

**The utilization and acceptability of the female condom among
female sex workers: A study in Zeerust, North West, South
Africa**

Daniel Chawatama

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of Master of Philosophy (HIV/AIDS Management) in the Faculty of
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Supervisor: Mr Burt Davis

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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.

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ABSTRACT

Women are disproportionately affected by HIV and account for more than 60% of adults living with HIV in sub Saharan Africa. To contain the spread of HIV, resources should be targeted at developing prevention methods that target women. One such promising method is the female condom.

The aim of this study was to examine female condom acceptability and utilization among female sex workers and exploring perceptions and beliefs held by sex workers regarding the female condom. The research employed a survey method targeting female sex workers aged 18-49 years in Zeerust, South Africa. Twenty-eight respondents were recruited and completed a self-administered questionnaire.

Female condom use by female sex workers was found to be moderate. The study revealed that 50% of respondents had used the female condom in the previous month as well as in the previous 3 months, and 57% had used the female condom in the previous 12 months. The study also found that the majority of sex workers believed the female condom was not easy to insert, that it looks unattractive and that their culture inhibited them from initiating its use. The study showed that respondents perceived the female condom to not be readily and conveniently available in Zeerust. Although the majority of the respondents found the female condom to be an unappealing protective device against HIV infection, half of the participants believed sex with a female condom feels good.

It was recommended that further research be conducted on why female sex workers perceive the female condom to not be well promoted or readily available in Zeerust. Factors mentioned above that according to respondents inhibit the use of the female condom also warrant further investigation.

OPSOMMING

Vroue word disproporsioneel deur MIV geaffekteer met meer as 60% van MIV-positiewe volwassenes in sub-Sahara-Afrika wat vroulik is. Dit is dus belangrik dat voorkomingsmetodes om die verspreiding van MIV te beperk spesifiek hierdie groep teiken. Die vrouekondoom is een so 'n MIV-voorkomingsmetode wat spesifiek ontwikkel is om vroue te bemagtig.

Die doel van hierdie studie was om die aanvaarbaarheid en gebruik van vrouekondome onder vroulike sekswerkers sowel as die persepsies en oortuigings wat hulle oor die vrouekondoom huldig, te ondersoek. Hierdie navorsing het 'n opname-metodiek nagevolg met vroulike sekswerkers in die ouderdomsgroep 18-49 jaar in Zeerust, Suid-Afrika as teikengroep. Agt en twintig deelnemers het 'n selfgeadministreerde vraelys voltooi.

Die resultate het gewys dat die gebruik van vrouekondome deur vroulike sekswerkers gemiddeld was. Die studie het getoon dat 50% van respondente in die voorafgaande maand sowel as die drie voorafgaande maande hierdie kondoom gebruik het en dat 57% van respondent dit in die voorafgaande 12 maande gebruik het. Die studie het ook bevind dat die meerderheid deelnemers geglo het dat die vrouekondoom nie maklik is om in te plaas nie, dat dit onaantreklik lyk en gevoel het dat hulle kulturele oortuigings hulle daarvan weerhou om dit te gebruik. Die resultate het verder gewys dat deelnemers gevoel het dat toeganklikheid tot die vrouekondoom beperk was en dat dit nie algemeen beskikbaar was in Zeerust nie. Alhoewel meeste deelnemers gevoel het dat die vrouekondoom nie baie aantrekkingswaarde as beskermingsmetode teen MIV het nie, was die helfte van die sekswerkers tog van mening dat seks met die vrouekondoom goed voel.

Dit is aanbeveel dat die redes waarom sekswerkers glo dat die vrouekondoom swak bemark word en nie gereedlik in Zeerust beskikbaar is nie, verder ondersoek word. Die bogenoemde faktore wat volgens deelnemers hulle inhibeer om vrouekondome te gebruik, verg ook nadere ondersoek.

ACRONYMS

AIDS:	Acquired Immunodeficiency Syndrome
CDC:	Centers for Disease Control and Prevention
CHANGE:	Center for Health and Gender Equity
STATSSA:	Statistics South Africa
FC:	Female Condom
FDA:	Food and Drug Administration
FHC:	Family Health Company
FSW:	Female Sex Worker
HIV:	Human Immunodeficiency Virus
MSM:	Men who have Sex with Men
NWP:	North West Province
PATH:	Program for Appropriate Technology in Health
PLWHA:	People Living With HIV/AIDS
PSI:	Population Services International
SADC	Southern African Development Community
SA:	South Africa
SSA:	Sub Saharan Africa
STI:	Sexually Transmitted Infections
UN:	United Nations
UNAIDS:	The Joint United Nations Programme on HIV/AIDS
UNFPA:	United Nations Population Fund
US(A):	United States (of America)
WHO:	World Health Organization

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DEDICATION

This research study is dedicated to all those children on the African continent who have been orphaned due to HIV

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CHAPTER 1

PROBLEM STATEMENT AND OUTLINE OF THE STUDY

1.1 Introduction

This chapter lays the foundation of the research topic through an overview of the research area. The research problem and the aims and objectives conclude the chapter.

1.2 Background

Situated in the North West Province (NWP) of South Africa, Zeerust town provides two exit road routes to Botswana and Namibia. It is a border area of many overlapping populations, institutions, sexual networks and patterns of mobility. Zeerust's population is composed of both sedentary populations and those passing through. Apart from transport and transient people, farms and mines around Zeerust are host to large numbers of migrant workers, particularly from Zimbabwe. Additionally, many migrants from Botswana, Zambia, Namibia, DRC and Zimbabwe use Zeerust as a stopover on their way to other areas of the country in search of employment. Often truck drivers have to wait long periods of time as they await inspection and approval from border authorities; thereby, there is ample time to develop a variety of relationships with the surrounding communities (for example, sex workers, fruit vendors and informal traders). Recently, a truck stop was established to provide parking space and accommodation for truckers thus

potentially providing a 'hot spot' for commercial sex. In addition, due to Zeerust's commercial role, farm labourers come to Zeerust at month end and engage in sexual acts with sex workers.

Studies have shown that the intersection between people moving in and out and through border areas is quite complex and dynamic and these interactions are not limited to formal activities (Vearey, Oliveira, Wilhelm-Solomon & Mahati, 2011). Dodson and Crush (2006) found that such border towns have high rates of HIV prevalence due to their transient populations which encounter a more stable local population usually remote from nationally centralised HIV/AIDS intervention programmes. Migrant workers are extremely high HIV prevalence populations with rates over double that of the general population (IOM, 2010). Vearey et al. (2011) report that the conditions associated with migration can increase HIV risk and vulnerability. Migrants in border areas live in conditions of extreme uncertainty and HIV is likely not one of their concerns. Compounded by a lack of adequate shelter and food, and the transient nature of their life, they are likely to have a reduced receptiveness to HIV messaging, including use of condoms. Border areas have been shown to include some high transmission areas where some groups who are at higher risk of acquiring and transmitting HIV are located, including border farms, and truck stops. Vearey et al. (2011) reported that men who visited sex workers at five truck stops in KwaZulu-Natal found that male condom usage was low, with almost one-third of the truckers reported never using male condoms, while less than half reported using male condoms.

Thus, factors such as mobility of workers, being a border town and migration make Zeerust an ideal breeding ground for HIV. As mentioned, these are activities known to increase people's vulnerability to HIV infection (also see for example Gita, Gouw, & Eleanor, 2002). Despite these factors, as far as could be ascertained, very few border-specific HIV prevention interventions are both document in both SADC and Zeerust.

One such HIV prevention intervention includes the use of female condoms. Since its introduction in South Africa, the female condom has attracted a lot of attention. The female condom has the potential to be a popular pregnancy and STI prevention

option, including HIV prevention among female sex workers. It is reusable and can be inserted without the knowledge of the client. As mentioned, little is known about HIV prevention interventions in Zeerust in general, which include research conducted about the use or lack thereof of the female condom among sex workers in the area and whether it makes a difference in HIV prevention efforts.

1.3 Research problem

With no studies reporting on sex work and female condom matters in Zeerust, little is known about the acceptability and usage of the female condom among sex workers in this area.

1.4 Research Question

The research question is formulated as follows: *Is the female condom used as HIV prevention method among sex workers in Zeerust, North West Province, South Africa? And if so, how acceptable is the female condom among these respondents?*

1.5 The Aim and Objectives of the Study

The aim of the research study is to assess acceptability and uptake of the female condom among female sex workers.

The objectives of the study were:

- To identify if female sex workers use female condoms during sex
- To establish other types of protection they use
- To establish the extent of knowledge female sex workers have on risky sexual behaviour
- To assess the beliefs female sex workers have regarding the female condom
- To make recommendations based on the findings of the study

1.6 Significance of the Study

Zeerust is situated in one of SA's poorest provinces, NWP. Women are highly vulnerable to turn to high-risky sexual behaviours due to their low socio-economic status. In the context of HIV/AIDS, the female condom can liberate and empower them, particularly those engaging in transactional and commercial sex. Establishing female sex workers' views of the female condom underpins prevention programming.

The findings from this study could benefit female sex workers, their clients and the community of Zeerust at large. Furthermore, it is envisaged that the findings could inform policy with regards to female and male condoms marketing and distribution.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter begins with a brief epidemiological status of the global, SSA and South African HIV epidemics. It delves shortly on the interplay between HIV and women and prevention interventions being implemented. It further sheds light on FC1, a model of the female condom, through reviewing existing literature, and demonstrates the relevance of the study within the existing body of knowledge. In this regard, this section will explore the following issues: knowledge about the female condom; effectiveness of the female condom and the female condom and sex workers.

2.1.1 The Global HIV Pandemic

According to UNAIDS Report (2012), a milestone has been achieved; AIDS responses (e.g. Prevention of Mother-to-Child Transmission, integrating HCT into other public health programmes, scaling-up of VMMC, provision of ARTs) have caused a 50% reduction in the rate of new HIV infections across 25 developing countries, particularly in Africa (World AIDS Day Report, 2012). The interventions are impacting greatly on the most vulnerable groups, pregnant women and new born babies. The same report notes that the number of children newly infected with HIV in 2012 was 35% lower than in 2009, whereas antiretroviral drugs were provided to

62% of pregnant women living with HIV. In low-and-middle income countries, a total of 9.7 million people received ARVs (UNAIDS, 2013).

Despite these massive efforts and achievements, the global picture still reflects “pockets of resistance”. Globally, 35.3 million people are estimated to be living with HIV (UNAIDS Report on the Global AIDS epidemic, 2013). The most affected subpopulation is the 15-49 year olds, of which 0.8% was living with HIV. This is the most productive and reproductive age group. The epidemiology of HIV is not uniform across countries and regions. It varies between countries, regions and provinces. In Eastern Europe and Central Asia, a wave of new HIV infections has been experienced driven by injecting behaviour.

In Asia, there are variations in the epidemics, both between and within countries. Some countries’ epidemics appear to have stabilised, others have decreased while Malaysia, the Philippines and Thailand are experiencing increasing HIV prevalence among people who inject drugs (UNAIDS, 2013).

The Caribbean, a region characterised by laws that criminalise sexual behaviours and orientations, has high HIV prevalence among men who have sex with men and sex workers. The 2010 report of UNAIDS reports that the region had an estimated 240 000 people living with HIV in 2009. Females are the most affected, accounting for 53% of all people living with HIV.

Central and South America is another region where the epidemics are concentrated primarily among men who have sex with men. The incidence rates of 3% - 5% among men who have sex with men are higher than those observed in Europe and North America among the same subpopulation. The overall figures of people living with HIV continued to grow to an estimated 1.4 million in 2009 (UNAIDS, 2010).

2.1.2 The Sub-Saharan Africa epidemic

The region home to about 11% of the earth’s population, sub-Saharan Africa bears an inordinate share of the global HIV burden (Goliber, 2002). According to UNAIDS report (2010), an estimated 22.5 million people were living with HIV in this region, accounting for 68% of the global total. The region, however, is experiencing marked decreases in HIV incidence and AIDS-related mortality due to a cocktail of

measures implemented. Apart from being primarily a heterosexual epidemic, pockets of drug injecting epidemics have surfaced in the region with prevalence of 36% (Kenya), 26% (Zanzibar) and 12% (South Africa).

2.1.3 The South African Epidemic

South Africa is among the countries in the lower part of SSA most affected by AIDS with an estimated 6.4 million people living with HIV in 2013 (Shishana, 2013). The adult prevalence (15-49 age group) is estimated at 17.9% and women continue to be disproportionately affected by HIV/AIDS, accounting for 3.4 million people living with HIV/AIDS (UNAIDS, 2013). South Africa bears the greatest HIV epidemic burden in SSA and is the third worst affected in the world. A recent HIV household survey by the Human Sciences Research Council found a national prevalence of 12.3% (Shishana, 2013).

Recent surveys show that the national prevalence is decreasing especially among antenatal women (Antenatal Sentinel HIV and Syphilis Survey, 2011) although provincial epidemics remain high with KwaZulu Natal having the worst provincial epidemic (27.6%) followed by Mpumalanga (26.0%) and Western Cape with the lowest prevalence (Shishana, 2013).

2.1.4 HIV and Women

In its infancy, HIV infection was mainly pronounced among gay men (MSM) (UNAIDS/World Health Organisation-WHO, 2003). Today, the HIV pandemic has become a heterosexual pandemic, striking women more than men. Worldwide, women account for more than half the 40 million people living with HIV. The situation is worse in SSA where 57% of adults with HIV are women, and young women aged 15-24 years are more than three times likely to be infected than young men (UNFPA Women and HIV/AIDS; Confirming the crisis, 2004).

Women are more vulnerable to become infected than men because of female physiology (that is, the anatomical design of their sexual organs), social and structural reasons (Nyoni, 2008). Many African women are subordinate to men in various aspects of their lives, politically, educationally, socially and sexually. Sexual inequality makes them highly vulnerable to sexually transmitted infections, including

HIV and unwanted pregnancies – and often unable to negotiate the use of the male condom. Studies have revealed women's dependence on men, lack of access to education, poverty, sexual exploitation, coercion and rape as factors that heighten their chances of becoming HIV infected (Walker, 2002).

In patriarchal societies, women lack the power to negotiate sexual relationships with their male partners. Relationships that are physically abusive constrain women's ability to negotiate safer sex. Studies have shown that sexually abused women in most cases do not protect themselves thus putting themselves at higher risk of HIV infection (Dunkle, 2004; Rauf, 2010 cited in Chirwa, 2010). Compounded with deeply entrenched socio-cultural norms and expectations on women and sexuality, the gendered nature of poverty makes women highly susceptible to HIV infection. As alluded to by Loewenson and Whiteside (1997), increasing economic insecurity makes women more vulnerable to sexual harassment and exploitation and to trading in sexual activities to secure income for household needs.

2.1.5 HIV and Sex Workers

Female sex workers, along with other marginalised groups such as men who have sex with men and injecting drug users, are often labelled a "key risk group" in the context of HIV/AIDS. HIV has been found to spread rapidly among sex workers, their clients, families and the extended sexual networks before it spreads into the general population (UNFPA, n.d.). According to Morison et al (2001), prevalence among sex workers may reach highs of 75% in mature epidemics. In 2002, a UNAIDS report estimated prevalence among sex workers in South Africa at 50%. Sex work is a highly stigmatised profession and sex workers experience discrimination.

In many settings where prostitution is illegal, law enforcement agencies use anti-prostitution laws to harass, threaten, arrest, beat and sexually coerce sex workers. Studies in Bangladesh, Namibia, India, Canada and United States show that cases of sex workers being harassed, raped, murdered or kidnapped are not acted upon by the police (Cler-Cunningham & Christeson, 2001; Thukral & Ditmore, 2003).

2.1.6 Preventing HIV infection in Women

In the absence of a cure, priority efforts must be put on preventing new HIV infections. According to Salomon (2005), of the 53 million new infections projected to occur in SSA between 2003 and 2020, 55% could be averted through expanded prevention programmes. The disproportionate impact of HIV on women requires that emphasis be put on interventions that reduce women's vulnerability to HIV infection.

Prevention strategies that have been widely implemented include comprehensive knowledge about HIV/AIDS, delay sexual debut (UNAIDS, 2010), and responding to the challenging contexts of women's lives by addressing the underlying vulnerabilities faced by women. These include accessibility to prevention options that women can initiate and control (UNFPA, 2010). One such option is the female condom. Its promotion has provided hope as an alternative tool in empowering women in sexual matters.

2.2 The Female Condom

The Female Condom (see Figure 1) is a sheath inserted in the vagina before sexual intercourse, providing protection against pregnancy and STIs, including HIV (UNAIDS & WHO, 1997). Most studies on the female condom (Feldblum et al., 2001; Fontanet et al., 1998; French, Latka, Gollub, Rogers, Hoover, & Stein, 2003) have concentrated on determining its acceptability, safety, effectiveness and usability when used in sexual intercourse, but little is known when used in anal sex (Napierala, Kang, Chipato, Padian, & Van der Straten, 2008) The female condom has brought hope for women in their endeavours to contain HIV as Peter Piot (former Executive Director of UNAIDS) asserts:

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. ...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 & UNFPA, 2006).

Despite early demand from women themselves, female condom use has remained low. Female condoms have remained relatively expensive compared to male condoms rendering them out of reach of many females (PATH et al., 2006).



Figure 1: The Female Condom: (Picture courtesy of www.avert.org/femcond.htm)

The original female condom (FC1), a product of the Female Health Company, was approved for use by the United States FDA in 1993¹. The FC1 represents the earliest generation of female condoms and is made up of polyurethane. It is odourless, less likely to cause an allergic reaction than latex and has the potential of being used with oil-based and water-based lubricants (WHO & UNAIDS, the Female Condom-A guide for planning and programming, n.d.).

Polyurethane-made female condoms do not require special storage facilities since polyurethane is not affected by variations in temperature, and gives the condom a life span of 60 months. Studies have also proved that the thin polyurethane material conducts heat well thus preserving sensation during sexual intercourse (Chirwa, 2011).

In spite of the above, polyurethane has proved expensive material and newer second-generation female condoms have been developed.

¹ Whenever the term “female condom” is used in this study, it will refer to FC1 polyurethane condom.

FC2 is a second generation female condom made of nitrile, a type of synthetic rubber that is latex-free (WHO, 2007). FC2 is also a product of the Female Health Company and provides the same safety and efficacy, but at a lower cost. FC2 obtained FDA approval in 2009 (Frost & Reich, 2009).

A much improved version of the female condom is one manufactured by Medtech Products Ltd of India. The VA w.o.w (meaning VA worn-of-women) is a female condom that awaits one more clinical trial to be approved by the FDA. Shorter than the FC2, the VA w. o. w is lubricated and made of latex material. The VA w. o. w female condoms claim to have 97% customer satisfaction especially in the EU where they have received the European Conformity (CE) mark for distribution (HIV and AIDS Charity AVERT, 1986).

The Programme for Appropriate Technology for Health Women's Condom is the furthest in the development of female condoms. It is a polyurethane condom developed by PATH in partnership with CONRAD, the Andrew W. Mellon Foundation, the Bill and Melinda Gates Foundation and a number of private donors (Frost et al., 2009). The product is user-friendly and less expensive compared with the FC and FC2. Accessibility studies conducted in SA, Thailand and Mexico have shown positive responses from users, particularly due to its ease of insertion and correct use from first attempt (Patricia, Coffey, Kilbourne-Brook, Austin, Seamans & Cohen, 2006).

The PATH Woman's Condom comes with four small dots of soft, absorbent foam that adhere gently to the interior of the vagina thus holding the condom securely in place during use and releasing easily from the vaginal walls on removal. Insertion is made easier by a rounded cap to the end of the condom, which gathers the condom pouch together until after insertion. Once the condom is inserted, the tip quickly dissolves often in less than a minute (PATH, 2013).

Other female condom variants include Silk Parasol (Silk Parasol Corporation, USA), The Belgian Female Condom (Mediteam, Belgium) and Purity Female Condom (Natural Sensation Company, Colombia) (Frost et al., 2009).

2.3 Effectiveness of the Female Condom

The female condom won initial approval as a barrier contraceptive for women despite relatively high pregnancy rate among users and limited data on its actual effectiveness against STIs. Subsequent studies, however, have provided evidence of its effectiveness. These studies are discussed below.

As a contraceptive, the female condom compares favourably with other barrier methods. A study in China that compared the contraceptive efficacy of the female condom with the male condom showed better results with the female than the male condom, i.e., 1.06 and 1.69 pregnancies per 100 women, respectively, over six months (Xu, Wu & Coa, 1999). Studies in the US and Latin America on the correct use of the female condom, revealed pregnancy rates of 2.6 in the US and 9,5 in Latin America (Farr et al., 1994). Trussel (2004) found in a US study that within the first year of consistent and correct use, about 5% of women relying on the female condom had unintended pregnancy, compared to 2% for male condoms and 6% for the diaphragm.

As an STI and HIV preventive measure, the female condom has proved effective. Soper et al (1994) found evidence supporting the effectiveness of the female condom in preventing recurrent vaginal trichomoniasis in a US study. In a male-female condoms comparison study among Thai sex workers, there was a 24% reduction in the rate of new STIs among those given the choice of using either the male or female condom, compared to groups offered only the male condom (Fontanet, Saba & Chandelying et al, 1998).

The female condom's polyurethane texture is impermeable to a number of small viruses, including HIV. In one study, the female condom's effectiveness was proved to range from 80%-95% at preventing HIV transmission (Sippel, 2008). Concurring with this observation is Trussel's (2008), who showed that correct and consistent use of the condom for a year by a woman having sexual intercourse twice a week with an HIV-positive partner could reduce her risk of acquiring HIV by more than 90%.

In sum, these findings point to the female condom being an effective preventive barrier to HIV and other STIs.

2.4 The Female Condom Acceptability and Use

Warren and Philpott (2003) define acceptability as “the willingness to try, actually use and continue using the method”. According to Chirwa (2011), there have been several studies to assess both short-term and long-term female condom acceptability. Many of these studies have involved female sex workers as study subjects because, according to Deniaud (1997), they generally accept the device more quickly than other women.

Since its inception in 1993, the female condom has gained some popularity in over 70 countries, including US, SA, Zimbabwe and Ghana (Frost et al., 2009). Results from studies conducted in these settings revealed that the female condom is especially popular among commercial sex workers, adolescents and young adults. In the Zimbabwean study, Ray and Maposhere (1997) discovered that both males and females prefer the female condom over the male condom. The female condom was perceived to absolve men from their responsibility for protection and does not interrupt the sexual act.

The female condom has gained acceptance both in the short-term and long-term. Short-term acceptability studies of the female condom undertaken at New York's Harlem Hospital between August 1993 and February 1994 that enrolled 52 women aged 18-57, have shown that two-thirds of the female condom users liked the product (Gollub, 1995), while another study in Zimbabwe (Chizororo & Natshalaga, 2003) found that 93% of women liked the female condom when introduced to it albeit not used it before. Musaba (1998) found that married couples in Zambia used the female condom in one-quarter of all coital acts at three, six and twelve months. Similar continued use of the female condom observations were noted in other studies in different settings. For example, Fontane's (1998) study of 250 Thai sex workers showed that 12% preferred the female condom over the male condom in all sexual encounters. This level of usage and preference continued for the entire six-month study period.

In South Africa, the world's largest market for female condoms after Brazil, a FHI study on the introduction of the female condom conducted among 198 women in four provinces in 2000 showed varying degrees of female condom acceptance. The women were randomly selected from among those who were supplied with the

device at least once. Many of the women interviewed continued using the device beyond initial experimentation. Forty-three percent reported repeated female condom use, with one-third using it more than 10 times. A small minority of respondents noted problems associated with the device, such as difficulty with insertion, noise during intercourse and slippage. Overall, female condoms served to complement – rather than replace – male condoms: 44% of current female condom users also reported using male condoms. Ninety percent of women interviewed said that they had used protection more often since accessing the female condom; however, when asked to elaborate, they referred more frequently to the safety and coverage provided by the female condom than to additional sex acts protected (Family Health International, 2001).

2.5 The Female Condom and Sex Workers

The link between sex work and HIV/AIDS is well documented and current prevention efforts target those with high rates of partner exchange in order to avert the spread to members of the wider population. Drawing from the work of the UNAIDS Inter-Agency Team on Gender and HIV/AIDS, sex work can be broadly defined as “the exchange of money or goods for sexual services, either regularly or occasionally, involving female, male, and transgender adults, young people and children where the sex worker may or may not consciously define such activity as income-generating”. Sex workers are thus adults who earn at least part of their income through the sale of direct sexual contact².

Female sex workers are at higher risk of HIV infection than people in the general population. Research data for more than 50 countries on the prevalence of HIV among female sex workers reveal that female sex workers have a 14-fold higher-risk of infection as women of a similar age in the general population (Overs, 2012). What heighten their vulnerability are not just behavioural factors but also structural factors, such as poverty, homelessness and gender inequality.

Female sex workers are receptive to condom use; however, usage is contingent on partner attitude and the economic reward of not using it. Studies have shown wide

² For the purpose of this study, the term ‘sex worker’ refers to an adult female (>18 years) who provides sexual services in exchange for money or goods.

disparities of condom use among sex workers, from 11% in Bangladesh to 78% in Cambodia (Shin, Kang & Chang, 2004). In another study on female condom acceptability among sex workers in the Dominican Republic, Lara et al (2009) found 76% reporting using the female condom at least once during the final month of the study, compared with 50% that used the diaphragm with male condom and only 9% reported using the diaphragm alone. Studies in the USA, SA, Zimbabwe and Ghana show that female sex workers are interested in using the female condom because it accords them an additional method of protection during sex (Agbiboa, n.d.).

In a Zimbabwean study conducted by Ray et al (1995), 74% of urban women and all the rural women interviewed said that their steady partners liked the female condom. Among sex workers, 92% said that their steady partners liked the female condom and 77% found that their random clients also liked it.

2.6 The need for further research

So far, studies have been reported exploring female condom acceptability and utilisation in SSA, Africa and the rest of the world. As far as could be ascertained, most of these studies did not focus on comprehensive analyses of condom use in both a variety of contexts and by many subgroups of the population. Very few studies have examined female condom acceptability among sex workers and none among sex workers in border towns. Furthermore, socio-cultural contexts and the sexual dynamics sex workers conduct their profession in are not uniform.

In view of the paucity of literature on the female condom as described above, the study encapsulated in this report necessitated and was therefore designed to assess the acceptability and utilisation of the female condom among sex workers, female condom awareness among sex workers, and the usability and general beliefs and perceptions about the female condom among this group in the border town of Zeerust, South Africa.

CHAPTER 3

STUDY METHODOLOGY

3.1 Introduction

This chapter focuses on the method used to conduct the study. The chapter presents details of how, and where, the study was conducted.

3.2 Study Setting



Figure 2: Location of Zeerust in North West Province, South Africa

(www.rainbownation.com)

South Africa is divided into nine provinces which are governed by Provincial Governments. North West is one of the provinces which lies in the north of the

country and borders Botswana in the north-west, Limpopo Province, Gauteng province in the east, the Free State and Northern Cape to the south. It is known as the Platinum Province for the wealth of the metal it has underground. Mahikeng is the provincial capital with Potchefstroom, Klerksdorp, Brits and Rustenburg as other cities and towns (<http://www.southafrica.info/about/geography/north-west.htm> Retrieved on November 13, 2013). Zeerust is habitant to 17 000 people (StatsSA, 2012).

The study was conducted in Zeerust at the following study sites: Club Bloomers, Cosmos Night Club, Boitapoloso Liquor Club and Zeerust Truck Stop.

3.3 Study Sample and Sampling Procedure

For the purpose of this study, the study population comprised of all female sex workers (≥ 18 years) residing in Zeerust. A sample size of 30 female sex workers was drawn from those who used the four night clubs and the 'truck-in' for purposes of selling sex.

A non-probability purposive sampling method was used. Neuman (1997), states that non-probability purposive sampling is appropriate in selecting members of a difficult-to-reach, specialized population. Sex workers are among specialized populations that could be accessed by visiting locations where they solicit and social groups with whom they associate.

Before sampling of the participants, the study was introduced to four field assistants (bar tenders). These used their relations and knowledge of sex workers to recruit and distribute the questionnaire.

3.4 Study Design

The study was a survey research that utilised a questionnaire distributed to participants. This is because the researcher wanted to explore the frequency of female condom use and beliefs regarding the female condom by female sex workers.

3.5 Data Collection Methods

Using the field assistants, participants received an anonymous 18 structured questionnaire they had to complete. The questionnaire gauged participants' demographic characteristics, behavioural and beliefs about the female condom use. Completed questionnaires were placed in and sealed opaque envelopes and submitted to the field researchers from whom the researcher collected.

3.6 Data Analysis

The collected data were analyzed using IBM SPSS Statistics 21. The demographics and condom use behaviours and perceptions by the subjects were analyzed by descriptive statistical methods.

3.7 Ethical Statement

Prior to field work, permission was sought and obtained from the University of Stellenbosch's Research Ethics Committee (REC) and the Departmental Ethics Screening Committee (DESC). In addition, permission was obtained to recruit the bar tenders for purposes of distributing questionnaires to and receiving completed questionnaires from the participants.

Besides ethical approval of the protocol, the field assistants signed consent agreements after the researcher had explained the elements of the study. After discussing the protocol with field assistants, all female sex workers involved in the study signed a letter of informed consent. The sex workers were granted the right to interrupt their participation in the study at any stage and not to be affected in anyway by choosing not to answer the study instrument questions.

3.8 Conclusion

Data was collected using a questionnaire from participants aged 18-49 years who patron four sites in Zeerust. The following chapter will present the findings of this study.

CHAPTER 4 STUDY FINDINGS

4.1 Introduction

This chapter is devoted to discussions of the findings of data elicited from 28 sex workers.

4.2 Demographic Characteristics

Age, marital status, level of education and the type of condom often used during sexual encounters were the characteristics analyzed.

4.2.1 Age of Respondents

Figure 3 shows that out of 28 respondents, 5 respondents were aged 18-20 (18%), 10 fell in the age group 21-29 (36%), only nine were aged 30-39 (32%), and four were aged 40-49 (14%).

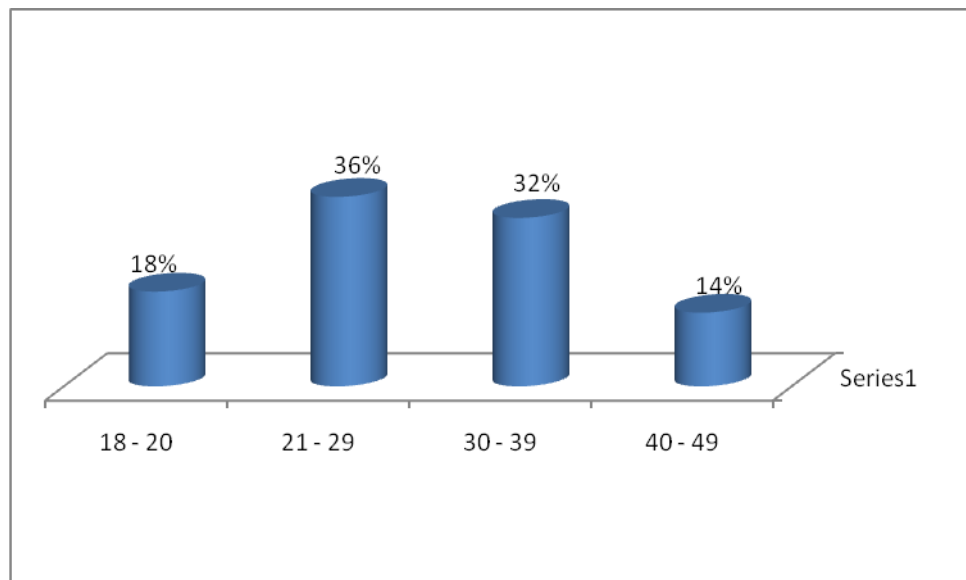


Figure 3: Bar Graph showing the distribution of participants by age

4.2.2 Marital Status of Respondents

Fourteen (50%) of the 28 respondents were single, three (11%) were married; two (7%) participants were cohabitating while nine (32%) participants were either divorced or separated. (see Figure 4).

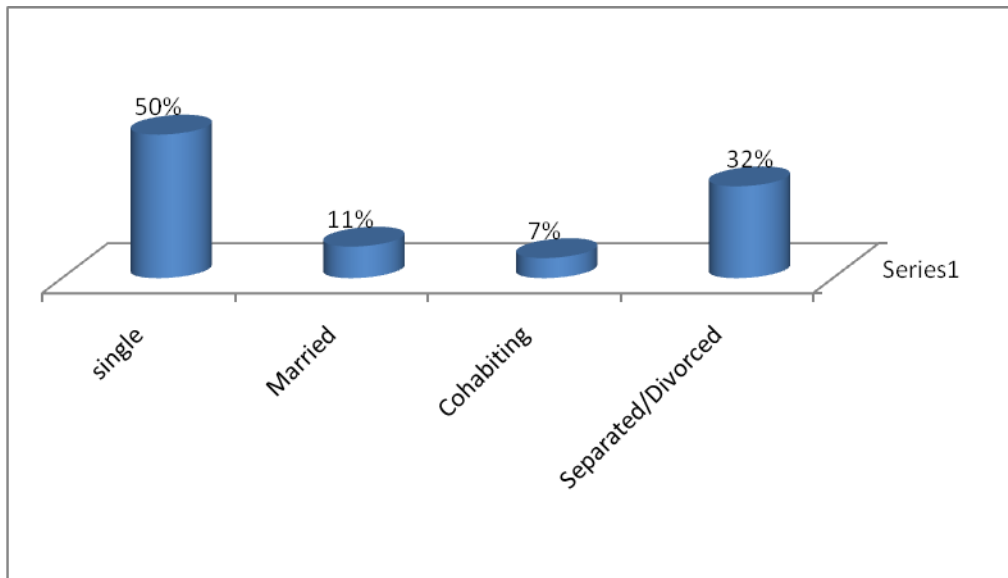


Figure 4: Bar graph showing the distribution of participants by marital status

4.2.3 Educational level

Of the participants (n=28), one participant had primary school education, 18 had completed matric or high school, eight went through a tertiary institution and had college diploma while one had bachelor's degree (see Figure 5).

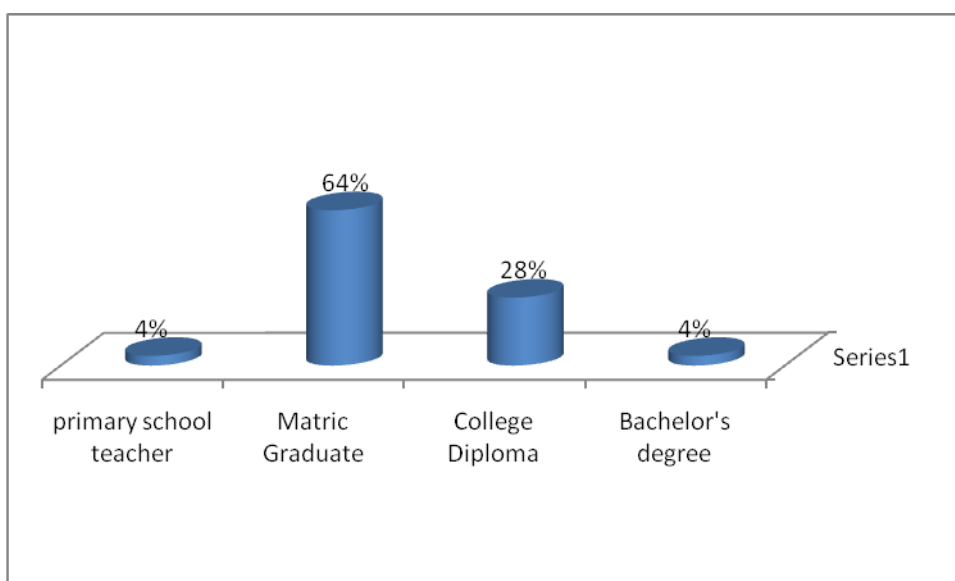


Figure 5: Bar graph showing participants' distribution by education

4.3 Male versus Female Condom Awareness

4.3.1 Awareness of the male condom as a protective device

One respondent (4%) out of 28 respondents indicated lack of awareness of the male condom as a protection device. Twenty-seven (96%) had awareness of the male condom's protective functions (see Figure 6).

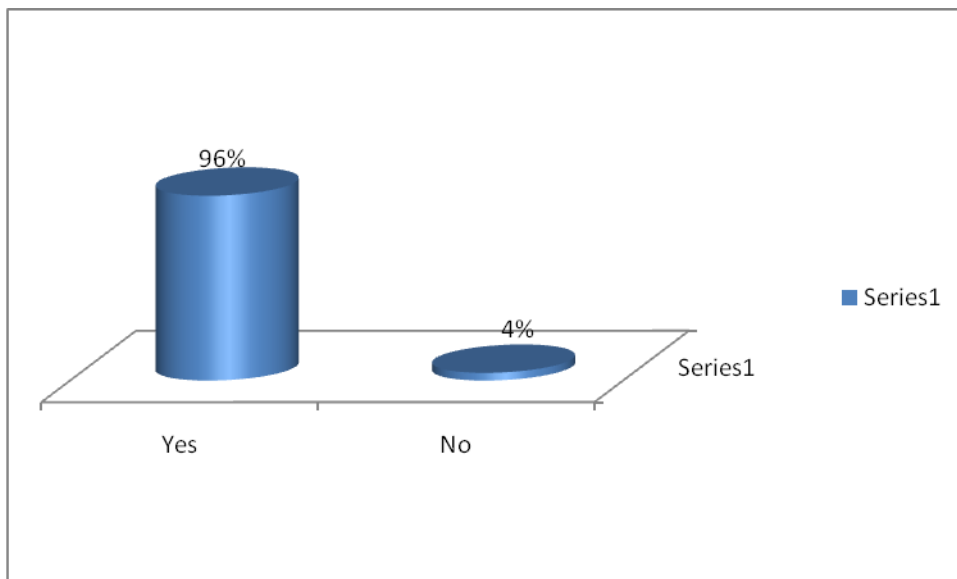


Figure 6: Bar graph: Awareness of the male condom's protective functions

4.3.2 Awareness of the female condom as a protective device

Two of the 28 responds (7%) lacked awareness of the female condom as a protection device, while 26 (93%) had awareness of the female condom as a protective device (see Figure 7).

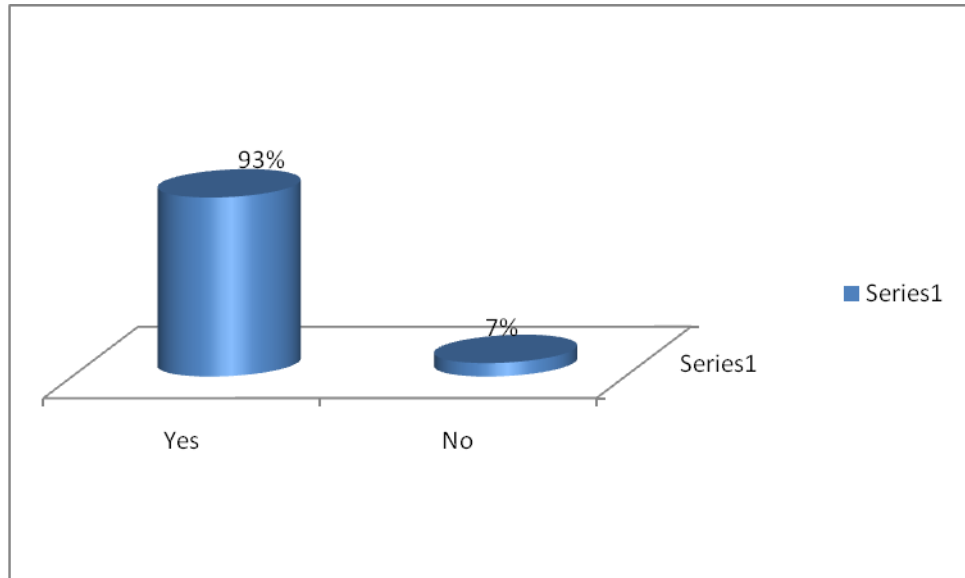


Figure 7: Bar graph: Awareness of the female condom's protective functions

4.3.3 Source of awareness about the male condom

Eighteen (64%) of the 28 respondents heard about the male condom from their sexual partners, five (18%) heard about it from a friend, three (11%) were introduced to it by a nurse, while NGOs and TV/radio account for 3% and 4% respectively. Figure 8 below depicts the distribution of respondents by source of information.

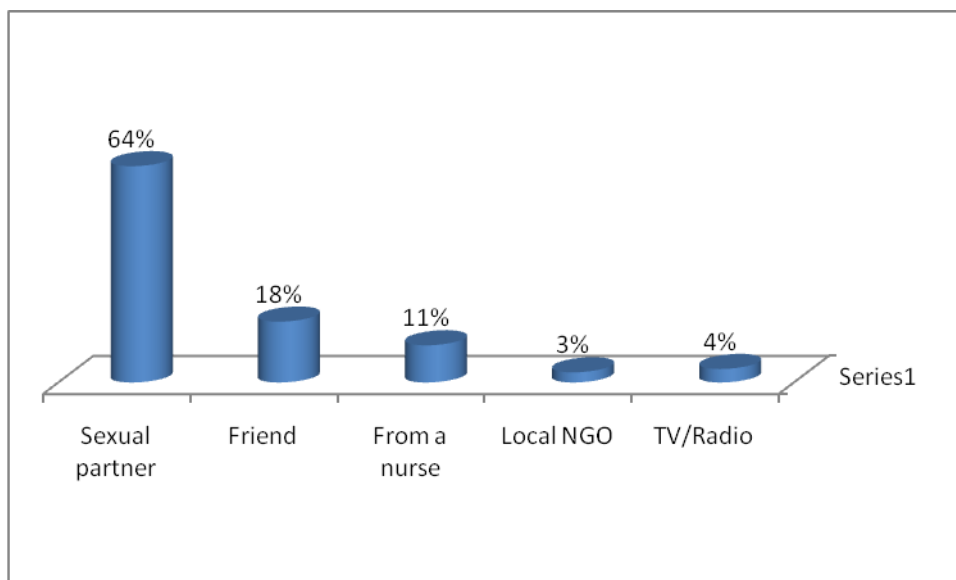


Figure 8: Bar Graph: Source of awareness of the male condom's protective functions

4.3.4 Source of awareness about the Female condom

Three (7%) of the 28 participants heard about the Female condom from their sexual partners, 14 women (50%) heard about it from a friend, six (21%) heard about it from a nurse, three (11%) from NGOs and two (7%) from TV/radio (see Figure 9).

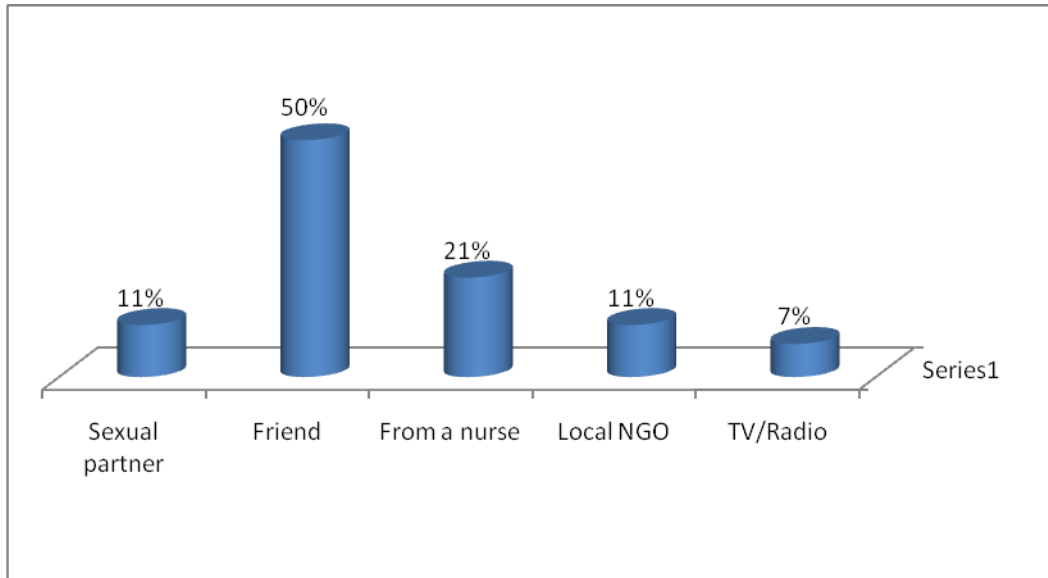


Figure 9: Bar graph: Source of awareness of the Female Condom's protective functions

4.4 Behavioural Characteristics

The section presents the frequency of Female Condom use in the previous one month, 3 months and 12 months

4.4.1 Female Condom Use in the Previous One Month

Fourteen (50%) participants had not used the female condom in the previous month; 12 (43%) of the participants had used the condom on at least on one occasion, while two (7%) had used the condom at least five times. No participant had used the female condom on 10 or more occasions (see Figure 10).

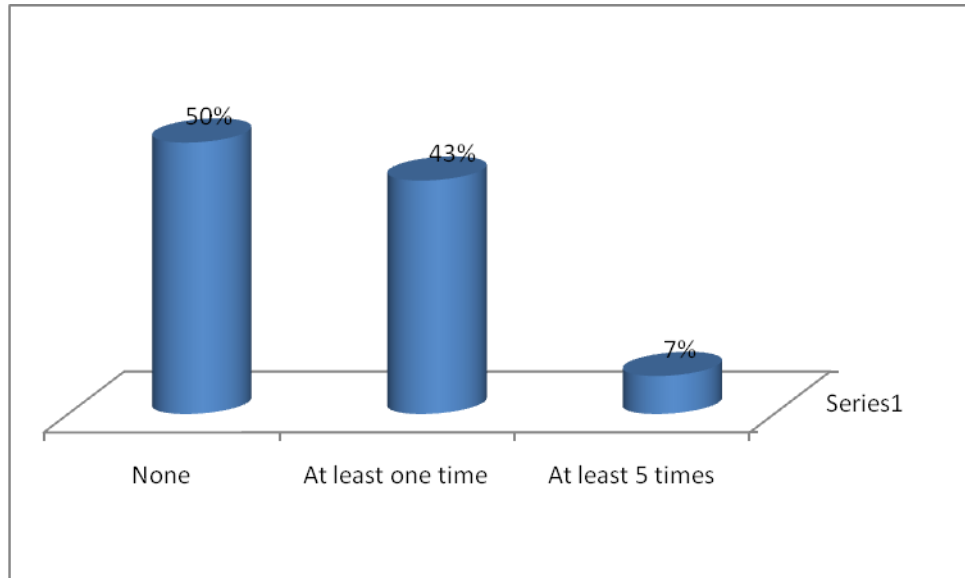


Figure 10: Bar graph: Female condom use in the previous month.

4.4.2 Female condom use in the previous three months

Ten (36%) of the 28 respondents had used the female condom at least in one occasion in the previous 3 months; four (14%) had used the condom at least on five occasions, 14 (50%) had not used the device at all while none had used it on ten or more occasions in the three months preceding the study (see Figure 11).

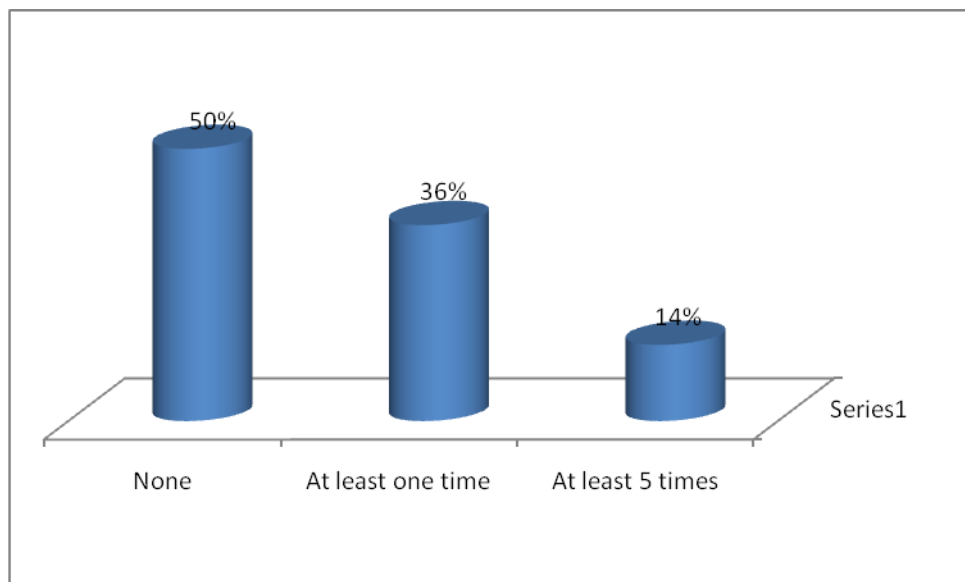


Figure 11: Bar graph: Female condom use in the previous three months

4.4.3 Female condom use in the last 12 months

Only one of the 28 respondents (4%) had used the female condom at least on ten or more encounters in the last twelve months. Four participants (14%) had used the condom on at least five occasions while 11 of the 28 respondents (39%) in the study had used the device at least once in the previous 12 months prior to the study. Only 12 participants (43%) had not used the female condom in the previous 12 months (see Figure 12).

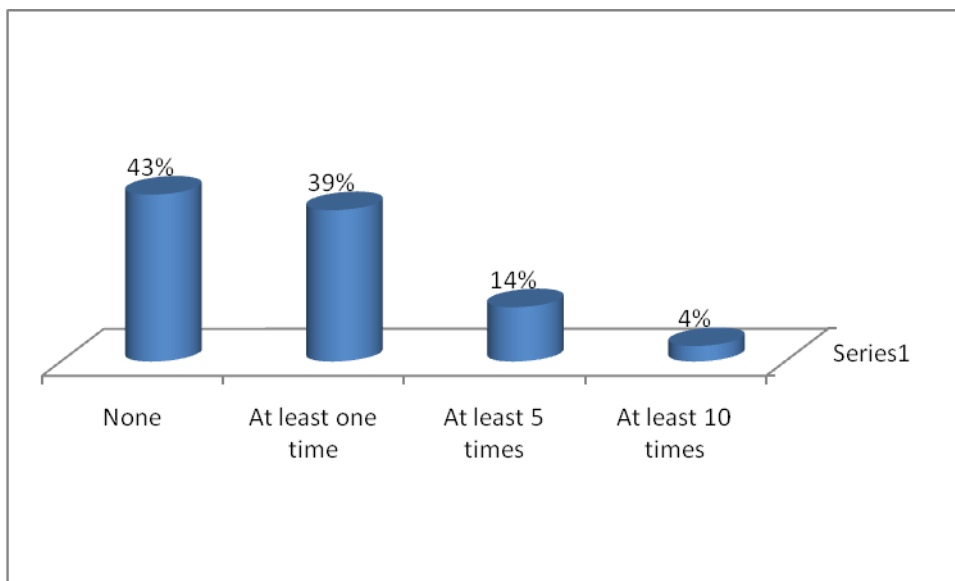


Figure 12: Bar graph: Female condom use in the previous 12 months

4.5 Beliefs regarding the Female Condom

The Likert Scale was used to measure participants' beliefs about the female condom.

4.5.1 Female Condoms are better than regular Male Condoms

Participants who strongly disagreed that that female condoms were better than male condoms were nine out of 28 (32%), nine (32%) disagreed, another nine (32%) were neutral, and only one agreed. No participant strongly agreed that female condoms were better than male condoms (see Figure 13).

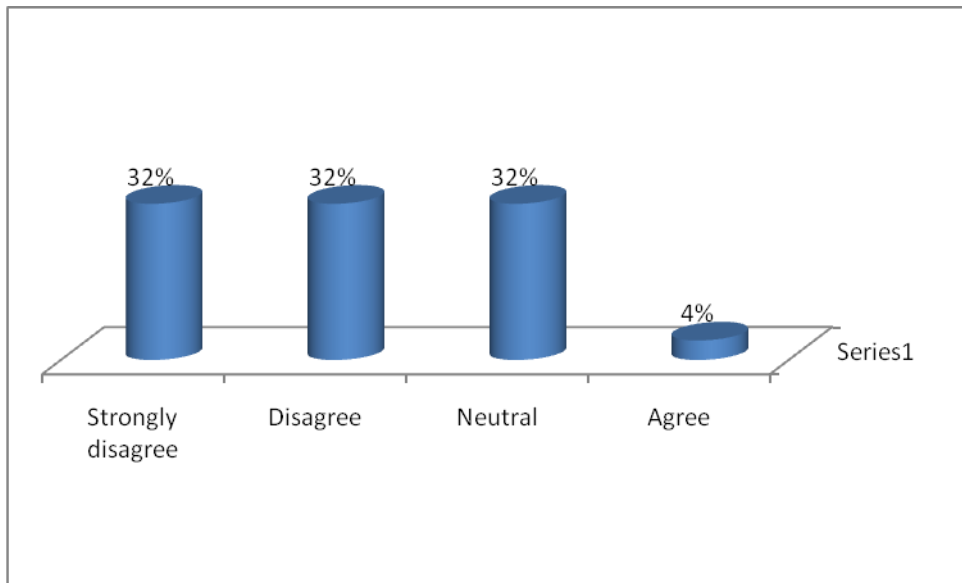


Figure 13: Bar graph: Female condom better than the male condom

4.5.2 Female Condoms are easy to insert

Eight (28.6%) of the participants strongly disagreed, another eight (28.6%) disagreed, 10 (35.7%) were indifferent and only two (7.1%) agreed that female condoms were easy to insert. No participant felt the device was easy to insert (see Figure 14).

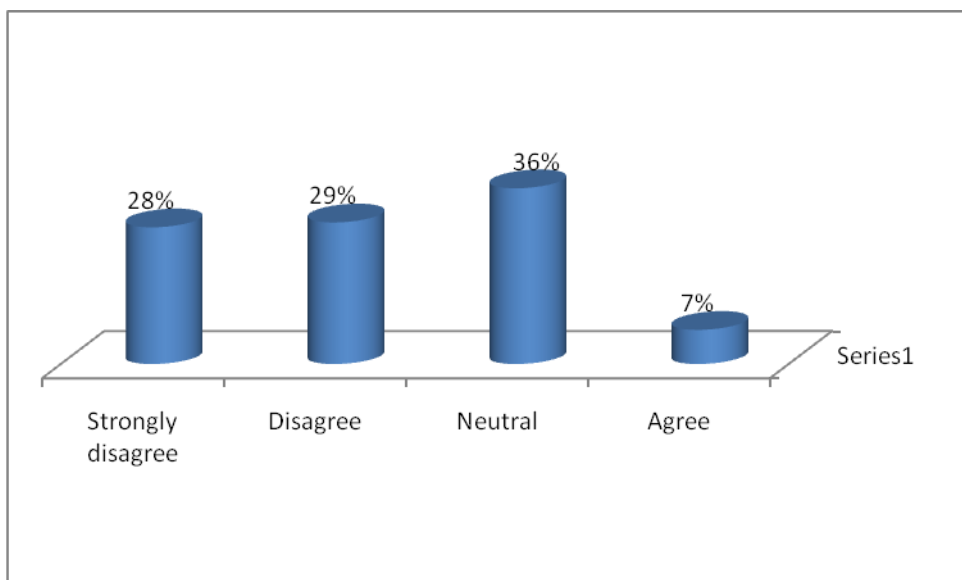


Figure 14: Bar graph: Female condom easy to insert

4.5.3 The female condom is more expensive than the male condom

Four participants felt that the female condom was more expensive than the male condom with strongly agree and agree with two (7%) respondents apiece. Four (15%) disagreed while two (7%) strongly disagree that the female condom is more expensive than the male condom. Eighteen respondents (64%) were neutral (see Figure 15).

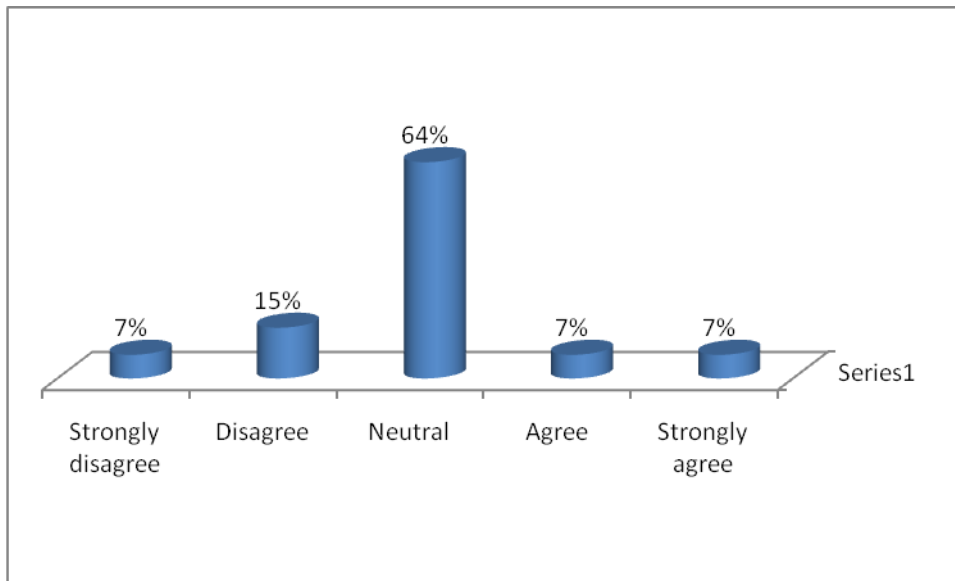


Figure 15: Bar graph: Female condom more expensive than the male condom

4.5.4 The female condom does not look attractive and it puts me off on sight

Twelve of the participants (42.9%) strongly agreed that the female condom looked unattractive and it puts them off on sight, ten (35.7%) agree while two (7.1%) of them disagreed. No respondent strongly disagreed that the device is unattractive and puts them off on sight. Four respondents (14.3%) were neutral (see Figure 16).

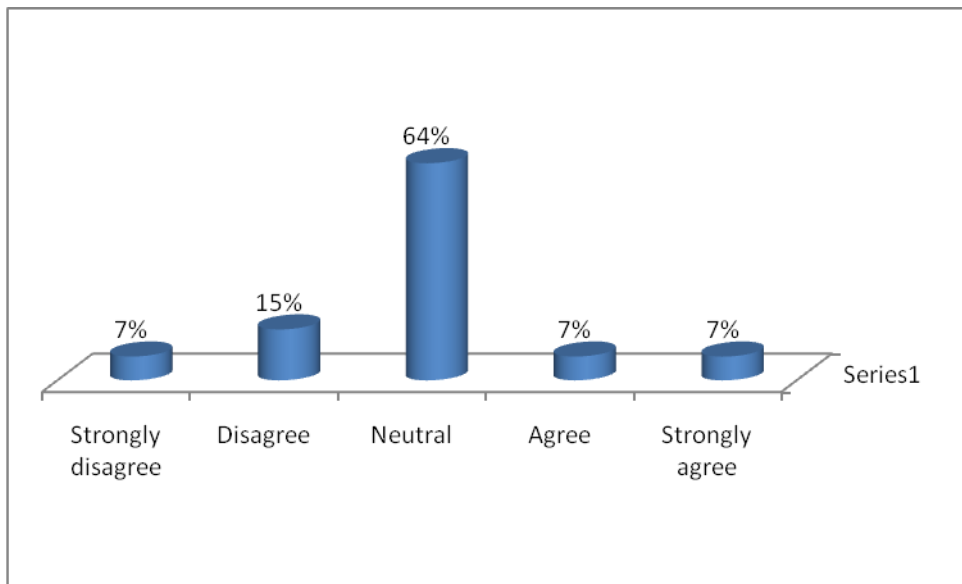


Figure 16: Bar graph: Female condom very attractive

4.5.5 Initiating the use of female condom is against culture

Fifteen out of 28 respondents (53.6%) agreed strongly, seven respondents (25%) agreed, one respondent (3.6%) disagreed and two respondents (7.1%) disagreed strongly that initiating the use of the female condom is against their culture. Three respondents (10.7%) were neutral (see Figure 17).

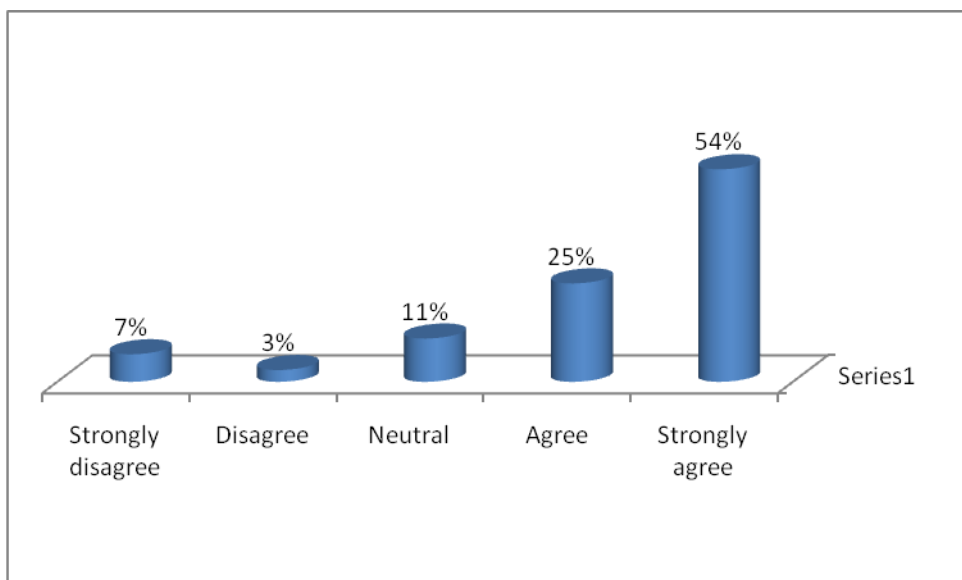


Figure 17: Bar graph: Initiating female condom use against their culture

4.5.6 Sex was as good with Female Condoms

In Figure 18, it can be seen that seven participants (25%) disagreed strongly, seven participants (25%) disagreed, two participants (7%) agreed and two participants (7%) agreed strongly that sex felt good when done using the female condom. Ten participants (37.5%) were neutral.

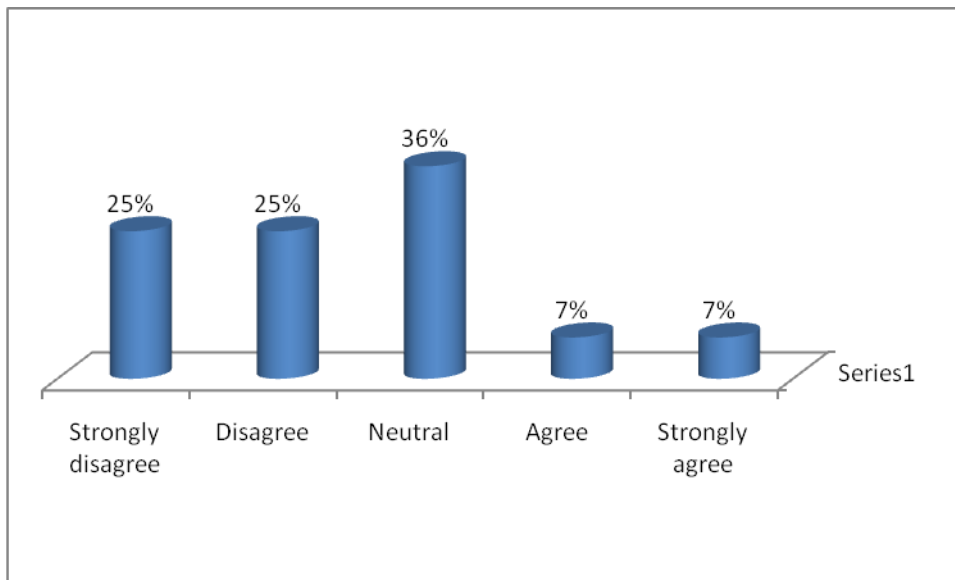


Figure 18: Bar graph: Sex good when done with the Female condom

4.5.7 Clients preferred Female Condoms to Male Condoms

Eighteen respondents (64%) disagreed strongly, seven respondents (25%) disagreed, one participant (3.6%) agreed, and two participants (7%) agreed strongly that their clients preferred the female condom to the male condom. No participant was neutral (see Figure 19).

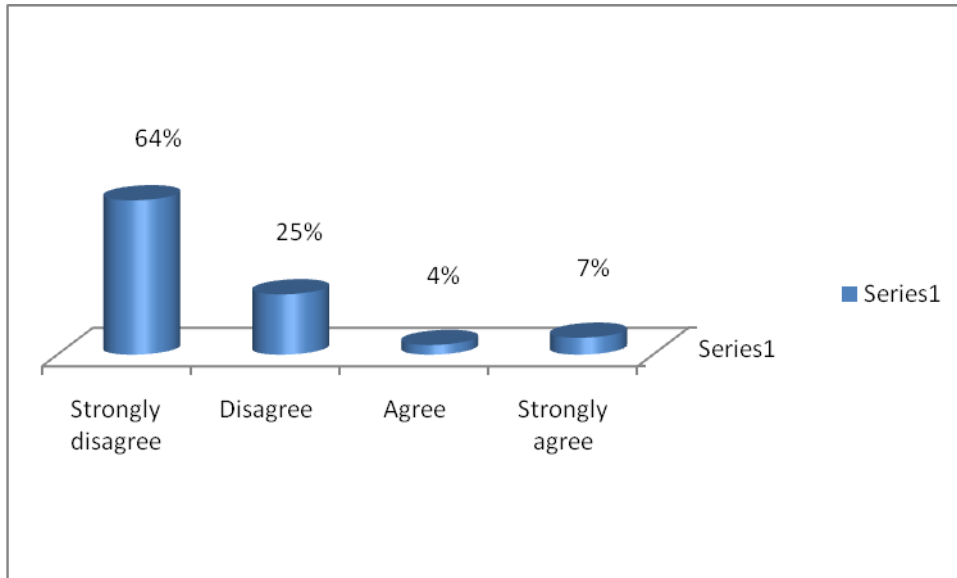


Figure 19: Bar graph: Clients preferred Female condom to male condom

4.5.8 It is culturally shameful for a woman to be seen purchasing condoms

Figure 20 shows that 13 respondents (46%) agreed strongly, 11 respondents (39%) agreed, one respondent (4%) disagreed, and two respondents (7%) strongly disagreed that it was culturally shameful for a woman to be seen purchasing condoms. One participant was indifferent.

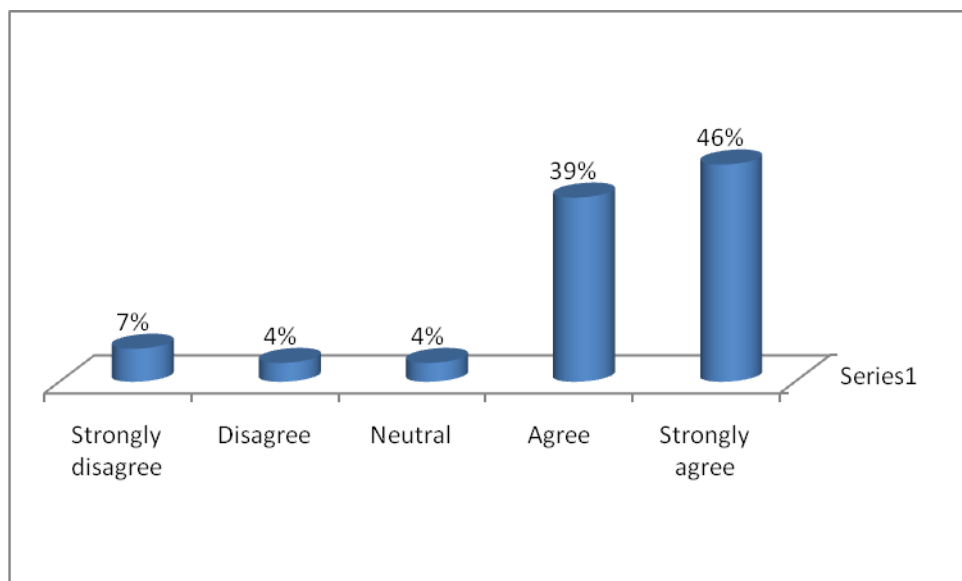


Figure 20: Bar graph: Culturally shameful for a woman to be seen purchasing a condom

4.5.9 Female Condoms not readily and conveniently available in Zeerust town

Ten of the 28 respondents (36%) strongly disagreed, seven respondents (25%) disagreed, two respondents (7%) agreed and no participant agreed strongly that female condoms were readily and conveniently available in Zeerust town. The remaining nine participants (32%) were neutral (see Figure 21).

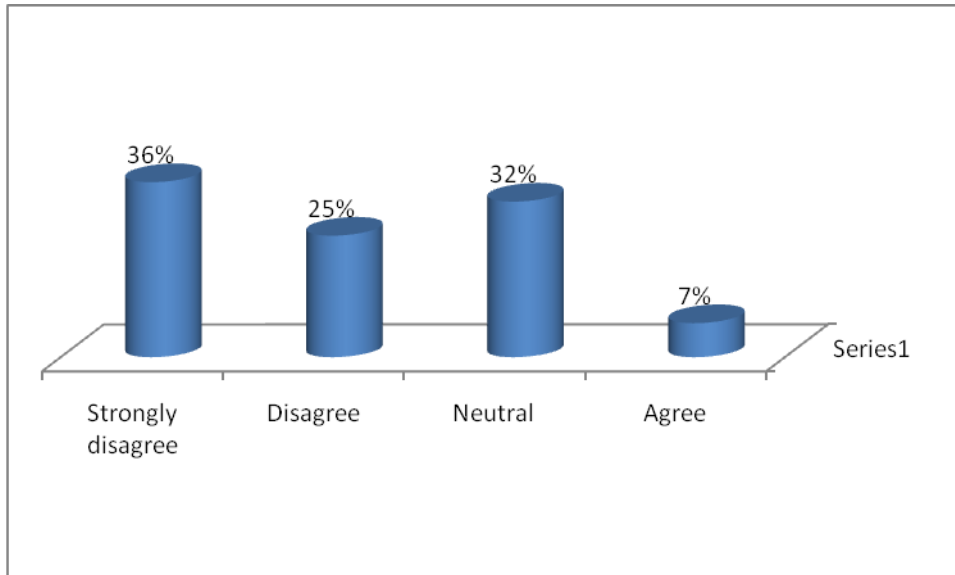


Figure 21: Bar graph: Female Condoms readily and conveniently available in Zeerust town

4.5.10 Female Condoms well promoted in Zeerust town

Ten respondents (36%) disagreed strongly and eight respondents (28%) disagreed that female condoms were well promoted in Zeerust town. No participant was in the affirmative. The remaining ten participants (36%) were neutral (see Figure 22).

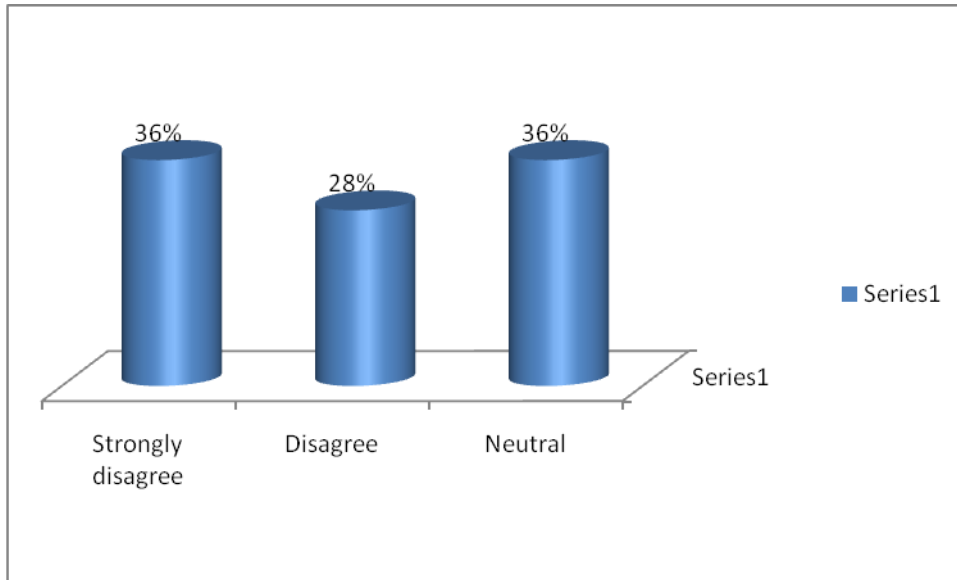


Figure 22: Bar graph: Female Condoms well promoted in Zeerust town

CHAPTER 5 DISCUSSIONS OF FINDINGS

5.1 Introduction

Chapter 5 presents a detailed discussion of the findings of the study. The chapter begins with a discussion on demographic characteristics, followed by a discussion on female condom acceptability. Finally, beliefs and perceptions about the female condom culminate into the conclusion of the chapter.

5.2 Demographic Characteristics

5.2.1 Age

The majority of the respondents were aged 20-29 followed by those aged 30-39. The two age groups constituted 68% of the total participants. These results correspond with findings from studies carried out in Africa which give the average age of sex workers between 25 and 35 years (WHO, 2011).

5.2.2 Marital Status

Eighty-two percent of the sex workers were not married with another seven percent cohabitating.

5.2.3 Educational level

The majority of sex workers (64%) had high school education with a further 32% gone through tertiary education. These results affirm the findings of Statistics South Africa (2011) that 64.4% of urban South African women aged 25 years and older are literate, i.e., they can read in at least one language.

Supporting these findings are findings of a study by Richter, Chersich, Temmerman and Luchters (2013) on sex worker characteristics and risk factors for STIs and ill-health in South Africa. Richter et al. (2013) found that cross-border female migrants in South Africa had higher education levels, predominantly worked part-time and mainly at indoor venues, and earned more per client than internal or non-migrants.

The same study revealed that a high proportion of sex workers in South Africa were cross-border migrants. This constituted 46.3% of the 1636 sex workers studied.

Given the location of Zeerust and the composition of its population, it could therefore be inferred that most of the research participants are cross-border sex workers.

5.2.4 Awareness of the male condom as a protection device

The study revealed that 96% of sex workers had knowledge about the protective purposes of the male condom. These findings are congruent to results obtained in a Zimbabwean study about male condom use among female sex workers. Nearly 70% of the female sex workers were using male condoms frequently with their clients (Ray & Maposhere, n.d.).

5.2.5 Awareness of the female condom as a protection device

With 93% of sex workers acknowledging knowing the protective purposes of the female condom, the study results conform to findings of various studies both in the developed and developing worlds. Acceptability studies done in developing countries have focused on the use of female condoms as means to prevent infections. Confirming the study results are findings of a study among 198 women in SA. The study revealed that 90% of women interviewed had used protection more often since accessing the female condom (FHI, 2001).

Thus, the results show that women in general (and sex workers in this study) are generally aware of the protective functions of the female condom and that it is comparable to the male condom.

5.2.6 Sources of information about both condoms

The results show that male condoms were introduced through personal contact either with clients (males) (64%) of female sex workers or their friends (18%). The conventional media (TV/Radio, local NGOs and nurses) accounted for only 18%.

In contrast, half of the sex workers were introduced to the female condom by friends and 12% by a nurse. The results conform to the generally accepted programmatic approach to condom promotion. In Zimbabwe, Population Services International (PSI) has gone beyond the traditional avenues by reaching female condom users using secure setting—hair salons (Mail & Guardian, 2010). More traditional outlets used are clinics, pharmacies, truck stops and service stations.

5.3 Female Condom Acceptability

5.3.1 Female Condom use in the Previous One Month and Three Months

The study revealed that half of the sex workers (50%) had used the female on one occasion or more in the previous one month and three months and the other 14 sex workers (50%) did not use the condom in the previous one month and/or three months.

These results point to female condom being accepted by the sex workers. However, there could be barriers prohibiting its uptake on a large scale. Studies that involved sex workers done in China, Thailand, Costa Rica, Côte d'Ivoire, and Zimbabwe (Yimin et al., 2002; Fontanet et al., 1998; Mandrigal et al., 1998; Ray et al., 2001, UNFPA, 2002) have shown moderate to high acceptability of the female condom among the participants thus lending strength to this study's findings.

The results concur with earlier results of a South African study which showed that the majority of sex workers continued using the female condom beyond initial experimentation, 43% used it repeatedly, while one-third used it more than 10 times (FHI, 2001).

5.3.2 Female Condom use in the previous 12 Months

The study revealed that more than half of the participants (57%) had used the female on one occasion or more in the previous 12 months. Twelve participants (43%) did not use the condom in the previous three months.

The results from the three attributes seem to point to increasing female condom acceptability among female sex workers in Zeerust town. These results further affirm findings by Beksinska and others (2001) which showed similarly moderate to high female condom use among women in four provinces of South Africa. Acceptability was beyond short-term with 43% reported repeated female condom use and one-third using it more than 10 times (FHI, 2001).

The results further concur with findings of an earlier study on female condom acceptability among sex workers carried out in the Dominican Republic. The study

revealed that 76% of the sex workers used the female condom at least once during the final six months of the study compared to 50% who used the diaphragm together with the male condom, while only one-third used the male condom alone (Lara et al., 2009).

Also supporting the study findings are findings by Musaba (1998) which revealed that married couples used the female condom in one-quarter of all coital acts at three, six and twelve months in a Zambian study.

5.4 Beliefs regarding the Female Condom

5.4.1 Female Condom better than Male Condom

Only one sex worker (4%) agreed female condoms were better than male condoms, yet nine of the participants (32%) disagreed. Another nine (32%) disagreed strongly and the other nine (32%) were indifferent. These results lend explanations to why the majority of sex workers had not used the female condom more often in the past 12 months. The sex workers believed the male condom to be better than the female condom.

These results affirm the findings of Kulczycki and colleagues (2004) that the majority of users rated the female condom as less acceptable than the male condom on a wide range of features. The findings therefore, demonstrate that although the female condom has gained acceptance, it is seemingly not acceptable compared to the male condom.

However, the findings are contrary to those found in the Zimbabwean study in which Ray et al. (1997) discovered that both males and females prefer the female condom over the male condom. The female condom was perceived to absolve men from their responsibility for protection and does not interrupt the sexual act.

5.4.2 Female Condom easy to insert

The results depicted the majority of participants (57%) disapproved that the female condom is easy to insert, whereas 36% were neutral. Only seven per cent believed that the female condom was easy to insert. These findings are similar to a female

condom acceptability study done in Alabama, USA, where the proportions of users finding the female condom difficult to insert were as large as 33-50% (Kulczycki et al., 2004). The results from these two studies seem to show that sex workers and women in general regard the female condom as difficult to use.

The 36% of respondents who were neutral provide an interesting observation. Many factors could contribute to their neutrality: either they have not tried female condom insertion; have tried once and have never used it again or were exposed to the condom but never practiced inserting the condom in an anatomic model and then in themselves under nurse guidance.

5.4.3 The Female condom is more expensive than the Male condom

In total, 14% of respondents agreed and 22% disagreed that the female condom was more expensive than the male condom. The 14% of the respondents who agreed lend credence to why female condom use is very low in Zeerust.

Price has also been identified as a prohibiting factor to continued uptake of female condoms. In South Africa, Femidom is not widely distributed due to cost. The South African government reported that to purchase single unit costs R7 in 2000, thus lowering availability to women as compared to traditional latex male condoms (Thohoyandou Victim Empowerment, 2008). The majority of respondents (64%) were not sure which condom type was more expensive than the other. It could be argued that this finding shows the lack of female condom use or overreliance on the male condom.³

5.4. 4 The Female condom looks physically unattractive and puts me off

The rate of diffusion of a product is among others a function of the product's physical attractiveness. Studies have revealed that the low acceptability of the female condom is due to its mechanical barriers. Physical appearance was identified to be a major snag to female condom use in a study among ICW HIV positive women

³ Although male condoms are freely distributed, there are brands of male condoms that are sold in most convenient outlets such as supermarkets, service stations and in most drinking places. It appears most users of male condoms prefer to buy for fear of being stigmatised. Therefore, the price differential that favours male condoms seemingly explains why sex workers use the female condom sparingly.

(Welbourn, 2006). Women claim the appearance is a turn off to sex. In a comparative qualitative study conducted in Central America, female commercial sex workers also reported negative reaction towards the appearance and size of the female condom (Mack et al, 2010).

With 79% of participants agreeing that the female condom is physically unattractive, the results of this study confirm that participants seem to regard the female condom as physically unattractive hence its low use. Only 7% of participants disagreed that the physical outlook of the female condom is not attractive and 14% of participants were apathetic. These results may explain why the device is still used.

5.4.5 Initiating and using the female condom is against our culture

Traditional and religious beliefs impact on the access, the introduction and usage of barrier methods for protection against HIV transmission. Men have been given the ultimate control over sexual decisions and their bodies as well as condom use; in the process giving them power to direct women's sexuality (Amien, 2008).

The results that showed 54% of participants agreeing strongly and 25% of participants agreeing that it was against their culture for women to initiate the use of a female condom conform to findings of studies done in Southern Africa. According to Southern Africa's traditions or cultural practices, women are not expected to refuse once a man initiates sex (Klugman, 2000). This puts women in a submissive position where they become reluctant to discuss condom use. These deeply-rooted cultural norms may explain why the only female-initiated protective device (female condom) has not diffused so rapidly within the African social system compared to the male condom.

5.4.6 Sex feels as good with the Female Condom

In total, 14% of respondents answered in the affirmative while half (50%) of respondents answered in the negative. Thirty-six percent of respondents were neutral. One reason which may explain these results is an ingrained belief about sex and men's sexual pleasure found in Southern Africa, that is, sex is primarily for men's pleasure (Nyoni, 2008). This could explain the low female condom use as evidenced by a large number of sex workers who felt indifferent in this regard.

5.4.7 Clients prefer the Female Condom over the male condom

The majority of the respondents (89%) disagreed that clients preferred the female condom to the male condom. Eleven percent believed that clients favoured the female condom over the male condom. These results are consistent with what Beksinska and colleagues (2001) observed in South Africa, where the female condom has been incorporated into the National Family Planning Programme. They noted that partner objection was the leading obstacle causing women to abandon use of this device.

Contrary to the study findings, are findings of a research conducted by Ray et al (2001) which revealed that 74% of urban women and all the rural women interviewed said that their steady partners liked the female condom. Among sex workers, 92% said that their steady partners liked the female condom and 77% found that their random clients also liked it. Other contrasting findings were revealed by previous studies among Femidom users in Kenya, Zimbabwe, United States and Venezuela which cited partner's refusal to use a male condom as a reason for introducing the female condom (Dube, 2011).

5.4.8 It is shameful for a woman to be seen purchasing a condom

The majority of sex workers (85%) in the study believed that it was shameful for women to be seen purchasing a condom. Eleven percent of the participants believed that it was not shameful. Four percent of participants were neutral. These results could explain the low female condom use among sex workers given that women must purchase it themselves if they wanted to use it.

5.4.9 Female Condoms readily and conveniently available in Zeerust

Sixty-one percent of the participants believed that female condoms were not readily and conveniently available in Zeerust. Hoke (2007) found that the availability of female condoms was associated with more condom use, and thus better protection against STIs. When female condoms were added to a male-condom distribution system for sex workers, the use of protection with paying partners increased. Extrapolating these findings, it is possible that female condom availability could impact positively on its uptake in Zeerust

5.4.10 Female Condoms well promoted in Zeerust

The majority (64%) of participants did not believe that female condoms were well promoted in Zeerust.

Meekers (1999) noted that promoting female condoms as contraceptives was associated with increased female condom acceptability, and more use. When female condoms were promoted through mass communication campaigns, women's use of the female condom during sex increased. Inferring these findings, it is seemingly possible that promoting the female condom through mass communication campaigns could positively influence female condom uptake in Zeerust.

5.5 Challenges Encountered

The researcher did not experience any major challenges from study planning through report writing. One notable limitation, however, was gaining access to sex workers. The stigmatisation and criminalisation nature of sex work means sex workers are a difficult to reach subpopulation. Furthermore, sex workers are a mobile population. These factors constrained the sample size, resulting in 28 respondents taking part in the study, where the initial aim was to reach at least 30 respondents. One notable limitation, however, was gaining access to sex workers.

The researcher utilised the services of bar tenders who are known by and socialise with sex workers to reach the study participants. Finally, the time frame for the study and the budgetary constraints could not make a big study feasible.

5.4 Conclusion

The study produced varying findings some supporting and others conflicting with the findings of previous research studies. Of possible importance in the context of this study were the findings that female condoms were not readily and conveniently available as well as not being promoted in Zeerust. These findings could help explain the seemingly moderate female condom uptake in the town.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The objective of this study was to investigate the use and accessibility of female condoms by female sex workers in a border town context. Zeerust was chosen as location to conduct this study. Chapter 6 begins with a general conclusion of the study. Then the recommendations constitute the second and last component of the chapter.

6.2 General conclusion

The study revealed that the female condom utilisation and acceptability by female sex workers in Zeerust was moderate.

Although participants had knowledge of the female condom, they believed its physical appearance puts them off and also make it difficult to use. Most believed the male condom was the favoured one by their clients. Cultural beliefs about women sexuality were portrayed as limiting women's freedom to purchase, initiate and use condoms in general. Finally, the study showed that the female condom was not promoted well, not readily and conveniently available in Zeerust.

6.3 Recommendations

The researcher makes the following recommendations based on the findings of the study:

6.3.1 Need for further research

The research established that knowledge of the protective functions of the female condom does not translate into its acceptability. It further, determined that there were mechanical and technical barriers to female condom use. In order to trigger demand-pull effect, research into user preferences, tastes and needs is required. Probably the one-size-fits all female condoms do not work.

The research found that the female condom is unattractive and puts off users on sight. There is, therefore, need to establish the mechanical features of female condoms which act as obstacles to their use. Such understanding would help positioning the product as well as forming the basis for training on condom insertion.

A programmatic challenge emerges from these findings:

If sex workers consider their clients to prefer the male condom over the female condom, are they going to purchase and initiate its use given the transactional nature of the sexual encounter and cultural perceptions? Secondly, even with the best form of promotion and distribution that would increase exposure of the device, would sex workers have the courage to use the female condom? Further research on the female condom has the potential to provide answers to the above programmatic challenges.

6.3.2 Promoting the female Condom

The study found that female condoms are not well promoted in Zeerust. Female condom promotion should be a partnership between government and civil society, drawing lessons from successes of female condom promotions in Ghana, Brazil and Zimbabwe (Barbosa, 1999; Sunanda, 2001).

The study revealed that sex workers have been introduced to the female condom. Pursuant of this observation, the researcher note that simply putting the female condom on the pharmacy shelf does not translate into acceptability. Strategies should integrate the female condom into a country's contraceptive method mix. For instance, PSI Zimbabwe used mass media to position Care female condoms as contraception. Positioning the female condom this way destigmatised its use for HIV prevention (Prevention Now, 2010).

The research identified cultural beliefs as stumbling blocks to increased female condom use. Again, drawing lessons from Zimbabwe's experiences, advocacy has the power to influence change. The researcher recommends government and civic organisations engaged in condom promotion to utilise health care providers and lay educators to endorse the female condom as a contraceptive and protective device.

Female condoms should be at the arm's reach of users. In this regard, the researcher recommends that the distribution of female condoms utilise outlets such as hair salons, nightclubs, truck stops, hotels, pharmacies, supermarkets and tuck shops.

Although the study revealed that the majority of the female sex workers had used the female condom in the previous 12 months, much needs to be done to promote the female condom in Zeerust. Organisations could for example, use theatrical street performances to provide education to both males and females, perform demonstrations on how to use female condoms and providing free samples for trials. Such strategies are credited with the success of female condom acceptability in Brazil. At the end of the Brazilian study, sex workers reported that practise using the female condom increased their comfort with the condom (Horizon, n.d). This could help allay fears that female condoms make sex feel bad as exuded by 86% of respondents.

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Appendixes

Appendix A: Informed Consent Form: RESEARCH ASSISTANT



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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE AS A FIELD WORKER IN RESEARCH

The Utilization and Acceptability of the Female Condom among Female Sex Workers: A study in Zeerust Town, North West Province.

1. Background

You are asked to participate in a research study conducted by **Daniel Chawatama** from the **Africa Centre for HIV and AIDS Management at Stellenbosch University**. The results of the research study will contribute towards the researcher's Master's level thesis as part of a requirement for the completion of the MPhil in HIV/AIDS Management programme. You were selected as a possible participant selector, questionnaire distributor and completed questionnaire collector in this study because of your position as a bar attendant at this night club/ caretaker at this truck-in. Your daily interaction with female sex workers and their clients makes it easier for you to contact them and them and distribute the questionnaire.

2. Purpose of the study

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

3. Procedure

You have been selected and qualify to distribute the study questionnaires. If you agree to take part, you will select eight (8) female sex workers who patron this night club and explain to them the contents of the participant consent form. Once she has understood it, you will ask her to sign the consent form and leave it with you. You

will then hand her a questionnaire and an envelope to be supplied by the researcher. Proceed to inform the participant to place the completed questionnaire in the envelope provided and seal it before submitting the sealed envelope to you.

4. Reimbursement

No remuneration will unfortunately be offered for your participation in this research study.

5. Right to Withdraw

Please note that participation in the distribution and collection of the questionnaire is entirely voluntary, you may refuse to participate. You may also, at any stage, withdraw from the study if you wish to do so without consequences of any kind.

6. 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 not recording any names or personal identifiers in any of the data collection tools. Signed consent forms will be stored in a locked cupboard at the researcher's house at all times. The researcher and his supervisor will be the only persons having access to the data. All information collected will be destroyed after successful completion of the research report, for the purpose of which it was collected. The anticipated period is after one (1) year. Confidentiality and anonymity will be maintained throughout.

The purpose of the study is for the completion of an MPhil degree in HIV and AIDS Management and due to the requirement of the publishing of research findings, the data collected, analysed and interpreted in this study will be reported on. In the writing of the research report, confidentiality, anonymity, and privacy of participants will be maintained at all times.

The information collected will only be used for the purpose mentioned above.

7. Identification of Investigators

If you have any questions or concerns about the research, please feel free to contact the researcher, **Mr. Daniel Chawatama**, at **083 4719085** during office and after hours. If you have any questions or concerns regarding the research, please feel free to contact the supervisor of my study, **Mr Burt Davis** at burt@sun.ac.za or **021 808 3707**.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Mr/s. in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate as a questionnaire distributor and collector of completed questionnaire in this study. I have been given a copy of this form.

Article I. Name of Subject/Participant

Article II. 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 no translator was used.



19 August 2013

Date _____

Section 2.01 Signature of Investigator

Appendix B: Informed Consent Form: RESEARCH PARTICIPANT



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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

The Utilization and Acceptability of the Female Condom among Female Sex Workers: A study in Zeerust Town, North West Province.

You are asked to participate in a research study conducted by **Daniel Chawatama** from the Africa Centre for HIV and AIDS Management at Stellenbosch University. The results of the research study will contribute towards the researcher's Master's level thesis as part of a requirement for the completion of the MPhil in HIV/AIDS Management programme. You were selected as a possible participant in this study because of your patronage to this night club/truck-in where the research will take place.

It is assumed that by agreeing to take part in this study, you are able to read and understand English.

1. PURPOSE OF THE STUDY

Determining the utilization and acceptability of female condoms among female sex workers is important since women-controlled methods are important in the response toward the HIV epidemic, particularly among female sex workers and their clients. The study wants to better establish possible problems to Female Condom use among female sex workers

2. PROCEDURES

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

You will be asked to complete the attached individual questionnaire. The questionnaire will be given to you by a bar attendant/caretaker together with an opaque envelope. Once you have completed the questionnaire, place it in the opaque envelope then seal it and return it to the bar attendant/caretaker. The bar attendant/caretaker will not be allowed to access the information contained in the sealed envelope as the sealed envelopes will be handed over to the researcher.

You may complete this questionnaire at home during a suitable time or at a venue and time which is convenient for you. Completing the questionnaire should not take you more than 20 minutes. Confidentiality, anonymity and privacy of information will be maintained at all times.

3. POTENTIAL RISKS AND DISCOMFORTS

Although there is no foreseeable risk, participants may experience some discomfort in expressing their opinions regarding HIV/AIDS and sexuality, which are topics relevant to Female Condom use and education. No questions will be asked regarding participant's sexuality or HIV status. Participants will be assured of the confidentiality, anonymity, and privacy of the information and that answers to questions are voluntary.

In terms of inconvenience, the questionnaires may be completed at a suitable time that the participant shall find appropriate.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The research results may benefit the female sex workers, their clients and the community at large. Furthermore, it is expected that the findings may inform policy with regards to female and male condoms marketing and distribution.

The study also hopes to benefit the society in that the aim of the study is directed to benefit not only the female sex workers and their clients who will eventually increase acceptance and user of the female condom, but the entire community. The study will allow neighbourhoods from where most female sex workers and their clients come to ultimately reap the benefits derived from increased acceptability and utilization of the Female condom.

5. PAYMENT FOR PARTICIPATION

No remuneration will unfortunately be offered for your participation in this research study.

6. 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 not recording the names or personal identifiers in any of the data collection tools. In reporting the results, care will be taken not to report results in a way that would enable any participants to be identified and/or stigmatized in their views. Completed questionnaires will be stored in a locked cupboard at the researcher's house at all times. The researcher and his supervisor will be the only persons having access to the data. All information collected will be destroyed after successful completion of

the research report, for the purpose of which it was collected. The anticipated period is after one (1) year. Confidentiality and anonymity will be maintained throughout.

The purpose of the study is for the completion of an MPhil degree in HIV and AIDS Management and due to the requirement of the publishing of research findings, the data collected, analysed and interpreted in this study will be reported on. In the writing of the research report, confidentiality, anonymity, and privacy of participants will be maintained at all times.

The information collected will only be used for the purpose mentioned above.

7. 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.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the researcher, **Mr. Daniel Chawatama**, at **083 4719085** during office and after hours. If you have any questions or concerns regarding the research, please feel free to contact the supervisor of my study, **Mr Burt Davis** at burt@sun.ac.za or **021 808 3707**.

9. 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; 021 808 4622] at the Division for Research Development.

In case you need more information about HIV/AIDS (that is, counseling, testing, Antiretroviral Drugs, condom supply) please visit the following organizations.

- **SWEAT Helpline number 0800 60 60 60**

Tel: 021 448 78 75

Email: info@sweat.org.za

- Zeerust Clinic
- Wellness Clinic at the Zeerust Truck Shop
- Zeerust Hospital

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Mr/s. in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.


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

Article III. Name of Subject/Participant

Article IV. 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 no translator was used.



15 June 2013
_____ Date

Section 4.01 Signature of Investigator

Appendix C: Study Questionnaire



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MPhil HIV/AIDS MANAGEMENT 2013/2014

QUESTIONNAIRE ON THE RELUCTANCE TO USE THE FEMALE CONDOM AMONG FEMALE SEX WORKERS: A STUDY IN ZEERUST, NORTH WEST PROVINCE-RSA

Hello, my name is **Daniel Chawatama**, a Masters in HIV Management (MPhil) student at the University of Stellenbosch in South Africa. I am conducting a research to determine factors that contribute to the reluctance to use Female Condom among Female Sex Workers in Zeerust.

Part A: Demography

The following questions will ask some background information about you.

1. How old are you?

18 – 20

21 – 29

30 – 39

40 – 49

2. What is your marital status?

Single

Married

Cohabiting

Separated/Divorced

3. What is the highest degree or level of school you have completed?

Primary School Leaver

GET graduate

Metric graduate

College diploma

Bachelor's degree

Master's degree

4. Have ever heard of the following protection devices?

Male condom

Female condom

5. How did you get to know about

a) Male condom?

Sexual partner

Friend

From a nurse

TV/Radio

b) Female condom?

Sexual partner

Friend

From a nurse

Local NGO

TV/Radio

Part B: Female Condom Use

Some questions in this section will ask personal information such as your sexual behaviour, and may make you feel uncomfortable. Remember there are no right or wrong answers and your honesty is greatly appreciated.

6. How many acts of sexual intercourse have you used the female condom in the last one month?

None

At least one time

At least 5 times

At least 10 times

Always

7. In how many acts of sexual intercourse have you used the female condom in the last 3 months?

None

At least one time

At least 5 times

At least 10 times

Always

8. In how many acts of sexual intercourse have you used the female condom in the last 12 months?

None

At least one time

At least 5 times

At least 10 times

Always

Part C: Beliefs regarding the Female Condom

Depending on what you understand, what do you think of each of the following statements about the female condom?

9. Female condoms are better than regular male condoms

Strongly Agree

Agree

Disagree

Strongly Disagree

Neutral

10. Female condoms are easy to insert

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

11. The female condom is more expensive than the male condom

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

12. The female condom does not look physically attractive and it puts me off on sight.

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

13. Initiating the use and using a female condom is against our culture

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

14. Sex feels as good when you use a female condom

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

15. Clients prefer the female condom to the male condom

Strongly agree

Agree

Disagree

Strongly disagree

Neutral

16. It's culturally shameful for a woman to be seen purchasing a condom.

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

17. Female condoms are readily and conveniently available in Zeerust town.

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

18. Female condoms are well promoted in Zeerust town

Strongly Agree

Agree

Disagree

Strongly disagree

Neutral

Thank you for taking time answering this questionnaire.