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Female condom awareness, use and concerns among Nigerian female undergraduates

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Summary

A cross-sectional study of female condom awareness, usage and concerns among the female undergraduates of the University of Ibadan was conducted in September 2004. The results of 850 out of the 879 female students interviewed were used for analysis (96.6%). Over 80% had knowledge of the female condom as a form of modern contraception and the majority of them learnt about it through the mass media (39.9%) and health workers (34.4%). However, only 11.3% had ever used the female condom, with most (40%) using it to prevent both unwanted pregnancy and sexually transmitted infections including HIV (STI/HIV). The sexual partners' approval was appreciable, accounting for about 42.7% among those that had experience of the female condom usage. Major concerns mentioned such as difficulty of inserting it into the vagina and lack of sexual satisfaction, were not different from those in earlier studies. The result of this study looks promising judging from a high awareness level of the female condom, even though its usage is low. The female condom may be an alternative strategy to combat unsafe sexual practises and its sequelae in a country like Nigeria that is male dominated.

Introduction

The male condom enjoys wider promotion worldwide among other barrier methods because of its dual potential role, especially among sexually active youths. Despite this global awareness, its use in achieving safer sex is almost entirely subject to the discretion of the male sexual partner (Cates 2003). Apart from this, the much expected decline in unwanted pregnancy and STI/HIV among the youths especially in developing countries is far from being achieved. For example, about half of the 40 million people living with HIV/AIDS worldwide are women and 60% of the newly infected people are women (UNAIDS 2002/3). Most of these affected women are either adolescent or young adults. The 2003 demographic and health survey (NPC 2004; UNFPA 1997; PRB 1992) showed low contraceptive usage among adolescents and young adults in Nigeria, a country with a restrictive abortion law (Okagbue 1990). This has led to a high rate of unsafe abortion in the country accounting for over 20,000 mortalities yearly. (Okonofua and Ilumoka 1992).

The female condom was developed in the 1980s as an alternative strategy aimed at ensuring a female controlled safe sex method (Hoffman et al. 2004; Deniand 1997). It is a loose fitting polyurethane sheath that functions like the male condom except that it is inserted inside the vagina. A flexible inner ring is used to insert the female condom, and the soft outer ring remains outside the vagina during intercourse. It is commercially available in several brand names such as Femidom, Reality, Femy, Myfemy, FC, Dominique, Protectiv' and Care. It has been demonstrated to be effective at preventing HIV transmission and other viral infections such as herpes virus and hepatitis virus.

The female condom use has gained some popularity in over 70 countries including the USA, Zimbabwe, and Ghana (USFDA 1993; Population Council 1992). Studies in these countries show that, this contraceptive method is especially popular among commercial sex workers, adolescents and young adults. The acceptability of the female condom in these countries ranges from 37% to as high as 98% when the clients are properly counselled and well motivated (Cecil et al. 1998; WHO 1997; Francis-Chisororo and Natshalaga 2003).

The concerns of the female condom users range from male partner objection (Ford and Mathie 1993; Welsh et al. 2001), its cost compared with male condoms (Cecil et al. 1998) and difficulty of insertion (Sly et al. 1997; Neilands and Choik 2002). Its efficacy has been found to be comparable with that of other barrier methods (WHO 1997). A recent study cited the refusal of men as the most common concern among female condom users because of the belief by men that women gained an undue advantage in controlling sex (Pool et al. 2000; Kaler 2001). Hence, the female condom is usually referred to as a female-initiated rather than a female-controlled method. Apart from this challenge, the promotion of female condom has witnessed many difficulties, even in developed countries. These range from ridicule by the mass media (Kaler 2004), lack of adequate training by the providers and limited distribution within the public health sector (Mantell et al. 2001).

The higher cost of the female condom compared with the male condom has necessitated re-use, especially in developing countries, which is against the initial recommendation of World Health Organisation of a single use per episode of sexual intercourse (WHO 2002). Available evidence from the USA (Pettifor et al. 2000), South Africa (Beksinska et al.

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2001) and Zimbabwe however, suggest that the female condom can be re-used provided the device is properly washed, dried and lubricated without compromising its integrity. One USAID-supported study by Family Health International found that couples who disinfected, washed, dried, re-lubricated and re-used the same female condom five times experienced no more adverse effects in the vagina, on the cervix or on the penis than did couples who used five female condoms one time only each (Joanis and Ballagh 2002; Ballagh and Joanis 2002). Several studies are still been conducted with the sole purpose of determining how long it can effectively last following re-use. In the light of these findings, the WHO in July, 2002 declared that the decision on whether or not to support re-use of the female condom must ultimately be taken locally.

The objective of this study is to determine the level of awareness, usage and concerns of those using the female condom among the female undergraduates of the University of Ibadan, Nigeria.

Materials and methods

A cross-sectional study was carried out among female undergraduates of the University of Ibadan in September, 2004. It is the oldest tertiary institution in Nigeria and is located in Ibadan the state capital of Oyo State. The university has a total population consisting of about 12,100 undergraduate students and a female population of about 4,350. The female undergraduates reside in four halls of residence (two halls are exclusive to the females, while the other two are shared with their male counterparts).

The study was carried out using a self administered questionnaire. The information that was sought from respondents included sociodemographic data, awareness and usage of the female condom, their concerns and their partners approval or otherwise.

A total number of 879 students were interviewed in all. A total of 220 students were selected from each hall of residence using a systematic random sampling technique. Thereafter, consent was obtained individually prior to the interview. The result obtained was entered into SPSS 11.0 software for analysis.

Results

Of the 879 respondents interviewed, the results of 850 respondents were suitable for analysis, accounting for 96.6% of the total sample. A majority (44.9%) of the respondents were within the range 21–25 years of age with a mean age of 21.4 years. All the respondents were fairly represented from all the undergraduate educational levels with a slight increase among those in the 400 level (i.e. 4th year) and above (28.3%). Among those interviewed, 81.1% were single, while 18.9% were already married. Most respondents were Yoruba (64.7%), while others were Igbo (19.4%), Hausa/Fulani (4.1%) and other minority ethnic groups accounted for 11.8%. About 60% of the respondents were Christians, 39% were Muslims and less than 1% belonged to other religious group (Table I).

Over 80% of the respondents had knowledge of the female condom (Figure 1) with the majority (39.9%) of them learning about it for the first time through the mass media. Others learnt about it from health workers (34.4%), friends (23.0%) and their sexual partners (2.7%).

Table I. Sociodemographic characteristics of the respondents ($n = 850$)

Variables	Frequency	(%)
1. Age group		
15–20	269	31.7
21–25	382	44.9
26–30	150	17.6
31–35	44	5.2
36–40	5	0.6
2. Level of education		
100 level	210	24.7
200 level	200	23.5
300 level	200	23.5
400 level and above	240	28.5
3. Marital status		
Single	689	81.1
Married	161	18.9
4. Religion		
Christianity	511	60.1
Islam	332	39.1
Others	7	0.8
5. Tribe		
Yoruba	550	64.7
Hausa/Fulani	35	4.1
Igbo	165	19.4
Others	100	11.8

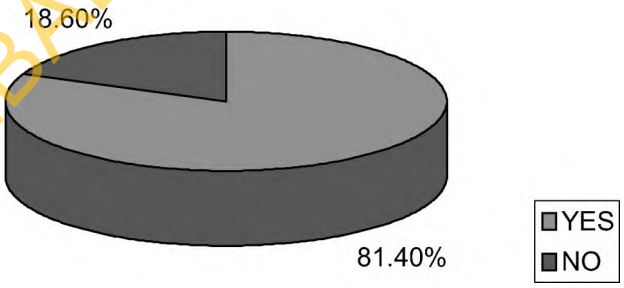

Figure 1. The knowledge of female condom among the respondents.

Only 11.3% of the respondents had experience of having used the female condom (Figure 2). Among the female condom users, about 40% of them used it to prevent both unwanted pregnancy and STI including HIV; 27.1% to prevent pregnancy alone and 19.8% to prevent STI including HIV only, while 12.5% used it on a trial basis. The majority (42.7%) of the sexual partners of the female condom users approved of it; however, 39.6% of sexual partners disapproved while 17.7% were indifferent. The most common difficulty identified by female condom users was lack of sexual satisfaction (30.2%). Other problems encountered included difficulty in inserting it into the vagina (21.7%), pain during sexual intercourse (5.2%) and method failure resulting in pregnancy in two (2.8%) of the respondents (Table II).

Discussion

Globally, gender dynamics contribute to a situation in which women are often not able to demand protective measures or refuse sex (DiClemente et al. 2002). This is due to the fact that male condom use is mostly at the prerogative of their male partner.

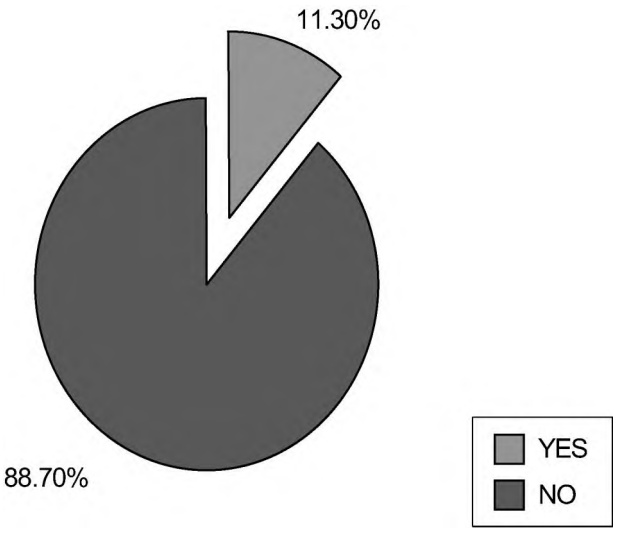

Figure 2. Previous female condom use among the respondents.

Table II. Information on female condom

Variables	Frequency	(%)
1. Source of awareness		
Friends	159	23.0
Sexual partner	19	2.7
Media	276	39.9
Health worker	238	34.4
2. Reason(s) for female condom use		
To prevent pregnancy only	26	27.1
To prevent STI including HIV only	19	19.8
To prevent both pregnancy and STI	39	40.6
Other reason (trial use)	12	12.5
3. Sexual partner's position		
Approve	41	42.7
Disapprove	38	39.6
Indifferent	17	17.7
4. Problems encountered during female condom use		
Difficult to insert into the genital	25	26.7
Cause pain during sex	5	5.2
Lack of sexual satisfaction	29	30.2
Got pregnant following use	2	2.8

In this study, the knowledge/awareness about female condom is about 81.4% among the respondents. This is an encouraging result, especially as most of the respondents were young and single. These are the people that are more likely to embark on sexual exploration that may predispose them to sexually transmitted infections including HIV. Most of our respondents first heard of the female condom through the mass media and from health workers, unlike in other countries, where it is being ridiculed by the press (Kaler 2004). Apart from this, a sizeable number of our respondents learnt about it through friends. Studies have shown that peer group pressure and other social support appear to stimulate its use (el-Bassel et al. 1998).

Despite this high level of awareness observed among the respondents, the proportion of those that had used the female condom was low (11.3%) compared with other studies in countries like Zimbabwe, Cote d'voire and Thailand, where the acceptability and use rate is put between 37 and 98% (Cecil et al. 1998). In fact, its use in many of these countries was most popular among the commercial sex workers and youths with risky sexual behaviour (Ray et al. 1995).

Prevention of unwanted pregnancy and other sexually transmitted infections including HIV was the most common reason offered for using the female condom in this study. This is in tandem with the earlier reason for its introduction over a decade ago. If this reason is harnessed, it should fortify the bargaining power of women in achieving safer sex. This will ultimately reduce the triad of infertility, unsafe abortion and genital malignancy.

There is a marginal partner approval in this study unlike other studies that showed male preference for its use because of the advantage of no sexual disruption (Meekers and Richter 2005).

Some of the concerns expressed by the respondents are similar to those in previous studies. Lack of sexual satisfaction may pose a challenge to promotion and acceptability but motivation by the providers may assist in circumventing this hurdle. Studies have shown that women who had used male condoms before prefer the female condom to the male condom because of better sexual satisfaction with the female condom (Ray et al. 1995).

Two (2.8%) respondents who had used the female condom reported getting pregnant. This risk of unwanted pregnancy following female condom use is comparable with that observed in other studies. This may however be especially serious in a country like Nigeria, with a restrictive abortion law. Recent studies suggest that the failure rate of the female condom can be substantially reduced by combining its use with spermicides, especially when re-used (Van Damme and Rosenberg 1999) but the cost of this combination and irritation of the genital tract with subsequent predisposition to STI, remain a challenge (Van Damme 2000).

There is a paucity of reports on the female condom in developing countries. The outcome of this study looks promising, especially with the high level of awareness and partner approval. It is our belief that the female condom may be a better alternative strategy of ensuring a safe sex in a male dominated society like Nigeria's, where the women folk are the most susceptible and vulnerable to the complications of unsafe sexual practises.

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