



Knowledge, use and availability of female condoms among North-West University students, Mafikeng campus

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Abstract

University students are perceived to be involved in risky sexual behaviour. If so, this results in negative reproductive health outcomes such as unwanted pregnancies and a high incidence of STIs including HIV/AIDS. One way of preventing these is by using female condoms. This study aims to explore factors that affect the uptake of female condoms among students.

The study used primary data collected from students and key informants. Three focus discussion groups (FDGs) were conducted whereby a total number of 28 participants were included and two key informants were interviewed. One informant is from the university and the other one from a local pharmacy. Five residence wardens were interviewed to determine the challenges they face regarding the supply of female condoms. ATLASTI software was used to analyze the data.

The results revealed that there are no female condoms available on campus. Many male students are willing to try using the condom but the resistance comes from their male partners. Also it has been found out that the female condom awareness campaign is available on campus but not emphasized as much as male condom. The awareness programme is not specifically for the female condom but for both male and female condoms. However, students are not aware of the female condom awareness programme running on campus. The reasons why women are not using, include among others the long duration it takes to prepare the female condom, the physical appearance that is not attractive, limitation of female condom when exploring more sexual pleasure, lack of publicity and education, also women are ashamed to be seen carrying condoms.

Targeting men in promotion of female condom, re-training of providers, making female condoms available in all campus residences, especially in female campus residences and making pamphlets available for prospective users to learn how to use female condom are recommended in this study. Pamphlets should also include information regarding the advantages of using female condoms.

DECLARATION

I, Harry Modisaotsile Pholo, hereby declare that this research title “Knowledge, use and availability of female condoms among North West University students, Mahikeng campus is my own work and that all sources have been accurately reported and acknowledged, and that this document has not previously been submitted in any University or Higher Training Institution in order to obtain a similar qualification.



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AIDS	Acquired Immune Deficiency Syndrome
FGDs	Focus Group Discussions
FAST	Faculty of Science and Technology
HSS	Human and Social Sciences
HIV	Human Immune Virus
IEC	Information, Education and Communication
NDoH	National Department of Health
NSP	National Strategic Plan
NWU	North-West University
NSP	National Strategic Plan
NGO	Non-Governmental Organisation
SADHS	South African Demographic and Health Survey
TOT	Training Of Trainer
TB	Tuberculosis
STI	Sexually Transmitted Infection

CHAPTER 1: INTRODUCTION

1.1 Background of the study

1.1.1 HIV Prevalence

In South Africa, a large proportion of pregnancies are unplanned, teenage pregnancy and unsafe abortion are major health concerns. In 2011, the prevalence of HIV among pregnant women attending public clinics was nearly 30% (Moore, *et al.* 2014: 2). According to the Department of Health (2012), the prevalence of HIV infection is rife among young women, being the highest between the ages 15-25 in the general population, while the number of girls aged 10-14 years in the antenatal survey was only 0.4%. However, the 2002 summary report of the Department of Health shows that the most infected age group was 25-29 during that time. This shows that the disease is now attacking the younger generation from age 15 to 25.

The Department also acknowledged that in Africa women are harder hit than men and that the difference between men and women in terms of susceptibility is pronounced, with women more likely to acquire HIV infection from an infected partner and also more vulnerable due to unequal gender relations. Table 1 illustrates the trends of HIV prevalence among South African women attending antenatal health care from 1990-2012:

Table 1: HIV prevalence among women from 1990-2012

Year	Prevalence %	Year	Prevalence %
1990	0.7	2002	26.5
1991	1.7	2003	27.9
1992	2.2	2004	29.5
1993	4.0	2005	30.2
1994	7.6	2006	29.1
1995	10.4	2007	29.4
1996	14.2	2008	29.3
1997	17.0	2009	29.4
1998	22.8	2011	30.2
1999	22.4	2011	29.5
2000	24.5	2012	29.5
2001	24.8		

Source: National Department of Health (2012)

In South Africa has shown that the main drivers of the HIV epidemic in young people between ages 15-24 can primarily be attributed to sexual behaviour risk factors such as early sexual debut, intergenerational sex, lack of hope and pessimism for the future, low self-esteem, sexual coercion (particularly for females), biomedical factors, gender-based violence, poverty, lack of education and leaving school at an early age (Department of Health, 2012: 46).

The first democratic elections in 1994 ushered in a new era in South Africa, with the concept of human rights and equity becoming the cornerstones of its constitution. This created an enabling environment for health care transformation including sexual and reproductive health and rights and it was within this context that South Africa's first contraception policy was written: contraception policy within a reproductive health framework and contraception service delivery guidelines were launched in 2001 and 2003 respectively (Department of Health, 2012: 13).

1.1.2 Unwanted pregnancy

Adolescents have suddenly taken the wrong path as “children having children” seems to be the popular lifestyle of society. Globally 15 million women under the age of 20 give birth, representing up to one-fifth of all births (Mudau *et al*, 2015: 528).

According to Mchunu *et al* (2012), evidence from sub-Saharan Africa indicates that 35% of pregnancies among 15-19 year olds were unplanned, unwanted or untimed. He further stated that a study conducted in Soweto, South Africa found out that 23% of pregnancies were carried by 13-16 year old young women.

In South Africa, the rate of teenage pregnancy seems to be increasing since the democratic government came to power in 1994. Each year thousands of youths fall pregnant, the worst hit are girls who became sexually active between thirteen and nineteen years of age (Mudau *et al*, 2015: 530).

However, all women of reproductive ages were said to be at risk for experiencing unwanted pregnancies (Izugbara & Egesa, 2014: 104). In his study, the respondents affirmed that unwanted pregnancies occurred at different points in their lives; some were single, others were married and yet others were divorced or widowed. Some were adolescents, some were adults, some already had children and some had not started child bearing when their pregnancy occurred. Izugbara (2014), mentioned that although married women experience unwanted pregnancy, unmarried girls were at higher risk for it.

According to Miriri (2014), the maternal education, women's employment opportunities, marital stability, family structure and poverty were seen as contributing factors to the adolescent pregnancy. He further stated that in rural South African communities, poverty contributes to adolescent pregnancy and adolescent pregnancy contributes to the perpetuation of the poverty.

According to Mudau *et al* (2015), as a result of poor or no parental guidance and control, children engage in sexual activities at a very young age and teenage pregnancy is high among child-headed households. He also noticed that lack of communication between adolescents and parents were the contributing factors. In his study, it was revealed that some parents believe that if they talk about sex with their children, they may start to engage in sexual relationship and it will appear as if they are the ones who permitted them to do so. However, other studies have found out that religion, peer pressure and lack of contraceptive knowledge are the contributing factors to unwanted pregnancies. For example, in the study conducted by Miriri

(2014), it was revealed that the majority of respondents experienced unintended pregnancy, hence (94.1%) of the respondents were Christians. He noticed that religion has an impact on fertility as contraceptives are usually not favorable, as abstinence is preferred which is difficult for teenagers.

Mudau *et al* (2015), noted that adolescent pregnancy occurring in girls remains a serious health and social problem worldwide, and has been associated with numerous risk factors evident in the young people's family, peer, school and neighborhood context. This statement was also supported by Mudau *et al* (2015), that teenage pregnancy and childbearing bring substantial social and economic costs through immediate and long term effects on teenagers, parents and their children. He further stated that such effects are significant contributors to high school dropouts' rates among girls, maternal mortality and incident of sexually transmitted infections.

1.1.3 Female condom programme in South Africa

The National Department of Health has been implementing a national male condom programme since 1992. Following concerns about the quality of public sector condoms in South Africa, in 2004 the NDoH launched the rebranded male condom named "choice" targeted at ages 18-35, repackaged in attractive colours in an effort to increase condom usage. Thereafter, the NDoH initiated the national introduction of the female condom programme in June 1998 and it was introduced in all 9 provinces (Beksinska, *et al*, 2012:3).

According to Mantell *et al* (2000) the aim of the NDoH was to empower women to take control of their health. However, to implement the policy, a Training of Trainer (TOT) programme was initiated to prepare service providers for introducing this new technology. Since the initial training, there has been additional nationally organised female condom training of health care providers, and distribution of free female condoms.

1.1.4 The National Strategic Plan (NSP)

The NSP on HIV, sexually transmitted infections and tuberculosis is the strategic guide for the national response to HIV, STI's and TB for the five years from 2012-2016. The plan addresses the drivers of the HIV and TB epidemics and builds on the achievements of the previous NSP to achieve goals (Department of Health-National Strategic Plan, 2016:12).

According to the National Department of Health (2011), the objectives and activities related to condoms under the national government, HIV and AIDS and TB programme were as follows:

- Ensure an uninterrupted supply of good quality condoms to all provinces.
- Expand condom supply to non-traditional outlets like hotels, clubs, spaza shops and taxi ranks.
- Make the female condom available in areas where there is a demand and to popularise it.
- Motivate for the provision of condoms in institutions of higher learning.
- Ensure condom supply in high transmission areas like trucking routes and single sex hostels, and where commercial sex work is prevalent.

1.1.5 Table 2: Total national female condom distribution and targets 2012-2016

Distributed 2012/2013	Targets 2013/2014	Actual 2013/2014	Targets 2014/2015	Actual 2014/2015	Distributed 2015/2016
8,804,176	7,500,000	11,495,276	15,000,000	19,838,751	27,000,915

Table 3: Total national male condom distribution and targets 2012-2016

Distributed 2012/2013	Targets 2013/2014	Actual 2013/2014	Targets 2014/2015	Actual 2014/2015	Distributed 2015/2016
387,576,754	1,000,000,000	506,433,332	1,000,000,000	734,124,322	839,600,768

Figure 1: national male and female condom distribution 2012/2016

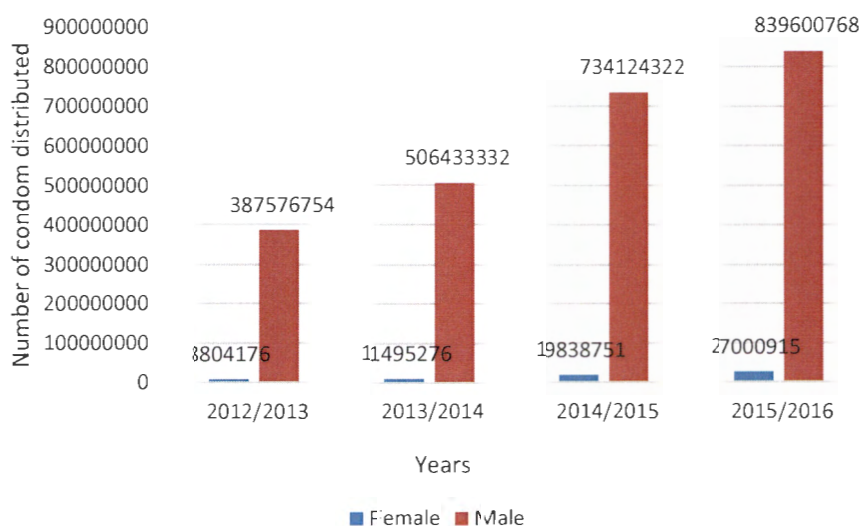


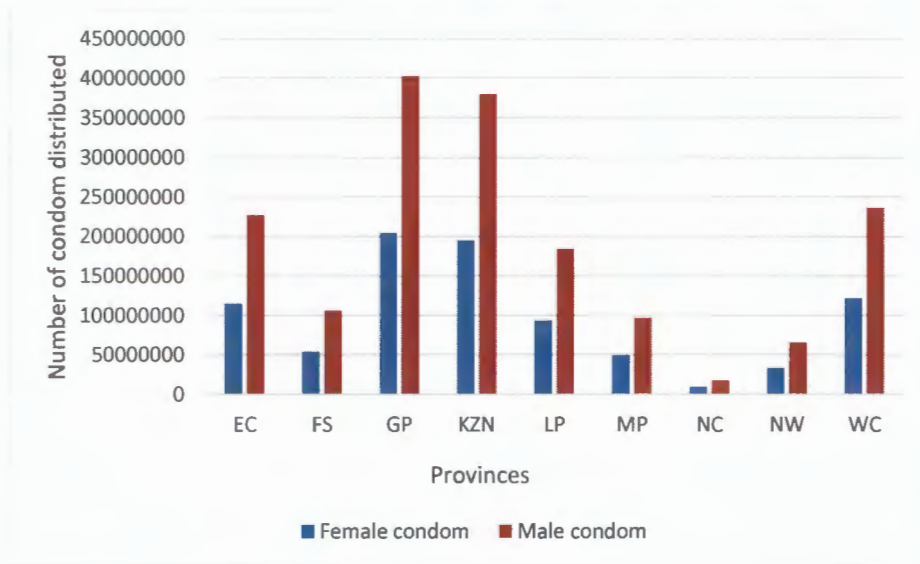
Table 4: Total provincial female condom distribution and targets 2012-2016

Province	Distributed 2012/2013	Target 2013/14	Actual 2013/14	Target 2014/15	Actual 2014/15	Distributed 2015/2016
EC	739,422	1,012,500	938,817	1,847,045	1,838,009	111,718,479
FS	540,815	442,500	320,500	793,999	1,306,337	52,246,633
GP	1,412,464	1,605,000	1,200,000	3,725,387	4,406,310	197,852,306
KZN	2,082,708	1,590,000	3,268,241	2,904,140	5,128,283	184,746,341
LP	847,917	787,500	630,000	1,571,163	2,063,378	90,565,129
MP	305,489	547,500	1,349,001	1,126,027	509,500	47,627,956
NC	618,163	172,500	351,640	950,961	258,975	8,513,384
NW	114,243	525,000	584,871	318,845	978,139	32,184,899
WC	2,142,955	817,500	2,852,206	1,762,433	3,349,820	114,145,641
ZA	8,804,176	7,500,000	11,495,276	15,000,000	19,838,751	83,9600,768

Table 5: Total provincial male condom distribution and targets 2012-2016

Province	Distribution 2012/2013	Target	2013/14	Target 2014/15	Distributed 2014/15	Distributed 2015/2016
EC	33,574,673	135,000,000	35,801,803	112,129,841	118,596,865	2,847,471
FS	19,006,563	59,000,000	17,626,961	52,692,163	34,758,379	1,423,046
GP	44,747,556	214,000,000	70,145,553	272,328,221	112,811,883	7,648,078
KZN	90,875,542	212,000,000	134,792,370	180,400,929	178,418,585	5,771,843
LP	34,109,619	105,000,000	46,952,045	93,477,432	63,193,567	2,401,742
MP	26,389,261	73,000,000	40,254,964	75,927,663	59,968,384	1,829,471
NC	21,604,003	23,000,000	28,847,888	22,107,169	7,823,811	385,141
NW	3,234,556	70,000,000	4,629,229	71,308,414	37,799,887	1,211,666
WC	114,034,981	109,000,000	127,382,518	119,628,168	120,752,961	3,482,457
ZA	387,576,754	1,000,000,000	506,433,332	1,000,000,000	734,124,322	27,000,915

Figure 2: Total provincial female and male condom distribution 2012/2016



1.1.6 Characteristics of a female condom

The female condom is a barrier contraceptive method consisting of a transparent polyurethane sheath that is inserted into the vagina before sexual intercourse. It is manufactured from a polyurethane material that is stronger than latex and it has been shown to be even stronger than the male condom (Beksinska et al, 2000: 67).

1.1.7 The need for a female condom

Although male condoms have been the cornerstone of HIV/AIDS and STIs prevention, the low usage rate has left many women at risk of contracting sexual transmitted diseases. Therefore there had been many calls for an effective female controlled barrier method that would reduce HIV transmission and other STIs, as Mantell et al (2000) state that the female condom provides a physical barrier that may offer some women protection against conception and sexually transmitted infections.

1.1.8 The development of a female condom

The development of a female-controlled barrier method called for by women’s advocates begin in the early 1990’s following a vigorous campaign. Later on, the U.S Food and Drug administration approved the use of the female condom in 1993 (Hoffman, 2004: 139). More than 90 developing countries including South Africa, introduced the method through public distribution, social marketing campaigns or commercial outlets, (Hoffman, 2004: 139).

1.2 Problem statement

According to Plan International ORG (2017), in Africa, 7.3 million girls become pregnant before the age of 18 each year, and half of those girls aged 15-19 have unintended pregnancies. In the case of South Africa, STATSSA reported that the rate of teenage pregnancy was 5.3% in the year 2015 and 5.1% in 2016 respectively (GHS 2015 & 2016). The General Household Survey also revealed that teenage pregnancy is rife among those girls between the ages of 18 and 19.

The prevalence of HIV is high among young people in the school-going age group. In South Africa young women constitute a high percentage of those infected compared to their male counterparts. An increase in HIV infections and unintended pregnancies increase human suffering and have financial implications for individuals, family members and government.

In addition to that, Gaearwe (2014) acknowledged that university students as a population of young adults are at higher risk of sexually transmitted infections including HIV, and unwanted pregnancies; this could lead to school dropout and them becoming potential victims of poverty and the health risk of engaging in unsafe abortion.

According to Dawad (2003), with regard to women, a major obstacle in HIV prevention is their limited capacity to exercise control over decisions about condom use, and they have limited power in decisions regarding sex. Hence they are unable to use or push for safer sexual practices. Condoms are available for free in South African public hospitals and clinics but unfortunately female condoms have not been well embraced in South Africa.

1.3 Objectives

1.3.1 Main objective

The main objective of the study is to determine the knowledge, use and availability of female condoms among students.

1.3.2 Specific objectives

- 1) To find out the availability of female condom in campus student residence, the campus clinic, other distribution areas in campus and nearest pharmacies.
- 2) To examine the role of male participation in the usage of female condom.
- 3) To determine whether there are any awareness campaigns/programmes available regarding the female condom in campus.
- 4) To examine the challenges faced by university students in the uptake of the female condom.

1.4 Rationale

Although some studies have been done on the female condoms and its challenges in South Africa, the studies have been limited to the adult population. But none have focused specifically on young women particularly in North West University.

The study will help to assess the magnitude of the need for contraceptive and family planning services for young women in North West University and their difficulty in accessing services. The outcome of the study will enable one to identify services needed for young people with respect to family planning services. The study will provide information on the level of awareness; utilization and difficulty young people may be having in accessing reproductive health services.

It will help to assess the quality of information young people have on contraceptives, which often shapes their attitude toward their use. The study will help to identify the needs of young people regarding their sexual health. The result of the study could also assist the Ministry of Education in developing an appropriate reproductive health education curriculum for schools, and the Ministry of Health on how to structure policies and strategies on health programmes for young people.

This study aligns itself with the National Development Plan of South Africa in terms of its targets. One of the NDP's target is to increase life expectancy to 70 years, and one of the proposed strategies to achieve that target is to promote consistent use of condoms, thus reducing new HIV infections in young women between the ages of 15 and 24. Encouraging women to use female condoms, will increase their life expectancy because they will be protected from contracting HIV/AIDS, STI and from unwanted pregnancy. Early pregnancy may lead to maternal death hence unwanted pregnancy poses a threat to the life of a women (Levandowski *et al*, 2012: 169). The study also aims at reducing the rate of university dropouts and illegal abortion by students who are experiencing unwanted pregnancies.

1.5 Outline of the study

The study is divided into five chapters. Chapter one introduces the study on hand, the introduction of the study gives an overview of what the study entails. Chapter one consists of the background regarding the topic at hand. The problem statement, main objectives and rationale of the study are also included in chapter one. Chapter 2 consists of a literature review whereby articles and journals related to the study are reviewed, then followed by chapter 3 which consists of methodology. This is followed by results in chapter 4 where analyses will be done in order for the researcher to achieve study objectives; this is where the researcher tries to make sense of the information obtained from participants. Conclusions are made in chapter 5 including recommendations, followed by a summary.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter will highlight issues concerning the female condom use, its characteristics, and cost effectiveness, attitudes towards the condom including perceptions by prospective users, attitude of promoters and other elements that may be useful in explaining and understanding the dynamics of the use of the female condom.

2.2 Prevalence of HIV/AIDS

In sub-Saharan Africa, more women are infected by HIV/AIDS as opposed to men and the average rate of infection for teenage girls in some countries is five times higher than for teenage boys (Ramasundaram, 2002: 183). Hoffman (2004), commented in the context of sub-Saharan Africa that nearly 60% of the newly infected are women and that women represent half of the 40 million people previously living with HIV or AIDS a decade ago. Hoffman also argued that the majority of women with HIV are married or are in established partnerships and they are likely to have been contracted with the virus from their primary male partners. Ramasundaram (2002), further stated that these infections occur through unprotected sexual interactions because of women's low economic and social status and because of the power that men have over women's sexuality.

Adding to the above argument, Mantell *et al* (2000), also noted that women and young women in particular feature more strongly in this decade of the HIV pandemic and that their increased vulnerability to HIV transmission is influenced by a number of social, biological, political and economic factors.

According to the paper by Beksinska *et al* (2000), more than a decade ago, South Africa was experiencing one of the fastest growing HIV epidemics in the world with antenatal rates of infection rising from 26% in 1997 to 32% in 1998. This was evident in the worst affected province, namely KwaZulu-Natal.

2.3 Teenage pregnancy in South Africa

According to the SADHS report (2016) adolescent pregnancy is a problem affecting both THE health of individuals and society as a whole. The argument is that children born to very young mothers are at increased risk of sickness and death, also teenage mothers are more constrained in their ability to pursue educational opportunities than young women who delay childbearing.

The report show that 16% of women aged 15-19 in South Africa have begun childbearing, 12% have given birth and another 3 % were pregnant with their first child at the time of interview. Furthermore the report shows that teenage pregnancy is higher in North West, Northern Cape and KwaZulu-Natal provinces.

2.4 Socio-economic background of women particularly in South Africa

Most of the world's women are poor and most of the world's poor are women, They make up almost two thirds of the world's illiterate people and are often denied property rights or access to credit; they earn 30-40% less than men for the same work and most of those who are working are employed outside the formal sector in jobs characterised by income insecurity and poor working conditions (Ramasundaram, 2002: 183).

Ramasundaram explained further that the most extreme manifestation of the unequal power balance between women and men is violence against women; between 10 to over 50% of women reported physical assault by an intimate partner and one third to one half of physically abused women also reported sexual coercion.

2.5 About female condom

2.5.1 The introduction of female condom in South Africa

The female condom was introduced in South Africa in 1998. The female condom programme has grown rapidly from a pilot phase to a national programme that is one of the largest government-funded programmes worldwide (Beksinska, *et al*, 2017:147).

2.5.2 Female condom sponsors in South Africa

According to Beksinska, et al (2017) the national programme has various sources of funding. They state that at national level, the programme is funded primarily by national government International funders include the US President's Emergency plan for AIDS relief (PEPFAR) and the United Agency for International Development (Match Research Unit). At provincial level, he stated that the programme is funded through a conditional grant, and NGO'S also receive international funding.

2.5.3. V-Condom

The V-Condom in South Africa is the PATH developed female condom product that was tested, marketed and distributed during the course of the Protection Options for Women Product Development Partnership (POW PDP'S) work in South Africa.

The manufacturing of the V-condom came after the realisation that the already available female condoms that are distributed for free by the South African government (FC1 & FC2) are not well utilized by women, hence POW PDP shifted the market by targeting the middle class and well-educated population including university students. PATH conducted a market research in 2012 in urban areas including Bloemfontein, Durban and Johannesburg. Results from the market research shaped the development of V condom-the South African brand for the V-Condom.

The V-Condom consists of a thin pouch, ring and dissolving capsule that encloses four foam shapes. All parts of the V-Condoms are made of medical-grade material that is safe and has been used in medical products for years. The product is for one-time use only. The V-Condom comes with a small sachet of water-based lubricant to be applied at point of use; this lets women and couples use the amount of lubricant that is right for them (PATH, 2011: 7).

2.5.4 Condom manufacture company in South Africa

Condoms are manufactured by company named RRT Medcon. According to PATH 2011 the company has a long history with male condom manufacturing and they are the only male condom manufacturer in Sub-Saharan Africa. They have sold male condoms to the South African national Department of Health as well as to non-governmental organisations and commercial outlets since 1993. In addition to that, the POW PDP chose RRT Medcon Company as its commercial partner to manufacture V condoms. RRT Medcon achieved South African Bureau of Standards (SABS) certification for the V-Condom

2.5.5. Characteristics of a female condom

According to Stein (1990) the sole physical barrier available for the prevention of sexual transmission of human immunodeficiency virus (HIV) infection from men to women is the condom, and cooperation of men in male condom use is very low. Therefore, it has been suggested that the female condom could provide greater protection against sexually transmitted infections than the male condom for the following reasons: the strength of the material, the outer ring partially covers the labia, and the device can be inserted before sexual activity takes place (Beksinska *et al*, 2000: 67).

Four features of female condom were noted from Mantell et al (2000) namely: 1) more protected sexual acts, 2) increased control and power for women, 3) an expanded range of contraceptive choice, 4) it acts as a catalyst for facilitating sexual communication and negotiations with partners. These features that were mentioned by Mantell serve as advantages of female condoms for women. For example, in reference to feature number 2 above; women are in a poor position to negotiate the terms of sexual relations hence a condom that does not require the active participation of a male partner could be of particular value in reducing the incidence of unprotected intercourse (Marseille, 2001:134).

However, the importance of a female condom is that due to a concurrent STI epidemic and upsurge in rapes that enhance the risk of HIV transmission among women in South Africa, it allows women to take control in sexual terms.

2.5.6 Effectiveness of the female condom

The female condom as the first female controlled barrier method for STD control has been demonstrated to be practical, safe and acceptable. Marseille (2001) made reference to the studies using polyurethane in artificial coital models which indicated no leakage of HIV and cytomegalovirus. According to Tarkang & Bain (2014), the female condom is estimated to be 94-97% effective in reducing the risk of HIV transmission if used correctly and consistently. Comparison was made between male and female condom by Marseille (2001), who noted that the effectiveness of the male condom in reducing HIV transmission per episode of intercourse has been estimated at 95% whereas the effectiveness of the female condom in preventing STD/HIV transmission has been estimated at 94-97% per episode of intercourse.

2.5.7 Cost effectiveness of the female condom

Although the female condom was marketed worldwide, distribution of this condom has been hampered by a unit price that is much higher than a male condom (Joanisa et al, 2010: 1). According to Marseille (2001), a female condom can be expensive even after price reduction which may accompany future increases in unit price. However, according to Joanisa et al, (2010) manufacturers have recently developed new female condom design features that may make them more acceptable.



2.5.8 Knowledge about the female condom

The study conducted by Beksinska, *et al.* (2017) revealed that nearly 90% of men and women interviewed had heard of the female condom and approximately 20% had used it. Despite the fact that most of the participants knew about female condoms, only a few were aware of the availability of female condoms in their health care facilities.

It is evident that knowledge about the female condom among women is sufficient. This statement is also supported by Ogunlela, (2014), that 91.5% of the respondents participating in his study know about female condoms while 4.3% had no knowledge of the female condom; therefore the majority of women know about female condoms.

According to Ogunlela, (2014) more than 50% of male participants strongly agreed that the female condom offers better protection than male condoms and 36.6% of female participants also strongly agreed that female condoms offer better protection than male condoms.

2.5.9 Sources of knowledge

when asked how they have heard about female condoms, 45.6% of the respondents cited friends, 36.2% the clinics, 1.1% billboards and 7.4% the media (Ogunlela, 2014: 93). The conclusion made by Ogunlela, (2014) indicated that the public sector is a secondary source of information about female condoms as most respondents obtained their information through friends.

Indeed information about the female condom is less from clinics and public institutions as a whole and this could be as a result of lack of posters, leaflets and demonstration models for the female condom. Those results about lower availability of the above mentioned promotion tools were found in the study conducted by the Match Research Unit (2017) when evaluating the South African national female condom programme in the year 2017.

Results from Chawatama's, (2014) study "The utilization and acceptability of the female condom among female sex workers: A study in Zeerust, revealed that female condoms were not readily and conveniently available in Zeerust.

2.6 Availability of female condom

According to Beksinska, M et al. (2017) male condom availability was much higher than female condom availability at all site distribution points where the research was conducted, particularly in areas outside of consultation rooms such as waiting rooms. However, students participated in the study of “Women, HIV AND AIDS: Perceptions of the female condom among students on UKZN Howard college campus” by Ogunlela (2014), revealed that female condoms are not easily accessible, this could be as a result of lack of availability of female condoms on campus.

2.6.1 Acceptability of female condom

Female condoms are mostly accepted by female sex workers as compared to the general female population. This was revealed by Chawatama, (2014), whereby female sex workers generally accept the device more quickly than other women.

2.6.2 Recommend use to someone

According to the findings generated from the study conducted by PATH 2011 as part of identifying a market for the V-Condom as a new female condom manufactured after fc₂, female students who used a V condom said that they would recommend someone to use it.

2.6.3 Willingness to pay

The main objective of the PATH study conducted in 2011 was to identify new markets for V condoms and they are targeting the middle and upper income population. The reason for those target market population is that they are intending to commercialise the female condom hence students were one of the target market population. When students asked how much they are willing to pay for the V condom, they suggested that they would be willing to pay between R8 to R20 but most settled around R15. They also suggested that the V condom be sold in prominent spaces in pharmacies and grocery stores.

2.6.4 Easy to use

The PATH study revealed that most of the women who used the V condom did not report much difficulty and felt comfortable after a few uses. In contrast, the other female condoms were not easy to use. It was revealed in the study of Chawatama (2014) that 57.2% of participants argued that female condoms are not easy to use.

2.7 Possible reasons for women not using female condoms

2.7.1 Mixed reactions about female condom

According to Ramasundaram (2002) rural women from South Africa and urban women from India reported not liking the female condom because they feared that if the condom fell inside the vagina it could get lost and perhaps travel to the throat or another part of the body.

Mantell *et al* (2001) mentioned that provider's acceptance and approval may be a key factor in the client's uptake and continued use of a method. This is evident as data collected from preparatory interviews in South Africa revealed that providers did not conduct sexual risk assessment or talk about sex with clients, although they knew the benefits of the female condom.

Beksinska *et al* (2000) also highlighted possible reasons for the lack of female condom use. He argued that women's partners were not willing to try the method and that when women show it to their partners they refuse to use it and there was no discussion; this shows that men have power over women in sexual negotiations terms. This was also emphasised by Hoffman *et al* (2004) that the nature of women's intimate relationships often rendered it difficult for them to request, much less insist on the male condom.

According to the instructions written outside the female condom packaging, women should hold the outer ring and guide the penis into the vagina, some women reported that they were not doing this (Beksinska *et al*, 2000: 677). However this shows lack of provider's efforts to teach clients on how to use the female condom. Peters *et al* (2014) also noticed the difficulties of inserting the female condom. He said that when women used the female condom for the first time, they often experience insertion difficulties and commented negatively about the amount of time it took them to insert it; also women were afraid that it might slip inside the vagina when using it for the first time.

The appearance of the female condom was a trigger to reject the device. Some women commented that the outer ring looked too big, sending negative impression to their sexual partners about the size of their vaginas, others were of the opinion that the inner ring looked painful and feared it would not fit into the vagina (Peters *et al*, 2014:40). The argument was also supported by Chawatama (2014) that most women indicated that the female condom does not look attractive and the sight puts them off.

It has been documented that many people thought that condoms decrease the enjoyment of sex; this view was more popular among female than males. Participants pointed out strongly that condom use was synonymous with mistrust (Dawad, 2003:25). In the study conducted by Dawad, the following arguments were outlined as influencing factors leading to the lack of condom use: the perception among male students that getting an STI is inevitable, hence this discouraged them for taking precautions in this regard; condoms were associated with immoral sexual behaviour hence individuals are likely to find it difficult to discuss the use of condoms with their partners and subsequently may be embarrassed to obtain them; the misperception that condoms are dangerous and may cause infertility by remaining in the body of the women (Dawad, 2003:25).

According to Ogunlela (2014), female condom is underutilised for a number of reasons beyond costs including availability, reduced sexual pleasure, gender inequality and culture.

2.7.2 Ineffective distribution channels

It has been revealed that most of the institutions responsible for distributing female condoms were no longer functioning. This statement was supported by Beksinska, et al (2017) that some of the sites where he conducted his study revealed that some of those sites were no longer functioning, and an additional nine of them opted not to participate in the distribution of female condoms. He further stated that NGO's distributing female condoms, such as tertiary institutions, social markets outlets and private sectors were not available. He noted that some of the reasons why female condoms are not effectively distributed are among others: 1) depleted female condom supply. 2) Late ordering. 3) No demand for female condom so staff did not order. 4) Rumours that female condoms were not used for what they were intended for so staff did not re-order.

2.7.3 Negative perception of providers towards female condoms

The results revealed that 38% of providers thought female condom were not appealing, 28% thought they were inconvenient and 42% thought they were messy (Beksinska, *et al.* 2017: 151). This negative attitude of providers towards female condoms influence promotion because they won't put a good word about female condoms to prospective users. Even though providers have received training in regard to female condom counselling and demonstration, most of them don't talk to women about female condoms. As said by Beksinska, *et al.* (2017), 65.5% of providers had been trained in female condom counselling and demonstration. He further stated that 66.7% of them had never counselled or given female condoms to men.

Mantell et al (2001) argue that some providers were aware that they could influence their clients concerning the female condom. However this depends on having a favourable attitude about the method and presenting a balanced view of its advantages and disadvantages that would be an important tool to use to achieve effective promotion.

In regard to the above argument, it is not always the case. Mantell et al (2001) mentioned that the master trainer's observations of the TOT workshop in South Africa indicated that providers had a high level of discomfort with discussion of sex. Unease in talking about sex could impede successful female condom introduction which requires providers to teach clients how to negotiate with sexual partners and to ask them about sexual partners and practices.

Also providers who had practiced insertion of female condom as part of the TOT experience expressed concern about its physical appearance and its effects on sexual pleasure; this negative perception about female condom may affect their role in promoting it (Mantell et al, 2001: 665).

2.8 Socioeconomic factors influencing the use of female condom

According to the NDoH (2012), women's socioeconomic status and residence in rural versus urban areas, women living in poor socioeconomic conditions and women in rural areas still tend to have less knowledge of contraception and less access to contraceptive services and these factors are associated with lower contraceptive use.

2.8.1 Culture

Dawad (2003), argued that in terms of socio-cultural factors, subordinate women may not adopt safer sexual behaviour since they feel/believe that such behaviour is beyond their control. There are partner, family and community expectations around fertility. This includes, for example, pressure on teenagers and young women to prove their love through demonstrating their fertility by childbearing, negotiations concerning condom and contraceptive use between partners, societal and familial expectations for women to have children (NDoH, 2012:15).

As noted also by Gaezarwe, L.M (2014), the reason behind the lower usage of condoms by females is as a result of culturally sexual behavioural norms reflecting gender inequality that only allows men to decide when, where and how to have sex and in particular, when or with whom to use condoms. Also Chawatama (2014), noted that initiating the use of female condom by women is against culture. He further explained that it is culturally shameful for a women to be seen purchasing condoms.

2.8.2 Religion

According to Tarkang & Bain (2014), religion influences the use of condoms in a way that women would feel guilty to use a female condom due to their religious beliefs. Another factor is the distance between the place of residence and the supply point of the female condoms; they argue that the supply point is too far away.

2.8.3 Gender inequality

According to Hoffman (2004), gender inequalities have not abated and, together with inequalities based on race, caste and class, they continue to fuel the spread of HIV/AIDS. Evidence has suggested that for men to have multiple partners is tolerated even though it is not acceptable (Dawad, 2003:28). Dawad also argues that infidelity is seen as being very sinful and women are highly penalised; sexual conduct is embedded in culture and social relations, and women find these beyond their control.

2.8.4 Education

According to Mativo (2010), the female condom users had higher levels of education and have access to household resources as compared to uneducated women. It could be that educated women have more easy access to female condoms due to affordability and also they have knowledge about the benefits of the female condom as a contraceptive method.

The NDoH also acknowledges that education has a strong impact on contraceptive use among women. Improving women's level of education is linked to contraceptive use; this statement is supported by the typical example that the current contraceptive prevalence among sexually active women with post-high-school qualifications is twice as high (75%) than among women with no education (38%).

2.8.5 Poverty

According to the NDoH (2011), poverty can be responsible for a lack of privacy for exploring and enjoying sexual relationships. It can mean that people lack money for transport to health services and that they are unable to take time away from work or childcare to access health services. The department also noted that poverty often motivates people to have sexual relationships in exchange for resources for themselves or their families; using their sexuality in this way increasing their chances of contracting STD,s or unwanted pregnancies.

2.9 Conceptual framework

The Health Belief Model adapted from Dawad (2003) states that it is a psychological model that attempts to explain health-related behaviour focusing on the attitudes and beliefs of individuals, and also tries to explain and predict health behaviour.

Perceived Susceptibility and Severity

This is one's subjective perception of the risk of contracting a health condition and also the concern of the seriousness of contracting an illness or of leaving it untreated. For example, previous studies have revealed that more women are infected by HIV/AIDS as opposed to men and the average rate of infection for teenage girls in some countries is five times higher than for teenage boys. In relation to the perceived susceptibility and severity, one of the respondent is aware that lack of female condom use may result in unwanted pregnancies and contracting HIV/AIDS. Therefore if more women and young girls are aware of the risk of not using female condom as their only protection this may encourage them to use and ultimately reduce the risk of contracting sexual diseases such as HIV/AIDS.

Perceived Benefits

This is the belief in the effectiveness of strategies that are designed to reduce the threat of illness. The study conceptualise that female condom is a strategy that is designed to protect women and young girls from contracting HIV/AIDS and unwanted pregnancies. It is also been noted by Tarkang & Bain (2014), that the female condom is estimated to be 94-97% effective in reducing the risk of HIV transmission if used correctly and consistently. However, the study revealed that most women know about the strategy designed (female condom) to protect them from sexually transmitted diseases but they haven't seen it with their naked eyes. In that note, it is believed that if women embraces the idea of a female condom being a strategy designed specifically to protect them from sexual diseases and ultimately empowering women; that will encourage them to use female condoms.

Perceived Barriers

This is the potential negative consequence that may result from taking particular health actions. This can include physical, psychological, and financial demands. According to the study, the physical barrier to utilise the female condom is lack of condom availability from the collection points. Only one student said that she only saw female condom once in campus residence (phase 5) collection point and the rest have stated that they haven't seen any female condom available in any of the campus residence, they even noted that the only condoms available are male condoms in the collection point. Even if students desire to try using female condom during sexual intercourse, they won't be able to do that hence there are no female condoms available in campus.

The study has revealed that female condom program or awareness in campus is not available, this may be a psychological barrier to not using female condom because female students are not psychologically influenced to use. It is believed that if female condoms are readily available and accessible in campus collection points, women will change their behaviour of not using the condom. In addition to that, when women are encouraged to use female condoms through the awareness and programs, this will change the negative perception of women towards the usage of female condom.

Cues to Action

This includes environmental (e.g. media publicity) or bodily (e.g. physical symptoms of a health condition) action that motivate people to take action. However, this has not been studied extensively. According to the study, female condom is not widely being publicised to potential targets through media. When respondents asked about the source of knowledge about female condom, they noted that they have firstly known about the female condom from their place of origin (from the street), community clinics, and workshops and also from their respective schools under their curriculum. Therefore the channels that the students used to get knowledge about female condoms are not sufficient enough to promote them, media such as television, radio and newspaper are more effective because they reach a large number of audiences. For example, one of the respondents in the study stated that female condoms are very scarce and they are not well known hence she won't be able to get hold of it even if she want to use it because they are not advertised like male condoms. The impact of media such as television may change the behaviour of women towards female condom usage because television is one of the most media used to get information by citizens of the country especially the youth.

NWU
LIBRARY

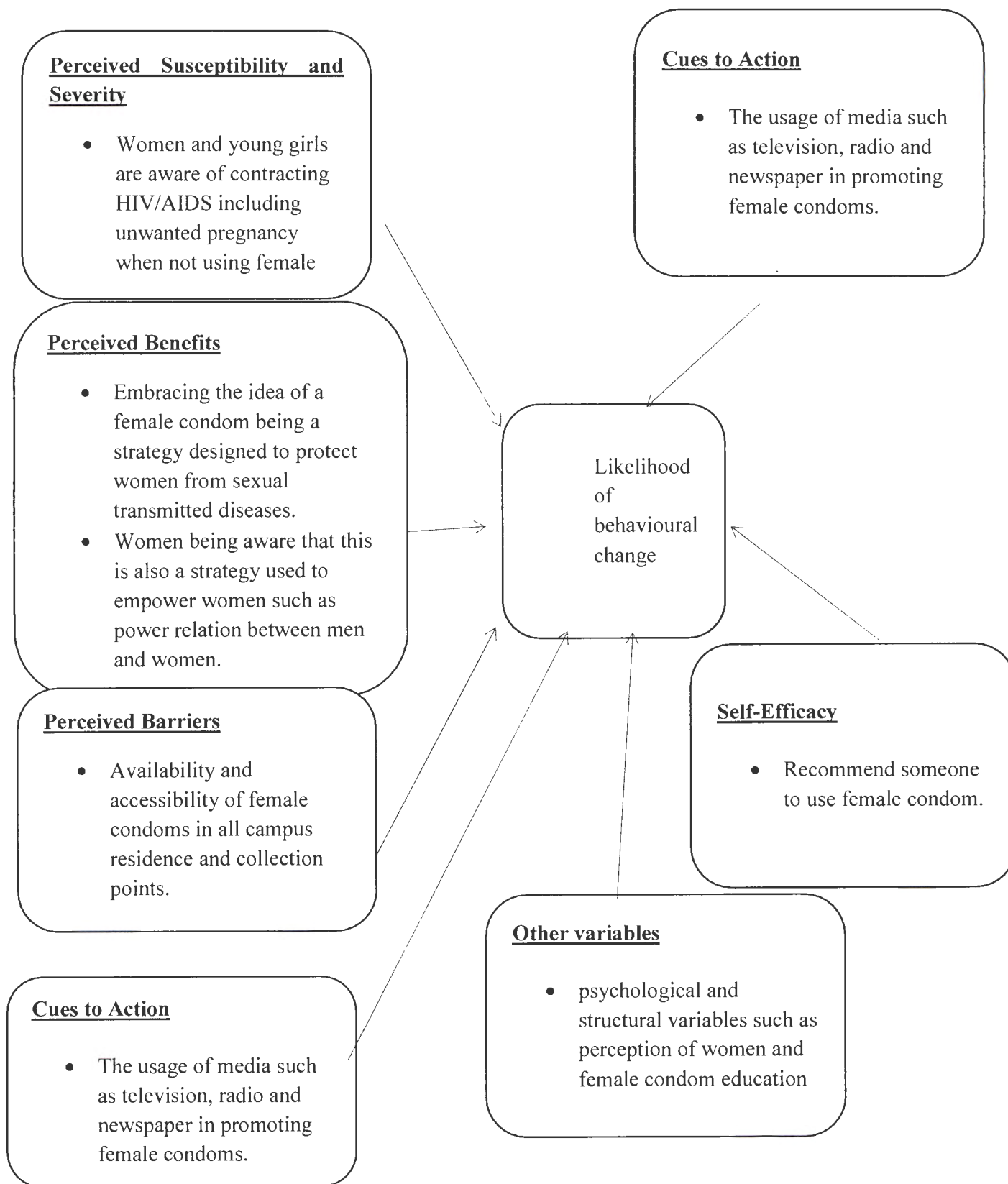
Other variables

These include demographic, psychosocial and structural variables that are responsible for an individual's perceptions and in so doing influence health-related behaviour. This variable is in conjunction with the perception of women not using female condom. According to literature reviewed in the study, women have mixed reaction in regard to the reasons why they are not using, they have noted among other things that they feared the condom may fall inside the vagina, women's partners were not willing to try the method, women not following instructions properly and the physical appearance of the condom that is not appealing. Other variables noted in this study that may be a barrier to utilising female condom include among others, Pride towards female condom, Lack of education, Limitation of female condom when exploring more sexual pleasure and the duration of a female condom's preparation during sexual intercourse. Therefore if structural elements such as education about how to use a female condom will encourage those women to use, especially those who tried using the condom in a first attempt failed because of proper usage. Education will encourage them to retain the usage of female condom.

Self-Efficacy

This is the belief that one is able to successfully carry out the behaviour that is required in order to obtain the desired outcomes. In this study, most of the respondents said that they can recommend to someone but they themselves cannot use female condom because of the reasons discussed in the study (chapter 4).

Figure 3: Conceptual Framework



CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter explains how the project is designed in terms of data collection, and instruments that will be used to collect and analyse the data.

3.1.1 Geographical setting of the study

The study was conducted at Mafikeng Campus of North-West University. North-West University is one of 33 institutions of higher learning in South Africa. The university emerged from a merger of the three universities, which are the Mafikeng campus, Potchefstroom campus and Vaal campus.

The campus consists of five faculties, which are: Humanities, Commerce and Administration, Education, Agriculture, Science and Technology and Law. Mafikeng campus has also 10 residences of which two are mixed and the rest are allocated according to gender (male and female residence). The two mixed residences are phase 5 and the postgraduate residences. James Moroka, Hopeville and Khayelitsha are male students' residences whereas Phase 4, Sedibeng and Modiri are only for female students; Lost City and Dr Nelson Mandela students' residences are divided into two (male and female).

3.1.2 Research Design

This study employed a qualitative approach in which first hand data was collected by the researcher in order to understand the behaviour of the target population in relation to the research question at hand.

3.1.3 Population and Sampling

According to the Management Information Report (2017), the number of students enrolled at Mafikeng campus in the year 2017 is 12,043. Females are more than males with a total number of 7,098 and males with a total number of 5,350. However the Management Information Report of the NWU shows that the number of students enrolled has been increasing from 2011 to 2017. The following table shows the student enrolment trends from 2011-2017:

Table 6: Number of students enrolled per gender

Year	2011	2012	2013	2014	2015	2016	2017
Male	3631	4048	4349	4474	4551	4978	5350
Female	5580	6209	6365	6551	6251	6644	7098
Total	9211	10257	10714	11025	10802	11622	12448

Respondents were purposively selected in different levels of study in accordance with their faculties. There is no consensus among researchers on the appropriate sample size for qualitative research yet to be reached by researchers. Different researchers have specified that there is a point of diminishing return to a qualitative sample—as the study goes on more data does not necessarily lead to more information (data saturation). Therefore for this study three FGDs, and ten key informant interviews that were conducted.

3.1.4 Focus Group Discussions

Three FDGs were conducted as follows: 2 were Human and Social Sciences students comprising first, second and third year students. The third FDG was a mixture of Commerce, Law, Education and FAST, both males and females. Each focus group comprised 10-12 participants. A uniform FGD guide was developed and used in data collection (Appendix One).

3.1.5 Key informants

Two health workers and six wardens were interviewed as key informants. One of the health workers from the university clinic is the “Health Programme Coordinator” and the other one is from the nearest pharmacy (Molemo Pharmacy). Key informants were asked questions on availability of female condom, male participation and challenges faced by prospective users.

3.1.6 Data Collection

Primary data was collected in this study. According to Kothari (1990), primary data is those which is collected afresh and for the first time, and thus happens to be original in character. The data for this study was gathered by means of in-depth interview and focus group discussion guides (See Appendix one). These guides were used to collect data on pertinent issues related to knowledge, use and availability of female condoms, attitudes towards female condoms

The in-depth interviews were conducted by the principal investigator alone whereas the FDGs were carried out using a structured guide with a help of a postgraduate student who has undergone training in research methodologies. The student was further sensitised to the aims of the study and was largely used as a note taker during the discussions. In-depth interviews were unstructured interviews carried out using an interview guide with discussion topics. Each focus group discussion and in-depth interview did not last more than one and half hours.

3.1.7 Data Analysis

Mahesh (2011) state that data which has been collected is analysed and a report is written out of the information gathered which embodies the survey findings. After the researcher collected data, transcripts were formulated and themes were described and used to categorize issues pertaining to the uptake of female condoms in the following manner:

- Knowledge of female condoms.
- Availability of female condoms on campus.
- The role of male participation in the usage of female condom.
- Challenges faced by university students in the uptake of female condoms.
- Availability of female condom programmes/awareness.

3.1.8 ATLAS TI

ATLAS TI software was used to analyze data, according to ATLAS TI user guide and reference (2013). It is a powerful workbench for the qualitative analyses of large bodies of textual, graphical, audio and video data; it offers a variety of tools for accomplishing a the task associated with any systematic approach to unstructured data, i.e. data that cannot be meaningfully analyzed by formal, statistical approaches.

3.2 Limitations of the study

Data collection was done during the first semester examination hence students were hard to get as they were very scattered. Therefore the researcher had to collect data to the small portion of students that were available at that time because most of them were in recess. The easily accessed group of students were from HSS, but one FDG was conducted inclusive of all other students from different faculties after recess.

The researcher couldn't get the recent HIV/AIDS statistics as required from the source. The researcher's source was unable to give recent statistics due to internal procedures in his office. The only HIV/AIDS data is from 1990 to 2012.

3.3 Ethical Issues

The study complied with the ethical standards and regulations for this kind of research. Permission was obtained to conduct this study from the university's ethics committee (See Appendix x, Letter of Ethical Approval).

Participation was voluntary and written informed consent was obtained from each participant. To ensure anonymity and confidentiality, respondents were asked not to mention or write their names anywhere, to protect their identity. After informing the participants the objectives of the study, each participant was given an informed consent form and was asked to read it and then to sign and provide their student numbers.

Confidentiality and anonymity was guaranteed to every participant. There were no direct benefits and there were no risks involved in participating in this research study and this was explained in the information sheet. There was no compensation offered to participants.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter presents the results of the findings of the study. The chapter is organized in such a way as to answer the research questions. The results of the study are aligned to the study objectives and will be presented in this chapter in a form of themes. The chapter is subdivided into four sections: Section 4.2 gives characteristics of the study population; Section 4.3 presents the knowledge and attitudes of students towards female condoms whereas Section 4.4 presents the views of key informants on female condoms. Lastly, section 4.5 presents brief summary.

4.1.1 Table 7: Characteristics of the study population

	STUDENTS	KEY INFORMANTS
TOTAL NUMBER INTERVIEWED	28	2
AGE OF RESPONDENTS	18-28	30-45
LEVEL OF STUDY/JOB TITLE	Undergraduate	• Pharmacist • University programme coordinator
EDUCATIONAL QUALIFICATIONS	Matric certificate	• Diploma in pharmacy • Master's Degree in Geography Philosophy

The study data was gathered from 28 students who participated in FGDs, and two key informants. The age of the participants ranged from 18-28 years and all of them were undergraduate students from different faculties.

The key informants were aged 30-45. The pharmacist has a diploma in pharmacy and the university programme coordinator has two masters, one in Geography and one in Philosophy on HIV and AIDS.

4.2 Student's perspective

4.2.1 Knowledge of female condoms

According to the respondents, most of them had heard of the female condoms although they hadn't seen one in a physical form. One female respondent however said that she did not have any clue regarding the female condom and that one of the reasons she agreed to participate in the study was hopefully to gain knowledge of the female condom.

"Yes we do know about them"

(FDG #1: As a group)

"Yes we know female condom (s)"

(FDG #2: As a group)

Although most students have heard about female condoms. There are still some who had not seen them.

"We know about them but we haven't seen them"

(FDG #3: As a group)

4.2.2 Knowledge and place of residence

All of the respondents who said they knew about female condom have known about it from their homes; their knowledge was not gained from the campus. Most of them have known about them from their community clinics during their visits; some reported that they had known about female condom (s) from the streets, at workshops and also from their respective schools when they were taught about "life orientation".

"I saw them twice, at the streets and also from school during life orientation class"

(FDG #1: Male respondent)

"At my previous school, there were people from the health department who came and talked to us about the female condom and demonstrated on how to use it"

(FDG #2: Female respondent)



“At high school, they were teaching us about it, it was a life orientation subject and they separated us from boys and they taught us about female condom”

(FDG #3: Female respondent)

4.2.3 Student’s knowledge about the advantages of using female condom

Students were also tested about their knowledge regarding female condoms by asking them about the advantages of using them. It shows that most of them know about the advantages of using hence they explained that using a female condom promotes women empowerment as women are able to make their own choices and decisions; some said that female condom does not break during sexual intercourse, it reduces unwanted pregnancies and promotes family planning.

“It’s all about women empowerment”

(FDG #1: Male respondent)

“Prevention of unwanted pregnancies, STI, and HIV”

(FDG #2: Female respondent)

“I think I can feel it when it bust”

(FDG #3: Male respondent)

4.2.4 Student’s knowledge about the disadvantages of not using female condom

When asked about knowledge in terms of disadvantages of female condom (s), they reported that prior to using a female condom, a lot of work is needed in terms of preparations. Some said it looks uncomfortable and probably painful. One male student said that it will hinder him from doing a foreplay. One respondent mentioned the issue of publicity, saying that female condom is not well advertised like the male condom; another respondent noted that the waiting period is long for a person to use it (she was referring to the old female condom where you had to put it in 8 hours before usage).

“It is not comfortable”

(FDG #1: Female respondent)

“It reduces sexual pleasure”

(FDG #1: Male respondent)

“Waiting period, I don’t think is a good idea to wait long to use the condom”

(FDG #2: Female respondent)

“I think it will hinder a couple from doing a foreplay”

(FDG #3: Male respondent)

“That thing has a lot of work to do when trying to use it even the waiting period is too long”

(FDG #3: Male respondent)

4.2.5 First knowledge at campus

One out of all respondents said that he first knew about female condom at the time of his arrival at the university, and the rest of the participants knew about them from outside the university.

“From Letlhabile (Brits) at one of the clinics”

(FDG #1: Female respondent)

“At Lonely Park’s clinic; where I stay”

(FDG #2: Female respondent)

“At high school, they were teaching us about it”

(FDG #3: Female respondent)

4.2.6 Availability of female condoms on campus

Out of all group discussions; only one student said that she saw a female condom at Phase five campus residence and the rest said that they haven’t seen any female condom around campus; most of the participants said that they only see male condoms around campus.

“I saw it at phase 5 dispensary, it looks big outside”

(FDG #2: Male respondent)

“No I haven’t seen it around campus”

(FDG #3: Female respondent)

When asked about first encounter of female condom, all of them excluding one respondent reported that they have known the condom from outside campus.

“At my high school where I was attending, there were workshop about wellness and HIV/AIDS”

(FDG #1: Female respondent)

4.2.7 Availability of female condom programmes/awareness on campus

When asked about the availability of female condom programmes/awareness in campus, most of the participants said that they haven't seen any awareness campaign on campus and one of them reported that there is only a male campaign that she is aware of and that campaign was promoting male condoms.

“I only saw male condoms and female students were also invited to take male Condoms instead of being called to take female condoms”

(FDG #1: Female respondent)

Another participant reported that they only see people who test HIV around campus and that they are not aware of any other awareness such as female condom promotion in campus.

“We haven't seen any awareness at campus, we only see those people who test HIV”

(FDG #3: Female respondent)

4.2.8 The role of male participation in the usage of female condom

The majority of male participants said that they didn't have a problem trying using a female condom if introduced by partners. In fact, one of the male respondent reported that he tried using it with his partner by introducing it during sexual intercourse but his partner refused.

“I tried to introduce it to my partner and she refused.”

(FDG #1: Male respondent)

Although female condom is not being used by participants, men don't have a problem trying to use depending on the female partner's interest.

“I don't have a problem trying it because if it is going to bore me during sexual Intercourse, I will simply take it out and use male condom”

(FDG#2: Male respondent)

“Yes I can try it if introduced by my partner, but not the other way round”

(FDG#3: Male respondent)

However, one male participant has shown a lack of participation in using female condom and he explained that it is because the condom is thick thus reducing sexual pleasure. This statement was supported by one of the female respondent saying that men don't like to use condom during sexual intercourse (including male condoms), then how will they use a female condom if they don't even use male condom? Hence male participation is lacking according to one of the female respondent.

“In my experience I would say no, he is not cooperating because he himself has A problem with a male condom then you can imagine introducing something as Big as a female condom to him”

(FDG #1: Female respondent)

4.2.9 Challenges faced by university students in the uptake of female condom

4.3 The duration of a female condom's preparation

There are various challenges facing students in the use of the female condom; one of them specified that the challenges she faces is the period in which the condom must be prepared before usage; even though she wanted to try it, she will be discouraged by the duration in which one has to wait before engaging in sexual intercourse.

“That thing has a lot of work to do when trying to use it even the waiting period is too long”

(FDG #3: Female respondent)

Another participant reported that:

“It looks like it needs a lot of efforts when trying to use”

(FDG #3: Female respondent)

Another respondent expressed his feelings by saying that female condom wastes time in a sudden sexual intercourse. He was actually saying that a female condom takes time in terms of

preparations and that would waste time when both partners are already in the mood of having sex; whereas a male condom can just be put within five minutes without wasting any time. This statement was supported by another female respondent; saying that a female condom must be put inside a vagina while the body of a woman is relaxed hence they can't wait for the body to relax while they are anxious to have sex.

"It waste time in an sudden sexual intercourse"

(FDG #3: Male respondent)

"I know that you have to put it when you are relaxed, so what if I am not relaxed by that time and we really have to get into action, hence I can't wait to be relaxed"

(FDG #2: Female respondent)

4.3.1 The physical appearance of female condom

Some of them complained about the appearance of the condom, saying that the condom is not appealing and that would discourage them from using.

"The inside sponge and the condom is too big"

(FDG #3: Female respondent)

Another participant reported that:

"It appears to be painful by just looking at the outside ring"

(FDG #3: Female respondent)

4.3.2 Limitation of female condom when exploring more sexual pleasure

One of the male respondent reported that it is a problem when using a female condom during sex when he want to do a foreplay. That would require them to use oral sex and a female condom would hinder them from doing that because it must be put in a women's vagina where the oral sex must take place. That it is also a challenge faced by prospective users when trying to use.

"I think it will hinder a couple from doing a foreplay"

(FDG #3: Male respondent)

4.3.3 Lack of female condom publicity

One of the respondent quoted that female condoms are very scarce and they are not well known hence she won't be able to get hold of it even if she want to use it because they are not advertised like male condoms.

"They are very scarce and they are not advertised than male condoms"

(FDG #2: Female respondent)

"I don't think that many people know that there is a female condom out there"

(FDG #1: Female respondent)

4.3.4 Lack of education

Despite lack of publicity, one of the respondents reported that lack of education regarding the instructions on how to use female condom also hinders using the condom. The respondent reported that she has noticed that at the clinics she visited they only put female condoms there but they don't explain to prospective users on how to use it and the advantages thereof.

"I think lack of education, I have noticed that in most of the clinics that I have visited; they only put a female condom there and they don't explain or promote it. I think they should do the same thing when they were promoting a male condom when it was first introduced, I don't think that many people know that there is a female condom out there"

(FDG #1: Female respondent)



4.3.5 Pride towards female condom

Some of the respondents acknowledged that they are ashamed to carry female condoms with them because they give out the wrong messages to people as if they are looking for sex when carrying them. Also one of them said that she and other female students don't like using free condoms and that since female condom is not available in other brands; she has no option but to use a male condom that is available with a variety of brands she can choose from.

"We are ashamed of carrying female condoms with us because we have this perception that when we are carrying a female condom then it means that we are asking for sex"

(FDG 1: Female respondent)

“Girls don’t want to use free condoms, they would tell you that they want specific brands and not choice for example and also there is a flavoured preference and also considering allergic persons”

(FDG 1: Male respondent)

“I think lack of education, I have noticed that in most of the clinics that I have visited; they only put a female condom there and they don’t explain or promote it. I think they should do the same thing when they were promoting a male condom when it was first introduced, I don’t think that many people know that there is a female condom out there”

(FDG 1: Female respondent)

4.3.6 Encourage someone to use

When asked whether they can encourage someone to use female condom, some said that they can recommend it to someone and some said no. One of the male participants said that he can recommend it to someone, his recommendations were directed to those girls who abuse alcohol and end up not knowing what happened the previous day. His argument was that those girls who get drunk can put female condom before going out partying so that if anything happens to them they will be sexually protected by female condom.

“I think I can recommend it to someone but for me I don’t know because I haven’t used it before but I am convinced that it is safer than male condom hence I can recommend it to someone”

(FDG #1: Female respondent)

“Yes I can recommend it to someone especially those girls who drink a lot of alcohol and end up not knowing what happened the previous night”

(FDG #3: Male respondent)

“I can’t recommend it to someone because I am not using it”

(FDG #2: Female respondent)

Another participant said that she can recommend it to someone and her recommendations were directed to prostitutes. Her argument is that most of the clients don't bring condoms along with them so it's better for a prostitute to have her own already being put in so that she can be safe during sex.

“I think it should be provided to prostitutes because most of the clients don't bring condoms along with them so it's better if the prostitutes put it already so that she can be protected from sexual diseases”

(FDG #3: Female respondent)

4.4 Key Informant's perspective

4.4.1 Availability of female condoms in campus and the nearest pharmacy

All of the wardens interviewed reported that they don't have female condoms in their residences under their supervision. They further reported that they only receive male condoms. Our observations confirmed warden's statements that there are no female condoms; we have observed all condom containers in all residence and indeed there were only male condoms inside the containers at that time.

This was also confirmed by the North West University's Health Coordinator/HIV Programme Promoter as the person who is responsible for the distribution of condoms in campus (both male and female condoms), that there are no female condoms available in all campus dispensaries. He reported that they are not distributing female condoms and that they are only distributing male condoms; they only distribute female condoms during the annual event at the University related to health programmes/awareness issues.

“To tell the truth, we are just giving them out during the event, we have only male Containers in all campus including residences but we don't have female condom Containers, we issue female condoms during events such as the STI awareness”

(IG #1: NWU Programme Coordinator)

Findings of the study also confirmed that female condoms are not available in the nearest pharmacies (Maponya Mall and Unit 7). The health practitioner from the nearest pharmacy reported that they are not selling female condoms and he never saw them for the past three years of service in the pharmacy, he also reported that they only sell male condoms. When he was asked whether the pharmacy sold female condoms before, he replied by saying:

“Honestly I have never seen female condoms since I came here in the pharmacy”

(IG #2: Health practitioner)

When asked why he is not selling female condoms, he replied by saying they are not selling because female condoms are not being demanded by their customers hence they are not selling.

“In our business perspective we can’t sell something that is not being demanded”

(IG #2: Health practitioner)

4.5 Challenges faced by university students in the uptake of female condom

4.5.1 Lack of education

Health practitioner from the nearest pharmacy also emphasized the issue of education. He acknowledged that most of the women don’t know how to insert a female condom correctly.

“Most of girls or women don’t know how to put it correctly”

(IG#2: Health practitioner)

He also spoke about lack of information, emphasizing that women don’t have the relevant information. Many of them think that condoms are meant for men and that it is therefore up to them (men) to ensure that they use them. That it’s not a women’s responsibility.

“People don’t have that kind of information and women think that men are better at using condoms than women”

(IG#2: Health practitioner)

4.5.2 Consistency

The health practitioner was of the view that when women fail to use females condom in first attempt due to improper fitting of the condom; they quit and they will never try it again and they will never make efforts to know how to use it.

“Another problem is that when a female condom didn’t work for the first time they just quit.”

(IG#2: Health practitioner)

4.6.1 Distribution of female condoms in campus

According to the NWU Reproductive Health Programme Coordinator, the university receive a limited number of female condoms from their supplier (government). In addition, the universities only receive more male condoms.

“First of all we are getting more supply of male condoms than female condoms, every time they tell us that the female condoms are expensive.

Table 8 shows the distribution of condoms at the Mafikeng Campus between 2007 and 2017.

Table 8: Male and Female condom distribution from the year 2007-2017

Year	Female condom	Male condom
2007	200	5000
2008	400	7000
2009	200	13000
2010	1000	20000
2011	900	16000
2012	1000	19000
2013	700	18000
2014	600	15000
2015	2000	4000
2016	9000	28000
2017	300	9000

Source: Mr. Mabile (Programme coordinator)

According to the table, more male condoms are distributed than female condoms from the year 2007 up to 2017. The smallest amount of female condom distribution on the campus was 200 in the year 2007 and 300 in 2017. However, the smallest number of male condoms was 5000 in the year 2007 followed by 4000 in the year 2015. Although male condom distribution was less in the year 2007, it was far more than female condom distribution, hence this confirms that there is a discrepancy between male and female condom distribution.

4.6.2 Distribution of female condoms during events

Although there is a supply of female condoms on the campus every year, the programme coordinator reported that they only distribute them during the special event once in a year, meaning that female condoms are not regularly distributed on all three campuses.

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“To tell the truth, we are just giving them out during the event, we have only male containers on all campuses including residences but we don’t have female condom containers, we issue female condoms during events such as the STI awareness”

(IG #1: NWU Programme Coordinator)

“We don’t put them at the residential containers because of the limited number of supplied condoms. We feel that they are very small to give them out”

(IG #1: NWU Programme Coordinator)

4.6.3 Availability of female condom programmes/awareness

The programme coordinator from the NWU said that they do have a condom programme/awareness in campus. He also stated that they are issuing both female and male condoms during the awareness but they issue more male than female condoms.

“We have a condom program, not specifically male and female; we just issue both of them but in most cases we are issuing more male condoms than female condoms”

(IG #1: NWU Programme Coordinator)

“We are getting more supply of male condoms than female condoms, every time they tell us that the female condoms are expensive. Also the usage is very low, we would collect the condoms back during recess as a results of lack of usage”

(IG #1: NWU Programme Coordinator)

4.7 Summary

This chapter presented the findings of the study. It summarised the background characteristics of the participants and discussed availability of and attitudes towards female condoms among students at the North West University, Mafikeng Campus. Knowledge about female condoms, use and availability is minimal. The next chapter will include the summary, conclusion and the recommendations of the study.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

This chapter summarises the most important findings of the study. Discussions and recommendations are also presented.

5.2 Discussions

The study revealed that there are no female condoms available in all campus condom containers including all residences. It has also been revealed that female condoms are not sold in the nearest pharmacy (Molemo Pharmacy). Therefore it can be concluded that female condoms are not readily available to students. According to the Health Belief Model, the “perceived barriers” such as the physical barriers to utilising female condom is being related to the findings that lack of female condom availability hinder women from using, particularly students.

The study also revealed that majority of women interviewed knew about female condom but they are not using. Reasons stated by women for not using are related to “other variables” such as psychological factors as suggested by the Health Belief Model. Those factors stated by women include among others the fear that the condom may fall inside their vagina, women’s partner not willing to try the method, women not following instructions properly and physical appearance of the condom that is not appealing.

The other issues emphasized by students were lack of publicity and education whereby female condoms are not publicised enough as compare to male condoms, one of the students did not even know about female condom during the time of the interview, hence education about female condom is very low. This finding is related to the Health Belief Model suggesting that “cues to action” such as media publication can change the behaviour of individuals to achieve desired behaviour.

Other findings is that young men have interest in using the female condom. It is their partners who are not willing to use. These results are similar to the study conducted by Koster, *et all* (2015), from Zimbabwe, Nigeria and Cameroon about the “views of males regarding the usage of female condoms” that males appreciated female condoms because of their pleasant feel,

effectiveness and lack of side effects. Although, Beksinska *et al* (2000), found that women's partners were not willing to try the method and that when women show it to their partners; they refuse to use it and there was no discussion, this type of behaviour is changing because men are now positively participating in sexual terms by giving women a choice of using a type of condom they prefer.

Most of the findings of this study in regard to why women are not using female condom don't differ much from the findings of other authors. For instance, female respondents were complaining about the appearance of the condom saying that it is not attractive due to its "big size and the outer ring". Peters *et al*, (2014), also found the same results whereby he stated that the inner ring looked painful and feared it would not fit into the vagina. One of the studies conducted by Ramasundaram, (2002), also revealed that women have fear towards the condom and they are having negative thoughts about it. For instance, he revealed that women feared that if the condom fell inside the vagina it could get lost and perhaps travel to the throat or another part of the body.

One of the factors responsible for lack of female condom usage is the issue of non-participation and negative attitude of female condom providers. Female condom providers are not encouraging prospective users to use female condom because they don't take time to talk about sex and the usage of female condom, they just give out the condom without even demonstrating on how to use it. This type of behaviour is also noted by Beksinska *et al*, (2000), that lack of provider's efforts to teach clients on how to use the female condom lead to lack of consistency due to inability to put the condom correctly because providers did not show them how to put it. He said that when women used the female condom for the first time, they often experience insertion difficulties and commented negatively about the amount of time it took them to insert it. Mantell *et al* (2001), also found out that providers did not conduct sexual risk assessment or talk about sex with clients during his study.

Although respondents were not using female condoms, they know the advantages of using a female condom. Most of them know that female condom promotes women empowerment because women will be given the freedom to choose whether to use or not, some noted that it protects women from unwanted pregnancies and STIs, some said it gives women protection in a case of rape. Gender inequality still exists in South Africa and mostly in culturally rural areas where culture is strongly practiced. Gaearwe, (2014), noted that the reason behind the lower usage

of condoms by females is as a result of culturally sexual behavioural norms reflecting gender inequality that only allows men to decide when, where and how to have sex and in particular, when or with whom to use condoms. However, the study shows that not all men are practicing cultural norms but rather encouraging women to participate in sexual terms. It is only that women are not using female condom that pose as a risk because men don't always use protection during sex.

However, PATH (2011), initiated a market research for female condom in 2011/2012 to identify new market for the new female condom named "The V Condom". The foundation of this initiative was built under the recommendations that female condom needs to be shaped in a better and more attractive way so that it can attract prospective users to purchase. The emphasis made by PATH is that packaging of female condom should be classy and communicate protection, romance and quality. Market research results conducted by PATH when testing the market revealed that participants liked the new female condom and its packaging, one of the respondents said that "I highly prefer it, I also like its design and shape and the packaging is charming". Based on that, other recommendations should be given to improve even further in the female condom arena.

5.3 Recommendations

The first recommendation emerged from the study comes from the issue of male participation. The study revealed that men are willing and interested in using female condom but their partners are the ones who are not participating. Hence it is recommended that men should be targeted in promoting the uptake of female condom so that they influence their partners to use.

The second recommendation comes from the availability of female condoms in campus residence. Participants who are residing in campus residence argued that there are not female condom available in all residence units. Therefore it is recommended that female condom should be made a priority when distributing both male and female condom and more of them should be allocated to female campus residences.

Another recommendation is based on lack of information, education and communication (IEC). Most of the respondents said that they have knowledge about female condom but they don't know how to use it, this shows that prospective users are not being educated on how to use female condom. Therefore it is recommended that re-training of providers should be conducted



in specified intervals (continuously) to refresh their counselling skills about female condoms. Another recommendation in regard to IEC is to have pamphlets ready in all government institutions responsible in distributing female condom.

The last recommendation is that the Campus Clinic should put in place mechanisms of ensuring that the family planning commodities including female condoms are available at the facility level and all strategic places such as halls of residence and toilets. This will ensure that female condoms are readily available to the students.

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APPENDIX ONE

Introductory remarks:

Greet participants. Data collectors need to introduce themselves. My name is Harry, I am a master's student studying population and sustainable development with the North-West University. I am carrying out a study on factors that affect the uptake of female condoms in university students in partial fulfilment of the Master's Degree. Your identity will be strictly anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation.

Name of Health Facility:.....

Position/Title

personnel:.....

IDcode:.....

Length of time facility has been involved in female condom programme:.....

Date of data collection:

General questions

What is your age?

How long have you been working in the Health sector?

What is your marital status?

What is your highest education?



In-depth Questions

1. Do you have a female condom awareness programme? If yes...explain. Any documents?
2. What is the role of your clinic in this female condom programme?
3. Who is your supplier of female condom? Government or the university?
4. Where do you disperse female condom? Student residential? Tuck-shop? Main gate?
5. Do you think that the current dispensation is accessible?
6. Explain the uptake of the female condom at this facility?

- Do students ask for female condoms?
7. What is your experience in female condom programme management at this facility?
 8. What are the successes of the female condom programme at your facility?
 9. What factors have contributed to these successes at your facility?
 10. How does the programme intend to maintain these successes?
 11. What are the barriers to female condom programme implementation at your facility? If any?
 12. What factors have contributed to development of the barriers experienced in female condom programme at this facility?
 13. How is your facility responding to the barriers faced by the female condom programme?
 14. What is the future of the female condom at your facility?
 15. What suggestions would you make to ensure smooth running of the female condom programme? (what should be done to ensure that more students use female condoms)

English Interview guide for District Pharmacist and Health Centre Pharmacy technician

Name of Health facility:.....

Position/Title of personnel:.....

ID code:.....

Date of data collection:.....

Introduction: Greet participants. Data collectors need to introduce themselves. My name is Harry, I am a master's student studying population and sustainable development with the University of North West. I am carrying out a study on factors that affect the uptake of female condoms in university students in partial fulfilment of the Master's Degree. Your identity will be strictly anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation. Anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation.

Consent: Consent form should be signed after reading and before interviews start.

General questions

What is your age?

How long have you been working in health sector?

What is your marital status?

What is your highest education?

In-depth Questions

1. Do you sell female condom in the pharmacy? If yes please answer the following questions:

1.1. How does your facility acquire female condoms?

1.2. Explain the uptake of the female condom at this facility.

- Do female condoms sell as much as male condoms? Why is that the case?
- Why is that few people come to buy female condom's condoms?
- What about university students, do they come to buy female condoms from your pharmacy?
- If yes, why do you think they like buying female condom?

- If No why do you think they do not like buying female condom?

- 1.3. What is the unit price of the female condom?
- 1.4. What is the unit price of the mc?
- 1.5. Do you advertise/promote female condom in your pharmacy?
- 1.6. If yes, how?
- 1.7. What is your opinion about female condom?
2. If your answer in “no” in question 1, please answer the following questions:
 - 2.1. Why are you not selling?
 - 2.2. Have you tried selling before?
 - 2.3. If yes, what was the unit price of female condom?
 - 2.4. What was the unit price of mc?
 - 2.5. What is your opinion about female condom?
 - 2.6. In your opinion, what do you think should be done to encourage more young people including university students to buy female use?
16. What is the future of the female condom at your pharmacy?
17. What suggestions would you make to ensure that more students use female condoms

English Interview guide for female students of the North West University

Name of Institution:.....

Level of student:.....

Faculty of student:.....

Date of data collection:.....

Greet participants. Data collectors need to introduce themselves. My name is Harry, I am a master's student studying population and sustainable development with the University of North West. I am carrying out a study on factors that affect the uptake of female condoms in university students in partial fulfilment of the Master's Degree. Your identity will be strictly anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation. Anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation.

Consent: Consent form should be signed after reading and before interviews start.

General questions

What is your age?

What is your marital status?

Do you reside on/off campus?

If you reside on-campus, which resident are living in?

And if you are residing off- campus which area are you living in?

How long have you been residing in campus?

In-depth Questions

1. Do you know female condom?
2. How do you know it? Did you know it from the mass media? Or from the public health clinics or the pharmacies?
3. Have you seen it? Where? (Have you seen it around campus disposals or in tuck shop).
4. Do you know the risk of not using protection during sexual intercourse?
5. Did you know that female condom condom is a strategy designed by government to protect you from getting pregnant, contracting STI's and HIV?
6. Do you think a lot of female students use female condoms?

In your opinion, what do you think is the reason why they are not using? (Are there problems in getting female condom/is there something wrong with female condom, Are female condoms readily available on campus/can you get female condoms from the clinic/pharmacy?
7. In your experience, do you think males are cooperative in the usage of female condom?
8. In your opinion, what do you think should be the role of men in the usage of female condoms?
9. Can you recommend someone to use it?
10. What is the future of the female condom at this university/country?
11. What suggestions would you make to ensure that more students use female condoms?

English Interview guide for male students of the North West University

Name of Institution:.....

Level of student:.....

Faculty of student:.....

Date of data collection:.....

Introduction: Greet participants. Data collectors need to introduce themselves. My name is Harry, I am a master's student studying population and sustainable development with the University of North West. I am carrying out a study on factors that affect the uptake of female condoms in university students in partial fulfilment of the Master's Degree. Your identity will be strictly anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation. Anonymous and responses given will be confidential. We expect you to be honest in your responses to assist in programme improvement. Thank you for your cooperation.

Consent: Consent form should be signed after reading and before interviews start.

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3. Have you seen it? Where? (Have you seen it around campus disposals or in tuck shop?)
4. Do you think a lot of female students use female condoms?
 - In your opinion, what do you think is the reason why they are not using? (Are there problems in getting female condom/is there something wrong with female condom, Are female condoms readily available on campus/can you get female condoms from the clinic/pharmacy?
 - Can you recommend someone to use it?
5. Do you personally have a problem with female condom?
6. What is the future of the female condom in this university/country?
7. What suggestions would you make to ensure that more students use female condoms?