



MIDLANDS STATE UNIVERSITY

**ASSESSING AND EXPLAINING THE FEMALE CONDOM UPTAKE IN
CHIKOMBA DISTRICT.**

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BY

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RELEASE FORM



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APPROVAL FORM

The undersigned certify that they have supervised the student Lucy Matenhese (R115338N)'s dissertation entitled: Assessing and explaining the uptake of the female condom in Chikomba district, submitted in partial fulfilment of the requirements of the Bachelor of Arts in Development Studies Honours Degree at Midlands State University.

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DECLARATION

The student (R115338N)thereby declare that this research is a product of her own work .It is being submitted in partial fulfilment of the requirements of Development Studies Honors in the Faculty of Arts at Midlands State University.

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Student

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Date

DEDICATION

This research is dedicated to my lovely parents Mr Elisha and Mrs Elizabeth giving thanks for having so much faith in me in whatever and wherever she go.

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ACRONYMS

AIDS	: Acquired Immune Deficiency Syndrome
ART	: Anti-Retroviral Therapy
BCF	: Behaviour Change Facilitator
CeSHHAR	: Centre for Sexual Health and HIV/AIDS Research
C.R.D.C.	: Chikomba Rural District Council
DAAC	: District AIDS Action Committee
DAC	: District AIDS Coordinator
DA	: District Administrator
EMTCT	: Elimination of Mother to Child Transmission
FC	: Female Condom
FP	: Family Planning
HIV	: Human Immune Virus
ISP	: Integrated Support Program
MoHCC	: Ministry of Health and Child Care
MSF	: Medicines San Frontiers
MWAGCD	: Ministry of Women Affairs Gender and Community Development
NAC	: National AIDS Council
NGO	: Non- Governmental Organisation
PS I	: Population Services International
STI	: Sexually Transmitted Infection

UNFPA : United Nations Population Fund

USFDA: United States food and Drug Administration

VMMC : Voluntary Medical Male Circumcision

WHO : World Health Organization

WAG : Women Action Group

ZAPSO : Zimbabwe AIDS prevention Service

ZICHIRE : Zimbabwe Community Health Intervention Research

ZNFPC : Zimbabwe Family Planning Council

ABSTRACT

HIV/AIDS has been a major problem in Zimbabwe and mostly affecting women such that of the infected people in Sub Saharan Africa women constituted 60% . This growing evidence led to the introduction of the female condom in 1997. In Chikomba district despite the introduction of the female condom its uptake is significantly low. The theory of planned behaviour and the Health belief model guided through understanding the findings of the research. The study was largely qualitative and with the use of interview and Focus group discussions as data collection methods. This was an analytical survey in which the sample size was 94 participants .Data gathered was analysed using thematic techniques. The study revealed that the female uptake in Chikomba district was significantly low and this was attributed to a number of factors such as lack of knowledge, socio cultural barriers, lack of male involvement, mechanical factors such as the shape of the female condom, myths and misconception surrounding, unavailability of the device and high cost .As means of enhancing the uptake of the female condom the government of Zimbabwe through the Ministry of Health and Child Welfare was recommended to channel funds to the promotion of the female condom as a long term program .Providers were also recommended to lower the cost of the device, educate people using models, involve males, and also target traditional and religious leaders.

INTRODUCTION

The study was focusing on the uptake of the female condom in Chikomba district. The study's objectives were to find out levels of uptake, establish the factors that influence accessibility and acceptability of the FC and come up with a way forward. The theory of Planned Behavior was used in the study and on conceptual framework the Health Behavior Model was also used. Data was collected using interview schedules and Focus Group Discussions and the target population was women of the reproductive health and National AIDS Council officials. Qualitative data was analyzed using thematic techniques.

1.1 Background to the study

Chikomba district is situated in Mashonaland East Province in Zimbabwe. In Zimbabwe HIV levels are high in women and according to ICASO (1998) women between the ages of 15-19 have HIV infection rate which is five times higher than males of their same age. The number of women living with HIV and AIDS has overtaken the number of infected men. By the end of 2002 in sub-Saharan Africa, 58% of adults infected with HIV were women (UNAIDS, 2002). Also sub Saharan Africa has already borne the brunt of this epidemic more than any other region in the world. Barnet and Whileside(2002). Generally, women are at a greater risk of acquiring HIV infection through unprotected heterosexual intercourse than men. In one study, Abercrombie (1996) found that female partners of HIV-infected men were 15 times more likely to become infected than male partners of infected women. Strebel (1993) attributes part of women's vulnerability to the anatomical design of women's sexual organs which puts them at risk of easily contracting HIV. Sub Saharan African countries including Zimbabwe have been hard hit by the epidemic and according to the Joint United Nations Program on HIV/AIDS (UNAIDS) report roughly 50 % affected people worldwide with HIV are women and in Sub Saharan Africa women make up close to 60% of the infected. UNAIDS(2010).

Advocacy of the female condom thus emerged due to the ever growing evidence that women are at an increased rate of contracting HIV and a barrier method over which women have control over a female condom was introduced in early 1990s. To this end the Population Council (2009) mentioned that with the support of UNAIDS both the public and private sector in more than 90 developing nations Zimbabwe included have introduced the female

condom to the public through public distribution ,social marketing campaigns and social outlets. Zimbabwe in 1997 became the first country in Africa to advocate for and successfully bring Female Condom supplies to the population. For multiple reasons the female condom uptake has been a cause of concern especially in rural areas thus the reason for the research to be conducted in Chikomba district where it is both an urban and rural setting.

Chikomba district is well known for high HIV prevalence in Mashonaland East since it is a district without much economic activity many people especially women tend to get into prostitution to earn income .Harare –Beitbridge road which goes to South Africa also passes through Chivhu a small town in Chikomba district and trucks are provided parking space and accommodation .It has been depicted that along trucking routes in Southern Africa there is very high HIV prevalence rate than in other areas. Truck drivers often develop relationships with sex workers and informal traders providing a very conducive environment for commercial sex to an extent that some of the young girls from surrounding farms could migrate to Chivhu town to be sex workers thus making Chikomba women more vulnerable to HIV/AIDS.

Due to these statics given above since HIV have no cure prevention is vital thus biomedical strategies of prevention and behavioral change encouragement through encouraging the use of female condoms will protect the women from being at a high risk of contracting HIV/AIDS,STIs and unintended pregnancies .Given the background of women's vulnerability interventions that target women need to be seriously considered .It is in light of these factors that a need of an increased condom uptake rate should be encouraged.

Strategies to prevent the spread HIV/AIDS which has been applied before the female condom include giving comprehensive information and knowledge about the virus and disease, delaying sexual activities, abstinence, and faithfulness (UNAIDS 2010). Though these strategies were universal the underlying vulnerabilities faced by women were not addressed .There was the absents of control measures that were meant to be controlled by women and that is what led to the introduction of the female condom and its promotion is very vital in terms of empowering women in sexual.

1.2 Statement of problem

Despite the female condom having been approved by the United States Food and Drug Administration in 1993 and Zimbabwe launching and advocating it in 1997 for the purpose of availing a female initiated protection tool for the control of pregnancy, HIV and Sexually Transmitted Infections, the uptake of the female condom has been low in Chikomba district. Therefore there is need to find out and address factors leading to the present uptake of the female condom in the district

1.3 Research Objectives

1. To find out the levels of female condom uptake in the district.
2. To identify factors leading to the present uptake of female condoms in Chikomba district.
3. To find out the knowledge levels of women in the district on the use of female condoms.
4. To make recommendations on what Chikomba district should do to increase the uptake of female condoms.

1.4 Research Questions

1. What factors have led to the present uptake of female condoms in Chikombadistrict ?
2. What has the levels of the female condom uptake been like in Chikomba district?
3. What is the knowledge level of people in Chikomba district on female condoms?
4. What are the recommendations needed to boost the uptake of female condoms in the district?

1.5 Significance of Study

The research on the uptake of female condoms might go a long way in helping to explain the reasons behind low female condom uptake not only in Chikomba but country wide among other developing nation and other interested stake holders. This will then help to develop mitigating strategies to maximize the uptake of female condoms which ensures women empowerment on their Sexual and Reproductive Health and Rights and prevent the spread of HIV, STIs and unwanted pregnancies.

The study will the National AIDS Council (NAC) office in Zimbabwe to shed more light on female condoms since strategies based on evidence will be available to address the challenges surrounding the uptake of the female condom.

Since there has not been much research conducted concerning female condoms in Chikomba district the findings of this study will assist in building a body of knowledge on the perceptions surrounding the female condom in the district.

This research also aims to strengthen district based research initiatives as it will build capacity needed to conduct more researches projects to address challenges facing districts. The study might also provoke other researchers to look into other districts as well and find out the challenges from the clients in other districts to ensure the whole country is addressed.

Findings of this study will identify specific areas in female condom usability and perceptions, and provide the Chikomba district and the Zimbabwe Ministry of Health with information that will help in planning female condom programs

The research may help lead to the increased uptake of the female condom in the district

Women in Chikomba district might benefit from the research since it will help improve women's knowledge of the female condom and do away with the myths and misconceptions attached to the use of the female condom. This increased use will then ensure that the country's goal of getting to ZERO will be achieved since there will be no new HIV infections the female condom is an effective tool of preventing HIV.

An understanding of the reasons behind the present uptake of female condoms could assist program implementers in the district such as the MoHCC Ministry of Health and Child Care, MSF Medicine San Frontiers (Belgium), ZICHIRE Zimbabwe Community Health Intervention Research, CeSHHAR to mention but a few, to change or make adjustments towards promoting the female condom to meet the expectations of their clients thus leading to the improved uptake of female condom.

The findings from this study could benefit female commercial sex workers their clients and the community of Chikomba at large .Furthermore, the findings could also inform policy with regards to female and male condoms marketing and distribution

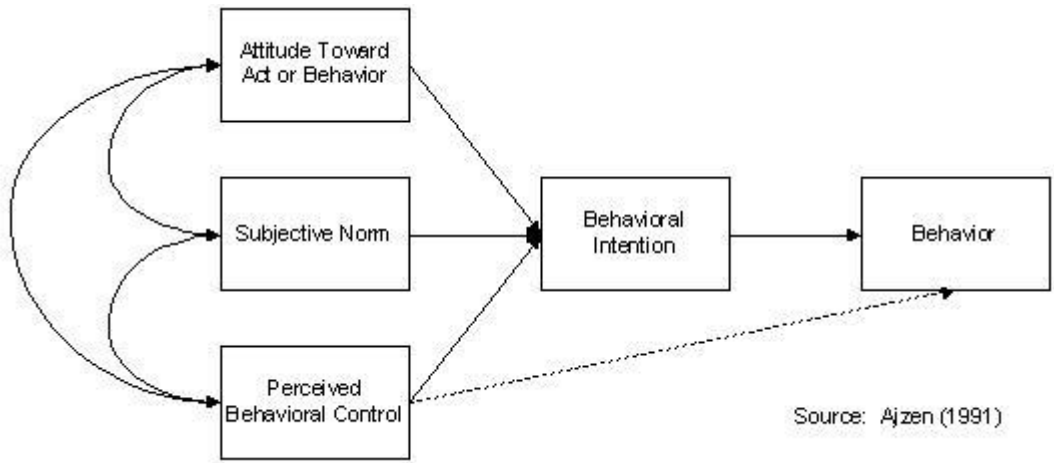
1.6 Theoretical Framework

The Theory of planned behaviour is a theory that is based on the idea that a change in behaviour starts with an individual having the right knowledge about a certain issue .An individual needs to change his or her attitude towards the issue, and finally alter his or her practices and behaviour. The theory was intended to explain all behaviors over which people have the ability to exert self-control. The key component to this model is that behavioral intentions are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome.

The analysis of the research will be based on the theory of planned behaviour. This theory distinguishes between two categories of mutually related factors that may influence intentions, behaviour, and behaviour change: personal factors and external factors. Personal factors include knowledge, risk perception, attitudes, skills, and self-efficacy. External factors include the social, religious, economic, and cultural contexts (including gender relations), social influence, and other external factors depending on the type of behaviour under study.

The theory however have its own weaknesses which are going to be explored by the study since it assumes the person has acquired the opportunities and resources to be successful in performing behavior being desired, regardless of the intention. It also does not account for other variables that factor into behavioral intention and motivation, such as fear, threat, mood, or past experience .Although it does consider normative influences, it does not take into consideration the environmental and economic factors that may influence a person's intention to perform a behavior. According to the theory behavior is the result of a linear decision-making process, and does not consider that it can change over time.

Fig 1 Diagram/schematic of theory



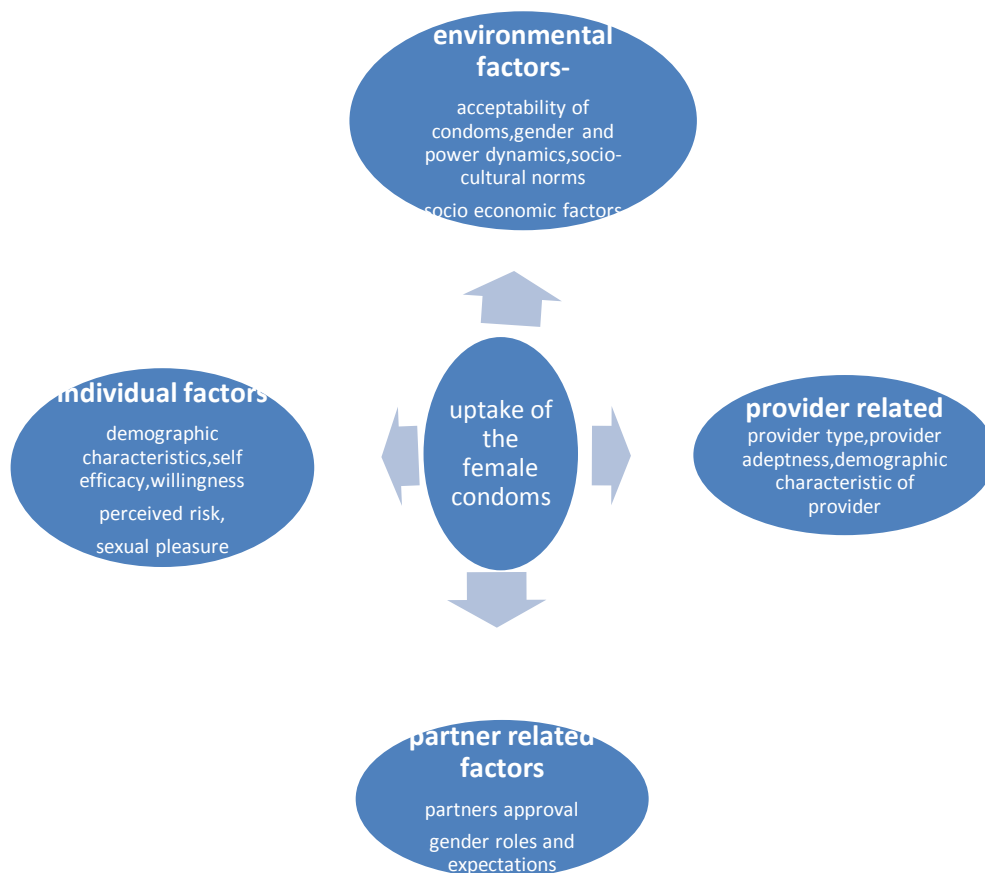
Source; Ajzen (1985); Ajzen (1991)

1.7 Conceptual Framework

A host of factors could be contributing to the low uptake levels of Female Condom in Chikomba district. It could be demographic factors for example gender, cultural reasons socio economic factors, lack of knowledge, the ineffective role of programme implementers and the unavailability of female condoms amongst others.

The term uptake in this study refers to the drawing up or absorption of a substance according to Mosby's Medical Dictionary (2009). In this study the uptake of the female condom then refers to the current use of the FC by the reproductive aged women.

Fig 2 Factors that influence the present uptake of condoms in Chikomba district



Source: Primary source

The framework was used as a guide for data analysis and discussion of factors that led to the present uptake of female condoms use in Chikomba district. Data analysis and discussion was also focusing on the Health Belief Model. The Health Belief Model according to Green and Kreuter (1999) suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behavior or action will predict the likelihood the person will adopt the behavior. In this case the person's action towards using the female condom is determined by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action, and self-efficacy.

- **Perceived susceptibility:** This stipulates that unless people know that they are at risk that is when they change their health behaviours for example they will use the female

condom if they knew they can acquire HIV from unprotected sex.

- Perceived severity: This alludes to the fact that a person changes his /her health behaviour depending on how serious he/she considers the consequence to be. Consequences such as death are often considered.
- Perceived benefits: This depicts that a person can only take a preventative measure or cures an illness if the person find something beneficial in the measure.
- Perceived barriers: This stipulates that performing a required health action is in most cases hindered by the perceived feelings of the victim leading to a cost benefit analysis .In most cases change health behaviour may be costly and time consuming.
- Cue to action: It is an action that triggers a person from wanting to make a health change to making the change in actual fact. These cues can be internal or external for example a poster of the effectiveness of the female condom, a relative dying of HIV/AIDS, newspaper article.
- Self-efficacy: This refers to the level of a person's ability and confidence in his or her ability to successfully perform recommended health behaviour. This has been found to be the most important factor in one's ability to negotiate for condom use.

The study was also be done on the basis of the Zimbabwe National Policy on HIV /AIDS 1999 section 4.3 subheading Condom/Barrier methods, which has been developed in order to promote and guide present and future responses to AIDS in Zimbabwe.

1.8Literature Review

The literature review is going to look at the female condom itself, its importance, levels of female condom uptake and it is also going to depict the factors affecting the uptake of female condoms globally, regionally and specifically Zimbabwe. Strength and weaknesses of the review will be noted and research gaps will be also identified.

1.8.1 Importance of the female condom

The female condom is important in terms of Sexual and Reproductive rights of women and its importance is the reason why women have to consider using the female condom.

Usmani (2002) states that results from a UNAIDS study in 1997 indicated that the availability of the female condom made the incidence of STD infection fell by 34% and the number of unprotected sex acts by also fell by 25%. Also Trussel et al (cited in Usmani, 2002) estimated that correct use of the female condom may reduce the annual risk of acquiring Human Immune Virus by more than 90% among women who have sexual intercourse twice weekly with an infected male partner. Another estimate is that perfect use of the female condom reduces the risk of STIs and HIV by between 94% and 97% per act of sexual intercourse (Usmani, 2002).

Cravero (2006) states that a female condom remains an effective tool for HIV prevention available for females giving them 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 (Prevention Now, 2011).

1.8.2 The uptake of the female condoms

1.8.2.1 Globally

According to Skaer and Ebin (2006) the poor uptake of the female condom has resulted from supply chain constraints, expensiveness of the female condom, lack of donor interest resulting in 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 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, poor commitment to make the female condom a success by programme implementers has also been noted as another reason for the poor uptake of the device .In

Nigeria, social marketing and weaknesses in advocacy and the supply chain have been alluded to be other reasons for the poor uptake of the female condom. Also 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. However there is a research gap because Oxfam Novib mentioned about other countries but not Zimbabwe and there might be a difference because of different cultures thus this research will explore the factors affecting the uptake of female condoms in Zimbabwe specifically Chikomba district.

Harrison (1996) reported on focus groups conducted in three sites in the United States in Delaware, St. Louis, and North Carolina. In the first session, 30 women were introduced to female condoms, asked to discuss their initial reactions and instructed to use them, then to return in two weeks to discuss their positive and negative reactions. Virtually all of the women reported difficulties in inserting the Female Condom the first time because the lubrication made it slippery and difficult to grasp. There is also a research gap because Harrison's study was conducted in the 1990s yet this is the 21st Century so what was considered to be barriers then might have been no longer viable with time. Also the study was conducted in the United States a developed country leaving a gap since the lifestyle in developed and developing countries are different and this study looked at a district in a developing country.

Peters also said that the FC1 condom which was a predecessor of the current FC2 condom, cost between 2-3 American dollars. Considering the state of the African women economically who most of them live on less than a dollar per day it was also a factor which led to the low uptake of female condoms then. However with the coming of the new nitrile product purchased by UNFPA, the cost per condom comes down to 0,22 US dollars (Peters et al, 2010). The male condom costs as little as 0,0385 US dollars as compared to the female condom. There is a research gap in light of this argument because the cost of the female condom is no longer a cause of concern since many service providers in Chikomba district distribute the Female Condoms for free.

According to Hoffman et al (2004) the difficulties in the insertion of the female condom is the other reason why the uptake of the female condom is low globally. The difficulty in insertion of the female condom may influence people to opt for the male condom which is not difficult to wear there by decreasing consistence use of the device. Thus the lack of adequate training of women on the insertion of the device using models was attributed to be one of the factors contributing to the low levels of uptake of the female condom globally especially in developing countries were their access to such training resources is limited .However, Hoffman’s argument was vibrant a decade ago and this study is going to scrutinize the present barriers since there is a ten years gap between the studies.

Studies have also depicted that another reason for the low female condom uptake worldwide is that higher levels of commitment and love especially in serious long relationships are associated with the low condom use be it male or female condom thus according to Ezumah (2003). In most prevention measures of HIV studies it was noted that condom use is popular between relationships that are casual and with prostitutes than between stable partners or spouses. This is depicted by Heise and Elias's study when they found out that most commercial sex workers use female condoms with their clients but in their private lives they were unwilling to use them. Heise and Elias(1995).This argument provide a research gap since Ezumah was provided data based on the globe not on a certain district.

Also in Cambodia, women demonstrated a high alertness of the benefits of the female male condom was demonstrated by the women constituting only 25% of their population .The remaining majority, 75% did not know of the existence of the female condom yet it is the marginalised women who suffers more in terms of unwanted pregnancy, unsafe abortions, HIV and AIDS infection .This depicts lack of knowledge as the major barrier to female condom uptake in Cambodia. However this research is going to analyse the factors leading to the present uptake of female condoms in Chikomba district in Zimbabwe there is a research gape since the case studies are different.

1.8.2.2Regionally

Female condom uptake is a cause of concern in Africa. In Nigerian DHS 2008 statistics depicts that although 14.7% of all women had heard about the female condom and 13.9% had heard a specific family planning message on the female condom, only 0.2% had ever used one.²⁵ In the baseline study conducted in 2011 by the Society for Family Health (SFH) in

Nigeria, 38.9% of respondents had heard about female condoms, but only 3.5% of these had ever used one. Thus 1.4% of all respondents had ever used a female condom; with relatively higher use reported among men (1.7%) than women (1.0%) that's according to Society for Family Health (2011)

Agha et al (2006) investigated the influence of religion on sexual activities among people in Zambia in line with the use of the female condom .The research showed that, religious beliefs had both negative and positive effects on determining the sexual behavior of women in Zambia. The study suggested that religion is another factor leading to a decreased rate of condomisation since the use of condoms especially on women will make them look promiscuous in the eyes of their male partners. Agha et al came to a conclusion that that religious affiliation is not likely to provide effective protection against HIV infection but is putting women at an increased rate of getting the disease due to limited information on safe sex. However there is a research gap because Agha et al looked into Zambia yet religious beliefs vary with geographical boundaries.

A study conducted in Ghana in the year 2008 showed that although there are awareness campaigns of the Female Condom, the uptake of the female condom is still a cause of concern. Ghana's community members perceive that uptake is low due to concerns that the product is big, messy, noisy, costly, and also difficult to use. Socio-cultural factors are also a major factor dissuading use of the FC. For example, gender dynamics may limit women's ability to negotiate use of a female condom, young girls and widowed or divorced women may feel uncomfortable to buy the FC for fear of being seen as promiscuous, and females may feel uncomfortable with the idea of having to touch or guide the penis during sexual intercourse. High cost of the FC was also a limiting factor to its uptake since there is at least a 10- fold difference in price between male and female condoms. Due to a relatively low national HIV prevalence (2.2%), the perceived need for dual protection is low; many married couples do not view themselves as the intended users of the FC. Negative perception on the female condom may also be the reason why the uptake is low in Africa since the introduction of the female condom was kind of directed to commercial sex workers thus many people see the FC as a product for commercial sex workers. Many providers have a bias against the FC, often due to negative perceptions about acceptability and lack of personal experience with the product. Thus, providers are likely not promoting or said to be deterring some prospective buyers, especially unemployed youth and others with championing the product very actively

which is also another challenge affecting the uptake of female condoms in Africa (ReshmaNaik and Martha Brady, 2008).

Another study done by the Medical Research Council Research Program on AIDS in Uganda in the use of female condoms against HIV and other STIs in South Western Uganda revealed that, the female condom was quite popular, but attitudes were negative, women did not like its shape and size, some complained of discomfort and the fact that they could not use it secretly and some few applauded for the female condom because it offered more certain protection against pregnancy, STIs and HIV (Nyanzi *et al.*, 2000).

According to March (2003) even if women comprise 58% of people living with HIV in Sub Saharan Africa they have very minimal options of preventing HIV/AIDS. Biologically women are socio-economic, and culturally disempowered meaning that the current HIV prevention strategies of abstinence, monogamy, condom use, fewer partners, and treatment of sexually transmitted infections (STIs) are not feasible for many women, since they often lack the ability to negotiate safe sex. There is, therefore, an urgent need for HIV prevention strategies that give women greater control. The female condom is the only female-controlled safe-sex method available. While this method is effective and relatively well-accepted by women, its usefulness is limited by cost, men's negative attitudes, its contraceptive properties, and practical aspects of its use. However there is a research gap on March's findings because in 2003 in Zimbabwe or Southern Africa as a whole, women empowerment programs were very minimal as compared to the present day thus disempowerment of women might no longer be feasible as a barrier to female condom use in 2015.

In Agha *et al.*'s study supported by Pullum *et al.*'s study, through southern Africa, it was discovered that in most cases condoms were usually used in the early stages of a sexual relationships and if ever the relationship becomes stable the use of the protection measures cease. As a rural Tanzanian women summed it: 'once you are used to each other there is no need for a condom' (Agha *et al.*, 2002: 8). In Pullum *et al.*'s study male respondents in Kenya also acknowledged that there is no need for female condoms in their marriages since their wives will be already taking family planning methods like the pill so the use of condoms should be used only outside marriages. (Pullum *et al.*, 1999). However there is a research gap on this literature because the scholars here were studying Tanzania and Kenya yet this research is to be conducted in Zimbabwe thus because of geographical boundaries even cultures differ and with these even the findings become different

1.8.2.3 Zimbabwe

In July 1997, population services international (P.S.I) at the request of the Zimbabwe National AIDS Co-ordination Programme (Z.N.A.C.P), launched a social marketing program for the female condom in Zimbabwe. Immediately after the social marketing program, the horizons project and P.S.I conducted a descriptive, cross-sectional study of female condom users, male condom users and no users of any barrier method. This research, established that users of the female condom were generally in their mid-twenties to late thirties and compared to the male condom users and non-users of either method, the female condom users had higher levels of education and access to household resources. An interesting finding in this research is that 13 % of women reported using the female condom without their partner's knowledge. However there is a research gap since the cross sectional study was done 18 years back thus with time the results might be different.

Though Zimbabwe is cited as a success story in female condom programming, one of the reasons why the female condom uptake is low in the country is because, the awareness of the female condom is very low particularly in rural areas. Some women report that it is painful on insertion, too noisy and too big. The perception that the female condom is very big in size is in most cases due to the fact that most people have poor understanding of female anatomy (Chizororo and Natshalaya (2011)). Even though the female condom is meant to empower women in terms of their sexual and reproductive rights its acceptance by the women is really questionable because for most women in Zimbabwe reproductive decisions are made by their male counterparts. This is mainly because of traditional power imbalances between men and women. This also constitutes a gap of knowledge that this study sought to fill since analysis was done looking at Zimbabwe as a whole and not Chikomba district specifically.

Another factor which attributes to low female condom uptake is about the fact that African men are said to love dry sex. Dry sex is a significant sexual practice in Zimbabwe. According to Van de Wiljgert (2001) it is believed that a dry vagina indicates that there have not been any sexual act recently, hence in a bid to sexually please their sexual partners, some women apply herbs to dry their vaginas. Women in Zimbabwe to be particular have been discovered to use a variety of drying agents to achieve these effects (Motsi and Mabvurira, 2011). This then became a barrier in terms of the female condom uptake since a female condom is

lubricated. This however, promotes the chances of women acquiring HIV and STIs because of the friction from those dry vaginas and complicates condom use as it can easily break (Civic and Wilson, 2009). After this has been said and done there is still a research gap because not all people in Zimbabwe believe in traditional sexual practices and their views should also be considered thus a need for a gap filling.

According to Koster (2012) in Zimbabwe another reason for the low use of female condoms is driven by men. Koster mentioned that the reason why the use of female condoms in Zimbabwe is because of men's refusal to use the condom. Married men were said to be against the use of the female condoms because of their trust towards their wives and the female condom is deemed unnecessary, also men are afraid that the female condom will encourage women to become promiscuous. The research gap is that the researcher was looking at Zimbabwe as a whole not Chikomba district specifically plus the study targeted men leaving a research gap since the target population for this study includes women.

According to Pullum et al (1999) in Zimbabwe his study showed that more than 40% of women's reason for not using condoms was due to the trust they had for their partners. For men the reason why they did not agree to condom use was indicated between 47% and 73% of respondents as a result of the trust they share as marital partners. In this case condom use is not practiced when there is trust between the partners. This gives an insight why condom use is very low between married couples. Though this has been noted there is a research gap because Pullum et al conducted his study looking at married couples not including the unmarried population.

A major research gap provided by this literature is that there has not been any studies concerning the uptake of the female condoms in Chikomba district thus research was necessary.

1.9 Methodology

This phase of the research proposal is going to focus on the research designs and methodology to be employed in this study. It will discuss the research design, sampling methods, research instrument, ethical considerations, and data collection procedures and data analysis.

A qualitative paradigm was used because the study was mainly there to air out the people's perceptions and identifies their perceived barriers towards using the female condom. The study's research design was analytical surveys and this attempt to describe and explain why certain situations exist. In this approach two or more variables are usually examined to test research hypotheses. The results allow researchers to examine the interrelationships among variables and to draw explanatory inferences.

The target populations in this study were the reproductive women residing in Chikomba District. The District Aids Coordinator from National AIDs Council, an officer from ZICHIRE, and the Ministry of Health and Child Welfare.

Sampling was done and sampling in qualitative research is usually purposive and theoretical Christensen et al 2011. Simple random sampling was used. The researcher adopted purposeful sampling when conducting interview with the program implementers in order to gain understanding of complex phenomenon in question. According to Doncilek (2004) purposive sampling compels researchers to choose their subjects specifically for their knowledge or insight into the subject being studied.

Data was collected using face to face interviews in this research study. 27 participants were reached through face to face interviews. Interview guides were there to help the interviewer to keep in track the questions viable to the research. Face to face interviews were conducted with 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 were covered. The interview guide covered such topics as the importance of the female condom, its effectiveness, acceptability, availability and factors leading to the present uptake. Semi-structured interviews offered topics and questions to the interviewee, but were carefully designed to elicit the interviewee's ideas and opinions on the topic of interest, as opposed to leading the interviewee toward preconceived choices. 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).

Focus group discussions were also used as a data collection method. 6 focus group discussions were held 5 groups had 12 participants and the last group had 7 participants. FGDs were conducted with the reproductive age women from the different wards and it was

easy to carry out these because National AIDS Council already had a community dialogue program where they would move around the districts addressing women thus from those groups participants for Focus Group discussions were easily reached. Among the advantages of a focus group discussion is that it allows a deeper understanding of the topic as the participants dig deeper into the problem at hand. Problems with the focus group include the need for a highly skilled facilitator to avoid a situation whereby few people make all the contributions while others are quite or just following the ideas of the dominant person (Bless et al, 2009). Participant Observation was done. The researcher used this to acquire first-hand information

On data analysis a set of spread sheets weremade and then manual content analysis was done by theme. 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.

On ethical consideration confidentiality was insured by not using participant's names or any other identifying data, rather study numbers were used. All the information shared was not to be disclosed or shared with anyone who is not part of the research. Respondents were given an opportunity to choose a place of their comfort where the interview could be conducted where the respondent will feel free to answer questions without any interference or others listening in.

Written consent was sought from all the participants, and each participant was entitled to keep a copy of the consent form. Participants were informed that participation in the study will be completely voluntary. In respect for culture, permission from traditional or community leaders will also be sought before the study in their villages commence. Benefits of the study were that, the acquired information will be used to positively promote the use of female condoms and to strengthen approaches towards prevention of new HIV/AIDS infections. There are no foreseen risks in this study, except that participants may feel uncomfortable in discussing personal matters.

Conclusion

In summation the study of female condom uptake in Chikomba district was conducted following the objectives of finding out the levels of uptake, knowledge levels, barriers to condom uptake and way forward using the qualitative methods of acquiring data such as interviews and focus group discussions. This was done with the aim of coming up with Chikomba district data that can be used for the benefit of the whole country in line with the Sexual and Reproductive rights of women .

CHAPTER ONE

2.A DESCRIPTION OF THE HIV AND AIDS SCOURGE IN CHIKOMBA DISTRICT

2.1 Introduction

This chapter is going to be looking at HIV and AIDS in Chikomba district, the statistics surrounding the epidemic in the district, past measures which were adopted by the district before the introduction of the female condom such as the word of mouth on abstinence through sensitizations and the introduction of the male condom. The introduction of female condoms as a measure will also be discussed the reason behind its introduction and its acceptance.

2.2 Statistics of HIV and AIDS in Chikomba District

It was estimated that 33.3 million people were estimated to be living with HIV/AIDS in by the Joint United Nation Programme on HIV /AIDS, (UNAIDS, 2010).The sub-Saharan Africa holds 22.5 million of the 33.3 million people living with HIV/AIDS .It was estimated that over 50% of the infected people were women and young girls worldwide butt in sub Saharan African women consist 60% of those infected by the virus. (UNAIDS).

In Zimbabwe the first case of AIDS was identified in 1985 and from that time the virus of HIV has been spreading at an alarming rate such that then the problem of HIV/AIDS has continued to grow at such that as of end of 1998 more than 1.5 million people have contracted HIV infection with more than 400,000 having developed AIDS. The prevalence rate of HIV infection has been decreasing compared to the 1990s were HIV infection rate was 26.5% in 1997 to 14.3% in 2010.HIV related deaths according to UNAIDS (2010).In 2012 HIV rate in Zimbabwe was 14.7% with 1,400,000 people living with the virus, though there is a decrease in the statistics of the virus HIV by 50 % from 1996 HIV related deaths remain the largest cause of death among the reproductive health age in Chikomba district

According to UNFPA Women and HIV/AIDS; confirming the crisis (2004).In the modern day HIV pandemic has become a result of unprotected heterosexual intercourse unlike of old when it was mainly found in homosexuals. In the present day the epidemic strike women more than men worldwide, they were said to account for more than 40 million people living

with HIV. In Sub Saharan Africa it is a cause of concern because women between the age of 15 -24 years are three times more likely to contract the virus than men of their same age.

According to the Chikomba 2014 Core district report new People living with HIV getting treatment there were 426 and of the 426,340 were women and 86 were males meaning in the district man comprised of 25.3% of the newly infected and women 74.7%. This shows a great need for an improved intervention for females starting by promoting the correct and consistence use of the female condom.

2.3 Past Measures taken to prevent the spread of HIV and AIDS in Chikomba District

The prevention of the spread of HIV efforts in Chikomba district have been spearheaded by the National AIDs Council, Non-Governmental Organisations, Business world, religious and academic organisations. Many measures such as awareness campaigns through mass media, advocacy of abstinence and faithfulness through the word of mouth, offering HIV education in schools and also advocacy of the increased male condom use.

Faith based organisations and churches in Chikomba district advocated for abstinence .By then it was considered to be the most effective measure to reduce the spread of HIV/AIDS .IEC material such as posters and pamphlets were made in a bid to spread the word of abstinence to young generation since it was found that around 50% of the people living with HIV in Zimbabwe become infected during adolescence or young adulthoodthus preaching abstinence or no sex before marriage was done in a bid to reduce the prevalence of HIV /AIDS among the youth. However even after preaching about abstinence the HIV prevalence among the youth did not change because since social attitudes toward sexuality varies thus in a bid to protect the girls virginity to be able to be put in the bracket of those abstaining, anal sex was said to be used according to Peter Agletto et al. This depicted that despite abstinence being the best option on HIV/AIDS prevention it is difficult to keep up thus ending up practising harmful behaviours such as anal sex which makes them more vulnerable to acquiring HIV and AIDS since according to Royce et al (1997) A person is about five times more likely to contract HIV through anal intercourse than through vaginal intercourse because the tissues of the anal region are more prone to breaks and bleeding during sexual activity.

Young adults and child education on HIV /AIDS was also taken as a measure to reduce the spread of HIV and AIDS in early 1990s in Zimbabwe ,Chikomba district to be included .HIV infection in Chikomba is high amongst the youth especially women and also With around half of the people living with HIV in Zimbabwe becoming infected during adolescence or young adulthood HIV education has been targeted to young people .In Chikomba district Guiding and counseling sessions were offered where HIV issues will be discussed in order to give an insight to the young in school adults on how to prevent the spread of HIV/AIDS .In school education was aimed at granting the youth with greater understanding of the virus to ensure a change in sexual behavior. Out of school youth also received education from NGOs such as ZICHIRE in form of dramas and video screenings so as to in cooperate even those who cannot read and write. This was seen to be useful but the number of new infections escalate since the knowledge was not translated into action leaving a gap which was sought to be filled with protective methods such as the use of condoms as 75 percent of deaths among hospitalized adolescents in 1990s were attributed to HIV and AIDS.

Even up to date in Zimbabwe HIV and AIDS is being taught in schools. Children in Zimbabwe are currently taught about HIV and AIDS in schools from the age of eight, and according to the Government has recently suggested that there are plans to make students take an exam on the subject. In 2006 the Ministry of Education, Sport and Culture, and UNICEF initiated an in-service training scheme of primary and secondary school teachers in HIV and AIDS life-skills and counseling. By the end of 2007 around 2753 primary and secondary schools had been reached by the schemes .According to Sexual Health Exchange, Girls and Young Women (2004) knowledge about HIV and AIDS is high amongst young Zimbabweans a 2002 survey found that 93% of women and 97% of men between the ages of 15 and 29 had heard of AIDS, while 83% of women and 92% knew of HIV. The survey also found that the majority of young people were aware that sexual contact was a major mode of HIV transmission. Women, especially those living in rural areas, are still at marked disadvantage with respect to understanding key issues about AIDS and HIV transmission .In 1999, more than a quarter of rural women still did not understand that a healthy-looking person can carry the virus that causes AIDS.This is a past measure before the introduction of the condoms which has proven to be very useful now working in conjunction with the current preventative measures such as the female condom.

The mass media has played a critical role as a measure in responses to HIV/AIDS prevention since the early days of the epidemic. In Chikomba district as a measure to combat the growing number of new HIV infections during the 1980s, the media produced advertisements in line with the disease in a bid to make sure necessary information about the spread of HIV/AIDS was made known to every household. However the mass media campaigns were not very useful since in Chikomba district by then many people had no access to radios and televisions except a few who were in Chivhu, a small town in Chikomba district. Also early mass media awareness fuelled stigmatisation such that it was scary to be known to be HIV positive and many people would hide their statuses hindering HIV prevention.

Also encouragement of faithfulness was another measure taken to reduce the spread of HIV/AIDS. This came into being after the realisation that having more than one partner is another driver leading to HIV/AIDS. Health organisations such as NAC and other faith based organisations like the Anglican organisation encouraged sticking to one partner as a measure to reduce the spread of HIV/AIDS on media and awareness campaigns were conducted in Chikomba rural to reach many people. Faithfulness only applies if both factors are negative and if one partner is already affected then it becomes a failure. However this was not very effective since it was found out that in Chikomba there are many cases of spousal separation due to work related migration thus faithfulness become questionable. Another factor was found to be due to the belief that many people considered faithfulness to be having sex with one partner at a time no matter how frequent the partners succeeds each other thus according to Sexual Health Exchange, Girls and Young Women (2004). This measure helped to a lesser extend since the continuous succession of partners also led to the transmission of HIV and AIDS.

The use of male condoms was also encouraged after the realisation of the growing pandemic in the district. The promotion of male condoms became the top priority for HIV/AIDS prevention programs in the district and Zimbabwe as a whole. The World Health Organization advocated the male condom as an effective preventative strategy besides abstinence which was also 100% effective. Male condoms were sold in shops, supermarkets and bars. The popular male condom which was familiarly sold was the Protector plus. The promotion of the male condom was also done through the use of advertisement on the media (radios and televisions). For the reduction of the spread of HIV the correct and consistent use of the male condom was raised as the greatest hope. However, according to Pool et al (2000) condom

promotion was biased towards men since they were the ones given right over the sexual realm especially across Southern African countries, women become voiceless in sexual decisions in terms of the use of the male condoms in their relationships since the male approval on condom use stands central. When men choose not to wear them women were left at a disadvantage since the female condoms were not yet in picture.

By the end of 1994 in the district according to the District AIDS Coordinator (DAC) Mr Mukuwe the survey conducted in 1994 indicated that condom awareness was universal with 19 of every 20 adult populations aware of the male condom both in Chivhu town and in rural Chikomba .However rural men and women of Chikomba were just aware of the female condom but the detail of how to wear it and other risks they were less knowledgeable about it. However though the message about female condom reached many people there has been conflict over the programme implementers and the society for example, some religious or traditional campaigns discourage the use of condoms and place emphasis on abstinence, contrasting with preventative strategies of using the male condoms of some other organisations such as PSI. This has led to confusion about how it is best to prevent HIV infection, particularly amongst young people.

Also the male condom had its major disadvantages which left a gap for the need of the female condom, the major one being that of bursting. Male condoms can burst according to the users, either when the sex is rough, or when the condom is not properly put on, or is exposed to something sharp even the nails of the person wearing it. This makes the male condom not 100% reliable. Also other man argues that the male condom is too tight that it may constrain the penis thus decreasing sexual pleasure. Some men and women react to the other male condoms with rashes on their sexual organs. Another barrier for male condom was said to be attributed by the fact that the male condom can slip off or stay in the vagina during intercourse or when the men loses his erection .Thus due to these above factors there was a need for the promotion of a different type of condom which was preferably the female condom.

The association of condoms with infidelity likewise emerged as large impediment to male condom use in marriage. The significance of unprotected sex in long-term relationships stands central to the male condom's neglect the willingness to engage in unprotected sex has become a cultural marker of intimacy Heise and Elias (1995).Thus efforts to prevent the

spread of HIV /AIDS through the use of male condoms was also compromised due to cultural beliefs

The male condom was not a very successful measure considering the fact that HIV /AIDS is most likely to affect females due to female physiology which is the anatomical design of their sexual organs, social and structural reasons (Nyoni, 2008). Many African women depend on their male counterparts in their socio –economic and political lives .This also leads to sexual inequality which makes them vulnerable to unwanted pregnancies, STIs and HIV/AIDS since they are often unable to negotiate for safe sex controlled by man which is the use of the male condom. This depicts the failure of a male condom as a measure looking at the gender perspective.

A major criticism of the early HIV/AIDS prevention strategies which are in most cases summed up as the “ABC” approach meaning Abstain ,Be faithful and use Condoms was that there were biased towards men most of them gave control over the sexual and reproductive health rights of women. These measures failed to give attention to women’s socio economic and political capabilities that may deny them the capacity to negotiate for safer sex and this realisation led to the promotion of the female condom.

2.4 Introduction of the female condom as a measure to reduce the spread of HIV and AIDS

With the acknowledgment that major forces which are driving HIV/AIDS are linked to gender inequality the development of a female condom as a barrier method which gives women control over their sexual inequalities ,Holmes (1990).Advocates for the improved health of women called for the initiative of the female condom in 1990s (Population Council, 2009). LasseHessel in 1988 invented the first female condom and it was manufactured by the Female Health Company using polyurethane. (Population Council, 2009). The female condom was approved in the United States by the (U.S.F.D.A) United States Food Health Company in 1993 after the British have introduced it in 1992 .Since its introduction many countries have been encouraging its use including Zimbabwe going down to its grassroots including Chikomba district.

On top of Sexually Transmitted Infections, HIV/AIDS, unprotected sex can lead to unintended pregnancy, which is a major cause of induced abortions and possible maternal

mortality if abortions are unsafe. It is estimated that mistimed or unwanted pregnancies .About 20% of all pregnancies in Zimbabwe were said to be mistimed and 13% unwanted .These unplanned pregnancies in most cases lead to unsafe abortions, as abortion is in Zimbabwe .ZDHS (2007)

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 organizations. Research has also shown that including the female condom as part of the prevention package that 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). This is so because the female condom is a women controlled barrier method of contraception, which stipulates that women are in control when they use them. The use of male condoms often has to be talked about over and over and more often in the form of an interruption during sex rather female condoms have to be negotiated only once and it is a different case because if the man agrees to use the female condom then it can be inserted each time before sex by the women rather than negotiating each and every time before having sex which makes it easier for women to gain control of their sexual and reproductive rights.

The female condom was introduced in Zimbabwe in the mid-1990s and it became the first African country to successfully bring the female condom in the picture of its society. Zimbabwe approved the female condom for use in 1996, and in 1997 Population Services International (PSI) began a social marketing campaign in which female condoms were subsidized and distributed in urban areas including Chivhu town (Warren & Philpott, 2003). Since women had very limited control over their own protection against STIs, HIV infection and unintended pregnancy Meekers et al 2006 a female condom came into being in Zimbabwe to empower women since they were voiceless on the male condom which was largely male controlled. The unfortunate part is that despite female condoms being available they are still not very popular because they are less promoted than the male condom. But the unfortunate part is that, female condoms are less promoted and not easily available .

2.4.1 Types of female condoms



Fig 3:Latex Female condom

Source:UAFC Female condom implementation Guide

The Latex Female condom is made up of latex (rubber) lubricant included and it has one triangular ring and one sponge to keep it in place.



Fig 4 FC2 Female condom

Source :UAFC Female condom implementation Guide

It is made up of Nitrile synthetic latex which conducts heat .Itas two rings to keep it in place. Lubricant included.



fig 5Cupid Female condom

Source :UAFC Female condom implementation Guide

The Cupid Female condom is made of latex rubber and, lubricant included. It has one octagonal ring and a sponge to keep it in place.

The FC1 which is said to be the original condom which is also produced by the Female Health Company was approved by the United States for use in 1993. The FC1 which is made up of female polyurethane resembles the first generation of female condoms. It is odourless and it does not cause allergic reactions. The FC1 can also be used with water or oil based lubricants. (WHO & UNAIDS, the Female Condom-A guide for planning and programming, n.d.). FC1 because of its polyurethane nature do not require special storage facilities since the material last for 60 months and is not affected by variations of temperature. Studies have also proved that the thin polyurethane material conducts heat well thus preserving sensation during sexual intercourse (Chirwa 2011). The FC2 condom which is the popular condom in Zimbabwe is a second generation female condom first being the FC1. The FC2 is made of nitrile, a type of synthetic rubber that is latex-free (WHO, 2007). The condom is produced by the Female Health Company at a lower cost. The FC2 obtained FDA approval in 2009 and that is when it reached Chikomba district. (Frost & Reich, 2009).

The FC2 is the only female condom with the World Health Organisation (WHO) certification on the market and this implies that the FC2 is the only female condom which is purchased by international organisations that is why the price of the FC2 is artificially high because it is only the Female Health Company which dominates the market.

Zimbabwe's female condom programming date back to 1996 and with the efforts of the government through the ministry of Health and Child care teaming up with Non-governmental Organisations such as PSI the social marketing of the device has been bearing success stories. According to the UAFC female condom implementation guide the female condom sales have increased from 120,720 to 2.1 million between 1997 and 2010. This figure also encompasses the condoms sold in Chikomba district and distribution as well. From Chikomba district PSI trained hairdressers and barbers in 2002. The organisation has also been targeting people living with HIV and sex workers in the district.

In Chikomba district a total market approach is used where under the Ministry of Health and Child care and National AIDS Council of Zimbabwe some organisations like ZICHIRE are given the female condoms in bulk to freely distribute them in the community using the Behaviour Change Facilitators under the Integrated Support Programme. Thus the Zimbabwe National Family Planning distributes the female condom freely and the PSI socially markets the female condom at a subsidised price and the private sector such as pharmacies sells other brands to those who can afford them. Zimbabwe a technical support group chaired by the Ministry coordinates and monitors condom programming in the country. Civil society implementing partners are part of the governance and implementation structure under the leadership of the Ministry of Health and Child Welfare. A total market approach is used whereby the Zimbabwe National Family Planning Council distributes the female condom for free, whilst PSI Zimbabwe socially markets the product. This implies selling the female condom for a subsidized price. The private sector sells other brands to those customers who can afford it. PSI Zimbabwe staff in the district supervise care promoters such as the hairdressers and the barbers in the district and help in interpersonal communication with willing users of the device.

The female condom brand such as the Care is the most common female condom found in the district. PSI Zimbabwe in partnership with United Nations Population Fund (UNFPA) promotes the Care brand by training their staff on everything required to be known of the female condom. This trained staffs are known as Care promoters and they also sell the condoms in the communities. Care promoters sell condoms in the communities. These trained work hand in hand with the BCFs, People living with HIV/AIDS, Hair Dressers and Sex workers in ensuring correct use of the condom is achieved. These behaviour change facilitators also move around communities with pamphlets, booklets and posters and branded

T-shirts to encourage the correct use of the device. The most vital Care condom sellers in the district are the hairdressers who distribute more than 50% with the remaining 50% sold through private health institutions and pharmacies then through sex worker queens.

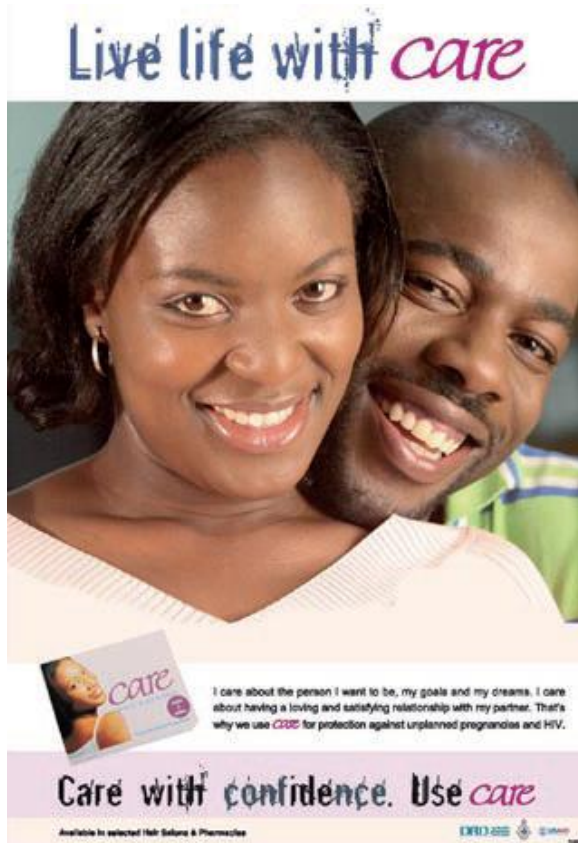


Fig 6 Posters used by Care Promoters to improve the use of the female condom

Source :UAFC Female condom implementation Guide

The private sector together with the ministry of Health and Child Welfare in the district conduct road shows in Chivhu town as well as Chikomba rural .Also to equip people with information concerning the female condom in the district the Community based Organisations and representatives from PSI and ZNFP conduct community dialogues or small group discussions .In order for the coverage to be wide the implementing partners of the Female condom integrate other messages such as the concurrent sexual partnership and Voluntary medical male circumcision (VMMC) so as to widen the audience. That is how the female condom programming has been conducted in the district.

The marketing of the Female condom as a contraception method came into play to do away with the stigma of Sexually Transmitted Infections that male condoms had in Zimbabwe (Meekers & Richter, 2005; Warren & Philpott, 2003). One study among people who purchased the female condom. The Ministry of Health and Child Care launched a female condom distribution program which targeted the rural areas and in Zimbabwe as a whole including the Chikomba rural the female condoms distributed rose from 300,000 distributed in 1998 to 1,6 million distributed in 2002 (Warren & Philpott, 2003). Also because of the Millennium Development Goal 3 which addresses gender equality and women empowerment, the marketing of the female condom was done to ensure women participate in decision making concerning their sexual and reproductive health rights. Also because women are rendered the most careful people in their relationships and families promotion of the female controlled barrier would reverse the AIDS pandemic in the district. According to Myer et al (2006) Zimbabwe had a high HIV prevalence rate of 15% with the contraceptive prevalence at 60.2% but reported a dual protection rate of 38%. This gave rise to the marketing of the female condoms since the figures were worrying for a country with a high HIV prevalence rate.

The female condom was introduced because of its effectiveness in reducing the risk of Sexually Transmitted Infections and HIV/AIDS. As indicated by Drew (1990) laboratory studies have evidenced that polyurethane is impermeable to small viruses such as cytomegalovirus, hepatitis B virus and HIV. Latka et al (2000) conducted a research on evaluating the effectiveness the female condom in preventing STIs. They compared the use-effectiveness of the female condom with the male condom in preventing four STIs - chlamydia, gonorrhoea, syphilis or trichomoniasis. The trial showed that there were no significant differences in STI rates between the female condom (5.27 per person months of observation and male condom arm (6.12 per person months). This shows that the female condom is more effective than the male therefore there is need to encourage the use of the FC.

Also to safeguard women against committing the crime of spreading HIV /AIDS knowingly, this is according to the Criminal Law (Act 23) of 2004. Women were encouraged to use the female condom if so that they protect their partners from contracting the virus

However acceptance of the female condom in Chikomba district has been like in any other part of Zimbabwe. Globally in 1997 a study on the acceptability of female condoms was conducted by the World Health Organisation (WHO). These studies showed that 37-96% of the product users rated it positive and acceptable. OxfarmNovib (2007) also conducted global meetings where the female condom was also stated that there was no problem with the female condom and women were very much interested in using it. However, these studies were short termed that only assessed acceptance at its early stages of its introduction. The results did not depict the actual acceptance after the 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 primary newness of the female condom had worn off (Hoffman, Mantell, Exner and Stein, 2004).

The acceptability of the female condom in Chikomba district at its early stages seemed to be a challenge since it was considered to be a tool for sex workers and for many young unmarried girls it was considered to be a taboo having sex before marriage so the confidence to accept the female condom in the society was undermined. With continues awareness and education by the Ministry of Health and Child welfare, National AIDS Council and other NGOS it became acceptable of the female condom. However, no acceptability studies have been done in Chikomba district to conclude whether women in the district accept the female condom for HIV prevention and/or contraception.

Conclusion

In a summation HIV/AIDS in the district is high especially in women and the past measures such as the male condom which were there before the female condom showed biasness towards men since they all did not give women power and authority to negotiate for safer sex till the introduction of their own barrier method the female condom. The female condom was introduced to grand women partial control over their Sexual and Reproductive Rights to protect themselves and their partner from HIV infection. Although the device has been accepted in the district its sustainability is still a cause of concern thus there is need to know the levels and the reasons behind the low levels as well.

CHAPTER TWO

3THE UPTAKE OF THE FEMALE CONDOM IN CHIKOMBA DISTRICT

3.1 Introduction

With the growing evidence of HIV/AIDS among women in the district the uptake levels and reasons behind the low uptake will be presented in this chapter. Data was analyzed using themes such as uptake against age, uptake against marital status and uptake against knowledge levels of the participants. Reasons behind the present uptake such personal factors, partner related factors, socio cultural factors, mechanical factors, provider related factors were also conceptualized.

3.2 Demographic data

3.2.1Participants reached

The researcher managed to reach 94 participants through random. Interviews based on random sampling were conducted reaching 27 women other 67 participants were reached through focus group discussions. Purposive sampling was also done and 3 participants were reached 1 from the National AIDS Council, 1 from the Ministry of Health and Child care and 1 from ZICHIRE a Female condom implementation partner.

3.2.2Age group of the participants

Of the 94 participants 21 were between the age of 16-20,35 participants were between the age of 21-29,20 were between the age of 30-39 and 18 participants from the age of 40-49.

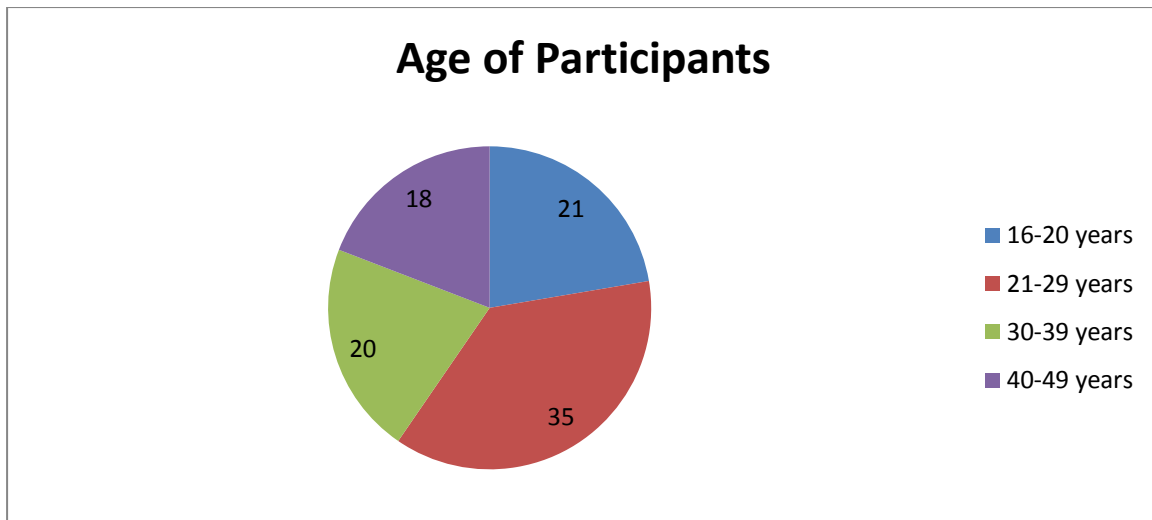


Fig 7: Age of research participants

Source: FDGs and Interviews

3.2.3 Marital status of the respondents

Of the women who participated in this research 42 women were single, 50 married and 2 separated. Married women dominated the research followed by the single women who some of them have been divorced, widowed or never been married.

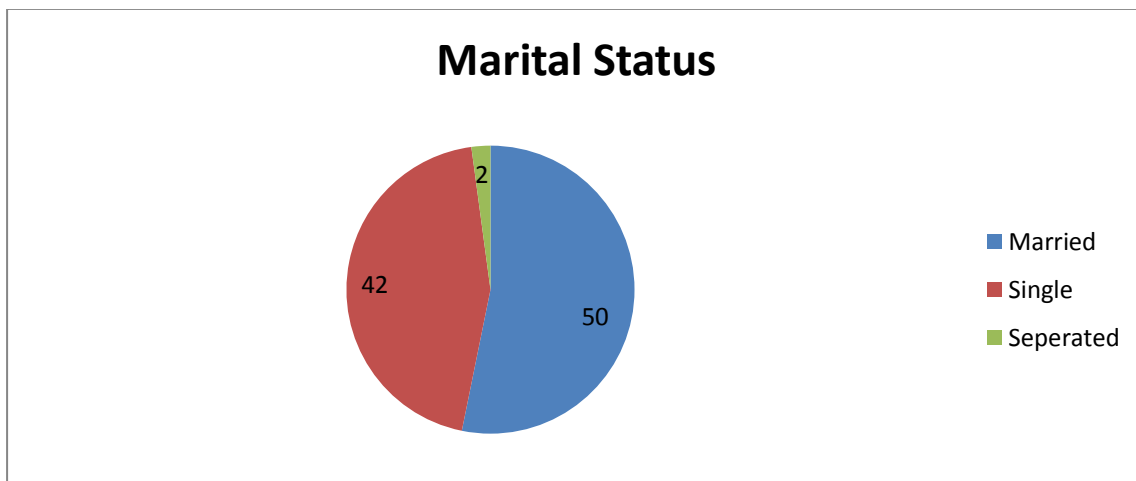


Fig 8 Marital status of the participants

Source: Interviews and FDGs

Level of education of the participants

Table 1 Education level of the participants

Level of Education	Number of participants
Non	0
Primary level	11
Secondary level	67
Tertiary level	16

Source: Interviews and FDGs

The research was dominated with participants whom their highest level of education was secondary level with 67 women then 16 who reached tertiary level and 11 who only attended primary level and none of the participants did not attend school.

3.3 Uptake of the Female Condom

The present uptake levels of female condoms in Chikomba district were assessed using results from women in the district who have used the female condom in the previous 6 months. Only 24 out of 94 women who participated in the research used the female condom. The results depicted that 74 % of the participants never used the device yet only 12.6% are frequent users of the device and 12.7% only used it once. Thus the uptake level of the female condom among the women of the reproductive age in Chikomba district was found to be 25.5%.

Table 2: showing female condom uptake by the participants in the previous 6 months.

Female condom uptake in the previous 6 months	Number of participants	Percentage
Never used	70	74.5%
Used at least once	12	12.7%
Used at least 5 times	9	9.5%
Used at least 10 times	3	3.1%

Source: Interviews and FDGs

Bar graph showing the female condom uptake for the past 6 months

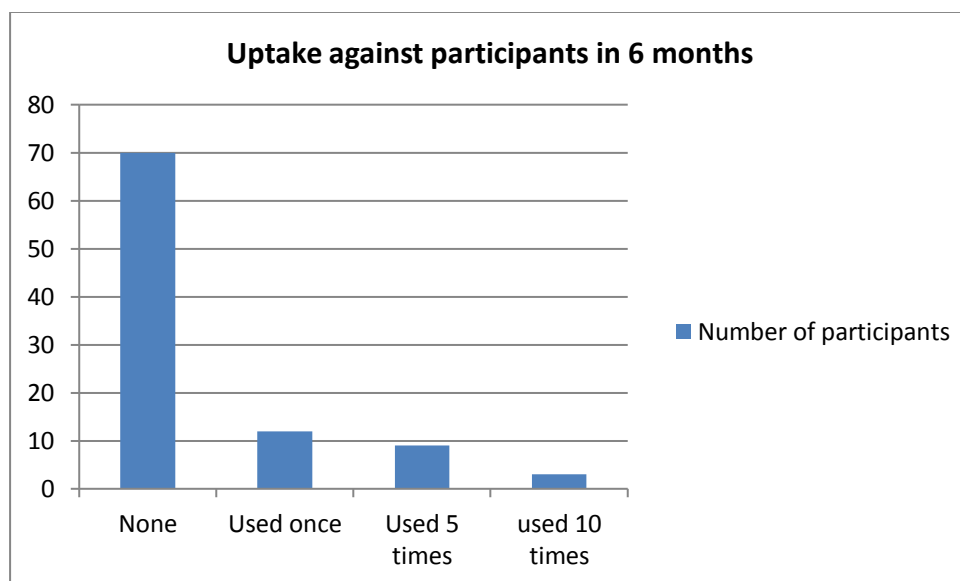


Fig 9;Female condom uptake in 6 months

Source: Interviews and FDGs

3.3.1 Age against FC uptake

Table 3 showing age group against female condom uptake

		Uptake of the female condom		Total
		Yes	No	
Age	16 – 20	5	16	21
	21 -29	14	21	35
	30 – 39	5	15	21
	40 – 49	0	18	18
Total		24	70	94

Source; Interviews and FDGs

The table revealed that most of the participants who used the female condom were between the ages of 21-29 occupying 58.3% of the users. The 16-20 age bracket occupy 20.8 % of the female condom users. The 30-39 age brackets occupy 20.8 % of the female condom users and lastly none of the 40-49 age groups used the female condom.

Bar graph showing the condom uptake against age

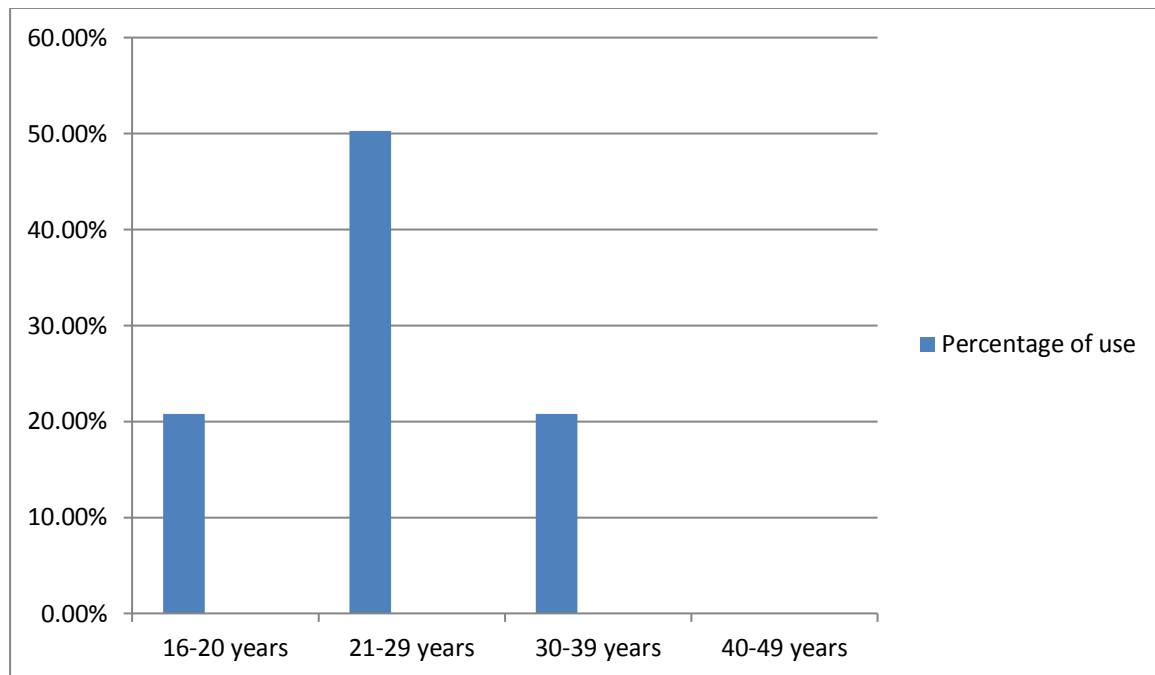


Fig 10 graph showing condom uptake against age of the respondents

Source; Interviews and FDGs

The graph shows that of the few who used the female condom the highest number was from participants from the 21-29 age groups which were attributed to the fact that they are the most sexually active group with young women most of them single who really need protective measures to avoid unwanted pregnancies. This was followed by 16-20 which of the 21 participants only 5 used the female most of them due to lack of knowledge and the younger ones feared that the female condom was too big for them and those who had sex for their first time could not use the FC because it could not be inserted into a virgin. The 30-39 age group also had 5 participants out of 20 and this was attributed to the fact that most of them were married and their partners did not approve the use of the female condom. Lastly the 40 -49 age group which had 18 participants and 0 users of the female condom and most of them did not know about the female condom because they view it as a generational device for young people, some saw it as useless when you are married and some of them were not approved by their partners to use FC.

3.3.2 Marital Status against Female Condom Uptake

Table 4 Marital status against uptake of the female condom in the district

	Level of Uptake		
	NO	YES	
Married	40	9	49
Single	27	16	43
Separated	2	0	2

Source ;FDGs and Interviews

According to the research findings female condom uptake was high among single women with 16 women using female condoms while only 9 married women use female condoms and none of the 2 separated women use condoms. Among the participants 37.4% of the female condom users were married and 66.6 % were single women, of the separated participants none of them used the female condom. The female condom use among the single was high because they had a say over their sexuality on their boyfriends and among these were female sex workers who alluded that they were able to use the female condom because sometimes their clients would not even recognize it and they will be paid double for not using protection that's why the uptake was high among the single unlike the married whom their husband did not approve of the female condom since they make the decisions interms of sexual matters.

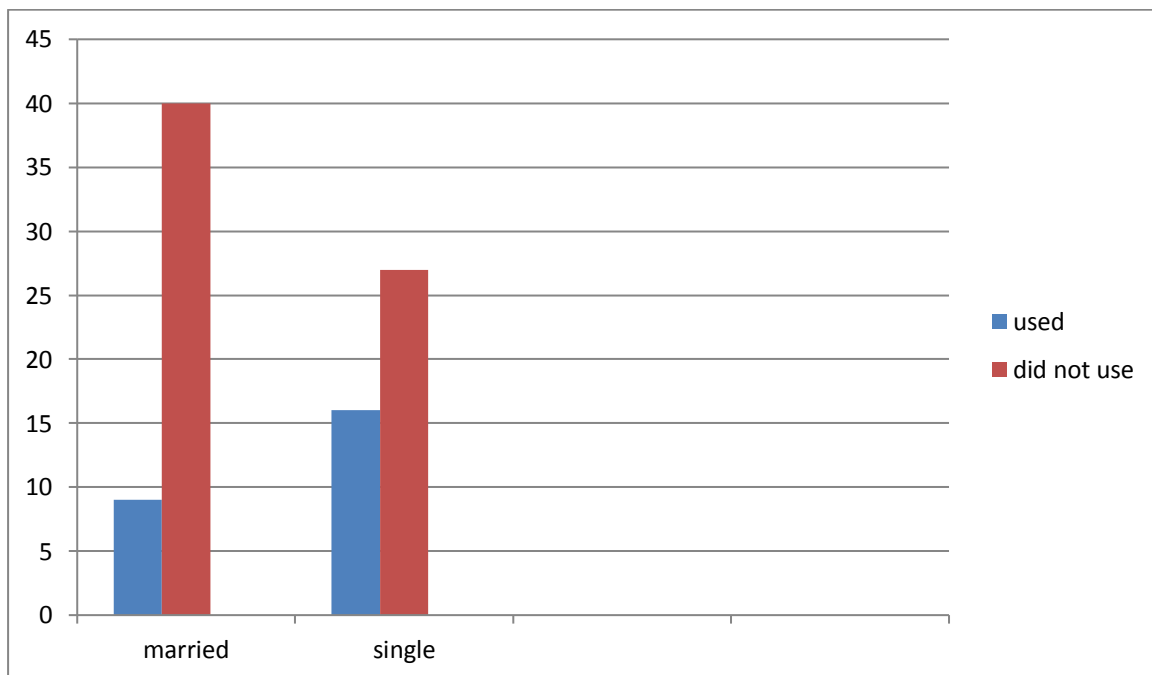


Fig 11: Bar graph showing marital status against use of the FC

Source; Interviews and FDGs

3.3.3 Education level against uptake of the female condom

Most of the respondents 17/24 who have used the female condom ended at secondary level .This might have been so because already the group dominated the research ,most participants were from that group.5 of the participants who have used the female condom attended tertiary education ,though this group constituted few participants their majority have used the female condom and this might be so because they might be well equipped with knowledge of the device .Of those who just attended primary level only 2/11 participants used the female condom, this group ranking last might be due to the fact that the group also had the least participants.

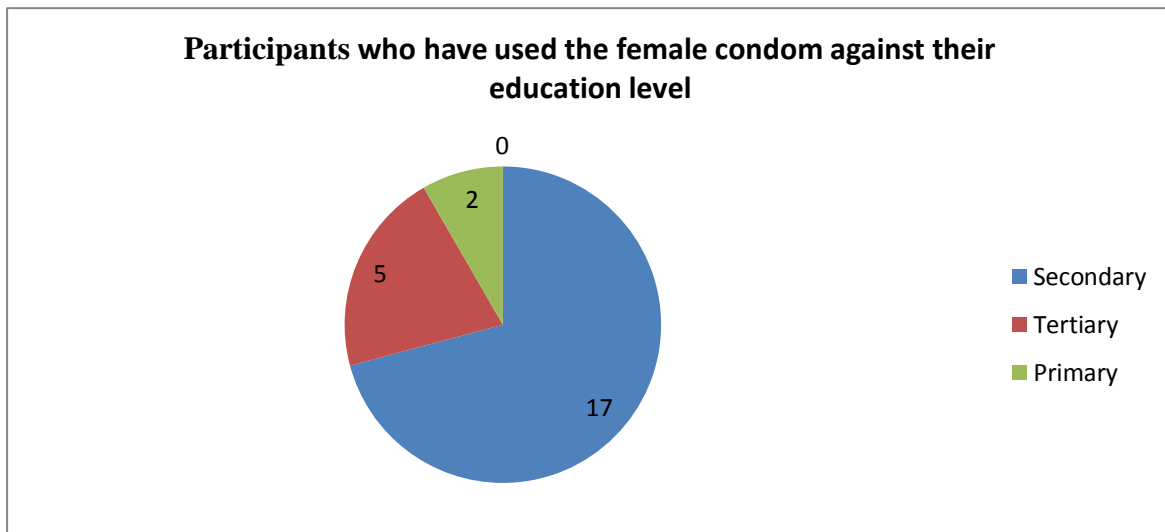


Fig 12: Chart showing level of education against Female condom uptake

Source; Interviews and FDGs

This depicts the fact that the level of understanding of people also determines their behavior as put forward by the Theory of planned behavior.

3.3.4 Levels of uptake of the female condom at district level annually

The following data was collected from the National AIDS Council regarding the uptake of the female. Data was collected from the District AIDS Coordinator of Chikomba district. The

table below shows that the number of condoms which were sold or freely distributed by the National AIDS Council and its stakeholders such as PSI,ZICHIRE BC, local clinics, and Ministry of Women affairs and Ministry of Health and Child care in the district.

Table 5. Number of Condoms sold or freely distributed in Chikomba district in 2014

Month	Number of condoms
January	3810
February	3448
March	800
April	5796
May	4872
June	12534
July	3080
August	5030
September	2331
October	2280
November	8781
December	2608
Total	13669

Source; NAC 2014 annual data

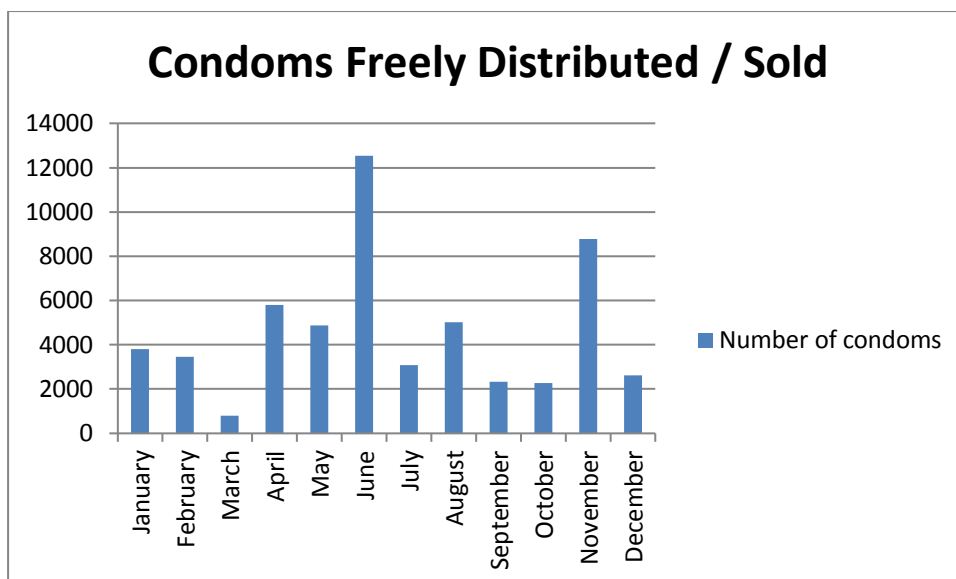


Fig 13: A bar graph showing female condom uptake in Chikomba District 2014

Source; NAC 2014 annual data report

This graph shows the uptake rate of both male and female condoms in the district in 2014. From the graph it shows that compared to the male condom the female condom seems to be non-existent since the rate the female condoms bought or taken freely from their sources do not even cover 1/9th of the male condoms bought or taken from source. In June that's where the female condom uptake rose to 12534 which was the highest in 2014 but all the same it cannot be compared to the highest level of the male condom which is almost 80000 condoms in July 2014. The rise of the uptake in June according to the Behavior Change Facilitator from ZICHIRE –BC who are responsible for distributing them was attributed to weather changes since June is when the winter starts more protection was required since more sex activities were carried out to warm out. That is what attributed to the high female condom uptake level in June.

3.4 Reasons behind the low uptake of the female condom

3.4.1 Individual factors

3.4.1.1 Female Condom reduces sexual pleasure

Of all the participants including those who have used the female condom and those who have not used the female condom 90% confirmed that the use of female condoms reduce sexual

pleasure and only 8 % denied the assertion arguing that the pleasure is the same as that of using the male condom and 2% did not know whether it reduces sexual pleasure or not .The subjective evaluation of the female condom as a device which reduce sexual pleasure determine the behavioural attitude of some women against the use of the female condom which proves the theory of planned behaviour applicable. Direct quotation from one of the interviews those who confirmed that it reduces sexual pleasure was that;

“Too much lubrication on the female condom made it messy and it was frustrating to the male partner and this made the whole process less sensational, also the vagina became too slippery such that the pleasure was minimised as compared to previous experiences where the vagina was dry and from that experience I never used the female condom again.”

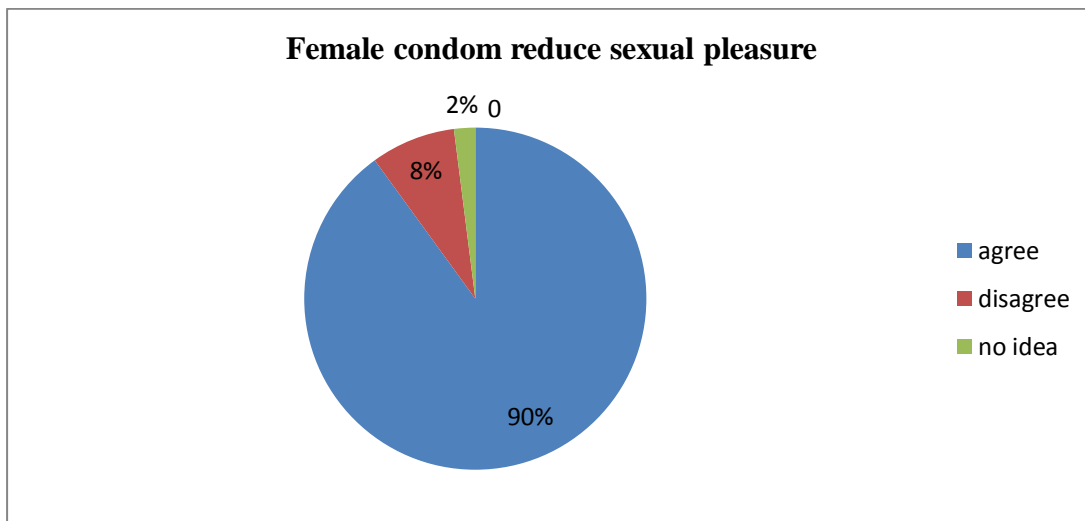


Fig 14 Female condom reducing sexual pleasure

Source: Interviews and FDGs

Other participants noted that the female condom disturbed their sexual pleasure since they feared that the female condom may disappear into the vagina which made them frequently check whether the outer ring is still there often putting both of them at unease during sex. The few who felt pleasure argued that with proper insertion there is no feel and the sex is pleasurable and feels natural since the condom would have taken shape of the vagina and there is no hurry to remove it even after sex unlike the male condom.

3.4.1.2 Female condom insertion is difficult

Of the research participants 88% responded that the female condom is perceived to be difficult to insert such that in most cases you take too long to insert and it hurts if not properly inserted., 10% responded that it was not very difficult to insert whilst 2% of the participants did not know whether the FC is hard to insert or not. The majority of the participants point it out as one of the reasons why they do not prefer the FC. Some participants air out that the FC looks like a bag and it not easy to insert such a big item into the vagina and since it should be inserted for hours before the act sometimes it is not comfortable to move around with a plastic in your vagina thus preventative measures are easily opted for at the expense of the female condom which lead to the quick abandonment of female condom use. A significant association between the uptake of the female condom and its comfort was recognised.

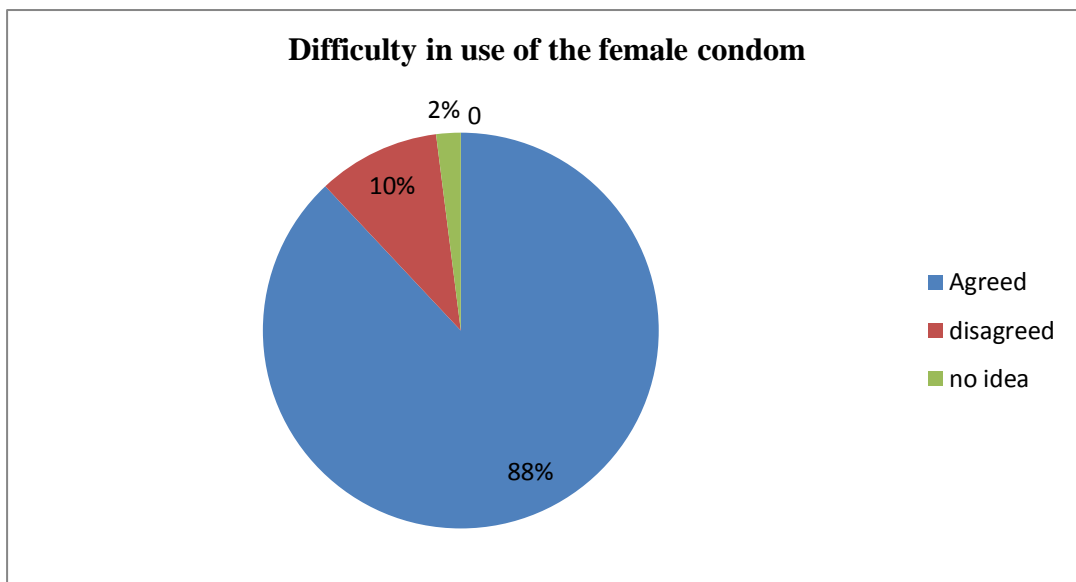


Fig 15: Female condom insertion difficult

Source; FDGs and Interviews

3.4.1.3 Female Condom is not comfortable to use

From the 94 participants 92 % of the 24 participants who have used the female condom before agreed that the female condom was not comfortable to use in any way ,6% disagreed and 2 % of the participants did not know whether the female condom was easy to use or not. The participants argued that since the insertion is very difficult during intercourse one cannot be carried away because of the fear that the female condom might slip inside and the

outer ring might need to be gripped so that it will not slip inside during insertion. One participant argued that it needs additional softening lubrication because if the female condom is inserted later than the hours recommended it hurts and it produces an unusual sound comfortable. Reasons given by women who experienced discomfort in using the FC were that the FC makes a lot of noise, it is too slippery and too often they felt the inner rings during intercourse which made sex uncomfortable.

Also the participants especially from focus group discussions argued that to insertion of the device is complicated leading to the whole process being uncomfortable and suggested that it was better to use the male condom which is familiar with both parties and comfortable to use. One of the respondents stated:

“The female condom is not comfortable to use, the inner ring sometimes causes pain during sex if improperly inserted and it is better to use the male because all things feel natural.”

This shows that the discomfort of the female condom during sex determines its uptake as well.

3.4.1.4 Preference of other Contraceptives

In regard to preference of other devices women who participate in the research revealed that 88% preferred other contraceptives such as the female condom, morning after, family planning pill to mention but a few. 12% of the participants opted for the female condom rather than other contraceptives. Those who preferred the female condom gave the reasons that the female condom is controlled by them and it is very effective on the prevention of pregnancy they are assured it will not burst unlike the male condom and it also does not have some side effects.

3.4.1.5 Male Condom is better than Female Condom

Another reason for the low uptake of the female condom was the individual perception that the male condom was better than the female condom. The study recognised that of the 24 that used the female condom 20 participants which is 80.7% then 3 which is 15.3 % were not certain which one is better than the other and 1 participant which is 3.8% dismissed the perception that the male condom was better than the male arguing the male condom was better. Most participants preferred the male condom as it was said to be easier to use and easily accessible than the female which was said to be burdensome. This was evidenced with

data presented in the bar graph below from the National AIDS Council 2014 annual data, comparing female and male condom uptake.

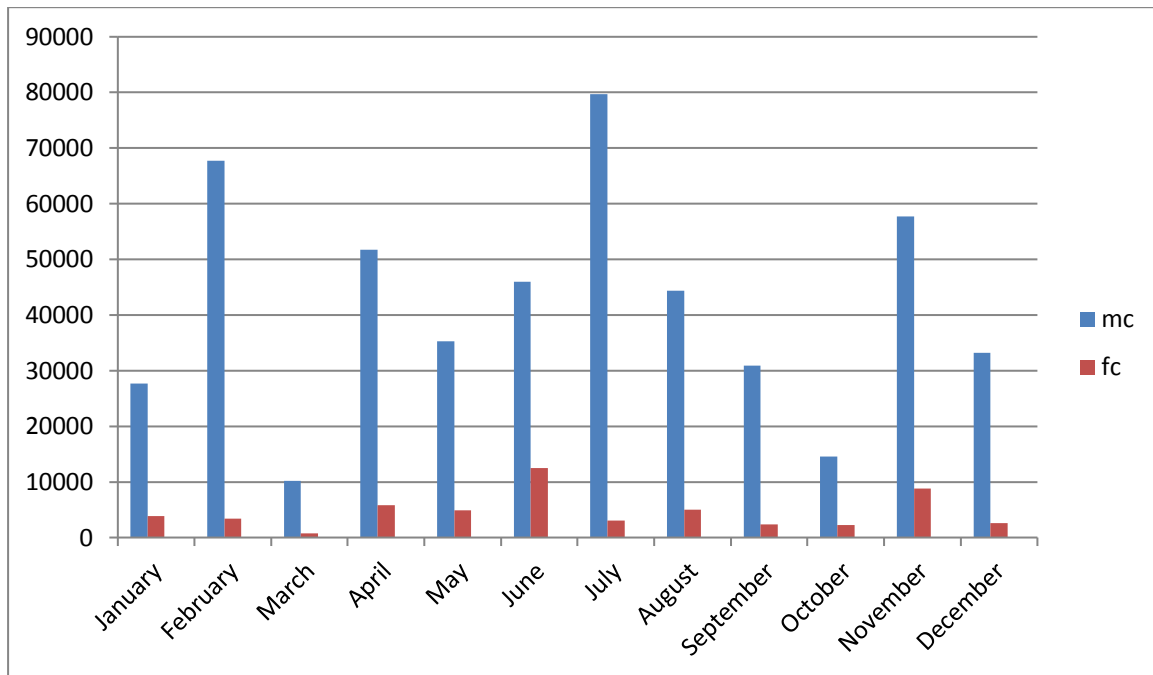


Fig 16: Bar graph on female and male condom uptake in Chikomba district 2014

Source; NAC 2014 annual data

3.4.2 Partner related Factors

3.4.2.1 Partners refusal to use the FC

Participants interviewed cited that the major barrier to condom uptake is the lack of partner's acceptance of the device. This lack of the partners concert lead to low uptake of the female condom because the study depicted that 86% of the participants would seek consent from their partners in terms of the female condom use. Only 14 % of the participants assured their independence in making the decision to use the female condom .Hence the study findings indicated that the female condom uptake is determined by the partners consent and in most cases man refuse the use of female condoms .One of the participants who is a commercial sex worker during interviews was directly quoted to have said;

“The partner’s consent matters because most men especially the truck drivers I deal with refuse the use of the FC because they argue that maybe I would have used it with another client since it is reusable thus they opt for a male condom where they will be assured that it is only them rather than the female condom they have doubts in.

3.4.2.2 The female Condom implies lack of trust for partner

It also emerged that the use of a female condom implied lack of trust between partners which is another reason why its uptake is low especially to permanent partners. Of the focus groups conducted 92% of the respondents responded that they do not use the female condom because it somehow proves their lack of trust to their partners. 8% of the participants dismissed the assertion and disagreed that it does not in any way indicate their lack of trust to their partners but rather it is just another type of a contraceptive which is used for a change.

3.4.2.3 Marital Status

Data analysis also depicted that marital status is another barrier to female condom uptake. 8 out of the 53 married participants used the female condom yet 18 out of the 45 single participants used the female condom. This revealed that only 15% of the married participants used the female condom which is less than the single women whom 40% of the participants used the female condom. Hence marriage showed displeasure in the use of the female condom leading to the low uptake of the FC and those who used the female condom used it as a safe family planning method which does not have side effects. One of the married participants among the non-users said that

“I do not understand the female condom and provided I did I would not use it because in our marriage the husband initiates the protection method to use.”

Another participant also said that:

In my marriage my husband has the right to unprotected sex which is the best and most pleasurable and there is no reason to use the female condom because we are husband and wife not boyfriend and girlfriend.

This is further supported by the assertion that married women may be unable to refuse unprotected sex with husbands because culturally protected sex is looked down upon and is not acceptable among most couples in Zimbabwe (Herald, 16 June 2011).

3.4.2.4 Male Circumcision

Because of Male Circumcision most male partners who got circumcised think that they are protected from acquiring HIV/AIDS so they do not see the use of female condoms as very

necessary .However these partners are wrong because MC only prevent acquiring of HIV/AIDS by 60% so there is need for double protection.

3.5 Provider related

3.5.1 Cost of the Female condom

Participants during focus group discussions were asked whether the female condom was expensive and the majority agreed. Most of them pointed out that although female condoms are freely provided the FC2 is the only which is freely distributed and can be found even in toilets. Most female condom users prefer the Care Female Condom but it is expensive as compared to male condoms. A survey in pharmacies and supermarkets in Chikomba district revealed that the female condom cost US\$ 0.20by PSI but in other outlets it cost US \$0.50 which is 5 times higher than the male condom which then divert the buyer to opting to the cheaper product.86% of the participants agreed to the fact that the female condom was expensive and 14% of the participants did not know whether it was expensive or not. The uptake of female condoms has been prohibited by the cost of the device in the district and people end up over relying on the male condom Protector Plus which is very cheap at 1 rand per 4 condoms. This problem of cost has dated back to 1999 when Norra Mac Ready indicated that the challenge of accessing the female condom was due to its cost as compared to the male condom.This is also in line with the Health Belief Model's notion of perceived barriers such as the cost as a limitation to behaviour change.

3.5.2 Unavailability of the female condom

The findings of this study indicated that the unavailability of the female condom is another barrier to the female condom uptake. The results from the focus group discussions which were conducted in ward 28 and 29 revealed that 96 % of the participants responded that they only hear of the Female condom but since they are far from Sadza growth point and Chivhu town they are not reached by many programs and the female condom they only see it. Only 8% of the participants know about the device through other relatives and partners who come from urban areas. In these two wards they are not available in shops or even clinics in that ward but the male condoms to where everywhere and easily available even in small bars in their community they find the male condom.In other focus groups conducted in other wards in the rural areas of the district other participants argued that the female condom is only available in clinics and those who live far from the clinics don't have easy access to the

female condom and also those who have close relationship with the clinic staff may not feel comfortable to request for the FC thus leading to the low uptake of the device.

One of the participants stated that:

“Sometimes I wonder whether the female condom is as useful as the male condom since the male condom is always available everywhere yet the female condom is not”

Of the interviews conducted the respondents confirmed that the female condoms 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.

When the participants were asked whether they thought the female condom was not accessible due to the combination of both its high cost and unavailability in the locality, 67.8% acknowledged that they could not access the female condom because it is both expensive and unavailable. 29.8% disagreed and commented that even though the female condom was expensive it was available while 2.4% responded that they did not know.

During participant observation by the researcher in urban areas in public toilets, saloons and other public outlets female condoms were available but in rural areas they were found in clinics only yet some of the participants stayed far from the clinics thus the device was not available to most of them.

3.5.3 Lack of male involvement

Another reason why the female condom is low is because of the lack of involvement of man in the initiation of the female condom. The FC targeted women only forgetting that women alone cannot use device alone but need man for support. Because of lack of knowledge by men towards the FC many male partners denies to use the device minimising the use of the female condom

3.5.4 Lack of adequate knowledge on female condom

Knowledge on the female condom especially among the rural women in Chikomba district was minimum. Participants who have little knowledge on the importance of the female condom occupied a large number and most of the women argued that the female condom may

sink inside the abdomen and it is also said to cause cervical cancer. Of the participants who have not used the female condom 88% responded that they lack proper knowledge on the female condom and only 12% seemed well informed and confident about the female condom and the majority of these were from Chivhu town. Lack of knowledge against the uptake of the female condom reviewed that the low uptake of the female condom was also attributed to lack of knowledge of the participants caused by provider bias to spread information concerning the Female condom.

Effort to educate people about the female condom in the district is a cause of concern, other programmes on HIV/AIDS get adequate awareness so at times the female condom will seem to be the last option in terms of prevention matters. In 2013 November there was a PMTCT Campaign and Male Circumcision sensitisation by the former Vice Mujuru at Madzivire secondary but no recognised sensitisations were conducted for the female condom thus people's knowledge on the device continues to be low and according to the theory of planned behaviour change of behaviour starts with the right knowledge about a certain issue and people lack that knowledge on the female condom thus undermines its uptake.

3.5.5 Promotion is urban biased

The female condom promotion in Chikomba district was found to be urban based. Female condom promoters were urban based and workshops conducted with women organisations such as WAG targeted women in Chivhu town and women leaving those in the rural areas from the rural parts of Chikomba confirmed that FC promotion programmes were largely urban based. This answers why the uptake rate was found to be low because 70% of the population in Zimbabwe lives in rural areas so the providers of the female condom targeted only 30% of the women in the district which answers why the uptake is low.

3.6 Mechanical barriers

3.6.1 Unattractiveness of the appearance of the female condom

The other reason why the female condoms have acceptability challenges is because of its physical look. Its unattractiveness appearance puts off people even before sex thus finding it unusable. Findings of this study have also revealed that the physical appearance of the female condom has a great impact on its uptake. Of the 100 participants 92% agreed to the fact that the female condom was unattractive, thus leading to its low uptake and 8% of the

participants find the device attractive. In a comparative qualitative study by Mack et al (2010) sex workers in Central America reported negative reactions towards the shape and size of the device.

3.6.2 Size and shape of the female condom

The size and shape of the female condom especially the size of the 2 rings the bottom ring and the other ring. The size of the female condom is big and many participants. The size of the female condom have been said to be deterring potential users of the female condom to use it. Women who are to have sex for the first time cannot use the female condom because it cannot be inserted inside a virgin it will automatically injure the female genitalia so the female condom is limited to women with bigger and wider private organs. The participants also stated that the female condom packaging is another barrier to its uptake since it is big that in wallets and pockets it cannot fit unlike the male condom which is small and easy to carry it around.

3.6.3 It takes a long time to be ready for use

Since the female condom is encouraged to be inserted 8 hours before the intercourse in order for it to take the body heat of the woman and take the shape of the genitalia, the majority of the research participants pointed it out as another challenge to female condom uptake since it is inconvenient. The participants argued that women are not certain when they will have sex and to single women in relationships the stigma of a woman not being the one to demand sex is within the people in the district so most women do not have the courage to wear the condom in preparation of sex to be conducted after 8 hours. Also it was said that wearing the female condom for such hours considering its size is a difficult thing thus undermining its uptake since it deters potential users from trying the device.

One respondent from those interviewed said;

“Honestly do I have to tell my husband who is really hungry to have me at that time to wait for eight hours for the female condom to be ready when a male condom which can take us through there and there is around, no I cannot do that.”

3.6.4 Unusual noise

The respondents from group discussions and interviews pointed out that the female condom is noisy especially when the sex become faster which is so uncomfortable to have sex

accompanied by a unusual noise .This noise is usually as a result of late insertion of the female condom or improper insertion since polyurethane which the female condom is made of on its own does not make noise.Of the 24/94who has used the female condom 14/24 which is 57.7% agreed to the fact that it makes noise and 52.3% dismissed the assertion that the female condom is noisy arguing that the noise is as a result of improper insertion.

One participant on focus groups said:

“As much as it is for our empowerment it was going to make us proud if we were to be given a device which is less noisy, the female condom is too noisy and it surely makes the whole act a misery”

3.7 Socio cultural and Perceptions about Female Condom

3.7.1Female Condom is associated with prostitutes

The female condoms are associated with prostitutes according to the participants. The introduction of the female condom in the district by the PSI targeting hair salons, barbershops, and beauty parlours have been made official sales points for female condom programmes, was viewed as an outlet which was targeting the female condoms. Female condoms were perceived to be associated with prostitutes because it emerged that 82% of the research participants viewed the female condom as associated with prostitutes,12,5 % did not agree with the assertion whilst 5,5 % were not certain whether the female condom is for the prostitutes or not. This assertion was also based on the fact that 1 female condom can be used with multiple sexual partners.

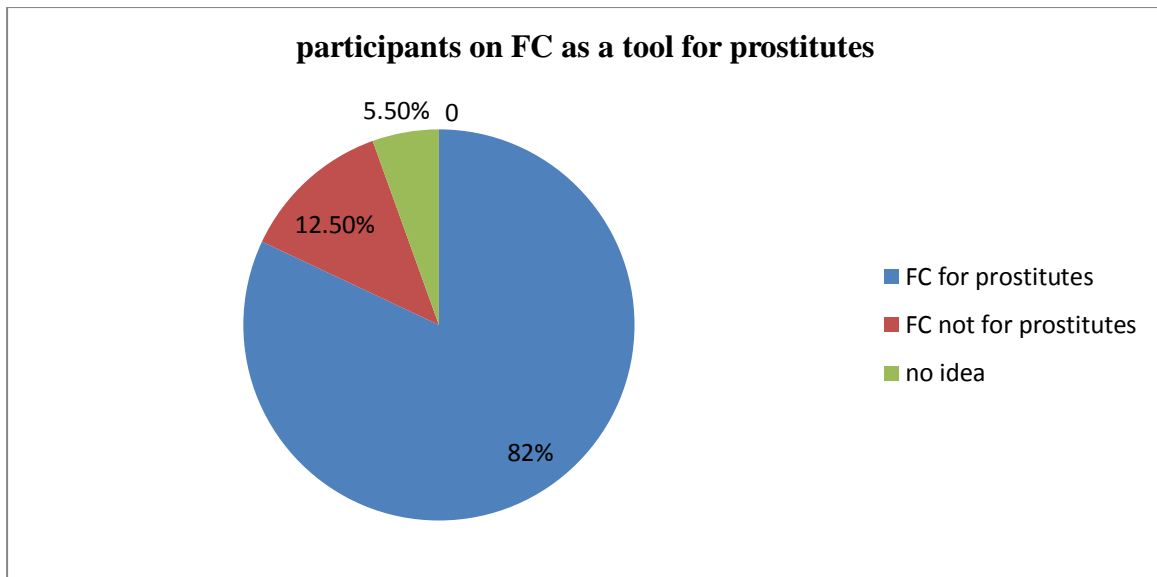


Fig 17:FC as a tool for prostitutes

Source; FDGs and Interviews

3.7.2 Male dominants in sexual matters

Women who participated in the research pointed out that female condom uptake in the district is undermined by the submissiveness of the women according to the culture which a real women is characterised by submissiveness allowing the man to take the leading role including that of initiating methods of contraception to use Traditionally, men have control over their wives and women have no right to resist or refuse sexual advances from their husbands. This complicates the women's capacity to negotiate for the female condom use. Married women whose behaviours violate this cardinal law of a good wife are often subjected to varying forms of reprimands or worse still violence in the home. Sex is usually coerced. It is almost impossible for women to negotiate condom use where sex is coerced.

Women according to the African culture are not to take the lead in sexual issues rather men are in control when it comes to sexuality issues, they are responsible for initiating contraceptives or preventative methods in line with reproduction in their relationships. This then undermines the female condom since the condom lead to power imbalance since it will be the women who will be taking the lead in the act.

3.7.3 Religious practices and beliefs

Participants identified religious practices and beliefs as one of the major barrier towards the uptake of the female condom. Some of the churches were said to condemn female condoms as they are associated with prostitutes.

From interviews one participant said that:

As Christians no female condom no sin since sex out of marriage is not justified by the bible, the use of the female condom justifies sex before marriage thus it is a tool of the Devil and the reason why Jesus came was to destroy such devils work so the female condom is an agent of Satan which should not in any case be justified.

Religion was pointed out as one of the major barriers to condom uptake. 56% of the participants agreed to the fact that religion is condemning the use of female condoms, 44% disagreed with the fact that religion is a barrier arguing that the behaviour of a person determines the health measure she /he wants proving the theory of planned behaviour correct. The participants alluded that religious practices and beliefs were one of the barriers to female condom use that was identified by respondents. All the Focused group discussions mentioned that some churches discourage their members from using any contraception stating it is a sin. This proves the theory of planned behaviour correct since it alludes that the behaviour of a person is attributed to social influence for example religion.

From the ZICHIRE office the Programs officer also supported the assertion that religion was a barrier to condom uptake because in community gatherings some members of other churches would not attend programs to do with Sexual and Reproductive Health Rights.

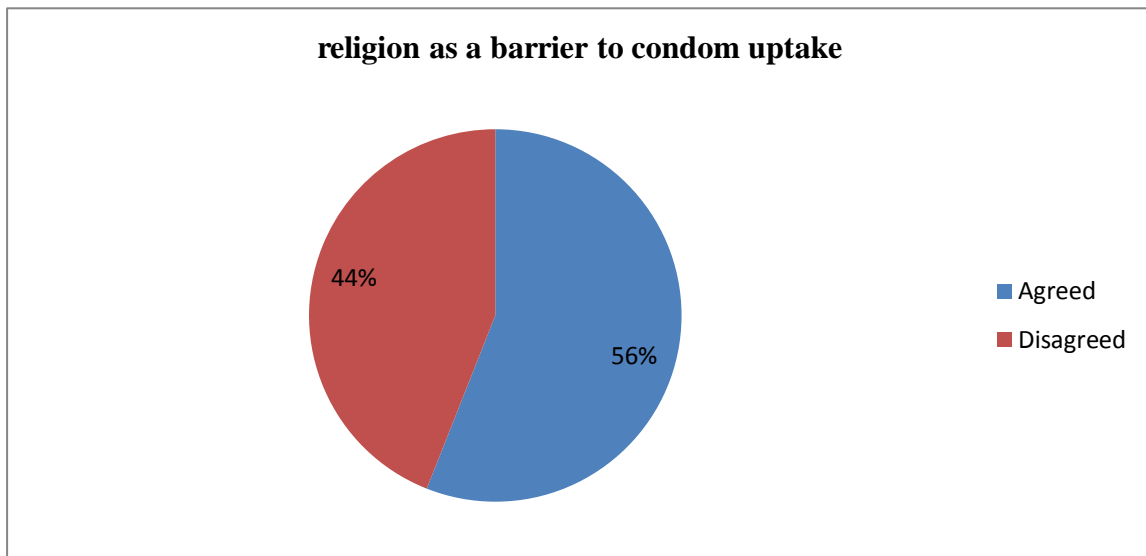


Fig 18: Religion as a barrier to FC uptake

Source; interviews and focus group

Conclusion

From all these findings in summation, the female condom uptake in Chikomba district is low. Only 24 of the 94 respondents have used the female condom which is a device which is supposed to be utilized at 100% since it is there to empower the same women who are rejecting the device. The low uptake of the female condom is attributed to lack of knowledge, the mechanical structure of the device socio-cultural factors such as religion and patriarchy to mention but a few. Thus there is need to enhance the female uptake in the district

CHAPTER THREE

ENHANCING THE UPTAKE OF THE FEMALE CONDOM IN CHIKOMBA DISTRICT

Introduction

In a bid to strengthen female condom uptake in the district, this chapter is going to address the challenges noted from the findings of this study pertaining the low uptake of the female condom. These recommendations were also based on the provisions of the Health Belief Model . The female condom in order to be acceptable it needs to be resized into a smaller package , people have to be sensitized to increase their knowledge concerning the device to do away with myths and misconceptions surrounding the female condom. To do away with partner related barriers the man have to be targeted as well as it is one of the major factor deterring condom uptake in the district. Traditional leaders and traditional leaders also need to be targeted to do away with sociocultural barriers of female condom uptake.

4.1 Change the mechanical structure of the device

From the findings of the major reason why the uptake of the female condom is low the make of the female condom which is not attractive to users. The shape, 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

4.2 Strengthening measures of promoting the female Condom

The female condom should be promoted adequately because putting female condoms in toilets, hair salons and in stores or clinics only is not adequate promotion of the device because it does not translate into its acceptability. There is a need to properly promote the female condom in ensuring information get to everyone in the country for example the way Male Circumcision is promoted the same must be done with the female condom. 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. Demonstration should always be there whenever there is female condom promotion program and participants should as well practice using a pelvic demonstration model.

4.3 Educating health care providers

Health care providers which in this district are the Behaviour Change Facilitators should receive proper training since they are the most reliable sources of female condom promotion especially in those areas far from clinics. The researcher recommends that the Behaviour Change Facilitators and other Health workers in communities should ensure that they are well versed with the device because of those who reported to have used the device most of them got the condom from the Behaviour Change Facilitators from ZICHIRE but then from those people insertion difficulties were high thus although they are distributing the device, they are not properly explaining how it is used to the clients maybe due to their lack of knowledge pertaining the device as well.

Thus it is very crucial to ensure that the providers of the female condom which includes the nurses, pharmacists, hair dressers and shop assistants feel confident to promote the device to their clients since they would be fully aware of the device. They also need to be sensitised and mobilised to accept the device on their own because most providers tend to have a bias towards the female condom thus there is no way they can positively influence potential users of the device.

4.4 Sensitisations on female Condom use in communities should be conducted

These sensitisations must be conducted in both Chivhu town and Chikomba rural communities in form of road shows or community dialogues because the major concern is the lack of knowledge of the people in the district interms of the use of the female condom. Sensitisations should include training on how to use the female condoms and it can be conducted as follows;

- Insertion practice

There should be an anatomical vagina model which should be used to illustrate how the female condom is inserted to help those who are slow to catch up and this should be done with an experienced trainer to do away with the insertion challenge that is a barrier to condom uptake as well

- There should also be testimonies of the positives of the female condom by fellow community members.

Sharing experiences might also get other women to try the female condom since tips will be exchanged and myths concerning the device will be done away with.

- Visual mass sensitisation should also be practised whether on television or posters. Video screenings should be conducted showing people what the female condom looks like and showing how it is inserted the procedures not just the advantages and the packaging but the process of getting ready as well. Posters should also be found everywhere because according to the Health Belief model this goes in line with Cues to action which are external events or something that helps move someone from wanting to make a health change to actually making the change.

4.5 Increase Knowledge levels of the Female Condom

Knowledge is power and key facilitator for an informed decision making process. There is need to increase awareness of the female condom because people will make a decision based on the information they have on that certain matter. This then depicts the great need for educating people on issues concerning the female condom because most of the barriers surrounding the low uptake of the FC in the district are due to the lack of knowledge of the people. Information on Female condoms has to disseminate even in the most remote areas of the district. IEC material have to be distributed and there is need to make sure that the language used will suit every audience to ensure that there will not be any challenges like improper translation. This way forward is significant in that according to the Theory of planned behaviour change in behaviour starts with having the right knowledge about a certain issue. Thus if partners are equipped with the right knowledge then their take on the female condom will change.

3.5 Ensure the FC is available and the cost is low

The price of the female condom should be equal with that of the male condom so the World Health Organisation should give licence to the other female condom manufacturers so that there will be competition on the market .Also the government should ensure that in its health policies it becomes a mandate for every clinic to have female condoms and the councils should also ensure that all public toilets are loaded with the Female condoms and to further subsidise its price. Sales points for female condom should be made available anytime,24 hours in some outlets. Increase sales points for female condoms, make them available day and night in some outlets, and look into whether female condoms can be even more subsidized in order to increase availability and affordability. Also to make sure the female condom is bought the female and male condom should be promoted together and do away with the perception that the male condom is a man's issue and the female condom is a woman's issue.

4.6 Dispel myths and misconceptions about Female Condoms

Myths and misconceptions surrounding the female condom have to be done away with so Female condoms programmers need to come up with strategies on how these myths can be addressed.Such myths and misconceptions like the female condom can only be inserted with women with big genitals and others are one of the major stumbling blocks of the uptake of the female condom in the district because according to the Health Belief model perceived barriers also affect the change of behaviour in health issues. Thus awareness and education programs on the female condom uptake must clearly dispel such misconceptions through the use of testimonies from those which have benefited from the device and scientific evidence as well.

4.7 Promoting the positive aspects of Female Condoms

Perceived benefits is one other factor which can improve the uptake of the female condom because it is difficult to convince people to change their behaviour if there is nothing for them to benefit it according to the Health Belief Model hence, there is need to promote and spread the positive aspects of the female condom identified .This will motivate those who haven't used the female condom to use the device. As such structuring of community awareness intervention should incorporate information that highlights such aspects. Key to it is the concept of women empowerment on deciding safe sex especially in an abusive environment where the male sex partner wants to engage in unprotected sexual intercourse..

4.8 Male involvement

Giving man a role in encouraging the use of the female condom is very thoughtful as a way to improve the uptake of female condoms this is because of the study findings most women did not use the female condom because their spouses would not allow them to so if man are to be targeted on the use of the female condom then the whole fraction would change. This is so because decision making power usually rest in man's hands especially in Zimbabwe. Male sensitisation should be done in areas where most men usually gather because on road shows just because the female condom is perceived to be the women's issue they don't usually attend. Thus places such as bars, club houses, sports fields, offices and barbershops are also recommended to carry out female condom awareness as a means to in cooperate men into the program.

Men also need to be incorporated using a strategy whereby sensitisation is done addressing them as couples. This is already done by the Behaviour Change Facilitators from Zichire while undertaking the door to door integrated support programme and of the women who responded to have used the female condom with the approval from their spouses 56% of them were convinced through this programme. Thus other FC programme developers should as well target men as much as they target the women. Men organisations also need to be targeted so that they would also encourage the use of the female condom, to young men they can be encouraged to use the female condom as a way of preventing STIs, HIV transmission and unwanted pregnancies yet to married men they can be encouraged to use the female condom as a family planning measure which do not have side effects.

4.9 Influential women in the communities should reach out to other women

Female condom promotion programmes must also make use of female community leaders to reach out to other women because in most cases other women culturally do not feel comfortable to discuss with male service providers on issues to do with sex thus sexual matters to do with female condoms become void. This was also put forward by respondents as another service provider barrier to condom uptake. To achieve this some women from the

community have to receive training and act as role models by disseminating information to other fellow women.

4.10 Community based leadership structures should take a lead.

Female condoms should be promoted starting from the grassroots in order for the programme to be a success. The Peer Educators from local society and Community Based Development Communities should as well be given the platform to spearhead the promotion of the female condoms. Traditional leaders should also take a lead because in most cases what is approved by the leaders of the society the majority of the community residents follow. Thus these people should as well receive training and also incentives if available that will motivate them to encourage the use of the female condom. In Chikomba district this approach have seem to be a success looking at how these leaders are taking a leading role in mobilising for Male Circumcision.

4.1.1 Document the Female condom good or bad practices

Documentation of success stories or bad stories from the female condom users has to be done at both local and district level so as to ensure that there is intervention from the upper provider the UNFPA. This is so because the female condom programming is largely based on donor requirement but feedback on problems and recommendations from the district level are not looked upon to and in that case specific interventions that would be able to address the needs of the district will be undermined. To the community these good practices are also vital because according to the Health Belief Model perceived benefits are crucial for behaviour change whereby it is noted that a person changes his/behaviour if he/she find something beneficial in it.

4.12 Engage Traditional and Religious leaders first.

Traditional leaders and Religious leaders are the most crucial stakeholders when it come to the use of the female condom .From the findings of this research the cultural and religious factors contributed much to the low uptake of the female condom because religion and culture was ranked top at not approving the use of the female condom .To this end there is need to target these community leaders into promoting the device since they are very influential to their people. These are to encourage their people even at dare or at any gatherings in their communities so as to make the female condom as common as the male condom not a taboo.

Conclusion

In summation of how the female condom uptake can be enhanced in the district, it is really vital to change the mechanical aspect of the female condom since many people lose even interest in acquiring more knowledge about the device because of how it looks. Also male involvement is another significant factor which should be taken into consideration since they are head of families male partners always dominate in sexual issues so if they do not know anything thus nothing works. Doing away with myth and misconception through educating people and consulting traditional and religious leaders were other recommendations which came based on the findings of the study. Hence the female condom uptake in the district may take a lead if the government, donor agencies and the community at large work hand in hand in trying to make a female condom a success.

5. CONCLUSION

In conclusion the female condom uptake level in Chikomba district is low and according to the participants only 24 of the 94 participants in the district use the device. After the effort of introducing the female condom to women as a way of empowering women to have say over their sexual and reproductive rights, the female condom use in the district is still a cause of concern that needs to be addressed. Knowledge levels of the female condom among the women were very low which was an important factor hindering female condom uptake. Most women in the district did not even know the female condom and they even confused the female condom with the male condom at times. From the interviews and Focus groups conducted in rural areas the situation was worse, other women could not even identify the female condom packaging especially the Care Female condom.

The low uptake level of the device was attributed to many factors such as the religious beliefs which barred women from using condoms, also myth and misconceptions surrounding the female condom such as it can cause cancer also deterred other potential clients from using the device. Lack of male involvement was another crucial factor which led to the rejection of the device by men. Among other reasons the mechanical structure of the female condom contributed much on the reasons behind its low uptake, many rejected the device because of its size, too much lubrication and the time required for insertion before the act, unavailability and cost together with the provider bias towards the condom also contributed. These are some of the factors which led to the low uptake of the device in the district.

To enhance the female condom uptake in the district the service providers should ensure the cost is minimized and the device is always available even in the remotest part of the district. Educating people through effective awareness programs such as video screening, distribution of Information, Education and Communication material written in Shona and workplace sensitization targeting all groups not just females but males as well is needed so as to improve the knowledge levels of the Chikomba residents. Gate keepers which are traditional leaders and religious leaders should also be targeted since they are the most influential people in their communities. Also myths and misconceptions of the female condom should be done away with. The female condom should also be designed in an attractive way and the Government should ensure that female condom is considered as an integral HIV prevention method on policy making. These among others were recommended to boost the uptake of the female condom in the district so as to ensure the utilization of the device which is meant to empower women in Chikomba district.

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APPENDIX A

Interview Schedule/ Focus group guide

Introduction

I am Matenhese Lucy a student at Midlands State University .I am carrying out a research study in partial fulfilment of the requirements of a Bachelors of Arts Honours Degree in Development Studies .My study seeks to assess female condom uptake in Chikomba District. Your responses are going to be used for academic purposes. Confidentiality and anonymity is going to be maintained.

Demography

Age

Marital status

Education level

1. Do you know the female condom?If yes how well do you know it in relation with HIV and STI prevention and pregnancy prevention?
2. Have you ever used the device in the past 6 months?
 - a.If you had how many times?
 - b.If u have not why.
- 3.How comfortable was the device during sex?
4. Do you think the Female condom can affect an episode of sex in any way? For example;
 - a. Can it reduce sexual pleasure? How?
5. Does your religion allow you to use the Female condom? Explain.
6. Does your culture allow you to use the Female condom? Explain.
7. Do your partners have any problem in regard to the use of this device?

8. Is the device necessary to be used with married couples of permanent sex partners? Give reasons to your answer.

9. Do you think the device is easily available? Explain why it is easily or not easily available.

10. In your opinion what do you think needs to be done to enhance the uptake of female condoms in the district?

Remarks

Thank you for your participation. The information you gave will make my research a success.

APPENDIX B

Interview guide to programme implementers

I am Matenhese Lucy a student at Midlands State University .I am carrying out a research study in partial fulfilment of the requirements of a Bachelors of Arts Honours Degree in Development Studies .My study seeks to assess female condom uptake in Chikomba District. Your responses are going to be used for academic purposes

1. What has been the uptake of the female condom been like in the district?
2. What has attributed to the low uptake of the device?
3. What are you doing to enhance the uptake of the female condom in the district?
4. What are your recommendations towards improving the uptake of the female condom?

Remarks : Thank you ,your response is greatly appreciated.