Factors contributing to the low uptake of female condoms in Chobe district of Botswana.

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ABBREVIATIONS AND ACRONYMS

AIDS  ACQUIRED IMMUNODEFICIENCY SYNDROME
CDC  CENTRE FOR DISEASE CONTROL AND PREVENTION
CSO  CENTRAL STATISTICS OFFICE
DMSAC  DISTRICT AIDS MULTI-SECTORIAL COMMITTEE
FC  FEMALE CONDOM
HIV  HUMAN IMMUNE VIRUS
HW  HEALTH WORKERS
IEC  INFORMATION, EDUCATION AND COMMUNICATION
NACA  NATIONAL AIDS COORDINATING AGENCY
MC  MALE CONDOM
STI  SEXUALLY TRANSMITTED INFECTIONS
MOH  MINISTRY OF HEALTH
UNAIDS  UNITED NATIONS PROGRAMME ON HIV/AIDS
SWAAS  SOCIETY OF WOMAN AGAINST AIDS IN AFRICA
Definition of concepts and terms

**Male condom** – Refers to a thin sheath made of latex worn by men to cover the penis during sexual act to prevent the transmission of Sexually Transmitted Infections including HIV.

**Female condom** – Defines a thin sheath made of polyurethane inserted into vagina women during sex to prevent transmission of Sexually Transmitted Infections including HIV.

**Perception** – Refers to views/opinion held by an individual or community.

**Intervention** – Is systematic plan of activities aimed at addressing a certain problem/need to achieve a desired result.

**Adult population** – Refers to both males and females aged 18 to 49 years.

**Chobe District** – Refers to all the nine (9) villages that constitute the population of Chobe.

**Health Workers** - In scope of this research health workers refer to Nurses.
Abstract
The study was cross-sectional, exploratory and descriptive. It used both quantitative and qualitative method of data collections. Data was collected from both males and females of ages 18 to 49 years and covered all the nine (9) villages in Chobe in 2010.

The findings revealed that culture, knowledge and accessibility are amongst the key factors that contribute to low uptake of female condoms. The study also evidenced that the health sector does not do much in promoting female condom. Almost all the health facilities did not have a female condom demonstration models. At the time of data collection only two out of ten facilities had condoms for the last three months

The study recommended that female condom programme should:

- Have targeted FC promotion interventions that focus on acceptability and skills building.
- Strengthen strategies/methods for creating awareness and increasing knowledge on FC.
- Make Chobe a model District in FC programming and document best practices to create evidence base
INTRODUCTION

1.1 Background

Chobe district is located in the Northern part of Botswana and has an estimated Population of 20,000. It borders Namibia to the west, Zambia to the north and Zimbabwe to the east. The District is made up of 9 villages and Kasane being its Administrative capital and the only urban centre. The population of Kasane accounts for 41.8% of the district Population. Chobe district covers an area of 22,559 square kilometres and has a population density of 1 person per square kilometre. (Refer to the map below)

Chobe district has HIV prevalence of 23% (CSO 2009:17). Amongst pregnant women attending Ante-Natal Care (ANC), Chobe district has the third highest HIV prevalence rate at 42.3% following Selebi-Phikwe at 48.4% and Bobirwa at 49.2% (MOH 2007:28). Over the years, Chobe has been one of the districts with
the highest HIV Prevalence in the Botswana. However, BAIS III of 2008 showed a decrease of HIV prevalence rate in the District. Refer to table below:

<table>
<thead>
<tr>
<th>District</th>
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<td>2004</td>
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<td>18.3</td>
<td>17.1</td>
<td>Kgatleng</td>
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<td>Francistown</td>
<td>24.6</td>
<td>23.1</td>
<td>Central- Serowe</td>
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<td>Lobatse</td>
<td>17.8</td>
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<td>Central-Mahalapye</td>
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<td>Selibe-Phikwe</td>
<td>23.3</td>
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<td>Central- Bobonong</td>
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<td>Orapa</td>
<td>18.2</td>
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<td>Central- Boteti</td>
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<td>Jwaneng</td>
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<td>Sowa</td>
<td>18.8</td>
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<td>North East</td>
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<td>Southern</td>
<td>12.4</td>
<td>13.3</td>
<td>Ngamiland East</td>
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<td>Barolong</td>
<td>14.2</td>
<td>13.9</td>
<td>Ngamiland West</td>
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<td>Ngwaketsi West</td>
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<td>Chobe</td>
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<td>South East</td>
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<td>Kweneng East</td>
<td>15.2</td>
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<td>Kgalagadi South</td>
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<td>Kweneng West</td>
<td>10.8</td>
<td>10.3</td>
<td>Kgalagadi North</td>
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</table>

*Figure 2: District HIV prevalence Rates for 2004 and 2008(Source Central Statistics Office)*

Botswana adopted a multi-sectoral response to the epidemic with a wide range of aggressive interventions, termed, “high prevalence, high response”. There is evidence of that the country is in overall gaining some ground. However there still exists a disproportionate high infection and prevalence rate among certain pockets of the country. Women are the most affected with an average national prevalence rate of 20.4% compared to 14.2% amongst males (CSO 2009:1). Figure 2 above evidence that, just like in other districts, women in Chobe are the most infected with HIV prevalence rate of 30% as compared to 13.1% of males in the district. The highest hit age group among women is the 30 – 35
years, followed by 25 – 29 years with prevalence of HIV prevalence rate of 68.8% and 52.5% respectively.

Indeed, given the statistics stated above, interventions that target and empower woman need to be expanded, strengthened and redesigned. Chobe in particular has programs and interventions that have been put in-place to avert the spread of HIV. Among the interventions widely employed is the condom programme which has a key message of correct and consistent condom use.

1.2 Statement of the problem

It is now close to two decades since United States Food and Drug Administration approved the use of female condoms. Following this approval, most of the Western Countries introduced female condom, with the assistance of the Joint United Nations Programme on HIV and AIDS (UNAIDS), development partners and manufacturers. Many developing countries made the female condom widely available. The Female condom was introduced in Botswana in 2006 as a female initiated method of preventing both unwanted pregnancies and Sexually Transmitted Infections (STIs), including HIV. However as observed by Kaler et al (2004), Uptake of the female condom in the West and in developing countries has been lower than was initially anticipated, showing that the successful introduction will not be as straight forward as thought.

While all these efforts are being made, the rapid spread of HIV continues unabated and still remains the greatest challenge facing humanity in the 21st Century. UNAIDS estimates that by December 2008, there were a total of 22.4 million people living with HIV, 1.9 million new infections and 1.4 million HIV related deaths in Sub Saharan Africa(UNAIDS 2009). Botswana is still among the most affected in the Sub-Saharan Africa with 17.5% women constituting the larger percentage of the infected population.

In Chobe District, women continue to bear the heaviest brunt of HIV with a prevalence rate of a 30% as compared to 13.1 % amongst males (CSO 2009:17). However, data from health facilities in Chobe District show that from January to November 2009, a total of 231,164 male condoms were distributed as compared to 7,108 of female condoms. Although they bear the heaviest brunt of HIV infection, it is interesting to note that majority of women shun the female condom which is a female initiated method and has the potential to empower women to better protect themselves and negotiate for safer sex.
This study seeks to investigate factors that make the female condom unattractive to many after decades of education and promotion.

1.3 Aims and objectives

The overall aim of this study was to determine the factors contributing to low uptake of female condoms in Chobe District. In order to realize its goal, the following specific objectives were pursued:

- To identify Socio-cultural barriers to female condom use in Chobe District
- To investigate perceptions of adult population 18-49 years in Chobe District on female condom use.
- To assess Knowledge on the use of female condoms amongst adult population 18-49 years in Chobe District.
- To determine the performance of the health workers in promoting female condom use.
- To make recommendations on what Chobe District should do to increase the uptake of female condoms.

1.4 Justification of the study

Chobe District has been reported to have one of the highest HIV prevalence in the country. Although so many interventions such as condom use (both male and female condoms), education on HIV and AIDS have been promoted, there still remains a major challenge of identifying factors contributing towards HIV infections.

1.4.1 Implications for Chobe District.

Evidence based strategies and interventions are needed to address the challenges and to strengthen the fight against HIV and AIDS in the district. This could be attained through research. Findings of this research will inform District Multi Sectoral AIDS Committee (DMSAC), Health Care service Providers,
Community Leaders and stakeholders of factors that lead to the low uptake of female condoms. Through their recommendations, the study team will point possible interventions that could be done in the district to promote the female condom. The research findings will guide the interventions to best reach women particularly that Chobe is amongst the districts with the high HIV prevalence and the most affected are women. Chobe DMSAC will also use the research findings in evidence in its Evidence Based planning process.

1.4.2. Implications for Government of Botswana
The government of Botswana has injected a lot of funds to ensure free availability of female condoms. Therefore it is very critical to evaluate if the condoms were being put to use, and if not why were they not being used, and what could be done to promote maximum use of female condoms.
The findings of this research would inform the government, policy makers and other stakeholders on the success or failure of female condom, which was aimed at empowering women on sexual matters.

1.4.3. Implications for Vision 2016
Through vision 2016, Botswana wishes to attain Zero new infections by the year 2016. The use of female condom is one of the strategies of preventing HIV infection and hence a research like this one would inform the nation on how to improve this strategy to bring about the desired results.

1.4.4 Implications for further Research
There has not been much research conducted around this area and hence this study will assist in building a body of knowledge on the use and perceptions surrounding female condoms in the district.
Low uptake of female condoms is a national issue and this study will inspire the national offices and other districts to commission a national study and to research to shed more light in this area respectively.
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.

1.5 Conceptual Frame work.
A host of factors could be contributing to Low uptake of Female Condom in Chobe district. It could be demographic factors e.g. age, gender, culture,
socioeconomic, knowledge, and availability of female condoms amongst others. The table below illustrates some of these factors.

![Diagram](image)

**Figure 3: Possible factors that lead to low uptake of female condoms**
LITERATURE REVIEW

Condoms are an integral part of STI and HIV/AIDS prevention, and their use has increased significantly over the past decade. Correct and consistent condom use reduces the risk of HIV transmission by more than 90%. Indeed male condom has been found to be 90% effective in preventing HIV Transmission (Hearst & Chen 2004). The female condom’s effectiveness is also rated between 94% to 97% by US FDA. Therefore, condom promotion has received considerable attention in the fight against AIDS pandemic because of high effectiveness (Peltzer, 2000:46). Many countries including those in the sub-Saharan African also embarked on strategies to fight HIV and AIDS, through the promotion and use of condoms, and indeed condoms are widely and freely distributed with the aim to improve access.

Several studies have shown that amongst the factors affecting condom use are: unavailability, shortage, partner trust, and knowledge and gender inequality. Cultural factors such as desire for children and female sexual compliance as a way to achieving economic status are a hindrance to use (Lule & Gruer: 1991; Peltzer, 2000:47). Also lack of acceptance of the family planning concept has often evidenced itself as a barrier to condom use (Peltzer, 2000:47).

Lule & Gruer (1991) have demonstrated that limited skills and knowledge of Health Care service providers have impacted on condom uptake, as the consumers do not gain confidence with regards to use. In Botswana, condom usage seems to have increased among different sexually active groups. According to CSO (2009:25) 81.1% of men and women aged between 15-49 years, who had sexual intercourse with more than one partner in the last 12 months reported condom use. In addition, the same age group who had sex with casual partners and used a condom stands at 6.0%. A large number of commercial sex workers reported the use of condom with their most recent clients (88.7%).

As the struggle against HIV and AIDS continued, the disparities to find cure or other successful interventional measures for the pandemic, led to the introduction of female condom, which was aimed at empowering the most affected population, being women. The female condom is not a replacement for the male condom; however, it is an expansion option for safer sexual behavior especially for women.
Several clinical trials such as the studies on Microbicides have been conducted, as a way of giving women options when it comes to HIV prevention. The Global Campaign for Microbicides in 2004 undertook an expert consultation in order to understand barriers and opportunities for increasing access to the female condom. In 2005 the Global Campaign for Microbicides noted that there was inequity in availability and distribution of male and female condoms. In response the United Nations Population Fund (UNFPA) launched the Global Female Condom Initiative to scale up female condom programming in at least 23 countries. The initiative was effective in increasing availability and distribution (www.global-campaign.org). Therefore the challenge for programme managers and implementers is to ensure that women are reached.

In Ghana, the Society of Women against AIDS in Africa (SWAA) achieved its programme goals by extending the female condom programme to districts and communities and empowered individuals through trainings. The programme marked increased awareness and improved women’s health rights (www.global-campaign.org).

However, the female condom initiative has reflected some problems in other countries with regard to use. Some of the problems highlighted included: excessive oiliness, difficulty in inserting the condom, discomfort with the inner ring of the condom which sometimes causes pain, and also cultural contexts in which some cultures prefer ‘dry sex’. A study that was conducted in Zimbabwe highlighted the latter as causal factors to low female condom use. According to UNAIDS (2004), power relations between men and women is stated as one of the factors that influence the extent to which condom use can be successfully negotiated, due to both social and economic factors that usually favor males.

It is true that the female condom is not being used. It is said to be clumsy and not attractive so what people are asking is whether we should continue to pretend as if it is a tool when in fact it is not used. Some contend that the reluctance on the female condom is deep rooted on the socialization of Botswana communities because they are not comfortable to look at female genitalia therefore as long as female genitals cannot be freely viewed, then a female condom will also be viewed in the same manner. But others have a different view and opine that the heart of the matter is not on visualization because even people in the Western countries who supposedly use the female condom do not freely view the genitalia, the problem is on the taste.
METHODS

3.1. Study Design

The study adopted a descriptive research cross sectional study design. The study used both qualitative and quantitative methods. According to Patton (2009:5) qualitative and quantitative paradigms and methods may be used in combination. Gall, Borg & Gall (1996:29) concurs by stating that qualitative and quantitative paradigms and methods complement each other. As the study is exploratory and descriptive in nature, it dealt with getting emic perspective on a subject that has not been researched before in Chobe District. Patton (2009:84) states that the emic perspective is achieved through doing observations, interviews, describing, and conceptualization of the culture of those that are being studied.

A qualitative paradigm was used because the study aims to explore the targets’ perceptions and identify their perceived socio-cultural barriers. The kind of data is achievable through use of qualitative approach. The quantitative paradigm has also been used to determine the knowledge of female condom among the target population and performance of the health sector, therefore quantitative data was more appropriate.

3.1.1 Study Sites

The study sites are all the nine villages in Chobe district and they are as follows: Kasane, Kazungula, Parakarungu, Pandamatenga, Satau, Kavimba, Mabele, Kachikau and Lesoma.

Only a cross section of the population was interviewed as opposed to everyone who met the inclusion criteria. This being due to the fact that time and other resources did not permit to allow for conducting a study that will cover all people in the district meeting the eligibility criteria.

3.2. Sampling

3.2.1 Study Population

The study targeted adult population residing in the Chobe District, in all the villages noted above. The sampling frame is people aged between 18 and 49 years, both males and females.
3.2.2 Sample size
The sample size required to obtain representative number of respondents for quantitative data was calculated using the Cross sectional Surveys design in Epi Info version 3.5.1 (Centers for Disease Control and Prevention (CDC), 2008). The estimated total numbers of sexually active adults in the Chobe district was 11,522. The estimated sample size for the whole district was estimated at 357 (with expected rates of female condom use 4% and worst acceptable estimate 6%). Due to possible non-response, incompleteness of data we estimated that 12% would be reasonable to increase the samples size and rounded off to sample size 405.

This sample size was then proportionally distributed to the villages in Chobe according to the estimated population size per village. The individual village sample sizes were then projected to be:

- Kasane Township - 204
- Kazungula village - 50
- Parakarungu Village - 21
- Pandamatenga Village - 40
- Satau Village - 20
- Kavimba Village - 13
- Mabele Village - 20
- Kachikau Village - 24

3.2.3 Sampling Methods
A census of Chobe villages was done and simple random sampling was employed for households selection. At household level we again employed simple random sampling.

Focused group discussions were conducted in two sites being Kasane (Semi Urban) and Pandamatenga (Rural). Members of these groups were identified using snow ball. In each locality two focused group discussions were held with women age groups ranges (18 to 29) and (30-49). Each focus group discussion was made up of approximately 8 participants.
3.3 Data Collection

Data was collected using three main methods. These are Survey Questionnaire, Focused Group Discussions and they are discussed below:

3.3.1. Data collection methods

Survey Questionnaire
Two structured questionnaires were used as data collection instruments. Both questionnaires were both interviewer and respondent administered depending on the preference of the respondent. One questionnaire was for health workers and another for respondents from the community.

Focused Group Discussions
Focused Group Discussion Guides were developed to be used in data collection and to ensure consistency of questions asked in all discussions. In total six (6) focus group discussions were held. Out of which four (4) were women groups, one (1) was a mixed group while the other (1) was men only.

Two (2) focused group discussions for female respondents were conducted in Pandamatenga and Kasane. Two discussions were held in each site with participants for the two groups consisting of females aged 18 to 29 years and the other 30 to 49 years. This was done to enable the members of the group to feel free to contribute to the discussions. Culturally, adults may not feel free to discuss sexuality issues in the presence of youth and youth also may not feel free to discuss issues of sexuality in the presence of adults. A focused group discussion exclusively for males was conducted and a combination of men and women group was held both held in Kasane.

3.3.2 Data collection procedures
The research team was led by District AIDS Coordinator and supported by other research team members. Data collection was done by members of the research team and followed this sequence:

- Pre testing the research tools was done for both the questionnaire and focus group discussion guide. After which modifying data collection tools according to pre testing results.
- Fieldwork- Collection of data took place, and this refers to capturing of data, sorting and analysis. A different questionnaire was used for health workers. Filed work or data collection was done in fourteen days.
- First an explanation of the research was given to the potential participant. This included the purpose of the research, any risks and benefits, the
issues of privacy and confidentiality and then a written consent was obtained.

- Participants were given options of either interviewer administered Semi structured questionnaire or they filled in the questionnaires themselves. The questionnaires were either in Setswana or English depending on the choice of the respondent.

The questionnaire had open ended questionnaires and focused group discussions were conducted to collect qualitative data. Close ended questions in the questionnaire used collected quantitative data.

3.3.3 Piloting/Pre-testing

The Draft research questionnaires and Focus Group Discussion guides were piloted in Kasane Township and Pandamatenga Village. Thirty volunteers who shared the same demographic characteristics as the study population were interviewed using the draft questionnaires after which they were adjusted accordingly. This adjustment included rephrasing questions that were not clear to the respondents or interviewers. Kasane was chosen to represent the semi urban population while Pandamatenga represented rural population.

3.4 Data Analysis

The Statistical package, SPSS was used to analyze quantitative while qualitative data was analyzed manually.

3.5 Ethical considerations

Ethical clearance was sought from Ministry of Health Research and Development Committee (HRDC) and from Ministry of Local Government, Department of Primary Health Care Services – Monitoring, Evaluation and Research Division.

The following measures were implemented to ensure maximum protection of the research participants:
3.5.1 Confidentiality

Confidentiality was insured by not using participants’ names or any other identifying data, rather study numbers were used. All the information shared was not be disclosed or shared with anyone who is not part of the study team.

3.5.2 Privacy

Respondents were given an opportunity to choose a private place where the interview could be conducted. In their homes a room was sought or any other private place where the respondent will feel free to answer questions without any interference or others listening in.

3.5.3 Consent

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 was completely voluntary. All the questions they had pertaining to the study were answered during the recruitment process to ensure that they indeed made an informed decision. In respect for culture, prior permission was sought from the community leaders (Dikgosi) before the study in their villages commenced.

3.5.4 Benefits & Risks

Benefits of the study are 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 were no foreseen risks in this study, except that participants may feel uncomfortable in discussing personal matters. Benefits and risks were communicated to the participants during the informed consent process.

3.6 Limitations of the Study

1. The study findings can only be generalized to Chobe District.

2. Analysis of qualitative data was cumbersome as it was done manually.
RESULTS/ FINDINGS

4.1 Background Characteristics

A total of 405 females and males aged between 18 and 49 were interviewed and/or given a questionnaire to answer. The respondents were drawn from nine (9) villages including two semi urban. Participants for the focus group discussions consisted of women and men. Four (4) groups were women only and there was one mixed and men only groups. These six (6) focus groups were divided into 2 age categories of 18-29 and 30-49. The groups had both village and semi urban representation. All the six groups had eight (8) participants. In total forty-eight (48) people participated in the FGDs.

4.1.1 Age Distribution of the respondents

The respondents aged from 18-49. Most respondents were aged between 25 and 29 which accounted for 27.7%, followed by 30-34 at 25.7%, 35-39 at 17.5%, 20-24 at 11.9%, followed by 40-44 at 9.9%, 45-49 at 4.2%, the less than 20 years accounting for 3.2%
4.1.2 Marital Status

The singles were leading at 72.1% followed by married at 13.6% then cohabitation at 11.9%. Widowed accounted for 1.2% while divorced and separated accounted for 0.5% each.

![Marital Status Chart]

Figure 5. Marital status of participants

4.1.3 Sex of the respondents

Interviews were conducted with 405 respondents with 243 being females and 162 being males which represented 60% females and 40% males.

4.1.4 Employment

Out of the 405 respondents, 312 were employed (77%), 68 were unemployed which is 16.8%, 25 self-employed accounted for 6.2%.
4.1.5 Educational level

The figure below shows that almost all the respondents were literate. More than half of the respondents (53%) had attained secondary Education, while 35% had tertiary school qualification, 11% had primary education, while only 1% had never been to school.

![Pie chart showing educational levels of respondents](image)

*Figure 6. Educational level of respondents*

4.1.6 First Heard about the Female Condom

More than half of the respondents indicated that they first heard about the availability of a female condom from a health facility as shown in the pie chart below.
Figure 7. Source where the respondents got information on female condom for the first time

4.2 Socio cultural and Perceptions about Female Condom

There are socio cultural and perception that the respondents identified as a hindrance to female condom use. Twenty four percent (24%) believe culture is a barrier to FC use. Culturally women are not expected to initiate sex; it is men who are in control when it comes to sexual activities.

This is what one respondent said:

“Go thata go se dirisa ka gore ka Setswana thobalano e laolwa ke rre. Go na le kgonagalo ya gore mme a tsenyse sekausu – mme go be go sa tle go thakanelwa dikobo ka gore rre o a bo a sa battle tsatsi leo”

(It is difficult to use it because culturally men are the ones who control sex. You may insert the condom but you might not have sex if the man feels he does not want that day, so it shall be).

In addition, women who carry condoms are perceived as promiscuous; hence no women would like to be identified as such.

One married respondent said:
“If I find condoms in the pockets of my husband’s clothes I do not have a problem but if my husband finds condoms in my handbag I’ll be asked what I’m doing with the condoms”

Another barrier stated by respondents is inadequacy and limited accessibility of FC. One married respondent said:

“Yone ya borre e teng gongwe le gongwe, ga go na fa o ka e tlhokang teng ... ya bomme yone e seyo ...”

(The male condom is everywhere but the female one is not there)

Lack of trust by some men surrounding fidelity and conception was also mentioned.

One married respondent said:

“Ke batla ya borre ka gore mo go sone ke nna ke tsayang taolo mo tlhakanelo dikobong, gape ke dumela gore motho wa mme o ka nthaya are o tsentse sekausu ntswa a sa se tsenya a batla gore ke mo imise”.

(I prefer a male condom. I’m in control because I’m the one who wears it when we want to have sex. In addition, I believe that women she can actually lie to me that inserted it just because she wants me to impregnate her)

Focus group discussions from both urban and rural revealed that FC is more enjoyable than the male condom.

One female respondent said:

“fa o batla monate wa thobalo dirisa sekausu sa bomme. Ka gore sone fa o se apere e ka re ga o dirisi sekausu, ga se tshwane le sa borre”

(If you want to enjoy sex with your partner use female condom. When you use it, is like you are not using a condom).

However, the size of the female condom and its external and internal rings is one of the factors that deter people from using the female condom. During a focused group discussions respondents lamented the big size of the condom including its packaging.
4.3 Knowledge on the use of Female Condom

Most of the respondents (38%) reported to have no knowledge on the use of female condom. Thirty two percent (32%) showed little knowledge, while only 1.5% of the respondents were knowledgeable. Figure 8 below summarizes respondents’ knowledge on the use of female condoms.

![Knowledge on how to use Female Condom](image)

*Figure 8. Knowledge on the use of Female Condom*
DATA ANALYSIS AND DISCUSSION

5.1 Socio cultural and Perceptions about Female Condom

(i) Male control and dominance in sex related issues

Culturally men are in control when it comes to sexuality issues and women are not expected to take lead or initiate sexual intercourse. Therefore inserting a female condom by a female could be construed as taking the lead and dominating. UNAIDS (2004) identified power relations as a barrier. This is in agreement with the finding that males are in control making it difficult for women to negotiate and/or take the lead in condom use.

(ii) Size of the condom and Ring

The size of the condom and its rings was also reported to be deterring users who suspected that it may injure the female’s internal organs. Moreover, due to its size, the female condom appears like it would enlarge the female genitalia, something that was seen as not desirable by females. Therefore it is a commonly held belief that, those who use female condom will have bigger and wider private organs.

In addition, female condom packing was also described as not convenient to put in pockets and hand bags due to its size. This therefore makes it unattractive to potential users. A study by Choi, Roberts, Gomez, & Grinstead raised another dimension as it described female condom as being uncomfortable because it requires the partners’ acquiescence’s and that somehow interferes with sexual experience. Eldridge, St Lawrence, Little, Shelby, & Brasfield, are in concurrence. In their study male condom was preferred for its convenience, availability, and safety. However, the necessity for active cooperation by the male partner was considered a hindrance to using the method. In deed the size and packing of female condom needs a revisit if its uptake is to be improved.

5.2 Knowledge on the use of Female Condom

According to Luke & Gruer (1991) and Peltzer (2000) lack of knowledge of female condom use is a barrier to its uptake. Their findings concur with the findings of this study as it has revealed that the respondent belief female
condoms have rules and regulation that need to be strictly followed. Issues of complicated use, time needed to insert it before use and noise were frequent and discussed.

(i) Complicated to use.

The study by Choi, Roberts, Gomez, & Grinstead, revealed that women stated the difficulty to insert, discomfort with vaginal insertion, and condom use norms as a barriers. MacReady (1999) also found out that one of the barriers contributing to low uptake complicated use hence the need for intensive practice to be able to use it correctly. This is agreement with the findings of this study as in all the focus group discussions, the issue of the complexity of the use of female condom was raised. They stated that it is complicated to use and hence preferred to continue using the male condom which they were familiar with. The direct quotations below give support the facts above:

One of the respondents stated:
“Sekausu sa bomme se thata go dirisiwa, ebile se na le melawana e mentsi”
(Female condoms are complex to use and have many regulations).

Another respondent said:
“I prefer male condom because I do not know how to use the female one”.

One of the respondents stated:
“I prefer male condom, it is easy to use compared to female condom”

(ii) It takes a long time

Focused Group members in all the discussions stated that they have been informed that the female condom is to be inserted for eight (8) hours before it is ready to use. They stated that this long time also deters potential users from using the condom as it is an inconvenience especially to women as they are never certain of when they will have sex. One respondent summarized it as follows:

“Imagine when a woman puts in a female condom and the husband comes and says he doesn’t want to have sex, or when the husband wants to have sex and he is told to wait for 8 hours.

On the contrary, MacReady (1999), argues how the possibility of inserting the female condom several hours in advance of sexual activity can be advantage, but none of respondents in the studies has picked that as a positive element.
(iii) **Unusual noise**

As the female condom is made of polyurethane, respondents complained of the unusual noise that is made by the condom during the sexual act.

One female on the focus group said
‘Khondomo e ya bomme e tsosa modumo thata’.
(Female condom is too noisy).

Polyurethane material on its own does not make noise, unless it is not inserted properly.

**5.3 Religious practices and beliefs**

Religious practices and beliefs was one of the barriers to female condom use that was identified by respondents. Thirty one (31%) of the respondents stated that religion hampers the use of contraceptives including Female Condom. All the Focused group discussions mentioned that some churches discourage their members from using any contraception stating it is a sin.

**5.4 Unavailability of Female Condom**

A study entitled “Female condom use still has barriers” by Norra MacReady, in 1999 revealed that the biggest challenge with FC is accessibility in stores as compared to male condom and that the cost is higher. Choi, Roberts, Gomez and Grinstead (1999:30 (1) 53-70; also lamented on the issues of lack of access to FC. The studies above concurs with the finding that thirty two percent (32%) of the respondents stated that Female condoms are not easily available and hence the low uptake. In addition, FGDs stated that male condoms are available everywhere even in bars, but female condoms are not easy to access. For example, at a Focused Group discussion in Pandamatenga, one of the women stated that in their village Female condoms can only be obtained from the Clinic. Therefore those who are far from the clinic or are shy to request do not have access to female condoms.

One of the respondents stated the following:
‘...yone ya borre e teng gongwe le gongwe, ha gona haoka e thokang teng...a modibareng, ko dispotong, ko kae hela leha o tsena o hithela dikhondomo tsa borre. Yone hela nna re ipotsa gore ehe e mosola kana e tshwanetse gore e dirisiwe ka gore gongwe le gongwe hao tsenang teng o hithela ya borre. Le tsone tse di rekisiwang o hithela ya borre, ya bomme e seyo...’.
(Unlike the
female condom, the male one is found everywhere, and we wonder whether this female condom is useful or not).

Out of ten (10) facilities in the district 8 did not have the female condom for the past 3 months, they only had male condom in their stock. Furthermore, availability of Male condom was also said to make it difficult for people to choose FC because they prefer something that they are comfortable with.

5.5 Performance health workers

This study also assessed the performance of health workers in promoting the use of female condom in the district.

(i) Training on Female condom use
The majority of health workers in facilities in the district have received training on the proper use of female condom. However, a significant percentage (40%) indicated that they have not received any training on the proper use of female condom. Those who have not been trained will not be in a position to promote its use and to educate the community.

(ii) Health Facilities without demonstration models.
Condom demonstration models are essential in teaching the community about the proper use of female condom. However this research revealed that most of the health facilities (69.2%) did not have Female condom demonstration models. Given the high percentage of people with no knowledge on the proper use of female condom, demonstration models are essential if proper education is to be conducted. Health workers are not actively promoting the product as evidenced by no pelvic models, no IEC materials, and no evidence of health talks about female condom.

(iii) Promotion of Female condom.
A total of (38.5%) of health workers indicated that in the last six months, they educated less than 25 people on the proper use of female condom. This therefore shows that health workers are not doing enough to promote the use of female condom in the district given the high number of people without knowledge on the use of this condom.
CONCLUSION

6.1 Socio cultural and Perception

Culture is a barrier to FC use. It has become evident that there is low interest in the use of female condom in Chobe District. This is attributed to a number of factors including culture, religion, and lack of knowledge amongst others. Most people do not have adequate knowledge on the proper use of Female Condom. Knowledge on proper use of FC is very low (1.5%). This is the reason why there are so many misconceptions surrounding its use. However, users of FC have positive attitudes as compared to non-users. Low uptake and utility is a direct result of unavailability, inaccessibility and unacceptability and low knowledge as well as inadequate promotion or creation of enabling environment by health sector.

6.2 Knowledge on the use of Female Condom

Most of people do not have adequate knowledge to facilitate them to use the female condom. Those who reported no knowledge and little knowledge constituted 70% of the respondents. The low usage of female condom therefore is more likely to be due to lack of knowledge and misconception on technical use.

6.3 Performance of Health Workers

Health sector response has been at the level of awareness creation for FC but has not transcend behavior change necessary to trigger empowerment nor use, resources and/or build capacity to enhance implementation of female condom programmes. Health workers are not doing enough to promote the use of the female condom. Only a few facilities carried activities aimed at promoting female condom. Moreover, not all health workers have received training on the proper use of female condom.

The health sector does not created conducive environment for implementation of female condom programmes. Currently, more than half of the facilities do not have the necessary equipment to better educate the community on the
proper use of female condom. Although demonstration models are important in teaching people less than half of the facilities have them.

RECOMMENDATIONS

Based on the findings the following recommendations are made:

- **Have targeted FC promotion interventions that focus on acceptability and skills building**
  - Train all health Workers on the proper use of FC to enable them to teach Community Members.
  - Health facilities should procure FC demonstration models to facilitate health talk or teaching of community members.
  - Improve on FC physical availability in all areas where male condom as available.

- **Strengthen strategies/methods for creating awareness and increasing knowledge on FC.**
  - Intensify Female Condom promotion in the district, not only with IEC materials, also with skills how to use it.
  - Empower women on the use of dual protection especially Female Condom because they have control.
  - Improve involvement of stakeholders such as influential persons e.g. MPs, Chiefs in FC related activities.

- **Make Chobe a model District in FC programming and document best practices to create evidence base**
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