

REVIEW OF RESEARCH ON ZIMBABWE EXPERIENCES WITH THE FEMALE CONDOM

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Acronyms

ACT	AIDS Counseling Trust
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Service Organization
CBD	Community Based Distributor
CSW	Commercial Sex Worker
DFID	Department for International Development
DTTU	Delivery Truck Top Up
HIV	Human Immunodeficiency Virus
FC	Female Condom
IEC	Information, Education and Communication
JSI	John Snow International , UK
MC	Male Condom
M&E	Monitoring and Evaluation
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non-Governmental Organization
PPTCT	Prevention of Parent to Child Transmission
STI	Sexually Transmitted Infection
TOT	Training of Trainer
UZ-UCSF	University of Zimbabwe – University of California, San Francisco
VCT	Voluntary Counseling and Testing
WAG	Women’s Action Group
WASN	Women’s AIDS Support Network
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council

1.0 Introduction

The Female Condom is a 17 cm polyurethane sheath. There are two rings, one internal, free-floating ring which anchors the end of the condom over the cervix and one external ring which covers the external genitalia during intercourse. It is intended for single use at this time, though a re-use protocol for up to 5 additional uses has been published by the WHO. This condom is intended for the dual protection purposes of preventing against HIV and other STIs, and for preventing unintended pregnancy. Zimbabwe was the first country in Africa to strategically introduce the FC in the public and private sectors and has established a history which informs the current discussion of how best to move forward in strategically planning for future FC efforts.

Besides being a dual protection barrier method, the FC offers several other opportunities. It is clear that the FC is not merely a product, but it is rather a programme. FC introduction requires accompanying education for use and negotiation. For many FC users, introduction to the FC has been the first opportunity that they have had to know their anatomy. Perhaps more importantly, FC has proved to be a tool of empowerment for women. It is indeed the only dual protection method that is female-initiated.

The FC is the first new product to be introduced for protection against HIV transmission since the beginning of the epidemic. Since its introduction into the African market in 1994 for Zimbabwean acceptability studies, much data has been gathered about how programmes have introduced the FC. These studies will inform the HIV/AIDS community about how other new tools in the epidemic will best be introduced. With microbicides, yet another female-initiated HIV prevention tool, in the development pipeline, the lessons learned from the strategic long-term promotion of FC in Zimbabwe will certainly prove key in the creation of new strategies.

Despite the success of the female condom social marketing programme, in Zimbabwe, the public sector FC programme has experienced wavering programmatic support and success. This research review, part of a broader female condom assessment, intends to inform the development of a new national strategic plan for female condom programming. This FC Strategic Plan will feed into the development of a national Condom Strategy and subsequently into the larger planning around HIV/AIDS prevention strategies at the national level. This research review will be accompanied by a subsequent situational analysis which will complete the set of information made available to the Zimbabwe Technical Support Group¹ on Condom Programming with recommendations as to how the strategic plan can best serve all stakeholders and make the most significant impact in the HIV/AIDS epidemic.

For the purpose of this exercise, several key issues were set out in the terms of reference. The history of FC activity in Zimbabwe will be embedded in the larger world context and the questions posed will be answered using primarily Zimbabwe data. Regional data from the Southern part of the continent has been used where Zimbabwe data could not be

¹ Members of the Technical Support Group include MOHCW, ZNFPC, NAC, MCAZ, DFID, USAID, UNFPA, UNAIDS, UNICEF, JSI Europe, JSI Deliver, PSI and other key stakeholders as necessary.

found or where it could illuminate the discussion. In addition, several key pieces of recent research which suggest future directions for FC program development are incorporated.

2.0 History

2.1 World History of the FC

Upon the recognition of the need of a female-controlled barrier method, The Female Condom was invented in the 1980s by a Dane named Lasse Hessel. The Female Health Company (FHC), as it is now known after several names and mergers, worked with Dr. Hessel to develop the FC Female Condom as it is known today. The FC factory was established in London in 1991 and the FC was first launched in the following year in Switzerland and then the UK. In 1993, the FC received approval from the Food and Drug Administration and it was launched in the United States. As the important role the FC could fill became more evident, UNAIDS and FHC signed an agreement fixing a reduced price for the global public sector purchase of Female Condoms in developing countries.

Other key approvals of the FC facilitated bringing the FC to the developing world. The European Commission and the ISO granted their approvals of the FC in 1996 and the Japanese followed in 1999. In 2000, FHC, the World Health Organization and UNAIDS publish the first guide intended to inform national level programmes. In the following years, the FC was incorporated into reproductive health and HIV/AIDS programmes in more than 100 countries.

2.2 Zimbabwe History of the FC

Prior to 1994, the Women's AIDS Support Network (WASN) had approached the National AIDS Coordinating Programme (NACP) advocating for the introduction of the FC in Zimbabwe. NACP responded to the "women's pressure group" by saying that approval for the medical device must first have approval of the Medicines Control Authority of Zimbabwe (MCAZ). In 1994, the first research on acceptability of the FC among rural and urban women and commercial sex workers was conducted by the Department of Community Medicine at the University of Zimbabwe and the Zimbabwe AIDS Prevention project with input from several WASN members, and subsequently published in 1995.¹

In April 1995 at a trade fair in Bulawayo, the FC was displayed by WASN and the FC generated wide media attention in the country. Later that year, WASN presented the findings of the FC acceptability studies at the Beijing UN Conference on Women. In 1996 at the National ruling party's Annual Assembly, Deputy Minister of Health Tusngirirai Hungwe presented the need for a Female Condom and the results of the acceptability research to the assembly. President Mugabe was present. The Minister of Health, Dr. Stamps, who had previously been opposed to FC introduction, was convinced. On December 1, 1996, World AIDS Day, WASN and their partners present a petition to the Zimbabwean

government that was signed by 30,000 people demanding the Female Condom be made available. Approval was granted by MCAZ and PSI was chosen to lead the socially marketing effort.²

Finally after much advocacy, the FC was launched in the private and public sectors in 1997. Also in 1997, PSI launched the *care* contraceptive sheath as an addition to their condom line. The Protector Plus male condom had been socially marketed in Zimbabwe since the late 1980s and PSI had rich experience in the field. The contraceptive sheath was and still is the exact same condom as what has been introduced in the public sector. The physical difference between the two condoms is in the packaging. The *care* condom has been positioned as a contraceptive sheath and thus as a hygienic family planning method and health product. The price of the FC was initially established at three Zim Dollars for two *care*.

Upon its introduction, the *care* sheath was enormously successful. The number of *care* anticipated for a one year period (120,720) were sold in the first four months of sale. In the following years, a short decline in sales followed by steady increase in sales has demonstrated that the FC has enjoyed wide acceptability.³ Clearly, there was some novelty demand early in the sale of *care*, which picked up with consistent, innovative programming.

Table: Sales of care socially marketed Female Condoms since introduction⁴

Year	Number of <i>care</i> Sold
7/1977 – 12/1997	120,720
1998	119,650
1999	165,769
2000	187,049 (175,951 public sector condoms were available in addition)
2001	455,566 (117,434 public sector condoms were available in addition)
2002	683,700 (773,300 public sector condoms were available in addition)
11/2002 – 6/2003	850,000+
2003	1,290,000 <i>care</i> and public sector combined
2004	1,240,000 <i>care</i> and public sector combined

The public sector FC had been launched by ZNFPC in 1997. In 2002, JSI Europe supported the ZNFPC to develop a targeted distribution strategy. From 2002-2003, there were introductory training activities in the public sector, including the monitoring and evaluation of programs and distribution logistics.⁵ The intention behind these first trainings was to cascade them to subsequent provincial and district levels. This, unfortunately, never was carried out to its intended extent.

Monitoring and evaluation activities were particularly problematic. In 2002, a FC Symposium, hosted by the ZNFPC, updated the stakeholder community as to the state of research and policy around FC in the country. In 2003, the ZNFPC initiated the Delivery Truck Top Up (DTTU) system with support from JSI Europe, JSI/Deliver and Crown Agents in order to ensure that service delivery points received family planning supplies, including Female Condom, directly, and to strengthen the monitoring and evaluation of commodity distribution.

When the ZNFPC first launched the female condoms in early programming years, there were sufficient stocks of female condom, but programming never blossomed. That training never cascaded to the most decentralized levels has impeded the ability of service providers to be effective in FC delivery. Fuel shortages in the country, shortage of foreign currency and lack of funds for programming have posed hurdles that still need to be leapt. More debilitating were changes in staff, including key leadership positions in ZNFPC, lack of clear priorities and FC expertise within the ZNFPC system and low levels of commitment. The current situation as of 2005 is explained in the situational analysis document supported under the same activity as this document.

What is remarkable is that Zimbabwe's FC programme development situates itself early in the world history. No other petitioning process or combination of grassroots demand coupled with government action led to such quick and early action. Zimbabwe has thus been a leader in FC programming and has informed the rest of the world. Of particular note is the PSI *care* campaign which is the largest FC marketing campaign in Africa to date. The public sector programme could be as successful provided adequate training, innovative programmes and steady and adequate supplies are supported. Zimbabwe then is well situated to continue to be a trend setter in FC programming. Issues which have been put on the table for discussion for the past several years in worldwide forums, such as re-use of female condoms and consideration of how FC could be used in the context of marriage and fertility promotion could thus also be considered in Zimbabwe.

2.3 Research History in Zimbabwe

Acceptability studies in Zimbabwe were among the earliest in the world. Since the Zimbabwe studies, over 70 studies on acceptability of the FC around the world have been published. This first study showed remarkably high rates of acceptability among all target populations, with 88% and 93% of CSWs in two groups, 56% of urban woman and 100% of rural women saying that they liked the FC very much. Partners liked the FC even more than the women in the study with 92, 91, 74 and 100% of partners saying they liked the FC. This first study was key in establishing the FC as a viable method for family planning (FP) and HIV prevention in Zimbabwe. It should be noted that in Zimbabwe negotiation of the FC is a key barrier.⁶ In 1997 research suggests that negotiation remains a key barrier and that the most effective way of addressing the negotiation needs as well as overcoming the mechanical troubles associated with new FC use are best

handled in one-on-one counseling. This research was key in suggesting that men are central in the FC negotiation scheme.⁷

In 1998, the NACP published its first document on how the FC should be made available via the public sector. By using the first years' experience and suggesting firm integration of the FC into the national HIV/AIDS response, the FC was firmly established in documentation as a method to stay.⁸

The most thoroughly documented FC experience in the country to date is that of PSI's *care* campaign. This research was key in the country and in the region at demonstrating the value of FC in the social marketing context. Lessons learned from this programme shape the world literature around how social marketing programmes of the FC should be designed.⁹

2001 research on CSWs indicated that introduction of the FC to programming around condoms did not prove a substitution effect. Male condom use did not decrease with the introduction of the FC, but rather, the addition of FC led to an increased proportion in protected sex acts. This study also revealed that the main obstacle to FC use by CSWs at that time was client distrust of unfamiliar methods, thus demonstrating a need to make the FC more widely known.¹⁰

In 2001, Dr. Zinanga presented a clear strategy for FC distribution which had been guided by the research to that date as well as by the state of the art for HIV/AIDS responses in the region. While this is not published research, it seemed to shape the way programmes were carried out thereafter, as evidenced in the situational analysis companion document to this one.¹¹

Research on the Postive Women "Voices and Choices" programme, published in 2003 demonstrated that in Zimbabwe, condom use markedly increased upon HIV diagnosis for women, thus creating the case for the FC to be embedded in VCT activities despite not being focused on the FC per se.¹² Again in 2003, JSI Europe supported two reviews of current practices relative to the female condom¹³. These reviews looked at the targeted distribution system and the provider training that had been conducted in that year. Though unpublished, these documents have shaped the current FC debate with their recommendations.¹⁴ Lastly in 2003, research on the acceptability and special needs of programming for the rural communities in Zimbabwe revealed again a difficulty in negotiation, an issue still unresolved, and an interest, but lack of availability and access in rural communities.¹⁵

All research published on Zimbabwe programmes since 2003 has been related to the PSI programme. A relatively successful new approach distributing FC through hair salons documents programme impact¹⁶ and the most recent analyses the previous PSI campaign (completed in 2000) as to what factors are positively associated with FC use.¹⁷

The remainder of this document will look more in depth at the contribution of the body of research from Zimbabwe and from the region to address some key areas of consideration in order to address current programme development needs. It is possible that this history of research in the country is not exhaustive despite all efforts that have been made to be so.

3.0 Key areas of exploration for Strategic Development

The subject headings for this portion of the research review exercise were developed by the Technical Support Group on Condom Programming as focal points for which previous experience can particularly inform current programme directions.

3.1 Barriers to FC use

3.1.1 User-related Barriers

There are several attributes of the FC itself that have been cited in the Zimbabwe and world research as barriers to its use. The first of these is the belief that the FC is too lubricated. This has more to do with cultural practices around dry sex and beliefs about what a wet vagina may mean more than it is related to an actual mechanical problem associated with the over lubrication of the FC. The second is that the inner ring can sometimes be painful. Social marketing research indicates that in addition to the previously mentioned mechanical difficulties, the FC being noisy, and insertion being perceived as difficult are also barriers.¹⁸

Being married is cited as a user-related barrier. Again, this is most likely related to the difficulties of negotiation of condom use for married couples, and especially around STI protection negotiation.¹⁹ In Zimbabwe, the nature of the relationship is expressed symbolically through condom use. Condoms are frequently used in casual relationships and with CSWs as there is no established trust around the safety of sexual relations. The more intimate the relation becomes, the more trusted that individual should become, regardless of if either partner is cheating in the relationship. Marriages, thus, are the most trusted relationships and in order to express that trust, it is implicit that condoms would not be necessary. Also, long-term committed relationships such as girlfriends/boyfriends and small houses are dear. The use of condoms in these relationships have implications that trust is eroding. Additionally, it could imply that either one partner is cheating or suspects the other of cheating. While this is clearly embedded in the culture, the nature of the relationship itself is a barrier to FC use.²⁰

One major barrier to FC use for CSW clients is the distrust of unknown methods. CSWs found it difficult to use FC with men who had never heard of or seen the FC.²¹

What seems to be the most significant user related barrier to FC use is that women in Zimbabwean culture lack the assertive powers, education and negotiation skills to make decisions in their intimate relationships around condom use. This is well documented especially among rural women who have less access to education and resources.²²

3.1.2 Service Provider Related Barriers

Supply, provider attitudes and the burden the FC presents as a new technology on the already strained public sector system are the key service provider related barriers identified in the literature.

Supply consistency may influence a provider's ability to promote consistent and continued use of the FC. When supplies are unavailable it makes no sense for the provider to create demand among his/her constituents.²³ For CSWs availability of all condoms is a severely restricting issue. In one study, 41% of CSW study participants said that the provider ran out of FC, 32% said that the FC were too expensive, 20% said that the provider gave only a limited supply.²⁴ Many PLWHAs had tried FC and liked it but had difficulty in obtaining the FC.²⁵

Lack of interest and commitment on the part of service providers has been reported as well as obstruction in the name of religion and bureaucratic delays in FC distribution. For example, providers have negative attitudes toward men needing condoms for PMTCT.²⁶ This issue is key as mechanical obstacles have been shown to be overcome by sympathetic and trained health workers and thus the mechanical barriers are relatively easy to overcome with appropriate programming.²⁷ It may be true that provider bias is underreported in the research across the board and attitudes among service providers may be significant barriers.

AIDS Service Organizations are good at using the logistical system in place for FC procurement but monitoring requested at the central level is shown to be too cumbersome for the already overburdened health care providers. Providers may not have time to promote FC and the information necessary for proper use and negotiation.²⁸

3.1.3 Socio-contextual Barriers

There are many aspects of the cultures in Zimbabwe which compromise a couples' ability to choose to use FC. Zimbabwean women have a deep distrust of male partners. Infidelity is widely accepted though rarely spoken about. Men frequently have extra marital affairs with women that they keep in "small houses" who may or may not be monogamous with the husband.²⁹ Logically, it would lead women to have a stronger desire to have protected sex, but because of beliefs about trust and protection previously mentioned and the woman's relative inability to negotiate safer sex, she is left more often unprotected in higher risk situations. Poor women, who are vulnerable to HIV infection for many other reasons, especially have fewer skills and opportunities to negotiate.³⁰

Many men have a preference for dry sex in Zimbabwe. This practice may make women more biologically vulnerable to HIV/AIDS infection³¹ but the lubrication of the Female Condom is incompatible with desires for dry sex. Compounded on this fact is that the sexual preferences of men are what dictate which sex acts are done, how they are done

and with what frequency. Women are not supposed to mention their need for sex or pleasure.³²

Sex without condoms is seen as an expression of trust or friendship for CSWs. Thus, sex acts with the steady boyfriends of CSWs, who may be the best and most consistent users of condom strategies, are frequently unprotected and a significant source of infection.³³

If a partner is opposed to condom use, a woman is more likely to have unprotected sex. Women are forced to risk “biological death” from AIDS to avoid the “social death” and poverty due to divorce and abandonment.³⁴

The sum total of all of these socio-cultural barriers to condom use indicates that the changes necessary to encourage condom use must equip users to stand up to some cultural barriers or work from within to change the culture within their own marriages and relationships. We know that negotiation skills are necessary, but the complexity of the socio-cultural context requires more sophisticated tools on negotiation.

3.2 Target Groups

When deciding which groups to target for FC distribution, there are very few clear policies or guidelines. Possibilities suggested in the literature include targeting risk groups, geographic groups and generalized distribution. In targeting risk groups, there are key criteria suggested upon which decisions can be made. The first criterion is that the target population should have the ability to benefit from the FC intervention and influence others. The second criterion is that those who are most able to use the FC and influence others to do so should be prioritized.³⁵ Groups meeting these criteria would be:

- Sero-discordant couples identified at PMTCT or VCT centers
- CSWs in general, and especially when having sex with their partners
- PLWHAs
- Pregnant and Breastfeeding women
- VCT attendees
- Family Planning clinic attendees
- CSWs on trade routes
- Female students at universities

One consultant’s report suggested geographically bringing one or two provinces to scale and assessing what can be possible and what the impact of FC may be on the HIV/AIDS epidemic. Within the geographic areas, distribution would be generalized.³⁶

Other reports and documents suggest that from a rights and equality perspective it is necessary to provide FC to the widest number of people possible. In generalized epidemics, such as Zimbabwe, targeting would be less advantageous in a situation where there are unlimited supplies.

3.3 Positioning/Promotion

If the FC were to be promoted in a generalized way to all women the research has suggested several strategies:

- Some women have had great success in using FC during their menstrual period.³⁷
- Promoting FC use for Health Workers may allow them to better be able to promote and support FC use in clients
- The majority of participants in one research preferred to receive IEC materials and FC from their medical providers because of the confidential nature of the provider/patient relationship.³⁸
- Radio 2 has the widest reach among target populations.

What is most clear is that face to face promotion is the best way to encourage people to use FC. Thus, male partners, family, friends, relatives and trained health professionals have the most convincing power over whether or not to use FC.³⁹

Specific target populations have had some success with certain promotion techniques:

For PLWHAs, one study suggested that support groups, hospital distribution, and beer halls are the best distribution sites for FC. PLWHAs need extra support to negotiate and information on rights to childbearing, the effects of HIV on the body and the likelihood of MTCT.⁴⁰

Other than the targeting dilemma, the question of how to integrate FC with RH/FP programmes and whether a health paradigm (disease avoidance) or a sexuality paradigm (promotion of the pleasurable aspects of FC use) should be considered.⁴¹

Many women become CSWs after divorce or sometimes as a result of infertility. Some CSWs have reported success with creating a reputation for using FCs in pleasurable ways. Clients seem to need different negotiating skills from boyfriends. If clients are too drunk, CSWs have had success in using FC. This is not to suggest that the FC be positioned for use with drunk clients, rather these aspects should be highlighted when positioning the FC as a useful tool for CSWs.⁴²

Historically, male condoms became a legitimate part of contraceptive strategies first outside of marriage and then later within, at least in developed countries until other contraceptives became available.⁴³ Married women represent the majority of sexually active young women in developing countries. In Kenya and Zambia (Zimbabwe data unavailable) married girls under 18 years old have 48-65% higher incidence of HIV than their unmarried counterparts.⁴⁴ While it is not cost-effective to target the FC as a contraceptive device to low-risk couples⁴⁵, married women are increasingly more at risk. Thus, married women need careful consideration in how the FC is positioned for them.

One interesting argument is that of using the Triple Protection aspects of barrier methods to promote condom use within marriage. That is, besides the dual protection strategies, a

third, more visible factor, that of fertility is suggested as a positioning tool. The proportion of infertility problems is around 15-30% in most African countries and that number is increasing every year. Most fertility problems in couples are related to STIs, however, STI and HIV status is “invisible”. Couples are able to hide between themselves if STIs or HIV is present, however, the effect of untreated STIs is often infertility. Fertility is a major social factor which is carried by women and families. Furthermore it is more visible to the community. FC, as well as male condoms, could be promoted among married couples as the option for protecting the couple’s fertility.⁴⁶ This positioning suggestion has not been tried in other countries. If considered, Zimbabwe would be continuing in its history of breaking new FC territory.

3.4 Successful Strategies in Female Condom Promotion

The following strategies have been successful in generalized promotion activities:

- Nurses who had used FC, were trained and had troubleshooting knowledge were better able to support their patients in the use of the FC.
- Peers encourage persistent dual protection behaviors.⁴⁷
- When integrated into RH programs women have the opportunity to outwardly express that they choose FC for contraceptive use while actually strategically using the FC for protection against STIs and HIV.
- When men are successful users, women have less difficulty negotiating and using FC
- Pleasure aspects encourage use
- Promoting FC for use during menstruation to have “cleaner” sex⁴⁸

Social marketing has established the following media as most successful in encouraging people to buy FCs: Radio 2 and peers were most successful; TV was ½ as popular as radio, men read newspapers and women were best approached at the point of sale. Package inserts are the most effective media in training people to use the FC. Mass media campaigns do not have as strong of an effect on an individual’s decision to use an FC as peer education does, but these campaigns do have population-level benefits and are good for starting discussion.⁴⁹ PSI has had remarkable success in promoting the FC at hair salons where women often spend extended periods of time and can speak very openly about sex.⁵⁰

PMTCT pilot studies suggested that women need one-to-one counseling over group counseling, but couples counseling is especially helpful in including men in the decision to use condoms.⁵¹

When CSWs had access to MC or FC, the proportion of protected sex acts increased, but they needed support specifically around clients being more knowledgeable and wider exposure to the FC. CSWs also needed more skill in negotiation of non-client relationships.⁵² One interesting strategy was used in the Chiredzi CSW population. Women there bound together in peer support groups where all CSWs in the geographic area agreed to use condoms so that men could not get naked sex elsewhere in that city. In addition, non-protected sex acts were penalized by the community.⁵³

3.5 Opportunities for Integration of Reproductive Health and the HIV/AIDS Response via the Female Condom

The HIV/AIDS community and the Reproductive Health community have long had vertical programs. FC is an ideal opportunity to integrate the FC into RH and HIV/AIDS programs. The most key element of this is actually distributing FC in RH programs. Despite FC not being the most cost effective contraceptive, placement of the FC in RH programs allows women to strategically negotiate with the contraceptive argument.

The triple protection argument presented earlier is also a key opportunity to integrate RH and HIV/AIDS programmes. With 40% of infertility being related to women's biological inability to conceive, an additional 40% is related to men's inability to produce viable sperm. 20% of couples' infertility is due to combined male and female causes. However, men's infertility is often dealt with in African cultures discreetly while women's infertility can be cause for divorce or abandonment.⁵⁴

Beyond integrating RH and HIV/AIDS services, poverty alleviation and training women more globally in assertiveness skills and then using FC as a tool in applying those skills has been successful.⁵⁵

3.6 Promoting Consistent Use

Consistent use of a method is important if that method is the only tool which a woman employs. In the fight against HIV/AIDS, however, people don't use methods, they use strategies. Consistent use of an effective strategy is thus what programmes must aim for. The following factors are helpful in encouraging consistent use of the method:

- Availability of FC
- Affordability of FC
- Personal Perception of risk
- Ongoing insistence and belief in protection of oneself and others.⁵⁶

The bulk of research on consistent use has been in the private sector in social marketing campaigns where consistent sales are much more salient. Within this context, we know that the best predictors of consistent use are the non-use of any other family planning method and having previously consistently used male condoms with their marital partners. Other predictors, though less powerful, were being married and desiring to use contraception. Social Marketing programs suggest face-to-face training, promoting support services for FC and facilitation of partner communication in order to encourage consistent use.⁵⁷ When social marketing data aggregated men and women users of the FC, researchers found that those who were the most consistent users of FC were those who had consistently used MC with their marital partners. Additionally, prior male condom experience improves consistency of FC use.⁵⁸ What these findings could be indicating, however, is that the social marketing program was successful in reaching its intended audience as *care* was marketed as a contraceptive sheath for couples who care, not specifically for the dual protection properties of the FC.

3.7 Increasing Cost-Effectiveness

In all possible scenarios tested in one unpublished cost-effectiveness research, the FC was a cost-effective, and often cost-saving dual protection method. FC became more cost-effective as substitution for male condom decreases, as STI treatment costs increase and as the number of partners a person has per year increases.⁵⁹ Thus, it would be most cost-effective to target to CSWs and those with many casual partners. Re-use of the female condom is possible, as suggested in the 2003 World Health Organization protocol for Re-use of the FC female condom, would also increase cost-effectiveness. Volume purchasing, perhaps in collaboration with neighboring countries, cost-recovery mechanisms such as tiered pricing and reducing FC use for solely contraceptive purposes all would make the FC more cost-effective. Research has demonstrated that any prevention strategy currently available is more cost-effective than treatment.⁶⁰

3.8 Improving Access and Availability

Public sector distribution of the FC has always been handled in Zimbabwe by the ZNFPC with varying degrees of success over the years. The issue of improving access and availability is a large one which has mostly been beyond the scope of most research. One consultant's report suggested that some of the barriers to access were cumbersome reporting required for service providers and inconsistent or non-existent monitoring of distribution and logistics. Proposed solutions include consolidating FC reporting into all other contraceptive reports and piloting distribution strategies in two clinics before going to scale.⁶¹ The DTTU system is addressing many of the access issues, but the major constraint is limited supply. The most perfect distribution system will never reach all of its intended audience appropriately unless the number of FC is sufficient to address demand. No research to date has addressed the issue of public sector demand. Even in the private sector, PSI may have had limited stocks and the numbers of FC sold probably do not reflect true market demand in that segment.

3.9 Priority Groups/Locations For Distribution and Training

Though the research has suggested that there are criteria that would best select target groups and that with unlimited resources the FC should be distributed generally in a generalized epidemic, the issue of priority groups is not necessarily related. The literature suggests that there are moral imperatives to address certain groups with training as well as access to the FC. CSWs who have been a primary target of FC programmes to date should not be denied further access to FC. In addition, married women, with their increased vulnerability and the programmatic difficulty in reaching over the cultural barriers to reach them, cannot be ignored. Research suggests that men, especially in VCT, PMTCT and Vaccination centers have long been peripheral participants in FC programming and could contribute significantly to the question of easing the difficulty of negotiation. Finally, ZNFPC employees that are responsible for distributing the FC must be the target of training for their personal use so as to better equip them to serve their constituents.⁶² In terms of prioritizing geographic areas, we have only one example from

the literature and it comes from the private sector distribution. PSI has been targeting border towns and urban centers where HIV incidence is reportedly highest.⁶³

3.10 Usage Patterns/ Usage Profile

There are three categories of user that the literature examines. The first is the user reached by social marketing campaigns who usually falls within a specific target audience. The second is reached by either ASO programming or by the generalized distribution in the public sector. The last is the re-user of the FC. PSI gives us very specific data about the users of *care*. These women are most often: in their mid to late 20s, have higher levels of education than their male condom using counterparts, have higher access to household resources, are unmarried, are the primary breadwinners, are mostly monogamous and have tried male condoms before using the female condom. Male users are typically married and use the FC outside of their marriages. This does not however represent the entire FC market. In the public sector, when given an unlimited supply of FCs, only 3-9% of one CSW population used FC only all the time. When the same population used male condoms and female condoms as a paired strategy, the proportion of protected sex acts increased. Those CSWs who used the FC stated that they had a high volume of clients or had had a previous breakage history with the male condom. Those who chose not to use the FC used agents to clean, dry or tighten their vaginas.⁶⁴ According to the NACP distribution strategy, those most accepting of and interesting in FC use were those with high levels of secondary education, rural women, those with low paying jobs and those who were interested in improving the quality of sex and pleasure.

Re-use is of particular concern to the programmatic community. If done properly, re-use could make the FC up to five times more cost-effective. If done improperly, it could seriously damage the reputation the FC enjoys as a safe and strong method. What we do know, however, is that even when we tell users not to re-use FCs, a small proportion of them do anyway. In one study, 2.2% of study participants re-used the FC and cited the following reasons: economic, inadequate supply, saving time by not changing their FC between sex acts, laziness or an interest in experimenting.⁶⁵ In another study involving CSWs 1-2% of participants re-used the FC despite being instructed not to do so.⁶⁶ Rural men and women in another study are considering re-use due to high cost of the FC. Men in this study were suspicious of re-use despite the woman using soap to clean the FC and relubricating the condom before re-use.⁶⁷

There is a protocol that was developed by the WHO in 2003 for the re-use of the FC. No Zimbabwe or regional research to date has taken up this protocol, however, research has been conducted in South Africa and the Zambia regarding the acceptability of re-use of the FC. Both studies showed re-use to be highly acceptable due to the perceived strength of the FC but did not employ the WHO protocol as the research had been conducted before the protocol was established.⁶⁸

4.0 Recommendations

- 1) Research conducted in Zimbabwe and the region should inform the strategic planning process around the Female Condom. Previous documented experiences, suggestions made by NACP and consultants and key resources should guide future programme endeavors. This being said, the body of research is not significantly large enough or consistent enough to suggest one clear way of proceeding at this time. Efforts to improve programme delivery should be made based on prior successes but not limited to already attempted approaches.
- 2) Zimbabwe should make efforts to continue to be a key leader in the successful integration of the Female Condom into HIV/AIDS and Reproductive Health programmes. It should consider attempting new strategies that have convincing arguments to support their use. These are:
 - a. Incorporating re-use as a cost-savings mechanism. As donor support is potentially never going to be as high as is necessary to demonstrate market demand for a free public sector condom, it would be imperative that re-use is at least considered and a clear policy is drafted.
 - b. Exploring the utility of the Triple Protection argument to support barrier method use.
 - c. Pairing MC and FC as complementary methods in a strategic approach to preventing HIV transmission. Though each method has its peculiarities, the net benefit of a barrier method is similar. By incorporating the strategic approach, we are not so much concerned with consistent use of a method, but rather consistent use of a strategy.
- 3) During the course of the situational analysis, the consultants should consider:
 - a. Attempting to find tools for programmes which teach effective negotiation skills for the Female Condom. If none exist, they should consider which partners may be most appropriate to develop one.
 - b. Looking carefully at issues of provider bias. Is access or training keeping providers from effectively distributing the FC or is there a genuine bias on the part of many service providers?
 - c. Consider how best men can be incorporated into FC programmes.
- 4) The question about which approach is more appropriate and feasible in Zimbabwe remains: do we target FC programmes and distribution or do we attempt to take on the generalized epidemic with generalized distribution? If we do target, the criteria established to prioritise target groups should be considered and expanded. The situational analysis must address this question and make strong suggestions as to what the key decision points are.

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