

Exploring women's perceptions on the use of the female
condom among female attendees at an inner-city family
planning clinic in Durban, South Africa.

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Declaration

Submitted in partial fulfilment of the requirements for the Masters Degree in Social Policy Programme in the Faculty of Humanities, Development and Social sciences, University of KwaZulu-Natal, Durban, South Africa.

I would like to declare that this dissertation is my original work. All citations, references and borrowed ideas have been dully acknowledged. The presented work is being submitted for the degree of Social Policy Programme in the Faculty of Humanities, Development and Social sciences, University of KwaZulu-Natal, Durban, South Africa. It has not been submitted in this respect previously for any degree or examination in any other University.

Student Signature

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Date

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Abstract

This research study seeks to explore perceptions of family planning clients towards the female condom, as well as examine factors that facilitate or inhibit the use of the device by women of different age groups. The study targets women aged 18-35 who attend the Commercial City Clinic located in Durban, South Africa. This study targets this group since they fall in the category of those most besieged by HIV, hence the need for protection against infection. While most research on condom use has focused the technicalities of barriers prevention methods, relatively less is known about attitudes, motivation and strategies employed by users or would-be users.

Although Femidom has been widely accepted as an effective method in STI and pregnancy prevention, nevertheless its usefulness is hampered by a number of factors. Factors range from partner's objection; men's negative attitude to use of the device; refusal to use any condom during sex; distrust of the method by male partner; Femidom insertion difficulties in women; reduced sexual sensation for some women when the device is in use; and preference of a discreet method by women not requiring permission by the male sexual counterpart to use the female condom

While this study acknowledges that the female condom is an imperfect technology, nevertheless, ways need to be found on how to raise its acceptability. Such a measure is necessary since the female-controlled HIV prevention device has great potential if better marketed and distributed. However, that potential can only be realized if women's vulnerabilities in the biological, cultural, economic and social domains are addressed. In so doing, this would enable women to gain greater control over their sexual health and also empower them in sexual relationships, thus bettering their lot than is the case at present.

Chapter One

1.1 Introduction

Across the globe, the sub-Saharan region continues to bear the highest rates of HIV infection on the African continent (Deniaud, 1997; UNAIDS, 2008, 2009), where 67% of the infected live (UNAIDS 2009). Of the 2.7 million new infections it is estimated that 1.9 million occurred in sub-Saharan Africa, bring the total number of people in this region living with HIV to 22.4 (UNAIDS, 2009; UNAIDS, 2008). Women make up over half of the world's people living with HIV (PLWHIVs), with 60% of HIV-infected females living in the Southern Africa region (UNAIDS, 2009). According to the World Health Organization (2009), globally, AIDS related illness is the leading cause of death and disease among women of reproductive age 15-49. The key challenge, therefore, is how to curb the spread HIV/AIDS, especially among women, who comprise the worst affected group in the pandemic (Walker, *et al* 2004). Worldwide, there are 33.4 million people living with HIV in 2008 (UNAIDS, 2009; UNAIDS, 2008).

SIDA (2007) reports that the main intervention in curbing AIDS should be the scaling up of HIV prevention measures. While prevention is one of the most crucial steps in this respect, condom use is generally low in sub-Saharan Africa. Condom use in most parts of sub-Saharan is low among adults, regardless of gender (Lagarde, Careal, Gynn et al, 2001; Foss, Watts, Vickerman & Sleaf, 2003; UNAIDS, 2009). However, in Southern Africa increased condom use toward safer sex is a new trend that has been observed among young people of both genders aged 15-24 (Gouws *et al.*, 2008). Many HIV prevention technologies such as the male condom, as well as female initiated vaginal microbicides and the female condom – albeit on a relatively lower scale – are increasingly used. Femidom (a female condom brand) is the most widely used female controlled barrier method in the world.

The need to access protection becomes increasingly urgent, especially for females as larger numbers are infected as compared to males (Parker, 2007). Under the circumstances, a strategy

that gives women a measure of control to protect themselves against HIV infection is high priority, especially in sub-Saharan Africa (Peters et al, 2010; Brown, 2003). This makes it imperative to increase the number of innovative intervention tools that are female-controlled, thus promoting women's empowerment in sexual relationships.

This qualitative research study seeks to explore perceptions of family planning clients towards the female condom, as well as examine factors that facilitate or inhibit the use of the device by women of different age groups. The study targets women aged 18-35 who attend the Commercial City Clinic located in Durban, South Africa. The clinic is among the few such facilities in Durban that dispenses female condoms free of charge. This study targets this group since they fall in the category of those most besieged by HIV, hence the need for protection against infection. Ideally, attention should be paid to providing HIV prevention tools that are female-initiated. While most research on condom use has focused the technicalities of barriers prevention methods, relatively less is known about attitudes, motivation and strategies employed by users or would-be users.

1.2 Background

In South Africa since the need for female controlled HIV prevention methods is especially urgent, since an estimated 5.7 million PLWHIVs – the world's largest – reside in this country (RSA, 2010; UNAIDS, 2009). Over three million among these PLWHIVs are women aged 15 and upwards. In 2008 alone over 250,000 people are believed to have died of AIDS in South African (Statistics South Africa, 2009). This nation falls in Southern Africa, where the HIV epidemic is defined a hyper epidemic, a term used when more than 15% of a population aged 15-49 are HIV positive (UNAIDS, 2008). According to UNAIDS (2009) South Africa qualifies under this categorization since the nation has a HIV prevalence of 16.9 among adults aged 15-49 in 2008, based on the national population based survey of conducted in that year.

Women continue to bear the highest figures of those affected by HIV epidemic in South Africa. Pettifor *et al* (2004) as well as UNFPA and PATH (2006) spell out the wide ranging factors that account for women's higher risk of infection. These comprise biological, socio-cultural and economic factors. Young women, especially adolescents, are more predisposed to HIV infection due to an immature physiology of the female reproductive tract as compared either to that of older women, or to male counterparts (Hallmark, 2004; AmFar, 2005). Consequently, younger women are at highest risk of HIV infection worldwide.

Apart from this biological attribute, other constraints that put females at relatively greater risk of infection as compared to males. Constraints include sexual norms, inequalities in access to material resources, sexual decision-making and sexual violence – all of which affect women more adversely. South Africa is plagued by extreme socio economic inequalities as a result of the previous apartheid political system (RSA, 2010). As Preston Whyte (1995) argues, the apartheid political era left women few economic options but to have to sell their bodies for survival, thereby putting themselves at risk of contracting HIV. Due to male migratory labour trends, women's sexual partners working away come home infrequently, a development that resulted in multiple concurrent partnerships by both men and women in heterosexual relationships. Such women tend to engage in transactional sex, thus increasing the HIV risk for both men and women. Parker *et al*, (2007b) observes that the current high HIV infection could be attributed to unprotected sex among such partners; the greater the number of sexual partners the higher the risk of contracting STIs, including HIV.

Currently in South Africa, the largely government – distributed Femidom is the only female initiated safe sex barrier method that could effectively mitigate the high numbers of new infections in that nation. The female condom extends the choice of contraceptive methods available while providing significant protection from the risk of pregnancy and infection with STIs, including HIV (Gupta *et al* 1995; Vijayakumar *et al* 2006; Brown, 2003). Thus Femidom offers a valid alternative to the male condom. Although Femidom has been widely accepted as an effective method in STI and pregnancy prevention, nevertheless its usefulness is hampered by a

number of factors. Factors range from partner's objection; men's negative attitude to use of the device; refusal to use any condom during sex; distrust of the method by male partner; Femidom insertion difficulties in women; reduced sexual sensation for some women when the device is in use; and preference of a discreet method by women not requiring permission by the male sexual counterpart to use the female condom (Brown, 2003; Deniaud, 1997; FHI, 2007).

Another challenge posed by this female initiated barrier method is lack awareness of its existence, and that it is not easily accessible. In South Africa Femidom is only available in few outlets. The female condom is distributed only in some government public hospitals and clinics, as well as a few chemists. This scarcity could be attributed largely due to Femidom's relatively high cost as compared to the male condom. Due to restricted its access in public facilities, female condoms are only available in few store outlets, costing between R6 and R7 a piece, yet one male condom is priced at R1 (Parker, 2010). Hence, availability to female condom in the developed world has influenced dismal accessibility of the device, especially due to pricing considerations. Since Femidom is relatively expensive, women are unable to afford the female condom from pharmacies, given that they cost US\$2–3 each (FC1, year). This cost price is estimated to be R15-22 in South African currency (Peters *et al*, 2010). However, this impacts indirectly on the uptake of this female controlled barrier method, with the regulated price for the female condom costing 29 times higher than the male condom, i.e. \$0.58 per female condom versus \$0.02 per male condom (Frost and Reich, 2008). This pricing gridlock is partly due to the current limited market for female condoms (van Mens, Smit I, 2008).

In addition, Femidom is not being promoted as widely as the male condom, especially in Africa. Moreover, in future women can also use a newly developed HIV innovation known as the microbicide gel that can be used discreetly without sexual partner's knowledge, but the substance is not yet available since the substance is still on trial (Kunda and Gibbs, 2010; University of Alberta, 2004). This female-controlled innovation was in the limelight at the 18th International AIDS Conference, held in Vienna, Austria, from the 18-22 July, 2010 (Boyer *et al*, 2010).

Unsafe heterosexual is the predominant mode of HIV transmission in the sub-Saharan Africa (UNAIDS, 2009), including South Africa; followed by mother-to-child transmission (Preston Whyte E, 1995; UNAIDS, 2009). The drivers of the epidemic in this sub region include migration, intergenerational sex, low perception of HIV risk, low condom use and multiple concurrent sexual partnerships, low male circumcision rate and alcohol abuse (Department of Health South Africa, 2008). As reported by many studies, the predominant mode of transmission is sexual contact, with a large proportion of HIV infections in Africa occurring within stable relationships – either because of prior infection of one of the partners, or due to infidelity (Desgrees-du-Lou *et al*, 2008).

The gendered nature of HIV infection remains a major area of grave concern. National HIV prevalence rate is 11%, with some age groups and gender particularly affected. The *South African National HIV Prevalence, Incidence, Behavior and Communication Survey 2008: A turning tide among teenagers?*, found that almost one-in-three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV in South Africa (Shisana *et al*, 2009). Women aged 25-29 were reported to have HIV prevalence of 32.7%, with 20-34 age group of women reflecting high prevalence rate of 33,3% in 2005 and slight drop to 33% in 2008. The 2008 national survey found men peaking at age 30-34, with a prevalence of 25.8%. In 2008, KwaZulu-Natal alone has 1.6 million adults living with HIV, comprising 16% of population aged 20-64.

According to the 2009 *National Antenatal Sentinel HIV & Syphilis Prevalence Survey*, released by the Department of Health Minister Dr. Aaron Motsoaledi on November 11, 2010 (Cullinan, 2010) the highest increase in HIV infections has been reported among women aged 35-39, up by 6 percent to 35.5 percent in 2009. KwaZulu Natal Province antenatal HIV prevalence has been cited as the highest among nine provinces in South Africa, with a close to four out of 10 females (39.5 percent) infected with the HI virus. Comparatively the lowest HIV prevalence rate was identified in Northern Cape Province.

At least 40% of women in reproductive age of 15-49 attending antenatal clinic are the most severely affected by the pandemic. New infections are estimated at 366 people daily, totalling 134 00 per year in 2008 (Nicholay, 2008). Durban, which is this dissertation's study site, falls

under the province facing unparalleled HIV prevalence among its population. This alarming situation calls for the investing in and promotion of a woman initiated HIV prevention devices to alleviate the plight of women. Though the *South African National HIV Prevalence, Incidence, Behavior and Communication Survey 2008* found a reduction in youth HIV infection, from 10.3% in 2005 to 8.6% in 2008. Although it is still disproportionally high among females as compared to males overall, but HIV prevalence depicts 25.8% among male age 30-34 in 2008.

Deaths HIV and AIDS are also reflected in infant mortality rates. It has been documented that HIV infection is among the key contributors to South Africa's infant mortality rate, which increased significantly between 1990 (44 deaths per 1000 infants) and 2008 (48 deaths per 1000) (Shisana *et al*, 2009). Over the episode of two years HIV prevalence rates have stabilized at around 11% in the 2-year-old toddlers (Shisana *et al*, 2010).

Sub Saharan Africa is a region with a high prevalence of intergenerational sexual partnerships, gender based violence and substance abuse: all factors that play a role in young women's disproportionate risk of HIV infection (Leclerc-Madlala, 2008; Dundle *et al*, 2006,). Studies on gender-based violence in South Africa reports that experiences of violence and controlling behaviour by male partners was strongly associated with increased risk of HIV infection among women (Dundle *et al*, 2006; Maman *et al*, 2002; El-Bassel N *et al*, 1998; and Jewkes *et al*, 2002). Further, sexual violence and gender inequalities frequently hamper women's and girls' ability to practise safer sex. For example a national survey in South Africa that included questions about experience of rape before the age of 15 found that schoolteachers were responsible for 32% of the disclosed adolescent rapes (Jewkes and Abrahams, 2002). Forced sex adversely affects a woman's ability to successfully negotiate the use of a HIV prevention tool such as the male or female condom (Wingood and DiClemente, 1997; Karim *et al*, 1995).

Intergenerational sex is another factor that influences the vulnerability of women in South Africa. The percentage of young women in South Africa who reported having a sexual partner of more than five years older than themselves, rose from 18.5% to 27.6% in 2008 (Shisana *et al*, 2009). A research study conducted in South Africa found that young women engage in sexual relationships with older men as a contributing factor to the spread of HIV (Pettifor *et al*, 2004). It

has been noted that such relationships are motivated by subsistence needs as well as being linked to materialism. Shisana *et al*, (2005) identified an increase in HIV infections among teenagers of both sex with sexual partner five years older than them. However, due to unequal, gendered power dynamics in sexual relationships vulnerability may be increase, especially in young girls who lack the capacity and power to negotiate condom use (Parker *et al*, 2007).

As noted in the literature, concurrent sexual partnership is yet another issue that exposes women to HIV risk. According to Parker *et al*, (2007:12) sexual concurrent partnerships are defined as a sexual relationship that overlaps over time either where two or more partnerships continue over the same time period, or where one partnership begins before the other terminates. Shisana *et al*, (2009) argue that concurrent sexual partnerships are common in South Africa. Other earlier enquiries show that concurrent sexual partnerships leads to sexual networks that are clustered; which don't occur in sequential relationships (UNAIDS 2006). However, it is illustrated that concurrent sexual partnerships create HIV vulnerability for partners engaging in unprotected sex. The greater the number of sexual partners the higher the risk of contract STIs, including HIV (Parker *et al*, 2007).

UNAIDS (2008) report that young people aged 15–24 accounts for an estimated 45% of new HIV infections worldwide. In some countries most affected by HIV, condom use is increasing among young people with multiple partners (UNAIDS, 2009). In many parts of the world, large numbers of young people are sexually active at an early age, are not monogamous, and do not use condoms regularly -- all high risk factors for HIV infection (UNAIDS, 2008; Kaaya *et al*, 2002). This predicament applies in the case of South Africa as well.

In sub-Saharan Africa, youth sexual activity is evident in unprotected sex practices such as unwanted pregnancy, illegal abortions and STIs, including HIV/AIDS. (UNAIDS, 2008). Yet the *South African National HIV Prevalence, Incidence, Behavior and Communication Survey 2008: A turning tide among teenagers?* registers that from 2002 to 2008 there have been remarkable changes among young people, with both sexes reporting condom use at last sex

(Shisana *et al* (2009). People aged 15-49 reported a condom use at last sex, with a rise from 31.3% in 2002 to 64.8% in 2008. Furthermore, males reported an increase from 36.1% in 2002 to 67.4% in 2008, while women increased condom use from 27.6% in 2002 to 62.5% in 2008. In the same period, condom use among South Africa youth rose to 87.4% among males and 73.1% in females. However, consistent condom use among multiple partnerships has increased despite the peak in some countries in the use of barrier methods, while other countries reflected a declined (UNAIDS, 2009).

In South Africa, the use of female condoms forms a focal point of the government's 2007 National HIV & AIDS and STI Strategic plan (2007-2011), which aims to half new infection by 2009 (Medindia, 2008; Department Of Health (DOH), 2007). Femidom is a resilient, transparent sheath that is 17 centimetres long (about 6.5 inches—the same length as a male condom) with a flexible ring at each end (Female Health (FHI), 2008). Femidom is inserted into the vagina, and can be positioned for up to eight hours before sexual intercourse. During sex, the protective device forms a physical barrier between the penis and the vagina. In South Africa the female condom is also promoted as a potential dual method strategy, for the prevention of STIs and well as pregnancy (FHI, 2007). South Africa's female condom distribution programme is among one of the largest in the world (FHI, 2007).

In 1998 this female controlled device was introduced to the nation in limited quantities to health care facilities, where distribution has since expanded to over 200 sites (Medindia, 2006), increasing from 1.3 million in March 2001 to 2.6 million in May 2004. Three million female condoms were targeted for distribution by June 2005 (Medindia, 2006). According to the National strategic plan (DOH, 2007), the target was to purchase and distribute 435 million male condoms and only three million female condoms were distributed (DOH, 2007). In 2007, the South African government distributed 256 million male condoms, down from 376 million in 2006. Over 3.5 million female condoms were distributed in 2006 and 2007 (Plus News, 2008). The South African National Strategic Plan on HIV & AIDS and STI (2007-2011) proposed the purchase and distribution of 435 million male condoms and only three million female condoms,

which is 0.006% of the total condoms available in South Africa (DOH, 2007). According to existing literature, condom distribution has increased over time but the female condom accounts for fewer condoms distributed as compared to the conventional male condom (DOH, 2007). Availability of female condoms is very limited, with the DOH distributing over 3 million free female condoms per year, despite acknowledgement of far greater need (love Life, 2009).

In South Africa's HIV prevention strategy, irregular distribution has prevented Femidom from becoming mainstreamed. The supply problem is also hampered by women either not having information on the existence of Femidom, or lack of knowledge on the benefits of the female condom (Spizzichino *et al*, 2007). Even though women could benefit from this device, a key challenge is that most women have never seen it let alone heard of it, but even where they have heard of it, they cannot access it when they need to (Peters *et al*, 2010; Nthwesane, 2010; Hoffman *et al*, 2008). The major limitation with female condom use is that they are generally inaccessible (Lancet, 2008). For instance, 1500 new daily infections occur in rural South Africa, where female condoms are not available (Mabasa, 2007). Conversely, some women avoid using Femidom often because sexual partners disapprove of the device.

Furthermore, women reported teething troubles in the usage frustration with the gadget because of related discomfort during sex: the need to get her partner's consent; aesthetic concerns, and the squeaky noise produced by the polyurethane during the sexual act (UNFPA and PATH, 2006; Lancet, 2008, Nthwesane, 2010). This condom, which is made of polyurethane, is noisier when it's used than the conventional rubber male condom. Despite such challenges, a number of studies show that some women like the female initiated device since it gives them greater control over safe-sex negotiation; increases sexual pleasure; and is a preferred option for men who do not like using male condoms (FHI, 2007). As a result the female condom has a limitation where consent for its use is required from a partner (Green *et al*, 2001). On the contrary, previous research studies in south-west Uganda report that women use Femidom because it helps obtain control over their sexual and reproductive health, with relatively less negotiation with the male partner as compared to over a male condom.

Morality issues also hamper female condom usage. A number of women are reluctant to use Femidom, associating it mainly with extramarital affairs, commercial sex work and one night stands (FHI, 2007; IRIN, 2010). By extrapolation, such women are of the belief, therefore, that Femidom users are also at risk, rendering them susceptible to STIs, including HIV (FHI, 2007; IRIN, 2010). However, such women are not aware that other risks factors are being married, or in long term relationships with unfaithful men. Although the female controlled implement is an option for women's protection against HIV infection, nevertheless it does not route out all causes of vulnerability (Mathew & Harrison, 2006). While this method will not suit everyone, it definitely offers women a vital alternative barrier method among others where male condoms cannot be bargained (Lara *et al*, 2009; Garcia *et al*, 2006).

1.3 Statement of the problem

In general Femidom provides relatively comprehensive protection against pregnancy and STIs, including HIV. Despite its usefulness, the female condom has failed to achieve the desired effect of empowering women to gain greater control over their reproductive health on the wide scale. The AIDS pandemic continues to worsen even with the introduction of the female controlled device in South Africa and elsewhere in the world. This so because regardless of its significant role of offering protection against pregnancy and HIV/ AIDS, the female condom is not as widely used as would be expected (FHI, 2007, Peters *et al*, 2010).

Reasons to limited use of the female condom have been identified in literature as follows. While the use of a condom in a sexual relationship is important, nevertheless it is difficult for women to initiate or use the female controlled device consistently, regardless of their socio economic status and education background. The prevalence of condom-less sex is highest among unmarried sexual partners in stable relationships, as well as among married couples (Maharaj and Cleland, 2005; Mash *et al*, 2010). The 2009 National Communication Survey on HIV/AIDS has also established that 15% of married men and women used a condom at last sex, compared to 74-83%

men and 55-66% of women who had casual sex or one night encounters (Shisana *et al*, 2009). Such circumstances call for prevention programmes that target married couples (Republic of South Africa (RSA, 2010).

However, there are numerous factors that women identify as obstacles to Femidom the utilization, including its curious shape and appearance in addition to mechanical barriers. This female controlled barrier method abounds in myths and misconceptions. Myths include the following: female condoms get lodged into the vagina (Preston-Whyte, 1995); the female condom is difficult to use, and the inner ring can cause pain to both the man and the woman (UNFPA, 2007:59). In addition, some men don't want to buy in into the use of this apparatus, fearing it will promote infidelity in respective sexual partners.

This study research investigates perceptions of users' of the female controlled among Femidom users at the Commercial City Clinic, including general information on the female condom and where they could be found. The study also highlights myths and misconceptions associated with Femidom usage. Furthermore, the study documents attitudes and behaviour associated with Femidom usage and the impact of the apparatus – whether negative or positive. In addition, the study, which captures wide-ranging sets of Femidom users, includes challenges encountered in the process.

1.4 General Aim of the study

The study's main aim is to interrogate users of Femidom on knowledge of the device as well as their experiences – if any – related to use of the apparatus.

The specific aims of the study are:

- to ascertain knowledge, attitudes, practice and beliefs linked to female condoms;
- to establish how gendered power dynamics affects the use of the female condom;

- to compare perceptions associated with the sexual pleasure between female and male condoms.
- to investigate the challenges of using the female condom;

In the research process, the study probes the extent of the uptake of the gadget as well as the outcome of initiating use of a female condom with a sexual partner. In addition, the study explored how factors such as social attitudes, gender inequality, peer pressure and socioeconomic factors contribute towards the use or non-use of the female condom. For the purpose of this dissertation, the research study also focuses on motivation for using the female condom, related myths, user attitudes and practice among the target age group 18-35. This study explores the above-mentioned variables to explain the strategies and challenges users employ to negotiate the use of this device with their partners, and factors that leads to the use and non-use of the apparatus.

1.5 Research Questions

The study is designed to address the following research questions:

1. factors that influence the use and non use of female condoms at the Commercial City Clinic;
2. the extent to which male partner's reaction determines the usage by their female partners;
3. what are perceptions associated with sexual enjoyment during the use of a female and male condom;
4. challenges women face in negotiating female condom use with their partners; and
5. whether knowledge of female condoms actually really translates to actual use in women.

1.5 Significance of the study

Past studies conducted on female condoms have focused mostly on acceptability and re-use of the device. Little attention has been given to raising awareness of the female condom, and challenges facing users of the female condom. Condoms in general have had lots of factors contributing to their use, or non-use based on gender inequality in sexual decision making; peer pressure; gender violence; as well as socio- cultural and economic status. Underlying issues of condom use might also impact on the uptake and popularity of Femidom, not forgetting that they were meant to offer options also for women whom a partner might refuse the use of Femidom. Therefore, this research study will also identify challenges women face when using Femidom.

1.6 Organisation of the Research Report

This dissertation will take the following structure. **Chapter One** identifies the significance of the female condom in the wake of the AIDS epidemic. **Chapter Two** provides relevant literature relating to factors determining condom use. **Chapter Three** explains the significance of behavioural change theories that could be applied to curb HIV infection. **Chapter Four** describes the methodology applied in the study. **Chapter Five** captures the findings through analysis, followed by discussion on the research findings. **Chapter Six** provides the conclusion and limitations of the research study, and in the process offers recommendations for further research.

Chapter Two

Literature Review

2.1 Introduction

The aim of this chapter is to shed light on Femidom, a female condom, through reviewing existing literature, and to demonstrate the relevance of the study within the existing body of knowledge. To this end, this section will focus on the following issues: knowledge about Femidom; factors that influence the use and non-use of female condom; male partner involvement; misconceptions and myths about Femidom, and challenges associated with Femidom use.

2.2 Background

Unlike other innovative HIV prevention tools which are currently available, the most popularly accepted among the four existing female condoms is the FC1, more widely known as Femidom. The significance of female condoms in HIV prevention is illustrated as follows:

...as nation states and international community create a plan to invest on male circumcision and microbicides including vaccines, they cannot afford to overlook an important and effective HIV prevention intervention that is designed to allow women to initiate protection and negotiate safe sex –female condoms. (Sippel, 2008:1)

Moreover it is part of a comprehensive strategy to assist in prevention of mother to child transmission and the spread of HIV and could assist in achieving the Millennium developmental goals by 2015(WHO, 2010).

However, Femidom this biomedical innovation is currently poses challenges such as lack of consistency of usage and sexual inhibition as key concerns, among other factors (Padian *et al*, 2008).

2.3 The Female condom: Efficacy and Acceptability

Acceptability is defined as: “as the willingness to try, actually use and continue using the method” [Warren and Philpott, 2003: p131]. Femidom (FC1) has been available in Europe since 1992, and was approved by the US Food and Drug Administration (FDA) in 1993 (Avert, 2008; FHI, 2008; Gender Health, 2010). Due to price implication to the FC1 prototype a second generation has been approved by US FDA in 2009 and is currently distributed in 105 countries (Joanis *et al*, 2010). Existing literature indicates that a large number of studies have been conducted on acceptability of female condoms in the recent years (Beksinska *et al*, 2007; Okunlola *et al*, 2006; Prudhomme *et al*, 2005).

Resembling the male condom, if used correctly and consistently, the female condom reduces the risk of pregnancy and sexually transmitted infections (STIs) as well as HIV. In addition, the female condom provides an alternative option to adequate contraceptive effectiveness and protection against STIs (Kulczycki *et al*, 2004; Feldblum, 2001; Fernandez *et al*, 2008; Arendse, 2008; Mack *et al*, 2010).

The above previous enquiries have focused on short-term and long-term acceptability of the device at large. Studies in a variety of countries and cultures show that, on the average, 50 -70% of male and female participants found the female condom to be acceptable to various women and men (FHI, 2008, Warren and Philpott, 2003). The women include sex workers, married women and adolescents. Contrary to the previous short-term studies on Femidom, acceptability has

highlighted higher rates of the use of Femidom, ranging from 37-96% of acceptance of the gadget (Hoffman *et al*, 2004).

An acceptability study involving 135 couples that were conducted in New York, demonstrated acceptability of FC1 as well as another type of female condom known as V-Amour (Latka *et al*, 2001). Conversely, in findings emanating from Birmingham's, Alabama Reproductive Health Clinic, 108 couples in a stable relationship found the female condom to be less acceptable, citing the following reasons: male condom's ease of insertion; penetration; removal and feel of the condom during coitus. However, with a small margin of use being 49.2% of Femidoms to 50.8% male latex condoms (Kulczycki *et al*, 2004). Similar to the above findings, a study of 45 young Spanish couples indicated a low acceptance of female condom in long-term usage, reporting only 17 couples (5.9%) continuing to use the device after a year. Ten men (58.8%) and eight women (47.1%) among the Spanish couples articulated a willingness to use the gadget in future. Twelve women (70.6%) and 11 men (64.7%) reported to have announced Femidom usage to their friends and acquaintances (Fernandez *et al*, 2008).

One acceptability enquiry carried out in Brazil indicated acceptance rate of 70%, with reported continued use of 76% among women (UNFPA and PATH, 2006). A comparative study conducted in South Africa found that 30% of the female participants used the female condom at least once, and of these 86% said they would use it again, while 95% said they would recommend it to friends. The female controlled device has not been widely accepted, although available in South Africa since 1998 (Beksinska, 2005). Whilst this device is an effective barrier method for HIV prevention, it is assumed to be more complex to use than its male counterpart. Acceptability of the female condom in South Africa is greater among the high risk women such as commercial sex workers (CSWs), than women in general (Brown *et al*, 2007).

An acceptability study conducted in Zimbabwe indicates that female condom users were mainly in their late 20s; with higher education levels; and were the decision makers in their respective

households. The study also found that most female users were unmarried; while the male users were married but used the female condoms with their casual partners (Kerrigan *et al*, 2000). Twenty seven percent of female users who are married have never used condoms previously. Thirteen out of 65 females used condoms consistently but are not consistent with male condoms use (Kerrigan *et al*, 2000).

Recently, manufacturers have began producing newly developed second generation of female condoms that costs less, which have maintained the same features of Femidom design that makes them more acceptable (Joanis *et al*, 2010). A study conducted among 276 women in Durban, South Africa, found that Femidom and FC2 to be equally acceptable, and have similar failure rates (Beksinska *et al*, 2006). A comparative acceptability study conducted in New York among 135 couples demonstrated acceptability of Femidom as a well as another type of female condom known as V-Amour (Latka *et al*, 2001)

Female condoms are used under various circumstances. According to a research studies, the use of the female condom largely depends on the availability of the devise (FHI, 2008). There is evidence from studies conducted in South Africa, Thailand and Zimbabwe that some women use female condoms in situations in which the male condom is rejected by their partners (FHI, 2008; Agha, 2001, Kulczycki *et al*, 2004). It has also been found that, among women who use female condoms, the dual method use is common (hormonal and barrier method). However earlier enquiries show that women alternate between male and female condom usage (FHI, 2007; Kerrigan *et al*, 2000; Mack *et al*, 2010). In a different vein, Arendse (2008) asserts it is significant to identify that easy availability of Femidom may not necessarily translate into widespread acceptability of this female initiated barrier method. This is due to the issues that might impact on acceptability, such as user's first experience with the female condom, male partner's reaction towards the device, and stigma associated with Femidom.

In disease prevention efforts, the female condom's polyurethane texture is regarded as impermeable to a number of pathogens as well as HIV. WHO (2007) report that studies indicate that with correct and consistent use, efficacy rates was found to be 98%. In addition, Femidom effectiveness ranges from 80-95% at preventing HIV transmission (Sippel, 2008). However, investigating the impact of the female condom in disease rates, randomized intervention trials were conducted in different countries and which showed conflicting results. A Thailand study conducted among commercial sex workers found that STI rates reduced among women who gave clients an option of a female condom over a male condom (Fontanel *et al*, 1998). Comparative findings have been observed in studies carried out in the South Africa and US are linked to a relatively higher number of protected sexual acts among women using Femidom, in comparison to the male condom used alone (Artz *et al*, 2000; Vijayakumar, 2006). On the contrary, an enquiry carried out in Kenya among the rural community women recognized that there were no differences in STI prevalence after the introduction of female condom (Feldblum, 2001).

Although dual protection from infection and unwanted pregnancy is often seen as a benefit of condoms, the fact that condoms act as a contraceptive may provide a disincentive for and use among some men and women. Arendse (2008) found that women visiting the family planning clinic are hardly known about the female condom as a part of the family planning package. Similar to the study conducted in Central America reflects that out of 35 contraceptive programmes, only one covered female condom promotion (Mack *et al*, 2010) Consequently, Femidom is deemed a novelty as a contraceptive barrier method and it was not promoted and distributed as widely as an alternative option to the male condom (Nicholson, 2008). It has been argued through the literature that female condom's efficacy as a contraceptive and prophylactic method relies heavily on the correct and the consistent use of this barrier method (Feldblum, 2001; Kerrigan *et al*, 2000; Mack *et al*, 2010)

2.4 Factors Influencing Female Condom Use and Non-Use

2.4.1 Introduction

Despite the benefits of condoms-- both male and female-- usage is still low in many countries worldwide. A number of factors that influence the use and non-usage of the condom in general including female condoms will be discussed below.

2.4.2 Knowledge of the female condom

Previous studies conducted in South Africa, Italy, Central America, Zimbabwe and Kenya, participants reported to have heard of the female condom, or possibly seen it or had seen it, but never used it (Mack et al, 2010; Spizzichino *et al*, 2007; Brady *et al*, 2009; Meekers and Ritcher, 2005). Literature reveals that respondents have the perception that very few people have ever used female condoms (Mack et al, 2010; Spizzichino *et al*, 2007; Brady *et al*, 2009; Meekers and Ritcher, 2005, FHI, 2001). This perception is sustained by the view that accessibility of Femidom is poor in developing countries because of lack of awareness due to non-dissemination of information on the usage of this kind of a condom.

On the contrary, one study conducted in Nigeria reflected a high level of knowledge of the device among university students (Mung'ala, 2006). Poor promotion of Femidom in the mass media has also impacted on the level of awareness among women (Spizzichino *et al*, 2007; Peters *et al*, 2010). Such lack of awareness of the female condom influences directly poor uptake of this barrier method for protection against STIs, including HIV (Smith *et al*, 1999; FHI, 2001). A study conducted in Kenya documents different places where female condoms can be found, such as clinics and pharmacies (Brady *et al*, 2009). Contrary to findings in Iraq's Diyala province found that female condoms are unknown to women (PATH, 2005).

2.4.3 Cultural, religious perspective and condom use

Overlapping cultural and religious norms impact on the access, the introduction and usage of barrier methods for protection against HIV transmission. An example is traditional and religious beliefs influencing the use of condoms in heterosexual relationships. For instance, boundaries created by tradition and religious restrictions decree giving women minimum control over sexual decisions and their bodies as well as condom use; in the process giving men power to direct women's sexuality (Amien, 2008). Klugman (2000) argues that Southern Africa's traditions or cultural practices, where men are responsible for sexual decision making, creates a problem for a woman once a man initiates sex. She is not expected to refuse. Patterns of such subordination of women have been known to also promote reluctance to discuss of condom use among women.

A qualitative study carried out in Zimbabwe among young people revealed that adoption of barrier methods was heavily influenced by traditional and religious beliefs (Marindo *et al*, 2003). Christianity regards pre-marital sex as immoral and that it should be prohibited, as it is deemed to encourage young people to engage in sex (Marindo *et al*, 2003; Mash *et al*, 2010; Lucea *et al*, 2010). The introduction of Christianity among Africans disrupted sexual socialization, contributing to the youth being poorly equipped to negotiate sexual debut and therefore, vulnerable to HIV infection (Leclerc-Madlala, 2006). Religious beliefs associated condom use as sinful, perpetuating the conviction that condom use promotes promiscuity and fostered the lack of sex abstinence until marriage (Amien, 2008; Lucea *et al*, 2010).

One study conducted in a predominantly Roman Catholic area located in the Philippines, found that married respondents indicated that church teachings against condom use led to avoiding condoms. (Lucea *et al*, 2010). It could be argued that such a norm that targets married couples only for condom use does not address the fact that young people engage in early sexual debut and the vulnerability of girls and women holistically. As a result, young people who ask for it are scolded. One study carried out among men and women reveals that condom usage among Christian women in Uganda and men in Tanzania is low, especially among married women.

Such an observation among these groups of females implies women's vulnerability to HIV acquisition (The Body, 2004). Contrary to other studies condom promotion has been reported among Uganda and Kenya Catholic group (The body, 2004; Ukwuani *et al*, 2003).

According to a research in Islamic religion, it has been pointed out that there was a transformation in relation to condom use among marriage partners. Islam permits condom usage among married couples to minimize the risk of HIV transmission (Gray, 2003). This religion has advocated actively other HIV risk reduction measures such as male condom usage and prohibition of alcohol consumption (Gray, 2003; Gray *et al*, 2007).

It is not all Muslims who promote such religious practices and risks reduction strategies. As a result HIV infection transmissions are not reduced due to sexual encounters that occur before wedlock (Amien, 2008). Literature concur that MJC reports that 80% of divorce in marriage are the result of extra marital affairs. Men practise infidelity and therefore encounter risky sexual relations. Men's infidelity puts in the process engaging Muslim women at high risk of HIV infection, since the latter are not expected to negotiate condom use (Voice of the Cape Fm, 2010). Marindo *et al*, (2003) observe that Muslim moral values restrict young people, especially young girls and women, from employing protective strategies against HIV infection and pregnancy.

2.4.4 Gender norms, sexual practices and decision-making associated with Femidom usage

Despite constitutional right of women to make informed decision about their bodies and lives, women still submit to male dominance; putting females at risk of HIV infection (van der Schaff, 2008). Most researchers agree that condom use is affected by many factors (Morrison *et al*, 2003).

Gender roles are best described as follows:

“Single or married girls and women are expected to abstain , be faithful or use condoms while for boys and men it is business as usual”[Gordon,2006:p 73].

One’s sexual behaviour is determined by economic, gender inequalities, social and cultural factors as well as individual factors (Croll & Parking, 1992; McPhail and Campbell, 2001). Gender inequalities, for example, play a key role in women’s vulnerabilities to HIV/AIDS and their ability to protect themselves and negotiate safe sex (WHO, 2009).

Aversion to condom use is the common theme, although explanations for this vary. Cultural beliefs are also barriers to condom use. Peer norms in young people; patriarchy; traditions and customs; and socio-economic status are some factors that influence condom use and non-use in women (McPhail and Campbell, 2001). In particular, patriarchal attitudes of African men towards women and sex have long been regarded as one of the key drivers of AIDS pandemic (Foreman, 1999). For example, findings from a study conducted in South Africa indicate that the ultimate decision to use or not to use a condom is left with the men (Leclerc- Madlala, 2003). Such gender norms also encourage women to engage in relationships with older men, where females tend to tolerate sexual coercion and violence (Varga, 1997; Harrison, *et al* 2001). Not surprisingly, Leclerc-Madlala (2006) reports that traditions and custom play a role in unsafe and condom-less sex in marriage. Furthermore, traditionally, the task of buying a condom or collecting one from where it is sold or distributed from lies with men; males hardly rely on their female counterparts to take that responsibility (24-7 press release, 2010). Negative perceptions were linked to women carrying a condom, implying she is promiscuous. In retrospect, both African and other western societies are characterised by patriarchal systems in which men superiority to women, that in return are subservient. In cultures where women do not traditionally hold unequal power to men, Femidom gives a woman a choice when her male partner does not want to wear a condom himself (Cole, 2008).

Gender inequalities make it difficult for African women to negotiate condom use (UNAIDS, 2004). In most cases, women don't even know how to introduce Femidom to their male sexual partners (Musomi, 2007). Due to unequal power dynamics in sexual relationship, vulnerability may be increased, especially in young girls and teenagers who lack capacity to and power to negotiate condom use (Parker *et al*, 2007). Another challenge in the female condom is men's perception that Femidom gives women more power or control over sex. This conviction limits wide spread adoption of female initiated barrier methods (Arendse, 2008 ;). Such an assumption could be said to reveal a gap of inadequacy of HIV prevention efforts. However, van der Schaff (2008) points out that limited access to, and availability of, Femidom could be associated with women's gendered position of less power when it comes to sexual decision making.

Accepted notions of masculinity and femininity also come into play. For instance, in many cultural settings, young women are supposed to be sexually innocent and may therefore be reluctant to carry or suggest using condoms for fear of being seen as promiscuous. Masculine ideologies encourage multiple sexual partners; as well as promote negative beliefs and attitudes on condom use. In addition to inconsistent use, women are not expected to question their partners, sexual decision-making. Many young men dislike condoms in what sees as interference in the carefree enjoyment of sex. This perception is strengthened by a stereotypical association of sex with risk-taking as a marker of masculinity.

A study carried out in India among 107 young men reveals that sexual coercive behaviour was used by men to show sexual power against women (Verma *et al*, 2006). Since condoms are also associated in many contexts with illicit or extra-marital sex, married women are often powerless to request their partners to wear a condom despite suspecting that he may be HIV infected. Women are fearful of reprisal at the implied accusation of being unfaithful should they request their partners to use condoms. Such perceptions leave women with no choice but to engage in unprotected sexual intercourse to prove their loyalty and fidelity to the male partner. Consequently, a paradox emerges among studies in Sub-Saharan Africa, indicating that women are less likely to use condoms than men.

Gendered power relations make it difficult for women to request condom use (Norman, 2003). Reasons for not using condoms are more likely associated with the attitude of the women or their partners, as opposed to knowledge and lack of access to them. Furthermore, the other attitude is the fact that condoms are associated with mistrust and stigmatised for certain partnerships even in young people (Marston & King, 2007). Women who desire pregnancy are also less likely to use condoms (Maggwa, 2004), yet in South Africa unsafe sex has been reported as the main mode of transmission in heterosexual contact. UNAIDS, (2009) reports that for most women and girls in developing countries, the ABC (**A**bstain, **B**e faithful, **C**ondomize) approach is of limited value due to their lack of social and economic power. Females are unable to negotiate sexual abstinence, nor can they insist their partners remain faithful or use condoms. The restricted power to choose a female condom as an HIV prevention tool is not considered, irrespective of the risk of HIV transmission through unprotected sex (van der Schaff, 2008). It could be argued that sexual decision making is limited to gender specific sexual behaviour in accordance with societal expectations encourage women to bear the brunt of HIV epidemic.

2.4.5 Economic and social dependence of women on men

Knowledge on how to protect oneself from infections may not always be applied in daily situations of economic and social disadvantage that characterize the lives of many young people. This pertains especially to females and married women (UNAIDS 2004). A major concern that is complicated by socio-economic circumstances such as poverty, limits women's ability to bargain for condom usage.

A study conducted among Zairois married they found that women could not negotiate condom use even if they suspect their husband of extra marital affairs (Cleland, 2005). A Comparative study conducted by South African Department of Health (2004) identified that under the Prevention of Mother to Child Transmission (PMTCT) programme, a large number of women were not using condoms at all, or were not using them consistently. Research has also shown that low economic status puts young girls and women at a disadvantage in sexual negotiations

because they are financially dependent on their partners (Abdool-Karim, 2001; Machel, 2001; Kessie, 2008), hence making condom use negotiation by females difficult (weeks *et al*, 2010).

This hitch over sexual bargaining is that women are more dependent on their partners for survival (Worth 1989; Collins and Rau 2000). Due to being economically dependent, women in South Africa are predisposed to high risk behaviours that place them at risk of contracting HIV (Ramkisson *et al*, 2007; Beksinska *et al*, 2006). Most women in this economically weak position therefore feel compelled to submit to the sexual demands of their partners (van der Schaff, 2008; Arendse, 2008). Discussing sexually sensitive topics may threaten the stability of the relationship, with potentially negative consequences for female's economic security. Lack of communication about sex and sexual practices makes it difficult for women to negotiate such conditions of sex.

Research among young people in South Africa has revealed that condom use is a difficult topic to introduce in conversation, with females reporting a fear that it could lead to negative emotional, physical, or economic consequences (Varga and Makabulo 1996; Wood and Jewkes 1997, Hallmark, 2004). It is crucial, therefore, to highlight the reality that men refuse to use male condoms due to different reasons and the fact that some women including younger women cannot insist on the use of this apparatus due to economic dependence or marital status and social status (UNFPA, 2006).

Age differences between partners may also inhibit female negotiation of safer sex practices (Varga, 1997; Wood and Jewkes, 2001, Hallmark, 2004). Significant age differences between partners frequently co-exist with female economic vulnerability, relegating the latter to bargaining positions even weaker (Luke and Kurtz, 2002). Increased vulnerability is reflected in relationships where women have constrained their ability to negotiate (Gollub, 2000).

Unexpectedly, male discussion of each topic increases with age, but older females are less likely to discuss condom use with their partners. The use of condoms in long-term relationships may

be viewed as signalling a lack of trust or an admission of infidelity, and is therefore often avoided (Varga 1997; Worth 1989; Abdool-Karim, 2001).

2.4.6 Stigma associated with Femidom usage

Another challenge in condom use is the fact that condoms are stigmatized since condoms are also associated with a lack of trust. This is another factor that contributes towards unsafe sex (Marston & King, 2007). In fact, condom use is thought to be suitable for casual partnerships and not for married couples (Garland, 2003) and or other sexual partners in long term relationship. In turn making it fairly difficult for women, especially married to use condoms when it's crowded by such perception. Maharaj, (2001) finds that despite frequency of sex being higher among married couples, paradoxically, condom usage is lower in this group than among non-married couples. Moreover, within sexual relationships, women are often expected to give priority to their partner's sexual needs and wishes. Further, women are compelled to submit to sexual demands to deter men to violence and death resulting to women bearing the brunt of HIV risk (Preston-Whyte, 1995; Ngugi, 1992). Another reason for non-use is that women often decide not to ask men to use condoms, or do not persist in asking, because of concerns about men's sexual pleasure (Wood 2000, cited in Jewkes *et al*, 2003).

As consequences of male risk taking norms of appropriate sexual behaviour, young men downplay the threat of HIV/AIDS and engage in sexual conquests that weaken the ability of young women to negotiate safe sex (Baylies 2000; UNAIDS/Panos 2001, Preston-Whyte, 1995). As cited above gender stereotypes and social expectations contribute in the use of a condom or just sexual behaviour at a large extent (Marston & King, 2007). These expectations hamper communication about sex in young people. In addition, condom use is also clouded by myths where men have reason for not using condoms such as male.

Literature review conducted on qualitative studies that focus on factors that affect young people's sexual behavior, reported that other factors that shape young people's sexual behaviour include social and cultural factors. Such factors explain why condom distribution programmes if implemented alone, are not enough to change behavior. Condom use is usually believed to be for casual partnership only (Mash *et al*, 2010; Maharaj and Cleland, 2005; Ali *et al*, 2004). However, marriage is regarded as a HIV prevention method with men using condoms in extramarital or casual affairs rather than with their wives (Preston-Whyte, 1995). Such stigma leaves married women more susceptible to HIV infection. Statistics indicates that more married women, and women in long term relationships, are infected with HIV (Worley, 2005).

2.4.7 Negotiation of Femidom usage

Negotiation has been a major concern over Femidom since usage depends heavily on male partner cooperation. Lack of negotiation skills could impact on the use of the female condom during sex. Most heterosexual relationship exists within power inequalities and patriarchal paradigm, therefore even where a woman wants to use it, she needs to be able negotiate the usage of the female initiated safe sex method. A research study carried out among women and men in Zimbabwe showed that as compared to men, women tended to be the initiators of the Femidom dialogues proposing the use of the device, though both partners jointly decide to use the method (Kerrigan *et al*, 2000).

A study conducted among International Community of Women Living with HIV/AIDS (ICW HIV Positive) women in indicates that several women from Africa found that the inability to discuss the use of protection against STIs was due to fear of violence towards women (Welbourn, 2006). Most women, including faithful married women find it difficult to discuss or directly negotiate female condom use even if they suspected their husbands or partners of infidelity or extramarital affair (Preston-Whyte, 1995; Walker *et al*, 2004; Cleland, 2005). Some studies have demonstrated an increase in condom use through interventions that encourage male and female condom use, teach necessary skills, and make condoms readily available (FHI, 2008).

For women to ensure the use of Femidom, they used indirect or enticing methods to persuade partner to using the apparatus (Meekers and Ritcher, 2005; Mack *et al*, 2010; Brady *et al*, 2009). Some women successfully negotiated female condom use by informing their husbands that it will be possible to have sex during menstruation as a pregnancy prevention strategy (Warren & Philpott, 2003).

2.4.8 Mistrust among sexual partners

The mere suggestion that sex partners should use HIV prevention tool might introduce an element of mistrust into the relationship, leading to suspicion of infidelity. Some males and females may be embarrassed to introduce condom use since it is perceived not only as lack of trust, thus, the suggestion to use a condom is an insult, but also implying lack of true love (Hatcher *et al*, 2008). Generally, unprotected sex implies loyalty and desired image of faithfulness (Mash *et al*, 2010). , the logical progression of heterosexual relationships once trust has been established, condoms becomes irrelevant (Lear, 1995). Reddy *et al* (1999) A study conducted by one among STI patients reported that 43% men and 35% women said condom use is associated with lack of trust. Suggesting condom use is even worse in a marriage setting where trust is regarded as a crucial component of marriage, where, ironically, an illustration of trust is engaging in unsafe sex (Walker *et al*, 2004).

2.4.9 Male involvement in female condom use

Female condom, the only female-initiated method cannot be used without the male partner's co-operation (Mathews, *et al* 2006). The effective use of the Femidom relies on various factors, including male involvement in the decision to use it. Research has revealed that a man's reaction to the female condom is often an important decisive factor; whether the female partner insists on using the device or not (Welsh, 2001).

In South Africa, where the female condom has been incorporated into the National Family Planning Programme, partner objection was the leading obstacle causing women to abandon use of this device (Beksinska *et al*, 2001). In comparison, previous studies among Femidom users in Kenya, Zimbabwe, United states and Venezuela cite partner's refusal to use a male condom as a reason for introducing the female condom (Kerrigan *et al*, 2000; Welsh *et al*, 2001; Meekers and Ritcher, 2005; Faas *et al*, 2005; Weeks *et al*, 2010). The male partner's negative attitude towards condom use in general creates an uncondusive atmosphere for females to introduce a female condom Mack *et al*, 2010). As a result, prior refusal of a male condom by her male partner leads to women being reluctant to initiate condom use. Such a prophylactic method is hardly brought up since women fear the rejection and losing a partner (Mash *et al*, 2010; Mack *et al*, 2010). Unprotected sex signifies loyalty in a woman in a relationship, risking contracting HIV infection in the process.

Pool *et al*, (2000) found that based on patriarchal power inequality, some men object to the female controlled device since it gives women control over their (female) sexuality. More attention should focus on sexual negotiation between men and women to increase use of female condom (Parker, 2007). Although both types of condoms usually require some level of partner cooperation, the female condom may provide women with a greater opportunity to engage in safer sex, especially for men who refuse to use a male condom. Conversely, a study conducted among sex workers in Central America shows that men who are used to male condom might be reluctant to try to use female condom (Mack *et al*, 2010), which may be due to the fact that some men worry about safety of the female condom device (French *et al*, 2003).

On the contrary, other studies report male partner satisfaction associated with repeated female condom use by women who find it easy to use (Hoffman *et al*, 2004; Meekers and Ritcher, 2005). A study recently conducted in South Africa reports that most men liked female condom as women (Kessie, 2008). Male partner satisfaction has been associated with repeated female condom use by women who find it easy to use (Hoffman *et al*, 2004; Meekers and Ritcher, 2005). Some acceptability studies state that men find that the female condom does not reduce

sexual sensation as much as latex male condom. In addition, since the female condom is worn by the woman and can be inserted prior to sexual activity, it can be less disruptive. Prior insertion of Femidom increases the likelihood that safer sex, and also takes the onus off the male partner. Although most women use female condoms with the full endorsement of the male partner, some women are apparently able to use them without the male partner being aware that the device is in place, hence circumventing partner compliance where the male is drunk. Positive male reaction coupled with effective negotiation skills have been regarded as crucial combination for prompt use of female condom (Artz *et al*, 2000; Beksinska *et al*, 2001; Choi *et al*, 2003; Hoke *et al*, 2007).

A taboo exists where many people believe that female condom encouraged promiscuity. A study carried out among young men in Mumbai showed that men are negative towards a woman who suggest the use, or and carries a condom, regarding her as being promiscuous, therefore warranting sexual harassment and violence against her (Verma *et al*, 2006). Such perceptions limit wide adoption of this device. Such concerns reveal a gap of inadequacy of HIV prevention efforts (Arendse, 2008).

2.5 Challenges to the use of Femidom

2.5.1 Mechanical barriers

There are several self-reported mechanical barriers attested by Femidom users as a challenge to utilizing this gadget. A study conducted by Welbourn (2006) among ICW HIV positive women reveals that appearance of Femidom is another major stumbling block to female condom use. Women claim the appearance is a turn off to sex. A comparative qualitative study conducted in Central American, female commercial sex workers also reported negative reaction towards the appearance and size of Femidom (Mack *et al*, 2010).

Previous studies conducted in South Africa, United States, Kenya and Zimbabwe note that women using the female condom view difficulty of inserting the Femidom before sexual intercourse as a major obstacle (Brady *et al*, 2009; Beksinska *et al*, 2001; Kerrigan *et al*, 2000; Welbourn, 2006; Mack *et al*, 2010). Similar findings were reported among studies carried out in Central America (Mack *et al*, 2010). Some women have complained that this device is noisy during sex, and some have felt that female condoms are too lengthy for the vagina (Musoni, 2007; Welbourn, 2006).

However, a study conducted in Central American sex workers established that insertion of a female condom in advance was proven to be a benefit to commercial sex worker, especially for clients who refuse male condom use (Mack *et al*, 2010). Such self-reported mechanical barriers might translate to lower Usage of the female condom to prevent HIV transmission (Galvao *et al*, 2005).

2.5.2 Cost price of Femidom

Another recurring argument about limited availability of this female initiated barrier method is the cost of producing Femidom. Currently, the cost price of the female condom is prohibitive to the majority of women at risk of contracting HIV infection (Arendse, 2008; Mack *et al*, 2010; PATH, 2005). Fourteen years after the introduction of the female condom to South Africa, Femidom is not widely distributed due to cost. The South Africa government reported that to purchase single unit costs R7 in 2004, lowering availability to women as compared to traditional latex male condoms (Thohoyandou Victim Empowerment (TVE), 2008). It is obvious from the cost point of view that latex condoms are not promoted by government and donors due to pricing. Arendse, (2008) argues that Femidom availability saves costs incurred as a burden on the health system if an individual is HIV infected. The cost of female condoms has prevented wide acceptance of this apparatus by women in different nation states and cultures. Consequently, a second generation of the female condom known as FC2 has been developed and cost less. These condoms are believed to transfer heat and sensation better than the first

generation FC1 also known as Femidom (Padian *et al*, 2008; FDA notifications, 2009). This economic challenge of female condom charging higher than male condom describes why the method has not reached its potential (UNFPA, 2009).

2.5.3 Inadequate promotion and distribution of Femidom

Another often cited barrier is lack of promotion as a challenge to the use of Femidom. Nicholson (2008) reveals that female condoms are hardly advertised, promoted, distributed or demonstrated compared to the male condom. Such a lack of promotion has been reported to be due to the high cost of the female condom (Kessie, 2008). However, Weeks *et al.*, (2010) argue that lack of Femidom promotion and support at the community level result to low uptake of the device. A study conducted among African American and Puerto Rican women found that availability of female condom impacted on consistent use of Femidom.

In 2007, only 25.9 million female condoms were sold worldwide and counted for only 0.2 % of global condom use (TVE, 2008). A similar trend has been observed in South Africa, where under the *National Strategic Plan HIV & AIDS and STIs (2007 -2011)*, annually target is to purchase and distribute 425 million male condom but only 3million female condoms are at selected sites concurrently (DOH, 2007). This trend indicates that during the period spanning 2007to 2011the female condom will be limited to fewer women accessing the device.

The results of non-accessibility will result in poor consistent use and exposure to HIV transmission if women are not in a position to insist on condom use. It is crucial to recognize that heterosexual couples choose between the use of the latex male condom and the polyurethane female condom as well as unprotected sex. This makes it necessary to promote Femidom usage where male condom is not exercised, to maximize a number of safe sex acts (FSGD social impact advisors *et al*, 2008). Mack *et al.*, (2010) advocate that the female condom should be aggressively promoted on the same magnitude as the male condom. However, the 2009 approved the second generation of female condoms (FC2) through the *US Food and Drug Administration*

(FDA), providing an opportunity to new recharge promotional efforts which might lead to programmatic success targeting all women (FSGD social impact advisors *et al*, 2008).

Poor accessibility of the female condom has been cited as another challenge by number of studies which expose women to HIV transmission (PATH, 2005; Haignere *et al*, 2000). A study conducted among ICW HIV Positive pinpoints cost as a major barrier to accessibility to Femidom. While some women can access this female-initiated HIV prevention tool free of charge, others still battle with affordability of the device due to cost (Welbourn, 2006). An enquiry carried out in Bangladesh found that female condom knowledge among doctors and nurses was very poor, with only a few having seen one. Comparatively, one study conducted in Nigeria reported that female condoms are not available in family planning clinics (PATH, 2005). Contrary to findings in Iraq in Diyala Province, found that female condoms are unfamiliar to women, and the condoms are unavailable on the market. Iraq's health education does not cover Femidom in its curriculum, as well (PATH, 2005). van der Schaff (2008) argues that limited access to and availability of Femidoms outline and can be associated with the gendered position of lesser power when it comes to sexual decision making.

2.6 Summary

Female condom acceptability studies have revealed that a lot of factors have to be taken into account when women take the decision of initiating the female controlled device, to protect against HIV/AIDS and pregnancy. It is clear, however, that currently HIV prevention message about the adoption of female condom is minimal especially among women, due to societal perceptions, mechanical barriers, gender power imbalance, biological vulnerability, traditional and religious practices, and programmatic challenges, —all the above factors pose an inherent lack of choice that women face in bargaining for safe sex. Regrettably, this puts women at risk of acquiring HIV, yet there is a female initiated that women can use. Lack of well articulated HIV prevention programmes that includes Femidom has left women at increased risk of HIV infection, where they could otherwise have been safer. Restricted access to economic resources

and gendered power imbalances in heterosexual relationships leave women no choice but to opt for economic survival, and possible HIV infection. Women's constitutional right to protect themselves becomes irrelevant where the above factors are not taken into consideration.

Chapter Three

Theoretical Framework

3.1 Introduction

This chapter looks at two theoretical models that focus on individual and social factors leading to behavioural change. Social Cognitive Theory and Health Belief Model are applied to explore motivation, perceptions, myths and challenges towards the use of the Femidom. Cognitive theories of behaviour, which have been the centre of HIV prevention intervention since the 1980's, include Social Cognitive Theory and the Health Belief Model among others (Parker, 2005). These two theories focus mainly on behaviour control, based on the assumption that the individual will adopt different strategies to eliminate the risk of HIV infection. In the context of this study, these strategies apply in condom usage and fidelity.

Parker (2005) notes that complicated power relations important in sexual encounters are not always explicit, but often hidden instead. Gendered power relations often guide decisions to use a barrier method, especially the female controlled HIV prevention tool. Ulin *et al* (2002) emphasize that qualitative researchers should note the limitation of behavioural frameworks, namely, their focus on individual behaviour. For instance, many women feel at risk of HIV not due to their own behaviour, but over that of male sexual partners who often engage in multiple concurrent sexual relationships.

However, it is sometimes impossible for these women to use condoms in their sexual relationships as results of the stigma and myths attached to the device. It is crucial therefore, to include a predetermined model that takes into account the social, cultural, normative influence and economic constraints (Ulin *et al* 2002). Among reasons that motivate the social cognitive theory was include forming a holistic picture that takes into cognisance the issue of gender and

power differences. Since these theories centres on any form of behaviour and can apply in a wide-ranging situations (Fisher & Fisher, 2000), they are therefore, applicable to this study.

3.2 Health Belief Model

The Health Belief Model (HBM) has been described as the most widely used model of health behaviour change research (Fisher and Fisher, 2000). It is defined as a psychological model that attempts to explain and predict health behaviors and behavioral change (Glanz *et al*, 2002). This model originated in the US in the 1950's to explain why people failed to use preventive measures (Fuemmeler, 2004). It guides the exploration of factors that contribute to a behavioural problem and how change can be affected (Glanz and Rimer, 2005). Moreover, it has been commonly used to explain and understand numerous health behaviours (Fisher and Fisher, 2000).

The Health Belief Model has been extensively utilised for condom use promotion. In a nutshell, the HBM asserts that a person's health beliefs influence their health behaviour (Glanz *et al* 2002; Rosenstock *et al* 1988). The theory is based on an assumption that a person takes a health related action if he or she feels that a negative health condition can be prevented. However, the likelihood to take steps towards reducing susceptibility depends on the perceived difficulties and benefits linked to change in sexual behaviour (Fisher and Fisher, 2000; de Wit and Stroebe, 2004). In addition, factors like knowledge of the condom, age, education level, economic status, social and cultural factors also influence the decision to either use a condom or not. For the Durban study, the focus is on the female condom, namely, Femidom.

One of the strengths of the Health Belief Model is that the concept of perceived barriers that go beyond health concerns (Feummeller, 2004). Secondly it is considered as a framework of explaining and predicting behaviour and acceptance of health care recommendation. Similar to

the HBM is the Theory of Reasoned Action has a predictive functionality (Strecher and Rosenstock, 1997). For instance the Theory of Reasoned Action in AIDS high risk perception enables people to commit to modification of risky sexual behaviour.

On the contrary, the Theory of Planned Behaviour has an economy predictive utility higher than of the HBM (Strecher and Rosenstock, 1997, Quinne *et al*, 2000). However the shortcoming of the Theory of Planned Behaviour model is, firstly, that it limits individual health beliefs to the cognitive factors, and ignores the influence of other factors such as social contextual factors such as peer pressure, individual habits and social networks as well as its impact on health decision making, community perceptions in shaping behavioural change (DiClemente and Peterson, 1994; Mantell *et al*, 1997; Edgar *et al*, 2008).

Whereas Protection Motivation Theory advances that persuasive messaging should focus on a perceived threat, which activates fear while enhancing convictions of the severity of the circumstances within which an individual is expected to apply effective action to counter the risk (Rosenstock *et al*, 1994).

In this study, HBM covers women's motivation in using female condom, challenges they face in instigating use of the gadget with a sexual partner, skills in negotiating use of the device, and handling the device effectively during a sexual encounter.

At the core of HBM is the concept of self efficacy, which in the context could be defines as the conviction that one can personally perform the preventative measures. For example, this could culminate in a positive experience leading to the desired outcome, such as successful prevention of an STI or pregnancy through consistent use of a condom (Fisher and Fisher, 2000). In addition, HBM helps in addressing the practical questions of predicting behavioural change. Notwithstanding all the modifications made on the HBM, it still glaring limitations. This model

focuses on individual motivation, ignoring the fact that people are also influenced by peer behaviour culture, class, environment and life experiences – all of which shape the use and non usage of Femidom, consistent use and perceptions of Femidom. Due to such shortcomings, the Social Cognitive Theory was consequently introduced to supplement HBM.

3.3 The Social Cognitive Theory

Social Cognitive Theory provides a framework for understanding, predicting, and changing human behaviour (Davis, 2006). The focal point of Social Learning Theory is that learning that occurs within a social context. Albert Bandura, the founder of this theory, proposed that learning is a three way interaction between the environment, the individual's and individual's outward behaviour (Gredler, 2001). Social Learning Theory initially proposed in the 1960s, centred around observation, modelling, and imitation as main components of learning process. In 1986, the theory was revised by Bandura to Social Cognitive Theory (SCT), emphasizing the role of societal morals in reinforcing and disciplining different kinds of behaviour change (Bandura, 1991).

The conceptual model outlines three factors that affect of SCT such as behavioral factors, personal factors, and environmental factors. Personal factors would be individuals biological, psychological or cognitive, or rather anything that would affect a person's learning that comes from other people (Bandura, 2001). As for environmental factors, these can be social or physical. This theory (SCT) identifies human behaviour as an interaction between personal factors, behaviour and the environment (Bandura, 1986; 2001). The theory argues that interaction between the person and behaviour involves influencing a person's thoughts and actions (Bandura, (1986). The interaction between the person and the environment encompasses human beliefs and cognitive competencies that are developed and modified by social influences and structures within the environment (Bandura, 2001). Also, interaction between the environment and behaviour involves a person's behaviour determined by the aspects of their environment, and

in turn, their behaviour is modified by that environment. For instance, in the case of a woman initiating the use of a female condom might be influenced by how her sexual partner is likely to react, or to how other people think about the device. Her perceptions on considering the two scenarios could lead to not using Femidom.

Social Cognitive Theory argues that the response of others to a particular behaviour will determine whether the behaviour will be repeated. According to Bandura (1986) self efficacy is the important component that determines if behavioural change will prevail based on the perception that the individual believes that he can carry out the expected outcome. For example women's confidence in inserting the female condom and negotiation skills determine the use of Femidom. However this model identifies the concept of rewards in carrying out the expected outcome that will shape behavioural change (Bandura, 2001). This study attempts to apply the theory, which helps determine how the partner reaction and societal norms are likely to influence consistent use of female condom.

The reason for choosing this model is that it looks holistically at some social factors that influence human behaviour. Social Cognitive Theory draws attention to the role of the social environment in relation to behaviour change. For example how media impact on the knowledge and use and consistent use of Femidom as well as perceptions. It also demystifies the individual's attitude and experiences that form part of change. To adopt a protective health measure, individual needs a convincing reason as to why he should act differently. Factors such as observations and reinforcement experience coupled with perceptions of environment may impact one's conviction of carrying out behaviour change (Mantell *et al*, 1997; Bandura, 2001). Further, argues that implementing a new behaviour is interaction of expectations about the outcome that lead to behaviour and expectation about self efficacy.

The strengths of SCT are that acknowledge the factors in the individual's environment likely to impact on sexual behavioural change. In this study's context, it centres on adopting use of a female condom as influenced by what people in the community perceive concerning usage of the female condom.

However, the limitation of SCT is that it does not consider the influence of social networks in the modification of sexual behaviour (Chui *et al*, 2006). On the contrary, the Theory of Reasoned Action proposes that change will not occur without the intention to perform behaviour that is influenced by a person's attitude alongside social norms (Mantell *et al*, 1997).

3.4 Application of the Models in the Durban Study

To situate the study within a broad theoretical framework, this section will assess and critique different behavioural models used in HIV research. Applied research in reproductive health commonly use theory to explain specific behaviour in relation to a programme development and policy (Ulin *et al*, 2002). Behavioural theories seem to explain and predict behaviour in various situations (Van Ryn and Heany, 1992). This study interrogates individual women's experiences with Femidom, or its absence; a female controlled device, perceptions of the female condom, knowledge, attitude of the community and other variables which go beyond the individual behaviour. The study also takes note of other social vulnerabilities of these very women and girls such as economic positioning and cultural factors, which leads to initiating the use of the gadget. Since an uncritical look at individual behaviour on its own may confound the issues mentioned about the use or even mere acceptability of Femidom.

With the advent of HIV/ AIDS, the model also has been used to gain a better understanding of sexual risk behaviors (FHI, 2004). For instance, women might see their susceptibility to HIV not due to their own behaviour, but that of their partner (Ulin, *et al*, 2002). The use of a female initiated prevention tool includes male involvement and therefore, regardless of benefits women envisage for themselves and that of their partner/s, Femidom use depends on the buy-in of the partner into her proposition. The following dimensions are regarded as significant in the HBM such as perceived benefits and perceived susceptibility, identified as the least significant

variable. Though studies conducted researchers are suggesting that an individual's perceived ability to successfully carry out a "health" strategy, such as using a condom consistently, greatly influences his/her decision and ability to enact and sustain a changed behavior (FHI, 2004).

Although, HBM acknowledges the importance of perceived severity as among the motive of modify risk behaviour, but it does not translate to intent or the actual adoption of the sexual reduced risk behaviour (women using the female condom). Thus severity belief is also prejudiced by partner's reaction, culture, sexual decision making power in a relationship. Since the Health Belief Model does not take this into account other matters that influence change of behaviour, it is of essence to consider whether using a condom and sexual behaviour change does not occur in isolation. The emphasis made for the need to take the social context into account by the Social Cognitive Theory is more relevant in that it indicates that it has direct and indirect factors influencing behaviour change. Subsequently the concept of self-efficacy described by both Health Belief Model and Social Cognitive Theory is a significant determinant of HIV sexual risk reduction behaviour (Mantell *et al*, 1997). For example, after a woman wins the battle of introducing the device and the partner agrees to its use, it is crucial that the woman is able to insert the device properly. She should be able to guard toward the desired outcome, which is protection against HIV or other sexually transmitted infections (STIs).

3.5 Summary

In applying the above theories in addressing the research questions, it helps us understand the issues surrounding Femidom usage. By reviewing these two behavioural models, it is apparent that they complement one another in furthering the understanding research topic. The next section, **Chapter Four**, focuses on the research methodology applied in this study for the collection and analysis of data.

Chapter 4

Research Methodology

4.1 Introduction

This chapter presents the methodology used to conduct this study. This chapter provides details of how, and where, the study was conducted. The study adopted a qualitative approach to gain insight into women's perceptions and experiences of the female condom.

4.2 Study Design

Due to the nature of the topic under discussion, a qualitative approach was employed to study this dissertation's subject matter. At the beginning of the study a literature review was done to allow the researcher to gain understanding of the topic and the methodology used in the research study. In order to understand women's perceptions of the female condom in the Durban study, focus groups and in-depth interviews among individuals' attendees in Commercial City Clinic, Durban, South Africa was conducted. The significance for choosing a qualitative approach is that it is appropriate when you need to interrogate people's knowledge, views, understanding, experiences and interactions. Such elements are meaningful properties of social reality. This has helped to develop a line of questioning in the study to investigate women's perceptions on the female condom. Another reason for choosing this approach is to provide depth, complexity and roundness of data as compared to surveys (Mason, 2002).

According to Ulin *et al*, (2002: 5) the main advantage of qualitative research is that it views the social phenomena holistically and provides insights into the meaning of decisions and actions. Even though it is challenging to analyze open ended questions, it gives participants the freedom

to give detailed explanations when giving answers (Crothers *et al*, 2002). Qualitative research enables one to describe the phenomena of interest in-depth (Trochim, 2006).

4.3 Project Site

The study was conducted at Commercial City Clinic (CCC) in Durban, South Africa. CCC is a Local Department of Health (DOH) sexual and reproductive health clinic. It is located in Durban's central business district. It draws women from different low and high density suburbs as well as from peri-urban communities in the vicinity of Durban city. The Clinic receives/attends an average of 4500 clients per month. Of these clients, 1125 seek family planning services; 500 attend for the purpose of diagnostic screening; and pap smears, 1200 for gynaecological problems and infertility; 300 attend for STI treatment; 400 for HIV screening (pre and post-test counselling); 125 for referral of termination of pregnancy; and 275 for rape crisis or counselling and health information (Kanjee 2009, personal communication, 2 November 2009).

Staffing at the study site is as follows: six registered nurses, two enrolled nursing assistants, three auxiliary service officers, one part time medical officer and three general assistants. Services offered at this clinic consist of STI management and treatment, health education, contraception, diagnostic screening such as pap smear, HIV counselling and testing. The clinic opening and closing times are Monday - Friday from 8am - 4pm. This facility is among the sites in public health institutions that provide female condoms in Durban. This clinic also offers a youth friendly educational programme for young people supported by Love Life. The programme focuses on HIV/AIDS awareness, prevention of sexually transmitted infections and pregnancy as well as abstinence (Kanjee 2009, personal communication, 2 November 2009).

4.4 Study sample and Sampling procedure

4.4.1 Unit of analysis

For the purpose of this study the target population or sample was women aged between 18 -35 years at the Commercial City Clinic. This age group selected fall within the reproductive group of women aged 15-49 who are mostly infected by HIV (UNAIDS, 2008). All study participants were women attending the Commercial Family Planning Clinic for Contraceptive and reproductive health needs; females who have used or not used female condoms. The study consisted of 30 eligible women of indigenous African origin. These 30 women took part in five focus group discussions, and 20 of them were later interviewed individually. All clients were allocated into groups according to their age category either in the 18 - 25 or 26 – 35 categories. The age classifications were created to ensure conducive environment, where these women feel free to communicate about their experiences and views since they are among their peer age groups during the focus group discussion. It was also to minimise cultural norms interfering, where one cannot talk free about sex in front of someone who can be their elder and vice versa, in-turn this will impact on the data elicited. Some respondents were either working or unemployed, while some were students. As body of literature describe a population, as being the targeted group of persons of interest to the researcher, or in other words, they meet the study criteria (Brink (1999)).

4.4.2 Sampling Procedure

This study used a non-probability purposive sampling, where women were approached and screened at the Commercial City Clinic. These women were approached while they waited in the queue to be attended to by the health care provider at the clinic; they were referred by the clinic health care providers to the researcher; and after they had been seen for the services they were visiting for that day. Due to a challenge with recruitment the researcher engaged the Commercial

City Clinic staff to help to with recruiting of study participants. Recruiting participants posed the following challenges:

- some clients refused to participate , fearing losing their place in the queue;
- a number of non users who had never seen the female condom disqualified themselves from taking part in the study;
- a few women could not spare the time to participate since they were rushing back to work; and
- various participants selected at focus groups discussions did not pitch for in-depth interviews. Due to the following reasons: some could not take time away from work; others had provided wrong telephone numbers while the rest did not answer their cell phone.

The study was introduced to clients in the clinic's waiting area, where participants volunteered to take-part in the research. For the woman to qualify to be in the research study the following criteria were used to screen participants:

- candidates must be 18 years or older, and not above 35 years of age;
- participants had to have been sexually active in past twelve months; and
- respondents should have used, or not used, the female condom previously

The strength of purposive sampling is that in many studies it makes certain that all information gathered is directly appropriate to the subjects under study. Nevertheless, the disadvantage of purposive sampling is the inability to generalise from the selected sample.

4.5 Data collection Methods

The study used focus groups discussions and in-depth interviews to collect data from 30 eligible women at the Commercial City Clinic. In total five focus group discussions and 20 face to face interviews were carried out with women respondents in the study. In this study, a pilot study commenced prior to data collection at the study site, to test the research tools and to verify the clarity of questions, to find out if they elicit the expected answers and to test tools before going to the field. This study carried out four in-depth interviews and one focus group discussion at this phase of research. These data collection instruments utilised included focus group discussion guides and in-depth interview guide and were written in English and translated into isiZulu. This translation (from English to IsiZulu) was to allow participants the option to answer according to their preferred language (See Appendix7-9).

Fieldwork commenced from second week of October to the second week of November 2009. The research project started with focus group discussion and later followed with in-depth interviews with women who participated in group discussion. Since issues related to sexuality are sensitive to discuss in a focus groups because people fear that they might be judged, in-depth interviews helped respondents to talk about personal experiences even more freely. Before women could take part in the study they signed an informed consent form to indicated voluntary participation into the study.

Both in-depth interviews and focus group discussion were conducted only after consent was received from participants. Out of the five focus groups conducted, each comprised a minimum of six participants. The researcher's guided group discussion deepened understanding of participant's beliefs and experiences. These groups consisted of both users and non users of female condom. In-depth interviews were conducted among 20 women identified in focus group discussions women were interviewed individually. All data gathered was audio recorded for the purposes of accuracy, and transcribed.

According to Desvouges and Smith (1988) cited in Green and Thorogood, (2004) focus group discussions has been widely used in studies to elicit on group perceptions. The strength of the focus group discussion is its potential to produce information from several people in a short space of time. It also provides wide ranging data on phenomenon, offering the opportunity to identify and facilitate interpretation of facts. The purpose of these group discussions was to uncover the factors that influence opinions, behaviour or motivations (Krueger and Casey, 2000:24-25). In addition, some sensitive issues are easily discussed in a group, as compared to face to face interview with an individual. One of the shortcomings of the focus group discussion is that sensitive in-depth information is not readily acquired in a collective setting (Green and Thorogood, 2004).

It's important to take note that conducting in-depth interviews is similar to making a conversation where there is interaction with people than making them fill out a questionnaire, which fits well with the interpretative approach to research. In-depth interviews offer the interviewer the opportunity to get to know respondents intimately, with the former understanding how they latter feel and think (Terre Blanche *et al*, 2006). Individual interviews were also employed because some people in the group discussion may be dominated by other people's views, failing to raise theirs. According to Green and Thorogood, (2004) semi structured in-depth interviews are used because they allow the researcher to probe and ask follow up questions thus allowing an interaction between the subject and the researcher (Mantell *et al*, 1997). Moreover, these interviews are open ended questions, thereby allowing the participant to give detailed information about their experiences, opinions, in the providing deep meanings to the topic being studied (Bernard, 1994; Ulin *et al*, 2002). In a setting where a respondent feel comfortable, they speak freely about their lives, generating data through a conversation (Ulin *et al*, 2002). The data collection method is flexible, enabling the interviewer to probe, aimed at getting the richest information that participant can give (Power, 2000; Ulin *et al*, 2002).

4.6 Research Ethics

Permission was obtained to conduct this study from the University of KwaZulu Natal's ethics committee and the Department of Health (KwaZulu-Natal) review committee, as well as at the site where data was to be collected (See Appendix 10 -11). Ethics reviews are there to warrant reduction and prevention of harm to subjects to be studied, as well as prevention ensuring a sound approach the researcher of the proposed study. Clients who agreed to participate in the study signed consent form. To ensure anonymity and confidentiality, respondents were allocated codes rather than names on questionnaires to protect their identity. To ensure privacy interviews were conducted in a room at the clinic. The form assured the respondent that there are no direct benefits and there were no risks involved in taking part in the research study. Some participants signed the informed consent after it was read to them, while others read it for themselves. When focus group discussions or in-depth interviews were conducted, participants were compensated for their time with R50. In this study subjects were compensated for the reason that most studies conducted previously in this site reimbursed participants for their time as well as transport costs.

Based on the four principles observed in the protection of human subjects, these bodies ensure that these rights of participants are respected. The four ethical principles taken into account are informed consent, confidentiality, anonymity (Green and Thorogood, 2004, Nueman, 2000) and voluntary participation of participants into the study (Masons, 2002; Nueman, 2000). However, as literature emphasize that compensation should not be considered payment, but rather compensation for both the time and inconvenience of participating in research activities (Duke University Health Systems, 2008).

4.7 Data Analysis

Analysis of the data begins by going back to the purpose of the study. In this study data analysis commenced after audio recording were transcribed and translated verbatim. Data elicited from the focus groups discussions and individual's in-depth interviews were analyzed using a thematic approach. Themes were developed based on the main aims and objectives of the study, after reading a subset of the transcripts to generate broad thematic codes. These were organized into

first- and second-level codes according to the categories they fell into. As more transcripts were reviewed, the code list was modified and refined accordingly. The data were entered into NVIVO 8 (a qualitative computer data management package) for coding and analysis. Double-coding was conducted to ensure reliability of the coding process.

A key principle is that the depth and intensity of analysis is determined by the purpose of the study (Krueger and Casey, 2000:127). Data produced by most data collection especially qualitative research methods undergo various stages to get them into a suitable form for analysis (Blaikie, 2000: 235). Themes developed through scrutinizing the data, are defined as recurrent ideas or language, and patterns of belief that link people and settings (De Vos, 2005: 338). These salient themes are interpreted through making sense of the data and drawing up lessons learned (Marshall and Rossman, 1995; Miles and Huberman, 1994; Pope *et al*, 2006).

4.8 Summary

In summary the qualitative approach elaborated above was used to obtain information on perceptions and experiences of women aged between 18-35 years among clients at the Commercial City Clinic. Most significantly, the ethical considerations for human subjects were valued in conducting the study. In total, five focus group discussions were conducted and 20 in-depth interviews were conducted. The subsequent chapter will furnish the findings from this study.

Chapter 5

Data analysis and Discussions

5.1. Introduction

This chapter will discuss findings of data elicited from five focus group discussions and 20 in-depth interviews conducted among women attendees at Commercial City Clinic an inner-city family planning clinic in Durban, South Africa. The sample was selected by sex and age, with the inclusion criterion for eligibility being women aged between 18 and 35. In total, the study population comprised 30 women. Half of the informants were users of Femidom, while the other half was non-users. The discussion below is based on the themes and sub-themes drawn from data gathered during the research exercise.

5.2. Factors Influencing the Use or Non Use of Femidom

5.2.1. Reasons for Initiating the Female Condom Usage

Femidom was introduced to prevention HIV and other STIs affecting disproportionately large number of women, as compared to their male counterparts. The use of the female condom is heavily influenced by how it is perceived by users. The Durban study respondents' motivation for using Femidom varied from user to user. Some women used female condom for its novelty or for experimentation, while others used the device for protection against pregnancy. The findings on pregnancy concurred with a study among married women with in Zimbabwe, which reveals that the main rationale for using female condom is to avoid conception is acceptable (Callegari *et al*, 2008). According to Callegari *et al*, (2008), Feldblum (2001) and Mung'ala (2006), studies have found the female condom to be more acceptable if it referred to pregnancy prevention method because does not question partner's fidelity.

The female initiated condom can also be used as a dual method, as *both a barrier and contraceptive methods simultaneously to prevent both HIV infection and unwanted pregnancy*. A respondent explained:

Ja, to prevent pregnancy it's obvious you can use injectables together with the female condom, because the injection alone won't prevent you from getting infected.

(FGD#2 (26-35), female)

While another concurred with the following statement:

You can't prevent HIV with an injection.

(FGD#3 (18-25), female)

Previous studies conducted in Zimbabwe and Zambia found that female condom users perceived the method as an effective contraceptive and STI/HIV protective method (Kerrigan *et al*, 2000; Meekers and Ritcher, 2005). An interesting finding emanated from the Durban study is that the women interviewed highlighted the use of dual method as being significant. These findings were consistent with those of prior studies conducted in South Africa (Myers, 2003; Brady *et al*, 2009) about the importance of dual protection of the barrier method. Myers (2003) however, found that use of this dual method strategy is low in South Africa. It could be argued while dual protection is significant; promoting the two methods simultaneously might counter the messaging, with one as proof using condoms or while the other is opposite. This is especially the case for married women, as well as other females who are cohabiting or in long term relationships and desire to have children.

Several used Femidom on the assumption that men never want to use a condom, so women should take responsibility to use one, to safeguard against HIV. Jivasak-Apimas *et al*, (2001) and Soper (1991) argues that the main reason for using female condoms is safeguarding against

HIV infection among high risk groups in particular and women in general. Moreover, often women hardly know about their partner's other concurrent sexual partnerships, a trend posing the danger of contracting HIV.

The Durban study findings pointed to women using the female condom as a HIV prevention tool as well as to safeguard against other sexually transmitted infections, validating Kerrigan *et al* (2000)'s research. The Durban study findings also concurred with those of UNFPA and PATH (2006) who report that friends, relatives and health care practitioners prompt use of the device.

Furthermore, findings in the Durban study illustrate that an extra impetus for using Femidom is that women lack confidence in sexual partners who claim to use the male condom during sexual act while in fact do not, confirming the findings of a study by PATH (2006). As one respondent explained:

You get women who don't trust their partner with the traditional male condom; like for instance, a man says he will put on the male condom but you are not sure if he honestly did.

(FGD# 4 (26-35), female)

Put a different way, an informant expressed a similar concern:

The female condom comes in very handy because you find that when he pretends he plans to use a condom but in fact does not.

(FGD#5 (18-25), female).

5.2.2. Barrier to Sexual Pleasure

With regards to sexual pleasure, a general view was that a majority of respondents find the use of a female condom less pleasurable. However, few interviewees reported more sexual enjoyment during the sexual intercourse. Informants disclosed the condom is often considered a barrier; a

perception stemming from the belief that condom-less sex is equated with a more enjoyable, natural sexual experience. A previous study argues that both women and men find unprotected sex more pleasurable, on a conviction that a barrier method diminishes intimate pleasure (Randolph *et al*, 2007; Nolen 2007). Mixed feelings concerning this were expressed by some women interviewed. Some complained about sex being interfered with by the noise created by Femidom during sex, difficulty of insertion, and the feel of the device during sex. Unintentionally, for instance the annoyance of noise dampers sexual desire as reported by some women in the Durban study. As one key informant pointed out:

The female condom was noisy during sex, so we decided to stop. My partner said we rather stick to the male condom because they are not as noisy.
(A137, woman)

Another interviewee complained:

You see this thing [referring to the inner-ring] it took me some time to get the hang of it. I failed to twist the inner ring.
(A106, woman)

The concerns raised above were similar to those of participants interviewed by Nolen (2007) in Uganda disclosing that women and men did not experience sexual gratification when using a female condom. However, Witte, *et al*, (2006), UNAIDS (2000) and Harrison (2001) maintain that sexual sensitivity and natural pleasure is not hampered by using this female controlled gadget. Nevertheless, it was interesting to observe that some women interviewed cited enhanced sexual pleasure for both self and partner when using female condom. These respondents explained:

I think we enjoyed more with a female condom than with a male condom.
(A126, woman)

I can say that female condoms are more enjoyable because a round with a male condom is quick, but with the female condom sex takes more time.

(A124, woman)

The above results contradicted those of Kulczycki (2004) that urban women in Alabama favoured the male condom because of ease of use and preferred the feel of the condom. The women reported minimized sex sensation and enjoyment of the female condom as even worse less than sex devoid of a male condom. This report runs counter to the UNAIDS (2002); UNFPA and PATH (2006) statements, that the female condom does not compromise the quality of sexual intercourse. Other studies of the female condom, women pronounced coitus with Femidom as more gratifying than with the traditional male condom reported by Gollub (1995; 1996; 2001). In other societies also, men may shun condom (both male and female) use citing reduced sexual enjoyment; which is seen as a blow to virile masculinity. An enquiry conducted in Zimbabwe among women and men documents that the female condom interferes with sexual pleasure (Buck, 2005). As a Durban study participant, explained:

I only used it once and I failed because it was got in the way for me to enjoy sex. As a result I returned into using these ones [male condoms].

(A102, woman)

5.2.3 Resilience of the Female Condom

Except that Femidom is female controlled, it is similar in that, like the male condom, it is worn during sex to prevent against STI infection and unplanned pregnancy (UNFPA & PATH, 2006). Nonetheless, the texture of female condom has been regarded as more sturdy as compared to the male condom. Participants in the Durban study concurred that Femidom is made of a tougher texture than the traditional male condom. A participant points out that you cannot bank on the male condom since:

At times you find that [male condom] is torn, yet with the female one you are sure as long as you properly insert it properly, it won't tear.

(FGD# 4 (26-35), female)

Women in the study attest to the fact that male condoms breaks more easily.

Female condoms don't break as easily as the male condoms.

(FGD# 4 (26-35), female)

This study's results are consistent with those of previous studies, which found the polyurethane texture of female condoms stronger than latex male condoms (Harrison, 2001). As compared to that of Femidom, mechanical failure is relatively higher in the male condom, resulting from the condom tearing (Walsh, 2003; Macaluso *et al*, 1999).

But otherwise, studies show commonality in that both barriers methods have a mechanical slippage during use of these devices. It may be argued that this sheds positive light on the use of female condom. In addition, the women interviewed felt that traditional male condom is not reliable because a man may tamper with it intentionally; without woman knowledge.

Some men perforate it intentionally without your knowledge, and then act as if it were just an accident.

FGD#3 (26-35), female)

5.2.4 Infidelity and mistrust over condom use

Condoms are integral part of ABC (Abstain, Be faithful, Condomise') HIV behavioural intervention associated with safer sex practices. The Health Belief Model proposes that

perceived risk is an important factor in protective behaviour such as using a condom. The condom plays a significant role in ensuring safe sex for both men and women, therefore carrying a condom by both should be promoted so that the responsibility does not have to rest with either partner. The Durban study found that participants considered either a man or woman as having the responsibility of carrying a condom.

It is both partners' responsibility to have a condom with them.

(FGD#3 (18-25), female)

The study results were contrary to a prior study, in which women who carry condoms are frowned at. Hynie *et al*, (2003) report that carrying a condom is normally regarded as male responsibility, especially in heterosexual relationships since men are usually perceived to be the initiators of sex. A woman respondent in the Durban study expressed the view that a woman carrying a condom is perceived as intending to request for sexual intercourse, in the process upsetting the traditional power balance in heterosexual relations in which the man is the instigator. As a Durban study points out a woman would be behaving like a man for openly seeking to initiate sex:

If as a woman you carry a condom it implies you are someone who is always expecting sex, [with multiple partners].

(FGD#5 (18-25), female)

This sentiment raises the issue of trust in a sexual relationship. This study's findings concurred with those of a similar one conducted by Cowan and Koziej (1979) in which a female who initiates sex is contrary to the norm. Traditionally a woman is expected to display the opposite behaviour, and even resist male sexual advances even if she desires sex (Helman, 2007). One may argue that to a certain extent considering that carrying a condom indicates an intention to have sex, this perception may hinder women's uptake of Femidom. Such an expectation may limit an individual's choice—in the case of a female—to use a condom of choice when necessary. On the contrary, some key HIV prevention messages deem a man responsible when he carries a condom, as participants explained below:

Ja, condoms are for men, what kind of a woman carries a condom?

(FGD#5 (18-25), female)

If you always carry condoms in your bag, they will say you are naughty.

(FGD#1 (18-25) (26-35), female)

You are just like someone who sleeps around.

(FGD#5 (18-25), female)

A female carrying a condom might raise issues of trust and fidelity. Responses from study participants concurred that the male partner may wonder whether such a woman trusts him. A respondent observed that initiating the use of a female condom with a male partner might cause him apprehension in various ways, as reflected in the following two comments:

Why do you have condoms? Where did you get them?

(FGD#1 (18-25) (26-35), female)

He would say *hawu*,¹ baby, am I not your only one?

(FGD#3 (18-25), female)

Such concerns confirm previous studies conducted by Mash *et al*, (2010), and Reddy *et al*, (1999) maintain that using a condom means you don't trust your partner, and that men accused women who carry condom of infidelity (Jewkes *et al*, (2003). Because of such reasons, it could be argued that carrying Femidom might therefore discourage women who are willing to do so.

¹ *Hawu* is a Zulu expression for surprise.

5.2.5 Negotiating for the use of Female Condom

Femidom aims to give women more control over STI, in cases where the male partner refuses to use a condom (Morisky *et al*, 2006). Among the results of the Durban study, women said that a major challenge against the female condom lies in how the social marketing campaign has failed to target the male partner. One participant voiced the widely representative view, that:

It all goes back to the way you introduced it, you would hardly just expect your partner to buy in to something he has never seen, would you?

(A112, woman)

In parallel findings to this study, UNFPA and DFID, 2005; Choi *et al*, 2008) identified the most cited challenge in female condom use as the inability for women to negotiate Femidom's usage with their male partners. Studies show that successful execution of this device is not possible without men (FHI (2007). The Durban study findings point to the fact that male partners reaction towards women's initiatives to use the female condom whether positive or negative-- contribute to its use-- . When a participant tactfully suggested the use of Femidom to her partner in a bid to interest him for future use, he responded positively:

He was interested because he wanted to see it, and said we would try to use it sometime.

(A109, woman)

The Durban study results validate prior Femidom acceptability studies, which report that men's positive attitude towards female condoms is a key determinant for usage of the device. A study conducted in Zimbabwe found that female condom might not work if the partner disapproves of it (Meekers and Ritcher, 2005). Nevertheless, other enquiries have found that the use of condom in general is low in regular partners as compare to between casual partners (Ray, 1997; Maharaj and Cleland, 2005).

The study finding also showed that expected sexual behaviour of a partner of either gender may interfere with the ease of communicating about condom and sexual behaviour in general. This confirms result found in a study conducted in Zimbabwe that more women initiate the use of female condom than men (Kerrigan *et al*, 2000), in agreement with other studies which that found woman tend to pretend to trust her partner, which means condom-less sex and no interrogation of the female's sexual history. Findings of this study indicated that women offer different reasons to instigate the use of female condom; ranging from being adventurous, changing from using of latex condoms, and prevention of pregnancy as well as disease. Kerrigan *et al* (2000); Meekers and Ritcher (2005) results confirm similar findings that most women introduced Femidom for pregnancy and disease prevention. Women interviewed in the Durban study reported showing their partner the gadget in order to make a joint decision to use it. According to one respondent:

It goes back to how you introduced and persuaded your partner to use the female condom; because you need to show your partner the condom and convince him it would be adventurous to try something new.

(A137, woman)

One may argue that good negotiations skills and communication are imperative in initiating the use of the female condom. This study reflects similar trends which have been observed by PATH and UNFPA (2005) that men assume Femidom will either promote promiscuity among female sexual counterparts (Kerrigan *et al*, 2000), or cast suspicion on the male partner's infidelity. Other inquiries have shown that even suggesting use of a condom is an insult that implies infidelity (Lamprey, 2005) or points to lack of true love (Mash *et al* , 2010). As one participant of the Durban study put it:

When you insist on using on a female condom your partner may fight with you, insisting that you're carrying a condom means you are not faithful to him.

(FGD#4 (26-35), female)

Contradictions arise where the use of Femidom is considered only significant for casual partnerships, especially in relation to stigma where HIV is regarded as a disease of prostitutes. Interviews with study participants indicated that a woman may not insist on condom use if a man raises such concerns due to fear of losing him usually on the economic grounds. As a respondent pointed out:

Rather than being concerned with protecting themselves, some women might not use Femidom because they fear that they might lose the partner who refuses to use a condom.

(FGD#3 (18-25), female)

Such concerns are confirmed by a study conducted in South Africa where women opt not to use because of fear of rejection by the partner (Mash *et al*, 2010). Another South African study conducted in Soweto, Umlazi and Khayelitsha found that fear of losing a partner was most significant challenge to women in this respect (Jewkes *et al*, 2001).

5.2.6 Stigma Associated with Femidom

Another challenge in condom use is the fact that condoms are stigmatized (Marston and King (2007); Noleen (2007)). Condom use is thought to be suitable for casual partnerships and not for married couples (Garland, 2003) primary partner. The Durban study findings indicate that the issue of stigma through use of the female condom is a potential barrier to its usage, where women in general, including married women, perceive it as being a tool mainly for sex workers. As a participant explained below:

Women think that using the female condoms is a shame.

FGD#5 (18-25, woman)

Another participant associated condom use to adolescence:

Maybe for youth aged 19 years and below don't think they should use it; they prefer flesh to flesh experience since they are just starting to have sex.

FGD#5 (18-25, woman)

Similar to earlier studies, a major obstacle to the acceptance of Femidom is that in some places the device is associated with the sex workers (Peters *et al*, 2010). Like the latex male condom, previous studies of the female condom show that this female initiated HIV prevention tool lowers stigma of being associated with promiscuity (FHI, 2007). A study conducted in Zimbabwe reports that the female condom may be an invaluable tool to married women whose partners are unfaithful, yet shun the traditional male condom (Kerrigan *et al*, 2000). The Durban study data reveals that if a woman initiates the use of Femidom, she might either be branded as promiscuous or making a claim that partner is unfaithful. A respondent predicts what her sexual partner would say:

Why do you want us to use a condom? Are you seeing someone, or is it because you don't have trust in me anymore?

(FGD#3 (18-25), female)

In addition, Mash *et al*, (2010) points out that another barrier to women's condom use is the issue of intimacy and trust established a regular relationship, ruling out the need to use a condom. Data from this research shows women had mixed feelings concerning married couples.

Some women said was no need to use a condom because there was a need to start a family, while others insisted that use of a condom indicated infidelity or lack of trust. A respondent observes that introducing Femidom in a marital sex might cause apprehension in a husband:

Your husband might think that you are up to something, otherwise why all of a sudden is she using these condoms now?

(FGD#3 (18-25), female)

Another respondent identified an instance where a condom use in the marital context was deemed permissible:

A married person may say: I don't use a condom at home, but if I want to be busy outside [have extra marital affairs], I do.

(FGD#4 (26-35), female)

Previous studies conducted show that the female condoms usage is lowest among regular sexual partners, including married couples (Ray, 1997; Maharaj and Cleland, 2005). Mash *et al* (2010) argue that sex without a condom helps maintain a semblance of faithfulness. As a result, in well established, long-term relationships, condoms are deemed irrelevant. Some past enquiries have reveals that the use of a condom underlines the fact that a sexual partner is at risk of contracting STI/HIV (Prata *et al*, 2006; Maharaj and Cleland, 2005).

The relationship between perception of risk and sexual behaviour is multifaceted, rather than implicit. Among diverse countries with different cultures, HIV risk perception is linked to numerous variables such as number of sexual partners, knowledge of sexual partners' past sexual behaviour, fear of AIDS, shame associated with having AIDS, community perceptions of AIDS risk, knowing someone with AIDS, discussing AIDS at home, closeness of parent-child

relationships, gender inequalities and religious affiliation (Macintyre *et al*, 2004). Socio-cultural norms and practices are major determinants of sexual risk-taking behaviour in Sub-Saharan Africa, (Caldwell *et al*, 1999; Mash *et al*, 2010). This information reflects that social context needs to be taken into consideration if the female condom is to be used. Kerrigan *et al* (2000) argues that the use of a female condom is often instigated when a woman suspects that her partner is unfaithful.

Likewise, this study found that use of a condom meant that you don't trust your partner. Moreover, research carried out in Kenya and Zambia in 2004 indicates that marriage ups coital rates but denies a woman the ability to negotiate condom use or abstain from sex. Married women, including women in long term relationships, are frequently terrified of suggesting the use of a condom to their male partners since it poses suspicion to their spouse infidelity (UNFPA and PATH, 2006; UNFPA, 2009; Jewkes *et al*, 2003). Choi *et al*, (2000) argue that training women to negotiate condom use is useless for women who don't have a say in sexual decision making. One may argue that the negotiation of condom use is clouded by gendered power inequalities. Associated perceptions that exist in society therefore don't make it easy for women to negotiate barrier methods such as Femidom.

5.2.7 Power Dynamics and Sexual Practices

Data collected in this study found that women may be scared to introduce Femidom for fear of being thought unfaithful, or insinuating a male partner's infidelity, thus risking losing the relationship in the process. This study's results were in accord with Helman's (2007), which highlights women's hesitance in initiating condom use in case they are regarded as sexual veterans, thereby engaging in risky behaviour. UNFPA and DIFD (2005) found that sex taboos exist in the discussion of sex and traditional gender roles, posing difficulties in condom use negotiation for both sexes. For example, previous studies show that some men regard that female initiated device give women power to control sex, usurping the male role in sexual decision-making (Kaler, 2001; Agbiboa, 2009). In addition, studies found that Femidom reduces

men's responsibility in taking protection against STIs (Meeker and Ritcher, 2005; Agbibo, 2009). In an unexpected twist, one of the women interviewed said it was relatively easy for her to adopt Femidom because her male partner introduced the device to her. As the respondent explained:

Actually, it happened the other way around; my partner came home with Femidom and introduced it to me.

(A106, woman)

Findings of this study illustrate that women rely on their partner's reaction towards the device, to determine whether or not femidom will be employed in the sexual activity.

Studies have shown that partner's approval or disapproval was among key challenges to using female condoms (Brady *et al*, 2009; Meekers and Ritcher, 2005). Women interviewed in the Durban study felt that at least the female condom gave them a measure of control over sex. It is widely acknowledged that while it's the only female controlled HIV-prevention tool at present, Femidom cannot single-handedly modify women's control over their sexuality in the way other contraceptive measures have done by offering women the opportunity to solely determine usage.

To a certain extent, however, Femidom gives women greater control than the largely male controlled latex condoms. This is in agreement with other qualitative studies that show that women view female condom use as a means to improve women safer-sex bargaining power, and sexuality and empowerment (Agbibo, 2009; Gollub, 2000; Pool *et al*, 2000). An interesting finding is that with Femidom's availability, the Durban study participants felt confident to refuse unprotected sex. As previous studies conducted in Brazil, Kenya, India, Madagascar and the US have shown, female condom use increases the number of protected sex acts. A fascinating finding of the Durban study that flies against conventional wisdom was that women insisted on *unsafe* sex:

Even guys say they are scared that their partners will question them, if they bring home condoms.

(FGD#4 (26-35), female)

Globally, gendered power dynamics globally, contribute heavily to women's inability to lobby for protective measures where male partners refuse to engage in unprotected sex (Agbibo, 2009). The lack of bargaining power is particularly pronounced in women's ability to insist on condom usage. A study conducted in Baltimore found that a barrier to condom use is its association with sexual prowess and conquest as evidence of masculinity (Whitehead, 1995). Another major problem is the key messaging in condom use asserts men's dominant role in decision making in sexual activity.

5.3 Challenges Faced by Femidom Users

5.3.1 Availability of the Femidom

One of the most important obstacles to Femidom usage for women is the issue of availability. Interviews with this study's participants indicated that the female controlled HIV prevention method has not widely available to all women. As respondents pointed out:

You can't find the female condom in any clinic as is the case of the male condom, because Femidom is only available in designated areas.

(FGD#5 (18-25))

The female condom is stocked only in very few clinics. Generally Femidom is short supply and as a result very few women know about it.

(FGD#2(26-35))

Besides here [referring to the Commercial City Clinic], you hardly get it anywhere else.

(FGD#3 (18-25))

Most studies on the female condom echo the lack of knowledge on the existence of the female condom (Mung'ala *et al*, 2006; Hogben *et al*, 2005), and that availability of this device is poor globally (Weeks *et al*, 2010; UNFPA and PATH, 2006). Such factors left vulnerable and economically disadvantaged populations, as well as women and young adolescents susceptible to contracting HIV infection. In South Africa, the introduction of Femidom was piloted in 33 sites and later extended to 249 sites (FHI, 2007). Currently, however, not all sites distribute the female condom (Nqanyi, 2000; Beksinska, 2007).

As a result very few women know about this device (Change, 2010). This is because merely 0.2% female condoms account for the total number of male and female condom distributed universally. Female condoms are not readily accessible to females in most countries (Lancet, 2008; Change, 2010). Many studies have previously also attributed cost as a key constraint to accessing this apparatus (Change, 2010). One may argue that the relatively high cost of Femidom should not bar availability of Femidom since it is crucial in saving lives, preventing unplanned pregnancy, abortions, maternal mortality-- all which hampers the Millennium Developmental Goal of 2015.

5.3.2 Promotion of Femidom

Women interviewed in the Durban study expressed great concern that Femidom was not being promoted enough; therefore other women and the community at large were not aware of the existence of the device. As a participant explained:

You find that health educations talks done by health care providers cover male condoms only.

(FGD#5 (18-25), female)

Previous researches have showed a similar pattern. An enquiry carried out in Ghana found that Femidom was largely unknown to most respondents (Lamphrey, 2005). In addition, lack of promotion of the device and research on it had left women vulnerable to HIV, other STIs and unwanted pregnancies (Cole, 2008).

5.3.3 Misconceptions about Femidom

Another challenge is the need to destigmatize Femidom among the few women who know about the device. By dispelling existing misconceptions and that surround Femidom. A respondent observed:

My friend often says she is scare of a female condom because it may slip into the vagina where it cannot be pulled out easily, requiring to be removed in hospital.

(FGD#4 (26-35), female)

Several other participants in this study expressed the same concern. Similar misconceptions of a more serious nature proliferate in other African countries. Schoef (1995) points out that widespread folk beliefs about condoms and supposed dangers to women in Central and East Africa include the device getting torn, consequently remaining in the vagina where it may cause permanent sterility. For example, a study conducted in Uganda reveals the device is regarded as a threat to women's fertility should it tear during sexual act (Obbo, 1995).

Another study carried out in South Africa identifies the myth that condom use (either male or female) predispose sexual partners to HIV infection (Preston-Whyte, 1995). Ideally, programmes developed to promote the use of female condom should run education campaigns to dispel misconceptions and demystify myths that deter women from using the female initiated product. The education campaign should focus on how Femidom works within the female reproductive anatomy.

5.3.4 Mechanical Barriers Related to Femidom

Previous studies have found that the physical appearance of Femidom poses a key challenge to its usage (Magazda, 2010; Brady *et al*, 2009; Lancet, 2008). Findings of the Durban study concurred agreement with the above-mentioned studies. For example, most women participants complained about the device being oversize in comparison to the conventional male condom. According to a respondent:

Some women prefer using male condoms usually because the female condoms are seen as too big.

(FGD#1 (18-25) (26-35), female)

Another respondent, however, thought otherwise:

At first I thought they are big, but after using them I think they are fine.

(A136, woman)

Women interviewed in the Durban study, like in the other studies mentioned above, experience difficulties when inserting the device into the vagina for the first time. A respondent explains:

I struggled quite a number of times trying to inserting a female condom it into my vagina. Maybe it's because I am a first time user...

(A138, woman)

This study also reveals that consistent use of female condom is low, which could be attributed to the fact that not only did very few women knows about this device, in addition to experiencing difficulty during use. Similarly, other scholars have documented women's painful experiences during insertion of this device (Meekers and Ritcher (2005); Artz *et al*, (2002); Brady *et al*,

2009) especially among first time usage (Hogben *et al*, 2001), thereby interfering with the sexual pleasure (Women24, 2010; Magadza, 2010). Another mechanical barrier most cited is noise during sexual activity caused by the polyurethane material used to make Femidom. The Durban study participants reported that such noise was a barrier to their sexual enjoyment. As a participant voiced the following concern:

Eish... the sound that the female condom made during sex, it's like that of a plastic bag.

(A110, woman)

Likewise, early enquiries found that some users in Zimbabwe and Kenya also encounter similar problem due to noise produced by the female condom during coital intercourse (Meekers and Ritcher, 2005); Brady *et al*, 2009). Another mechanical barrier cited in the Durban study was the waiting period when using a female condom, where a woman is instructed by the provider to wait at least 8 hours after insertion before having sex with Femidom. As respondents explained below:

In fact I was told to wait at least for 3 to 4 hours after insertion, for the female condom to bond with my body well before sex. So I did the problem that in the process sex lost its spontaneity.

(A137, woman)

Conversely another respondent reported:

Most women love the male condom because you don't wait long after insertion you use the condom right away.

(FGD#3 (18-25))

In a parallel study conducted in Zimbabwe, inserting a female condom in advance in anticipation of sex was regarded negatively, as a woman was regarded as stepping outside her traditional gender role since a man is expected to initiate the act (UNFPA and DIFD, 2005). Enquiry at the Nyangabgwe referral hospital in Zimbabwe found that for some couples, the fact

that Femidom has to be worn in-advance of the sexual intercourse is a turn off (Nthwesane, 2010).

5.4 Knowledge versus Usage of Femidom

Former studies conducted on knowledge of the existence of the female condom indicated that awareness is not wide spread as compared to its alternative, the male condom (Smith *et al*, 1999; FHI, 2002). Most of the Durban study respondents said they knew of only a few women who knew Femidom as an HIV prevention tool. One participant expressed of the widely representative view that:

Most people don't know even about female condoms, so hardly anymore talk about them.

(FGD#3 (18-25), female)

Data in the Durban study indicates that very few respondents claimed to have received the information about the female condom from government clinics, which provide this barrier method. Nor did they get the information from friends; women in their community; through participation in a research study; or from institutions of higher learning. Existing literature indicates that introduction of the female condom in South Africa covered a limited number of sites across the country (FHI, 2007), which may explain why only a few women know about Femidom in the later nation. Another study also highlights a similar response among women in Italy (Spizzichino *et al*, 2007). However, a prior study contradicts this view Haignere (2000) found that the majority of adolescents had knowledge about Femidom. These results partially support findings in Nigeria about high levels on knowledge of female condom amongst undergraduate students (Mung'ala, 2006). Nevertheless, some participants in the Durban study knew different places where the female condom might be accessed, such as:

At pharmacies,

(FDG # 1 (18-35), female)

Tuck shops and containers.²

(FGD #5 (18-25), female)

You can get them at the clinic.

(FDG # 4 (25-35), female)

A previous study in Kenya documents similar findings (Brady *et al*, 2009). None of the women respondents reported having seen information about the female condom in the mass media, for instance, in magazines, newspapers, on TV or billboards. Research conducted in Italy (Spizzichino *et al*, 2007) reported that the mass media hardly promote the use of Femidom.

Data from Durban study indicates that even though it has been years since its debut in South Africa, awareness of Femidom remains poor among women. Lack of knowledge on Femidom distinctively affects its uptake, knowledge and or awareness. Therefore, one may argue, that lack of knowledge indirectly renders women susceptible of contracting HIV infection, and hence the need to promote this device more aggressively.

The findings of the Durban study are in accord with other studies in that although some women know about the female condom, very few had actually tried using the device. The respondent

² A *container* a disused cargo shipping container, in this case converted to business premises, mostly used by network related public phones such as Vodaphone, MTN or Cell C container.

below found it too cumbersome to follow instructions issued for Femidom usage so she chose, instead, to remain in her comfort zone, reverting to the tried and tested male condom.

Though I heard about them [female condom], when it was explained to me at the clinic I thought it's just too much work, so I choose to stick with the male condoms.

(FDG # 2 (26-35), Female)

The above reaction clearly indicates that knowledge of the female condom does not translate to actual usage. Brady *et al*, (2009) confirm the prevalence of the above response, explaining that among potential users only relatively few ever try to use the product either once or a few times.

5.4 Summary

This chapter focuses on various themes that highlight the perceptions and challenges associated with the use of Femidom among family planning female attendees in an inner-city Durban clinic, the Commercial City Clinic. Study participants who are femidom users drew comparisons between female and male condoms and in the process reflected on how feminization of the AIDS epidemic stems from cultural, social and economic inequalities which jointly hamper use of the female condom. Such issues should not be downplayed since they are significant in enhancing intervention efforts to alleviate women's vulnerability to HIV infection. Since Femidom has the potential to be part of a comprehensive HIV prevention intervention, an education campaign would be crucial in raising awareness of the device as widely as possible, while looking into how its prohibitive cost price could be lowered. Countering prevailing and misconceptions associated with this gadget would also be necessary. Effort should also be made learn from best practices in other countries that have successfully adopted the female condom to both sexes.

The key message concerning Femidom use is that the device empowers women to exercise control over sexual activity. Traditionally, women did not exercise sexual agency, therefore, providing men a dominant role since the latter were supposed to be in charge of women's sexuality. Even today, this power imbalance in favour of male sexual dominance still persists, especially in the marital context where condom use is considered inappropriate since it implies lack of trust in partner's fidelity. Programmes that zoom in on married couple especially women would be advantageous to minimize their vulnerability to HIV risk.

Chapter 6

Conclusion

6.1 Introduction

In South Africa, the heightened HIV prevalence rate among women of reproductive age 15-49 has demonstrated a dire need for this category of females to protect themselves without relying solely on their male counterparts concerning negotiation on condom use. However, while the innovative HIV technology Femidom exists, the device has not achieved the anticipated drop in the new infection rate in females. Femidom is a female condom invented 25 years ago to curb women's vulnerability to the virus. Public health proponents have proposed that if used widely in South Africa, Femidom could be key in reducing HIV infection in girls and women; this device has the potential to alter the epidemic's magnitude significantly in this nation. This study attempts to determine the extent of the women's awareness of the existence of Femidom, and to establish users' perceptions on their experiences with the female controlled barrier method. To this end, a qualitative study was conducted among female attendees aged 18-35 at Commercial City Clinic, an inner-city family planning clinic located in the hub of the central business district of Durban, South Africa.

Firstly, this chapter presents the Durban study on findings drawn from **Chapter 5**. Secondly, this section discusses the pros and cons of Femidom usage. Thirdly, this section identifies limitation of this research, and suggests further research on this subject matter. Finally, the section identifies limitations to the study, and maps the way forward as to how women's vulnerability to HIV infection could be addressed through using Femidom.

6.2 Key Research Findings

In line with the research purpose to document perceptions of women concerning Femidom in the prevention of HIV infection, this section highlights key issues identified in the analysis. The issues could be classified broadly according to the personal, cultural, societal and programmatic aspects of usage of device which influence use of the female condom. Since the different issues are closely interwoven within the complexities of sexual relations, in some instances the above-mentioned categories overlap.

It is clear from the literature that the key challenge is how to curb the spread of HIV among women, who comprising 60% of the infected population in sub-Saharan Africa. South Africa is among the countries with the highest HIV prevalence. In order to prevent further infections and deaths among women from HIV and AIDS, the use of Femidom should be championed. Data from the Durban study associated with Femidom indicate that misconceptions and challenges faced by users should be understood and addressed by interventions targeting sexually active women and adolescent girls. Based on the study findings intervention measures need to focus on the following hindrances occurring to the user at the personal, societal, cultural and programmatic levels.

6.2.1 Usage at Personal Level

At the personal level, study participants highlighted a number of issues that barred them from using that capacity with the use of Femidom. The focus is on factors influencing the use or non use of Femidom. However, it soon became clear that participants' motivation for using or not using the female condom was not based only on individual agency. In keeping with the Social Cognitive Theory, it became increasingly obvious that perceptions of peers and other people played a significant role in the adoption of HIV prevention behaviours, more often than not associated with socially constructed gender roles.

The Durban study data indicated that Femidom had the potential to serve as a viable option for prevention against pregnancy, as well as sexually transmitted infections; including HIV. The female condom was found to be more durable than the male condom, a feature of the female controlled device that served as a key motivation for women to consider using this HIV innovation technology.

Concerns such as barriers to sexual pleasure; myths and misconceptions about Femidom; lack of extensive promotion and marketing; inadequate counselling administered by health care providers, have all undermined Femidom usage. For example, most study participants pointed out that male condoms are more widely promoted and distributed as compared to the female condoms. What is clear in the Durban study is participant's suggestion that women need negotiation skills when introducing female condom, and in the process persuade the male partners to buy into the expensive device. Femidom use requires a male partner's cooperation in order to reach a consensus in sexual decision making.

While how to use a female condom is important, study participants indicated that it was imperative for one to be well equipped with negotiation skills not only to introduce the device, but also to use it. It also became clear that acceptability was influenced by how the device was introduced to the partner. It was noted that in some instances the device became more acceptable if it was introduced as a contraceptive or a sex toy. Generally, it was found that female condom usage was low in relationships where a woman took the initiative in suggesting use of Femidom, a move that men tended to construe as her having other sexual partners, which implied she was not trustworthy. Participants pointed out that lack of trust in a sexual relationship hampers male acceptance of the female condom barrier method. In addition, mistrust of the female by the male partner might end the sexual relationship, on which women were often economically dependent.

6.3.2 Usage at the Societal Level

Perceptions at the societal level could contribute heavily to the vulnerability of women and girls to HIV infection, especially where key public health intervention messages on HIV prevention often fail to take cognizance of the social and cultural contexts as they affect females. As study participants pointed out, another challenge to female condom use was the negative effect of how social categories of women in society are demarcated. The categories determine expected behaviour that predicts women to vulnerability to HIV infection. For instance, in the case of married women, tension occurs when wives suggest Femidom use, prompting negative reaction in husbands. This perception is linked to the practice of sex workers who place condoms within arm's reach to protect their health by demanding that clients use the device during sex. Assumed fidelity among steady couples implies there is no need to use a safe sex tool for protection. Such an assumption implies that marriage is a safety net against STIs for both females and males, and that condoms are only used to safeguard against unplanned pregnancy. In this respect, participants pointed out that neither the male and female condom was used where women desired children within the institution of marriage.

Conversely, some study participants reported that the female condom was deemed appropriate for casual partnerships only, with non condom use symbolizing trust in a sexual partner. Tension; occur therefore when a woman initiates a barrier method already stigmatized due to being associated with promiscuity. Due to such perceptions, should a female insist on the use of a safe sex device she is regarded as being promiscuous. Participants observed that such stigma associated with the female condom barred women from carrying this device in anticipation of sex. Such thinking demonstrates gendered societal perceptions on the traditional patriarchal stand where male authority is paramount in heterosexual decision making; therefore it is assumed only men are responsible for carrying condoms. Due to such perceptions, health conscious women who know the value of safer sex hesitate to carry condoms for fear they would be branded as loose women always prepared for indiscriminate sex.

Misconceptions circulating among community members also hamper Femidom usage. For example, a prevalent myth that surrounds the female condom is that it might be stuck inside the vaginal passage during sex. Such myth need to be dispelled through raising awareness of the female reproductive anatomy.

The Durban study findings also indicate the need to direct Femidom promotion campaigns to men, since to some extent the usage of this device relies on the male partner's reaction and attitude. Hence a positive reaction on the part of the male has been shown to lead to acceptability of the device by his female sexual partner, while disapproval leads to its rejection. The latter might ultimately lead to unprotected sex.

6.2.3 Usage from a Cultural Perspective

Some cultural norms and practices interfere with the use of HIV prevention tool as illustrated by this study's finding. The Durban study reflects how gendered powered relations relate to the use and non use of the female condom, leaving women vulnerable to sexually transmitted infection in the presence of female initiated tool. Some women do not want to introduce the female condom into a heterosexual relationship since they will be deemed more sexually experienced than their male counterpart, in what is deemed as a male prerogative in a patriarchal society.

Despite the pervasiveness of such perceptions, the Durban study demonstrated agency exercised by participants who went ahead and used Femidom regardless of what their male sexual counterparts thought, in a move such women deemed empowering. Such an expression of agency brings to fore the need to involve men more in the promotion of the female condom, as well as tackling thorny patriarchal issues of gender roles and masculine expectations. There is need to acknowledge that culture is not static in the current changing world where women's voices also need to be heard and acknowledged.

6.2.4 Usage at a Programmatic level

While Femidom is distributed in 93 countries worldwide accessibility remains a problem. The current *National Strategic Plan HIV & AIDS and STIs – 2007-2011* states that a key priority lies in curbing the spread of HIV, with the target to reduce new incidence rate by 50 % through adequate provision of both male and female condom. However, the implementation of these policies remains a challenge. Programmatic challenges in the promotion and distribution of Femidom continue to hamper HIV prevention intervention among South African females. The Durban study findings indicate that after a decade of its debut in South Africa, knowledge of and access to Femidom remains low. According to above-mentioned National Strategic Plan, at least 435 million male condoms and 3 million female condoms should be targeted for distribution annually. Consequently, South African adolescent girls and women, who are hardest hit in HIV epidemic, continue to remain the most vulnerable group since the only woman-controlled HIV prevention tool is not readily available to women.

Study participants highlight the lack of knowledge among the key challenges to female condom uptake. One explanation for this is that male condom promotion and distribution takes priority over the alternative female condom. Consequently, Femidom's ability to effectively protect against sexually transmitted infection in heterosexual couples becomes almost pointless if existence of the device is neither widely known by women nor available to those willing to use it.

In retrospect, Durban study participants pointed out that there was a dearth of mass media coverage through newspapers, TV programmes and advertising promoting the female condom as compared to the male condom. Participants blamed the imbalance to promotion and distribution to the relatively high cost of Femidom. For instance, *National Strategic Plan HIV & AIDS and STIs (2007 -2011)* aims at annually buying and supplying 425 million male condom but only 3million female condom at selected sites concurrently. This distribution trend follows an international donor or government patterns where money is spent on an average of three

condoms per male but only one female condom for every 250 women. While female condoms are only available in few store outlets, costing between R6 and R7 a piece, yet one male condom is priced at R1. On contrary while the unit cost of one female condom seems high, it could be argued that Femidom helps prevent pregnancy, abortions and new HIV infections. Not spending more on Femidom ultimately adds up to as prohibitive in terms of national health expenditure.

Challenges posed by practical aspects of Femidom usage also influence the use and uptake of the device, consequently leaving women and girls susceptible to sexual transmitted infections, including HIV. The Durban study findings show that mechanical barriers pose a number of obstacles to the use of the female condom. Mechanical barriers include difficulty with the insertion; noise created during coital intercourse by polyurethane used to make the female condom; and the waiting period while it bonds with the inner genitalia of a woman. Such obstacles hamper wide adoption of Femidom either by user or her partner, leading to preference of the male controlled male condom over the female condom. New evidence shows that attempts to address the above mechanical challenges include the developing of a second generation of a female condom known as FC2, which is crafted from different material.

The most pressing question begging an answer is what should be done to raise current usage of the female initiated condom in the HIV prevention? Partnerships with stakeholders such as the male folk; governmental and non-governmental organizations; faith-based organizations; community-based organizations; traditional healers as well as leaders, the mass media; and policy makers among others, are crucial in the campaign to empower women in the battle against HIV infection. However, a multifaceted approach is more comprehensive than that of lone stakeholders working, say, in the field of conventional medicine. In this instance, a biomedical approach would need to be supported by socio-cultural, economical and political forces if the proposed intervention has to succeed. In such a case, intervention could promote the scale up and integration of female condom promotion and distribution with other services, including both the conventional and traditional medicine structures. Femidom distribution could be incorporated into other reproductive health programmes encompassing family planning, antiretroviral therapy, sexually transmitted infection and voluntary counseling and testing (VCT) services to help

bridge the gap in women's unmet needs. For example, Femidom could be promoted as dual method for prevention of pregnancy or STI in both the family planning clinics and antiretroviral therapy clinics. Training would be among the most important component on female condom programming for stakeholders, who would be required to offer clear instruction and guidance on of Femidom usage to clients or potential clients. Hence promotion and distribution also become part and parcel of spreading the message Femidom usage.

Interventions should utilize appropriate multi-media methods and channels in stimulating and sustaining demand. Such strategies should include creative and non-traditional outlets for promoting and distributing of female condoms, such as advertising through billboards, cell phones, road shows, and workshops, apart from the traditional channels such as TV and the press. Since usage of the device cannot occur without the male sexual partner's approval, the promotion of pro-men social marketing initiatives needs to be considered.

6.3 Limitations of the study and future research

A major limitation in this study is that perceptions on Femidom were based on the target group of women aged 18-35, in the process limiting the elicited views to one sex. Further research should consider the views not only of men, but also include those of health service providers and programme managers. Such follow up studies should prioritize men in Femidom usage because they have the potential to be active participants in instigating use of this barrier method. This female initiated device cannot work without men's involvement since women cannot use it discreetly. It is anticipated men's involvement would increase uptake of the device, thus lowering HIV infection among women.

6.4 Conclusion

While this study acknowledges that the female condom is an imperfect technology, nevertheless, ways need to be found on how to raise its acceptability. Such a measure is necessary since the female-controlled HIV prevention device has great potential if better marketed and distributed. Femidom has the potential to become a key HIV prevention technology that ensures that women are not only protected against HIV infection, but also against unwanted pregnancies. However, that potential can only be realized if women's vulnerabilities in the biological, cultural, economic and social domains, with the aim of gaining greater control over their sexual health than is the case at present. Whatever the domain, addressing women's susceptibility to HIV infection needs to be centered, first and foremost, in gender relations, women's status and women's knowledge about protection and HIV risk perception. However, a more comprehensive approach would include promoting Femidom toward greater male involvement at both the public and private levels. Among important measures in this respect would be to encourage frequent and frank communication on the taboo subject of sex, with a view to establishing safer sex patterns that would result in a drop in HIV infection among females.

APPENDICES

Research questionnaires and other instruments

APPENDIX 1 (English and Zulu version)

Exploring women's perceptions, facilities and challenges of female condom use among the female attendees at an inner-city family planning clinic, Durban.

Eligibility screening script for focus groups

Screening ID_____

Date of screening of eligibility (yyyy/mm/dd) _____

Interviewer reads: Thanks again for agreeing to talk to me. The focus group discussion is designed to help us learn about myths, attitudes, knowledge and use of female or male condoms. I am going to ask you few questions to see if we can invite you to participate in this study?

Q1. How old are you? _____

The respondent should be 18 yrs and older.

[IF under 18 end the interview by saying] say I am sorry but we are only interviewing 18 years and older so that's the end of the interview. Thank you so much for taking your time to answer these questions.

Q2. Are you currently sexually active in the past 12 months?

Yes____

[If no end the interview by saying] say I am sorry but we are only interviewing people who have been currently sexually active in last six months. So that's the end of interview.

Q3 Have you ever used female condoms

Yes/No Continue

[NOTE TO INTERVIEWER]: Participants are 18 years old of age and have had sex before, read the following statement: We would like to invite you to participate in the study, and need your contact information so that we can remind you about the date, time and place for the focus group discussion. You will be in a group of 8/10 other [women]. The focus group discussion will last about an hour or so. At the end you will be paid R50 in cash. If you have any questions between now and when I contact you, you can phone me at the number give in the information sheet.

Exploring women's perceptions, facilities and challenges of female condom use among the female attendees at an inner-city family planning clinic, Durban.

Amazwi okubhekeleka kokuvumeleka ukuba kwizigxoxo zamaqembu

Screening ID _____

Usuku obhekelle ngayo ukuvumeleka (yyyy/mm/dd) _____

Okufundwa obuzayo:

Ngiyabonga ngokuvuma ukukhuluma nami. Izingxoxo zamaqembu zenzelwe ukusiza sifunde ngezinsu, isimo, ulwazi kanye nokusetshenziswa kwamakhondomu abesifazane noma abesilisa. Ngizokubuza imibuzo emibalwa ukubona ukuthi singakumema ukuba ubambe iqhaza kulolucwaningo?

Q1. Ingabe uneminyaka emingaki? _____

Oziphendulelayo kumele abeneminyaka engu-18 nangaphezulu.

[Uma engaphansi kweminyaka engu 18 kumele miqhede ingxoxo] isho ukuthi uyaxolisa ngenxa yokuthi sixoxisana nabantu abaneminyaka engu 18 nangephezulu, ingxoxo yethu kumele iphelele lana. Ngiyabonga kakhulu ngokunginikeza isikhathi sakhongokuba uphendule lemibuzo.

Q2. Njengamanje kuya ezinyangeni eziyishumi nambili ezedlule ingabe unabo ubudlelwane bezocansi?

Yebo____

[Uma ethi cha iqhede ingxoxo ngokuthi] uthi uyaxolisa ngenxa yokuthi sixoxisana kuphela nabantu abanobudlelwano ngokocansi ezinyangeni eziyishumi nambili ezedlule. Kumele iphelele lapha ingxoxo.

Q3 Usuke wawasebenzisa amakhondomu abesifazane?

Yebo/Cha qhubeka

[Okubhalelwa obuzayo]: Abazimbandakanyayo kumele ube no-18 ubudala futhi kubengukuthi usuke waya ocansini, funda umusho olandelayo:

Singathanda ukukumema ukuba ube ingxenye kukolucwaningo, futhi sidinga umininingwane kokuthinta ukuze sikukhumbuze ngosuku, nesikhathi kanye nendawo yezingxoxo zamaqembu. Uzoba seqenjini labantu besifazane abangu 6-10. Lezizingxoxo zizothatha isikhathi esingangehora elilodwa nemizuzu engamashumi amathathu Ekupheleni uyobe usukhokelwa uR50. Uma unemibuzo kusukela manje kanye nangesikhathi ozothintwa ngaso ungathintana nami kwinombolo ozoyithola kwiphepha lolwazi.

APPENDIX 2

Recruitment Log

Date: _____

Approached					Screened			
#	Age	Race	Screening status		Eligible		Interested in participation	
	(self reported, Apparent)	(African, Indian, Coloured or white)	Accepted	Refused	Yes	No	Yes	No
1								
2								
3								
4								
5								
6								

7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
	Total							

Total Approached _____

(Add all the people in the approached column)

Total Screened _____

(Add the people in the screened column)

refused _____

Eligible _____

#Eligible /Interested _____

Eligible / not interested _____

Ineligible _____

APPENDIX 3 (English and Zulu version)

Informed Consent Document- focus Group Discussion

Background

Hello my name is **Cindile Charmaine Dube**, I am a student at the University of KwaZulu Natal doing a research study about knowledge, perception, attitude, gender roles towards HIV prevention programs, and female condom use among women aged 18-35 at the Commercial City clinic. This is a comparison research study where small focus group discussions will be conducted with women aged 18-35.

Purpose of the study

The purpose of this study is to gather information on issues that affect the use of the female condom. This study will generate new ideas on new strategies that can be implemented in promoting female condom use among women, which suits their needs.

Procedure

You have been selected and qualify to take part in these discussions. If you agree to participate, you will meet in a group of about 6 to 10 women. These group discussions will be conducted in a private setting and will take about one and half hour at this clinic. All focus group discussions will be audio taped, which is a requirement for the study participation.

Benefits and risks

By participating in the study you will not receive any direct benefit and there are no risks involved.

Reimbursement

Each volunteer will be given an incentive of about R50 in cash for their participation in the group. This will be a token of appreciation for making their contribution.

Right to Withdraw

Please note that participation in these discussions is entirely voluntary, you may refuse to participate. You may also, at any stage, withdraw from the study if you wish to do so. The decision not to participate or withdraw will not affect any future services you should require or any other benefits to which you would be entitled to at this clinic.

Confidentiality

Discussions will be conducted in a private setting. Your name will not appear on the study records and in the information gathered. Your opinions will be combined with that of other women and will only be used for the purposes of research.

Who to contact if you have questions

If you have questions about this research you can contact **Ms Charmaine Dube** on 0781419855. For further information about the study you can contact the study supervisor **Prof P Zulu** on 031 260 2344.

If you have any inquiries about rights as a participant you can call the University of Kwa-Zulu Natal ethics review committee. Your contact person is **Ms Phumelela Ximba** at 031 260 3587.

Sample code

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Certificate of consent:

I have been invited to take part in the focus group discussion on the study of “**female condom knowledge and use**”. I have read the information / it has been read to me. I have had an opportunity to ask questions. These have been answered to me to my satisfaction. I consent voluntarily to be a participant in this research study and I understand I have a right to withdraw at any time without in anyway affecting me or my medical attention, if appropriate.

Participant’s Signature: _____ Date: ____/____/____

Facilitator’s Signature: _____ Date: ____/____/____

Imvume unolwazi – Yezingxoxo zamaqembu

Isendlalelo

Sawubona igama lami ngingu **Cindile Charmaine Dube**, Ngingumfundi enyuvesi yaKwaZulu Natal ngenza ucwaningo ngolwazi, ngokuqonda, ngesimo, ngezobulili nabakwenzayo mayelana nezinhlelo zokuvikela isandulela ngculaza kanye nokusetshenziswa kwamakhondomu abesifazane, kwabesifazane abaneminyaka engu 18-35 ekhlinikhi yaseCommercial city.

Lolucwaningo lizobe seliqhathanisa ulwazi lwalezizingxoxo zamaqembu ezizoba kubantu besifazane abaneminyaka engu 18-35.

Inhloso yalolucwaningo

Inhloso yalolucwaningo ukuthola ulwazi ngezinto ezinomthelela ekusetshenzisweni kwamakhondomu abesifazane. Lolucwaningo luzosiza ukuthola izindlela ezitsha ezingasetshenziswa ekuququzeleni ukusetshenziswa kwamakhondomu abesifazane okuzohambisana nezidingo zabo.

.

Uhlelo lalolucwaningo

Ukhethithiwe futhi uyavumeleka ekubambeni iqhaza kulezizingxoxo. Uma uvuma ukuzibandakanya, uzohlangana eqenjini labantu besifazane abangu 6-10. Lezizingxoxo zizobambelwa ezindaweni ezingasese futhi zizothatha isikhathi esingange hora elilodwa kanye nemizuzu engamashu amathathu lapha ekhlinikhi. Zonke izingxoxo zamaqembu zizokuqoshwa, okungokuye okudingekayo uma uzozibandakanya.

Inzuzo nobungozi

Ukuzibandakanya kwakho kulolucwaningo angeke kube nenzuzo eqondene nawe ngqo.

Imbuyiselo

Yilowo nalowo obambe iqhaza ozokunikwa imali engu R50 ukubonga ngokuba yingxenye yeqembu. Lokhu kungukubonga ngeqhaza abalibambile.

Imvume yokuyeka

Ngicela ukhumbule ukuthi ukuzimbandakanya kwakho kungukuzikhethela, unganqba ukubamba iqhaza. Ungayeka nanoma yisiphi isikhathi ocwaningweni uma ufisa ukwenza njalo. Isinqumo sokungabi yingxenye noma ukuyeka angeke kuthinte ukusizo ongase ulidinge esikhathini esizayo noma ezinye inzuzo ongazi thola kuleli klinikhi

Ubumfihlo

Lezizingxoxo zizokwenzelwa endaweni yangasese. Igama lakho alingeke liboniswe ezincwadi zocwaningo kanye kulolulwazi olibuthiwe. Izimvo zakho zizohlanganiswa nezabanye abesifazane futhi zizosetshenziselwa inhloso yocwaningo kuphela.

Ubuni ongathintana naye uma unemibuzo

Uma unemibuzo nganoluncwaningo ungathintana no **Ms Charmaine Dube** kulenombolo 0781419855.

Ngemininingwane eyeluliwe ngocwaningo ungathintana noBheke ucwaningo u **Prof P Zulu** kulenombolo 031 260 2344.

Uma unemibuzo ngamalungelo njengobambe iqhaza ungathinta inyuvesi yakwa Zulu Natali ikomiti le-ethics. Ungathintana no **Ms Phumelela Ximba** kule nombolo 031 260 3587.

Sample code

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Isitifiketi semvume

Ngimenyiwe ukuba ngizibandakanye ezingxoxweni zamaqenbu kucwaningo ngolwazi kanye nokusetshenziswa kwamakhondomu abesifazane. Ngifundile noma ngifundelwe ngenhloso yocwaningo. Ngilitholile nethuba lokubuza imibuzo. Ngiqinisekile nangezimpendulo. Ngiyavuma ukuzibandakanya kulolucwaningo, futhi ngiyaqondo ukuthi nginalo ilungelo lokuyeka noma ukwenqaba ukuphendula imibuzo ngaphandle kokuphazamiseka noma kukunikezwa kwami unakekelo lezempilo, uma kunjalo.

Ophendulayo noma ozobuzwa: _____ Usuku: ____/____/____

Obuza imibuzo: _____ Usuku: ____/____/____

APPENDIX 4 (English and Zulu version)

Focus group discussion Information sheet

Background

Hello my name is **Cindile Charmaine Dube**, I am a student at the University of KwaZulu Natal doing a research study about knowledge, perception, attitude, gender roles towards HIV prevention programs, and female condom use among women aged 18-35 at the Commercial City clinic. This is a comparison research study where small focus group discussions will be conducted with women aged 18-35.

Purpose of the study

The purpose of this study is to gather information on issues that affect the use of the female condom. This study will generate new ideas on new strategies that can be implemented in promoting female condom use among women, which suits their needs.

Procedure

You have been selected and qualify to take part in these discussions. If you agree to participate, you will meet in a group of about 6 to 10 women. These group discussions will be conducted in a private setting and will take about one and half hour at this clinic. All focus group discussions will be audio taped, which is a requirement for the study participation.

Risks

There are no physical risks from participating in this study.

Benefits

This study is not designed for your specific benefits. However, you may find it helpful to talk or share your experiences about life, relationships, contraception and HIV prevention with other participant and facilitator.

Voluntary participation

Participation in this study is entirely voluntary and you may withdraw at anytime. This will not affect your status to receive medical attention or service that you get from this clinic / health facility in anyway.

All efforts will be made to keep the information in confidence but it can only be disclosed if required by law and organizations that will require records for quality assurance and data analysis including the Research Ethics Committee.

Reimbursement

Each volunteer will be given an incentive of about R50 in cash for participation in the group. This will be a token of appreciation for making their contribution.

Confidentiality

All information you give it will be treated in confidence. All study information and material will be kept confidential. No names will be use on the document but a code will be use to identify these records. All participants will be instructed not to discuss any identifying information they learn about study participants with anyone.

More Information

If you have questions about this research you can contact **Ms Charmaine Dube** on 0781419855. For further information about the study you can contact the study supervisor Prof **P Zulu** on 031 260 2344.

If you have any inquiries about rights as a participant you can call the University of Kwa-Zulu Natal ethics review committee. Your contact person is **Ms Phumelela Ximba** at 031 260 3587

Iphepha lolwazi– Izingxoxo zamaqembu

Isendlalelo

Sawubona igama lami ngingu **Cindile Charmaine Dube**, Ngingumfundi enyuvesi yaKwaZulu Natal ngenza ucwaningo ngolwazi, ngokuqonda, ngesimo, ngezobulili nabakwenzayo mayelana nezinhlelo zokuvikela isandulela ngculaza kanye nokusetshenziswa kwamakhondomu abesifazane, kwabesifazane abaneminyaka engu 18-35 ekhlinikhi yaseCommercial city.

Lolucwaningo lizobe seliqhathanisa ulwazi lwalezizingxoxo zamaqembu ezizoba kubantu besifazane abaneminyaka engu 18-35.

Inhloso yalolucwaningo

Inhloso yalolucwaningo ukuthola ulwazi ngezinto ezinomthelela ekusetshenzisweni kwamakhondomu abesifazane. Lolucwaningo luzosiza ukuthola izindlela ezitsha ezingasetshenziswa ekuququzeleni ukusetshenziswa kwamakhondomu abesifazane okuzohambisana nezidingo zabo.

.

Uhlelo lalolucwaningo

Ukhethithiwe futhi uyavumeleka ekubambeni iqhaza kulezizingxoxo. Uma uvuma ukuzimbandakanya, uzohlangana eqenjini labantu besifazane abangu 6-10. Lezizingxoxo zizobambelwa ezindaweni ezingasese futhi zizothatha isikhathi esingange hora elilodwa kanye nemizuzu engamashu amathathu lapha eklinikhi. Zonke izingxoxo zamaqembu zizokuqoshwa, okungokuye

Ubungozi

Ubukho ubungozi ongase ubuthole ngokuzimbandakanya kulolucwaningo

Inzuzo

Kulolucwaningo angeke kube nenzuzo eqondene nawe ngqo. Kodwa, ungakuthola kunosizo ukuba usixoxele noma usitshale ngesipiliyoni sakho ngempilo, nobudlelwano, kuhlela kanye nokuvikela isandulela ngculaza kanye nabanye ozobe ubambe nabo iqhaza kanye nozobe nixoxisana naye

Ukuzimbandakanya akusiyo impoqo

Ukuzimbandakanya kulolucwaningo akusiyo impoqo futhi ungayeka nanoma inini uma uthanda. Loku akuzothinta ukuthola kwakho usizo lwezimpilo okuthola kuleklinikhi noma ingayiphi indlela.

Konke kuzokwenziwa ukugcina yonke imininingwane iyimfihlokodwa ingazisa uma idingwa ngumthetho kanye nenhlangano ezodinga ulwazi ukuze iqinisekise ubunjalo bolwazi kanye lokutholakale kholwazi lokukuhlanganisa ikomiti le Ethics yocwaningo.

Imbuyiselo

Yilowo nalowo obambe iqhaza ozokunikwa imali engo R50 ukubonga ngokuba yingxenyeyeqembu. Lokhu kungukubonga ngeqhaza abalibambile.

Ubumfihlo

Lezizingxoxo zizokwenzelwa endaweni yangasese. Igama lakho alingeke liboniswe ezincwadi zocwaningo kanye kulolulwazi olibuthiwe. Izimvo zakho zizohlanganiswa nezabanye abesifazane futhi zizosetshenziselwa inhloso yocwaningo kuphela.

Ubuni ongathintana naye una unemibuzo

Uma unemibuzo nganoluncwaningo ungathintana no **Ms Charmaine Dube** kulenombolo 0781419855.

Ngemininingwane eyeluliwe ngocwaningo ungathintana noBheke ucwaningo **u Prof P Zulu** kulenombolo 031 260 2344.

Uma unemibuzo ngamalungelo njengobambe iqhaza ungathinta inyuvesi yakwa Zulu Natali ikomiti le-ethics. Ungathintana no **Ms Phumelela Ximba** kule nombolo 031 260 3587.

APPENDIX 5 (English and Zulu version)

Exploring women's perceptions, facilities and challenges of female condom use among the female attendees at an inner-city family planning clinic, Durban.

Focus group – Topic guide

Section A

Knowledge of Female condom

I would like to know about your knowledge of condom and where you can condoms especially female condom.

1. Have you ever heard of female condom?

Usuke wezwa ngamakhondomu abasesifazane?

2. Where did you first hear about female condom?

Nezwa kephi ngamakhondomu abesifazane.

Probe

- Clinic
- School
- Friend
- Neighbours
- Health care provider

3. Where you can get the female condom?

Atholakala kuphi amakhondomu abantu besifazane?

Probe

- Clinics
- Pharmacies
- Supermarket
- Dispensary boxes
- Work

4. Have you, your friends, colleague and your neighbors had a talk about female condom?

Ngabe wena, abangane bakho, abalingani bakho kanye nomakhelwane bakho nike nakhuluma ngamakhondomu abantu besifazane?

Section B

Perception of female condom

I would like to know what you or other people feel about female condoms.

5. What do you think about how this female condom looks?

Ucabangani ngokubukeka kwalekhondomu yabesifazane

Probe

- Size
- appearance

6. Do you think you can ever use a female condom?

Uma nicabanga ningawasebenzisa amakhondomu awesifazane?

Probe

- What reasons would make you initiate the use of a female condom?

Iziphi izizathu ezingenza ukuthi uqalise ukusebenzisa ikhondomu yabesifazane?

7. Do you think there is a difference between a male and a female condom?

Ngabe uma nicabanga ukhona yini umehluko phakathi kwamakhondomu abesilisa nawesifazane?

Probe

- In terms of use and length

Ngokuyisebenzisa kanye nobude bayo

8. What do you and other women from your community think about using female condoms as compared to male condoms?

Ingabe ucabangani wena nabanye besifazane emphakathini wangakini bathini ngokusebenzisa amakhondomu abesifazane kunawesilisa?

Section C

Attitudes

I would like to discuss what you and maybe other women in your community/neighbourhood (family, friends, co-workers, and community leaders) think about sex, STDs/HIV, and using condoms.”

9. How do other women feel about male condoms?

Ngabe abantu emphakathi wangakakini bathini ngamakhondomu abesilisa?

10. What do other women in your community/neighbourhood think about female condoms?

Bacabangani abantu emphakathini wangakini/omakhelwana ngamakhondomu abesifazane?

11. What do women or people in your community think about women being in control of protecting themselves against STI's and HIV?

(Bacabangani abantu emphakathini wangakini mayelana nabesifazane abanegunya elikhulu ekuzivikeleni ezifweni ezithathelwana ngocansi kanye nengculaza?)

12. What do other women or people in your community/neighbourhood think about how to protect against STDs/HIV or AIDS?

Bacabangani abantu emphakathini wangakini/omakhelwana mayelana nokuzivikela ezifweni ezithathelwana ngocansi?

13. What do people or other women in your community/neighbourhood think about married people using male or female condoms?

Bacabangani abantu emphakathini wangakini ngendaba yabashadile abasebenzisa amakhondomu esilisa noma awesifazane?

14. How do we address these concerns that people from your community have about female condoms, what do you think can be done?

Singakushitsha kanjani lokhu, abantu basemphakathini wangakini abakucabangayo ngamakhondomu abesifazane, ngabe nicabanga ukuthi kungenziwanjani?

15. What do you think can be done to encourage female condom use as compared to male condom use?

Yini engenziwa ukuze kuqgugquzelwe ukusetshenziswa kwamakhondomu abesifazane kunawabesilisa?

16. What do people or other women from your community feel who should decide / whose responsibility is it that you should use condoms?

Ngabe abantu emphakathini wangakini bacabanga ukuthi ubani okumele anqume ukuthi kumele kusetshenziswe amakhondomu?

Section D

Sexual behavior

Let us now talk about how you and other women behave sexually with your partners.

17. Do people or other women use condoms during menstrual period?

Ingabe abantu noma abesifazane bayawasebenzisa amakhondomu uma besesikhathini?

18. What type of a method do people use to consider themselves as protected against HIV?

Iziphi izindlela ezisetshenziswa abantu ukuze bazibone bevikelekile kwisandulela ngculaza?

19. What type of contraceptive methods do people use protect themselves against pregnancy?

Hlobo luni lwezindlela zokuhlela abantu abazisebenzisayo ukuzivikela ekukhulelweni?

20. In the first sexual encounter what do women and men normally worry about?

Uma abantu beya ocansini okokuqala ngqa iziphi izinto abaye bakhathazeke ngazo?

21. If a woman introduces condoms to her partner, what is the normal partner's react?

Uma ngabe owesifazane ekuqalisa ngendaba yamakhondomu kumlingani wakhe, ngokujwayelekile umlingane wakhe angayiphendula kanjani?

22. If he refuses how you would tackle it?

Uma ngabe enqaba ungenze njani?

23. What sorts of myths or beliefs do people or other women have about a person ensuring condom consistency in a relationship?

Iziphi izinkolelo abantu abanazo ngomuntu oqikekela ukusetshenziswa kwamakhondomu njalo?

24. How would you advice a woman who is infected if her partner refuses condom and she is pregnant?

Ungambonisa uthini owesifazane osulelekile ngesandulela ngculaza uma umlingani wakhe enqaba ukusebenzisa amakhondomu uma futhi ekhulelwe?

25. How do people in your community regard sex for HIV infected people?

Abantu emphakathini wakangakini bacabangani uma kukhulunywa ngokuya ocansini kwabantu abasulelekile ngegciwane?

Section C

Use of female condom / Male condom

I would like to know what you or other women think about the use of condoms during sex.

26. How do you use female condom properly?

Iyiphi indlela ongasebenzisa ngayo ikhonomu yabesifazane ngendlela eyiyo?

27. How can you ensure that the condom is used all the time?

Ungenza njani ukuze nisebenzise ikhondomu izikhathi zonke uma niya ocansini?

28. What strategies would you use to ensure that condom use is consistent?

Iziphi izindlela ongazisebenzisa ukuze uqikelele ukuthi amakhondomu asebenza ngezikhathi zonke uma kuyiwa ocansini?

29. Have any of you used female condoms before?

Ngabe kukhona okewasebenzisa amakhondomu abesifazane ngaphambilini?

30. What do you like about using a female condom?

Ngabe yini oyithanda noma ongayithandi ngalama khondomu abesifazane.

APPENDIX 6

Contact form

No.	Name & Surname	Contact details	Signature

APPENDIX 7 (English and Zulu version)

Informed Consent Document- In-depth interview

Background

Hello my name is **Cindile Charmaine Dube**, I am a student at the University of KwaZulu Natal doing a research study about knowledge, perception, attitude, gender roles towards HIV prevention programs, and female condom use among women aged 18-35 at the Commercial City clinic. This is a comparison research study is trying to understand women experiences with the female condom.

Purpose of the study

I will be talking to women of this family planning clinic about important issues concerning their prevention strategies that they use. This study will generate new ideas on new strategies that can be implemented in promoting female condom use among women, which suits their needs.

Procedure

You have been selected and qualify to take part in these discussions. If you agree to participate, you and other women will be interviewed individually at a private setting. To ensure confidentiality all what will be discussed it kept in confidence and the interview will approximately take about 30- 40 minutes at this clinic. The interview will be audio taped, which is a requirement for the study participation.

Risks

There are no risks involved in participating in this study.

Benefits

There is no direct benefit for partaking in the study, but you might find it helpful to share or tell us about your life experiences, relationships, contraception and prevention of HIV.

Reimbursement

Each volunteer will be given an incentive of about R50 in cash for their participation in the group. This will be a token of appreciation for making your contribution.

Right to Withdraw

Please note that participation in these discussions is entirely voluntary, you may refuse to participate. You may also, at any stage, withdraw from the study if you wish to do so. The decision not to participate or withdraw will not affect any future services you should require or any other benefits to which you would be entitled to at this clinic.

Confidentiality

Discussions will be conducted in a private setting. Your name will not appear on the study records and in the information gathered. Your information will be combined with that of other women and will only be used for the purposes of research.

Who to contact if you have questions

If you have questions about this research you can contact **Ms Charmaine Dube** on 0781419855. For further information about the study you can contact the study supervisor **Prof P Zulu** on 031 260 2344.

If you have any inquiries about rights as a participant you can call the University of KwaZulu Natal ethics review committee. Your contact person is **Ms Phumelela Ximba** at 031 260 3587

Sample code

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Certificate of consent:

I have been invited to take part in the research study on “**female condom knowledge and use**”.
I have read the information / it has been read to me. I have had an opportunity to ask questions.
These have been answered to me to my satisfaction. I consent voluntarily to be a participant in
this research study and I understand I have a right to withdraw at any time without in anyway
affecting me or my medical attention, if appropriate.

Participant’s Signature: _____ Date: ____/____/____

Facilitator’s Signature: _____ Date: ____/____/____

Imvume enolwazi lobambe iqhaza

Isendlalelo

Sawubona igama lami ngingu **Cindile Charmaine Dube**, Ngingumfundi enyuvesi yaKwaZulu Natal ngenza ucwaningo ngolwazi, ngokuqonda, ngesimo, ngezobulili nabakwenzayo mayelana nezinhlelo ngokuvikela isandulela ngculaza futhi amakhondomu abesifazane kuba abantu besifazane abaneminyaka engu 18-35 baseklinikhi yase Commercial city. Lolucwaningo luqhathanisa luzama ukuqonda isipiliyoni sabesifazane namakhondomu abesifazane.

Inhloso yalolucwaningo

Ngizobe ngikhuluma nabesifazane kuleliklinikhi lokuhlela ngezinto ezibalulekile ezimayelana nezinhlelo zokuvikeleka abazisebenzisayo. Lolucwaningo luzosiza ukuthola izindlela ezitsha ezingasetshenziswa ekuququzeleni ukusetshenziswa kwamakhondomu abesifazane okuzohambisana nezidingo zabo.

Inqubo

Ukhetshiwe phakathi kwabanye abesifazane ukuba sixoxisane ngempilo yabesifazane. Uma uvuma ukuba yingxenywe, ngizokubuza imibuzo ngikucele ukuba uyiphendule. Lengxoxo izothatha imizuzu engamashumi amathathu kuyakumashumi amane lapha eklinikhi.

Ubungozi

Ubukho ubungozi ongase ubuthole ngokuzimbandakanya kuloluncwaningo

Inzuzo

Kulolucwaningo angeke kube nenzuzo eqondene nawe ngqo. Kodwa, ungakuthola kunosizo ukuba usixoxele noma usitshale ngesipiliyoni sakho ngempilo, nobudlelwano, ukuhlela kanye nokuvikela isandulela ngculaza.

Imbuyiselo

Yilowo nalowo obambe iqhaza ozokunikwa imali engu R50 ukubonga ngokuba yingxenyeyeqembu. Lokhu kungukubonga ngeqhaza abalibambile.

Imvume yokuyeka

Ngicela ukhumbule ukuthi ukuzimbandakanya kwakho kungukuzikhethela, unganqba ukubamba iqhaza. Ungayeka nanoma yisiphi isikhathi ocwaningweni uma ufisa ukwenza njalo. Isinqumo sokungabi yingxenyeye noma ukuyeka angeke kuthinte ukusizo ongase ulidinge esikhathini esizayo noma ezinye inzuzo ongazi thola kuleli klinikhi

Ubumfihlo

Ingxoxo izibanjelwa endaweni engasese. Igama lakho alingeke liboniswe ezincwadi zocwaningo kanye kulolulwazi olibuthiwe. Izimvo zakho zizohlanganiswa nezabanye abesifazane futhi zizosetshenziselwa inhloso yocwaningo kuphela.

Ubuni ongathintana naye uma unemibuzo

Uma unemibuzo nganoluncwaningo ungathintana no **Ms Charmaine Dube** kulenombolo 0781419855

Ngemininingwane eyeluliwe ngocwaningo ungathintana noBheke ucwaningo u **Prof P Zulu** kulenombolo 031 260 2344.

Uma unemibuzo ngamalungelo njengobambe iqhaza ungathinta inyuvesi yakwa Zulu Natali ikomiti le-ethics. Ungathintana no **Ms Phumelela Ximba** kule nombolo 031 260 3587.

Sample code

--	--

Isitifiketi semvume

Ngimenyiwe ukuba ngizibandakanye kucwaningo ngolwazi kanye nokusetshenziswa kwamakhondomu abesifazane. Ngifundile noma ngifundelwe ngenhloso yocwaningo. Ngilitholile nethuba lokubuza imibuzo. Ngiqinisekile nangezimpendulo. Ngiyavuma ukuzibandakanya kulolucwaningo, futhi ngiyaqondo ukuthi nginalo ilungelo lokuyeka noma ukwenqaba ukuphendula imibuzo ngaphandle kokuphazamiseka noma kukunikezwa kwami unakekelo lezempilo, uma kunjalo.

Ophendulayo noma ozobuzwa: _____ Usuku: ____/____/____

Obuza imibuzo: _____ Usuku: ____/____/____

APPENDIX 8 (English and Zulu version)

Information sheet for individual interview

Background

Hello my name is **Charmaine Cindile Dube**, I am a student at the University of KwaZulu Natal doing a research study about knowledge, perception, attitude, gender roles towards HIV prevention programs, and female condom use among women aged 18-35 at the Commercial City clinic. This is a comparison research study is trying to understand women experiences with the female condom.

Purpose of the study

I will be talking to women of this family planning clinic about important issues concerning their prevention strategies that they use. This study will generate new ideas on new strategies that can be implemented in promoting female condom use among women, which suits their needs.

Procedure

You have been selected from other women to discuss about female condoms. If you agree to participate, I will ask you some question that I would like you answer. The interview will approximately take about 30- 40 minutes at this clinic. The interview will be audio taped, which is a requirement for the study participation.

Risks

There are no risks involved in participating in this study.

Benefits

There is no direct benefit for partaking in the study, but you might find it helpful to share or tell us about your life experiences, relationships, contraception and prevention of HIV

Voluntary participation

Participation in this study is entirely voluntary and you may withdraw at anytime. This will not affect your status to receive medical attention or service that you get from this clinic / health facility in anyway.

All efforts will be made to keep the information in confidence but it can only be disclosed if required by law and organizations that will require records for quality assurance and data analysis including the Research Ethics Committee.

Reimbursement

Each volunteer will be given an incentive of about R50 in cash for their participation in the group. This will be a token of appreciation for making your contribution.

Confidentiality

If you agree to participate, the interview will be conducted in a private setting to ensure that you are not disturbed and that your answers are kept confidential. No one from the clinic will be present during our interview. All details that you will give to us, your name, your address and other information that affect you will be kept confidential, it won't be given to anyone. Your information will be combined with that of other women and will only be used for the purposes of research.

Who to contact if you have questions

If you have questions about this research you can contact **Ms Charmaine Dube** on 0781419855.

For further information about the study you can contact the study supervisor Prof **P Zulu** on 031 260 2344.

If you have any inquiries about rights as a participant you can call the University of KwaZulu Natal ethics review committee. Your contact person is Ms **Phumelela Ximba** at 031 260 3587

Iphepha lolwazi lwalowo obambe iqhaza

Isendlalelo

Sawubona igama lami ngingu **Cindile Charmaine Dube**, Ngingumfundi enyuvesi yaKwaZulu Natal ngenza ucwaningo ngolwazi, ngokuqonda, ngesimo, ngezobulili nabakwenzayo mayelana nezinhlelo zokuvikela isandulela ngculaza kanye nokusetshenziswa kwamakhondomu abesifazane, kwabesifazane abaneminyaka engu 18-35 ekhlinikhi yaseCommercial city. Lolucwaningo lokuqhathanisa lizama ukuqonda isipiliyoni abanao ngokusebenzisa amakhondomu besifazane.

Inhloso yalolucwaningo

Inhloso yalolucwaningo ukuthola ulwazi ngezinto ezinomthelela ekusetshenzisweni kwamakhondomu abesifazane. Lolucwaningo luzosiza ukuthola izindlela ezitsha ezingasetshenziswa ekuququzeleni ukusetshenziswa kwamakhondomu abesifazane okuzohambisana nezidingo zabo

Inqubo

Ukhethiwe phakathi kwabanye abesifazane ukuba sixoxisane ngamakhondomu abesifazane. Uma uvuma ukuba yingxenye, ngizokubuza imibuzo ngikucele ukuba uyiphendule. Lengxoxo izothatha imizuzu engamashumi amathathu kuyakumashumi amane lapha eklinikhi.

Ubungozi

Ubukho ubungozi ongase ubuthole ngokuzimbandakanya kulolucwaningo

Inzuzo

Kulolucwaningo angeke kube nenzuzo eqondene nawe ngqo. Kodwa, ungakuthola kunosizo ukuba usixoxele noma usitshale ngesipiliyoni sakho ngempilo, nobudlelwano, ukuhlela kanye

nokuvikela isandulela ngculaza kanye nabanye ozobe ubambe nabo iqhaza kanye nozobe nixoxisana naye.

Ukuzimbandakanya akusiyo impoqo

Ukuzimbandakanya kulolucwaningo akusiyo impoqo futhi ungayeka nanoma inini uma uthanda. Loku akuzothinta ukuthola kwakho usizo lwezimpilo okuthola kuleklinikhi noma ingayiphi indlela.

Konke kuzokwenziwa ukugcina yonke imininingwane iyimfihlokodwa ingazisa uma idingwa ngumthetho kanye nenhlangano ezodinga ulwazi ukuze iqinisekise ubunjalo bolwazi kanye lokutholakale klolwazi lokukuhlanganisa ikomiti le Ethics yocwaningo.

Imbuyiselo

Yilowo nalowo obambe iqhaza ozokunikwa imali engo R50 ukubonga ngokuba yingxenye yeqembu. Lokhu kungukubonga ngeqhaza abalibambile.

Okuyimfihlo.

Uma uvuma ukuzimbandakanya, ucwaningo luyokwenzelwa ngasese ukuqinisekise ukuthi awuphazamiseki, nezimpendulo zakho ziyoba yimfihlo. Akekho noyedwa waseklinikhi oyoba khona ngesikhathi sengxoxo yethu. Imininingwane osinika yona, igama, ikheli, nezinye izinto ezikuthintayo ziyoba imfihlo kanti futhi ngeke kunikezwe noma ubani. Imininingwane iyohlanganiswa neminye yabesifazane, iyosetshenziselwa ucwaningo.

Ubuni ongathintana naye una unemibuzo

Uma unemibuzo nganoluncwaningo ungathintana no **Ms Charmaine Dube** kulenombolo 0781419855.

Ngemininingwane eyeluliwe ngocwaningo ungathintana noBheke ucwaningo u **Prof P Zulu** kulenombolo 031 260 2344.

Uma unemibuzo ngamalungelo njengobambe iqhaza ungathinta inyuvesi yakwa Zulu Natali ikomiti le-ethics. Ungathintana no **Ms Phumelela Ximba** kule nombolo 031 260 3587.

APPENDIX 9 (English and Zulu version)

Individual in-depth -topic guide

Experiences with Female condom

I would now like to talk to you about your personal experiences with female condoms. It might be a sensitive topic but please feel free to discuss anything relating to the topic.

1. How did you introduce female condoms to your partner?

Wawangenisa kanjani okokuqala amakhondomu abesifazane kuphathina wakho?

Probe:

Beg / **ukuncenga**

Explained about female condoms and its functions / **wachaza ngakubaluleka kwamakhondomu esifazane**

2. Did you ever try to negotiate using the female condom with a partner? / Wake wazama ukucela ukusebenzisa ikhondomu yabesifazane nomlingani wakho?

Probe:

- Approach/ **indlela yokumngena**

3. Tell me about your experience with using female condom?

Ngixoxele ngokusebenzisa kwakho amakhondomu abesifazane?

Probes:

- From the very first time if you can remember please tell me starting from insertion / **Ukusukela ngosuku lokqala ngqa uma ukhumbula ngicela ungitshele kusukela ekuyifakeni**
- Breakage / **ukuqhuma**
- difficulties / **ukuyifaka**

4. Many women say that the female condom gets easier to use with practice or continued use. Was this true for you? Tell me about this experience? **Abesifazane abanengi bathi kuya ngokubalula ngokujwayela ukuyisebenzisa noma ukuyisebenzisa njalo ikhondomu yabesifazane. Kuyiqiniso nakuwe? Awungitshele kabanzi ngalokhu?**

Probe:

- Describe the insertion process. Was it the same as the first time? / **Awuchaze ngokuyifaka. Bekufana nasekuqaleni?**
- Did your partner's reaction change from the first time you used this condom? If yes, how so? / **Ngabe ohlekisana naye ushintshile yini indlela abeyibuka ngayo ekuqaleni? Uma kunjalo, kwenzeke kanjani?**
- Did you use these condoms for more than one round of sex? / **(Ngabe uwasebenzise izikhathi ezingaphezu kwesisodwa lamakhondomu?**
- Who removed the condom? / **Ubani oyikhiphile ikhondomu?**
- How was the condom removed? / **Ikhishwe kanjani ikhondomu?**
- How did you dispose of the condom? / **Uyilahle kuphi ikhondomu?**

5. Describe how this female condom feels to you when it is inserted in your

vagina? / **Chaza ukuthi izwakala kanjani lekhondomu kuwena ngesikhathi uyifaka enkomeni?**

Probes:

- Too big/Too small/Just the right size? / **Inkulu kakhulu/ Incane kakhulu/Wusayizi okahle?**
- Too wet? / **Igcobeke kakhulu?**
- Too dry? / **Yome kakhulu?**
- Warm? / **Ifudumele?**
- Comfortable/uncomfortable? / **Iphathana kahle/Ayiphathani kahle?**

6. If possible, please describe how this female condom feels to your

Spouse/partner during intercourse?

Uma ungakwazi, chaza ukuthi lekhondomu yabesifazane izwakala kanjani kohlekisana naye ngesikhathi nenza ucansi?

Probe:

- Arousal affected? /**Ukuvukelwa kuyathikamezeka? Akwakwazanga ukumisa induku yakhe isikhathi eside.**
- Length of sex act prolonged? /**Isikhathi socansi silulekile?**
- Complains? / **izinsolo?**

7. How do you feel about the lubrication that the female condom provides? / Usizwa kanjani isigcobiso esikumakhondomu abesifazane?

Probe:

- Too wet? / **Kumanzi kakhulu?**
- Too dry—did you or your spouse/partner use extra lubrication? / **Komile kakhulu – Ngabe wena noma ohlekisana naye nisebenzise esinye isigcobisi ngaphezulu?**
- Slippery—difficult to keep in place? / **Ukubhinyilika – kunzima ukuyigcina endaweni?**
- Pleasure was enhanced? / **Ubumnandi budlulele?**
- Pleasure was reduced? / **Ubumnandi behlile?**

8. Did you have any trouble using the female condoms? / Ngabe ubenenkinga ngesikhathi usebenzisa ikhondomu yabesifazane?

Probe:

- Insertion / **Ukuyifaka**
- Removal / **Ukuyikhipha**
- Comfort or other problems during vaginal sex / **Ukuphatheka kahle noma ezinye izinkinga ngesikhathi nenza ucansi?**
- Partner reaction / **Ukuphawula kohlekisana naye?**
- Persuading partner to use FCs during sex / **Ukuncenga ohlekisana naye ngokuthi nisebenzise ikhondomu yabesifazane uma nenza ucansi?**
- Anything else? / **Okunye futhi?**

9. If your spouse/partner does not want to use a male or female condom, what are some ways you use to change his mind? / Uma umkhwenyana noma ohlekisana naye engathandi ukusebenzisa amakondomu esilisa noma awabesifazane yiziphi izindlela ozisebenzisayo ukumshintsha umqondo?

Probe:

- Did you attempt to persuade your spouse/partner? / **Ngabe owesifazane uke azame ukuncenga ahlekisana naye/umkhwenyana wakhe?**
- Bargaining? Negotiating? / **Ukuxoxisana? Ukuvumelana?**
- Withholding sex? / **Ukunqaba ukuya ocansini?**

10. How can you make female condoms as popular as male condom in your community? What do you think you should be done?

Ungenze kanjani ukuzi amakhondomu abesifazane azekenze noma athandekwe njengalana awesilisa emphakathini wangakini? Ukuphi ongakwenza?

Probe:

- Education? **Ukufundisa**
- Other/ **okunye**

11. What do you like about female condoms?

Yini oyithandayo ngamakhondomu abesifazane?

12. Will you use female condoms in the future?

Ungawasebenzisa yini futhi amakhondomu esifazane?

13. How has using female condoms changed the way you think about female condoms?

Ukusebenzisa amakhondomu abesifazane kulolucwaningo kuyishintshe kanjani indlela ocabanga ngayo ngamakhondomu abesifazane?

Appendix 10 (Letter for request of permission to the study site)

528 Mandela Park

PO BOX 2035

Pinetown

3600

26/08/2008

The Manager

Commercial City Family Planning Clinic

Shop 14 Commercial Road

Durban

4000

Dear Sister in Charge

Request to conduct a Research study at Commercial City Family Planning Clinic

I hereby request a permission to conduct a short study on Female condom. The title of my research study is “Knowledge versus usage of female condom among young women aged 18-35 at Commercial City Clinic, Durban”.

My name is Sindile Dube. I am a student at the University of KwaZulu Natal, doing Masters in Social Policy. I have chosen the site because that’s where most women from different communities come for family planning and Commercial City clinic is one of National government sites that freely distribute female condoms.

I hope my request will be granted.

Thank you.

Yours sincerely

Ms Sindile Dube

Appendix 11 (Approval letters for the study site, ethics clearance and department of health)

Commercial City Family Planning
40 Commercial Road
Durban
4001

17 September, 2008

Ms. Chamaine Cindile Dube

I Mrs. R. Kanjee, the Operational Manager of Commercial City Family Planning Clinic hereby, grant permission for the conduct of your study, "Exploring women's perceptions, facilities and challenges of female condom use among the female attendees at an inner-city family planning clinic". Kindly note that minimal interruption to the service must always be considered.

Thanking You

Yours sincerely,

Mrs. R. Kanjee



Clinic Manager



FAMILY PLANNING CLINIC
SHOP 14, COMMERCIAL CITY
COMMERCIAL ROAD
DURBAN
4001



**UNIVERSITY OF
KWAZULU-NATAL**

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

22 SEPTEMBER 2009

Ms. Charmaine Cindile Dube (205524731)
Social Sciences
HDSS
Howard College

Dear Ms. Dube

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0607/09M

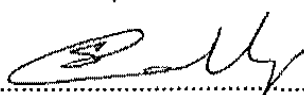
I wish to inform you that your application for ethical clearance has received full approval for the following project:

"Exploring women's perceptions, facilities and challenges of female condom use among the female attendees at an inner-city family planning clinic".

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
PROFESSOR STEVEN COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Prof. P Zulu)
cc. Suzette van der Westhuizen



Health Research & Knowledge Management sub-component
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Reference : HRKM124/09
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

20 October 2009

Dear Ms Dube

Subject: Approval of a Research Proposal

1. The research proposal titled **‘Exploring women’s perceptions, facilities and challenges of female condom use among the female attendees at an inner-city family planning clinic, Durban’** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at **Commercial City Clinic**.

2. You are requested to undertake the following:
 - a. Make the necessary arrangement with identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to **hrkm@kznhealth.gov.za**

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely


26.10.09
Dr S.S.S. Buthelez
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health

References

24- 7 press release 13 February, (2010). *Safe Sex Week in Jamaica, Female Condom Use at Forefront of Event*. Available at <http://www.24-7pressrelease.com/press-release/safe-sex-week-in-jamaica-female-condom-use-at-forefront-of-event-136989.php> (1 of 4). Accessed on 14 July 2010.

Abdool-Karim, Q (2001). *Barriers to preventing human immunodeficiency virus in women: Experiences from KwaZulu-Natal, South Africa*. Journal of the American Medical Women's Association 56: Pp 193-196.

Agbibo D, (2009). *Female condom in sub-Saharan Africa: Unanswered calls for normalisation*. Available at www.consultancyafrica.com/index.php?option=com...id. Accessed on February 2010.

Agha S, (2001). *Intention to Use the Female Condom Following a Mass-Marketing Campaign in Lusaka, Zambia*. American Journal of Public Health 91(2): Pp 307-310.

Ali M, Cleland J, and Shah IH, (2004). *Condom use within marriage: a neglected HIV intervention*. Bulletin of World Health Organization 82(3): Pp 180–186.

AmFar AIDS research brief, (2005). *Gender-based violence and HIV among women: assessing the evidence*. Issue brief 3. Available at

http://www.amfar.org/uploadedFiles/In_the_Community/Publications/Gender%20Based%20Violence%20and%20HIV%20Among%20Women.pdf. Accessed on 13 September 2010.

Amien J, (2008). *Prescribed by institutions...Religion and condom use for married couples*. AIDS Legal Network June 2008: Pp 26-29.

Arendse J, 2008. *The female condom...A novelty*. AIDS Legal Network June 2008: Pp 14-18.

Artz L et al, (2000). *Effectiveness of an intervention promoting the female condom to patients at sexually transmitted disease clinics*, American Journal of Public Health 90(2): Pp 237–244.

Avert AIDS website: *The female condom*. Last updated at 6 May 2008. Available at (www.avert.org/femcond.htm) Accessed May 15, 2008.

Bandura A, (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs: Prentice Hall Inc.

Bandura, A. (1991). *Social Cognitive Theory of moral thought and action*. In W. M.Kurtines & J. L. Gewirtz (Eds.), *Handbook of moral behaviour and development* (Vol. 1, pp. 45-103). Hillsdale, New Jersey: Lawrence Erlbaum associates Inc.

Bandura, A. (2000). *Health Promotion from the perspective of social cognitive theory*. In P. Norman, C. Abraham, & M. Conner (Eds.), *Understanding and changing health behaviour* (pp. 299-339). UK: Harwood.

Bandura, A. (2001). *Social cognitive theory of mass communication*. Media Psychology, 3, 265-298.

Baylies CL and Bujra JM, (2000). *AIDS, sexuality and gender in Africa: collective strategies and struggles in Tanzania and Zambia*. USA and Canada: Routledge.

Beksinska M and Smit J, (2007) *Country experiences South Africa*. Available at <http://www.slideshare.net/rhru/female-condom-mags-presentation>. Accessed on 05 September 2010.

Beksinska M, Joanis C, Manning J et al, (2007). *Standardized definitions of failure modes for female condoms*. Contraception 75: Pp 251–255.

Beksinska M, Mullick S and Kunene B, (2006). *Maternal care: antenatal, peri and post-natal. South African Health Review 2006, Durban, South Africa*. Health Systems Trust.

Beksinska M. (2005) *Sharing country experiences with the female condom: South Africa*. Presented at global consultation on female condom, September 26-29, Baltimore, Maryland.

Beksinska ME, Rees VH, McIntyre JA, and Wilkinson D, (2001). *Acceptability of the female condom in different groups of women in South Africa —a multicentred study to inform the national female condom introductory strategy*. South African Medical Journal 91(8): Pp 672-678.

Bernard H, (1994). *Research methods in Anthropology: Qualitative and quantitative approaches*. Walnut Creek Thousand Oaks, CA: Sage Publications.

Blaikie N, (2000). *Designing social research*. Cambridge: Polity Press.

Blanche TM, Durrheim K, and Painter D, (2006). *Research in Practice: Applied methods for the social sciences*. (2nd Ed). Cape Town: University of Cape Town Press.

Boyer M, Blauw N, Sippel S, (2010). *Female Condoms Remain Underfunded, Ignored by Donors, Governments Microbicide Potential Promising for Prevention Options for Women, Yet Proven- Effective And Life-Saving Tool Undermined By Bias And Stigma*. Center for Health and Gender Equity (CHANGE) and Universal Access to Female Condoms (UAFC). Available at www.genderhealth.org/files/.../Press_Rel_Female_Condoms_Vienna_F.pdf. Accessed on 23 July 2010.

Brady M, Kilonzo N, Austrian K, Ngari H, Njoki E, Mwangi D, Khisa G, Sudha S, Ajema C, (2009). *Female – initiated prevention: Integrating female condoms into HIV risk –reduction activism in Kenya*. Nairobi: Population Council Inc.

Brink H, (1999). *Fundamentals of Research Methodology for health Care Professionals*. (2nd Ed). South Africa: Juta & Co, Ltd.

Brown GF, Raghavendran V and Walker S, 2007. *Planning for Microbicides Access in Developing Countries: Lessons from the Introduction of Contraceptive Technologies*, Silver Spring, MD, USA: International Partnership for Microbicides.

Brown H, (2003). *The female condom: Women control STI protection*. Population Reference Bureau. Available at

<http://www.prb.org/Articles/2003/TheFemaleCondomWomenControlSTIProtection.aspx>.

Accessed on 20 June 2009.

Buck J, Kang MS, van der Straten A, Khumalo-Sakutukwa G, Posner S, Padian N, (2005). *Barrier method preferences and perceptions among Zimbabwean women and their partners*. AIDS and Behaviour 9: Pp 415–422.

Caldwell JC, Orubuloye IO and Caldwell P, (1999). *Obstacles to behavioural change to lessen the risk of HIV infection in the African AIDS epidemic*. Resistances to Behavioural Change to Reduce HIV/AIDS Infection: Pp 113-124.

Callegari L, Harper CC, van der Straten A, Kamba M, Chipato T, Padian NS, (2008). *Consistent Condom Use in Married Zimbabwean Women after a Condom Intervention*. Sexually Transmitted Diseases 35 (6): Pp 624-630.

Center for Health and Gender Equity. 2008. *Saving Lives Now: Female Condoms and the Role of U.S. Foreign Aid*. Washington D.C: Center for Health and Gender Equity.

Change health, (2010) Prevention now .net. *Fact sheet*. Available at http://www.genderhealth.org/files/uploads/prevention_now/publications/femalecondomfactsheet2010.pdf. Accessed on 20 June 2010.

Chiu C, Hsu H, Wang ETG, (2006). *Understanding knowledge sharing in virtual communities: An integration of social capital and social cognitive theories*. Decision Support Systems: 42: pp 1872–1888.

Choi K-H C, Hoff C, Gregorich E S, Grinstead O, Gomez C, and Hussey W, (2008). *The Efficacy of a Female Condom Skills Training in HIV Risk Reduction among Women: A Randomized Controlled Trial*. American Journal of Public Health 2008(10): Pp1841-1848.

Choi KH, Gregorich SE, Anderson K, Grinstead O, & Gomez CA, (2003). *Patterns and predictors of female condom use among ethnically diverse women attending family planning clinics*. Sexually Transmitted Diseases 30(1): Pp 91–98.

Choi K-H, Roberts KJ, Gomez C, Grinstead O, (2000). *Facilitators and barriers to use of the female condom: qualitative interviews with women of diverse ethnicity*. [Women & Health 30](#): (1): Pp 53-70.

Cleland J, (2005). *Use of the male condom within marriage*. IPPF Medical Bulletin 39(3): Pp1-2.

Cole T, (2008). *Women pass on female condom*. Available at <http://www.canada.com/business/fp/Women+pass+female+condom/796998/story.html>.

Accessed on 15 May 2008.

Collins, J and Rau B, (2000). *AIDS in the context of development*. UNRISD Programme on Social Policy and Development, Paper No. 4.

Cowan G and Koziej J, (1979). *The perception of sex inconsistent behaviour*. *Sex Roles* 5: Pp 1 – 10.

Croll E and Parking D. (1992) *Bush base: forest farm culture, environment and development*. London and New York: Rutledge.

Crothers C, Brown D, Naidoo, Waters G. Devey R, Ellery K, Jones S, and Searle R, (2002). *Research Methodology in the Social Sciences*. Durban: University of Natal Press.

Cullinan K, (2010). *Battle against HIV prevalence rages on*. The Mercury (12 November 2010): Pp5.

Davis A, (2006). *Social Cognitive Theory*. Available at www.istheory.yorku.ca. Accessed on 05 May 2008.

De Vos AS, (2005). *Qualitative data analysis and interpretation*. In De Vos AS, (Ed) Strydom H, Fouche'CB and Delpont CSL, (2005). *Research grassroot: For social sciences and human services profession*. 3rd ed. Pretoria: Van Schaik Publishers.

De Wit J and Stroebe W, (2004). *Social cognition model of health behaviour*. In Kaptein AA, Weinman J, Health psychology. Carlton and Oxford: Blackwell Publishing.

Deniaud F, (1997). *Actualité du préservatif féminin en Afrique*. Santé 7(6): Pp 405-415.

Department of Health South Africa (DOH), (2007). *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 Report*. Pretoria: Department of Health.

Department of Health South Africa, (DOH) (2004). *An impact assessment of programmes of the HIV and action Unit of the KwaZulu Natal*. KwaZulu Natal: Department of health.

Desgrees-du-Lou A and Gliemann J, (2008). *Couple-centred Testing and Counseling for HIV Serodiscordant Heterosexual Couples in sub-Saharan Africa*. Reproductive Health Matters 16 (32): Pp 151-161.

Desvougues WH and Smith VK, (1988). *Focus groups and risk communication: the science of listening to data*. Risk analysis, 8, pp 479-484. In Green J, Thorogood N *et al*, (2004). *Qualitative Methods for health research*. Thousand Oaks, CA: Sage Publications.

DiClemente R and Peterson JL (1994). *Preventing AIDS: theories and methods of behavioral interventions*. New York: Plenum Press.

DOH, (2008). *South Africa National HIV and Syphilis Prevalence Survey*. Pretoria: Department of Health.

Duke University health systems human research protection program: *Compensation and payment to research participants and research personnel* (2008). Available at www.irb.duhs.duke.edu/.../compensation_payment_to_research_participants_94.pdf. Accessed on 28 July 2009.

Dunkle KL, Jewkes RK, Nduna M, Levin J, Jama N, Khuzwayo N, Koss MP, Duvvury N (2006). *Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa*. AIDS 20(16): Pp 2107-2114.

Edgar T and Noar SM (2008). *The role of partner communication in safer sexual behavior: A theoretical and review*. In Edgar T, Noar SM, Freimuth VS, Communication perspective on HIV/AIDS for the 21st Century. New York: Lawrence Erlbaum Associates Inc and Taylor & Francis group.

Edwards A and Talbot R, (1994). *The hard-pressed researcher*. London: Longman.

El-Bassel N, et al, (1998). *Partner violence and sexual HIV-risk behaviors among women in an inner-city emergency department*. Violence and Victims 13(4): Pp 377-93.

Faas L, Pernía N and Rodríguez-Acosta A, (2005). *Venezuela-the next frontier for HIV/AIDS: what about female protection*. Revista de la Facultad de Medicina 28(1): Pp 40-49.

Family Health International (FHI), (2001). *Technical update on female condom*. Available at <http://www.fhi.org/en/rh/pubs/booksreports/fcupdate.htm> . Accessed on 10 November 2010.

Family Health International (FHI), (2004). *Behavior Change -- A Summary of four*. Available at <http://www.fhi.org/en/RH/Pubs/Briefs/FemCondom/southafrica.htmf>. Accessed on 01 May 2008.

Family Health International (FHI), (2007). *Female condom introduction in South Africa*. Female condom research briefs series no: 6. Available at <http://www.fhi.org/en/RH/Pubs/Briefs/FemCondom/southafrica.htm>. Accessed on 01 May 2008.

Family health international (FHI), 2007. *Female condom acceptability and sustained use*. Female condom research briefs series no. 4. Available at <http://www.fhi.org/en/RH/Pubs/Briefs/FemCondom/southafrica.htm>. Accessed on 01 May 2008.

FDA notifications, (2009). *FC2 female condom receives FDA approval*. AIDS Alert 24(5): Pp 58-59.

Feldblum PJ, Kuyoh MA, Bwayo JJ, Omari M, Wong EL, Tweedy KG et al, (2001). *Female condom introduction and sexually transmitted infection prevalence: results of a community intervention trial in Kenya*. AIDS 15(8): Pp 1037-1044.

Female Health Company (2008). *FC and FC2 female condom, the product*. Available at www.femalehealth.com/theproduct.html. Accessed on 05 May 2008.

Fernandez ML, Garrido JMF, Castro YR, Mangana AMN, Fernandez MVC and Foltz ML, (2008). *Assessing female condom acceptability among heterosexual Spanish couples*. European Journal of contraceptive and reproductive health care 13(3): Pp 255-263.

Feummeller BF, (2004). *Promotion of health behaviours*. In Brown RT, Handbook of pediatric psychology in school settings. Englewood Cliffs, New Jersey: Lawrence Erlbaum Associates Inc, pp. 81-98.

FHI, (2007). Lessons from a female condom community intervention trial in rural Kenya. Female condom research briefs no.7. Available at <http://www.fhi.org/en/RH/Pubs/Briefs/FemCondom/Kenya.htm>. Accessed on 21 September 2010.

FHI, (2008). *Encouraging News in the Development of a New Female Condom*. Female condom research briefs (2008). Available at http://www.fhi.org/en/RH/Pubs/Briefs/FemCondom/new_female_condom.htm. Accessed on 20 July 2010.

Fisher JD, and Fisher WA, (2000) *Theoretical approaches to individual-level change in HIV risk behavior*. In Peterson JL and DiClemente RJ (Eds), Handbook of HIV Prevention. New York: Kluwer Academic/Plenum Pp 3–55.

Fontanet AL, Saba J, Chandelying V, et al, (1998). *Protection against sexually transmitted diseases by granting sex workers in Thailand the choice of using the male or female condom: results from a randomized controlled trial*. AIDS 12: Pp 1851–1859.

Foreman M, (1999). *AIDS and Men: Taking Risks or Taking Responsibility?* London: Panos, Zed Books.

Fouche'CB and De Vos AS, (2002). *Qualitative data research design*. In De Vos AS, (Ed) Strydom H, Fouche'CB and Delpont CSL, (2002). *Research grassroot: For social sciences and human services profession*. 2nd Ed. Pretoria: Van Schaik Publishers.

Fouss A, Watts C, Vickerman P, Slep B, (2003). *Are people using condoms?* Available at www.global-campaign.org/clientfiles/LSHTM-condom pdf file. Accessed on 20 August 2009.

French PP, Latka M, Gollub EL, Rogers C, Hoover DR, Stein ZA, (2003). *Use-effectiveness of the female versus male condom in preventing sexually transmitted disease in women*. Sexually Transmitted Disease 30: Pp 433–439.

Frost and MR Reich, (2008). *Access: How Do Good Health Technologies Get to Poor People in Poor Countries?* Cambridge: Harvard University Press, (2008).

FSG Social Impact Advisors, Marseille E, and Kahn JG, (2008). *Smarter programming of the female condom: increasing its impact on HIV prevention in the developing world*. Boston: FSG Social Impact Advisors.

Galvao LW, Oliveira LC, Diaz J, et al (2005). *Effectiveness of female and male condoms in preventing exposure to semen during vaginal intercourse: a randomized trial*. Contraception 71: Pp130–36.

Garcia-Calleja JM, Gouws E, Ghys PD, (2006). *National population based HIV prevalence surveys in sub Saharan Africa: results and implications for HIV and AIDS estimates*. Sexually Transmitted Infections 82(suppl.3): Pp 64-70.

Garland CJ, (2003). *AIDS is real and it's in our church*. Bukuru Plateau State: Honey City Press.

Gender health, (2010). *Female condom fact sheet*. Available at www.genderhealth.org/files/uploads/prevention_now/publication/femalecondomfactsheet2010.pdf. Accessed on 12 July 2010.

Glanz K, Rimer BK, and Lewis FM, (eds.), (2002). *Health behavior and health education: Theory, research, and practice*. (3rd Ed). San Francisco, CA: John Wiley & Sons, Inc. Available at http://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Health%20Communication/Health_Belief_Model.doc. Accessed on 12 October 2010.

Glanz K, Rinner B K and Lewis F M (2002). *Health behaviour and health education: Theory, Research and Practice*. San Francisco: Wiley & Sons.

Glanz K, Rinner BK and Lewis F M, (2005). *Health behaviour and health education. Theory, Research and Practice*. San Francisco: Wiley & Sons.

Gollub E, (1996). *The women's safer sex hierarchy: interim data. Initial responses to counseling on women's methods of STD/HIV prevention at an STD clinic*. XI International Conference on AIDS, Vancouver, Canada.

Gollub E, (2000). *The female condom: empowerment tool for women*. America Journal of Public Health 90: Pp 1377-1381.

Gollub EL, Stein Z and El-Sadr W, (1995). *Short-term acceptability of the female condom among staff and patients at a New York City hospital*. Family Planning Perspectives 27(4): Pp 155-158.

Gordon G and Mwale V, (2006). *Preventing HIV with young people: a case study from Zambia*. Reproductive Health Matters 14(28): Pp 68-79.

Gouws E, Stanecki KA, Lyerla R and Ghys PD, (2008). *The epidemiology of HIV infection among young people aged 15-24 years in southern Africa*. AIDS 22 (suppl.4): Pp s5-16.

Gray B, (2003). *HIV and Islam: Is HIV prevalence lower among Muslims?* Social Sciences and Medicine: Pp 1-6.

Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S et al, (2007). *Male circumcision for HIV prevention in men in Rakai, Uganda: a randomized trial*. The Lancet 369 (9562): Pp 657 – 666.

Gredler M, (2001). *Learning and instruction: Theory into practice*. (4th Ed.). New York: Prentice Hall.

Green G, Pool R, Harrison S et al, (2001). *Female control of sexuality: Illusion or reality? Use of vaginal products in south west Uganda*. Social Science and Medicine 52(4): Pp 585-598.

Green J, and Thorogood N, (2004). *Qualitative Methods for health research*. Thousand Oaks and CA: Sage Publications.

Gupta GR, Weiss E, Whelan D. (1995) *Male-female inequalities result in submission to high – risk sex in many societies. Special report: women and HIV*. AIDS Analysis Africa 5 (4): Pp 8-9.

Haignere C, Gold R, Maskovsky J, Ambrosin J, Rogers C, Gollub E, (2000). *High risk adolescents and female condoms: Knowledge, attitude and use patterns*. Journal of Adolescent health 26(6): Pp 392- 398.

Hallman K (2004). *Socio economic disadvantage and unsafe sexual behaviours among women and men in South Africa*. Population Council Inc. Policy research division 190.

Harrison A, Xaba N, Kunene P (2001). *Understanding safe sex: gender narratives of HIV and pregnancy prevention by rural South African school going youth*. Reproductive Health Matters (17): Pp 63-71.

Harrison LD et al, (2001). *The acceptability of the female condom among U.S. women at high risk from HIV*. Culture, Health & Sexuality 3(1):Pp101-118.

Hatcher RA, Trussel J, Nelson AL, Cates W, Stewart FH and Kowal D, (2008). *Contraceptive technology*. USA: Contraceptive Technology communication Inc.

Helman C, (2007). *Culture, health and illness*. (5th Ed). New York: Oxford University Press.

Hoffman S, Mantell J, Exner T and Stein Z, (2004). *The future of the female condom*. International Family Planning Perspectives 30(3): Pp 139-145.

Hogben M, Gange SJ, Watts DH, Robison E, Young M, Richardson J, (2001). *The effect of sexual and physical violence on risky sexual behavior and STDs among a cohort of HIV seropositive women*. AIDS and Behaviour 5: Pp353–361.

Hoke TH, Feldblum PJ, Van Damme K, Nasution MD, Grey TW, Wong EL et al, (2007). *Temporal trends in sexually transmitted infection prevalence and condom use following introduction of the female condom to Madagascar sex workers*. International Journal of STD and AIDS 18(7): Pp 461-466.

Hynie M, Schuller RA, Couperthwaite L, (2003). *Perceptions of sexual intent: The impact of condom possession*. Psychology of women quarterly 27: Pp 75-79.

International Planned Parenthood Federation (IPPF)/United Nations Population Fund (UNFPA)/Young Positives. 2007. *Engendering Development: Though Gender Equality in Rights, Resources, and Voice*. Available at <http://www.ippf.org/en/Resources/Reports-reviews/Change+Choice+and+Power.htm>. Accessed on 30 June 2008.

IRIN, (2010). *Blog: The female condom - you've got to sell it right*. Available at <http://www.irinnews.org/report.aspx?ReportID=89950>. Accessed on 22 July 2010.

Jewkes R, Abrahams N, (2002). *The epidemiology of rape and sexual coercion in South Africa: An overview*. Social Science and Medicine 55(7): Pp1231-1244.

Jewkes R, Levin J, Penn-Kekana L, (2003). *Gender Inequalities, Intimate Partner Violence and HIV Prevention Practices: Findings of a South African Cross-Sectional Study*. Social Science and Medicine 56(1): Pp125–134.

Jewkes R, Levin J, Penn-Kekana L, (2003). *Gender inequalities, intimate violence HIV-preventive practices: Findings South African cross-sectional study*. Social Sciences Medicine 56: Pp 125-134.

Jivasak-Apimas S, Saba J, Chandeying V, Sakondhavat C, Kiriwat O, Rugpao S, Rojanapithayakorn W and Fontanet AL, (2001). *Acceptability of the Female Condom among Sex Workers in Thailand: Results from a Prospective Study*. Sexually Transmitted Diseases 28(11): Pp 648-654.

Joanis C, Beksinska M, Hart C, Tweedy K, Linda J, Smit J, (2010). *Three new female condoms: which do South-African women prefer?* Journal of Contraception 7483: Pp 7-16.

Kaaya SF, Flisher AJ, Mbwapbo JK, Schaalma H, Aaro LE and Klepp K, (2002). *A review of studies of sexual behaviour of school students in sub-Saharan Africa*. Scandinavian Journal of Public Health 30: Pp 148–160.

Kaler A, (2001). *It's Some Kind of Women's Empowerment: The Ambiguity of the Female Condom as a Marker of Female Empowerment*. Social Science and Medicine 52: Pp 783-796.

Kalichman SC, Williams EA, Cherry C, Belcher L and Nachimson D, (1998). *Sexual coercion, domestic violence, and negotiating condom use among low-income African American women*. Journal of Women's Health 7(3): Pp 371-378.

Karim QA, Karim SS, Soldan K, Zondi M, (1995). *Reducing the risk of HIV infection among South African sex workers: Socioeconomic and gender barriers*. American Journal of Public Health 85(11): Pp 1521-1525.

Kerrigan D, Mobley S, Rutenberg N, Fisher A, Weiss E, (2000). *The female condom dynamics of the use in urban Zimbabwe*. Population Council Inc.

Kessie E, (2008). *Values and beliefs make people vulnerable...Realities and challenges of condom use*. AIDS Legal Network June 2008: Pp 22-25.

Klugman B, (2000). Sexual rights in Southern Africa: A Beijing discourse or a strategic necessity? *Health and Human Rights* 4(2): Pp 144-173.

Krueger RA and Casey MA, (2000). *Focus Groups: A Practical Guide for Applied Research* (3rd Ed). Thousand Oaks, CA: Sage Publications.

Kulczycki A, Dhong-Jin K, Duerr A, Jamieson DJ and Macaluso M, (2004). *The Acceptability of the Female and Male Condom: A Randomized Crossover Trial*. *Perspectives on Sexual and Reproductive Health* 36(3): Pp 120-126.

Kunda R and Gibbs A, (2010). *Towards Microbicide Rollout in sub-Saharan Africa: Ensuring microbicides are an effective tool for HIV prevention and women's empowerment* Health Economics and HIV/AIDS Research Division Microbicide issue brief 14 July 2010. Available at www.heard.org.za/downloads/microbicide-issue-brief-14-july-2010.pdf. Accessed on 12 August 2010.

Lagarde E, Carael M, Glynn JR, Kanhouhou L, Abega SC, Kahindo M, Musonda R, Auvert B, Buve A, (2001). *Educational level is associated with condom use with spousal relationships in four cities of sub-Saharan Africa*. *AIDS* 15(11): Pp 1399-1408.

Lamptey AS, (2005). *Final report on the female e condom (FC) promotion project.* Communication initiative. Available at <http://www.comminit.com/en/node/216292/347>. Accessed on 21 August 2010.

Lara K, Grossman DA, Muñoz JE, Rosario RS, Gómez BJ, García SG, (2009). *Acceptability and Use of the Female Condom and Diaphragm among Sex Workers in Dominican Republic: Results from a Prospective Study.* AIDS Education and Prevention 21(6): Pp 538–551.

Latka M, Joanis C and Glover L, (2001). *Acceptability of the reality female condom and a latex prototype.* Journal of Urban Health 78(4): Pp 614-626.

Lear D, (1995). *Sexual communication in the age of AIDS: The construction of risk and trust among young adults.* Social Science and Medicine 41(9): Pp 1311–1323.

Leclerc-Madlala S (2006). *What prevents prevention? An overview of the sociological and gender context of HIV prevention in Southern Africa.* AIDS legal quarterly June 2006.

Leclerc-Madlala S, (2003). *Modernity, meaning and money: urban youth and the commodification of relationships.* Paper presented at the 1st South African AIDS Conference, ICI, 6 August, Durban.

Love Life (2009). *A gauge of HIV prevention in South Africa, 2009*. Available at http://www.lovelife.org.za/research/PREVENTION_GAUGE.pdf. Accessed on 12 September 2010.

Lucea MB, Hindin MJ, Rose L, Kub J, (2010). *The context of condom use among young adults in the Philippines: Implications for HIV risk Prevention*. Available at <http://paa2010.princeton.edu/download.aspx?submissionId=100451>. Accessed on 12 September 2010.

Luke N and Kurtz KM, (2002). *Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices* Washington, D.C. Population Services International and International Center for Research on Women.

Macaluso M, Demand M, Artz L, Fleenor M, Robey L, Kelaghan L, Cabral R and Hook III EW, (2000). *Female condom use among women at high risk for sexually transmitted disease*. Family Planning Perspectives 32(3): Pp138–144.

Macaluso M, Kelaghan J, Artz L, et al, (1999). *Mechanical failure of the latex condom in a cohort of women at high STD risk*. Sexually Transmitted Diseases 26: Pp 450–458.

Machel J Z, (2001). *Unsafe sexual behaviour among schoolgirls in Mozambique: A matter of gender and class*. Reproductive Health Matters 9(17): Pp 82-89.

Macintyre K, Rutenberg N, and Brown L, (2004). *Understanding perceptions of HIV risk among adolescents in KwaZulu-Natal*. AIDS and Behavior 8(3): Pp 237-250.

Mack N, Grey TG, Amsterdam A, Williamson N and Matta CI, (2010). *Introducing female condom to female sex workers in Central America*. International Perspective of Sexual Reproductive Health 36(3): Pp149-55.

Magadza M, (2010). *Female condom? Hell, No! Says politician*. Gender links for equality and justice for all (19 March 10) Available at <http://www.genderlinks.org.za/article/female-condom-hell-no-says-politician-2010-03-19>. Accessed on 15 May 2010.

Maggwa N B, Smit J, Beksinska M, Rees H (2003). *Dual protection in sexual active women*. South African Medical Journal 93: Pp 854-85.

Maharaj P and Cleland J, (2005). *Risk perception and condom use among married couples or cohabiting couples in KwaZulu Natal, South Africa*. International Family Planning perspectives 31(1): Pp 24- 29.

Maharaj P, (2001). *Obstacles of negotiating dual protection: perspective of men and women*. African Journal of Reproductive Health 5(3):Pp150-161.

Maman S, Campbell J *et al*, (2000) .*The intersections of HIV and violence: directions for future research and investigations*. Social Science and Medicine 50: Pp 459-478.

Mantell JE, DiVittis AT, Auerbach MI, (1997). *Evaluating HIV prevention interventions*. New York: Plenum Press.

Mantell JE, Stein ZA, Susser I, (2008). *Women in the time of AIDS: barriers, bargains, and benefits*. AIDS Education and Prevention 20 (2): Pp 91–106.

Marindo R, Pearson S and Casterline JB, (2003). *Condom Use and Abstinence among Unmarried Young People in Zimbabwe: Which Strategy, Whose Agenda?* Working policy division no 17. Population Council Inc.

Marshall C. and Rossman G, (1995). *Designing qualitative research*. (2nd Ed.). Thousand Oaks, CA: Sage Publications.

Marston C & King E, (2007). *Factors that shape young people's sexual behaviour: a systematic review*. Evidence Based Nursing 10(4): Pp124.

Mash R, Mash B, de Villiers, P, 2010. *Why don't you just use a condom? Understanding the motivational tensions in the minds of South African women*. African Journal of Primary Health Care & Family Medicine 2(1): Pp 1-4. Available at <http://www.phcfm.org/index.php/phcfm/article/viewArticle/79/101>. Accessed on 21 August 2010.

Masons J, (2002). *Qualitative researching*. (2nd Ed). Thousand Oaks, CA: Sage Publications.

Mathews J and Harrison T, (2006). *An update on female-controlled methods for HIV prevention: female condom, Microbicide & cervical barriers*. Southern Africa Journal of HIV and Medicine Pp7-11.

Mc Phail C and Campbell C, (2001). *I think condoms are good but, aai, I hate those things: condom use among adolescents and young people in a Southern African township*. Social Science and Medicine 52 (11): Pp1613-27.

Medindia .com, (2006). *Networking for health: Rise in the use female condom in South Africa*. Posted on line 31 August 2006. Available at www.medindia.net. Last updated at 6 May 2008. Accessed June 03, 2008.

Meekers D and Ritcher K, (2005). *Factors associated with the use of the female condom in Zimbabwe*. International Family Planning Perspectives 31(1): Pp 30-37.

Miles M and Huberman A, (1994). *Data management and analysis method in: Handbook of qualitative research*. Thousand Oaks: SAGE Publication.

Morgan DL and Krueger RA, 1998. *Focus group kit*. Thousand Oaks: SAGE publications.

Morisky DE, Stein JA and Chaiao C, (2006). *Impact of a Social Influence Intervention on Condom Use and Sexually Transmitted Infections among Establishment-Based Female Sex Workers in the Philippines: A Multilevel Analysis*. Health Psychology Journal 25(5): Pp 595-603.

Morrison DM, Gillmore MR, Hoppe MJ, Gaylord J, Leigh BC and Rainey D, (2003). *Adolescent drinking and sex: Findings from a daily diary study*. Perspectives of Sexual and Reproductive Health 35: Pp162–168.

Mqoqi N, Mqhayi M, Tshukudu D *et al*, (2000). The National Introduction of the Female Condom and Emergency Contraceptive Pills Program, Pilot Phase – Final Report. Bertsham, South Africa: Reproductive Health Research Unit, Chris Hani-Baragwanath Hospital.

Mung'ala L, Kilonzo N, Angala P, Theobald S, Taegtmeier M, (2006). *Promoting female condoms in HIV voluntary counseling and testing centers in Kenya*. Reproductive Health Matters 14(28): Pp 99-103.

Musoni E (2007). *Culture hindering use of female condoms*. Posted on line 18 June 2007. Available at www.allafrica.com. Accessed on 28 May 2008.

Myer L, Mathews C and Little F. Measuring consistent condom use: a comparison of cross-sectional and prospective measurements in South Africa. International Journal of STD and AIDS 13(1): Pp 62-63.

Ngugi EN, Plummer FA, Sajabi R, Wambugu P, Njeru EK and Ndinya-Achola JO, (1992). *Development of an educational booklet for STD/AIDS control among female Commercial sex workers in Kenya*. Paper presentation at VIIIth International Conference on AIDS. 19-24 July Amsterdam.

Nicholson F, (2008). *Why are we so accepting? Female condoms...Human rights issue?* AIDS Legal Network June 2008: Pp 10-13.

Nicolay N, 2008 .*Summary of provincial HIV and AIDS statistics for South African Metropolitan*.

Available at http://www.metam.co.za/documents_v2/File/RedRibbon_2009/Provincial%20HIV%20and%20AIDS%20statistics%20for%202008.pdf. Accessed on 15 December 2009.

Noleen S, (2007). *28 stories of AIDS in Africa*. Canada: Walker and company.

Norman LR, (2003). *Predictors of consistent condom use: a hierarchical analysis of adults from Kenya, Tanzania and Trinidad*. International Journal of STD/AIDS 14 (9): Pp 584-590.

Nthwesane V, (2010). *Female condom not so blissful*. Available at <http://www.mmegi.bw/index.php?sid=1&aid=1895&dir=2010/April/Monday26>. Accessed on 5 June 2010.

Nueman B, (2000). *Designing social research: The logic of anticipation*. Cambridge: Policy press.

Obbo C, (1995) *Gender, age and class: discourses on HIV transmission and control in Uganda*. In: Culture and Sexual Risk: Anthropological Perspectives on AIDS (ten Brummelhuis H and Herdt G. eds). Reading: Gordon and Breach Pp 79–95.

Okunlola MA, Morhason-Bello IO, Owonikoko KM et al, (2006). *Female condom awareness, use and concerns among Nigerian female undergraduates*. Journal of Obstetric and Gynaecology 26: Pp353–356.

Padian NS, Bove A, Balkus J, Serwadda D and Cates W, (2008). *HIV intervention to biomedical interventions to prevent HIV infection: Evidence challenges and way forward*. Lancet 372: Pp 585-599. Available at www.thelancet.com. Accessed on 11 August 2009.

PANOS, (1992). *The hidden cost of AIDS: the challenge of HIV to development*. London: The Panos Institute.

Parker F, 15 August 2010. *Hunt is on for elusive female condom*. Mail & Guardian online. Available at <http://www.mg.co.za/article/2010-08-05-hunt-is-on-for-elusive-female-condom>. Accessed on 17 September 2010.

Parker W, (2005). *HIV/AIDS, claims making and the public sphere: Are we being critical enough about the epidemic?* Cape Town: CADRE Available at http://www.cadre.org.za/files/Critical_Parker_%20AIDS2005.pdf . Accessed on the 20 May 2008.

Parker W, Makhubhele B, Ntlabathi P, Connolly C, (2007). Concurrent Sexual Partnerships amongst young adults in South Africa. *Challenges for HIV prevention communication*. CADRE.

Parker W, Rau A, Peppia P, (2007). *HIV/AIDS communication in selected African countries: Intervention, response and possibilities*. SIDA: Lusaka.

PATH, (2005). *Female Condom Consultation held in Baltimore, MD, USA and provided these other references as well. Presentations from the Global Consultation*. Available at <http://info.k4health.org/femalecondomforum.shtml>. Accessed on 12 November 2010.

PATH, (2007). *Global consultations on female condom*. Available at www.path.org/project/womans-condom_gcfc2005. Accessed on 11 August 2010.

Peters A, Jansen W and van Driel F, (2010). *The female condom: the international denial of a strong potential*. Reproductive Health Matters 18: Pp 119-28.

Pettifor A et al, (2001). *The Acceptability of Reuse of the Female Condom among Urban South African*. *Women Journal of Urban Health* 78 (4): Pp 647-57.

Pettifor AE, Maesham DM, Rees HV & Padian NS (2004). *Sexual Power and HIV Risk, South Africa*. *Emerging Infectious Diseases* 10: Pp 1996-2004.

PlusNews, (2010). *Global HIV/AIDS news and analysis*. Available at <http://www.plusnews.org/Report.aspx?ReportId=86081>. Accessed on 20 June 2010.

Pool R, Hart G, Green G, Harrison S, Nyanzi S and Whitworth J, (2000). *Men's Attitudes to Condoms and Female Controlled Means of Protection against HIV and STDs in South-western Uganda*. *Culture, Health and Sexuality* (2): Pp 197-211.

Pool R, Whitworth JAG, Green G *et al*, (2000). *An acceptability study of female-controlled methods of protection against HIV and STDs in south-western Uganda*. *International Journal of Sexually Transmitted Disease and AIDS* 11(3): Pp 162-167.

Pope C, Zuebland S, Mays N, (2006). *Analysing qualitative data in Qualitative Research in health care*. 3rd Ed. London: Blackwell Publishing.

Power I, (2002). *The role of quantitative research in HIV/ AIDS*. *AIDS* 12(7) pp 687-695.

Prata N, Morris L, Mazive E, Vahidnia F and Stehr M, (2006). *Relationship between HIV Risk Perception and Condom Use: Evidence from a Population-Based Survey in Mozambique*. *International Family Planning Perspectives* 32 (4): Pp 192-200.

Preston-Whyte EM, (1995). *Half-way there: anthropology and intervention-oriented AIDS research in Kwazulu/Natal, South Africa*. In: Culture and Sexual Risk: anthropological Perspectives on AIDS (ten Brummelhuis H. and Herdt G. eds). Reading: Gordon and Breach Pp. 315–37.

Prudhomme M, Boucher J, Delberghe P et al, (2005). *Female condom or male condom: Offer a choice*. Gynaecology Obstetrics and Fertility 33: Pp 891–897.

Quine L, Rutter DR and Arnold L, (2000). *Comparing the theory of planned behaviour and the health belief model: the example of safety helmet use among schoolboy cyclists*. In Norman, P Abraham, C. and Conner. M. (Eds), Understanding and Changing Health Behaviour: From Health Beliefs to Self-regulation. Amsterdam: Harwood, pp. 73–98.

Ramkissoo A, Coutsoodis A, Coovardia H, Mthembu P, Hlazo J and Smit J, (2007). *Options for HIV positive women South African Health Review 2006. Durban, South Africa*. Health Systems Trust.

Randolph EM, Pinkerton SD, Bogart LM, Cecil H and Abramsom PR, (2007). *Sexual Pleasure and Condom Use*. Sexual Behaviour 36(6): Pp844–848.

Reddy P, Meyer-Weitz A, Van den Borne B et al, (1999). *STD-related knowledge, beliefs and attitudes of Xhosa-speaking patients attending STD primary health care clinics in South Africa*. International Journal of STD and AIDS 10: Pp 392–400.

Republic of South Africa (2010). *Progress report on declaration of commitment on HIV and AIDS: Reporting period January 2008- December 2009*. Available at

data.unaids.org/.../Report/2008/south_africa_2008_country_progress_report_en.pdf. Accessed on 15 January 2010.

Rosenstock I, Strecher V and Becker M, (1994). *The Health Belief Model and HIV risk behavior change*. In DiClemente RJ and Peterson JL (Eds.), *Preventing AIDS: Theories and Methods of Behavioral Interventions* New York: Plenum Press, Pp.5-24.

Schoepf BG, (1995). *Culture, sex research and AIDS prevention in Africa*. In: *Culture and Sexual Risk: Anthropological Perspectives on AIDS* (ten Brummelhuis H and Herdt G. eds). Reading: Gordon and Breach Pp 29–51.

Shisana O, Rehle T, Simba LC, Zuma K, Jooste S, Pillay-Van Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S (2009). *South African National HIV Prevalence, Incidence, Behavior and Communication Survey, 2008: A Turning Tide among Teenagers?* Cape Town: HSRC Press.

Shisana O, Rehle T, Simba LC, Zuma K, Jooste S, Pillay-Van Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABBSM III Implementation Team (2009). *South African National Prevalence, Incidence, Behavior and Communication Survey 2008: A turning tide among teenagers?* Cape Town: HSRC Press.

Shisana O, Rehle T, Simba LC, Zuma K, Jooste S, Pillay-Van Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S (2010). *South African National HIV Prevalence, Incidence, Behavior and Communication Survey, 2008: The health of our children*. Cape Town: HSRC Press.

Shisana O, Rehle T, Simbayi LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste S, Pillay V, *et al*, (2005). *South African National HIV Prevalence, HIV incidence, Behavior and Communication Survey, 2005*. Cape Town: HSRC Press.

Sippel S, (2008). *Female condom... Saving lives now*. Aids Legal Network June 2008: Pp 1-9.

Smith RA, Hirkky AE, Shedlin M, Tross S and Kim J, (1999). *Attitudes towards and experience with the female condom: results of a qualitative study with heterosexual women and male injecting drug users, and with men who have sex with men*. Paper presented at *The National AIDS Prevention Conference in USA*.

Soper DE, Brockwell NJ, Dalton HP, (1991). *Evaluation of the effects of a female condom on the female lower genital tract*. *Contraception* 44: pp 21-29.

Soper DE, Shoupe D, Shangold GA, Shangold MM, Gutmann J, Mercer L, (1993). *Prevention of Vaginal Trichomoniasis by Compliant Use of the Female Condom*. *Sexually Transmitted Diseases* 20 (3): Pp 137-139.

Spizzichino L, Pedone G, Gattari P, Luzi AM, Gallo P, Valli R and Rezza G, (2007). *The female condom: knowledge, attitude, and willingness to use. The first Italian study*. *Ann 1st Super Sanita* 43 (4): Pp 419-424.

Statistics South Africa (2009, July). *Mid-year population estimates 2009*. Available at <http://www.statssa.gov.za/publications/P0302/P03022009.pdf>. Accessed on 10 December 2009.

Strecher V J and Rosenstock IM, (1997). *The Health Belief Model*. In Glanz K F, Lewis M and Rimer BK. *Health Behavior and Health Education: Theory, Research, and Practice*, eds. San Francisco: Jossey-Bass.

The Body, (2004). *Condom Use for Preventing HIV Infection/AIDS in Sub-Saharan Africa: A Comparative Multilevel Analysis of Uganda and Tanzania*. Available at <http://www.thebody.com/content/art26757.html>. Accessed on 15 November 2010.

The Lancet Infectious Diseases, (2008). *The female condom: still an underused prevention tool*. The Lancet Infectious Diseases 8 (6): Pp 343-400. Available at <http://infection.thelancet.com>. Accessed on 05 December 2010.

Thohoyandou Victim Empowerment (TVE), (2008). *The 2008 Thohoyandou Victim Empowerment Dialogues: Universal Access to Female Condoms....A Human Rights Issue!* Available at <http://www.health-e.org.za/uploaded/eb36b4d2e02db96e65f255bf44498b38.pdf>. Accessed on 12 August 2010.

Trochim W K, (2006). *The design*. Available at [www.socialsciences methods.net/kb/intval.php/](http://www.socialsciencesmethods.net/kb/intval.php/). Last updated at 20/10/06. Accessed on 17 September 2008.

Ukwuani FA, Tsui AO, Suchindran CM, (2003). *Condom Use for Preventing HIV Infection/AIDS in Sub-Saharan Africa: A Comparative Multilevel Analysis of Uganda and Tanzania*. Journal of Acquired Immune Deficiency Syndromes 34(2): Pp 203-213.

Ulin PR, Robison ET, Tolley EE, McNeil ET, (2002). *Qualitative methods a field's guide for applied research in sexual reproductive health*. North Carolina: Family Health International.

United Nations Programme on HIV/AIDS (UNAIDS), (2000). *AIDS Epidemic Update: 2000*. Geneva: UNAIDS.

UNAIDS, (2002). *AIDS Epidemic Update 2002*. Geneva: UNAIDS.

UNAIDS, (2004). *2004 Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNAIDS, (2005). *UNAIDS Report on the Global AIDS Epidemic. A UNAIDS Special 10th Anniversary Edition*. Geneva: UNAIDS.

UNAIDS, (2006). *Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNAIDS, (2008). *2008 Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNAIDS, (2009). *2009 Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNFPA (2009). *Donor support for contraceptives and condoms for STI/HIV prevention 2008*.

UNFPA and Department for International Development (DFID), (2005). *Situational analysis of the female condom in Zimbabwe*. Available at http://www.jsieurope.org/docs/situational_analysis_female_condom.pdf. Accessed on 20 August 2010.

UNFPA and PATH, (2006). *Female condom: A powerful tool for protection*. Accessed on 18 August 2010. Seattle: UNFPA & PATH.

United Nations Population Fund (UNFPA), World Health Organization (WHO) Department of Reproductive Health and Research and International Planned Parenthood Federation (IPPF), (2007). *Preventing HIV promoting reproductive health: Myths, misperceptions and fears addressing condom use barriers*. Available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2007/myths_condoms.pdf. Accessed on 15 May 2008.

University Of Alberta, (2004). *Female Condoms Overlooked In Fight against Spread of HIV/AIDS*. Science Daily. November 26, 2004. Available at

<http://www.sciencedaily.com/releases/2004/11/041124155045.htm>. Accessed on 15 September 2010.

van der Schaff, (2008). *Where are the Femidoms?* AIDS Legal Network June 2008: Pp 19-21.

van Mens L and Smit I, 2008. *Female condoms: a life saving alternative*. Available at <http://healthexchangeneeds.com/2009/02/20/female-condoms-a-life-saving-alternative/>. Accessed on 20 May 2009.

van Ryn M, and Heaney CA, (1992). What's the use of theory? *Health Education Quarterly*, 19: Pp 315-330.

Varga C (1997). *Sexual decision making and negotiation in the midst of AIDS: youth in KwaZulu/Natal, South Africa*. Health transition Review 7 (suppl.2): Pp13-41.

Varga, CA and Makubalo L, (1996). *Sexual non-negotiation*. Agenda 28: Pp 31–38.

Verma RK, PulerWitz Z, Mahendra V, Khandekar S, Barker G, Fulpagare P and Singh SK, (2006). *Challenging and changing gender attitudes among young men in Mumbai, India*. Reproductive Health Matters 14(28): Pp 135-143.

Vijayakumar G, Mabude Z, Smit J, Beksinska M, Lurie M, (2006). *A review of female-condom effectiveness: patterns of use and impact on protected sex acts and STI incidence*. [International Journal of Sexually Transmitted Disease and AIDS](#) 17(10): Pp 652-659.

Voice of the Cape FM, (2010). *Muslim religion*. Available at <http://www.vocfm.co.za/public/articles.php?Articleid=18172>. Accessed on 12 August 2010.

Walker L, Reid G and Cornell M, (2004). *Waiting to happen HIV/AIDS in South Africa*. Cape Town, Colarado, and London: Lynne Rienner Publishers Inc & Juta and Co Ltd.

Walsh TL, Frezieres RG, Peacock K, Nelson AL, Clark VA, Bernstein L, Wraxall BG, (2003). *Use of prostate-specific antigen (PSA) to measure semen exposure resulting from male condom failures: implication for contraceptive efficacy and the prevention of sexually transmitted disease*. *Contraception* 67 (2): pp 139- 150.

Warren M, & Philpott A, (2003). *Expanding safer sex options: introducing the female condom into national programmes*. *Reproductive Health Matters* 11(21): Pp130-139.

Weeks MR, Li J, Coman E, Abbott M, Sylla L, Corbett M and Dickson-Gomez J, (2010). *Multilevel Social Influences on Female Condom Use and Adoption among Women in the Urban United States*. *AIDS Patient Care and STDs* 24(5): Pp 297-309.

Welbourn A, (2006). *Sex, life and the female condom: some views of HIV positive women*. *Reproductive Health Matters* 14(28): Pp 32-40.

Welman JC and Kruger SJ, (2003). *Research methodology for the Business and Administrative Science*. Cape Town: international Thomson Publishing LTD.

Welsh MJ, Feldblum PJ, Kuyoh MA, Mwarogo P, and Kungu D, (2001). *Condom use during a community intervention trial in Kenya*. International Journal of STD and AIDS 12(7): Pp 469-474.

Whitehead, T.L. (1995). *Urban low-income African- American men, HIV/AIDS, and gender identity*. Medical and Anthropological Questions (New Ser.) 11(4): Pp 411–47.

WHO, (2009). *Women and health: today's evidence tomorrow's agenda*. Geneva: WHO.

WHO, (2010). *PMTCT strategic vision 2010-2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals*. Available at http://www.who.int/hiv/pub/mtct/strategic_vision/en/index.html Accessed on 12 August 2010.

Wingood GM, DiClemente RJ, (1997). *Child sexual abuse, HIV sexual risk, and gender relations of African- American women*. American Journal of Reproductive Medicine 13(5): Pp 380-384.

Witte SS, El Bassel N, Gilbert L, Wu E, Chang M, Hill J (2006). *Promoting female condom use to heterosexual couples: findings from a randomized clinical trial*. Perspectives of Sexual Reproductive Health 38: pp148-54.

Women24.com, (2010). *Female condoms don't work*. Available at <http://www.women24.com/LoveAndSex/SexAndSizzle/Female-condoms-dont-work-20100324>. Accessed on 09 September 2010.

Wood K and Jewkes R, (1997). *Violence, rape, and sexual coercion: Everyday love in a South African township*. Gender and Development 5(2): Pp 41–46.

Wood KM, (2000). *Coercive sex, violent contexts: Ethnographic observations on talking and (non)/condom use in a South African township*. Oral presentation at XIII International AIDS Conference, Durban, South Africa, July 9–14 (abstract WeOrD563).

World Health Organization (WHO), (2002). *The safety and feasibility of female condom reuse: Report of a WHO consultation*. Geneva: WHO. Available at www.femalehealth.com/images/WHO_report_reuse.pdf. Accessed on 10 May 2009.

World Health Organization (WHO), (2002). *Women and HIV/AIDS, fact sheet no. 242*. Geneva: WHO.

Worley H (2005). *Obstacles remain to wide adoption of female condom: Method could be critical in reducing HIV rates for married women*. Available at [<http://www.prb.org/Articles/2005/ObstaclesRemaintoWideAdoptionofFemaleCondom>]. Last updated at November 2005. Accessed at May 15, 2008.

Worth D, (1989). Sexual decision-making and AIDS: *Why condom promotion among vulnerable women is likely to fail*. *Studies of Family Planning* 20(6 Pt 1): Pp 297-307.