-drafted response and attachments and I recommend approval/clearance without comment. If you have any questions, please feel free to contact me at 690-5560.

Carlos Velez, J.D.
HIV/AIDS Prevention Cluster Lead

Attachment

PHS CORRESPONDENCE

T64576

REFERRAL DATE: 2-16 **DUE DATE:** 2-18

TO:

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- ☐ PCPFS
- ☐ OEEO
- ☐ OEP
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ACTION:

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Denese Shervington, M.D., M.P.H.
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Dear Dr. Shervington:

I am responding to your letters to Secretary Donna Shalala and Dr. David Satcher regarding your concern about promoting use of the female condom. The use of the female condom was specifically addressed in an article in the Centers for Disease Control and Prevention's August 6, 1993, *Morbidity and Mortality Weekly Report* entitled "Update: Barrier Protection Against HIV Infection and Other Sexually Transmitted Diseases" (copy enclosed). This report stated, "When a male condom cannot be used, couples should consider using a female condom."

Compelling evidence shows that the latex condom is highly effective for prevention of HIV infection, based on large studies of couples discordant for HIV infection. Information regarding the effectiveness of the female condom is primarily based on a study of 147 women followed for 6 months to evaluate the use for pregnancy prevention. In that study, the estimated 12-month failure rate for pregnancy prevention was 21 to 26 percent, and 11 percent among 86 women who used this method cosistently and correctly.

The latex condom is highly effective for HIV prevention; however, women need methods for HIV prevention over which they have direct control. For this reason, we are working to develop and evaluate new methods that provide this important option for women. We are most anxious to have a variety of options that women can use to protect themselves from HIV infection and other sexually transmitted diseases (STDs) that can seriously affect women's health.

Thank you for your interest in improving the health of women.

Sincerely yours,

Philip R. Lee, M.D.
Assistant Secretary for Health

Enclosure

cc:
OD
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OHA
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ES/PHS
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H Official File
CDC Official File (Return to CDC, Atlanta)
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CDC:DSatcher:pkg:02/10/94; (404) 639-3291; CNL/02/10/94
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Department of Psychiatry

Jan 5, 1994

Donna Shalala Ph.D
Secretary of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Dr. Shalala,

As a participant in your December 1993 Conference to Establish a National Plan on Breast Cancer, I was very encouraged by your seeming dedication to improving the health of women.

It therefore was very disappointing to hear your position yesterday promoting condom use in the war against HIV disease, without the inclusion of the newly FDA approved FEMALE CONDOM, the only female-controlled barrier device.

For many of us in the health care arena fighting the battles to put a halt to the current inequities that exist in women's health, in particular concerning HIV disease, this was certainly a set back. One which was made even more painful by the fact that it was steered by a woman herself.

It is my hope that your office will find some mechanisms to correct this gross oversight. I am enclosing a copy of my recent article of the acceptability of the female condom among African American women. As you are probably aware, HIV disease has now become our disease.

Yours truly,

Denese Shervington M.D., M.P.H.
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ORIGINAL COMMUNICATIONS

THE ACCEPTABILITY OF THE FEMALE CONDOM AMONG LOW-INCOME AFRICAN-AMERICAN WOMEN

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Among women, African Americans are at the highest risk for contracting the human immunodeficiency virus (HIV). Unfortunately, the majority of African-American women do not perceive themselves to be at risk nor perceive the need to engage in safe-sex practices. Given the alarming rate of increase of HIV disease among African-American women, more in-depth information about the sociocultural factors influencing these nonhealth-promoting beliefs and behaviors is needed immediately in order to design effective Information, Education, Communication campaigns. As part of such an effort, a premarketing study of the recently developed female condom, Reality (Wisconsin Pharmacal, Jackson, Wisconsin), was used as an opportunity to assess not only acceptance and relevance of the product, but also knowledge, attitudes, and practices among a group of African-American women in New Orleans.

The methodology chosen was focus group discussions. The main finding from these discussions is that the previously reported low-risk perception of HIV disease among African-American females is also true among this group. The discussions suggest that cultural norm of female submission and passivity in sexual negotiation is a major barrier to preventive actions among these African-American women, ie, insistence on condom use during sexual intercourse. The second important finding from these focus group discussions is that the women enthusiasitically endorsed the female condom because they felt this condom allowed them control over safe-sex practices without having to challenge the power of their male partners.

This study also demonstrates that the dynamics of universality and interpersonal learning inherent to insight-oriented or support groups can also be present in focus groups. When occurring in the nonthreatening environment of the focus group, such processes can be extremely helpful in encouraging and motivating participants to adopt more positive health actions. (*J Natl Med Assoc.* 1993;85:341-347.)

Key words • female condom • human immunodeficiency virus • safe sex •African-American women

The 1991 report of the National Commission on Acquired Immune Deficiency Syndrome, *America Living With AIDS*, states, "The number of women and children infected with HIV—particularly within communities of color, continues to grow dramatically. In fact, AIDS cases among women are growing faster than AIDS cases among men. As of June 1991, women accounted for 10% of all AIDS cases. In 1991, AIDS is projected to be one of the top five causes of death for

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young women."[1]

Similarly, the April 1992 human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) surveillance report from the Centers for Disease Control and Prevention[2] shows that:

- African Americans account for 63 941 of the 218 301 cases of AIDS, ie, 29% of total AIDS cases (African Americans comprise only 12% of the total US population).
- African-American women account for 12 896 of the 24 307 cases of AIDS in women, ie, 53% of the cases.
- African-American children account for 1971 of the 3692 cases of AIDS in children, ie, 53% of the cases.

Among women, African Americans of lower socioeconomic status have been the hardest hit by the disease—these women are the most at risk for unprotected sex with an HIV-positive, intravenous drug-using partner, or for being intravenous drug users themselves. Eventually, all sexually active African-American women are going to be at equal risk, given the complex web of sexual relationships permeating all socioeconomic boundaries.

However, the majority of African-American women do not perceive themselves to be at risk for infection with HIV. A 1991 nationwide Women of Color Reproductive Health Poll conducted by the National Council of Negro Women found that 6 of 10 respondents did not believe they were at risk for contracting AIDS.[3] In the 1992 follow-up poll on contraception, approximately 40% of the sexually active African-American women surveyed between the ages of 18 and 44 used no method of contraception. Of the 60% of women who did use contraception, only approximately 25% used condoms.[4] Similarly, a study on sexuality done by Gail Wyatt in Los Angeles found that 69% of the African-American women interviewed (compared with 31% of the white women) did not use any contraception.[5]

Known mechanisms of HIV transmission are contact with HIV-infected body fluids through sexual intercourse, sharing intravenous drug paraphernalia, blood transfusion, placental transfer, and breast feeding. For African-American women, unprotected sexual contact is the major risk factor for HIV infection. The studies cited above suggest that the contributing sociocultural factors are low levels of any contraceptive use, a preference for contraceptive methods that do not prevent transmission of body fluids,[5] and low perception of susceptibility.

The most effective method of decreasing the spread of HIV disease has been educational programs on safe-sex practices, stressing the use of barrier protection. In San Francisco, such approaches were noted to have resulted in "dramatic and sustained reduction in risk behavior."[1] Similarly, in Kinshasa, Zaire, there was a significant difference in the rate of HIV infection among female prostitutes reporting condom use by 50% or more of their partners compared with women reporting less frequent condom use among their partners.[6]

Until recently, the only condom available to women in the United States has been the male condom, the use of which requires the cooperation of the male partner. The assumption of female responsibility for condom use during sex has been very difficult, given the usually passive female role in sex. As stated in the 1991 National Commission on AIDS report, "Perhaps the most unrealistic prevention message for women is the nearly exclusive focus on the use of condoms, advice that is naive regarding anatomy, gender roles, and power."[1] The report recommended, "Increased efforts are necessary to develop a wide array of chemical and physical barriers to block vaginal HIV transmission that do not depend entirely on the male partner's cooperation."[1]

A female condom, the Reality Vaginal Pouch, recently developed by Wisconsin Pharmacal (Jackson, Wisconsin), is one such potential physical barrier. Given the alarming rate of the increase of HIV disease among African-American women, it is of utmost urgency that extensive efforts be directed at Information, Education, Communication (IEC) campaigns within this community, based on a sound understanding of the sociocultural determinants of sexuality and reproductive health behaviors among African-American women.

Given the low level of awareness among African-American women of their susceptibility to AIDS, compounded by their powerlessness in sexual negotiation, it is important that any such intervention:

- capture the attention of African-American women and realistically appraise them of their risks and susceptibility to HIV infection,
- empower African-American women in the sexual decision-making process, and
- allow for interactive participation to maximize the potential for learning and mastery of risk-reducing behaviors.

The focus group was chosen because its format lends itself to all the above-stated communication objectives. Focus groups are specialized groups that are used to

"gain insight into the dynamic relationships of attitudes, opinions, motivations, concerns, and problems related to current and projected human activity."[7] Focus groups can be used for both phenomenologic and clinical purposes; in this study it could therefore be used simultaneously to both gather data and assess the determinants of general reproductive health knowledge and practices, and to communicate information about HIV disease and the female condom.

When gathering information considered taboo or embarrassing, focus groups have been found to be very effective. Zimmerman et al successfully used focus groups in assessing the acceptability of Norplant in four countries.[8] Likewise, Michielutte et al found focus groups to be very effective in the development of community-based public health education designed to reduce mortality from cervical cancer among black women in Forsyth County, North Carolina.[9] The use of focus groups for social marketing programs has increased markedly in recent years.[10]

METHOD

Group Formation

Three groups consisting of 12 African-American women were recruited in June 1992. Within groups, educational and socioeconomic status were homogeneous; age and degree of sexual exposure varied.

Group 1. Participants in this group were medical students recruited from a major university medical center. This group was chosen to serve as a comparison for the effects of higher social and educational status. The average income was under $15 000 annually. The average age of Group 1 participants was 23 years old (range: 21 to 26 years). Ten women were present.

Group 2. This group was comprised of low- to middle-income women, with the majority being high school graduates. The women were recruited from a self-help, community-based, health-improvement group. The average age was 31 years old (range: 14 to 65 years). Initially, 12 women were recruited for this group; however, several women brought friends and asked that they be allowed to observe. The recruits felt that this was important information that needed to be shared. Twenty women were present. (It is recognized that the generally recommended number for focus group participants is from 6 to 12 and that ideally members should not be acquainted with each other. However, given the health urgency and immediacy of combating HIV disease within the African-American community, the women were allowed to stay.)

Group 3. Group 3 was comprised of low-income women. The majority of the women in this group had high school backgrounds and were recruited from a housing project health clinic. The average age was 31 years old (range: 17 to 53 years). Initially, 12 women were recruited, but as with Group 2, a few women also brought friends along to observe. Fifteen women were present.

Location of Group Meeting

Group 1 was conducted in a hotel conference room, during which breakfast was served. Group 2 was conducted in the home of a community member, during which lunch was served. Group 3 was conducted in a community center, during which an afternoon snack was served. Meals were served at the beginning of each group.

Group Process and Format

All groups were moderated by the author, an African-American female psychiatrist experienced in group process and dynamics, and the modified focus group. A female assistant was present at all three meetings, her primary task being record-keeping. All groups were audiotaped with the prior permission of the participants. All groups followed the same protocol and covered the same topics.

The group format was divided into two segments. The first segment was for gathering information on the reproductive knowledge, attitudes, and practices among these women. Data was collected from guided discussions on the following topics:

- general attitudes regarding sex and sexuality,
- knowledge of sexually transmitted diseases (STDs),
- knowledge regarding contraception,
- knowledge regarding barrier protection devices,
- acceptability of the female condom, and
- readability and comprehension of the proposed instruction guide.

The second segment was experiential and educational. The participants were each given a female condom and oriented to it by the moderator. They were then asked to report their feelings about the meaning of such a device. Then each group member took turns reading a portion of the instruction guide and demonstrating their comprehension.

In all three groups, it was observed that the women were very open and uninhibited in discussing highly personal subject matters. This is similar to the observations of other focus group leaders. Folch-Lyon and Trost hypothesized, "The group situation may also encourage participants to disclose behaviors and atti-

tudes that they might not consciously reveal in an individual interview situation. This occurs because participants often feel more comfortable and secure in the company of people who share similar opinions, attitudes, and behavior or simply because they become carried away by the discussions."[7]

The meetings lasted approximately 90 minutes. Participants were paid $35. At the conclusion of the groups, all participants were invited to sign up to receive a free Reality condom when it became available; they all did.

RESULTS

The results of the discussions are summarized by topic for each group.

Sexuality

Group 1. Most participants in Group 1 expressed frustration at the culturally sanctioned dominant roles of males in sexual relationships. Many resented that women were taught to rely on male approval for their self-worth. As a result, they were not assertive in their relationships. A majority of these women concluded that despite their intellectual and professional achievements, they too looked to relationships for validation. They expressed concern about the growing trend of early exposure of African-American youth to sexually explicit language and behaviors in the media (TV and music), which were often degrading to women. Several women expressed anger at the then-popular song, "Baby Got Back," which they felt exploited the sexuality of African-American women.

Group 2. Initially, most participants in this group expressed satisfaction with their roles in sexual relationships; toward the end of the group, however, many admitted to being frustrated by the infidelity of their spouses. They worried about their exposure to STDs. Despite these fears, these women felt that they had to accept these relationships because this was "the way things were." They also discussed concerns about the early exposure of children to sex, which they felt was responsible for the high rate of teenage pregnancy. Several women gave examples of 10- and 12-year-old sexually active youth who either became pregnant, developed STDs, or both.

Group 3. The topic of sexuality immediately triggered a discussion of HIV transmission in this group. An adolescent discussed being saddened by the knowledge that a 19-year-old former classmate was dying of AIDS. These women, too, expressed fears of the health hazards resulting from their partners' infidelity. Some women were concerned about the denial of homosexual acts by some men, in particular, those that had been incarcerated; they felt this placed them more at risk. These women also felt powerless to make any changes in their relationships with their spouses; like the Group 2 participants, these women felt that they had to accept their spouses' behaviors.

Sexually Transmitted Diseases

Group 1. Participants were highly informed about STDs and were extremely knowledgeable about the etiology and modes of transmission of the various diseases. Participants did not perceive themselves at risk, and no one discussed any personal experiences. Most of these women got their health information from reading and also from their involvement in medical education.

Group 2. Participants generally were very misinformed about STDs; however, their information about HIV was the most accurate. Several participants shared many myths regarding sources of STDs and recounted humorous stories of being blamed by their spouses for being the source of these diseases. Most of the women relied on friends for their primary source of information (especially those friends who worked in the health field).

Group 3. Participants had some knowledge about the causes and transmission of STDs; they were very curious to get more information about such diseases, particularly HIV. Many of the women were very knowledgeable about community resources for the treatment of STDs. Most of these women relied on physicians and the media (TV) for health information.

Contraception

Group 1. The majority of these women expressed anger at the lack of male responsibility in matters of contraception. They felt that women were unfairly burdened with the responsibility for contraception. They questioned why more effort was not being put into the development of male contraception. One woman asked, "Why isn't there a male birth control pill?"

Group 2. The women discussed their concerns about the low rate of contraceptive use among women in their communities. They felt that this was responsible for the high rates of pregnancy, especially among teenagers. A majority blamed low contraceptive use on poor communication about sexuality between mothers and their children.

Group 3. These women also discussed concerns about low contraceptive use among their peers. One woman stated, "It's free, and women are still not using

it." Many of these women felt that women were having babies in their search for someone to love them. As one woman stated, "They expect love from the baby or the baby's father."

Barrier-Method Contraception

Group 1. These women liked the idea of the protection of condoms, but reported that male partners were resistant to condom use. However, they felt strongly that women who respected themselves and hence expected respect from their mates would not engage in unprotected sex. As one woman stated, "Turn down that man who refuses to use a condom." Only half of these women reported use of the male condom during most acts of sexual intercourse. All of the women liked the idea of a female condom because they felt that it gave women more control over their protection from diseases. A few of these women raised the concern that some women may not be comfortable with touching themselves in intimate ways and therefore may not like inserting a condom.

Group 2. Most of these women reported that it was difficult to get their partners to consider condom use. The majority did not use condoms (only 4 of the 18 sexually active women used condoms), even though they would have preferred to do so. These women were unwilling and afraid to insist that their partners use condoms, and did not feel that they could refuse to engage in unprotected sexual intercourse. All of these women were excited about the female condom because it offered them more control in protecting themselves from diseases and pregnancies. One woman stated that she found the condom preferable to taking pills or other medication for contraception.

Group 3. The majority of these women discussed their frustration trying to get their partners to use condoms. "They say sex doesn't feel the same; they say condoms are not big enough," were some of the reasons their partners gave for refusing to use condoms. These women also felt powerless to insist on condom use or to refuse sex if it was not used. These women also were very excited about the female condom, as they felt it put them in control. As one woman stated, "you know it's on because you put it on." Several women stated that since they were in control of its actual insertion, they would use the female condom, with or without partner approval.

Feedback Regarding the Reality Condom and Ability to Understand the Proposed Instruction Guide

Group 1. The reactions to the feel of Reality by the women in this group were quite neutral. As one stated, "It feels like an exam glove." Several women expressed concerns about the appearance of the outer ring outside of the vagina. Most felt that the instruction guide was too cluttered, making it difficult to follow. They recommended that the instructions be simplified by using less words and bigger and brighter illustrations. Many questions were asked about the physical aspects of the condom, such as its durability, ability to stay in place after insertion, and possible harmful effects. Despite some hesitancy and skepticism about Reality, the group felt that they would use Reality if it became available and that they would definitely recommend it to acquaintances. They also felt that men should be informed regarding Reality and also be expected to participate in its use.

Group 2. This group liked the feel of Reality. One woman said that it felt like a "safe shield," and another woman said it felt "like a Ziploc." The group expressed no dissatisfaction with Reality. They demonstrated no difficulty in their ability to understand the instruction guide. The majority felt that it was good to have a lot of information in the instruction guide to ensure proper usage. The group did not express much concern about the appearance of Reality and did not perceive that they would have much difficulty in using it. The group strongly endorsed using Reality for themselves and felt that they would definitely recommend its use to acquaintances. Some women asked that similar meetings be held for other women in the community.

Group 3. These women also liked the feel of Reality, the majority opinion being that it felt strong, and hence made them feel safe. A few women did not like the appearance of the outer ring hanging from the vagina. Some women had questions about possible movement of the condom during intercourse that could result in the loss of protection. This group felt that the instruction guide was easy to understand and did not think that it was cluttered. Like the women in Group 2, they felt that it was better to have too much than too little information. This group overwhelmingly endorsed Reality. One woman said that she was anxiously awaiting the opportunity to use the condom. The group felt that the information on this condom was very important and needed to be shared with other women. Several women asked that similar meetings be conducted for other women in the clinics and that younger children should be included.

DISCUSSION

The discussions of the women in all three focus

TABLE. RECOMMENDATIONS FOR MARKETING REALITY CONDOM TO AFRICAN-AMERICAN WOMEN

- Testimonials on television by popular female African-American celebrities, encouraging women to be more assertive in protecting themselves, eg, using variations on the theme "PUT YOUR HEALTH FIRST"
- Rap poetry on large print media such as billboards, posters, and flyers, with images and messages encouraging women to take control; such themes could be put to music and broadcast on radio: "Ladies, protection no longer is random; for guess what, Reality is now your condom"
- Interactive small-group condom theme parties (modeled after the Avon party concept)
- Mail order through popular African-American magazines, such as *Essence* and *Jet*
- Availability of Reality in nontraditional markets such as beauty salons and nightclubs, in addition to traditional health markets

groups indicated that they were aware of the transmission of the HIV virus and knowledgeable about mechanisms to protect themselves from HIV disease by the use of condoms. They were also aware of the increasing threat of the AIDS epidemic within the heterosexual African-American community.

The majority of these sexually active women, however, did not perceive themselves to be personally at high risk. They therefore engaged in unprotected sex without much conscious fear of becoming infected with HIV. The majority indicated they would prefer that their partners use condoms during sexual intercourse because of some doubt about the fidelity of their partners. However, they do not insist on condom use because they feel powerless in negotiating the real or perceived refusal to do so by their partners.

The discussions indicated that the fear of relationship loss is more operant in the health beliefs and actions of the majority of these African-American women than fear of infection with the deadly virus. The majority placed more value on being in a relationship than on wellness and disease prevention. In fact, for some women, wellness was equated with being in a relationship. Only the few women who seemed to have an internal sense of self-worth were willing to value their health above and beyond being in a relationship.

It appears that this cognitive dissonance between knowledge and risk appraisal results from the extremely high value placed on male-female relationships within the African-American culture. A major source of self-validation and esteem for many African-American women is "being in a relationship." To prevent the perception of self-disintegration and preserve self-cohesion, many African-American women appear to use strong denial defenses to prevent relationship loss. One might hypothesize that for many such women, the death instinct (self-nothingness) is driven more by the fear of relationship loss than by the fear of physical disease.

Such a maladaptive schema results in behavioral submission and passivity. As one woman in the group stated, "A bad relationship is better than no relationship." This could explain why the majority of the women in the focus groups avoided asserting the need for condom use by their partners. Such behavior is viewed as a challenge to the authority and dominance of the male partner.

A very positive and encouraging finding of this qualitative study is that the majority of the women participating in the focus groups were able to confront their nonhealth-promoting behaviors within the context of the group. This is similar to Basch's observations that, "Group based intervention programs appear to be useful in assisting individuals to modify or maintain many health behaviors, for example, compliance with therapeutic regimens, cessation of cigarette smoking, maintaining exercise, and weight control programs, improving appropriate utilization of health services, and managing and mediating adverse effects of stressful life events."[10]

The inherent group dynamics of universality and interpersonal learning are present in these focus groups, albeit that they are not insight-oriented. Group participation seems to have afforded the women the opportunity to clarify for themselves and each other the value of good health. It also allowed them to help each other recognize their own power in assuming more responsibility for protecting themselves from disease. This resulted in the women becoming highly motivated to reduce their risk of exposure to HIV by the use of barrier protection. The women positively endorsed the female condom. They particularly liked that it afforded them control over its use and enabled them to overcome the obstacle to use of the previously only available mechanical barrier, ie, the male condom. The liking of the female condom was particularly pronounced in those women who had friends or family members who were dying or had died of AIDS.

The previously cited reasons for not liking Reality—that it is cumbersome or that the appearance of the ring

outside the vagina was not aesthetically pleasing—was not a major barrier among these women. In fact, many took ownership of Reality, referring to it as a "safe shield."

CONCLUSION

Recommendations for marketing the female condom to African-American women are summarized in the Table. That men play a dominant role in the sexual decision-making process presents a major obstacle to the use of male condoms among African-American women. The majority of African-American men do not like using condoms. Given that the female condom allows women the ability to assume responsibility without having to challenge their male partners' need to dominate the negotiation of sexual matters and given that the female condom has been enthusiastically accepted by the women in this study, much potential lies in the use of this product in the battle to decrease the spread of HIV within African-American communities.

Literature Cited

1. *The 1991 Report of the National Commission on Acquired Immune Deficiency Syndrome. Living With AIDS.* Washington, DC: US Government Printing Office; 1991.
2. Centers for Disease Control and Prevention. *The 1992 HIV/AIDS Surveillance Report.* Atlanta, Ga: Centers for Disease Control and Prevention; 1992.
3. The National Council of Negro Women and Communications Consortium Media Center. *The 1991-1992 Women of Color Reproductive Health Opinion Poll.* Washington, DC: Consortium Media Center; 1991.
4. National Council on Negro Women and Communications Consortium Media Center. *The Follow-Up Birth Control Survey Summary Report.* Washington, DC: Consortium Media Center; 1992.
5. Wyatt GE, Blumenthal S, Eichler A, Weissman G. Ethnic and cultural differences in women's sexual behavior. In: *Women and AIDS: Promoting Health Behavior.* Washington, DC: US Dept of Health and Human Services; 1991:174-182.
6. Devita V, Hellman S, Rosenberg S. *AIDS, Etiology, Diagnosis, Treatment and Prevention.* 2nd ed. Philadelphia, Pa: JB Lippincott Co; 1988.
7. Folch-Lyon E, Tost JF. Conducting focus group sessions. *Stud Fam Plann.* 1981;12:443-449.
8. Zimmermann M, Haffey J, Crane E, Szumowski D, Alvarez F, Bhiromrut P, et al. Assessing the acceptability of NORPLANT implants in four countries: findings from focus group research. *Stud Fam Plann.* 21:21-22, 92-103.
9. Dignan M, Michielutte R, Sharp P, Bahnson J, Young L, Beal P. The role of focus groups in health education for cervical cancer among minority women. *J Community Health.* 1990;15:369-375.
10. Basch CE. Focus group interview: an underutilized research technique for improving theory and practice in health education. *Health Educ Q.* 1987;14:411-448.