Women's Experiences with the Female Condom: A Case of Lavumisa Female Commercial Sex Workers, in Swaziland.

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ABSTRACT

The female condom has the potential to protect the health of millions of women at risk of sexually transmitted infections, including HIV, as well as unwanted pregnancies. Increased use of the female condom and its positive impact on health is therefore substantial, particularly in the context of the growing feminisation of HIV/AIDS epidemic and high maternal mortality as well as high unmet need for contraception. However, female condoms in Swaziland do not seem to have attracted much attention. Using sex workers, this study aimed to explore the factors that facilitates and inhibits use of the female condom.

Their main reasons for using the female condom were protection from sexually transmitted infections and pregnancy prevention. The qualitative interviews revealed that women like the female condom and prefer it over the male condom because it offers them more options and moreover they control its use. Other factors that facilitate its use include the fact that it can be inserted up to eight hours before intercourse and that it can be negotiated as a contraceptive. Partner objection, cultural and social beliefs, and limited availability served as barriers to the use of the device.

Some women reported secret use, but a majority had to negotiate its use. Although women have to negotiate its use with their sexual partners, the fact that the female condom provides women with an independent method of protection that they can use on their own increases their ability to control their sexual health. The study indicates the potential benefits of female condom use in increasing protected sex acts.

DECLARATION

Submitted in partial fulfilment of the requirements for the degree of Master of Population Studies, in the Graduate Programme in the School of Development Studies,
University of KwaZulu-Natal,
Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master of Population Studies, in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Date

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Editor name and surname (*if applicable*)

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHANGE	Centre for Health and Gender Equity
CSA	Centre for the Study of Adolescence
DCP2	Disease Control Priorities Project
FDA	Food and Drug Authority
FHC	Female Health Company
FHI	Family Health International
GCWA	Global Coalition on Women and AIDS
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
NATICC	Nhlangano Aids Training Information Counselling Centre
NGOs	Non- Governmental Organizations
PAI	Population Action International
PATH	Program for Appropriate Technology in Health
PHR	Physicians for Human Rights
PSI	Population Services International
SDHS	Swaziland Demographic and Health Survey
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	Joint United Nations Programmes on HIV and AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The link between women's powerlessness and their sexual and reproductive ill health is now widely recognised and accepted (Amaro et al 2001; Murphy 2003; Fathalla 1998). In fact, ample evidence has been generated that establishes that women's health disadvantages often arise from the underlying gender power inequalities (DCP2 2008; Schoepf 1992), which severely limit their abilities to protect themselves against infection and unwanted pregnancy (Elias and Heise 1994; Okojie 1994; Santow 1995). This fact is most evident when measuring women's excess disease burden, particularly sexual and reproductive ill-health (WHO 2002). The AIDS pandemic has also starkly demonstrated this fact (Blanc 2001; Gupta and Weiss 1993); particularly in sub Saharan Africa where women account for 60 percent of all HIV infections (UNAIDS 2009).

Gender inequality is not the only driver of the HIV/AIDS pandemic, but hampers the overall well being of women**,** as Murphy (2003) captures it in the title of her paper, "being born a female is dangerous for health". Because of their low social status, women and girls often lack the ability to determine the course of their own lives. Limited access to economic resources and fear of violence force many women to yield control over sexual relations to men (Ankrah 1996; Gupta 2000; Murphy 2003; UNFPA 2000). Thus, in poor countries with strong male dominance, women usually have little control of their sexual lives, are rarely able to choose when to have sex, how many children to have or whether to use contraception or protection against sexually transmitted infections (STIs) (Holtz 2007; Murphy 2003). This is clearly manifested in the 80 million women who have unintended pregnancies annually, (Glaiser et al. 2006), the half a million women who die from complications associated with pregnancy and childbirth every year**,** which leaves 210 million women with disabilities (UNFPA 2009), and the 7000 women who are newly infected with HIV every day (GCWA 2006).

Effective prevention methods are available to avert these needless deaths and suffering (Obaid 2006). However, the female condom is the only prevention tool available that is uniquely suited to respond to these women's prevention needs; providing women with their

own source of protection against STIs, including HIV. The device is a soft loose polyurethane plastic pouch that is 17 centimetres long with a flexible ring at each end to aid insertion and hold the condom in place during intercourse. The United States Food and Drug Authority (FDA) approved the female condom as a safe and effective contraceptive and protective device impermeable to various STI organisms, including HIV (Peters et al. 2010). The device was developed as an alternative strategy to the male condom, aimed at ensuring a female controlled safe sex method (Hoffman et al. 2004). Women health advocates trumpeted this new innovation; a woman initiated device that offers women control over their own health and survival (Kaler 2004; Shane 2006). This device could provide a life saving choice for women in Africa and elsewhere who are at risk for HIV and other STIs (PATH/UNFPA 2006). Thus, Daisy Nyamukapa, UNFPA Zimbabwe asserts, "...it [female condom] is a necessity that determines life or death" (PATH/UNFPA 2006, 5). Therefore, ensuring greater access to female condoms cannot only help contain the AIDS epidemic, but also give women control over their sexual lives.

In fact, female condoms are a vital tool in decreasing maternal deaths, improving maternal health and promoting sexual and reproductive health and rights (CHANGE 2008). The potential for increased use of the female condom and its positive impact on health is therefore substantial (Shane 2006), especially in the context of the growing feminisation of HIV/AIDS epidemic and high maternal mortality as well as high unmet need for contraception.

1.2 Female Condom: Potential for Pregnancy Prevention

The female condoms have the potential to protect the health of millions of women at risk of unwanted pregnancies, but are not using any form of contraception for one reason or another. The World Health Organisation (WHO) estimates that in developing countries more than one third of all pregnancies are unintended (WHO 2004). This has wider implications for the health of women as unwanted pregnancies are more likely to end in induced abortion (FHI 1995), even when the only available procedures are unsafe and illicit (Kwast and Liff 1988). In fact, more than half of the unwanted pregnancies end in abortion – and half of those are performed in unsafe conditions. About 68 000 women die annually from complications of unsafe abortion (Grimes et al. 2006) and the many millions that survive it suffer extreme blood loss, infection, pain, damage to internal organs and infertility (Murphy 2003). Meanwhile, every minute, one woman dies from complications related to pregnancy or childbirth (WHO 2005). Hence, United Nations asserts that maternal health remains a

regional and global scandal. The odds that a woman in sub Saharan Africa will die from complications of pregnancy and childbirth during her lifetime are high: one in 16 compared to one in 3800 in developed countries (UN 2007). Therefore, the saying that "once a woman gets pregnant she has one foot in the grave" is nowhere else more true than in sub Saharan Africa, where pregnancy can be the beginning of a journey to the end of a woman's life (CSA and PAI 2009). Use of contraception can prevent this whole tragedy and cut maternal mortality. It is estimated that 90 percent of the abortion related and 20 percent of the pregnancy related morbidity and mortality, along with 32 percent of maternal deaths could be prevented by use of contraception (Cleland et al. 2006). By itself this is a very effective strategy.

Yet 137 million women worldwide lack access to modern forms of contraception (UNFPA 2004; Singh et al. 2004) and those who have access are not using it. Contraceptive prevalence in sub Saharan Africa is considered to be the lowest in the world; only 13 percent of married women aged 15-49 use a modern method of contraception, and only 19 percent use any contraceptive method (Westoff 2002) and an even larger percentage of women – 25 percent report having an unmet need (Gribble and Haffey 2008). Therefore, it is not surprising that every year in sub Saharan Africa; 14 million women are confronted with unintended and unwanted pregnancies (Hubacher et al. 2008) and will face the deadly consequences of unsafe abortion.

Partner opposition has been put forward as a reason for non-use of contraception. However, Sedgh et al. (2007) found that it was reported infrequently, but prominent in a few countries in the sub Saharan African region. They document that more than half of the women who cited partner opposition indicated that they nevertheless intend to use contraception in the future. It is rather fear of side effects that accounts for the larger proportion of the reasons cited for non-use of contraception (Harrison and Rosenfield 1996). Murphy (2003) contends that many women have access to contraceptives but fear side effects and health complications of contraception or are contraceptive dropouts – frequently because they were not prepared for the troubling side effects. Research on barriers to contraceptive use has found that use of hormonal methods was limited by concerns of severe side effects, especially fear of infertility (Williamson et al. 2009; Silberschimidt and Rasch 2001; Konje and Ladipo 1999; Sedgh et al. 2007; Woods and Jewkes 2006). Some women believe that modern contraceptives are not only unsafe but toxic to women's health. They fear that the hormonal contraceptives are

likely to have a detrimental effect on their health and render them infertile (Gorishti and Haffey 1996, 11).

Hence, women's health advocates are emphasizing the development of contraceptive methods that do not have the side effects associated with hormonal methods. In addition, they are advocating for methods that women can initiate and control and do not rely upon the assistance of the healthcare provider for use and that are immediately reversible (WHO/UNAIDS 2000). According to Brown et al. (2006) the female condom has virtually no side effects. Studies have found that when the female condom is used correctly with every act of sex, there would only be an estimated five unintended pregnancies in one year for every woman using the female condom (FHI 2001). Research has found widespread acceptability of the device, where condom promotion campaigns have stressed the contraceptive function. The studies have further documented sustained use in cases where it is employed primarily for contraception (Ankrah and Attika 1997; Kerrigan et al. 2004). Family planning experience has shown that increasing the choice of family planning methods leads to an increased uptake and more consistent and continued contraceptive use (Mantell et al. 2008). Thus, it may help address the high unmet need for family planning, as couples will have access to more methods that meet their needs and preferences.

1.3 Female Condom: Significant Potential for STI Prevention

Sexually transmitted infections (STIs) are taking an enormous toll on health, particularly on women's reproductive health (UNFPA 2004); the disease burden of STIs in women is five times that of men and the impact is particularly evident among women of childbearing age with the youth being disproportionately infected (WHO 2002, 2006). In fact, next to complications of pregnancy and childbirth, they are the leading cause of health problems for women of reproductive age (Glasier et al. 2006; UNFPA 2009). In addition, STIs further increase the risk of contracting HIV (WHO 2006). Individuals with an STI are two to nine times more likely to become HIV infected through intercourse with an infected partner than those who do not have an STI (Population reports 2000).

Women now comprise 50 percent of the people currently living with HIV (UNAIDS 2009). Gupta (2006, 1) finds it a cruel irony that in AIDS related illness and death, women now have equality with men - equality that has denied them in life. However, sub Saharan Africa is unique as there are 61 percent of women living with HIV and 75 percent of young people infected with HIV are female; for ages 15-24 years the rates of infection among women are

between three to six times that of their male counterparts (UNAIDS 2009). Hence, Lewis (2004, 1) described the lethality and impact of HIV/AIDS on women as "raging with Darwinian ferocity in sub Saharan Africa."

In addition to HIV there are 340 million new cases of curable STIs occurring each year (WHO 2001, 2006; Shane 2006; UNFPA 2004). Each day, 500 000 young people, mostly young women are infected with an STI, excluding HIV (UNFPA 2004). WHO (2008) contends that STIs are among the five most important cases of adults seeking health care and of healthy productive life lost. They cause high morbidity, pregnancy related complications, including spontaneous abortions, premature births, still births and congenital infections (UNFPA 2000). This underscores the need to expand HIV prevention efforts that will include all available methods, particularly methods that women can initiate (Stein 1990) given the complexities they are faced with in negotiating safer sex in heterosexual relationships. Gupta (2000) asserts that ensuring greater access to female condoms and accelerating the development of microbicides can greatly reduce women's vulnerability and help to contain the AIDs epidemic. But, Barbosa et al. (2007) ask that we do not standby and applaud progress in vaccine and microbicide development, without attending to women's immediate needs. The female condom is available now and can offer women dual protection against STIs and pregnancy, thus ensuring them the needed control over their sexual lives (Gullob 2000; Shane 2006). Barbosa et al. (2007, 261) contend, "...as a currently available device that women might use to protect themselves against HIV, the female condom stands alone". Dr Piot recommends that making the female condom more accessible is an important step forward in increasing the prevention arsenal for women (AIDS weekly plus 1996).

A number of studies have shown that female condom use increases the number of protected sex acts, consequently reducing STIs and the risk of transmission and contracting HIV. A number of women report alternating between the male and the female condom, thereby increasing the number of protected sex acts (Hoffman et al. 2003; Hoke et al. 2007; Kerrigan et al. 2004; Musaba et al. 1998). Dr Steve Sinding, Director General, International Planned Parenthood Federation sums up the existing research on increased number of protected sex acts with the following statement: "the female condom works… When it is offered with good counselling and support, female condom availability results in significantly safer sex… More choice equals more protection. It's that simple." (PATH/ UNFPA 2006, ii).

The female condom is a cost effective contraceptive and STI prevention method in terms of averting disability adjusted life years (Oxfam 2008). However, it should be noted that this device does not transform the social forces which lead to women's vulnerability to infection, but it redresses some of the injuries of misogyny and sexism and thus reduce women's vulnerability to infection (Kaler 2004, 4).

1.4 The Need for Female Condoms in Swaziland

HIV/AIDS is a serious public health problem in Swaziland (Buseh et al. 2002; UNDP 2008). In fact, Swaziland holds the unenviable position of having the highest HIV prevalence rate (26 percent) in the world (SDHS 2006/07; Whiteside et al. 2003). And the increasing incidence of HIV infection among women and particularly girls is dramatic. The Swaziland Demographic and Health Survey estimated that one in two women aged 25-29 are HIV positive. It further noted that women become infected earlier, with almost two times as many girls aged 15-19 testing positive to HIV compared to their male counterparts.

Sackey and Raparla (2001) argue that Swazi women's (particularly young women) vulnerability to infection is because of biological and cultural predispositions. However, Thoraya Obaid asks that "while we recognise the 'natural' biological susceptibility of women to HIV, it is the manmade structural elements of culture, economic and social inequalities that are significantly pushing HIV infection rates to unacceptable levels among women and girls" (*speech at the annual conference of the Australian society of HIV medicine AUSAID symposium, on 31 august 2005*). Whiteside et al. (2003) also affirms that the issues of gender, women's relative lack of power and women's status in society are critical in influencing the spread of HIV in Swaziland. The low status of women in Swaziland is further entrenched by a number of cultural practices like polygamy and widow inheritance (Zwane 2005). In addition, notions of masculinity that equate being a man with dominance over women, sexual conquest and risk-taking are prevalent in Swaziland (Tobias 2001; PHR 2007) which further exacerbates women's vulnerability to infection.

In traditional Swazi culture, young women have little power to determine their sexual behaviour (Buseh et al. 2002). Also the population based study undertaken by the Physicians for Human Rights in Botswana and Swaziland attest that women's lack of control over sexual decision-making was increasing women's vulnerability to contracting the virus (PHR 2007). In Swazi culture decision-making has traditionally been a male prerogative (Government of

Swaziland 2009). For example, a recent report of the state of the Swazi population reported a widespread knowledge of birth control, but found actual use not to be reflective of the knowledge. As a result, women have been subjected to a number of unwanted pregnancies to the detriment of their own health and survival in order to satisfy their husbands and in-laws (Government of Swaziland 2009). Also misconceptions about modern contraceptives are also fairly widespread, further increasing their risk of unplanned and unwanted pregnancies.

In fact, unplanned pregnancies are common in Swaziland: overall 37 percent of births are unwanted (SDHS 2006/07). As a result, maternal and prenatal morbidity and mortality in Swaziland remains relatively high, with a maternal mortality ratio of 589 per 100 000 live births (SDHS 2006/07). Teenage pregnancies are also very common: it was observed that young people between the ages of 15-19 years accounted for 27 percent of recorded deliveries (Ministry of Health and Social Welfare Report 2001-2005) which constitute a substantial percentage of maternal mortality, as well as unacceptably high STI prevalence rates (WHO 2002-2005): almost 10 percent of the population was treated for STIs in 2008 (Government of Swaziland 2008), indicating prevailing high risk sexual practices in a country that has alarming rates of HIV. Dr Gill Greer, Director General of International Planned Parenthood Federation, asked that one should not forget what these statistics represent, "behind each of these statistics is a complex story, the complex story of a woman entitled to a life of dignity and meaning" (*speech at the 5th International Dialogue on Population and Sustainable development, on 17 October 2006*). The female condom can help restore the dignity of Swazi women by giving them more control over their sexual lives, and perhaps in other avenues of their lives as well. As Ankrah and Attika (1997) argue that it has the potential to open up the possibility of greater equality in sexual relations between men and women.

However, female condoms in Swaziland do not seem to have attracted much attention. It has only been largely marketed to the high risk groups (sex workers), leaving out many women in the general population who could benefit from it. Therefore, its use by the general population remains miniscule. Also its supply remains low; the national strategic plan 2004-2008 objective was to increase the number of available female condoms from 19 966 in 2004 to 80 000 in 2008 (Avert 2009). This is significantly below the levels needed for it to make an impact on the HIV/AIDS epidemic, as well as on Swazi women's reproductive health in general.

In view of the unpopularity and unavailability of this life saving tool for women this study seeks to explore women's experiences with the female condom and since there is such a low use of the female condom by the general population, sex workers of Lavumisa were chosen as non-governmental organizations (NGOs), (Nhlangano Aids Training, Information Counselling Centre (NATICC) and Population Services International (PSI)) have successfully promoted the female condom use among this group. This study seeks to explore sex worker's experiences with the female condom in order to inform female condom programming and therefore increase access and uptake of this much needed device, as well as maximize effective and consistent use of the device.

1.5 Objectives of the Study

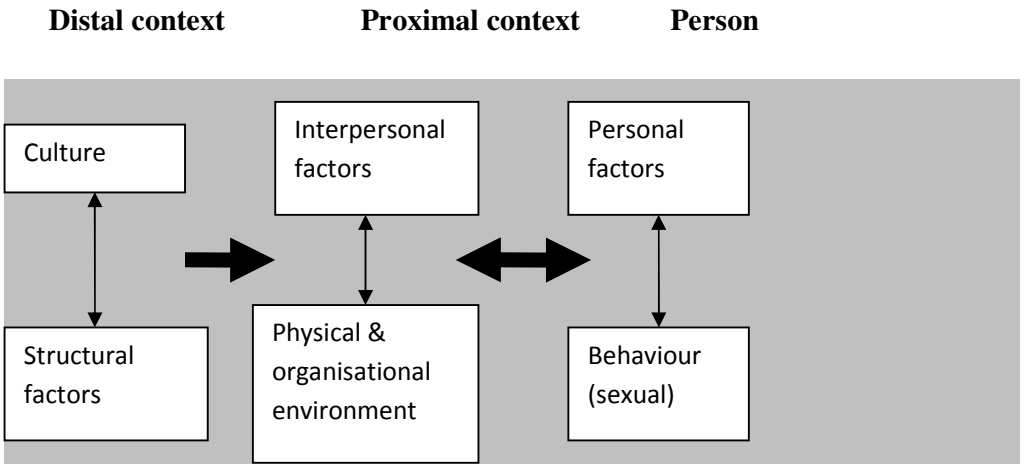
The main objective of the study is to explore women's experiences with the female condom.
The specific objectives of the study are to identify factors influencing use and non-use of the female condom. In particular, the study focuses on the ways in which the device affects women's ability to negotiate protection against pregnancy and HIV.

1.6 The Theoretical Framework

This study draws on Eaton and colleagues' model of unsafe sex behaviour among youth in South Africa to understand women's experiences with the female condom. This model proposes that if we are to understand sexual risk behaviour we need to consider the interactive effects of factors at three levels: within the person, within his or her proximal context, and within the distal context (Eaton et al. 2003, 2). It should be noted that these three domains are not separate they overlap to a certain extent and reciprocally influence each other. Meyer-Weitz et al. (1998) states that this model considers the difficulties that people experience in negotiating condom use at the interpersonal level which are made worse by personal factors such as self-esteem and self-efficacy for condom use and cultural taboos against frank sexual discussions between men and women.

Figure 1.1 presents a framework for organising the relationship between sexual behaviour, personal factors and the proximal and distal contexts.

Figure 1.1: The interactive effects of sexual behaviour at the three levels



Source: Eaton et al. (2003)

According to Eaton et al. (2003) personal factors reside within the individual person, such as cognitions and feelings relating to sexual behaviour and HIV/AIDS (knowledge and beliefs, perception of low personal risk, intentions, and perceived costs and benefits of undertaking the health related behaviour), as well as thoughts about oneself including self-efficacy and self-esteem. These personal factors influence sexual behaviour and HIV risk. The proximal context encompasses interpersonal relationships and their physical and organizational environment that impinge upon an individual (Mathews 2005, 147). They include factors related to interpersonal relationships: negotiating condom use: coercive, male dominated sexual relationships: relationships with parents and health workers, and peer pressure. The physical and organizational environment encompasses factors such as place of residence (urban or rural), and access to condoms (Mathews 2005; Eaton et al. 2003). The distal context includes cultural factors, such as traditions, the norms of the larger society, the social discourse within the society and shared beliefs and values, and structural factors such as the legal, political, economic and organizational elements of a society (Eaton et al. 2003). Mathews (2005, 147) further argue that discourses that support the unequal distribution of sexual power between men and women, and the subordination of women's needs and rights have an influence on sexual behaviour and HIV risk.

In summary, the theoretical framework discussed above takes into account all the complexities involved in condom use. As Kaler (2004) commented that in as much as the

female condom is supposed to liberate women from their reliance on men for protection, it is not sufficient in itself to overthrow the status quo.

1.7 Organization of the Dissertation

This dissertation consists of five chapters. The first chapter provides a background to the study and outlines the aims and objectives of the study. Chapter two reviews literature of previous studies on female condoms and identifies the contributions made by these studies and also identifies the gaps in the literature. Chapter three outlines the methods used in the study. The research findings are presented in chapter four and the last chapter summaries the findings of the study and compares it with other studies, and also presents the recommendations for action.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Increasing advocacy for the female condom emerged in the context of the growing feminisation of HIV (Holmes et al. 1990; Hoffman et al 2004). Women's health advocates called for the development of female-controlled barrier methods, microbicides and vaccine. At the XVIII International AIDS Conference in Vienna, CAPRISA reported some promising results on microbicides. A microbicide gel made from antiretroviral drug tenofovir, proved effective in preventing transmission of HIV, cutting the overall infection rate by 39 percent (Abdool-Karim et al. 2010). However, it is still not available for public use as they still have to confirm the results. The female condom therefore remains the only method of protection that is under women's control. The product is known by several brand names in different countries: Reality, Femidom, Dominique, Care, Feminine, etc. In 2005, a new type of female condom was developed, the FC2. It retains the form of the FC1, but is made from a synthetic rubber called nitrile and is available at a lower cost than the FC1. There is also another type called Condom Feminine (VA), like male condoms it is made of latex and uses a sponge to secure the condom in the woman's vagina. However, it is not yet approved by the FDA. This chapter will review what has been learnt about the female condom and the factors that facilitate and serve as barriers to its use.

2.2 Acceptability and Use of Female Condoms and Challenges Involved

Many countries rushed to try this female initiated method; it has gained popularity in over 90 developing countries. However, in most of these countries they are not readily accessible and its use remains low (CHANGE 2008; Shane 2006). Many of the programmes in these countries are small projects and make the female condom available in randomly chosen outlets or make it only accessible to the population in pilot studies and experimental programmes. Hence, Hatzell and Feldblum (2001) conclude that its use remains largely miniscule because many women who could benefit from it cannot access it or have never heard of it. It has rather been largely promoted among high risk populations (World Population Foundation and Oxfam Novib 2007; Oxfam 2008). Macaluso et al. (2000) observed high levels of female condom acceptability and use among women at high risk of STIs. In fact, having multiple sexual partners has been demonstrated as the most potent

predictor of female condom use, hence its widespread promotion among female sex workers (Deniaud 1997; Holmes et al. 2007; Macaluso et al. 2000). However, this marginalises the female condom because it does not attempt to create demand among the general public (Oxfam 2008). Furthermore, targeting only high risk groups ensures that the female condom will never be adopted in a meaningful way (Centres 2008).

Nevertheless, in some countries, such as Brazil, Ghana, South Africa and Zimbabwe, it is widely used (CHANGE 2008; Brown et al. 2007; Avert 2010). These countries have actively promoted its use, suggesting that effective programmes can create demand (Hoffman et al. 2004). Research in these countries found three elements that were critical to the programmes success: offering specific training for healthcare providers, and most importantly offering counselling to users and lastly ensuring consistent supply of condoms (CHANGE 2006; FHI 2007). Counselling potential users on how to use this device is particularly pertinent because critics of the female condom claim that it is cumbersome to use and hence the conclusion that women do not like using it. Warren and Philpott (2003) find this to be a tendency where the introduction of the technology is not successful and consequently explanation of programme failure fall too heavily on the product itself, rather than on the failures of the introduction strategies. Hence, in the female condom information pack it is clearly stated that for the female condom to provide the greatest public health impact it must be introduced strategically (UNAIDS/WHO 2000).

However, strategic introduction requires a great deal of funding which Warren and Philpott (2003) found to be lacking in most of the introduction programmes. Many donors and governments prefer to fund trials, pilot programmes and studies rather than long-term commitments (Oxfam 2008), yet for the female condom to provide the envisaged public health impact it has to be available to the general public, outside the orbits of pilot studies and experimental programmes (Kaler 2001). Acceptability studies have shown that women are keen to try this female initiated device and their partners acquiesce to its use and sometimes have preferred it to the male condom (Gollub et al. 1995; Gollub 2000; Hoffman et al. 2003; Kerrigan et al. 2004; Vieira et al. 2004). Now the issue is ensuring expanded access, as well as widespread acceptance and consistent use by the general public for it to provide the greatest public health impact (Seal and Ehrhardt 1999).

2.3 Use as a Contraceptive

PATH/UNFPA (2006) asserts that women want the means to protect themselves from unplanned pregnancy and that they are eager to try products that offer them protection. The female condom provides a physical barrier that offers women simultaneous protection against conception and STIs (Hoffman et al. 2003; Gollub 2000; PATH/UNFPA 2006). A randomised control trial among Japanese family planning clients reported pregnancy rates of 0.8 percent among consistent and correct users, and 3.2 percent among typical users (Trussell 1998). While another study in the USA estimated higher pregnancy rates: 9.5 percent (Farr et al 1994). Even so, there is a consensus that its contraceptive efficacy is in the same range as those of other barrier methods. Over the course of one year the accidental pregnancy rates range from 15 percent to 25 percent for actual use to as low as 5 percent for correct use with every act of intercourse (UNAIDS and WHO 2000).

Women find it easier to negotiate the use of the female condom as a contraceptive than for disease prevention (Kerrigan et al. 2004; Ray et al. 1995). For example, in the acceptability study of the female condom in Zimbabwe, several women reported that they were interested in the method for disease prevention, but were not comfortable to discuss this with their partner. Instead they would discuss pregnancy prevention. Rivers and colleagues (1998) did a multi-site study of the impact of the female condom on sexual communication and in negotiation. They found that women used the contraceptive role of the female condom to negotiate its use to male partners who were reluctant to use the device. One participant states, “sometime after the start of the follow up, my husband, began to grow weary of the [female] condom and no longer wanted to have sexual intercourse [with it]. I told him that I was very attached to it because it is a good form of contraception and as we had agreed to space out my pregnancies, he had to accept...” (Rivers et al. 1998). Another participant from Brazil affirms, “when he doesn’t want to use condoms, I pretended that I could get pregnant, because I was not taking the pill” (Dias et al. 2006, 72). Another woman in Nairobi explains how she had to convince her husband who had initially quarrelled with her and stated that he would never eat a sweet with its wrapping, to try the device by telling him about the side effects she experienced with the coil and the pill. As a result, “he soon listened because he did not want any more children” (Mwakisha 1996, 47). Thus, the conclusion that female condoms offer an option to hormonal methods of contraception (Vijiyakumar et al. 2006).

Negotiating the female condom use for pregnancy prevention has been found to distance the product from the stigma associated with male condoms and STIs. Usmani (2002) argues that where it is negotiated as a contraceptive, negotiations proceed without insinuations of infidelity or guilt. This results in an attitudinal change and consequently ensures wide acceptability. This is particularly true in Zimbabwe, where the device was marketed as a "contraceptive sheath"; as a result greater acceptability of the device was reported. Also South Africa has the second largest market of female condom in the world and this has been attributed to its strategic introduction programme; It was introduced through family planning clinics to avoid stigmatising it as being purely for disease prevention (FHI 2007; Mqhayi et al. 2003). Furthermore, consistent condom use is reported when condoms are the only contraceptive method used (Wilson et al. 1999).

However, there are few married women who use condoms as their primary method of contraception. Morroni and colleagues (2003) investigated the prevalence of dual protection and use of condoms alone among women attending primary health care clinics. They found that being unmarried among other factors was a strong predictor of dual method and condom use. This is in accord with Alan Guttmacher Institute (1997)'s finding that unmarried couples use condoms in greater proportions to prevent unwanted pregnancies. UNFPA (2007) reported that 20 percent of this group use condoms as a primary method for contraception. Thus, Sappire (2006) contends that it is plausible that young couples will adopt this device as a contraceptive option. Gomez and Marin (1996) further argue that many women who never use condoms may feel that they are making a rational decision based on the risk of pregnancy. Holmes and colleagues (2007) did a study examining the predictors of female condom use among African-American women. They found that users of the female condom were less likely to use oral contraceptives indicating that users of the female condom are more likely to be people not using contraception; therefore they are more likely to adopt the method primarily for pregnancy prevention.

Furthermore, people who are living with HIV continue to be sexually active and choosing whether and when to have children remains their fundamental right. Population Action International (2008) implies that high rates of unintended pregnancies among people living with HIV is an urgent health and rights crisis. Preventing unintended pregnancies among women living with HIV and those at risk is critical for preventing mother to child transmission of HIV. In Welbourn's (2006) words "for HIV positive women and girls using a

condom...is a matter of life and death." Besides, using female condoms could play a major role in protecting HIV positive women's sexuality and continued sexual activity as a fundamental part of their sexual and reproductive rights.

However, the promotion of condoms as a contraceptive method remains somewhat controversial amongst family planning providers. Proponents against are concerned about migration from contraceptive methods with higher method effectiveness (Mantell et al. 2000; Cecil et al. 1998). It should be noted though that the importance of preventing reproductive tract infections is being increasingly recognised as essential to good reproductive health care.

2.4 Female Condom and STIs Prevention

Perhaps the most significant role of the female condom is its use as a preventative method against HIV and other STIs. Several laboratory studies show that the material used in female condoms, polyruthane, is an effective barrier against many common STI organisms, including HIV and other viruses (FHI 1995). A test simulating sexual intercourse found that the female condom was impermeable to HIV (Drew et al. 1990). Modelling exercises estimate that the perfect use of female condoms for one year by a woman having sexual intercourse twice per week with a partner that is HIV positive can actually reduce the risk of contracting HIV by 90 percent (PATH and UNFPA 2006). French and colleagues did a head to head comparison of the effectiveness of female and male condoms in preventing new infections. Study participants were randomly assigned to one of two arms: one receiving training, support, and supplies for male condom use: the other was equipped in the same way for female condom use. Findings show that women in the latter group had reduced risk of new STIs compared with the women in the male arm (French et al. 2003).

A recent study on female sex workers in Madagascar documented a reduced STI prevalence after short to medium term promotion of male and female condoms. In six months the STI prevalence declined from a baseline of 52 percent to 50 percent with the use of male condoms only. After addition of the female condom, STI prevalence dropped to 41 percent at 12 months and 40 percent at 18 months. These studies provide promising evidence of public health benefits which can be gained by adding the female condom to male condom distribution (Hoke et al. 2007). However, Hoffman et al. (2003) argue that for the female condom to be able to offer this added benefit, intervention programs would have to aim at

increasing the proportion of episodes of sex that are protected among women and men who use condoms inconsistently, or to target those who use protection rarely, if at all.

In addition, the female condom offers more protection because it covers the outer parts of the clitoris and labia (FHI 1995; WHO/UNAIDS 1997), protecting the woman against herpes infection or re-infection. Women in South Africa when interviewed on the increased number of protected sex acts, they kept referring to the safety and coverage provided by the female condom (Mqhayi et al. 2003; Beksinkska et al. 2001). Also Kerrigan et al. (2004) reported that some women perceive the female condom to be stronger than the male condom because of its strength and resistance against breakage. As one participant remarked, "... I trust them more than male condoms (I have had several of them split)" (Oxfam 2008, 14). And many women in the acceptability studies have emphasized the fact that the female condom made them feel more protected and safe (Hoffman et al. 2003; Kerrigan et al. 2004; Ray et al 1995), as cases of men making pinholes or tears in male condoms are not uncommon (Hart et al. 1999; Pool et al. 2000). In an acceptability study of female condoms in Zimbabwe, women expressed a deep distrust of their partners. One participant remarked, "men sometimes take their condoms off during intercourse. You can't rely on them." (Ray et al. 1995, 72). Another participant reiterates, "...all we know is that these male condoms break very often and we are suspicious they have been tampered with" (Ray et al. 1995, 73). The female condom therefore, is more appealing in this context because women insert the condom themselves and know that it is not tampered with.

Welbourn conducted an informal email survey among the e-group members of the International Community of Women Living with HIV/AIDS to find out about their attitudes and experiences as HIV positive women of using the female condom. She documented an interesting, but out of the ordinary finding, one woman stated, "my husband is not positive and he feels more comfortable if I use a female condom because it protects him better than using a male condom" (Welbourn 2006, 35). In as much as this may not be technically accurate as the female condom offers the same amount of protection as the male condom, but what is significant is that her partner felt more protected.

2.5 Increased Total Number of Protected Sex Acts

One critical question that is usually asked is whether promoting and distributing the female condom leads to an increased proportion of protected sex acts (Hoffman et al. 2004; Mantell et al. 2003; Shane 2006). Intervention studies that have tracked the patterns of female condom use over a period of time (6 months to a year) have documented an increase in the level of protected sex among participants who were offered female condoms, although at times the increase is miniscule (Hoffman et al. 2003; Hoke et al. 2007; Kerrigan et al. 2004; Musaba et al. 1998). A study conducted on STI clinic clients in the US, documented a significantly higher overall proportion of episodes of sex that were condom-protected – 50 percent compared with 40 percent at baseline. An estimated 25 percent of sex acts were female condom protected (Artz et al. 2000). Also the study on female sex workers in Madagascar, reported an increased total number of protected sex acts which subsequently reduced STI prevalence. With the addition of female condoms the number of protected sex act increased from 78 percent with male condoms only to 83 percent at 12 months and 88 percent at 18 months (Hoke et al. 2007).

Choi and colleagues did a longitudinal survey on ethnically diverse women attending family planning clinics in the United States to examine female condom self efficacy, frequency of and comfort with communication about sex, comfort with device insertion, and traditional gender role expectations to determine whether these predictors of male condom use have the same explanatory power for female condom use. They reported a significant increase in the proportion of vaginal acts protected by either the female or male condom, from 44 at baseline to 59 at 3 months (Choi et al. 2003). Another study done in South Africa also yielded an increase in the number of protected sex acts. Although there was no comparison group, the overall proportion of protected episodes was estimated to be 50 percent at six months compared with 40 percent at baseline (Mqhayi et al. 2003). Hence, the authors argue that the availability of female condoms provides couples with more options thus increasing the total number of protected sex acts. This is illustrated in the study done on sex workers in India, 65 percent of participant sex workers reported the use of female condoms when their clients or partners did not use the male condom (HLFPPT and TNS 2007).

Also Gullob (2000) observed a synergistic or greater than additive effect where the female condom was introduced in the context of concurrent male condom availability. An outcome of greater overall protection, whether measured in behavioural change or disease reduction is

found. In Choi and colleagues study, they found a significant increase in the proportion of vaginal acts protected by the female condom at 3 months compared to baseline and little changes in male condom use during the study (Choi et al. 2003). These results also suggest that female condom use supplements male condom use, which in turn leads to an increase in overall protection. This supports the view that the more options for disease prevention, the more likely that people will engage in safer sex (Cecil et al. 1998; Choi et al. 2003; Macaluso et al. 2000). Hence, advocates of the female condom contend that the female condom can play an important role in curbing the spread of HIV by filling the protection gap left by male condoms.

2.6 Empowerment

In the information pack about the female condom, the authors summed up existing research on the device with the following statement, "the female condom has been shown to contribute to women's sense of empowerment" (WHO/UNAIDS 1997). Acceptability studies have also shown that the female condom contributes to women's empowerment (Ankrah and Attika 1997; Gullob 2000; Kerrigan et al. 2004; Welbourn 2006) and Kaler (2004) argue that the female condom is part of a long tradition of empowering women which has animated women's health movements for decades. Chege (1999) finds this view of the female condom as a tool for empowerment to be founded on the observation that women can now protect themselves and are no longer helpless like in the past where they had to rely on men to use their (male) condom. This is clearly illustrated in the Preston-Whyte study where the participants demanded the female condom to free them from their dependency on men. Actually, they envisaged the possibility of a gender dispensation in which the female condom may provide a basis for independence from male control. As one participant put it, "…if we earn money we have power…if we wear them we will be free" (Preston-Whyte 1995, 221).

However, Kaler (2001) argue that this device is for women who are already empowered, who believe that they have the right to autonomy and is acting on that right by using her own condom. Hence, the new found sense of autonomy that the female condom is reported to arouse in women when they handle this device for the first time. As Gollub (2000) reported that there is some sort of special freedom that women feel when they hold "their own" condom.

Qualitative studies over the past decade have shown that women view the female condom as a means of enhancing safer sex bargaining power within the relationship (Hoffman et al.

2004; Green et al. 2001; Okunlola et al. 2006; Rivers et al. 1998). The studies have established that the female condom changes the dynamics of the dyad, rather than adding to the burden of what women normally need to negotiate with their partners and raising the risk of emotional or physical retribution (Ankrah and Attika 1997; Gullob 2000; Kerrigan et al. 2004; Welbourn 2006). As Clement Naunje put it, "it has always been difficult for women to have the courage of telling a man to put on a condom whenever they are having sex, but this time around they will have a chance to protect themselves" (Banja Lanatsogolo 2006, PATH/UNFPA 2006, 11). Gullob (2000) observes, "in the past, the refusal of a man to use the male condom left women with one option, to refuse sex and a few succeeded. For most this strategy created an antagonism in the couple which could result in violence, but now this female initiated tool can be used in ways that are not threatening to the partner". One participant from Brazil expresses this, "for me the female condom is better, at least I don't have to keep asking him, insisting that he uses it [male condom]. Because all the time that I insist, there is a fight…then I use the female condom" (Dias et al. 2006, 72). However, a research gap exists in the use of female condoms in situations of gender based and partner violence (Harrison 2007 cited in CHANGE 2008). Mqhayi and colleagues did an evaluation of the introduction of the female condom in South Africa. A third of the women interviewed indicated that they could use the female condom in situations where their partners refused to use the male condom. More than two thirds believed that it would be easy to get a partner to use the female rather than the male condom (Mqhayi et al. 2003).

Studies have further shown that women like the female condom better than the male condom because it gives them control over their sexual lives (Ankrah and Attika 1997; Dias et al. 2006; Kerrigan et al. 2004; Welbourne 2006). In the acceptability study done in Zimbabwe, several study participants reported that they liked the feeling of being 'more in control' which this new technology offers them (Kerrigan et al. 2004). Also, a number of respondents in another study reported feelings of being more in control and confident during sex when using the female condom than with the male condom or during unprotected sex (Welbourne 2006). Kaler (2001) attributes this to the fact that, it not only emancipates them from relying on their male partners to protect them from STIs, but also gives them greater autonomy. As one respondent bluntly put this feeling, "once I put this in me, what can he do?" Another study participant remarked, "with the female condom I can take control and I feel more confident" (Welbourn 2006, 35). Basically it increases their sense of ownership over their bodies and their sexuality, thereby increasing their self-esteem.

Gollub et al. (2001) found that as a result of using the female condom, 32 percent of subjects drawn from the STI clinic felt more at ease about their bodies, and 14 percent felt more comfortable about undergoing a papanicolaou test. In view of this, Gollub (2000) argues that women's vulnerability to infection stems from their lack of knowledge about their bodies and in the resulting void they distance themselves from their bodies. This is manifested in the results of a group intervention session where women commonly reported feelings of shame, embarrassment and lack of control over their own bodies, and yet this is the same body we are asking them to be proactive about protecting (Gollub 2000, 1379). Therefore, the female condom could help instil in girls the knowledge of and confidence in their bodies. In fact, Ankrah and Attika (1997) recommend the female condom as a tool for the development of women's sexual confidence and autonomy. They assert that this may in a small way open up the possibility of greater equality in sexual relations between men and women and therefore its introduction can increase women's sense of self efficacy and self worth in ways that have effects beyond the issue of condom use.

For many women the introduction of the female condom has given them a chance to communicate to their partners about sex, pregnancy, sexually transmitted infections and family size (FHI 1999; Rivers et al. 1998). In the 1998 study done by Rivers et al. women reported that the female condom gave them an opportunity to talk to their partners about safer sex. In Costa Rica, the introduction of the female condom was accompanied by the lessening of inhibitions in sexual communication and occasional hilarity: "I put it in and; well we had to try another day because we both nearly died because of laughing. My husband said "to me it looks like a Costa Rican [coffee] filter bag" and that made us laugh!" (Rivers et al. 1998, 284). A number of women reported a greater degree of male involvement in using female condoms. Women who had difficulties with insertion asked for or were offered help by partners and this was unexpected as there is poor sexual communication in this culture. The authors then assert that this involvement may be essential in encouraging the beginning of a sexual dialogue between men and women (Rivers et al. 1998).

In Kenya where men are typically responsible for sexual decision making, the study participants reported that the female condom enabled them to talk about a broad range of topics, including intimacy and sexual pleasure (Ankrah and Attika 1997). Another study done by the UK Institute of Education in four countries showed that, the female condom empowers

women in sexual communication and further encouraged dialogue that went beyond sex to other important issues (Kalckmann et al. 1997).

On the other hand, the Zimbabwean study mentions that if there is too much focus on women's empowerment men feel threatened. Some men fear that the female condom might facilitate increased freedom for women, by providing them with opportunities to engage in sexual relations out of marriage. Hence, advocates suggest that the marketing of the female condom is directed at women, but should also involve men.

2.7 Source of Pleasure

Some women find sexual pleasure with the female condom superior to that of the male condom, as one woman who participated in the Brazilian study of female condom users put it: "you feel more sensation with the female condom" (Dias et al. 2006, 71). This increased sexual pleasure is attributed to its soft and lifelike feel. Unlike the latex, the polyurethane material in the female condom allows the transfer of body heat, thus preserving the sexual sensitivity and natural pleasure (Spizzichino et al. 2007). As one respondent remarks "it feels like I am doing it live" (Kerrigan et al. 2004, 26). Additionally, the external ring produces increased stimulation of the clitoris, enhancing orgasm (Dias et al. 2006; Kerrigan et al. 2004; Welbourne 2006).

For men the feeling is closer to that of sex without a condom because the female condom does not constrict the penis like the latex male condoms (Edlin et al. 2006). As one truck driver in the acceptability study in Ghana, remarked, "the female condom is more pleasant…because it does not feel as tight as the male [condom]" (FHI/population council 2000). Another man upon seeing the female condom for the first time asserted "I think I would rather use this other [female condom]. I think it's a lot easier. The girl just put it up there. The guy still has freedom. I think this would actually work better than the male condom." (Seal and Ehrhardt 1999, 100). However, few studies have directly asked men about their experiences with the female condom. Indirect responses from their partners show that they like and find it to be better than the male condom. Indirect responses from women in South Africa found that men felt that sex with the female condom was like flesh to flesh (Smit et al. 2006). Another participant stated, "it felt like there was no condom" (Smit et al. 2006, 397). Another participant from Brazil said, "he thinks it's better than the male condom" another stated, "he liked it! It's 1000 times better" (Vierra et al. 2004). They all seem to give

emphasis to its non-constricting factor. One participant from Zimbabwe remarked, “because the material is soft, it does not interfere with his erection which is something every man worries about” (Ray et al. 1995, 75). Hence, authors assert that it will be more appealing to men who have erection problems as it has been documented that men’s failure to maintain erection has sometimes interfered with male condom use (Gollub et al. 1995).

Moreover, it does not have to be removed shortly after ejaculation. Several women from the Zimbabwean acceptability study commented that their partners liked not having to withdraw from the vagina immediately after sex, as with the male condom, and that they could even fall asleep still inside the woman (Ray et al. 1995). In addition, the non latex versions can be used with any kind of lubricant (JHBSPH et al. 2007 cited from CHANGE 2008), which can bring added pleasure. Also, because the female condom can be inserted up to eight hours before intercourse (FHI 2001) it does not interfere with the moment. Interruption of sexual intercourse has been found to be a serious obstacle to male condom use, thus undermining its impact in the fight against the HIV pandemic. Higgins and Hirsch (2008) used an inductive approach to explore the range of sexual motivations and goals and analysed the relationship these sexual goals and contraceptive practices. They found that respondents had strong preferences for uninterrupted sexual flow. In fact, the respondents sought sex that was felt as close and natural as possible, spontaneous and free flowing. The female condom does not break the spontaneity of the encounter and a number of respondents have reported sex with it to be as close to sex without a condom.

Randolph et al. (2007) argue that any device that interferes with the pleasures of sex is likely to be avoided or accepted reluctantly. One woman remarks, “with the male contraceptive I do not feel anything, and I don’t want my partner to use it”, showing that perceptions of sexual pleasure tend to override concerns for health protection (Rivers et al 1998, 283). This has given birth to the growing demand for the promotion of female condoms as a way of enhancing sexual pleasure for both men and women. The authors argue that the pursuit of pleasure is one of the main reasons that people have sex; therefore pleasure must be addressed when trying to motivate people to use condoms and to participate in safer sexual behaviour (Philpott et al. 2006).

Actually there is growing evidence that shows that promoting pleasure alongside safe sex messaging can increase the consistent use of condoms and other forms of safer sex. This may

help contain the spread of HIV, as the impact of condoms in the fight against HIV has been limited by inconsistent use (Hearst and Chen 2004). Actually many studies of why condoms fail have found that inconsistent and incorrect use are the more likely causes of failure. But scholars argue that consistent use of condoms vary by the type of relationship, with more consistent use in high risk relationships (Kerrigan et al. 2004; Hearst and Chen 2004).

The female condoms have other advantages. In the Brazilian study of sex workers, one female sex worker participant reported that the female condom helps men to maintain their erection and ejaculate: "I had found clients who use the male condoms had difficulties to come. With the female condom they come with no trouble" (Dias et al. 2006, 71). Another sex worker from the study in Zimbabwe stated, "with male condoms men take longer to ejaculate and this is more tiring if we see many men in one day" (Ray et al. 1994, 74).

Perhaps the most significant advantage of female condoms is that they can be inserted up to eight hours prior to sexual intercourse. One woman from the Brazil study underscores the importance of this fact, "when I am going to a date and I know I am going to drink, then I put the female condom before, because I think it is more safe, because I know that if I drink I can forget to put it on" (Dias et al 2006, 73). This ensures consistent condom use even in cases of intoxication.

2.8 Barriers to Female Condom Use

2.8.1 Cumbersome Design

However, as with any other method of HIV prevention and contraception, female condoms are not a perfect method and they are not universally acceptable. Welbourn (2006) argue that it is these kinds of concerns that spread widely and gain ground as rumours and make people have second thoughts about the female condom. In the acceptability studies, several women reported that they were initially surprised by the large size (Kerrigan et al. 2004; Welbourne 2006) and displeasing appearance (Fernandez 2006). In the study in India, over 75 percent of respondents felt it was too big when they first saw it (HLFPPT and TNS 2007). One woman bluntly put it, "the first sight of it is a serious turnoff'' (Welbourn 2006, 34), another participant remarks, "I'm put off by the shape" (Fernandez 2006, 194). Some women in Ghana have nicknamed the method "polytank", a reference to the large plastic water containers used throughout the country (FHI/Population Council 2006). However, Welbourn

(2006) contends that the concerns about its appearance appear to be widespread especially amongst women who do not use the female condom or who have only heard of it.

Because it covers the external female genitalia some women find it unappealing and it is a commonly cited reason for discontinuation of its use. And some say it makes them feel self conscious (Fernandez 2006; Kerrigan et al. 2004, Welbourne 2006). Fernandez (2006) finds these disadvantages to be linked to the preconceived image of condoms, conditioned by the familiarity with the male condom and the perception of the sexual act from the male perspective.

They further find it difficult to insert the device (Sapire 1995 and Ruminjo et al. 1996 cited at Hoffman et al. 2003). One participant put it, "it was not very easy to put it in until I asked my partner to help. It was sort of irritating me while it was inside, so I had a lot of lubrication…I tried to put it in myself. I squatted until I had to ask my partner to push it" (Mantell et al. 2000, 593). Several respondents report that the excessive oiliness and lubrication of the device make its insertion and use, time consuming and messy (Kerrigan et al. 2004). This can pose a problem in cultures where men prefer dry sex or consider wet women dirty.

In-depth interviews and focused group participants from the study in Zimbabwe reiterated concerns about initial difficulty with inserting this device and discomfort, especially with the inner ring which several people reported as uncomfortable and even painful at times (Ray et al 1995). This is more likely if the condom is not positioned so that the inner ring is anchored around the cervix. However, the participants reported that they were able to overcome these difficulties by the third or fourth use (Kerrigan et al. 2004). This clearly indicates that barriers and perceptions are effectively altered with practice particularly when coupled with education and training. As in the study done on sex workers in India, at the beginning almost half of the study participants found it difficult to use, but after a year of intensive effort to promote the female condom, 45 percent of respondents found it easy to use (HLFPPT and TNS 2007). Moreover, more satisfaction is reported with ability to finally "master" their own protection.

Devanter et al. (2002) argue that women who receive instruction in female condom use along with opportunities to practice method related skills on pelvic model have an increased likelihood of using the method, of using it correctly and of viewing it in a favourable light.

2.8.2 Noise

Some studies have reported that certain brands of the female condom are noisy, especially the first generation female condom (FC1) (Ankrah and Attika 1997; Kerrigan et al. 2004; Mathews and Harrison 2009; Welbourn 2006), as one woman put, "a wrinkling noise, like a supermarket bag" but another woman said "once you have the female condom warmed up to body temperature the noise seems to stop..." (Welbourn 2006, 33). The noise make women self conscious, as participants from a study in Zimbabwe reported feeling embarrassed by the noise it caused during sex (Kerrigan et al. 2004). However, it is found that some men have grown to recognise this sound as a sexual turn on (Welbourn 2006). For example, in Senegal they use the noise it makes during sex to market the product. They sell the female condoms with noisy bine beads, an erotic accessory that women wear around the hips. The rustle of the polyurethane is now associated with the clicking of the beads and so a turn on (Smith 2005). The nitrile in the second generation female condom (FC2) is found to be less noisy. Women interviewed in Uganda stated that the new condom was less noisy, more comfortable and well lubricated (IRIN news 2008).

2.8.3 Partner Objection

As Sacco et al. (1991, 1) commented that "condom use is a unique behaviour because it typically involves either explicit or implicit agreement between both partners". In as much as the female condom was designed to give women greater control over their own protection, without having to rely on their partners to use a condom, but studies have shown that there is still a need for partner cooperation if women are to use the female condom successfully (Hoffman et al. 2004). Vierra and colleagues did a comparative study of the use of female condoms and male condoms among HIV positive women and women at risk of becoming infected with HIV, in Brazil. When they asked the participants why they liked the female condom, the participants reported their partners likes and dislikes (Vierra et al. 2004). This shows that women place a greater emphasis on their partners' approval of the method.

Acceptability studies between 1991 and 1993 found that female participants tended to drop out of the studies before completion mainly due to partners' reactions (Ankrah and Attika 1997; Deniaud 1997). In the study done in Kenya, the women in the general population as well as in commercial sex work, dropped out because of their partners' reactions. In fact, male partner objection is reported to be the main reason for non use or discontinued use of

the female condom (Oxfam 2008). Although some level of male acceptance seems to contribute to successful female condom use, Hoffman et al (2003) argue that women who have greater personal comfort with the method may place less importance on their partner's satisfaction.

It should be noted though that the male objection does not deter the demand for the device as one participant from KwaHlungwane commented, "…if we have this new condom we will get our men to use …it will help us a lot" (Preston-Whyte 1995, 221). Nonetheless, it is critical to find ways to promote the female condom among men. As several studies have shown that once some men become familiar with the female condom they like the device as much as, and sometimes more than, the male condom (Gollub et al. 1995; Hoffman et al. 2003; Kerrigan et al. 2004).

According to Rivers et al. (1998), another way of promoting female condoms among men will be to teach them how to help their partners with insertion and this in turn may help men to feel that they still have the power and control over the form of protection used. Beksinska et al. (2006) did a multi-site, randomized, cross over trial to test the performance and acceptability of the Reality female condom compared to a prototype similar in design and appearance but made of synthetic latex (FC2). In the study women were asked about male partner assistance in female condom use. Half of the respondents reported some assistance with either insertion or removal or both from their male partners. Most of the assistance comprised complete insertion pushing the device into place after the woman had inserted it or holding the device in place during penetration. The authors then recommend that the partners should assist by checking if the device is in place externally, ensure that the device does not slip into the vagina (invagination) and ensure that the penis does not enter to the side of the female condom (misdirection).

On the other hand, men may prefer to use the female condom because they are no longer responsible for protection and that the women had something to use, especially if the men are drunk (Ray et al. 1995).

2.8.4 Cost

Perhaps the most complex barrier to access of this most needed product has been its cost. In 2008 it had a unit cost of about 18 times higher than the male condom, while giving a

comparative protection (personal communication 2008). Thus in a situation where a couple could use either a male or female condom, the male condom is clearly the more cost effective. Conversely, studies have shown that users do not generally switch from male to female condoms, but often use female condoms in situations where they would have otherwise had no protection (Oxfam 2008). As sex workers from Zimbabwe reported being forced to have unprotected sex after they ran out of their supplies and their male partners were no longer willing to accept male condoms (Ray et al. 1995).

This high cost has led some women to reuse the female condoms (Beksinska et al. 2001; Deniaud 1997; Kerrigan et al. 2004). Consequently a number of studies were convened to examine whether repeated washing and drying affects the structural qualities of the female condom. These studies found that, for two of the main tests (bursts and seam strength tests) for examining structural integrity and safety standards, results remained well above manufacturing specifications after eight washes, showing that the structural integrity of the female condom can endure up to eight washes (Beksinska et al. 2001; Pettifor et al. 2001).

WHO also convened two consultations to address considerations regarding such reuse. Based on these consultations WHO does not recommend or promote reuse of female condoms. Yet, recognising the urgent need for risk reduction strategies for women who cannot or do not access new condoms, the consultation developed a draft protocol for safe handling and preparation of female condoms intended for reuse. A critical feature of the protocol is the disinfection step (disinfect using bleach), incorporated as the only known means of inactivating potentially infectious organisms. But, the decision to reuse female condoms must ultimately be taken locally (WHO 2002).

2.8.5 Availability

The high cost has resulted in this life saving tool being unavailable and unpopular. In Africa a woman has a much higher chance of having a stable supply of antiretroviral drugs than female condoms (Factsheet 2009). Respondents in one study also reported that access to the female condom was at best sporadic and at worst very limited. Pharmacies appear to be unaware of its existence and one participant remarks, “every pharmacist I asked didn’t seem to know what I was talking about...” (Welbourn 2006, 33). In the study in Zimbabwe, women reported that they could not find the female condom after they ran out of their supplies (Ray et al .1995). Hence, Kaler (2001) contends that until the retail price of the female condom

makes it more available to ordinary women, it is likely to remain a distant rumour rather a present reality for the people who hear about it and are so much in need of it.

In 2007, an estimated 26 million female condoms were distributed worldwide (FHC 2007), this is compared to roughly 11 billion male condoms (CHANGE 2008; UNFPA 2007). This represents only half of the condoms needed to protect the world population against HIV and other STIs. Of particular concern is the pitiful number of female condoms that were distributed, which cover not even half of the lives of women which need to be saved from HIV. This undermines female condoms' contribution to the fight against the HIV/AIDS epidemic as low supply of condoms lead to inconsistent use of condoms (UNFPA 2007).

Oxfam (2008) argue that the hold-up in expanding access to female condoms is not at the user's end (as women are desperate for this life saving tool), but at the start of the chain. The main issue is how much money donors and governments are willing to invest in buying female condoms, support female condom programmes, as well as develop low-cost female condoms. Recently the international community has been more concerned with improving access to treatment of HIV (UNAIDS); yes, the gains made in treatment are laudable, but treatment efforts cannot be sustained without greater progress in reducing the rate of new infections (UNAIDS 2009). Farah Karimi, Oxfam publicist, admits "the female condom is a poorly funded invention and has been ignored by policy makers, making it expensive, unavailable, unpopular, and user-unfriendly" (New Vision 2009 cited from Oxfam 2008, 12).

Nilcéa Freira, Minister, Special Secretariat for Policies for Women, Government of Brazil, then remarks, "we have the study reports, we know that women use them, so why do people often portray the female condom as a product that is not user friendly? Is this something that is just in people's minds? Aesthetically, I must admit, the female condom is not beautiful. But that does not mean that one should disqualify the product. Is the male condom such a pretty thing?"(Oxfam 2008, 28). Hoffman et al. (2004) concludes, "despite both successes and disappointments, promotion of the female condom remains important, especially in the face of heterosexually acquired HIV infection rates that are soaring globally." To this end, Katy Pepper, the African Programmes Director for the Female Health Foundation commented, "women are desperate for it. I know they are. I hear it all the time. (In places like) Crossroads, Khayelitsha, Langa, KwaZulu-Natal, it's the same thing. (In the 14-nation

Southern African Development Community) SADC countries included. The women are saying let us give it a chance." (Edmunds 2009).

2.9 Summary

Research has demonstrated that the female condom is an effective, acceptable and desired dual protection method. Women like it despite initial aesthetic concerns and sometimes have preferred it to the male condom. Therefore, ensuring access to this much needed device, will greatly improve women's health, particularly their sexual and reproductive health which is responsible for a third of the disease burden. But, more importantly it will save their lives and ensure them control over their own health and survival.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology employed by the study. It draws on qualitative data from focus group discussions and individual in-depth interviews. The chapter will start by describing the study setting, Swaziland, as well as the study site and then provides a rationale for using sex workers. It then describes the research methods used and lastly discuss**es** the limitations and ethical issues related to this study.

3.2 Study Context

This study was conducted in Swaziland. Swaziland is one of the world's last remaining absolute monarchies, ruled since 1987 by His Majesty King Mswati III. This tiny landlocked country is completely surrounded by South Africa, except for the eastern part which is bordered by Mozambique. It is one of the smallest countries in southern Africa, covering 17 600 sq kilometres and has a population of 1.12 million (SDHS 2006/2007). The majority of the population is Swazi, mixed with a small number of Zulus and non-Africans. Swaziland is known for its strong cultural traditions, practices and norms that have stood the test of time, principal of which is the cultural annual reed dance and polygamy with the King having 13 wives.

Despite Swaziland being classified as a lower middle income developing country, 66 percent of Swaziland population live in rural areas and the economy is largely based on agriculture. The prevailing dry spells and HIV/AIDS have exacerbated the already poor agricultural performance, thus pushing the country into deeper poverty and hunger (Swaziland report 2008). The 2001 Swaziland Household Income and Expenditure Survey estimated 69 percent of the population live below the poverty line.

The link between poverty and poor health outcomes is well established in the medical and sociological literature. Researchers have documented the inverse correlation between socio-economic status and poor health indicators (Cohen 2006, 1). WHO (2002) contends that diseases associated with poverty account for 45 percent of the disease burden in poor countries, it should be kept in mind that these are preventable or treatable diseases. This is illustrated in the greater disparity in maternal mortality between rich and poor countries.

Rugalema et al. (1999) in the context of HIV, argue that it is not that information, education and counselling activities are unlikely to reach them, but rather that such messages are often irrelevant and inoperable given the realities of their lives. He contends that the poor understand what they are being urged to do, but they do not have the incentives or resources to adopt the recommended behaviours. Therefore, it is not surprising that Swaziland holds the unenviable distinction as having the highest HIV level in the world (UNAIDS 2006; Whiteside and Whalley 2007).

The health situation in Swaziland is further compounded by the fact that 66 percent of the population live in rural areas where inaccessibility of health services is not uncommon. Boutayeb and Serghini (2006) argue that inaccessibility of health services contributes to poor health indicators in the rural areas. Medecin Sans Frontiers (MSF 2009) found that the rural habitat is organised into a multitude of small, isolated homesteads, far from the main lines of communication and access to care is difficult for a large number of families. Also the Health Sector Study (1998) found that rural areas are not well serviced (cited from Zwane 2005).

This study was conducted in Lavumisa. Lavumisa is situated in the southeast edge of the kingdom of Swaziland on the border with KwaZulu Natal, South Africa. As a border crossing town Lavumisa receives many visitors. In fact, it is considered a high traffic border town. Mobile lifestyles are common in this small town of 2000 people (Wines and Lafraniere 2004). The truck drivers make overnight stops and turn to commercial sex workers for sex (FHI 2003) which is considered high risk sexual behaviour. In fact, Halls (2002) argue that the prevailing poverty, unemployment and lack of opportunities in this town have forced many women to turn to transactional sex. Also Tobias (2001) reported that poverty is a key cause of commercial sex work in Swaziland. Hence, the one hut to hut survey found that one in four households in the town's poorer neighbourhood lost someone to AIDS in 2002 (Government of Swaziland 2003).

As mentioned in the first chapter, use of female condoms by the general Swazi population is very low, despite the unprecedented need for it. In other parts of the world studies have shown that female condoms are largely marketed among high risk populations and they found high levels of use among women at risk of HIV infection (Denaiud 1997; Holmes et al. 2007; Macaluso et al. 2000). However, the most at risk survey found that the female condom was

largely used by sex workers from Lavumisa only (Government of Swaziland 2010). From the outset it was clear that to accomplish this project's objectives, the participants would have to be users of the device. Hence, female sex workers of Lavumisa were chosen as the study participants. Because sex workers are a sensitive and hard to reach group a 'trusted associate' who was going to serve as a 'go-between' was needed to introduce the researcher to the group. The trusted associate had to have good relations with the potential respondents. NATICC was chosen as a point of entry.

NATICC is a non-profit, faith-based organization that was launched in October 2003 by a Norwegian missionary nurse and a Swazi nurse because of the concern about the devastating impact of HIV/AIDS in Swaziland and the lack of involvement of the church in the fight against the epidemic. The mission of NATICC is to empower the people of Swaziland with the relevant information and life skills in order to deal effectively with the problems and threats posed by the HIV and AIDS pandemic, and to reduce the risk of infection by promoting a change in behaviour, encouraging and supporting those already infected and affected, and delivering a message of faith, hope and love. Initially, NATICC primarily worked as an educational vehicle to provide HIV/AIDS information to churches, schools and public. However, as the need for a free-standing voluntary counselling and testing (VCT) centre in Nhlangano town and peri-urban became evident, NATICC expanded its services, and in 2004, a VCT centre was initiated and opened at the NATICC headquarters in Nhlangano. The need, however, for VCT services stretched beyond the Nhlangano doors, and as the numbers of people visiting the centre increased, NATICC began a mobile VCT outreach programme in 2005 to cover many of the rural and difficult to reach communities in the Shiselweni region. This led further to the establishment of another branch in Lavumisa. Today the services of NATICC include counselling and testing, HIV prevention, and care and support. The Lavumisa branch has an additional intervention that targets vulnerable groups (sex workers).

In 2007, the organization partnered with government to conduct a situational analysis on sex work in Lavumisa. They identified 30 commercial sex workers. They found low levels of knowledge about HIV and AIDS amongst this group. They established that sex workers and their sexual partners do not always use condoms. This was worrisome because a large number of this group is living with HIV. The need to inform the group about HIV/AIDS, as well as promote condom use was evident. As a way to increase level of condom use and safer

sex amongst sex workers, NATICC actively promoted the use of the female condom as an additional method for the practice of safer sex. NATICC trained the sex workers as peer educators to give health education on HIV/AIDS to other sex workers and long distance truck drivers. They also distributed information, education and communication (IEC) material and condoms at the border gate by mounting both mobile and static information desk.

The programme has evolved into a multifaceted community effort to empower sex workers in ways that go beyond HIV prevention. It now works as a rehabilitation centre for the sex workers who want to leave the industry. They have opened a car wash for them as an income generating project for those who want to get out of the trade. Because of their relationship with this group and the trust that they have built the researcher felt that NATICC would serve as a good go-between to gain access to the potential respondents. The researcher has a relationship with the organization (NATICC); she worked as a volunteer between 2007 and 2008. The researcher communicated to the director of the organization about the study and the need for participants who had used the female condom. The director was willing to introduce the researcher to the group and recommended potential participants that would generate a productive discussion. NATICC agreed to pay the respondents 50 Emalangeni for the interviews. The staff at the Lavumisa branch further helped with organizing the interviews.

3.3 Qualitative Research

The study relies on qualitative research with the sex workers. The aim of the study is to elicit women's experiences and perceptions of the female condom. Therefore, qualitative research methodology was more suitable for the study. Qualitative implies a direct connection with experience i.e. 'lived' or 'felt' (Sherman &Webb 1988). It focuses on exploring in as much detail as possible, aiming for understanding rather than scope (Punch 1988), involving consideration of size and magnitude and is usually perceived as being more analytical.

Qualitative methods are usually useful when describing a phenomenon from the subjects' point of view (Vidich and Lyman 1994), in this case from the users' perspective. Greenhalgh and Taylor (1997) contend that the strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue, in this case how women experience the female condom. It provides information about people's beliefs, opinions and attitudes. Using this approach, the underlying assumptions and attitudes are

examined and the rationale for these are also elicited. It also helps to understand difficulties encountered by people because of the nature of investigation.

Qualitative methods rely on open-ended questions which help respondents to avoid predetermined set of answers; this then gives respondents much more freedom to respond in their own words. This also allows the researcher to be flexible in probing questions, especially when some issues arise during the interviews. This also requires a researcher to employ certain skills during the interview such as listening attentively to the respondent. Probing skills help in establishing what is being said. Respondents can elaborate more on their answers rather than choosing from a set of answers. The use of qualitative methods encourages respondents to provide more detailed information than in quantitative methods.

However, collecting and analysing this unstructured information can be messy and time consuming. Also it is very costly. It requires the researcher to build trust with the respondents, especially if it is a sensitive topic.

3.3.1Focus Group Discussions

Robinson (1999) defines a focus group as an in-depth, open ended, group discussion of one to two hours duration that explores a specific set of issues on a predefined or limited topic. He further asserts that focus groups are a direct method of obtaining, rich information within a social context. Wong (2008) recommends the use of focus group discussions to obtain knowledge, perspectives and attitudes about issues and explanations for behaviours that would be less accessible in responses to direct questions. Wong (2008) underscores the effectiveness of focus group discussions in sensitive issues, such as sexual topics. Therefore, two focus group discussions, averaging one and a half hour in length, were used to gain a deeper understanding of women's experiences with the female condom. The main objective of holding focus groups discussions is to get beneath the surface of a particular topic presuming that respondents will reveal more when they are stimulated by the camaraderie and comments of others (Kaplowitz and Hohn 1998). Each group consisted of approximately eight women. The groups were convened with the assistance of NATICC.

Focus groups employ an interviewing technique and Robinson (1999) assert that it is not a discussion, neither a problem solving session nor a decision making group. It is an interview. An interview guide was used which provided a framework for the issues to be covered and to

increase comprehensiveness of data collection, as well as make the data collection more efficient (Wong 2008). The group was asked to reflect on a series of questions posed by the interviewer, probing the underlying assumptions that gave rise to particular views and opinions. To ensure the comfort of the respondents, a private room was used and the interviews were conducted in siSwati. A major advantage of this method is the natural setting of the focus group. Information is expressed in the participants' own words and context without having constrained categories. Also in a group members are prone to be open.

However, the problem with focus groups is that confidentiality can be a problem between participants when interacting in a group situation. A major issue with focus groups is that there is the possibility of people expressing an opinion which is in line with the rest of the group even if that opinion is at odds with their own personal one. Also facilitating the group requires considerable expertise and the interview process needs to be well managed so that the less articulate can share their views (Robinson 1999).

3.3.2 In-depth Interviews

The focus group discussions were complemented with 10 in-depth interviews to provide the researcher the opportunity to gain a greater understanding of women's experiences with the female condom. According to De Vos (2001) in-depth interviews are focused, discursive and allow the researcher and participant to explore an issue in detail. The advantage of in-depth interviews is that they provide a relaxed environment in which to collect information. Furthermore, people feel comfortable having a conversation with the researcher as opposed to filling out a survey (Boyce 2006). The researcher engaged with the participants by posing questions in a neutral manner, listening attentively to participants' responses and asking follow up questions and probes based on those responses. An interview guide which served as a basis for the discussion rather than a rigid roadmap was used. Interviews were conducted in siSwati and averaged 45 minutes in length and were done in a private room. This enabled the respondents to be more relaxed.

Conducting in-depth interviews offered several advantages for this study. First, they offered an opportunity to address sensitive topics that respondents might be reluctant to discuss in a group setting. In-depth interviews eliminate the negative effects of group dynamics in which some people are more interested in communicating "politically correct" views, rather than how they truly feel (Greenbaum 2000). Also it is easy to discuss an issue in-depth with one

person than with a group. In-depth interviews are an effective qualitative method for getting people to talk about their personal feelings, opinions and experiences.

However, like any data collection tool in-depth interviews have their own disadvantages. For instance, interviews can be very time consuming and some respondents may become annoyed if the agreed amount of time is extended. The limitation of using in-depth interview is that respondent can limit the amount information provided, especially if the researcher keeps on probing. However, this may be overcome by building trust at the beginning of the interview. Other disadvantage of using in-depth interview**s** is that respondents may not be honest. The large amount of data obtained during the interview can be very time consuming especially during the transcription and data analysis phases. Boyce and Neale (2006, 3) acknowledge that "interviews can be a time-intensive evaluation activity because of the time it takes to conduct interviews, transcribe them, and analyse the results". In-depth interview does not necessarily represent the situation of the whole population.

3.4 Sampling Procedure

In order to accomplish the objectives of the study, participants had to be recruited on the basis of their experience with the female condom hence purposive sampling was used to recruit participants. Maxwell (1997) defined purposive sampling as a type of sampling in which "particular settings, persons or events are deliberately selected for the important information they can produce that cannot be gotten as well from other choices" (p.87) (cited from Clark and Creswell 2008, 201). This type of sampling allows the researcher to identify the specific individuals who have the information the researcher needs related to the research questions. The aim of the study was to gain insights and understanding of the factors that facilitate and inhibit female condom use. Therefore, the researcher had to identify specific individuals who had used the female condom.

Selection was made using expert judgement. The researcher felt it would be best to use women who had used the device more than five times because they have passed the first stage of female condom use which is generally associated with difficulty to use and negative attitudes towards the female condom (Hoffman et al. 2004). Therefore participants were selected on the basis of the number of times that they had used the female condom. The sex workers were asked about the number of times they had used the device. If it was five times or more she was eligible to participate in the study. However, interviewees are not created

equal: some are informative, others are unwilling to talk, and still others can talk for hours without saying anything useful. Morse (1994, 228) states that in general terms a good informant, "has the knowledge and experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed and is willing to participate in the study" (cited from Palys 1997, 137). The researcher sought the help of the staff of NATICC to identify the individuals that would be able to generate the most productive discussions. Out of the people that had confessed to using the female condoms, the site manager of the Lavumisa branch recommended women that would produce a fruitful discussion.

3.5 Skills used during the Interview

According to Fontana and Frey (1994) establishing rapport is very critical in gaining entrance to the respondents. This was more important because the interview was on a sensitive issue, experiences with the female condom, also involved a hidden population (sex workers). Glesne and Peshkin (1992, 94) argue that rapport in qualitative inquiry should be a "distance-reducing, anxiety-quieting, trust-building mechanism." As mentioned earlier, the researcher was introduced to the group (sex workers) by the director of NATICC. He explained my role and requested them to be cooperative. This helped to build trust in the participants. I conducted informal discussions with the group to establish the number of times they had used the female condoms. If it was more than five times then they were selected to participate in the study. Danlap and Johnson (1998) in the context of drug dealers assert that the 'go between' is critical because he explains the researcher's role to the dealer and helps arrange an initial meeting between the researcher and the seller. Once the go-between has provided an initial introduction, the researcher marshals the communication skills necessary to convince the respondents to allow further contact and conversations. Another key element in gaining ability to talk with this group is the availability of funds to compensate respondents for interviews. As mentioned earlier NATICC agreed to pay the respondents 50 Emalangeni for the interviews.

As a researcher I had to demonstrate listening skills, by showing keen interest on what the respondent were saying and at the same time be able to analyse an interview while participating in it. Chirban (1996) maintains that good listening skills improve the discussion in a relationship and move the participants from a static role. Moreover, when a person feels that someone is actually listening to him/her this encourages him/her to talk more. Josselson (in Collins 1998, 8) states that "at the root of unstructured interviewing is an interest in

understanding the experience of other people and the meaning they make of the experience". This also afforded me the opportunity to have a broader understanding of their experiences with the female condom.

3.6 Data Analysis

All the interviews were tape recorded and field notes were taken during the interviews for key points. Interviews were conducted in siSwati; this was done in order for the respondents to be able to express themselves freely. Then later the interviews were transcribed and translated into English. This study used interpretative analysis to analyse the data that had been given.

Bochner (2001) states that "qualitative inquiry honours people's stories as data that can stand on their own as pure description of experience or be analyzed for connections between the psychological, sociological, cultures and political and dramaturgic dimensions of human experience to reveal larger meanings (cited from Patton 2002, 478). Therefore, the actual words and behaviours of the participants were used to assist in answering the research question Trauth and Jessup (2000, 12) state that "the objective of interpretive research is to piece together people's words, observations, and documents into a coherent picture expressed through the voices of the participants". The first step was to produce verbatim transcripts of the entire discussion and compare it with the handwritten notes in order to fill in the gaps. I then identified the major themes and organised them into different sub-headings or categories to make it easier to compare similarities and differences.

3.7 Ethical Considerations

Ethical approval for this study was received from the University of KwaZulu Natal, and the researcher made every effort to adhere to the ethical standards in undertaking this project. De Vos (2000, 63) contends "ethics is a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects". Babbie (2001) affirms that anyone involved in research needs to be aware of the general agreement about what is proper and improper in scientific research. Before the interview I provided the women with a background of the study and what was involved in it and then asked for their consent to participate in the study and for permission to use the tape recorder. I made sure that respondents signed the consent form which stated the aims of the study. I also gave them

the assurance of confidentiality and also the fact that respondents have a right not to respond to questions which make them uncomfortable. In the consent form I stated that the respondents can feel free to withdraw from the study.

Obtaining informed consent implies that all possible or adequate information on the study, the procedures that will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subjects or their legal representatives (Williams et al. 1995). De Vos (2000) also argues that participants must be legally and psychologically competent to give consent and they must be aware that they would be at liberty to withdraw from the investigation at any time.

Sieber (1982) defines confidentiality as a continuation of privacy, which refers to agreements between persons that limits other's access to private information. This is further supported by De Vos (2000) who attests that "confidentiality indicates the handling of information in a confidential manner". For this study the researcher obtained respondents' permission to use the tape recorder during the interview and they were assured that all information provided will remain confidential. All the information obtained from participants was treated confidentially.

3.8 Reliability and Validity

Reliability means that the measurement made are consistent, and if same experiment is performed under the same conditions; the same measurements will be obtained (Goddard and Melville 2001). Bostwick and Kyte (1993, 113-20) defines reliability "as accuracy or precision of an instrument, as the degree of consistency or agreement between two independently derived sets of scores; and as the extent to which independent administrations of the same". They further argue that the more reliable the instruments and observations, the more consistent and dependable the results. Basically this means that after I have conducted the research, I should be able to compare previous studies finding with those of this study, to see if is there are any similarities and differences. Mitchell (1979) state that a high level intercoder agreement is evidence that a theme has some external validity and is not a figment of the investigator's imagination (cited from Ryan and Bernard 2000, 785). Bernard (1994) argues that the validity of a concept depends on the utility device that measures it, as well as

the collective judgement of the scientific community that a construct and its measure are valid. Valid measurements make valid data, but validity itself depends on the collective opinion of researchers (cited from Ryan and Bernard 2000, 786).

To ensure the validity of the study, the interviews were only conducted by the principal investigator of the study in order to maintain high quality of data. All the interviews were tape recorded and field notes were taken during the interviews for key points. This helped in ensuring the reliability of data. I also made use of studies in female condoms conducted in Zimbabwe, South Africa, Kenya, Ghana Brazil and Italy.

3.9 Limitations

Due to the high sensitivity of the topic of sex, some respondents did not talk openly at the beginning of the interview. Some respondents felt that I was too young to be discussing such issues with them and they would try to use words that were not vulgar. It took time for the researcher to build trust with participants that facilitated full and honest representation. In addition, because of the low use of the female condom by the general population, the study was limited to sex workers of Lavumisa and they are not representative of the general female population. Sex workers are a specific group of women and it is argued that they are more likely to be in control of sexual decision making than other women. Furthermore sex workers are hard to reach and are highly mobile and move regularly between regions and towns. In addition, the sample size was relatively small; therefore it is not possible to make generalizations to the entire population.

3.10 Summary

This study is purely qualitative and used focus group discussions which were complemented with in-depth interviews. Since, the study dealt with sensitive issues, it was imperative for the researcher to employ relevant skills during the interviews, including establishing rapport and listening skills. Ethical considerations were also discussed that include informed consent and confidentiality of the information provided by respondents. Lastly, limitations of the study were discussed.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter outlines the main findings from the focus group discussions and in-depth interviews. The women interviewed ranged in age from 22 and 40 years and the majority (63%) had a long-term partner. Levels of education were relatively low, with the majority (63%) having never attended school. Four fifths of the participants reported that they were living with HIV. All the participants were not using hormonal contraceptives they were rather relying on condoms for preventing pregnancy. This chapter attempts to highlight and explain some of the factors that facilitate use and non use of the female condom. In addition, it focuses on how women negotiate female condom use and their general experiences with this device.

4.2 Acceptability of the Female Condom

The participants were very appreciative of the female condom. In fact, the majority of the participants like the female condom and even prefer it over the male condom reporting greater satisfaction with this female-initiated device. They reported using the female condom regularly arguing that it was easier to negotiate as they initiate and control its use. It also helps facilitate consistent condom use as it provides them with an additional method to practice safer sex:

> *"I like the female condom better because it gives me control in sexual matters." (IDI #5)*

> *"I like the female condom, I just wish I had gotten it earlier, I would not be where I am today." (IDI #9)*

> *"I prefer it because it is easier to use since I initiate its use, unlike the male condom which I have to ask him to wear. And when he refuses there is nothing I can do because I cannot really force him to wear it." (FGD #2)*

However, some of the women reported that they occasionally face difficulties in negotiating use with some clients and long-term partners who view it unfavourably because of the big

size of the female condom. Nonetheless, participants were not deterred by male opposition as they almost always resort to other means, like secret use of the female condom:

> *"... there are times when a client does not the bulge and that is when you have to resort to other strategies like secret use." (IDI #2)*

The majority of respondents use the female condom in commercial relationships. However, initial use was reported to be with regular partners or spouses because they felt that they needed to gain experience and confidence in the method before using it with their clients. Participants were asked to reflect on the impressions they had when they first saw the female condom. Most women reported that their first impression of the female condom was generally negative and this was related to its appearance and size. Also some participants had concerns about touching their genitals. They also had fears that the female condom may cause trauma to the lower genital tract or it may get stuck in their vagina. However, their initial negative perceptions of the device were replaced with more positive reactions after using it several times.

> *"When I first saw it, I thought: Yo! Could it be that my vagina is that big. But after using it I realised that it just takes the shape of it." (FDG #1)*

> *"In the beginning I had such silly thoughts about it, thinking that it is too big, it will tear the wall of my vagina or may slip up and get stuck inside my vagina or the inner ring will injure the penis. But after using it, I realised that I was just being silly." (IDI #3)*

4.3 Factors Facilitating the Use of Female Condoms

4.3.1 Perception of Risk

One factor that has been found to be critical to the adoption of condoms, whether male or female is individual perception of risk. Therefore accurate assessment of one's own risk is vital in the adoption of safer sexual practices, such as condom use. It was evident from this study that the participants perceived themselves to be at an increased risk for STIs as well as pregnancy. When asked why they were using this newly introduced device they frequently cited how unsafe sex may predispose them to STIs and HIV re-infection as the majority of them are already living with the virus. And the fact that they are having sex with different partners (truck drivers, police officers, etc) further increases the risks.

"When having sex with about three different people in a day the risk of getting diseases are high and to ensure that you do not get those diseases you have to use condoms."(IDI #3)

"In this industry you meet someone today and you do not know him or where he comes from and what he has in his blood. You just have to use condoms or you will find yourself with some unknown disease."(FGD #2)

"The people that we meet we do not know them. You do not know if they are on ARVs or what and you do not want a person giving you a new strain of HIV that is resistant to treatment or affecting your CD4 count."(FGD #1)

They also had concerns about malicious men who are living with HIV and are on a mission to infect them [sex workers] on purpose because they think that they got it from them. One participant explains,

"Some men are very vindictive, they have HIV or any other STI and they want to spread it all over. They usually target us [sex workers] with the aim of infecting us all, arguing that they got it from us so they have to take it back to where it belongs. So to avoid all this you have to use condoms." (FGD #1)

4.3.2 Greater Control

Participants found the female condom to be a welcome additional method, particularly because they feel that they control its use. Therefore, it offers them an independent method of protection that they can use on their own. In the interviews participants stressed that this method gave them greater autonomy. In all the interviews participants articulated that it was hard to enforce the use of the male condom because its use greatly relied on the cooperation of the male partner. However, this new method gives them an opportunity to take an active role in the practice of safe sex as they can use it independently. With the advent of the female condom participants now offer the male partner a choice between the male or female condom. This then leads to an increased number of protected sex acts because if a man refuses the male condom then the woman use the female condom.

"The female condom came to free us from being controlled by men... Now I do not have to keep asking a man for protection. I ask him, if he refuses I just wear my [female] condom." (IDI #6)

"The reason at times we find ourselves engaging in unprotected sex is because the use of the male condom is dependent on the man. It is tiring having to keep asking a man for protection because every time you ask he will come up with all kinds of excuses. However, with the female condom there is no need to keep begging a man for protection, you ask once and if he refuses, guess what I can wear mine [female condom]" (FGD #1)

4.3.3 Distrust of Men

Also, women reported that they prefer the female condom because it is controlled and initiated by them and they therefore feel more protected because they felt that they could not trust men. They expressed concern about men tampering with the male condom. In addition, the participants reported a number of cases where men had removed the male condom during intercourse or pricked the male condom. They felt that the female condom eliminates the opportunities for men to manipulate this device as the woman can place the female condom autonomously and hence she can trust that it is not torn or otherwise manipulated by the partner. This therefore motivates women to use this device as it guarantees their protection. Some women felt that the female condom provides them with protection against the risk of pregnancy.

"Men cannot be trusted; they always manipulate their [male] condoms. You see they always make pinholes in the condoms because they want to give us diseases, but with the female condom there is no room for them to manipulate it as I insert it myself." (FGD #1)

"men manipulate their condoms all the time, either they will remove them during intercourse or they will make pinholes, and what is sad is that you will be busy thinking that you are protected when he is taking you for a fool. But the female condom guarantees my protection because I can trust that it is not torn." (FGD #2)

"Men cannot be trusted to act in our best interests. He can wear the condom at the start of the act and then remove it later or he will just tear it. I think it is best that we depend on ourselves. The female condom is just for that, to liberate us from men." (IDI #6)

"…men are generally not trustworthy; they deliberately put holes in the male condoms at times so they can get their partners pregnant." (IDI #2)

4.4.4 Provides an Alternative to Problems of Male Condoms

The female condom has physical characteristics that offer some advantages over the male condom. Firstly, polyurethane or nitrile female condoms are less likely to cause an allergic reaction than the latex male condom, thus offering the participants an alternative method to use in such cases.

> *"...the male condom would give me a serious rash and burning sensation and as a result I would find myself engaging in unprotected sex more often... So the female condom was really an answer to my problem." (IDI #7)*

Also, women argued that the female condom is better lubricated than the male condom. Some of the women reported that the male condom at times becomes dry and causes them pain, especially when the sexual act is prolonged. They also reported that in commercial relationships they are usually dry because there is no foreplay. Therefore, the female condom was appealing in this instance because it has enough lubrication.

> *"Some clients take forever to come and then the male condom gets dry and then it starts to hurt. However, this does not happen with the female condom, even if he can take five hours it is still smooth because of the oil." (IDI #5)*

> *"...there is no time to make you wet. So the female condom has got a lot of oil that compensates for the fact that you are not turned on, so it does not hurt." (FGD #1)*

In addition, the material that the female condom is made of is stronger than the latex male condom and hence more resistant to breakage. When participants were asked what they liked about the female condom they kept mentioning that the female condom was stronger than the male condom; reporting that it never breaks, even during vigorous sex. This makes them feel safer and more protected.

> *"The female condom does not tear even during vigorous sexual acts, however, that cannot be said for its counterpart [male condom] which breaks all the time." (IDI #9)*

> *"The female condom is strong, it never breaks. Since I have started using (2006) it has never broken, but I have had several splits with the male condom, I cannot even count." (IDI #5)*

"I feel safer with the female condom because I know that no matter what he can do it is not going to break." (IDI #7)

The effectiveness of female condoms was emphasized by participants who had experienced breakages with the male condoms. One participant remembered when parts of the male condom remained inside her vagina and she had to go to the hospital for it to be removed.

"…so now I prefer the female condom because I know that nothing can happen to it." (IDI #2)

Because the material is strong, they also perceive it to be less permeable to STIs. And the fact that it is big, covering a larger surface area, thus it provides more protection. Some participants referred to it as Noah's oak, stating that it catches everything:

"…because it is big, it catches everything, even pubic lice." (FGD #1)

It should be noted though that this finding is not technically correct as female condoms do not protect against pubic lice, however it is worth noting that participants feel more protected with the female condom. This therefore makes them prefer the female condom. One participant even recommended that the female condom is the only method that is protected for safer sex because it does not easily break. Condom breakage is much more common with the male condom.

4.3.5 Sexual Pleasure

Because women feel more protected with the female condom, it allows them to relax and hence enjoy the sexual experience. Participants reported that the use of male condoms brings a greater deal of anxiety because most of the time they are worried about breakage thus they cannot fully enjoy the sexual experience.

"When I am using the male condom, I have to stay alert so I can keep checking if he still has it [male condom] on or if it is not broken. But with the female condom, I just relax and let nature takes its course." (FGD #2)

In addition, the female condom brings added pleasure. The majority of the participants reported feeling greater sexual pleasure with the female condom than the male condom.

"…with the male condom I do not feel anything, but with the female condom there is more sensation." (IDI #1)

"…it feels like the real deal." (FGD #2)

It was reported by some women that the external ring of the female condom produces greater sexual pleasure because it stimulates the clitoris and the inner ring massages the head of the penis. However, some participants reported that the inner ring of the female condom at times creates discomfort. Other participants disputed this arguing that the discomfort was signalling that the device is not properly inserted. There was an agreement that if it is properly inserted with the inner ring resting on the cervix there should be no discomfort.

They also reported that their partners preferred the female condom because it does not compromise their sexual pleasure. Participants explained that their partners liked the female condom because it is not tight and does not constrict the penis as the male condom. Others liked the fact that men were no longer responsible for protection, but this belief was more prevalent among educated partners. The majority of women reported that men were in general indifferent to female condoms.

4.3.6 Timing of Insertion

Perhaps the greatest advantage of the female condom is that it can be inserted up to eight hours before sexual intercourse. Therefore it does not interrupt the sexual sequence. However, the participants did not value this fact much; they were rather more interested in the fact that it ensures them protection at all times, even in extreme cases. The participants preferred to wear the female condom before venturing outside at night. In Swaziland there is a saying that once it becomes dark it becomes a bush, meaning that you are not safe at night. The participants used this saying to explain why they wore the female condom at night. One participant related a story of how she was gang raped by nine men at night:

"...luckily I was wearing the female condom. Well it does not make it better, but I was comforted by the fact that I was protected from diseases and pregnancy." (IDI #4)

"I wear the female condom when going out at night... no one knows the day of death, therefore it is best to be always protected. And the female condom ensures our protection at all times." (FDG #2)

Other participants reported that they usually wear the female condom when going out to drink or partying. They explained that they usually find it difficult to insist on use of condoms after consuming too much alcohol and that at times they totally forget about them. Also men are more likely to take advantage of women when they are drunk because they are more vulnerable and this increases their risk of unprotected sex.

> *"When I know that I am going to drink, I wear the female condom because I know that once I get drunk I will forget or I may not be able to insist on condom use." (IDI #1)*

> *"The time when one is more vulnerable to practice unprotected sex is when you are drunk. ...because your perception is decreased and also that is the time when men are more likely to take advantage of you." (FGD #1)*

In addition, the female condom does not require a fully erect penis for it to be inserted. For men the fact that there is no need to sustain an erection while putting a condom in place removes a commonly reported source of anxiety (Gullob and Stein 1993). This also ensures consistent condom use as failure to maintain an erection has been found to interfere with male condom use (Gullob et al. 1995). Participants found the female condom more appealing to use with men who usually report that they have a reaction to the male condom or it affects their erection.

> *"You know the good thing about female condoms is that it does not have any side effects. When you ask men to use the male condom, they will tell you all kinds of stories from how it interferes with their erection to how it gives them a rash, but with the female condom there is no excuse." (IDI #1)*

4.3.7 Use as a Contraceptive

As mentioned earlier the female condom offers simultaneous protection against STIs and conception, this therefore offers women another method of contraception. The majority of the participants could not tolerate the side effects of hormonal contraceptives and this factor served as an incentive to use the female condom as it does not have any known side effects.

> *"The injection gave me terrible side effects, so did the pill and then I decided to stop using hormonal contraceptives altogether. Consequently I would have closely spaced children. The female condom was like a messiah to me because it is not systemic so it*

does not affect me in anyway and now I am practising contraception like any other woman." (FGD #2)

In addition, when condoms are the only method used for preventing pregnancy they are used consistently. Participants explained that the reason they used condoms consistently was because they were not using other methods for preventing pregnancy. The majority of the participants were not using hormonal contraceptive**s** and therefore relied on condoms for contraception.

"The reason I use condoms all the time is because I am not using other contraceptives, so I am relying on it for contraception." (IDI #8)

"What drives us at times to engage in unprotected sex is when you are using something else for contraception because you know that after all you are protected from pregnancy. So you give it to him and he will take whatever he takes and leaves whatever as long as it is not a baby." (IDI #1)

They also reported that it was easier to access condoms than other family planning methods as the health care providers are often judgemental of young women accessing contraceptives. Access is a major barrier to use of contraceptive methods.

"It is difficult to access family planning when you are young (16 years), the only thing that you have access to are condoms, and well the male condom we do not really control its use, so the female condom is the best option." (IDI #6)

4.4 Factors Inhibiting Use of the Female Condoms

4.4.1 Needs Practice

There was a consensus among the women that use of the female condom needs a great deal of practice because in the initial stages users find it difficult to insert the device. Most participants experienced difficulties in inserting and properly positioning the device when they first started using this method. The women reported that they often had to deal with discomfort and even pain at times. These factors may discourage some women from using this device. However, with continued use these difficulties disappeared and many of the women highlight the importance of experience with using the devise. The women pointed out that female condom use becomes easier with practice.

"At first, it is not comfortable; at times the inner ring hurts. But as I continued using it I realised that the problem was not the inner ring rather it was that I had not properly inserted it." (FGD #1)

"In the beginning it is not good. I mean you have to insert something in you and that was really uncomfortable because I was not used to that, and I would be so conscious of it. But as I continued I got used to it and now I love it." (IDI #10)

"You try it and it is uncomfortable or hurts, but you have to try again. You do not have to say well it is difficult and then give up." (FGD #2)

However, they mentioned a feeling of satisfaction that came with being able to master the use of this woman initiated device at the end. The women reported that the support they received from friends helped to overcome some of the initial difficulties they experienced with the female condom. Participants explained that they were able to overcome the initial difficulties because of the advice from friends who had experience with the female condom. Their friends often encouraged them to be patient until they obtained experience in using this method.

"At the end it was worth every bit. It felt like I had achieved something big. I guess it is big because it is our condom, it was made for us. So, one should be proud to finally know how to use it." (IDI #6)

"It took me five months to master its use and so many times I gave up, but my friend insisted that I keep trying. She was very supportive and without her I would not have learnt how to use it." (IDI #6)

4.4.2 Previous Use of Condoms

One factor the women identified as critical for the use of female condoms was past experience of male condom use. The participants reported that it was difficult to convince someone who has never used condoms to accept the female condom. The challenge therefore was how to convince men who had never used condom to accept the female condom.

"*…a person who has never used a condom in his life can never accept the use of female condoms."(FGD #2)*

"When a client refuses the use of a female condom, then you should know that he has never used a condom in his life." (FGD #2)

4.4.3 Cultural and Social Attitudes

Use of condoms whether female or male has been stigmatized often due to cultural, social as well as religious attitudes about sex and condoms (CHANGE 2008). Condoms are often seen as appropriate only for use in commercial or casual partnerships. In fact, condoms are associated with promiscuity and disease. This belief makes it difficult to negotiate the use of condoms in marital or long-term partnerships. Often there is a widespread resistance to the use of condoms in this type of partnerships. Participants had difficulty negotiating use of female condoms with long-term partners. They perceived the use of condoms with long-term partners as a violation of trust. They frequently found it difficult to suggest the use of condoms in these partnerships as it introduces an element of suspicion in the relationship and is usually perceived to be threatening or confrontational. They reported that it may lead to distrust and their partners may see it as sign that they are not using condoms in commercial partnerships which may result in violence.

"It is not easy to ask for condoms with regular partners or spouses. It always gets emotional." (IDI #9)

"Commercial relationships are different from steady relationships. In these relationships there is the assumption that you have to use condoms with the other guys, not with them as they are your primary partners and are entitled to skin to skin sex. So requesting the use of condoms with them is suggestive of not using condoms in the commercial partnerships and may resort to violence." (FGD #2)

In addition, negotiating condom use involves communication about disease prevention. Participants were not comfortable discussing disease prevention, especially with long-term partners because it raises suspicions. This is worsened by the Swazi culture which prohibits frank sexual discussions between men and women.

"culturally it is not appropriate to discuss sex with men... It is suggestive of being easy." (FGD #1)

Female condom use is further compounded by the fact that it has to be inserted before intercourse to give it time to warm up to the body heat, lest it will make a noise.

Traditionally, however, Swazi women are expected to be passive and submissive when it comes to sexual matters. Women who ask for the use of condoms are often perceived as sexually experienced or promiscuous. This therefore puts women in an awkward position because when men find them wearing the female condom they judge them as easy women. The participants reported that some men when they find them wearing the female condom they called them names such as 'whores', and they are perceived as sexually available.

"…men call you all kind of names." (FGD #2)

Nonetheless, participants are not deterred by this as they have come to accept themselves and this kind of job they are doing, opting to protect themselves rather than worrying about other people's perceptions of them. However, this may pose a challenge to some women who are more conservative and are particularly concerned about their social reputation.

4.4.3 Partner Objection

In as much as the female condom was made to give women greater control over safer sex practice without relying on their partners for protection, women still feel the need to ***gain*** partner approval. At times participants tried to negotiate the use of the female condom with their partners, but were unable to get their partners to cooperate. This is particularly true with partners who still prefer skin to skin sex and view condoms as a violation of intimacy. And insisting on condom use at times may result in violence. Given the nature of the relationship they may be able to refuse sex; they have a direct approach "no condom, no sex" or request that clients accept the female condom as part of the deal. But such a strategy may not be possible with long-term partners because in Swazi culture women are not allowed to refuse sex to a man, especially if she is married to him.

"…it is difficult… Some men do not want condoms, the moment you suggest them, they get angry and threaten to beat you." (IDI #2)

"At times you have to practically beg the client to accept the condom as part of the deal, even bring your price down if need be, so that you may use the condom." (FGD #2).

4.4.4 Time Consuming

Because the female condom needs time to adjust to body heat it therefore poses a challenge in cases of sporadic sex acts. The participants perceived the delay needed for the female

condom to adjust to body heat that it might serve as a barrier to the use of this method as they cannot ask the clients to delay sex while they wait for the method to adjust to their body heat. Therefore, use of this method could make them lose clients:

> *"in this kind of work time is everything, you cannot ask a client to wait for 15 minutes whilst waiting for the condom to adjust to your body heat. He will just say okay and go get someone else." (IDI #6)*

Thus they found it to be more appropriate with pre-planned sex, which gives them time to insert it beforehand. They also found it difficult to use this device when selling sex on the streets stating that there was no private and safe place to insert the device.

> *"...there is just no place to insert the female condom when selling on the streets. You cannot go to the dark corners as there is danger there... so it is only possible with the first client because you will come wearing it from home." (IDI #5)*

4.4.6 Limited Availability

The greatest barrier to the use of female condoms is the limited availability. Participants reported that the device was only available at NATICC. So when one cannot go to NATICC there was no other place to access the device. And when NATICC runs out of stock they are forced to have unprotected sex with men who refuse to use the male condom.

> *"The only place where one can get the female condom is NATICC. ... and when NATICC runs out of stock there is no other place to get them and we are forced to engage in unprotected sex with the clients who do not want the male condom." (IDI #6)*

> *"The female condom seems to be unavailable in other places. One time when NATICC was out of stock I went to the clinic but they told me that they have never had it... the nurse did not even know that there was a female condom in Swaziland." (IDI #4)*

This limited availability has led some participants to reuse this device despite clear instructions from counsellors to use one condom per sexual act. In the individual in-depth interviews participants confessed to using one condom with more than one client. It should be noted that this is the same condom that was used with the first client and it has not been

cleaned. The majority reported using one condom with three clients. They found this to be the only way of ensuring that they do not run out of stock.

"... I usually use one condom with three clients." (IDI #3)

"...because of the limited supply I use one condom the whole night" (IDI #6)

4.5 Strategies they use to Negotiate the use of Female Condoms

4.51. Communication

Despite the female condom being a woman initiated device the majority of the participants reported the need to negotiate its use with partners whether commercial or long-term partners. Participants suggested that one has to be strategic when requesting the use of condoms, as negotiations are usually contentious and sometimes result in emotional or physical retribution. The participants underscored the need for communicating with partners when negotiating the use of the female condom. They usually discuss disease prevention. This helps them assess their partner's feelings about the use of condoms. They often use their own discretion to determine if it is safe to request the use of condoms. If they perceive their partners as disapproving they use it covertly. The majority of women preferred to use the female condom covertly in order to avoid male disapproval.

"Communication. You have to talk to your partner; you do not just leave things to chance." (FGD #2)

"You assess the person's attitudes towards condoms and then you can tell if it is safe to suggest condoms… with other participants you can just tell that this one cannot agree to the use of condoms instead it will trigger violence." (IDI #2)

Other participants found it difficult to discuss disease prevention, particularly with long-term partners. They suggest use of female condoms for contraception purposes as women usually take responsibility for pregnancy prevention. They reported that requesting the use of the method for pregnancy prevention takes away the emotional baggage associated with condoms and facilitate continued use.

"It is not easy to discuss disease prevention with long-term partners, they always perceive it as a question of trust and then it gets too emotional. It is best to just talk about pregnancy." (FGD #2)

"If you do not want a fight, just say you are using it to prevent pregnancy." (IDI #2)

It should be noted though that they are interested in it for disease prevention and to a lesser extent for pregnancy prevention. A majority of participants were able to convince their partners to use the female condom by telling them about the side effects they experience with hormonal contraceptives.

> *"I talked to him about the side effects that I had experienced with the pill and injection and then requested that we use the female condom as it is not systemic, so there are no side effects." (FGD #2)*

Other participants reported using other strategies to convince their partners to use the female condom. They convinced their partners that sex would be more enjoyable with the female condom than the male condom. The majority of the participants found this strategy to work as men usually complain that the male condom reduces sensation.

> *"You know the reason that people do not like using condoms is because it decreases pleasure, but when you tell them that this particular condom increases the pleasure they are usually willing to try it." (FGD #2)*

Interestingly, the device was recommended to the participants by a friend and they were willing to try it on the basis that it will maintain or even heighten sexual pleasure.

> *"…I wanted to see if my friend was telling the truth. Well she was right, there is more sensation and now I have fallen in love with it." (IDI #6)*

4.5.4 Experimentation

For many women the primary reason for initial use of the female condom is for sexual experiment. Participants reported that they first tried the female condom to see how sex would feel while using this device. Also female condoms are a novel method in Swaziland. Therefore some men are driven by curiosity and the desire to experiment with the female condom. Participants reported some of their clients come and specifically request female condoms. It should be noted though that novelty wears off after using it several times.

> *"Some clients come and practically beg you to use the female condom and they even offer to pay more." (IDI #5)*

4.5.5 Secret Use

When communication fails most women resort to secret use. A number of the individual in-depth interviews yielded an interesting finding of secret use of the female condom when partners refused the use of condoms. The participants explained how they often find themselves in an awkward position when men refuse to wear the male condom. In these cases men offer to pay more money for sex without a condom. However, the availability of the female condom has ensured that they practice safe sex all the time. When clients refuse the use of condoms, participants use the method secretly. Covert use is usually necessary with drunk partners. However, they emphasized that it is important to make sure that the client does not find out that the female condom is used secretly because if he does he may resort to violence.

> *One of the dilemmas we are frequently faced with in this kind of work is that you ask a client to use a condom [male] and he offers you more money for sex without a condom. This is very difficult because you look at the money and think of how much you need it. You have to make a hard choice, either to refuse sex and go home empty handed or engage in unprotected sex. And to be honest with you a majority of us always went with the latter option as we are doing this thing for money. But now, you just pretend to him that you are not going to use a condom and you just go to the toilet and insert the female condom and everyone is happy." (IDI #3)*

Another participant reported the unusual finding of covert use of the female condom with her regular partner. The regular partner did not find out about female condom use until after five months of secretly using the method.

> *"My boyfriend has never liked condoms, every time I suggest the use of condoms he will tell me one story after another and it was irritating because they are just excuses. Then I resorted to the female condom, I would insert it before I go to bed and then ask him to turn off the lights. All I had to do was guide him when he enters to avoid misrouting." (IDI #6)*

A small number of participants felt that there was no need to ask the partner for the use of the female condom as they control its use. They felt that if the woman requests female condom use it is likely to give him an opportunity to refuse use.

"The female condom came to free us from being controlled by men. I see no reason to go back and ask permission from a man for protection." (IDI #6)

"If you talk about it he will then want to convince you otherwise. Just do not open that window." (FGD #2)

The problem though with not talking opens the possibility of using two condoms at the same time. At least one participant reported a case where they used both female and male condoms. The use of male and female condoms at the same time may be dangerous as the condoms may cause friction, which may result in breakage. This therefore underscores the need for greater communication in all sexual encounters.

4.6 Female Condom an Alternative to Male Condom

One critical public health question that has to be answered is whether promotion of both female and male condoms results in higher level of protection than does promotion of the male condom alone (Hoffman et al. 2004). And for the female condom to do that it has to supplement the male condom rather than replace it. As the whole point of another method is to provide additional protection to the couple and for the female condom to bring this added benefit it has to be used in cases where the couple would otherwise have unprotected sex rather than replacing the use of the male condom. This would not be a viable option as the female condom is expensive.

The findings suggest that the female condom complements the male condom rather than replaces it. The participants reported using both methods in different situations. In fact, they mentioned using the female condom in cases where they could not persuade the man to use the male condom. Therefore, the female condom has provided women with an alternative method of protection.

"The arrival of the female condom has really helped a lot. It has provided us with an alternative. When a man refuses the male condom then I propose the use of the female condom. Then he is left with no option but to comply."(IDI #10)

Furthermore, participants reported using protection more often since the arrival of the female condom stating that they were alternating the use of the method for specific situations. For example, they use the female condom with intoxicated partners, or partners that are opposed to male condoms.

> *"You use your own discretion to assess the situation. You determine whilst talking what kind of a client you have and there are people you know that can never agree to the use of condoms, so for those you do not even bother because you will be wasting your energy. Just tell him how much you charge and go to the toilet and insert the female condom." (FGD #2)*

There was a consensus that the advent of the female condom has made it possible to practice safer sex with long-term partners. Participants explained that in the past they found it difficult to ask men to use the male condom because they are usually associated with disease and promiscuity. However, they found it easier to use the female condom because they are able to convince their partners to use this method to prevent pregnancy.

> *"It is difficult to insist on condom use with your steady partner when you have been in the relationship for a long time because it always comes across as a question of trust and is always accompanied with accusations. But the female condom helps you avoid all that drama because you do not have to ask him for anything. You just tell him that you are using a new method of contraception that has no side effects, female condom." (IDI #2)*

This shows that the female condom is not a replacement of the male condom, but rather expands the options for safer sexual behaviour, particularly for women. The social and economic power imbalances that usually exists in sexual relationships puts women in a precarious position and makes it difficult for them to insist of condom use. The female condoms, however, do not eliminate the need for sexual negotiation, but increases women's power and control over safer sex and hence provide an alternative to the male condom. Therefore this woman initiated device is an essential supplement to the male condom and fills an important niche.

4.7 Summary

It is evident from the findings that the female condom offers women a much needed and effective alternative to the male condom given unequal power relations and male partners'

frequent refusal to use condoms, mainly because they do not require the same degree of cooperation as well as initiative from the male partner. Hence it is their preferred method for the practice of safer sex. However, female condoms are not a perfect method, they have unique challenges. But they are certainly an effective, acceptable and desired dual protection method which can greatly improve women's health, particularly their sexual and reproductive health.

CHAPTER FIVE

CONCLUSION

5.1 Introduction

To date, the female condom remains the only approved female-initiated method that offers dual protection against STIs (including HIV), as well as pregnancy. This device offers women a method of protection that they can use independently. In fact, it affords women an opportunity to take a proactive role in safer sex practices in spite of the prevailing gender inequalities and power imbalances in sexual relationships. Since gender inequality is the major driver of HIV/AIDS in Swaziland, female condoms have an essential role to play in stemming the tide of the epidemic. They can provide a life saving choice to women at risk of HIV and other STIs, as well as unwanted pregnancies. Thus, improving women's sexual and reproductive health and ensuring their own survival. Hence, the participants find the device to be a necessary and welcome additional option especially for those who have trouble using the male condom or other family planning methods. However, certain limitations must be acknowledged in interpreting the results of this study. First, the data are not generalizable to the entire population because they are based on a relatively small sample. In addition, the study was carried out with a select group of women, sex workers. It is hypothesized that sex workers are more likely to be in control of sexual decision making than other women given the contractual nature of the relationship (Dietz et al. 1998). Nevertheless, the study does provide some insights into the factors that facilitates and inhibits use of the female condom.

5.2 Summary of Results

The study found that the participants prefer the female condom over the male condom because it offers them more options and furthermore they control its use. Of relevance here is the issue of female control and safety that this product seems to afford women. Across all interviews the participants articulated that the male condom does not guarantee safety because men usually manipulate the use of condoms by sometimes making pinholes in them. Therefore, they found the female condom to be appealing as women insert it themselves without depending on men. Hence, they can be sure that it is not torn or otherwise tampered with. Furthermore, the participants perceived the female condom to be stronger and more resistant to breakage than its male counterpart. They reported feeling more protected with the female condom. Other studies of the female condom have also emphasized the fact that the

female condom made women feel more protected and safe (Dias et al. 2006; Gullob 2000; Hoffman et al. 2004; Kerrigan et al. 2004; Ray et al. 1995). This feeling is to a greater extent attributed to the widely held perception that the female condom is stronger and therefore more resistant to rupture (Beksinska et al. 2001; Dias et al. 2006; Vierra et al. 2004; Welbourne 2006).

Perhaps the significant contribution of the female condom to public health is that it widens the options for safer sex. The findings support the notion that the more options available the more likely it is that couples will use protection. The participants reported that they used protection more since the advent of the female condom. Firstly, because those who had negative reactions to the latex male condoms now had an alternative method to use. The female condom is an option for women who are not in a position to negotiate the use of the male condom either because of cultural or personal constraints. Literature has also shown that when there are more alternatives available, couples are more likely to use protection (Cecil et al. 1998; Choi et al. 2003; Macaluso et al. 2000). Hence, there was a reported increase in the proportion of protected sex acts although miniscule at times, where there was access to female condoms along with male condoms (Hoffman et al. 2003; Hoke et al. 2007; Kerrigan et al. 2004; Mantell et al. 2003; Musaba et al. 1998). Also contraceptive experiences show that expanding the range of options increases the likelihood that each couple will find the method that meets their needs (Ross et al. 2001). Participants found the female condom to be a welcome alternative to hormonal contraceptives. This was emphasized by participants that had experienced side effects with hormonal contraceptives.

The majority of the participants reported alternating between the two methods. The participants reported using both methods in different situations. In fact, they mentioned using the female condom in cases where they could not persuade the man to use the male condom. In other words, the female condom was used in cases where there would otherwise have unprotected sex. This therefore suggests that the female condom complements the male condom, which in turn leads to increased overall protection. Therefore alternating the two methods may facilitate consistent condom use and hence help stem the tide of the HIV/AIDS epidemic. As inconsistent condom use has been shown to undermine the potential of condoms in the fight against HIV/AIDS (FHI 1998).

The fact that the female condom is woman-initiated affords women an independent method of protection that they can use on their own. Therefore, it emancipates them from their reliance on men to use the male condom for protection. Participants cited that they found it difficult to insist on male condom use because its use is entirely contingent on the cooperation of the male partner. However, with the advent of the female condom they were no longer dependent on men for protection; instead they offer the male partner a choice between his or her condom. This therefore, puts women in a stronger position than trying to persuade a man to use the male condom if he does not want to. Hence, the conclusion that the female condom enhances women's safer sex bargaining power (Green et al. 2001; Hoffman et al. 2004; Okunlola et al. 2006; Rivers et al. 1998). Previously when a man refused to use the male condom, the one and only option for self protection for women was to refuse sex. This may be easy in commercial partnerships given the contractual nature of the relationship. However, in long-term partnerships, such as marriage, it becomes hard given that in Swazi culture a woman has no right to refuse a man sex. This therefore creates a conflict in the relationship with the possible outcome of violence. However, this device offers women another option to practice safer sex. Hence, Gullob (2000) contends that it changes the dynamics of the dyad rather than adding to the burden of what women normally need to negotiate protection with their partners. Consequently, when a man refuses to use the male condom, they opt to use the female condom; which they reported can be used in a non-threatening way. Protection is then used consistently even if the partner disapproves of its use.

Continued use is further facilitated by the fact that this device can be used covertly. This shows that some women can be in total control of this method. The participants reported using the method secretly, especially with intoxicated partners. Other studies have also documented covert use of this device (Kerrigan et al. 2004; Green et al. 2001). However, the issue of covert use has been overstated, particularly with the advent of female-initiated methods, like microbicides and vaccine which may be completely invisible. There is a growing discourse that microbicide gels are superior to the female condom because they can be used covertly. However, Green et al. (2001) found that women still feel the need to inform their partners about using the gel or they fear that their partner would become aware of the gel during intercourse. Hence, Mantell et al. (2008) contend that the issue of covert use is an illusion rather than the reality. Besides, women cannot succeed in concealing the use of the device indefinitely. This therefore underscores the need for negotiation skills.

A majority of the participants reported the need to negotiate its use. This corroborates the findings that condom use is typically not a unilateral action, but involves either implicit or explicit agreement from both partners (Edgar et al 1992; Sacco et al. 1993). So, women felt that they had to inform their partners about using this method of protection. Unfortunately, negotiation involves communication whether direct or indirect about sexual behaviour which has been found to be the most difficult aspects of heterosexual relationships. Discussing disease prevention with partners, especially long-term partners was reported to be uncomfortable. Eaton et al. (2003) reiterates that discussions about condoms tend to be awkward and limited. This is further worsened by the Swazi culture that prohibits frank sexual discussions between men and women. Furthermore, suggesting the use of condoms may imply that one has not been using condoms in the commercial partnerships and this may raise the risk of violence. Also, use of condoms with long-term partners is usually perceived as a violation of trust and intimacy. This points out to the complexity of sexual behaviour, showing the influence of factors at the interpersonal level (type of relationship) and distal context (culture). Hence, the growing argument that female condoms do not resolve the inherent difficulties involved in negotiating condom use (Green et al. 2001; Hoffman et al. 2004; Mantell et al. 2005).

However, the advantage of the female condom is that it can be negotiated in non-threatening ways. Women can readily justify its use on the grounds of pregnancy prevention, to enhance pleasure or avoid the allergic reactions associated with the latex male condom. Women find it easier to negotiate the use of the female condom for pregnancy prevention. A number of the participants reported that it was easier to discuss pregnancy prevention with their partners rather than disease prevention. Firstly because contraception is seen as women's responsibility, therefore requesting condoms for pregnancy prevention removes some of the barriers to the negotiation of use. Also positioning the device for contraception changes the widespread association of condoms with promiscuity and disease. This is consistent with female condom acceptability studies which have documented successful negotiation when the female condom use was requested on the grounds of pregnancy prevention (Gullob 2000; Hoffman et al. 2003; Kerrigan et al. 2004; Mwakisha 1994; Rivers et al. 1998; Welbourne 2006). Scholars argue that negotiating the device for contraception distances the product from the stigma associated with male condoms and STIs and thus ensures wide acceptability (Kerrigan et al. 2004; Hoffman et al. 2004; Gullob 2000; Ray et al. 1995). This is clearly the

case in South Africa where the female condom has been marketed as a contraceptive method and consequently has documented the second largest sales of female condoms in the world (Avert 2010; FHI 2007; Mqhayi 2003). In addition, using the female condom primarily for contraception facilitates continued use. Cates (1996) attest that condoms are more likely to be used consistently when they are used as a dual purpose method rather than in combination with another contraceptive method.

Consistent use is further facilitated by the fact that the female condom can be inserted up to eight hours before intercourse. Participants valued this because it gives them more control over the situation, rather than having to scramble for condoms at the last minute. Also when the man finds the woman wearing the female condom he is left with no option but to concede to its use, although it is usually grudgingly. For women who anticipate difficulties in using condoms due to alcohol or unfortunate circumstances like rape the female condom was the preferred method of choice. This suggests that the female condom does contribute to consistent use of condoms as alcohol consumption has been documented as the reason for inconsistent use of condoms. However, the disadvantage of inserting the female condom prior to intercourse is that one may be perceived as being suggestive of wanting sex or being labelled promiscuous. This may serve as a barrier especially to women with low self-esteem as they are more concerned about what their partners think of them (Eaton et al. 2003).

A key factor influencing the adoption of the female condom is the perception of risk. Findings from this study support the notion that a greater perception of risk is associated with increased condom use. The participants perceived themselves to be at an increased risk for STIs hence the wide use of this device. This result is consistent with studies that have found high prevalence of female condom use among women at high risk of STIs (Denaiud 1997; Holmes et al. 2008; Macaluso et al. 2000; Warren and Philipot 2003). However, understanding one's risk of contracting infections does not automatically translate into the use of the device. As it has been explained that a sexual behaviour like condom use is influenced by factors at three levels; personal, proximal and distal context, therefore perception of risk is an important step, but it is not a sufficient precondition for use of condoms. Also previous use of male condoms emerged as a strong predictor of female condom use. The participants articulated that a man who has never used condoms in his life will never concede to the use of this device. This finding is not unique since acceptability studies have shown that prior experience with the male condom is associated with the use of

the female condom (Holmes 2008; Ray et al. 1995; Meekers and Richter 2005). The challenge therefore is how to convince both men and women to support the use of female condoms for it to have the greatest public health impact.

The findings suggest that participants are appreciative of the female condom and prefer it to the male condom because of its durability and other features that offer advantages over the male condom, such as timing of insertion, lubrication. However, just like any other method of contraception, female condoms are not a perfect method. The method elicits mixed reactions, especially when it is tried for the first time. Participants reported that they were initially surprised by its size and they also had aesthetic concerns about it. Their greatest concern was that it takes time to master its use. This is consistent with other studies that have documented that users had difficulties with insertion in the initial phase (Gullob 2000; Hoffman et al. 2004; Kerrigan et al. 2004). However, practice and patience seem to alter the difficulties. This strengthens the need for support by peers, counsellors and health care providers to solve the difficulties (Choi et al. 2008; Gullob 2000; Kalckmann et al. 1998; Simons 2009). This is particularly pertinent because opponents of the female condom who criticise the device as a viable prevention method claim that it is cumbersome to use and that women do not like using it (Morris 2007; Welbourne 2006). Also the fact that it needs time to adjust to the body warmth for it not to make noise may serve as a barrier to its use, especially in cases of sporadic sex. However, new improved brands are reported to be less noisy (FHC 2009).

Perhaps the greatest barrier to the use of this device is its limited availability. The device seem to be unavailable, participants reported that the device was only available at NATICC. Therefore, when NATICC runs out of stock they have no other place to get the condom. Because of this some participants reported being forced to have unprotected sex when they run out of supplies and their partners refused to use the male condom. This has led some participants to use one condom throughout the night in order to ensure that they do not experience shortages. However, this undermines the device's contribution to the fight against HIV and other STIs. Other studies have also documented reuse of device (Beksinska et al. 2001; Deniaud 1997; Ray et al. 1995). In Swaziland reuse is prohibited.

5.3 Implications and Recommendations

The findings of this study suggest that the use of condoms is a complex process. Acceptability studies on the female condom as well as surveys of male condom use patterns

have also shown this. The model developed by Eaton et al. (2003) also points to the complexities of sexual behaviour. Women's unequal social status and power imbalance in sexual relationships make it difficult for them to take a proactive role in safe sex practices. The difficulties that women experience in negotiating condom use at the interpersonal level are made worse by personal factors such as self-efficacy to use condoms and self-esteem and are further compounded by cultural taboos against women who appear sexual assertive. This shows that attitudes, norms and skills to use the female condom play a major role in the adoption of female condom use. Such findings underscore the need for a change in the negative images of condoms as well as social norms discouraging condom use, also overcoming interpersonal as well as structural obstacles. How this will be accomplished, however, remains an open question.

The literature review shows that effective promotion of female condoms is possible. There is a need to identify effective individual as well as structural interventions in order to realize the potential this much needed device has to contribute to increased levels of protection. Thus, ongoing behavioural intervention research is required to identify the most effective promotional strategies. UNAIDS and WHO (2000) declare that for the female condom to provide the greatest public health impact they must be introduced strategically. This underscores the need for high quality female condom programmes that will create demand and uptake, as well as continued use of this essential device. As has been previously mentioned for the female condom to provide the envisaged public health impact it must be used by those who use condoms inconsistently, as well as those who do not use condoms at all and are at risk of STIs. This therefore calls for a clear identification of the target audience after which appropriately crafted messages and quality information will be delivered. Furthermore female condom introduction programmes can pave the way for future microbicide use when they become available.

As the participants find it easier to negotiate the device as a contraceptive it is therefore recommended that the product be integrated into already existing family planning programmes. The benefit of this includes reduced stigmatisation of the device as purely for disease prevention, making the device more acceptable and therefore can increase safer sexual practice. Also the countries that have documented success have shown that the female condom has a significant role to play as part of the contraceptive mix, therefore well planned strategies have to be developed to integrate the female condom into the country's contraceptive mix.

Moreover, the device can be promoted as a way of enhancing sexual pleasure in sexual relationships. This is in light of the findings that participants reported using eroticism to convince partners who were initially reluctant to use this woman initiated device. And also the majority of participants reported having tried the method on the grounds that it increases sexual pleasure.

However, this does not invalidate the need for negotiation skills as some participants reported that they faced difficulties in negotiating the use of the device. Potential users have to be helped to develop effective negotiation strategies that are contextually appropriate such as how to introduce the female condom in marriage or established partnerships given the fact condoms are less likely to be used in long-term relationships. First, women in established partnerships should be made aware of the fact that they are still at risk of STIs; taking into consideration the need for trust and intimacy in these kind of relationships and the contradictions which it raises in relation to the practice of safe sex. Peer support groups are an essential and effective channel for introducing the female condom in sexual relationships. Also good communication skills are essential. At the same time, acceptance among men has to be established as lack of it has been documented as the reason for non or discontinued use of this essential device. In fact, it is argued that men dictate the terms of the heterosexual encounter. In Swazi culture it is usually the man who controls and moderates the sexual interaction process. Therefore, it is critical that men are included in all awareness raising initiatives. Also research is needed that will directly examine men's attitudes towards the female condom.

Given that the female condom needs a great deal of practice before users can finally master its proper use, users and potential users need skills training on the proper use of the device. Condom use skills' training typically involves the demonstration of condom use by health educators on the pelvic model. Actual fitting of the female condom by a health professional such as a nurse may be more useful given the complex nature of the insertion process. Also users have to be warned to anticipate a period of adjustment which the difficulties in using the female condom are considered normal and should be expected. Testimonials from others who have adopted the female condom may be useful at this stage. Ongoing support and contact with health care providers, educators and counsellors, and education about basic reproductive anatomy may also help overcome negative feelings related to vaginal insertion.

Communication with a provider or peer educator has been reported to have a direct positive impact on female condom uptake (Warren and Morris 2002). Therefore specific training has to be offered to the health care providers to ensure that they provide accurate, unbiased information about female condoms to their clients.

A consistent supply of the product is crucial because the potential of the female condom is usually undermined by constantly running out of stock. This also facilitates the reuse of the product and with participants not following the protocol its contribution to the prevention of STIs may be further compromised. Therefore, a consistent supply of the device has to be ensured. The government needs to be strongly proactive as lack of political will has been documented as leading to inaccessibility of the device. The device must be provided at public health clinics**,** pharmacies, public restrooms, toilets, as well as all the places that one finds its male counterpart. It also has to be provided at a subsidized cost through social marketing programmes. Strong grassroots advocacy has emerged as a crucial element of successful national programmes. Experiences from Zimbabwe illustrate the powerful advocacy role that women organisations can play as catalyst in promoting the female condom (Meekers 1999).

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