

# ACCEPTABILITY OF THE FEMALE CONDOM BY FEMALE HEALTH WORKERS IN FRANCISTOWN, BOTSWANA

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## Abstract

**Background:** Women account for nearly half the global population of persons living with HIV. In sub-Saharan Africa women constitute 60% of adults living with the virus. The situation makes it necessary to develop and improve prevention actions that target women. The female condom is a practical option. It is the only available dual protection method that protects against sexually transmitted infections and unwanted pregnancies, and is designed for women to initiate.

**Objective:** This study aimed to measure condom use by females as well as their attitude and perceptions about female condom use in Francistown, Botswana.

**Research Design:** The research design employed was the survey method. Seventy-one participants were enrolled. Participants were asked to complete a self-administered questionnaire which consisted of demographic characteristics, and attitudes and perceptions of female condom use.

**Results:** The study found that 15.5% of women had used the female condom in the previous month, 12.9% had used the condom in the previous 3 months, and 17.2% had used the female condom in the previous 12 months. The study also showed that the majority of participants believed the female condom was readily available (71.4%) and that it empowered women (63.3%), and the majority of women (78.9%) would recommend its use. However, only 22.8% believed that the female condom was better than the male condom, 28.6% believed it was easy to use, and only 9.8% thought it was popular with clients. The majority (53.5%) believed the female condom was not well promoted and (56.3%) of participants did not know if sex with the female condom was as good.

**Conclusion & Recommendation:** Female condom use by female health workers was low. There is need for more research to examine why the condom is not acceptable among female health workers.

**Keywords:** : female health workers; female condom; male condom; condom use; condom acceptability.

## Introduction

In the early stages of the pandemic, HIV infection was predominantly among men who have sex with men (MSM) in many developed countries (UNAIDS/World Health Organization - WHO, 2003). As the pandemic continued to spread to other parts of the world, the picture began to change. The number of women living with HIV and AIDS has overtaken the number of infected men. By the end of 2002 in sub-Saharan Africa, 58% of adults infected with HIV were women (UNAIDS, 2002). Generally,

women are at a greater risk of acquiring HIV infection through unprotected heterosexual intercourse than men. In one study, Abercrombie (1996) found that female partners of HIV-infected men were 15 times more likely to become infected than male partners of infected women. Strebel (1993) attributes part of women's vulnerability to the anatomical design of women's sexual organs which puts them at risk of easily contracting HIV. Economic disparities between women and men have also been cited as an additional cause of HIV transmission among women

(Coates & Makadon, 1996; Wood, 1997; de Klerk, 2002).

Certain prevalent cultural norms and practices related to sexuality contribute to the risk of HIV infection among women. In Zambia, Simpson (2007) found that some men did not want to use condoms regularly because of beliefs that unprotected sex was equated with masculinity and was necessary for male health. In addition, condoms have been associated with unfaithfulness and lack of trust and love in relationships (Baker, 2005). According to Reddy (2009), sexual practices such as “dry sex” where the vagina is expected to be small and dry carry a high risk of HIV because they cause abrasions to the lining of the vagina and on the penis. Physically abusive relationships limit women’s ability to negotiate safer sex. For example, Dunkle (2004) argued that women who are victims of sexual violence or rape were at a higher risk of being exposed to HIV. Rauf (2010) further revealed that people who do not possess accurate, relevant information on HIV/AIDS and sexuality often do not protect themselves because they lack the skills, support or incentives to adopt safe sexual behaviors. Preventing new HIV infections is an urgent global priority. An analysis found that in sub-Saharan Africa alone, expanded prevention could prevent 55% of the 53 million new infections projected to occur in the region between 2003 and 2020 (Salomon, 2005). With the number of HIV-infected women outnumbering HIV-infected men, there is an urgent need to develop and promote prevention efforts that will reduce the vulnerability of women. Prevention strategies – often summed up by the “ABC” approach: - Abstain, Be mutually faithful and use Condoms – do not enable women to adequately protect themselves from HIV. A UNAIDS-sponsored survey conducted among young women in Harare, Zimbabwe, and Durban and Soweto in South Africa found that 66% of the women reported having one lifetime partner, and 79% had abstained from sex at least until the age of 17, yet 40% of these young women were also HIV positive, and most had been infected despite staying faithful to one partner (UNAIDS, 2005). According to the United Nations Populations Fund (UNFPA) (2010), HIV prevention strategies must be broadened so that they better respond to the challenging contexts of women’s lives by addressing the underlying vulnerabilities faced by women, including by expanding affordable access to

prevention options that women can initiate and control. One such option includes the promotion of the female condom. Thus this study aimed to measure condom use by females as well as their attitude and perceptions about female condom use in Francistown, Botswana.

## **METHODOLOGY**

### **Study Setting**

Botswana is divided into administrative districts which are managed by local councils (Government of Botswana, 1981). Francistown, Botswana’s second largest city with a population of about 83,000 people (<http://www.cso.gov.bw/index>) is administered by the Francistown City Council (FCC). The council, through the Francistown District Health Management Team (FDHMT), is responsible for provision of primary health care in Francistown. The facilities that were chosen as study sites are Jubilee, Area W, Masego, Gerald, Lapologang, Botsele, Tshwaragano, Botswelole, Boikhutso, and Tati Town Clinics.

### **Study Sample**

The study sample was derived from a population of clinic health care workers (HCWs). The workers included both clinical staff such as nurses, counselors, and laboratory technicians; and non-clinical workers such as orderlies and drivers. The non-probability purposive sampling method was used. The purposive sampling technique was used to select women working at the health facilities. Before sampling, the study was introduced to all HCWs during the clinic morning briefs. Female HCWs aged 21-49 who could understand English were approached and asked to participate. A total of seventy-one participants were enrolled into the study. The sample size of 71 participants represented more than 25% of the total number of health workers at all the study sites.

### **Study Design**

A cross-sectional survey method was used to obtain the relevant data.

### **Data Collection Method**

Participants were given a 15-item structured questionnaire to complete anonymously. The questionnaire asked about demographic characteristics, behavioural and beliefs regarding female condom use. Completed questionnaires

were placed in opaque envelopes and collected for analysis by the researcher.

**Ethical Considerations**

In accordance with the requirements of human subject research, prior to beginning this study, the research proposal was submitted for approval to the Research Ethics Committees of the University of Stellenbosch and the Health Research Unit at the Botswana Ministry of Health. Written permission was also obtained from the Medical Officer at the FDHMT. Participants were assured that all data collected would be treated with absolute confidentiality and that all the records would be kept safe. The data collection instrument did not have

names or particulars linking the participants with the study. Participants were also informed that they were allowed to withdraw at any stage of the study without fear of being victimized or intimidated. Participant's written consent was sought and only participants who fully understood the procedure and consented were recruited for the study.

**RESULTS**

From the total number (n=71) of participants, thirteen (18.3%) participants reported not using any type of contraceptive, forty (56.3%) women indicated using the male condom, 18 (25.4%) used the female condom. A summary of the frequency of female condom use by the participants in reflected in Table 1

**Table 1: Frequency of female condom use (n=71)**

Female Condom Use	Past Month	Past 3 months	Past 12 months
Never used	60 (85%)	61 (87%)	58 (83%)
Used on at least one occasion	6 (8%)	5 (7%)	4 (6%)
Had used at least 5 times	5 (7%)	5 (7%)	9 (13%)

Out of the total number (n= 71) of participants, 9 (12.7%) participants strongly agreed that female condoms were better than male condoms, 7 (9.9%) agreed, 5 (7%) disagreed, and 30 (42.2%) strongly disagreed. Twenty (28.2%) participants were neutral Out of 70 participants, 11 (15.7%) participants strongly agreed, 9 (12.9%) agreed, another 9 disagreed, 25 (35.7%) strongly disagreed that female condoms were easy to insert. Sixteen (22.9%) participants were neutral Out of the total number (n= 71) of participants, 28 (39.4%) participants strongly agreed, 17 (23.9%) agreed, 4 (5.6%) disagreed, 14 (19.7%) strongly disagreed that female condoms put women in charge. Eight (11.2%) of participants were neutral

From 71 participants, 12 women (19.7%) strongly agreed, 9 (12.7%) agreed, 3 (1.4%) disagreed, and 7 (9.9%) strongly disagreed that sex with the female condom felt as good as without condom. Forty (56.3%) participants were neutral

Six (8.4%) participants strongly agreed, 1 participant (1.4%) agreed, 4 (5.6%) disagreed, and 56 (78.9%) strongly disagreed that clients preferred the female

condom to the male condom. Four participants were neutral.

Out of the total number (n= 71) participants, 34 participants (47.9%) strongly agreed, 22 (31%) agreed, 4 (5.6%) disagreed, and 6 (8.4%) strongly disagreed they would recommend the female condom. Five participants (7%) were neutral

From 70 participants, thirty-five participants (50%) strongly agreed, 15 (21.4%) agreed, 7 (10%) disagreed) and 9 (12.9%) strongly disagreed that female condoms were readily available. Four participants (5.7%) were neutral.

Out of the total of 71 participants, 11 women (15.5%) strongly agreed, 16 (22.5%) agreed, 16 participants disagreed, and 22 (31%) strongly disagreed that female condoms were well promoted. Six women (8.4%) were neutral

**Discussion**

The majority (62.9%) of the women were unmarried. These results correspond with findings of the Botswana Demographic Survey (BDS) of 2006

which showed that 64.2% of women aged 18 and above had “never married” (*Central Statistical Office - CSO, 2009*). The study revealed that 81.7% of women used contraception with the male condom being the most common type of contraceptive used by the participants. The female condom was less popular. These findings are in contrast to the 2001 CSO report in which use of contraception in Botswana was reported by 44% of women aged 15 to 49 years. The study shows that the most popular method used by women was the pill, followed by condom, injection, intrauterine device, and female sterilization. Condom use was low among women aged 35 years and above, despite its widespread distribution. The study showed that 11 women (15.5%) had used the female on one occasion or more in the previous one month and sixty women (84.5%) did not use the condom in the previous one month. The number of users was so small that further analysis according to age, marital status, or education was not supported.

The current study revealed that only 9 participants (12.9%) had used the female on one occasion or more in the previous 3 months. With more than 80% of the study participants reporting that they had not used the female condom in the previous 1 month, 3 months or even 12 months, these findings indicate low short-term and long-term acceptability of the condom among female HCWs in Francistown. These results correspond with the findings of the Jacklass (2010) study which showed similarly low female condom use among women in Botswana. The popularity of male to female condoms was shown by Kulczycki et al. (2004) in a study conducted in Alabama. A sample of 108 women in stable relationships recruited from an urban, reproductive health clinic were randomly assigned to use 10 male or female condoms, followed by use of 10 of the other type. Across a range of criteria, the female condom was less acceptable than the male condom to most women and their partners.

The results reveal that the majority of women felt the female condom was not easy to use. The general negative perception regarding female condom insertion is interesting considering the low condom usage. According to Artz (2002), women who have a negative perception regarding female condom insertion fall into two groups: one group which refuses to try inserting the condom, while the other

group tries but experiences difficulties.

The majority of participants felt the female condom empowered women. The study makes an interesting observation: *if women were offered a method over which they had greater control, they would not necessarily adopt it*. There were 17 participants (32.4%) who agreed that sex with the female condom was as good as with male condom; ten participants (11.3%) disagreed. The majority – 40 participants (56.3%) were neutral. Again, low female condom use could explain the high number of women who were neutral on this question.

Seven participants (9.8%) believed clients preferred the female condom; the majority, sixty participants (84.5%) disagreed. This finding raises an important question: *If health care workers believe clients do not prefer the female condom, should the condom be promoted?* It would seem that making female condoms available at health facilities is not cost-effective if HCWs have negative perceptions and also do not choose to use this barrier method, their predispositions might filter into the way in which they provide education about this method and whether they promote its use.

The study observes that *women would recommend a method they were not using*. This may seem unusual but is not surprising. A study conducted by Sakondhavat and colleagues (2001) in Thailand revealed similar findings. The study enrolled twenty sex workers from a massage parlor and 21 from a brothel who were trained in the use of the female condom. The participants were instructed about the risk of HIV and advised that they could use the female condom as an alternative method to the male condom for protection. The female condom was used in 28.4 per cent and 17.8 per cent episodes of sex in each site during the two weeks. Female condom use increased from 0 per cent in the first group to 43 per cent in the second group. Participants discontinued condom use citing partners' objection and the “inconvenience” of the device. However, the participants mentioned that they would recommend it to others as most felt that other women would want to try it.

It would generally be assumed that female condom availability would have a positive impact on its uptake. The study reveals the contrary and makes an

important finding: *female condom availability does not necessarily translate into increased condom use*. Study findings correspond with results of an intervention study conducted in Mombasa, Kenya. Thomsen (2006) established that the availability of the female condom led to reduction in the levels of unprotected sex but only a small increase in the percentage of participants who reported protected sex with all the women are more in charge of their reproductive health, not being controlled by men. The study contradicts findings by Hoke (2007) which showed that the availability of female condoms was associated with more condom use, and thus better protection against STIs. When female condoms were added to a male-condom distribution system for sex workers, the use of protection with paying partners increased.

Twenty-seven (38%) agreed that the female condom was well promoted compared to 38 participants (53.5%) who disagreed. Generally participants believed female condoms were not well promoted. This finding is important to policy and decision makers. The importance of female condom promotion is illustrated by the Jivasak-Apimas (2000) study which led to the development of the "100 percent condom" promotion in brothels in Thailand. The study involved a female condom promotion campaign among female commercial sex workers. As a result of the campaign as well as improved STI treatment services, condom use among commercial sex workers increased to more than 90 percent; reported visits to commercial sex workers by men declined by about half; HIV infection rates among military recruits decreased by about half; and the cases of five other STIs decreased by nearly 80 percent among brothel workers (*UNAIDS, 2000*).

The researcher recommends that health workers be trained on the female condom to ensure they fully understand it because health care providers play a key role in increasing women's access to the female condom. Agha (2002) found that in Tanzania more than half of women using the female condom had heard about it from a clinic or hospital and that communication with a peer educator or health care provider had a direct positive impact on female condom uptake.

It is crucial that providers receive training as well as

information and support about the female condom, so that they in turn feel confident and comfortable in promoting it to their clients. Service providers may have a bias against barrier methods such as the female condom, so it may be necessary to desensitize the workers in order to prevent their beliefs from negatively influencing potential users.

Training can be conducted through the following activities:

- Insertion practice

Using an anatomical model and then under the guidance of an experienced trainer offers a great opportunity to learn the insertion technique.

- Testimonials by satisfied users

Sharing experiences and exchanging tips among staff can help develop confidence and can help women develop condom negotiation skills with their male partners.

- Face-to-face communication and counseling

Interviews with the health workers can elicit in-built fears or misconceptions about the female condom.

### **Promoting the female Condom**

The study showed that HCWs did not believe the female condom was well promoted. The researcher therefore proposes an enhanced female condom promotion in Botswana, and that program should begin with promoting the condom among health workers.

*Why promote the female condom when the male version is so popular?*

Artz (2000) showed that many clients will try, and some will continue, to use female condoms when they are promoted positively and when women are trained to use them correctly and to promote them to their partners.

There are several strategies that can be used to promote the female condom among health workers:

## **Integrating female condom use into HIV and STI prevention programs**

The study showed that female HCWs did not believe the female condom was popular with clients. Despite this, the researcher recommends that the female condom be made available to all clients at various service points of health care. The researcher recommends that female condoms be integrated into the core service package of existing HIV prevention and reproductive health programs, including the health ministry, and maternal and reproductive health services at health facilities. The importance of this is that the health worker receives feedback from both the policy makers on female condom procurement, and from clients on female condom usability. In an intervention in Nigeria, when the female condom was introduced along with the male condom as part of the dual protection strategy in family planning clinics (Avni, 2001), results showed that in the first year of the program, there was a modest increase in male condom, but a significant interest in the female condom and an increased discussion of dual protection by providers.

## **Making female condoms accessible**

It is important to ensure a steady supply of female condoms through the support of governments and donors. Although the study showed that female condom availability does not guarantee its use, and that participants felt that the condom was not popular, the researcher recommends that the Botswana government should continue to make female condom available at all health facilities. The researcher believes change at time takes time. One article reported that it took 17 years before the tampon was accepted and used by women (Learning from the female condom experience. Microbicides May 2002 Antwerp . <http://archives.healthdev.net/gender-aids>).

## **Conclusion**

The study showed that both short-term and long term female condom the frequency of use was low and generally negative to neutral perceptions were held i.e. female condoms. Participants believed that although the female condom was readily available and that it empowered women, it was difficult to use. The women did not think the female condom was better than the male condom. The majority of participants believed the condoms were not popular with clients and that not enough was being done to

promote them. The study also observed that the participants would recommend female condom use to clients.

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