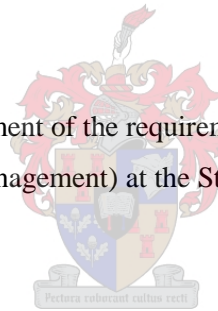


**Knowledge and attitudes of women attending the antenatal care clinic at  
Piggs Peak Government Hospital as regards the female condom in HIV  
prevention**

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Assignment presented in partial fulfilment of the requirements for the degree of Master of Philosophy  
(HIV/AIDS Management) at the Stellenbosch University



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## **DECLARATION**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signed: Nkululeko Gwebu

Date: March 2012

## Summary

**Introduction:** The female condom is the only currently available method that offers women partial control in protecting themselves from HIV infection. Despite the availability of this condom, its uptake among women has remained disappointing. This study was an attempt to understand why this is the case and to come up with recommendations to improve uptake of the female condom at Piggs Peak Hospital antenatal care department in Swaziland.

**Methodology:** A qualitative research study was conducted using in depth face-to-face interviews and a focus group discussion. The target population consisted of clients visiting the antenatal care clinic at Piggs Peak Hospital.

**Results:** Respondents were aware of the female condom and its effectiveness in preventing HIV infection, other sexually transmitted diseases and as a contraceptive procedure. Acceptance of the female condom was high among respondents, though uptake was low. Some of the reasons that were mentioned as resulting in the poor uptake of the female condom included lack of training on use and little marketing of the device. The design of the current female condom was found to be a major concern for those who refused to accept the female condom.

**Implications:** There is a need for the government of Swaziland and its partners to reconsider their strategy as regards the promotion of the female condom in the country. Educating the general public about the condom and training them how to use it is vital. People need to know why they should use the female condom. Its advantages to women should be fully explained. The cost of the female condom also needs to be addressed with a view of having the female condom freely and widely available.

## Opsomming

Die vrouekondoom is tans die enigste beskikbare metode wat aan vroue gedeeltelike kontrole bied om hulleself teen MIV-infeksie te beskerm. Ondanks die beskikbaarheid van hierdie kondoom is die omvang van die gebruik daarvan onder vroue steeds teleurstellend. Dié studie was 'n poging om te probeer bepaal wat die rede(s) hiervoor is en om aanbevelings te doen om die gebruik van die vrouekondoom te vermeerder -- pogings en optrede in hierdie verband is in die swangerskapsorgafdeling van Piggs Peak-hospitaal in Swaziland uitgevoer.

**Metodologie:** 'n Kwalitatiewe navorsingstudie is van stapel laat loop en dit het persoonlike onderhoude en 'n fokusgroepbespreking ingesluit. Die teikengroep het bestaan uit kliënte wat die voorgeboortekliniek by Piggs Peak-hospitaal besoek het.

**Bevindinge:** Respondente was bewus van die vrouekondoom en sy doeltreffendheid wat betref die voorkoming van MIV-infeksie, ander seksueeloorloordrabbare siektes en as 'n voorkomingsmaatreël. Daar was 'n hoë vlak van aanvaarding onder die respondente, maar die gebruik daarvan was beduidend laag. Van die redes wat vermeld is waarom die vrouekondoom nie in veel groter maat gebruik word nie, het gebrek aan opleiding ten opsigte van die gebruik daarvan ingesluit, asook powerre bemerkingspogings. Daar is bevind dat die ontwerp van die huidige vrouekondoom vir diegene wat weier om dit te probeer gebruik, 'n kommerwrekkende aangeleentheid is.

**Implikasies:** Dit is nodig vir die regering van Swaziland en sy vennote om hulle strategie ten opsigte van die promosie van dié vrouekondoom in die land in heroorweging te neem. Dit is noodsaaklik dat die publiek oor alle aspekte van dié kondoom ingelig word en geleer word hoe om dit te gebruik. Mense behoort bewus te wees waarom hulle die kondoom moet gebruik. Die kondoom se voordele behoort omvattend en indringend aan vroue verduidelik te word. Die kostefaktor rondom die vrouekondoom behoort ook aangespreek te word met die oog daarop om dit gratis en vrylik beskikbaar te hê.

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## Chapter 1: INTRODUCTION

### 1.1 Background

The Joint United Nations Programme on HIV/AIDS (UNAIDS) report on the global AIDS epidemic for 2010 states that 33.3 million people were estimated to be living with HIV/AIDS in 2009 (UNAIDS, 2010). The report also shows that the prevention efforts, care, treatment and support services for people living with HIV are working. Fewer people are getting infected with the virus or dying from the disease compared to previous years.

Sub-Saharan Africa is the region that has been worst hit by the epidemic. Of the 33.3 million people living with the virus in 2009, 22.5 million of them are in sub-Saharan Africa (UNAIDS, 2010). Roughly over half of those infected worldwide are women and girls. The situation is even worse for women in sub-Saharan Africa where women and girls make up close to sixty percent of those infected with the virus (UNAIDS, 2010). Young women aged 15-24 years are eight times more likely to be infected compared to men in the same age group.

Swaziland has the world's highest prevalence of HIV infection at 25, 6% in 2007 (CSO, 2008). The prevalence of infection in women and girls over 2 years in the country was estimated at 31% compared to males of the same age group at 18% (CSO, 2008). The drivers of the epidemic in Swaziland are thought to include multiple concurrent partners, early sexual debut, low and inconsistent use of condoms, intergenerational sex and transactional sex (Government of Swaziland, 2009).

Due to the absence of a cure for HIV, prevention is the cornerstone of all public health efforts to fight the epidemic. HIV prevention strategies can be divided into three groups; biomedical strategies, behavioural strategies and structural strategies (Setswe, 2010). The biomedical strategies include male circumcision, male and female condoms, Highly active anti-retroviral treatment, prevention of mother to child transmission, treatment of sexually transmitted infections, microbicides, cervical barriers and HIV vaccine (Setswe, 2010).

Behavioural strategies include abstinence only, abstinence as part of the abstinence, consistent and correct condom use, and being faithful to one negative partner, voluntary counselling and testing and reducing multiple and concurrent partners. Setswe (2010) describes structural strategies as including those that provide education and microfinance to

women and girls so that they are financially independent as this has been shown to reduce their chances of being infected with HIV.

The focus of this study is on the female condom as an effective way of reducing the spread of HIV particularly among women and girls. This is an attempt to address the higher prevalence of HIV infection among women when compared to men. Educating women and girls about the female condom may help to lower their chances of getting infected. Education has been shown to act as a social vaccine as young girls who are educated seem to be at a lower risk of getting HIV compared to the uneducated girls (Ubaidullah, 2004).

Condoms are currently the third most effective HIV prevention strategy after abstinence and being faithful to one mutually faithful partner. However, in practice condoms are the most effective method as abstinence and mutual faithfulness are more difficult to achieve. The male and female condoms are estimated to be over 90% effective in preventing HIV infection if used correctly and consistently (PreventionNow, 2010).

The female condom is of particular interest because of the partial control that it offers to women to protect themselves and their partner from HIV infection. Traditionally, women have had little or no say in sexual matters especially among cultures in sub-Saharan Africa. A method of HIV prevention that has some degree of female control is thus much sought after by gender activists and other concerned organisations. Research has also shown that including the female condom as part of the prevention package that includes male condoms leads to an increase in the number of sexual acts that are protected and hence less probability of HIV transmission (Vijayakumar, Mabude, Smit, Beksinska and Lurie, 2006).

## **1.2 Research problem**

Despite the evidence that female condoms may be at least as effective as the male condoms in preventing HIV and other sexually transmitted infections among women and girls, the uptake of the female condom in Swaziland has been, to a large extent, disappointing. Due to the absence of an effective, female initiated and controlled method of HIV prevention, it had been hoped that the female condom will be a natural in filling that gap. The Ministry of Health and its partners in the country have tried to ensure that the female condoms are widely available in convenient places all over the country.

This statement by the Executive Director of UNAIDS, Dr Peter Piot helps to highlight the research problem “Female condoms are of enormous importance to the fight against AIDS because they are the only existing, effective female-controlled preventive tool against HIV and other STIs. However, their use has remained frustratingly and tragically low, despite growing demand from women themselves. The barriers of price and supply must be overcome. Female condoms must be brought within the reach of all women as a core part of the world’s commitment to moving towards universal access to HIV prevention, treatment, care, and support” (PATH, 2006)

Further emphasizing the importance of the female condom is Dr Steve Sinding, Director General of International Planned Parenthood Federation, who says “The female condom works. It is effective in preventing pregnancy and STIs, including HIV. When it is offered with good counselling and support, female condom availability results in significantly safer sex ... More choice equals more protection. It’s that simple. Increased choice helps to empower women. As part of a rights-based approach to health care, women should by right have access to female condoms” (PATH, 2006).

Women attending antenatal care services clinics (ANC) are shown how to use the female condom and are offered the condom together with male condoms as part of sexual and reproductive health services. However, their uptake and enthusiasm towards the female condom has been noticeably poor. As an example of this, at Piggs Peak Hospital’s ANC department there was not a single female condom requested by women visiting the clinic during the month of February despite being taught about it and shown how to use it. During the same month hundreds of male condoms were requested.

This study attempted to understand what women visiting this clinic knew about the female condom and what their attitudes are concerning its use in HIV prevention. It was also a goal of the study to come up with recommendations on how to improve the uptake of the female condom among women visiting the ANC clinic.

### **1.3 Research Question**

What are the attitudes to and knowledge of women attending the antenatal care clinic at Piggs Peak Hospital in Swaziland concerning female condom use in HIV prevention?

## **1.4 Aim**

To understand the knowledge and attitudes of women attending the antenatal care clinic at Piggs Peak Government Hospital as regards female condom use in HIV prevention in order to make recommendations on how to increase the uptake of the female condom in the public health sector in Swaziland

## **1.5 Objectives**

- To establish the knowledge of women attending antenatal care as regards female condoms in HIV prevention
- To establish their attitudes towards the female condom
- To make recommendations to increase the uptake of the female condom among antenatal care clients at Piggs Peak Hospital.

## **1.6 Significance of the Study**

The significance of this study is that:

- It may help to understand the knowledge levels of women attending the antenatal care clinic at Piggs Peak Hospital about female condoms and HIV prevention.
- It may help to understand the attitudes of women attending antenatal care concerning the female condom.
- It may lead to an understanding of the factors preventing the uptake of the female condom at Piggs Peak Hospital antenatal care unit.
- It may provoke other researchers to look at the female condom in other types of clients in the country.
- It may help towards improvement of the female condom uptake by incorporating the suggestions of the users.
- An understanding of why women are not using the female condom could assist programs that are promoting the female condom to make changes to meet the expectations of their clients
- Increased uptake of the female condom could increase the number of sexual acts that are protected leading to reduced HIV transmission.

## **1.7 Format of the study**

The study is divided into six chapters. The first chapter consists of the introduction. This includes a description of the background of the HIV/AIDS situation the world over in general and Swaziland in particular. Strategies of HIV prevention such as the female condom are introduced. Chapter two of the study is the literature review. The literature review sets out the available literature on the female condom in terms of availability, affordability and acceptability. The next chapter, chapter 3, focuses on the research methodology. This describes the design of the study and how the study was conducted.

Chapter four is concerned with the presentation of the results of the study. The results are mostly presented in graphical form. The findings of the study are discussed in chapter five. The literature review is used to try and compare the researchers' findings and those from other researchers. The discussion and recommendations make up the last chapter of the research. In the discussion, the researcher takes a deeper look into the study results and tries to answer the research questions. The final part of this chapter features the recommendations from the study participants on how to improve the uptake of the female condom at Piggs Peak Hospital. There is a bibliography and appendix attached at the end of the presentation. The appendix shows the research instrument that was used to collect the data.

The next chapter is a presentation of the literature that is available on the female condom and such features as its availability, acceptability, affordability, and failure of uptake.

## **Chapter 2: LITERATURE REVIEW**

### **2.1 Introduction**

The literature review contains a description of what the female condom is and why it is an important product. Factors influencing the uptake of the female condom such as its effectiveness, acceptability, availability and affordability are also discussed. Finally the reasons why the female condom has not been a resounding success in many countries are considered.

### **2.2 The Female Condom**

#### **2.2.1 Description**

The female condom currently available in Swaziland is a nitrile rubber type called FC2. It is a thin, loose fitting plastic tube that is closed at one end. It consists of two rings, one at each end of the tube. The smaller ring is inserted into the vagina and over the cervix by squeezing it while the larger outer ring remains on the outside above the vulva. The sheath can be made out of either latex, polyurethane or nitrile rubber. The nitrile rubber condom is thought to have fewer side effects such as noise and allergies when compared to the latex condom. FC2 is manufactured by the Female Health Company and is approved by the World Health Organisation.

Another type of female condom is produced in India and is called the Dr Reddy condom or V-Amour. It is not approved by the WHO and thus will not feature in this article (Oxfam-Novib, 2007). A newer type of female condom produced by PATH called the Woman's Condom is currently being introduced in Swaziland. The condom is said to be more preferable to women than the FC2. In a study conducted in Durban, South Africa, the researchers found that most participants preferred the Woman's Condom and FC2 over Dr Reddy condom and the Woman's Condom was preferred over the FC2 in several acceptability measures (Joanis, Beksinska, Hart, Tweedy, Linda and Smit, 2010). However, since the Woman's condom is in the introductory phase, it is not part of this study.

#### **2.2.2 Importance of the Female Condom**

Women are significantly more affected by the HIV/AIDS epidemic compared to men in the developing world. In sub-Saharan Africa, women and girls make up 60% of all those infected

with HIV/AIDS. In Swaziland, 31% of women and girls between the ages 2 and above are infected with HIV compared to 18% of males in the same age group (CSO, 2008). The prevalence among girls in the country rises from 12% between 15-19 years, to 38% between 20-24 years and 49% between 25-29 years (CSO, 2008). These statistics show that women need more protection against HIV/AIDS in Swaziland. In sub-Saharan African countries that have a high prevalence such as Swaziland, women have little power over sexual matters. This means that the decision as to when, where and how to have sex is largely in the hands of men.

PATH (2006) lists the following as responsible for the greater vulnerability of women and girls to HIV infection; Biology, gender roles, sexual norms, and inequalities in access to resources and decision-making power put women and girls at greater risk of infection than men and boys. Many women have insufficient information about sexual and reproductive health and do not understand the risks associated with their own or their partners' sexual behaviours. Many of those who do recognize their vulnerability are powerless to protect themselves.

Women who receive information and counselling, and who learn to use the female condom, can protect themselves even if their partners refuse to use a male condom (PATH, 2006). In this scenario it thus became very important to have a method of HIV prevention that women can use to protect themselves against HIV infection. The more widely used male condom is under the control of the male partner. The female condom has been advanced as a method that could give women this type of control. This is because women may be able to negotiate the use of the female condom more easily compared to the male condom, giving them potentially more power to protect themselves in a sexual relationship (Mung'ala, Kilonzo, Angala, and Taegtmeier, 2005). Women, therefore, need protection against HIV/AIDS and unwanted pregnancies through methods that they may themselves initiate and control. The female condom is important because it is the only method that is currently available that offers women dual protection against sexually transmitted diseases and unwanted pregnancies. It is the only method that the woman can initiate to protect themselves and their partner. Female condoms also provide an additional protection option for anal sex, which has the highest probability of infection.

### **2.2.3 Effectiveness**

The female condom is stated to be at least as effective as the male condom in HIV prevention. It is claimed to be 97% effective in reducing the per-act probability of HIV



infection (PreventionNow, 2011). According to Usmani (2002), there is limited data on the use effectiveness of the female condom in preventing STI/HIV transmission. A randomized trial carried out in Thailand brothels showed that STD incidence was reduced by 23% among prostitutes using both male and female condoms above and beyond the reduction observed with male condoms only (Usmani, 2002).

Usmani (2002) also states that results from a UNAIDS study in 1997 found that when the female condom was made available, the incidence of STD infection fell by 34% and the number of unprotected sex acts by 25%. Trussel et al (cited in Usmani, 2002) estimate that perfect use of the female condom may reduce the annual risk of acquiring HIV by more than 90 percent among women who have sexual intercourse twice weekly with an infected male partner. Another estimate is that consistent and correct use of the female condom reduces the risk of sexually transmitted infection [including HIV] by between 94% and 97% per act of intercourse (Usmani, 2002).

Cravero (2006) further states that the female condom remains the best tool for HIV prevention available for women and girls which offers them some degree of control over their health. Studies conducted in Brazil, Kenya, India and Madagascar have also shown that the promotion and use of female condoms increases the total number of protected sexual acts, reducing rates of sexually transmitted infections and the risk of HIV infection (PreventionNow, 2011).

Although user dependent, the female condom may be slightly less effective than the male condom as a contraceptive method. As commonly used it will prevent pregnancy in 79 out of a 100 women in the first year compared to 85 out of a 100 pregnancies for the male condom (PreventionNow, 2011). However, the female condom is of similar effectiveness to the male condom in the prevention of HIV infection and as a contraceptive method in the long term.

#### **2.2.4 Knowledge levels**

Knowledge of the female condom is still low in Swaziland with only 46% of women and 28% of men knowing where to source it (CSO, 2008). This is an improvement from the findings of Nkambule (2004) who assessed the knowledge of a group of police officers, Kombi drivers, seasonal workers, Watchmen and military officers concerning where to source the female condom and if they have ever heard about it. Knowledge of the female condom ranged from 10% among seasonal workers and Watchmen to 38% among the police.

On the question of ever heard about the female condom the range was from 61% among seasonal workers to 95% among the police.

### **2.2.5 Acceptability**

A number of studies have been carried out in different parts of the world with different cultures and religious groups to assess the acceptability of the female condom. A 1997 review of acceptability studies of the female condom in 40 different countries conducted by the World Health Organisation found that 37% to 96% of female condom users rated the product as positive and acceptable. Further highlighting the acceptability of the female condom is Oxfam Novib (2007) which stated that global meetings on the female condom since 1993 have shown that there is no problem of user resistance with the female condom as all available research showed that women were interested in using it . However, all of these acceptability studies were short term studies that assessed use after a month or two following introduction of the female condom. They did not measure acceptability and sustainability after the initial novelty of the female condom had worn off (Hoffman, Mantell, Exner and Stein, 2004).

Peters et al (2010) stated that the acceptability of the female condom seemed to be high if education, training and support accompanied the introduction of the condom and if the introduction was sustainable. In most countries where the condom has been introduced sustainability seems to have been the main reason for the ultimate failure of the programme. However, no acceptability studies have been done in Swaziland to determine whether women in the country accept the female condom for HIV prevention and/or contraception.

### **2.2.6 Availability**

The UNAIDS Global report (2010) showed that female condom availability is increasing significantly with over 25 million female condoms provided through international and non-governmental funding sources in 2009 as compared to 10,9 million financed through these sources in 2006. However, female condoms still make up a tiny fraction of the total number of condoms distributed in 2009. According to PreventionNow (2011), 11 billion male condoms were distributed in 2007 as compared to 26 million female condoms worldwide. Stock outs of the female condom are regular and have been reported in many countries such as Malawi, Cameroon, Ghana and Zimbabwe (Peters et al, 2010). An important reason for the stock outs has been stated as the limited production capacity of the Female Health Company.

The global production of the company is limited to 34, 7 million female condoms per year against the 12 billion male condoms (Peters et al, 2010).

### **2.2.7 Affordability**

The cost of the female condom has been cited in many studies as being one of the important reasons why it has not been very successful taken up by women (Banerjee and Sharma, 2007; Esplen, 2007). The cost has meant that the mainly poor women in developing countries who need the female condom the most are not able to buy it for themselves. In addition, governments in the developing world have also preferred the male condom, which is some 29 times cheaper than the female condom (Peters et al, 2010).

Peters also says that the FC1 condom which was the precursor to the current FC2, cost between 2-3 American dollars. This amount is too high for women in the developing world many of whom live on less than a dollar per day. However, when the new nitrile product, FC2, is purchased in bulk by agencies such as the UNFPA, the cost per condom comes down to 0, 22 US dollars (Peters et al, 2010). This is still too high compared to the male condom that costs as little as 0, 0385 US dollars (Center for Health and Gender Equity (CHANGE), 2008).

Other costs that are associated with the introduction of the female condom include program costs, training, education and support costs. Programme costs usually reduce with programme expansion and increasing sales (CHANGE, 2008). However, other studies have also shown that despite the cost per unit of the female condom being too high, it is cost-effective when compared to, for example, anti-retroviral treatment. A study was conducted in South Africa and Brazil by Holtgrave, Sweat and Dowdy (2005) where they wanted to evaluate the cost-effectiveness and potential impact of expanded female condom distribution. They found out that in South Africa increasing the volume of the FC2 to 10% of male condoms will avert 9577 new infections at a cost of 985 American dollars per infection averted. This compares to the cost of 1503 American dollars of treating one HIV infected person in the country.

Moreover, if FC2 is acquired through a global purchasing mechanism and distribution is increased three times, the cost of expanded distribution per infection averted will fall to 374 American dollars in South Africa (Holtgrave et al, 2005). Similar big reductions were found to occur also in Brazil. Holtgrave et al (2005) therefore concluded that the “expanded distribution of the nitrile FC2 condom in Brazil and South Africa could avert substantial

numbers of HIV infections at little or no net cost to donor or government agencies. FC2 may be a useful and cost-effective supplement to the male condom for preventing HIV”.

Re-use of the female condom has also been suggested as a way to decrease the cost of the condom per act. Studies have shown that the female condom can be used up to seven times without losing its structural integrity (Hoffman et al, 2004). The World Health Organisation has not recommended the re-use of the condom but has left that decision to national programs. The acceptability of re-using the female condom is also an issue that will be culturally and individually dependent. A recent television article showed people in Kenya explaining that they wash and re-use the male condom because of shortages of the product in their community (etv news, 26/03/11, 1900hrs).

### **2.2.8 Failure of Uptake**

Why has the uptake of the female condom been less than would have been expected in most countries? Skaer and Ebin (2006) argued that the poor uptake of the female condom has been as a result of supply chain constraints, the high cost of the device, lack of donor interest, lack of mutual advocacy and publicity campaigns. They advocated for renewed interest in the social marketing of the female condom for it to be successful. Oxfam Novib (2007) claimed that there is more support by donors for other products such as microbicides and vaccine research at the expense of the female condom. They further stated that this was irrational as these other products are still in development, and when developed are likely to be less effective than the female condom, which is already available and offers dual protection against sexually transmitted infections and HIV. They attributed the failure of the female condom to be widely used to an insufficiency of scale, insufficiency of intensity and insufficiency of long-term vision.

In Brazil, insufficient commitment to make the female condom a success has been suggested as a reason for the poor uptake while in Nigeria reasons such as little social marketing and weaknesses in procurement and the supply chain have been alluded to. In Malawi, distribution of the female condom through the public health system was said to have failed because public health workers were not fully committed to the product and there was lack of support from donor agencies (Oxfam Novib, 2007). Lack of full commitment of the public sector workers such as nurses working in antenatal care departments may also explain the poor uptake in Swaziland. Other reasons included targeting the female condom to commercial sex workers, which leads to stigmatisation of the female condom and abstinence

only programmes that were promoted by some influential non-governmental organisations such as PEPFAR.

Another possible reason for the poor uptake and acceptability of the female condom is the difficulty associated with the insertion of the device. The difficulty in insertion may make many women unwilling to use the female condom and may be associated with inconsistent use. Some studies have shown proportions of users finding the female condom to be difficult to insert at 33-50% (Hoffman et al, 2004). However, when women are shown how to use the female condom and they practice on themselves with vagina models, the proportion of women finding the condom difficult to insert decreases markedly (Hoffman et al, 2004). This shows the importance of training women on the use of the female condom in improving the uptake of the condom.

UNAIDS (1998) in their Gender and HIV/AIDS technical update declared “introducing and distributing the female condom at affordable prices to both adult and young women should also be done with sensitivity to the gender implications of this new technology. Care must be taken to ensure that women are given the skills to negotiate its use and employ it correctly and that men are well informed of its benefits to them and their partners”. The failure to carry out the above recommendation concerning the female condom can be largely blamed for the seemingly poor uptake of the condom by women and their partners.

### **2.2.9 Summary of Literature review**

The female condom’s importance lies in the fact that it is currently the only available method of HIV prevention that gives women at least some control in protecting themselves against HIV infection. Female condoms are at least as effective as the male condom in preventing the per-act probability of HIV infection and as a contraceptive method in the long run. Knowledge levels about the female condom are still very low among both men and women in Swaziland. The acceptability of the female condom seems to be high in countries where this has been tested; however, no acceptability studies are available for Swaziland. Female condom availability worldwide is very poor compared to male condoms with 25 million female condoms distributed in 2007 compared to 11 billion male condoms. The affordability of the female condom has also been found to be an important hindrance to uptake with the female condom costing some 29 times more than the male condom. Insufficient commitment by governments, lack of social marketing, and attitudes of public sector workers are some of the factors that have been identified as reasons for the poor uptake of the female condom.

These findings from the literature review were used in formulating questions for the interview guide and the focus group discussion in this study. The next chapter presents the methodology used in the study.

## **Chapter 3: RESEARCH METHODOLOGY**

### **3.1 Introduction**

A qualitative research process was carried out for this study. Qualitative research explains attitudes, behaviour and experiences through such methods as interviews or focus groups (Sanchez, 2006). An attempt is made during qualitative research to get an in-depth opinion from the participants. It is ideal where there are a few participants but the contact time tends to be longer. Data for the study was gathered using semi-structured interviews and a focus group discussion.

### **3.2 Target population**

The target population for the study consisted of women who attended the antenatal care clinic for its services at Piggs Peak Hospital during the months of October and November.

### **3.3 Sampling strategy**

Sampling in qualitative research is usually purposive and theoretical (Christensen, Johnson and Turner, 2011; 162). This means that particular people are identified to study in-depth during the conduct of the study. The people who are believed to be information rich are selected and permission for the study obtained from them (Christensen et al, 2011; 162). The type of sampling strategy that was used for this study is called typical-case sampling. In typical-case sampling the researcher identifies and selects what is believed to be a typical or average case and conducts in-depth interviews with those identified (Christensen et al, 2011). However, due to the sensitivity of the study topic, a third person, who was a senior nurse in the antenatal care clinic, was asked to select the respondents, and explain to them the purpose and process of the research. Those that agreed to take part were then sent to the researcher for the interviews. The same sampling strategy of typical-case sampling was used for the focus group members with the same nurse choosing the respondents. The inclusion criteria for the in-depth interviews included the first twenty women between the ages of 18 and 49 who agreed to participate, who were attending ANC in the month of October and November, and who were pregnant or had come for contraception. For the focus group it was the first eight women, who agreed to participate, and were seen on one day in November.

To reduce negative labelling of those women taking part in the research, only the researcher and the assistant nurse who directed the participants and the participants themselves were aware of the study particulars. To maintain confidentiality of the focus group discussions, all participants were asked to sign a non-disclosure agreement promising that they would not talk about the study to outsiders after the study.

### **3.4 Data collection**

Semi-structured, in-depth, face to face interviews were conducted with twenty women seen during the period of the study. An interview guide was used in the study in order to ensure that all the pertinent questions are covered. The interview guide covered such topics as the importance of the female condom, its effectiveness, acceptability, availability and why uptake has been disappointing. The participants were also be asked what they thought should be done to increase uptake of the female condom in the country. Semi-structured interviews offer topics and questions to the interviewee, but are carefully designed to elicit the interviewee's ideas and opinions on the topic of interest, as opposed to leading the interviewee toward preconceived choices (Methfi, undated). The interviewer also had to follow up with probes so as to come up with a deeper understanding of the issues at hand.

The advantages of the semi-structured interview are that it establishes a positive exchange between the interviewer and interviewee, it has high validity, it allows the discussion and clarification of complex issues using probes, it removes pre-judgement, and is easy to record (Methfi, undated).

A focus group discussion was also conducted with 8 women who were visiting the antenatal clinic on one day during the period of the study. Among the advantages of a focus group discussion is that it allows a deeper understanding of the topic as the participants delve deeper into the problem at hand. An idea from one person may trigger a whole lot of related ideas and thoughts in another person. Problems with the focus group include the need for a highly skilled facilitator, few people making all the contributions while others are quite or just following the ideas of the dominant person (Bless, Higson-Smith, Kagee, 2009).

### **3.5 Data Analysis**

The data obtained from the interviews and the focus group discussions was downloaded from the tape recorders and transcribed soon after the interview while the conversation was still



fresh in the mind of the researcher. The transcripts served as the primary sources of data for qualitative content analysis. Qualitative content analysis is defined as a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon, 2005). In this study there were preset themes such as knowledge about female condoms, effectiveness, availability, affordability, failure of uptake and recommendations. The data that was obtained from all the participants was grouped into these preset categories. The frequency of appearance of a code in each group was used as a proxy for the importance of that code.

### **3.6 Pilot Study**

A pilot study of the interview schedule was conducted with five respondents visiting the Gynaecology clinic at Piggs Peak Hospital. A pilot study is defined as an investigation designed to test the feasibility of the methods and procedures for later use on a large scale or to search for possible effects and associations that may be worth following up in a subsequent larger study (Everitt, 2006). The results of the pilot study had the effect of causing the researcher to conduct semi-structured interviews instead of the originally planned unstructured interviews. This was because the amount of data obtainable from the unstructured interviews was too small and people were not willing to talk even when prodded. Directing them on what to talk about improved the results. Each of the respondents in the pilot study was then asked the following questions as suggested by Bell, 2006: (147-148);

- Were the instructions clear?
- Were any of the questions unclear or ambiguous? If so, will you say which and why?
- Did you object to answering any of the questions?
- In your opinion, has any major topic been omitted?
- Any comments?

The answers to these questions enabled the researcher to amend, rephrase, and remove some of the questions that we deemed to be inappropriate.

### **3.7 Changes to Interview schedule**

As a result of the pilot study, the researcher decided to shift from an unstructured form of interview to a semi-structured interview type. This was because it was noticed during the pilot study that all respondents seemed to be shy to initiate talk about sexual matters. This may have been exacerbated by the fact that the women were talking to men. Trying to prod and encourage did not result in any significant improvement in the amount of information obtained. In this section the researcher explains the consequent changes to the interview guide.

The first question was on knowledge of the female condom. Before the pilot study, the question was ‘what do you know about the female condom and HIV prevention and contraception?’ After the pilot study, the researcher added ‘according to your knowledge, does the female condom prevent HIV or pregnancy? Have you ever used the female condom? If yes, how frequently? If no, why not? This change allowed more information to be given.

The next question was on the effectiveness of the female condom and it asked ‘what do you think about the female condom verses the male condom in terms of effectiveness for HIV prevention and contraception? Which do you think is more effective? This question was maintained unchanged after the pilot study.

The next question was on acceptability of the female condom. ‘What do you think about the acceptability of the female condom? To women? To partners? This question was also maintained without change after the pilot study.

The next question on availability asked about how easy or difficult it is to find the female condom when one needs it. From the pilot study findings the researcher thought it necessary to add ‘where can you find the female condom if you need it?’

The question on affordability was asking if the woman would be willing to pay for the female condom and how much they would pay for it. The last part of this question was eventually scrapped, as no woman was willing to pay for the female condom.

The question on attitude towards the female condom was also scrapped. This was because the women’s attitudes towards the female condom can be deciphered from what they had to say about the female condom on their responses to the other questions in the interview schedule. The rest of the questions on failure of uptake and recommendations remained unchanged.

### **3.8 Ethical considerations**

Informed consent was obtained from all the participants to the study. The consent was obtained after the aims of the study and its implications had been explained and every participant was made aware of their right to refuse and withdraw without consequence. A non-disclosure agreement was signed with all the participants in order to prevent negative labelling. Every participant was assured of anonymity, confidentiality and privacy. Permission to carry out the study was obtained from the Piggs Peak Hospital administration, while ethical approval was also obtained from the ethics committee at the Ministry of Health in Swaziland and at Stellenbosch University. The audio-tape recordings and all transcripts were stored safely until such a time as when they can be safely destroyed.

### **3.9 Summary**

This study was conducted using a qualitative research process in order to understand the knowledge and attitudes of the respondents towards female condoms. The target population consisted of women attending antenatal care services at Piggs Peak Hospital. Typical case sampling strategy was used to identify subjects for the research. Twenty women were interviewed for the study while eight were involved in the focus group discussion. Tape recorders and field notes were used to collect data that was later interpreted using qualitative content analysis. A pilot study was also conducted before the main study to test the feasibility of the data collection instrument. The next chapter presents the results of the study.

## Chapter 4: RESULTS

### 4.1 Introduction

This section presents the results obtained from the semi-structured interviews and the focus group discussion. Graphs are used where appropriate to better illustrate the findings.

### 4.2 Demographic data

**Table 1: Age group**

| Age   | Frequency |
|-------|-----------|
| <20   | 8         |
| 20-29 | 14        |
| 30-39 | 4         |
| 40-49 | 2         |

Most of the women involved in the study were in the age group 20-29 years at 50%. The next populous group was the under 20 years at 28, 6%. The 30-39 year old group made up 14, 3% of the participants while the 40-49 age group made up 7, 1%.

**Table 2: Education**

| Level     | Frequency |
|-----------|-----------|
| Primary   | 10        |
| Secondary | 14        |
| Tertiary  | 4         |

Most of the women were educated at least up to secondary level. This group made up 50% of the participants. Those who went up to primary education made up 35, 7% of the participants while 14, 3% had tertiary education.

**Table 3: Civil Status**

| Status     | Frequency |
|------------|-----------|
| Married    | 11        |
| Single     | 8         |
| Cohabiting | 9         |

The group was fairly equally divided among those who were married at 39, 3%, those who were single at 28, 6% and those who were cohabiting at 32, 1%.

**Table 4: Occupation**

|            |    |
|------------|----|
| Employed   | 8  |
| Unemployed | 20 |

Most of the participants in the study were not formally employed. This group made up 71, 4% of the participants. The remaining 28, 6% were in formal employment.

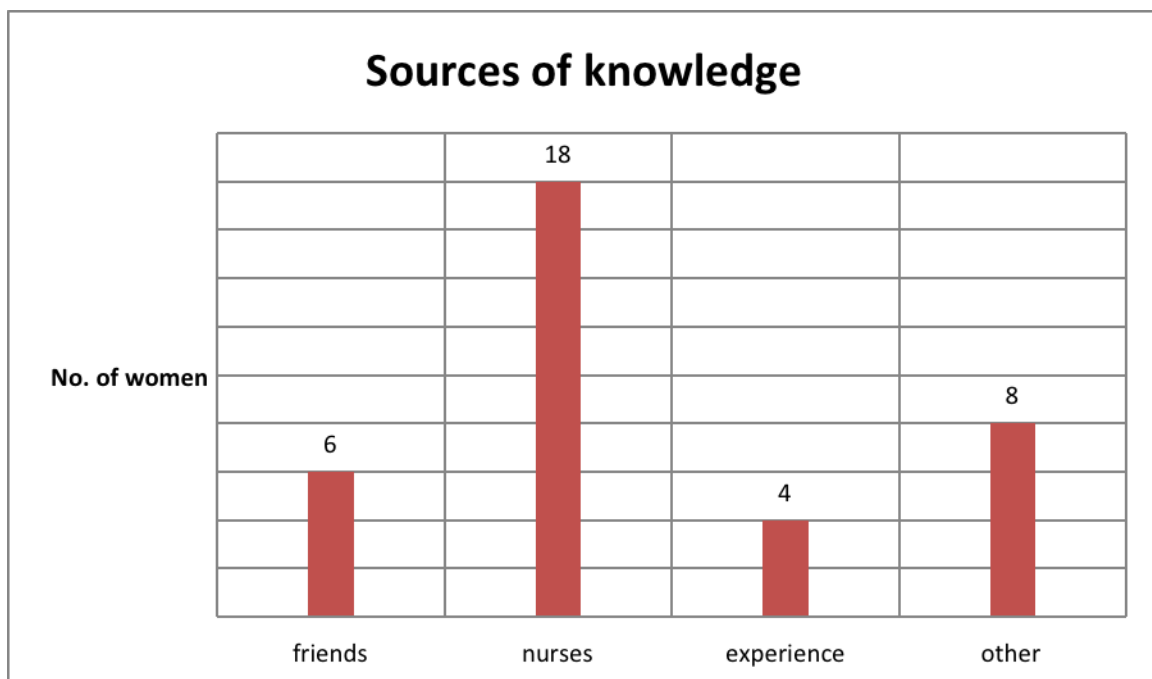
**Table 5: Environment**

|       |    |
|-------|----|
| Urban | 8  |
| Rural | 20 |

The rural group made up 71, 4% of the participants compared to the urban group that made up 28, 6% of the participants.

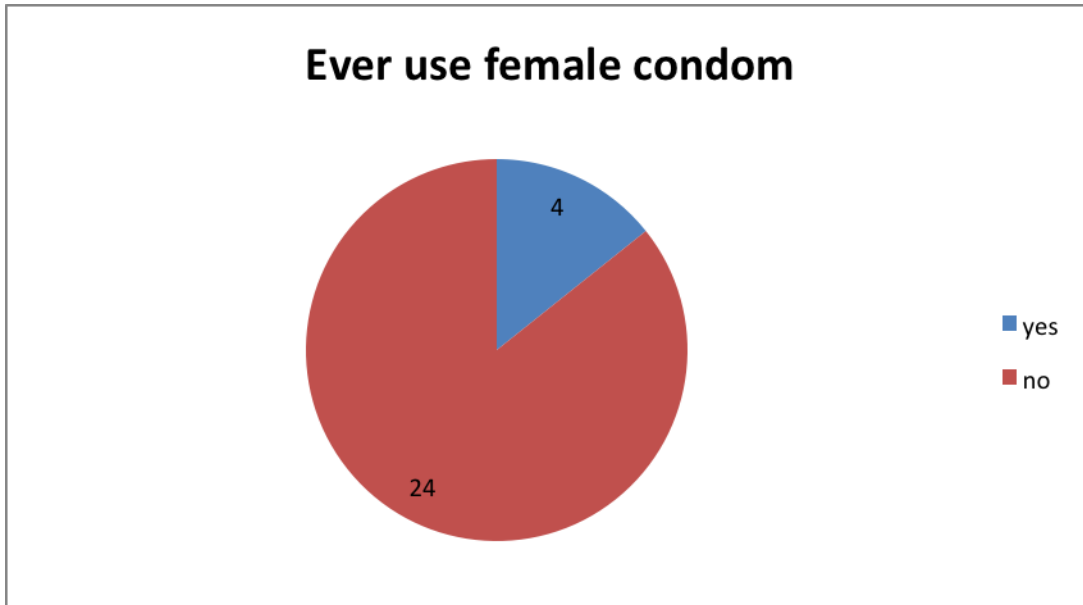
### 4.3 Knowledge of the female condom

The total number of respondents for the study was twenty-eight. This included twenty respondents for the semi-structured interviews and eight respondents in the focus group discussion. As per the selection criteria all the respondents had at least some knowledge about the female condom. The sources of knowledge about the condom ranged from being taught by nurses at the clinics, talking to friends and personal experience.



**Figure 1.** Source of knowledge. A graph showing the source of knowledge about the female condom.

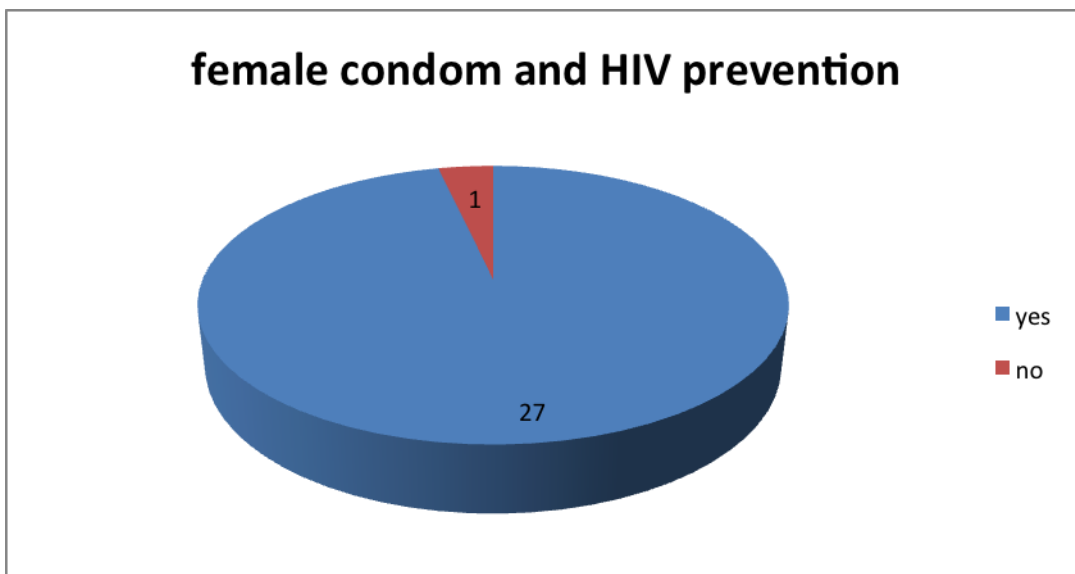
This graph shows that there was more than one source of knowledge about female condom for the respondents. However, the major source of knowledge accounting for 50, 0 % of the total was nurses at clinics and health centres. The next major group was the ‘other’ group which included such sources as television, radios and newspapers. This group accounted for 22, 2% of the cases. Next in importance as a source of information were friends who gave 16, 7% of our respondents their knowledge about the female condom. Lastly, the remaining 11, 1% of the respondents got their knowledge about the female condom from experience.



**Figure 2.** Ever use the female condom. A graph showing the results obtained for the question on whether the respondent has ever used the female condom.

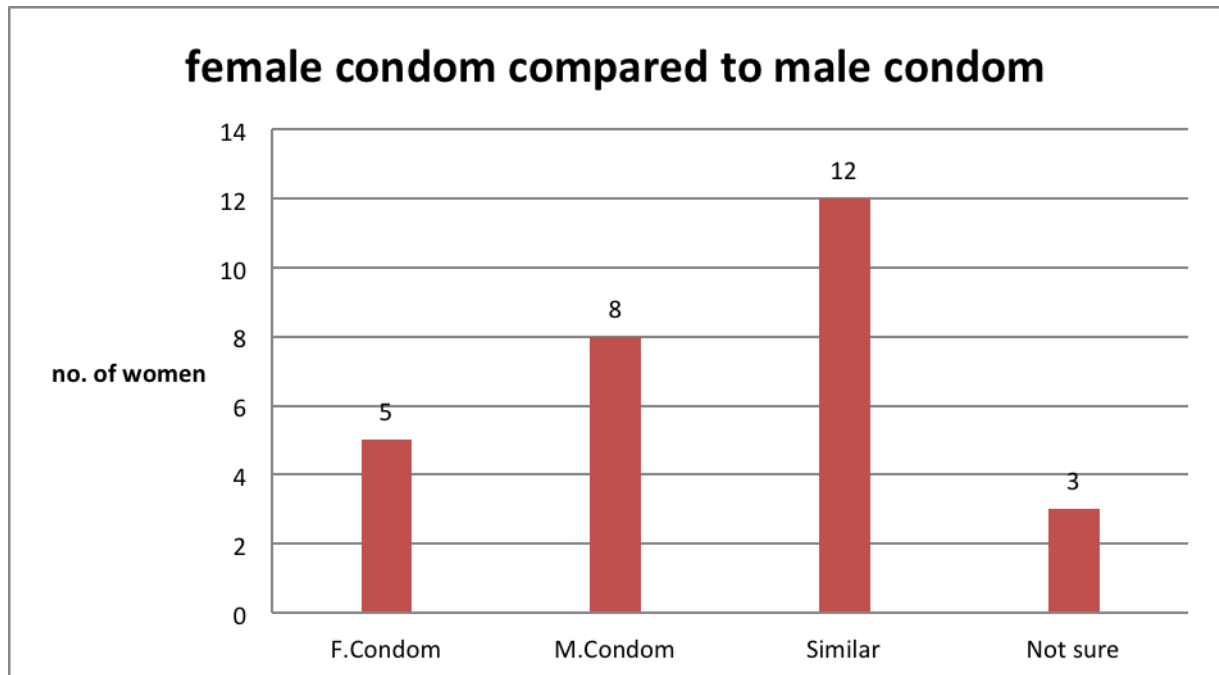
This pie chart shows that most of the respondents (85, 7%) stated that they had never used the female condom. Only 4 out of the total number of 28 women (14, 3%) said they have used the female condom previously.

#### 4.4 Effectiveness



**Figure 3.** Female condom and HIV prevention. Is the female condom effective in preventing HIV infection?

The majority of the women interviewed stated that the female condom was effective in preventing HIV infection. Only one of the respondents said that the female condom cannot protect against HIV infection.



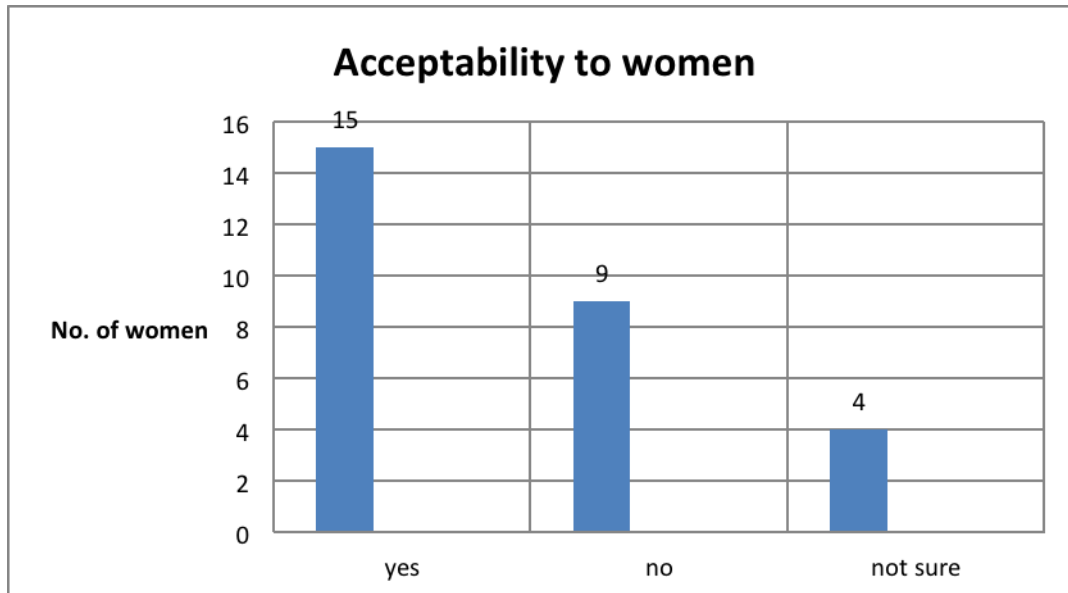
**Figure 4.** Effectiveness compared to the male condom. This graph shows the results of the question on which is more effective in HIV and as a contraceptive procedure between the male and female condom

The majority of the women interviewed at 42, 9% thought that the female condom is of similar effectiveness to the male condom. This was followed by the 28, 6% who thought that the male condom is more effective in preventing HIV infection compared to the female condom. The next group were those who thought that the female condom is more effective at 17, 9%. Lastly, 10, 7% of the respondents were not sure as to which condom is more effective.



## 4.5 Acceptability

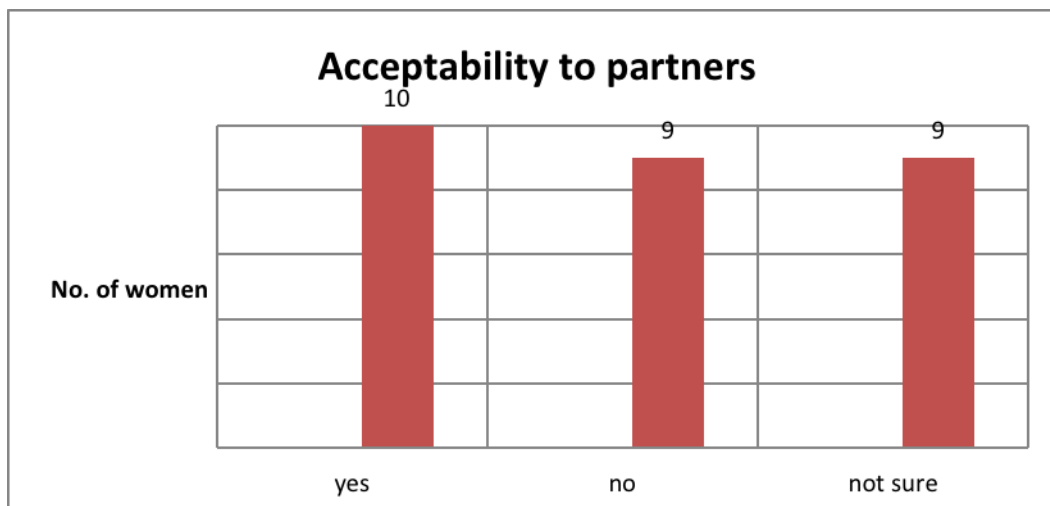
### 4.5a Acceptability to women



**Figure 5.** Acceptability to women. A graph showing acceptability of the female condom to women in the study.

From the above graph, it is clear that most of the women interviewed (53, 6%) found the female condom to be an acceptable device. About a third of the women (32, 1%) said that the female condom was not acceptable while the remainder (14, 3%) were undecided.

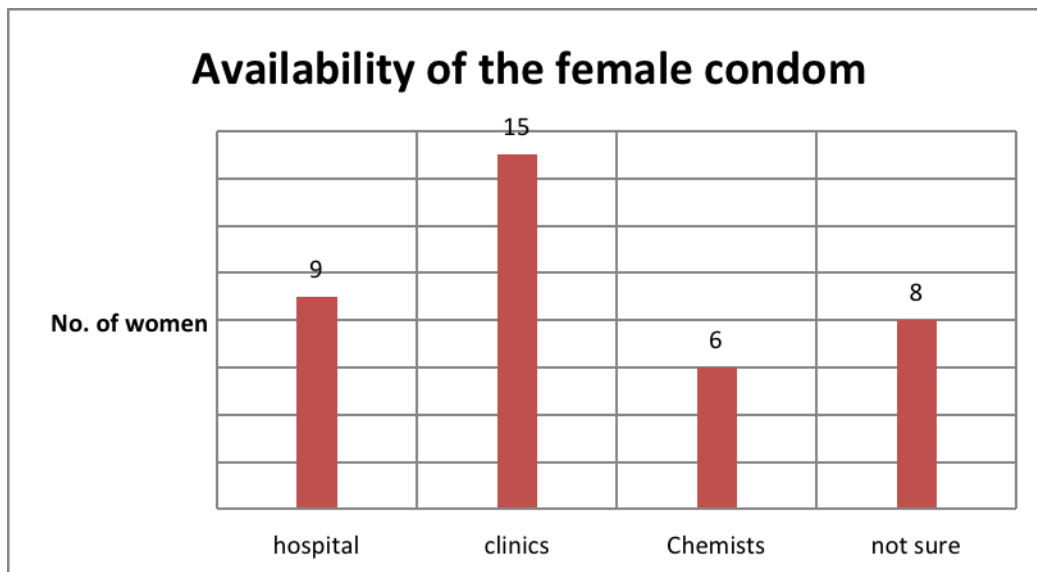
### 4.5b Acceptability to partners



**Figure 6.** Acceptability to partners. This graph shows what the respondents thought on whether their partners would accept the female condom or not.

The graph shows that 35, 7% of the women thought that their partners would have no problem using the female condom while the remaining 64, 3% was divided equally between those who said their partners would not accept the female condom and those who were not sure.

#### 4.6 Availability of the female condom



**Figure 7.** Availability of the female condom. A graph showing responses to availability of the female condom.

Clinics and hospitals in the country were the most common sources of the female condom for the women that were interviewed. Pharmacies were the least mentioned as a place where the female condom could be obtained. Further, 28, 6% of the women that were interviewed were not aware of a place where they could get the female condom.

## 4.7 Affordability

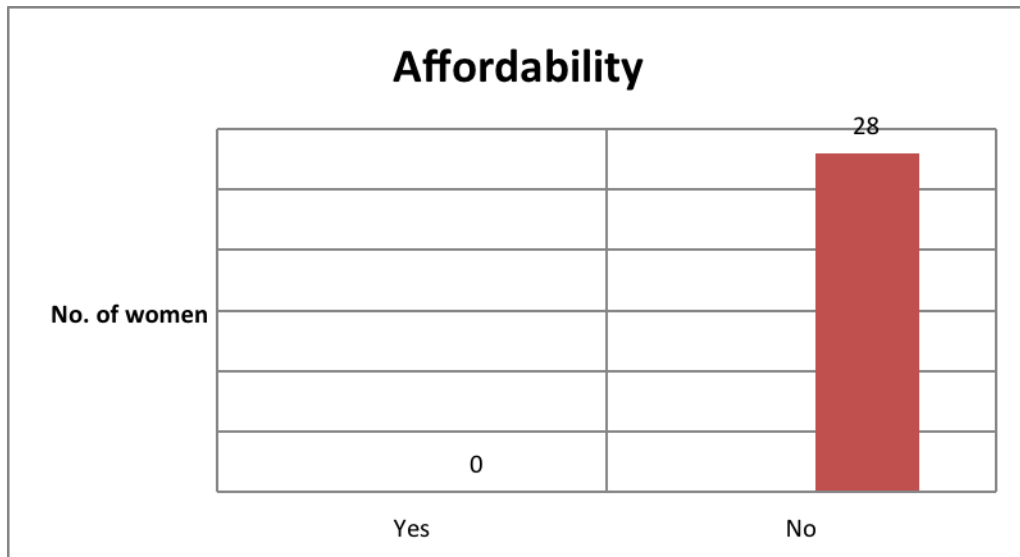


Figure 8. Affordability of the female condom. A graph showing the response to a question on willingness to pay for the female condom.

All the women in the study said that they would not be willing to pay for the female condom. Willingness to pay for the female condom was assumed to be a function of the affordability of the female condom. The main reason stated for the women not willing to pay for the female condom was that the male condom is freely available.

## 4.8 Failure of Uptake

A number of reasons were stated as responsible for the poor uptake of the female condom by women at the Antenatal department in Piggs Peak Hospital including;

- The female condom was not advertised properly.
- It is tedious to use.
- You have to put it in for eight hours for it to take your temperature, what about if you want to repeat immediately after the first time.
- Lack of knowledge about the importance of protecting oneself from HIV.
- Lack of knowledge about the female condom.
- Forgotten the demonstration on how to insert the female condom.
- Partners do not want it.
- I am afraid of it. It is not popular.

- Have to hold during sex until you finish. Fear that it will disappear inside if you leave it.
- It causes cancer.
- There is a need for a different model. This one is not appetising. When you see it all desire disappears.
- We use the male condom. I do not see the reason for the female condom.
- Afraid of the big ring.
- It twists and can sink inside.
- Not sure whether it is in position after insertion.
- Difficult to convince husband to use it.
- Used it and it injured me. It is not comfortable. It is scary.

## **4.9 Recommendations**

Some of the recommendations that were suggested that may help to increase the uptake of the female condom among women at the health centre included the following;

- Need for demonstration of how to use the female condom as much as the male condom has been demonstrated
- Tell both women and men about the advantages of the female condom
- Teach men about the female condom
- The condom should be redesigned to be more appealing
- Tell women that it is their own gadget hence they should use it
- Start afresh and teach women at clinics
- Increase the number of female condoms
- Have fewer male condoms

A common theme for most women in this study was education. They insisted that women had not been properly taught about how to use the female condom. They also had not been told of its advantages compared to the male condom. The women also insisted that men should also be involved in the education process.

## **4.10 Conclusion**

This section presented the results of the study using pie charts and bar charts. The next section includes a discussion of these results in view of the objectives of the study and the

literature review. Recommendations and the conclusion to the study complete the study process.

## **Chapter 5: Discussion, Recommendations and Conclusion**

### **5.1 Introduction**

This is the final chapter in the study in which the results of the study are discussed and recommendations are given.

### **5.2 Knowledge of the participants about the female condom**

All of the women in the study had at least some knowledge about the female condom. This was part of the requirements of the study. Over half of the women claimed that they had obtained their knowledge from nurses while attending clinics and hospitals. This finding highlights the importance of health workers in any effort that tries to improve the uptake of the female condom. Health care worker attitudes to the female condom, therefore, are an important determinant to the uptake of the female condom.

If health workers are not keen on the female condom they will transmit their scepticism to their clients thus resulting in poor uptake of the female condom. Zimbabwe managed to increase female condom uptake fivefold from 440000 in 2005 to 2, 6 million in 2009 (Maguwu, Xaba, Nyamukapa, Mugerungi, Tambashe, Campbell, Chiriva and Butau, 2010). One of the reasons that they state for this increase was the training provided to health workers in condom promotion. They further make the recommendation to improve service provider attitudes towards the female condom.

Other media such as television, radio and newsprint were next in importance as they were mentioned by 22, 2% of the participants. The majority of the participants (71, 4%) were from a rural background where television reception in Swaziland is very poor. It can therefore, be assumed that in this group the most important media is the radio and newspaper. Focusing marketing efforts on these media will increase the knowledge about female condoms and possibly increase uptake. Friends were also an important source of knowledge about the female condom for our participants with 16, 7% of them mentioning friends as having provided them with information on the female condom.

### **5.3 Knowledge through experience**

Usage of the female condom among the respondents for the study was quite low. Only 14, 3% of the women in the study had used the female condom previously. Meanwhile, all the

women had used the male condom before. However, the researcher was not too sure how to take these results because of the possibility that some of the participants may not have been truthful. This is because one participant who had initially claimed to never have used the female condom later changed her mind and said that they had used it only once before. One reason for this change was that the respondent got more comfortable as the interview progressed and more open. It is usually difficult for women to talk about sexual issues with an unknown male even if that male is a medical doctor. Despite this uncertainty, these figures represent a significant difference when compared to the Swaziland Health and Demographic Survey (SDHS) for 2007 which found an ever use rate for the female condom of 3, 3% (CSO, 2008). These figures are not directly comparable however, because of the qualitative nature of this study.

## **5.4 Effectiveness of the female condom**

Almost all the women involved in the study were aware of the female condom being effective in preventing HIV infection. Only one participant claimed that the female condom could not prevent HIV infection.

Most of the participants (42, 9%) when comparing the female condom to the male condom as a method of contraception and a method of HIV prevention thought that they were of similar effectiveness while 28, 5% thought that the male condom was more effective. The female condom was said to be more effective than the male condom by 17, 9% of the women. The rest of the women (10, 7%) were not sure which of the two products was more effective.

More women thought that the female condom was more effective than the male condom (17, 9%) compared to those that had actually used the female condom (14, 3%). This means that other factors are at play other than effectiveness that may be preventing more widespread use of the female condom. These other factors need to be targeted in trying to improve the uptake of the female condom.

## **5.5 Attitudes towards the female condom**

### **5.5.1 Acceptability**

The studies done all over the world on the acceptability of the female condom among women users has shown that the condom is well accepted (Hoffman et al (2004); Peters et al (2010); Oxfam Novi (2007)). However, no acceptability studies could be found that were conducted

in Swaziland. In this study, the researcher divided acceptability into two parts. In the first part, the interview question asked about acceptability of the female condom by women in general. The second part asked about acceptability by the male partners of the respondents.

Over half of the respondents (53, 6%) declared the female condom to be acceptable to women. About a third (32, 1%) of the respondents were of the view that the female condom was not acceptable to women. The remaining 14, 3% of the respondents were not sure what women thought regarding the acceptability of the female condom.

On acceptability of the female condom to male partners the group was more evenly split among the three options. Just over a third (35, 7%) of the participants claimed that their partners would have no problem with the female condom. The next group (32, 1%) expressed the view that their partners would not accept the female condom while 32, 1% were not sure either way.

These figures suggest that the use of the female condom should be higher than it actually is currently. If 53, 6% of the women are receptive to the use of the female condom and 35, 7% thought that their male partners would have no problem with the condom; one would have expected usage rates to be higher than what is currently prevailing. This shows that the acceptability of the female condom may not be the reason why usage of the condom is so low among women attending antenatal care at Piggs Peak Hospital.

### **5.5.2 Affordability**

The question on whether our participants were willing to pay for the female condom resulted in some interesting revelations. None of the women interviewed said they would be willing to pay for the female condom. The main reason that they gave was that the male condom was freely available. Therefore, the female condom should also be available free of charge. The researcher thought that this was a reasonable argument. As a result, the question on how much they would be willing to pay for the female condom was scrapped.

Another reason why our respondents showed an unwillingness to pay for the female condom may have been that most of them were from a low social class. Piggs Peak Hospital is a semi-urban environment but most of the people attending the hospital come from the surrounding plantations where people receive low wages. Paying for condoms will be very low on their priority lists.



There are two pharmacies and three supermarkets in Piggs Peak town. None of these also stock the female condom. This is probably because there is no demand for it as people would not be willing to pay for it.

The cost of the female condom needs to be zero cents for it to be taken up by some of the women. This is because the male condom is also freely available in most places. It is not the fault of women that the female condom costs more to manufacture. The female condom does not do a better job than the male condom. Research shows that they are more or less similar in effectiveness against HIV/STDs and as a contraceptive procedure (Usmani, 2002; PreventionNow, 2011). They should as a result cost the same. As long as the female condom remains more expensive than the male condom for governments and individuals, its uptake will remain poor.

### **5.5.3 Failure of uptake**

A popular theme that can be seen from all the reasons that were given as to why uptake of the female condom has been poor is education and training on how to use the female condom. Under this theme, women mentioned lack of knowledge about the female condom in general and its use in particular. Others said that women had little knowledge on the importance of protecting themselves from the HIV/AIDS pandemic. There were women who also expressed fear of the female condom. They claimed that it causes cancer or that it could disappear inside the abdomen. Still others talked about it twisting and sinking inside or lack of confidence in the position after insertion. All these reasons show a lack of proper knowledge about the female condom. It shows that there is a need for more education and training on how to use the female condom.

Women and their partners need to be informed of both its real advantages and disadvantages. Lack of education and training on the female condom is an important theme among research articles looking at why uptake of the female condom has been poor (Hoffman et al, 2004; UNAIDS, 1998).

Other women mentioned the failure to convince their partners to use the female condom as a reason for why they are not using the female condom. This is a reason also highlighted by UNAIDS (1998) in the Gender and HIV/AIDS technical update which recommended that women should be given the skills to negotiate female condom use and that men should be

well informed of its benefits to them and their partners. Implementation of such recommendations would go a long way in improving the uptake of the female condom.

Lack of proper marketing of the female condom is another reason for its continued poor uptake. This study found that most of the respondents got their knowledge of the female condom from health care workers. A problem with this source of information is that only those who come to hospital will get the information. There is therefore a need to improve advertising using the more mainstream advertising methods such as radio and newsprint. This will ensure that more people are exposed to the correct knowledge about the female condom.

One woman who had used the female condom previously claimed that it injured her and that it was not comfortable. This would probably have been a feature of not being able to insert it properly and points towards a need for training on use.

Recently, Population Services International (PSI) (Kunene, 2011) launched a new, supposedly sexy and streetwise condom in Swaziland. The new female condom, codenamed Angel, was launched at a pyjama party held for college students. The condom comes in attractive pink clutch bag like packets and has been described as intelligent, accommodative, smart and special (Kunene, 2011). This condom was designed with the input of the women who use it and it is therefore hoped that uptake will be good.

#### **5.5.4 Availability**

Health centres such as clinics and hospitals were the most common sources of the female condom. This may be because the pool of respondents included mainly pregnant women who frequent health centres for antenatal care services. However, what was worrying is that 28,6% of the women interviewed claimed not to know where to find the female condom. This suggests that there has been inadequate advertisement of the product. It shows that there is a need to increase marketing efforts so that many women become aware of where to find the female condom.

#### **5.6 List of recommendations**

- Increase health care worker attitudes to the female condom in order to improve uptake among women visiting health centres
- Increase marketing efforts using social media such as the radio and newspapers
- The female condom should be made freely available just like the male condom

- Improve the design of the female condom taking into account the views of the users who want it to be more appealing
- Involve men in all activities related to the female condom in order to increase acceptance of the condom
- Increase the number of places where the female condom is available such as shebeens and toilets of public places
- More training for both men and women on the advantages and on how to use the female condom is still needed.

### **5.7 Limitations of the study**

- The women in the study seemed to be shy to discuss sexual issues with a male.
- The sensitivity of the topic and some of the questions may have caused some of the participants to be economical with the truth. People want to be seen in a good light and anything that will show some negativity will be avoided.
- Recording people as they talk may also affect what they say despite assurances about confidentiality.
- Men were not involved in the study despite evidence that they have the lion's share in deciding whether to use condoms or not and what type of condom to use.
- The small number of respondents may affect the validity of the results obtained.
- The number of respondents who had actually used the female condom was low. This may have affected the quality of information that could be obtained about use of the female condom.

### **5.8 Conclusion**

The knowledge concerning the female condom and HIV prevention among women attending antenatal care at Piggs Peak Hospital is generally good. All the women in the study except one agreed that the female condom was effective in HIV prevention if used correctly and consistently. Of concern was that few of the women in the study had actually used the female condom themselves. However, this low use could have been because the women were not comfortable to admit use of a condom to a man. Maybe a similar study conducted by a woman would come up with a more real picture. The general attitude to the female condom was also positive. This was despite that some women were concerned about the design of the female condom.

One of the main points that could be drawn as to why the uptake of the female condom has been disappointing was the lack of education and training on the use and the advantages of the female condom. The absence of male partner involvement in promotion efforts was also highlighted as very important in improving uptake. More broad studies need to be undertaken to involve more women and men and to allow generalisation of results.

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## Appendix 1



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### **STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH**

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#### **KNOWLEDGE AND ATTITUDES OF WOMEN ATTENDING THE ANTENATAL CARE CLINIC AT PIGGS PEAK HOSPITAL AS REGARDS THE FEMALE CONDOM IN HIV PREVENTION**

You are asked to participate in a research study conducted by Nkululeko Gwebu (MB, ChB), from the Africa Center for HIV/AIDS Management at Stellenbosch University. The results of obtained will contribute towards a research paper as partial fulfillment of the Master of Philosophy degree in HIV/AIDS Management. You were selected as a possible participant in this study because you are a woman attending the antenatal care clinic during the period of the study

#### **PURPOSE OF THE STUDY**

This study is designed to establish the knowledge and attitudes of women attending the antenatal care clinic as regards the female condom in HIV prevention in order to come up with ways to improve the uptake of the female condom.

#### **1. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do one of the following things:

##### **In-depth interview**

This is a face to face interview with the researcher lasting for about one hour. During the in-depth interview you will be asked to discuss what you know and think about the female condom, what your attitudes are regarding it and finally to recommend ways to improve the uptake of the female condom

##### **Focus group**

A group of eight women will be selected for the focus group discussion. This will be a round table discussion with a moderator and a note taker. A tape recorder will also be used during the focus group discussion. The women will talk about the same issues as raised in the in-depth interview. The focus group discussion will be conducted in the antenatal care department and will last for an hour.

#### **2. POTENTIAL RISKS AND DISCOMFORTS**

It is not anticipated that they would be physical or psychological risks to participation in the study. However, participants may be inconvenienced in as far as their time is concerned. Further, some of



the questions may be of a personal nature and some discomfort or embarrassment may occur. This is because sex and condom usage are private issues that some people may have reservations talking about. All attempts will be made to avoid those types of questions that the respondent does not feel comfortable with answering or discussing.

### **3. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The participants may come out of the interview and the focus group with a better understanding of the female condom and its role in reproductive and sexual health. Their attitudes towards the female condom could improve and this may increase usage and thereby increase the number of sexual acts that are protected and hence reduce her chances of becoming infected with HIV or spreading the infection if already infected. As more women take up the female condom, this could ultimately lead to reduced prevalence of HIV infection among women and the population at large.

### **4. PAYMENT FOR PARTICIPATION**

No payment will be made to those women agreeing to participate in the in-depth interview. For the focus group a sum of R50 will be paid to each participant at the end of the focus group session. Only those staying for the duration of the focus group will get the payment.

### **5. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of identifying participants, if need be, by numbers instead of their names. Participants will not be asked their names. The data obtained from the respondents will be kept in a safe place and will only be assessed by the researcher and authorized University of Stellenbosch research staff for purposes of analyzing the quality of the research. Participants will have the right to listen to the audiotapes from the interviews and focus group and to edit any information that they are not comfortable with. The tapes will be destroyed as soon as they become unnecessary to keep them for the purposes of the research.

### **6. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

### **7. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact the researcher, Nkululeko Gwebu, at Piggs Peak Government Hospital, phone: +26824371111; cell no: +26876879205; e-mail: [newts2007@gmail.com](mailto:newts2007@gmail.com) or my Study leader Mr. Burt Davis on +021 808 4622 or [burt@sun.ac.za](mailto:burt@sun.ac.za).

### **8. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me.....by Nkululeko Gwebu in English. A translator.....Mr. Samukeliso Mdluli.....was asked to explain in my own language sections that I could not understand. I am in command of this language...SiSwati..... and where necessary it was satisfactorily translated to me. I.....was given the opportunity to ask questions and these questions were answered to my satisfaction. I am aware that the results of the study will anonymously be processed into a study report and that at any stage I can withdraw my consent and participation in the study.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

\_\_\_\_\_  
**Name of Subject/Participant**

\_\_\_\_\_  
**Name of Legal Representative (if applicable)**

\_\_\_\_\_  
**Signature of Subject/Participant or Legal Representative**

\_\_\_\_\_  
**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_  
\_\_\_\_\_. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in English and/or SiSwati and a translator was used in this conversation. The conversation was translated into \_SiSwati\_\_\_\_\_ by \_\_\_Mr. Samukeliso Mdluli and Nkululeko Gwebu\_\_\_\_\_.

\_\_\_\_\_  
**Signature of Investigator**

\_\_\_\_\_  
**Date**

## Appendix 2

### Interview Schedule/ Focus group guide

#### Demography

Age

Marital status

Residence

Education level

#### Knowledge of Female condom

What do you know about the female condom and HIV and contraception? According to your knowledge does the FC prevent HIV/ pregnancy?

Have you personally ever used the female condom? If yes, how frequently? If no, any reasons why not?

#### Effectiveness

What do you think about the female condom versus the male condom in terms of effectiveness for contraception and HIV/STI prevention? Was the female condom able to meet the purpose for which you used it?

#### Acceptability

What do you think about the acceptability or otherwise of the female condom? To your partner? Socio-culturally? Did you find the female condom to be acceptable or not? Explain.

#### Availability

How easy/difficult is it to find the female condom when you want it? Where can you find the female `condom when you need it?

#### Affordability

Will you be willing to pay for the female condom? Why /why not? How much would you pay for the FC?

#### Failure of uptake

Which condom do you think is used the most, male or female? Why? Why do you think the FC is not as popular as the male condom?

Attitude towards female condoms

In general, what do you think about the female condom? What is good and what is bad about the female condom?

Recommendations

In your opinion, what needs to be done to improve the uptake of female condoms in the country? Do you think it is important to increase uptake?

## Appendix 3



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### PARTICIPANT INFORMATION SHEET

**RE:** Knowledge and attitudes of women attending the antenatal clinic at Piggs Peak Hospital concerning the female condom in HIV prevention

Dear Respondent

In partial fulfilment of the Master of Philosophy degree in HIV management at Stellenbosch University, I am conducting a study on female condoms.

The information that will be obtained from you as a participant will be used for academic purposes and may be used to improve services delivery within the antenatal care department at the hospital. Every care will, however, be taken to ensure that your trust in me by giving me this information will not be abused.

Face to face, in-depth interviews and a focus group will be conducted with participants in order to answer the research question. The aim is to understand the respondents' knowledge and attitudes as regards the role of the female condom in HIV prevention.

Objectives of the study

- To establish the knowledge of women attending antenatal care as regards the female condom in HIV prevention
- To establish their attitudes towards the female condom
- To make recommendations to increase the uptake of the female condom among clients at Piggs Peak Hospital

Please feel free to contact me should you have any questions or need clarification. Thank you for your participation.

Yours sincerely

Dr N. Gwebu