

## *Female condoms in South Africa: Promoting availability and use*

### Executive summary

The female condom is the only female-controlled device that offers women dual protection from sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), and from unplanned pregnancy. Access to female condoms is thus central to protecting the sexual and reproductive health and rights (SRHR) of South Africa's women and girls. We have recently reported statistically significant associations between knowledge (i.e., having heard of the female condom), the use of the female condom, and several demographic variables for sexually active females in South Africa (Guerra & Simbayi 2014). Many demographic groups exhibited a high level of knowledge but a low level of use of the female condom, which is a common phenomenon. Of greater interest, however, is the fact that some groups with a relatively lower level of knowledge exhibited high or higher levels of use relative to their more knowledgeable counterparts. Our data suggest that prevalence of female condom use could potentially increase if

females in key demographics (e.g., rural localities – both on commercial farms and in tribal authority areas; elderly females; divorced/separated females; certain provinces) are targeted in female condom programming. Clearly, what should have been a true game changer and golden opportunity in the ongoing fight against HIV/AIDS in South Africa has been missed. This policy brief, which has as its intended audience the national Department of Health (DoH), provincial health authorities, international development agencies and donors, among others, recommends the following in terms of both policy and programmes on female condoms:

- the promotion of the use of female condoms as dual protection for preventing both STIs, including HIV, as per the National Strategic Plan (NSP) for HIV, STIs and TB 2011–2016 recommendation, and unplanned pregnancy as part of SRHR in general (SANAC 2012);
- the immediate implementation of the recommendation by the NSP to increase the availability of female condoms; and

- the distribution of female condoms across all income and age groups as well as geographical areas.

### Introduction

It has been almost 20 years since the development of the female condom and nearly 15 years since it was introduced in South Africa. Although knowledge of the female condom among sexually active South African females over the age of 15 years is relatively high at 77.74%, its use remains low at 7.20%. While South Africa boasts of having one of the highest female condom distribution rates in the world, it is still lower than the national rate at which male condoms are distributed (Beksinska et al. 2012). In fact, relative to male condom distribution, the DoH provides significantly less support for female condom use (see Table 1). As the country with the greatest number of HIV-positive individuals in the world, with a national prevalence of 12.2% that is disproportionately female (Shisana et al. 2014), South Africa must be strategic in employing diverse mechanisms to curb

Women have dual sexual health needs: protection from sexually transmitted infections (STIs), including HIV, and prevention of unintended pregnancies. The female condom is the only available method of dual protection that females can initiate and ideally control.

**Table 1:** Male and female condom distribution targets in South Africa

	Unit cost	2012/13	2013/14	2014/15	2015/16	2016/17	Total cost
<b>Male condom distribution</b>		1 bil	1 bil	1 bil	1 bil	1 bil	
<b>Cost</b>	R0.25	251	251	251	251	251	1.255 bil
<b>Female condom distribution</b>		9 mil	12 mil	17 mil	22 mil	25 mil	
<b>Cost</b>	R8.72	78	105	148	192	218	741 mil

Source: SANAC 2012

the spread of HIV. At the same time and with regards to SRHR, South Africa must uphold its constitutional obligations and the provisions of its NSP, both of which take a rights-based approach to health. This can be achieved by promoting the female condom in South Africa.

This brief suggests that the expansion of female condom programming could be both strategically beneficial in reducing new HIV infections while also upholding the SRHR of South Africa's women and girls. It makes some recommendations for both policy and programming efforts.

### **The need for female-controlled dual protection**

Similar to other parts of sub-Saharan Africa, the female population in South Africa has a disproportionately higher rate of HIV than is the case among males (Shisana et al. 2014; Tarkang & Bain 2014). The vulnerability of South African females to HIV relative to males is due to both biological and societal factors. The statistics speak to the role of gender in South African society, and the fact that women occupy an inferior position in many social spheres. They are more vulnerable to HIV and AIDS due to lower education levels, economic disadvantages, patriarchal traditions, gender-based violence and other social and institutionalised forces (Dworkin et al. 2013; Masvawure et al. 2014; Mthembu et al. 2014; Van Loggerenberg et al. 2012; Wagman et al. 2015).

Due to the gendered nature of intimate relationships, females may have a male partner or partners who refuse to wear a male condom, thereby putting both parties at risk of HIV, STIs and unplanned pregnancy (if no method of contraception is being used). The female condom allows females to protect themselves and their partner/s from infection and/or reinfection. Although

the female condom is often promoted as a female-initiated method that is useful in instances where females cannot successfully negotiate male condom use, it has been suggested that female condom use may also encourage safer-sex dialogue between men and women and may positively impact gendered relationship dynamics (Gross et al. 1999). In a similar vein, making female condoms widely available is a step towards gender equity and equality. In the absence of a female condom, South African women must rely on their male partners to agree to wear a male condom. Providing women with female condoms begins to shift the power imbalance that has compromised women's ability to negotiate safer sex (Peters et al. 2014).

### **Promises made: Realising development and strategic goals**

The expansion of female condom programming is an opportunity on many levels, one of which is addressing development and strategic aims globally and domestically. When considering the global health agenda set by Millennium Development Goal (MDG) No. 3, 'Gender Equality', and No. 6, 'Combating HIV/AIDS', the female condom has the potential to impact both goals simultaneously. Domestically, the 2012–2016 NSP (SANAC 2012) identifies its Strategic Objective No. 1 as 'Addressing Social and Structural Drivers of HIV, STI and TB Prevention, Care and Impact', which includes gender- and rights-based mainstreaming, both of which would be reflected in the expansion of female condom programming. The South African 2012–2016 NSP aims to reduce HIV and AIDS rates by 50% by 2015, and the female condom holds similar potential to the male condom in preventing new infections and achieving this goal.

### **How things have changed for the female condom since 1993**

#### *New designs, price and acceptability*

The female condom has undergone many changes in response to consumer needs, but false and dated misinformation is pervasive and undermines the potential suitability of currently available female condoms for women and girls in South Africa. For example, the original female condom, which was called Reality (or FC1) and made of polyurethane, was no longer being produced as of October 2009 (Joanis et al. 2011). The Female Health Company has since created FC2, which is made of nitrile and is 30% cheaper than FC1 while retaining very similar specifications. MedTech Products has created V-Amour, which is made of latex and available in some European Union countries. The most distinct new design, however, is PATH's polyurethane Woman's Condom (WC), which incorporates a number of innovations aimed at raising acceptability. A recent study testing the functionality and acceptability of the FC2, V-Amour and WC found that all three functioned similarly and were generally acceptable when tested among 170 women in Durban, South Africa (Joanis et al. 2011).

#### *The female condom as a cost-effective health resource for women*

The higher unit cost of the female condom compared to the male condom (R8.72 versus R0.25 at one point in South Africa) (SANAC 2012) has been attributed to the materials, design, demand, and the fact that until recently there was only a single manufacturer. However, studies ultimately found the female condom to be a cost-effective tool for reducing the risk of STI and HIV transmission (Dowdy et al. 2006; Marseille et al. 2001; SANAC 2012). Yet initial cost remains a cited barrier for

many governments, particularly when accompanied by poorly evidenced concerns about acceptability (Hoffman et al. 2004). Nevertheless, with three female condoms currently on the market and generally testing well with females in South Africa, the near future may hold more choice in terms of female condom style and cost (Joanis et al. 2011).

### Supply and demand issues reinforce the need for stronger support of the female condom

The issue of demand remains frustrating, with manufacturers, government and international organisations, researchers and users caught in a stalemate of high prices, perceived low demand, lack of investment in female condom programming, stock outages and frustrated underserved users (Peters et al. 2010). South Africa can make an impact on this cycle by scaling up female condom programming.

### Shortcomings of the current female condom implementation strategy

Although female condoms are currently distributed in all public sector facilities, the supply is limited and therefore does not meet the demand. Furthermore, 22.3% of sexually active South African females aged 15 years and over have never heard of the female condom.

### Key findings

Tables 2–4 below summarise the main findings of the study.

Key statistical conclusions include:

- Having used a female condom was associated with condom use at last sex. Those who indicated previous female condom use were more likely to use a condom of any kind at last sex than were non-female-condom users. As such, 65.59% of previous female condom users used a condom at last sex compared to 59.84% of females who never used a female condom.

- For condom use at last sex, females who had never used the female condom cited 'Partner will object' at a rate of 11.0%, whereas females who had used the female condom before cited this reason at a rate of 17.9%.<sup>1</sup> This is not surprising given that the primary advantage of the female condom over the male condom is that it may function as an alternative when male sexual partners refuse to use the male condom.
- Although females in rural localities were considerably less likely to have heard of the female condom, they were only slightly less likely to have used the female condom relative to their urban counterparts. This suggests that stereotypical notions of rural resistance to technologies should be challenged, and that lack of technologies in these localities may not be an issue of acceptance but rather inaccurate assumptions about acceptance.

<sup>1</sup> The difference was not statistically significant at  $p = 0.05$ , but was close to approaching significance.

**Table 2:** Have you heard of a condom women can use called the female condom? % (n)

	Urban formal	Urban informal	Rural informal	Rural formal		$\chi^2$
<b>Yes</b>	83.04 (2 029)	78.52 (486)	70.55 (648)	68.94 (238)		$p = 0.000$
<b>No</b>	16.96 (512)	21.48 (137)	29.45 (269)	31.06 (108)		
	<b>15 thru 24</b>	<b>25 thru 49</b>	<b>50 and up</b>			
<b>Yes</b>	80.14 (886)	80.8 (2 108)	58.92 (407)			$p = 0.000$
<b>No</b>	19.86 (187)	19.2 (554)	41.08 (285)			
	<b>Married/ civil union</b>	<b>Single</b>	<b>Divorced/ separated</b>	<b>Living together</b>	<b>Widower, other</b>	
<b>Yes</b>	73.37 (1 609)	82.66 (1 355)	88.1 (125)	75.42 (233)	69.15 (71)	$p = 0.000$
<b>No</b>	26.63 (603)	17.34 (291)	11.9 (21)	24.58 (67)	30.85 (39)	
	<b>Western Cape</b>	<b>Eastern Cape</b>	<b>Northern Cape</b>	<b>Free State</b>	<b>KZN</b>	<b>North West</b>
<b>Yes</b>	83.85 (443)	72.68 (431)	76.78 (282)	76.97 (220)	72.77 (579)	82.01 (294)
<b>No</b>	16.15 (88)	27.32 (146)	23.22 (77)	23.03 (70)	27.23 (237)	17.99 (64)
	<b>Gauteng</b>	<b>Mpumalanga</b>	<b>Limpopo</b>			
<b>Yes</b>	84.88 (593)	74.38 (267)	71.9 (292)			$p = 0.000$
<b>No</b>	15.12 (150)	25.62 (86)	28.1 (108)			

**Table 3:** Have you or your partner ever used a female condom? % (n)

	Urban formal	Urban informal	Rural informal	Rural formal	$\chi^2$	
<b>Yes</b>	7.31 (98)	9 (37)	6.18 (39)	6.46 (12)	$p = 0.224$	
<b>No</b>	92.69 (1 378)	91 (345)	93.82 (452)	93.54 (146)		
	15 thru 24	25 thru 49	50 and up			
<b>Yes</b>	2.91 (33)	8.54 (143)	8.88 (10)		$p \leq 0.001$	
<b>No</b>	97.09 (755)	91.46 (1 408)	91.12 (158)			
	Married/civil union	Single	Divorced/separated	Living together	Widower, other	
<b>Yes</b>	8.9 (82)	5.92 (82)	14.91 (10)	5.43 (11)	4.07 (2)	
<b>No</b>	91.1 (905)	94.08 (1 128)	85.09 (76)	94.57 (146)	95.93 (59)	
	Western Cape	Eastern Cape	Northern Cape	Free State	KZN	North West
<b>Yes</b>	6.06 (24)	3.85 (16)	13.58 (12)	10.52 (16)	3.25 (21)	5.38 (14)
<b>No</b>	93.94 (284)	96.15 (307)	86.42 (135)	89.48 (149)	96.75 (445)	94.62 (198)
	Gauteng	Mpumalanga	Limpopo			
<b>Yes</b>	9.46 (36)	10.13 (20)	11.45 (24)			$p \leq 0.05$
<b>No</b>	90.54 (426)	89.87 (193)	88.55 (184)			

**Table 4:** Reported reasons for not using a condom at last sex, comparing females who have used an FC to those who have never used an FC % (n)

Reason	Have you or your partner ever used the female condom?	
	Yes	No
<b>If you did not use a condom, what were the reasons for not doing so?</b>		
Did not have a condom	6.5 (3)	7.5 (87)
Partner will object	<b>17.9 (11)</b>	<b>11 (106)</b>
Use other contraceptive	0.8 (2)	6.7 (76)
Don't like them; lack of sexual feeling; reduces sexual pleasure	0 (0)	1.4 (21)
Didn't think it was necessary	6.7 (9)	10.1 (132)
Because I am married	35.6 (28)	26.7 (403)
Because I am faithful	25.8 (24)	22.7 (304)
Breaks the moment	0 (0)	0.5 (5)
I was drunk/high	0 (0)	0.3 (2)
Other	6.6 (7)	13.2 (158)
<b>Total</b>	100 (84)	100 (1 294)

- The level of knowledge of the female condom was lowest in Limpopo at 71.9%, a mostly rural province but which had the second highest level of use at 11.45%. These data suggest female condom promotion is lacking in Limpopo compared to other provinces and scaling up of

distribution and promotion would likely result in greater use.

- Females 50 years and over had the lowest level of female condom knowledge, but they also had the highest level of use and were more than three times as likely to have used female condoms than were females 15–24 years old. This

finding challenges notions of elderly people resisting new technologies and suggests that if elderly females were targeted in female condom programming, there would be a good likelihood of uptake. Nevertheless, it also makes sense that, because of living longer, older women are more likely to have used a female condom relative to younger females.

- Divorced or separated females had the highest level of female condom knowledge (88.10%) and use (14.91%) when considering marital status. This is a population of females who are sexually active (part of the filter in our sample) but may not be in steady or exclusive relationships, and thus may perceive themselves at risk of HIV, STIs or pregnancy.

The data presented highlight misconceptions of acceptability in demographics with low levels of knowledge and high levels of use. This suggests that prevalence of female condom use could potentially increase if females in key demographics

are targeted in female condom programming or, ideally, if female condoms are more widely promoted and available.

## Conclusions

Male condoms remain a key tool in stopping the spread of HIV, and the female condom holds similar potential. Unfortunately, although knowledge of the female condom in South Africa is relatively high at 77.74%, use remains relatively low at 7.20%, which is largely determined by the poor availability of female condoms in public health clinics. Instances where knowledge is low and use is high reflect uninformed misgivings and injustices on the part of high-level stakeholders in erroneously determining 'demand' and acceptability. The gendered nature of the HIV/AIDS epidemic in South Africa requires that the sexual and reproductive health of women and girls be supported in ways that acknowledge, negotiate and ideally dismantle gender inequities. The use of female condoms should play a key role in South Africa's efforts to curb the HIV/AIDS epidemic and reduce the prevalence of unwanted pregnancies. South Africa has served as a model for the successful adoption of a female condom distribution programme. To remain a leader in the commitment to women's rights and the fight against HIV/AIDS, South Africa must aggressively scale up its female condom distribution (Beksinska et al. 2012; Pettifor et al. 2001). In short, if female condoms were more widely available in South Africa, females would probably use them more, thereby offering women a form of contraception and STI risk-reduction that is female initiated.

## Recommendations

- NGOs and provincial health authorities must update female condom promotional materials and training of clinic staff to align with

changes to female condom design that may impact user acceptability.

- In order to support continued use, supply of female condoms must meet demand at all distribution sites.
- Clinics that serve rural localities should promote the female condom among these populations with the same if not greater commitment than that used for females in urban localities.
- Clinic staff should be informed that females over the age of 50 report relatively high levels of use if they know about the female condom, but in general have a significantly lower level of female condom knowledge than other age groups. Thus, female condoms should be promoted among females in all age groups and not only among those within childbearing age groups of 15–49.
- Clinic staff should be informed that divorced/separated females report relatively high knowledge and use and should be supported with further education and supplies of female condoms.
- Provincial health authorities in Limpopo should scale up female condom promotion and education as knowledge is the lowest in this province, but it has one of the highest rates of use, suggesting more potential users.

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