PERCEPTION AND ATITTUDE TOWARDS UTILIZATION OF FEMALE CONDOM AMONG MARRIED WOMEN IN IBADAN NORTH LOCAL GOVERNMENT AREA OF OYO STATE

BY

EGECHI LYNDA OLUCHI
MATRIC NUMBER 154760

A PROJECT IN THE DEPARTMENT OF EPIDEMIOLOGY, MEDICAL STATISTICS AND ENVIRONMENT HEALTH, SUBMITTED TO THE FACULTY OF PUBLIC HEALTH, COLLEGE OF MEDICINE

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SCIENCE (MSC) IN EPIDEMIOLOGY UNIVERSITY OF IBADAN

JUNE, 2011

CERTIFICATION

I certify that research work was carried out by MISS LYNDA EGECHI under my supervision in the Department of epidemiology, medical statistics and Environmental Health, Faculty of public Health, college of Medicine, University of Ibadan

.....

Supervisor

DR, B.O. Adedokun

M.B.B.S. (IB), MSC (IB)

DEDICATION

I dedicate this work to almighty God who granted me fortitude to complete the Master Degree programme and to my parents and well wisher.

ACKNOWLEDEMENT

I acknowledge the support and assistance of every member of my family, and my friends throughout the period of the MSC degree programme. I would like to acknowledge my dedicated supervisor and lecturer in person of DR ADEDOKUN for his immense contribution towards the success of this study. To you I owe a great debt of gratitude.

TABLE OF CONTENTS

LIST OF TABLES

Abstract

Many married women in the less developed countries would prefer to avoid unintended pregnancies and STIs but the use of female condom among them is low. This study aimed to determine the perception and attitude of married women towards utilization of female condom and prevalence of its use.

A descriptive cross sectional analytical survey was carried out in Ibadan North Local Government Area of Oyo State. Simple random sampling was used to select the participants and interviewer administered questionnaire was used for data collected. Data on socio-demographic characteristics, awareness, perception and utilization of female condom was collected.
The data was analyzed using descriptive statistics, bivariate analysis and logistic regression. The level of statistical significance was set at 95% confidence level.

The mean age of the respondents was 32.4 years (±6.6). More than half (67.5%) of the respondents have heard about female condoms. On perception, 30.4% agreed that female condom protect against unplanned pregnancy, 34.0% agreed that it protect against STIs. On attitude, 59.8% of women agreed that the female condom is unfavorable and 69.1% would not recommend female condom to other women. On prevalence of female condom use, one-third (18.1%) respondent had ever used a female condom. Majority (99.5%) of educated women, had knowledge of female condom use. Cross tabulation revealed a significant relationship between attitude of women and use of female condom ($p<0.001$); perception of married women was significant with female condom use ($p<0.001$).
On logistic regression, perception of married women showed significant relationship with use of female condom among married women (OR: 5.64; 95% CI 2.6-14.13). Education was not significantly related with female condom use (OR: 0.79; 95% CI 0.14-4.30).

In conclusion, awareness, perception, attitude towards female condom remains low among married women in Ibadan North Local Government Area of Oyo state.

There is need to maximize the level of awareness of female condom use among the rural women and those with low level of education about HIV/AIDS, sexually transmitted infections

LIST OF ACRONYMS

AFRH..... Association of family and reproductive Health

FC1..... Female-condom 1

FCI2..... Female condom 2

HIV..... Human Immune Virus

MSM..... Men Sex Men

MWRA..... Married Women Reproductive Age

NDHS..... National Demographic Health Survey

STIs.....Sexually Transmitted Infections

UNFPA.....United Nation Population Fund

WHO..... World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

More than 100 million women in less developed countries, or about 17 percent of all married women, would prefer to avoid a pregnancy but are not using any form of family planning. Demographers and health specialists refer to these women as having an "unmet need" for family planning—a concept that has influenced the development of family planning programs for more than 20 years. Over the past decade, rising rates of contraceptive use have reduced unmet need for family planning in most countries (Christopher and Allan, 1998). In some countries, however, unmet need remains persistently high or is increasing, indicating that greater efforts are needed to understand and address the causes of unmet need. Unmet need for contraception can lead to unintended pregnancies and also contribute to increase in sexually transmitted diseases among married women. An estimate of 2.6 million women are infected with STIs/HIVs (WHO,2008), which pose risks for women, their families, and societies an estimate of 18 million unsafe abortions take place each year among women, contributing to high rate of maternal death and injury (Carl,2002). In addition, unwanted births pose risks for children's health and wellbeing, and also contribute to rapid population growth in resource-strapped countries. (Carl, 2002).

The current use of contraceptive in Nigeria varies among urban and rural women. In spite of the high rate of the sexual activity among women, the contraceptive use is very low, about 11 to 13% (Monjok et al, 2010). In the northern part of Nigeria the use of modern contraceptive methods has been reported to be 9% among women using modern contraceptives in 2003.In addition, only 3% of women from the northeast and northwest use modern contraceptives (Odumosu et al, 2003).

Moreover, Female condoms are one of the effective dual protection methods available to women for preventing HIV, sexually-transmitted infections (STIs), and unintended pregnancies. Building on the progress of Beijing, for the global community to achieve the Millennium Development Goals both female and male condoms must be well-programmed and made accessible to all people who wish to use them. This means female condoms must be made as available as male condoms: In a situation where men do not agree to use male condom, the

woman should use female condom to protect herself from unwanted pregnancy and sexually transmitted diseases (Choi Kyung-Hee et al, 2008).

The female condom, moreover, gives women an important option for initiating protection and negotiating condom use. It has good acceptability, and evidence shows that when the female condom is promoted alongside the male condoms, the total number of protected sex acts increases

(Choi Kyung-Hee et al, 2008). Female condoms can be used to prevent unintended pregnancy; reduce risk of STI transmission when partners suspect infidelity in marriage, allowing the women to pursue safe and satisfying sex lives.

1.1 PROBLEM STATEMENT

The issue of Sexually Transmitted Infections and unwanted pregnancy do pose a serious threat on the lives of married women both in developed and developing countries around world. (UNFPA, 2005).

Between 18-28% of adults aged 15-49 years are infected, and more than 80% of all adults who are infected by HIV are transmitted through sexual intercourse (WHO, 2000).

With the rapid spread of HIV throughout sub-Saharan Africa of which Nigeria is a part of, new approaches such as female condom use to HIV prevention are urgently needed, especially among married women. Family planning service have traditionally focused on promotion of methods that are highly effective at preventing pregnancy but provide no effective serves for women to protect themselves them self from sexually transmitted diseases, therefore putting many married women who have access to these services at risk of contracting HIV (Adeokun et al, 2002).

Moreover, many Nigeria women of reproductive age experience an unwanted pregnancy which results to abortion (NDHS, 2003). In 2000, 15% of the total lives births resulted from unplanned pregnancies – which is the leading cause of unsafe abortion among women (NDHS, 2003).

Previous studies carried out by (Monjok et al, 2010) in contraceptive practice in Nigeria found that that the current prevalence rate of contraceptive use in Nigeria is as low as 11-13%. In-spite of the sky rocketing increase in spread of STI especially HIV, and high fertility rate as a result of unplanned pregnancies and despite the ease and non medical complications associated

with the utilization of female condom as compare to other contraceptive method such as pills and intra-uterine device, the prevalence rate of female condom is as low as 2% (Olunike et al, 2010).

1.2 JUSTIFICATION OF THE STUDY

Despite the availability of female condom and theoretical –based interventions to promoted its use. Studies have indicated low level acceptability of their use among women in most populations (Holmes et al, 2007). Unprotected sexual intercourse, young Africa-American women are a group at high risk for HIV transmission and acquisition, and yet understudied in terms of predictors of female condom use (Locke, Newcomb and Goodyear, 2002). Available evidence suggests that the prevalence proportion of female condom use is particularly low among African women (Krishman et al, 1996). Studies with other populations have shown the difficulties involved in using female condoms (Dencand et al, 1997). Nigeria women may have similarity difficulties using female condoms and often are not well informed on the steps involved in proper condom use.

1.3 RESEARCH QUESTIONS

1. What is the level of awareness on female condom use in Ibadan North Local Government Area?
2. What are the socio-demographic factors that influence female condom utilization in Ibadan North Local Government?
3. What is the perception of married women in Ibadan North Local Government towards female Condom utilization?
4. What is the attitude of women in Ibadan North LGA towards female condom utilization?

1.4 BROAD OBJECTIVE

This study aimed to determine the opinion and perception of married women reproductive age of 15-49 years, to the utilization of female condoms in Ibadan-North Local Government Area

Specific Objectives

1. To determine the level of awareness of female condom use among married women
2. To determine the prevalence of female condom among married women
3. To determine the perception of married women concerning female condom use
4. To identify socio-demographic factors influencing female condom use among married women.

HYPOTHESIS OF RESEARCH

1. There is no significant relationship between socio-demographic factors and female condom use among married Women.

2. There is no significant relationship between married women's attitude and utilization of female condom in Ibadan north local government area

3. There is no significant relationship between the perception of married women and female condom use among women in Ibadan North Local Government Area.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1. CONTRACEPTIVE PREVALENCE

Women in more developed countries have historically used, and continue to use family planning to control their fertility more often than women in less developed countries. For example, about 71 percent of married women of reproductive age (MWRA) in the United States used contraception in 1990, compared to an average of 47 percent of women in the largest less developed countries in the late 1980's or early 1990's (Maine et al, 2001). While this kind of disparity underscores the continuing disadvantage of women in the developing world in terms of reproductive health, it is also true that contraceptive use is widespread in a number of less developed countries. Among the largest countries, over three-quarters of married women in China (Mainland) and two-thirds of married women in Brazil use some method of contraception (Omran et al, 2004).

Within the developing world, use of contraception by married women of reproductive age varies substantially from region to region, as well as from country to country (Westoff et al, 2004). In Asia, the majority of countries now have prevalence rates for MWRA above 50 percent (Ochoa et al, 2004). In China (both Mainland and Taiwan), as well as in South Korea and Hong Kong, recent information indicates that over three quarters of MWRA use some means of contraception to control their fertility (Maines et al 2001). In most of the larger countries of Sub-Saharan Africa, contraceptive prevalence is under 30 percent (Ochoa et al 2004). The highest rates are 50 percent of MWRA in South Africa and 33 percent in Kenya and lowest at 15 percent in countries like Tanzania, Ghana, Sudan, Nigeria, Uganda and Ethiopia (Westoff and Ochoa, et al, 2004).

2.2 WHAT ARE FEMALE CONDOMS?

Female condom is a prophylactic device or thin sheath worn by women during sexual intercourses to prevent sexually transmitted disease and unwanted pregnancy (WHO/UNAIDS. 2000). It is made up of Polyethane (Fc1), synthetic nit rile (Fc2).

The Fc1 and Fc2 sheath or pouch is 17cm (6-5) in length. At ends there is a flexible ring at the closed end of each ends of the sheath. The flexible ring is inserted into the vagina to hold the female condom in place. The other end of the sheath stays outside the vulva at the entrance to

the vagina. The ring act as guide during penetration and it also stops the sheath from moving up inside the vagina (United Nation Population fund 2005).

2.3 FACTORS INFLUENCING FEMALE CONDOM USE

In as much as female condom use is to some extent gaining wide acceptability, there exist some major obstacles militating against its widespread usage. The reasons range from encumbering beliefs to adverse experiences, reduced sexual pleasure, gender related fears and tension, to social stigma.

Lack of women's empowerment and gender equality

The promotion of equality between men and women is essential to successful STIs prevention, addressing both barriers to empowerment and sexual pleasure and performance (Drezin et al, 2005). Inside a heterosexual relation, gender power relations are directly tied to a woman's ability to negotiate safer sex with her partner (Drezin et al, 2005).In many cultures, women lack the power to insist on female condom use, both inside and outside marriage. Violence against women inside and outside marriage, including rape and sexual assault, takes away women's control over when, with whom, and how they have sex, and over whether or not they can negotiate condom use during sexual intercourse (Ann et al, 2005). Furthermore, many women do not feel comfortable talking about sex with their partners or may stop using condoms when involved in a long term relationship as a sign of trust and faithfulness. Whether or not protection is used-and what kind-is often decided by the man (Daly et al, 2005), Sometimes even the suggestion of using a condom will be seen as an accusation of the partner's infidelity, or an admission of adultery on the part of the woman. Such interactions could provoke violence and silence a woman from speaking up, even if her partner's faithfulness is suspect. In South Africa, for example, fear of violence is reported as a major barrier to condom use (Jenny et al, 2005) In Morocco, the appearance of fidelity is so important that women can rarely insist on condom use even when her partner is HIV positive and she is not (Drezin et al, 2005). Women also refuse to use condoms as many relate condoms.only with contraception (and not with protection against STIs) and given that in many cultures, becoming pregnant is an indicator of intimacy and commitment, women fear negative repercussions from their partners. Married couples are among the least likely groups to use condoms (Mary et al, 2002), and marriage itself has become a

prime risk fa[c]tor for women. In Nigeria, as elsewhere, the majority (65%) of HIV positive w[o]men have been infected by their husbands (Ann et al, 2005). In some cultures where adultery or polygamy is common unprotected sex within marriage is inherently risky (Torres et al, 2005).

Early marriage (sometimes forced) and desire or social pressures to have children are other factors complicating female condom use. Gender norms around masculinity dictate that men should be sexual risk takers and should be aggressive within sexual activity (Daly et al, 2005). This of course affects the power dynamics in the relationship either in a heterosexual or homosexual relation. Men who have sex with men (MSM), feminized men and transgender people also experience difficulties with condom negotiation and experience high levels of sexual violence (Kieran et al, 2005).

Stigmatization and social exclusion further disempowers these populations, increasing their vulnerability to HIV infection. For many, the sexual and gender roles they perform within male sexual practices lead to significant levels of 'dominant' sexual partners, sexual abuse, violence, rape, and harassment, often from an early age and of course, such vulnerability to HIV infection (Kieran et al, 2005).

Personal beliefs and pleasure

Lack of understanding about HIV-including misperceptions of risk-impedes condom promotion efforts. Research has shown that condom use is lowest amongst married partners, who tend to trust their regular partner, and young people who may feel invincible from disease (Jenny et al, 2002). The rates of condom use are even lower among women and men in the general population who have not been exposed to condom promotion. This data also showed that men are generally less willing to use condoms with their long-term partners than they are with casual partners or paid sex partners (Mary et al, 2005). In most cultures, a 'real man' is defined by his sexual conquests. Some men consider sex to be their right, and pleasure an obvious by-product of sexual relations. Across the world, however, concern exists-primarily among men-about whether condoms reduce the sensation and enjoyment of sex, and affect sexual performance.

Men in multiple contexts compare wearing a condom to "taking a bath with your boots on" or "smelling a rose through a gas mask" (Daly et al, 2006). Social pressures on men to enjoy sex or prove their masculinity may impede condom use, even in high-risk situations. In Nigeria, for example, low levels of female condom use among sex workers stems from a lack of

acceptance by male clients (Iyayi, et al, 2010). Growing evidence exists that associating pleasure with male and female condoms increases their use (Anne Philpott et al, 2005). Conversely, emphasis on disease and the negative potential outcomes of sex may limit the effectiveness of prevention and condom promotion (Jenny et al, 2005).Focusing on positive approaches and eroticizing condom use therefore is a means for overcoming concerns of pleasure and performance. Social marketing efforts can capitalize on these opportunities. Packaging condoms along with lubricant to diminish friction and discomfort, and promoting condoms along with other kinds of erotic accessories are only a few of the means that have been used to boost female condom sales. In Mongolia, for example, the Lady Trust brand of female condoms, explicitly marketed to increase male and female pleasure, experienced high sales growth (Torres et al, 2005).

Economic and financial barriers

Female Condom use is one of the least expensive, most cost-effective methods for preventing HIV and other STIs. In addition, HIV infections averted now can save millions of dollars spent later on treatment, lost productivity, and lives. Yet, cost continues to be a major barrier to accessing condoms (Kerrigan et al, 2006). Many governments have consistently failed to keep condom prices affordable through the imposition of taxes and a lack of investment in social marketing. This lack of support has also been affected by the financial influence of international donors imposing ideologically motivated restrictions on condom promotion (Kieran et al, 2006).

Religion and morality

An overly rigid, or moralistic, view of sexual activity – and the belief that condom promotion encourages sex-is a strong deterrent to female condom use. Cultural and religious notions of "morality" equating condoms with promiscuity limit both the availability of condoms and personal ease of comfort in using them. Many faith-based organizations, and governments influenced by religious ideology, have adopted the 'ABC' approach to prevention: Abstinence, Be faithful; and use Condoms (Ann Torres et al, 2005). Often their emphasis is only on abstinence and be faithful, positioning condom use for those unable to meet 'moral standards'.

This ABC approach fails to deal with the need for a more comprehensive approach to prevention including, for example, empowerment, sexuality and life skills education. This

particular approach is most problematic because it increases the stigma and discrimination of those using condoms (Kieran et al, 2005). In Nigeria, many people are reluctant to buy female condoms for fear of seeming sexually "loose" because female condom primary associated with marginalized group such as sex worker (Abanihe et al. 1994). In El Salvador, pharmacists refused to sell condoms due to religious beliefs, which also influenced health care workers' willingness to promote condom use (Drezain et al, 2005).

Legislation and policy

Female condom availability in some countries is restrictive, measures on condom use is institutionalized as official government policy. In the Philippines, for example, the governments refused to supply female condom to public sectors with national funds, condoms were prohibited from health clinic and police actively interfered with condom promotion (Drezin et al, 2005). In Nepal, MSM and sex workers- the highest risk groups- have been arrested for carrying female condoms (Jenny et al, 2005). In Jamaica, Ministry of Health has developed specific prevention messages for young people and women yet nothing targeting MSM or sex workers, even in Canada, a country with universal health care, high standards of living and an awareness of human rights, some of the most vulnerable populations-youth, Aborigines, small rural communities, refugees, and trafficked women- have limited access to female condoms (Torres et al, 2005). In Romania, while the government has carried out campaigns for urban youth, out of school youngsters and rural youth are virtually excluded from condom promotion activities (Torres et al, 2005). Despite high levels of adolescent sexual activities in Jamaica, health workers cannot freely offer prevention options to youth instead they must balance the best interests of the child with the parent's right of consent (Jenny et al, 2005). Prisoners remain another excluded group, often without regular access to female condoms. Reports from Honduras to Romania commented on the lack of condom distribution within prisons and the need for better prevention efforts within jails (Daly et al, 2006).

In Canada, female condoms, and lubricant are not available in some provincial prisons, and in many provincial prisons they are not easily or discreetly available (Drezin et al, 2005). In Morocco, prisoners can only get condoms in basket meals brought by visiting families (Kieran et al, 2005).

Taxes, economic restriction and cost

The female condom –high cost and limited marketing cost still remain the principal barrier to female condom use and access in most countries (Daly et al, 2005), even when available in limited quantities as in Peru and parts of Indonesia. The price of female condoms is often so high as to make it inaccessibly to most of the population (Mary et al, 2002). Female condom universally cost more than male condoms, often significantly more than the average person can afford. In Peru, for ~~example,~~ the female condom cost around US$8.50, whereas more than half of the Peruvian populations live on less than US$ 2.00 per day (Ann et al, 205). However, the high price is in part due to limited global markets. In 2004, for example, 346 million male condoms were available in South Africa, compared to 2.6million female condoms (Ann et al, 2005). If female condom were heavily marketed and seen both as a prevention method as well as sexual aids, their desirability and consequently affordability could dramatically increase worldwide.

Governments from developing countries have consistently failed to adequately prioritize female condom purchase in their budgets (Drezin et al, 2005). Consequently, in much of the developing world, female condom available has been overly dependent upon a small group bilateral And multilateral donors such as the United States, Germany, the United Kingdom and UNFPA, as well as international organization such as PSI. In 2004 donor governments provided fewer than four male condoms per man per year in the developing world (Kieran et al, 2005). This has resulted in a significant undersupply problem. In the year 2000, donors provided support for fewer than one billion condoms to the developing world, only one-eighth of what was needed (Torres et al, 2005). In 2002 that figure rose to 3.6 billion, or one –third of estimated condom need. However this increase was only due to one –time contributions from Canada, Netherlands and the United Kingdom (Ann et al, 2005). If donor government give the same percentage in 2015 as they did in 2002, there will be a 12.6 billion condom gap (Daly et al, 2005).

Influence of donors on female condom access.

Added to this lack of funding, the reliance on a few donors leaves female condom access and availability open to influence by individual donor policies and agendas. This includes the imposition of ideologically motivated restrictions on female condom over evidence –based prevention approaches, violating recognized human right (Ann et al, 2005). For example, while the United State has been the single largest source of condoms for developing world, recent

changes in policies, through the President's Emergency Program for AIDS Relief (PEPFAR), has seen budget allocations emphasize abstinence and fidelity over condom use. (PEPFER) stipulates that one- third of prevention funding must be spent on abstinence before marriage interventions. It advocate condoms promotion only for so called high risk groups such as sex workers, truck driver and HIV- discordant couples (Kieran et al, 2005).This approach does not only sufficiently recognized marriage as a risk factor or include married couples as a special focus of its programming interventions. By designing certain groups as a 'high risk' it not only promotes stigma of condom use, but implies that other groups are somehow immune to HIV and do not need access to condoms. Furthermore, their focuses on HIV-discordant couples are futile in countries where the majority of people are unaware of their HIV status. As the provide a huge influx of new resource to countries with significant epidemics, primarily those in sub-Saharan Africa. However, with the current reliance on international funding of condoms, PEPFER is strongly affecting policies and programming priorities around condom-based prevention (Mary et al, 2005). Some civil society actors and governments have responded to these budget restrictions by changing the direction of their work to abstinence and faithfulness over condom promotion or more comprehensive prevention approaches. In Nigeria, for example, it is evident that there has been an increasing shift within the prevention budget of the projects supported by PEPFER to favor abstinence and faithfulness approaches (shift from 40 percent of the allocation of the 2004 budget to 70 percent in 2005).

Supply and distribution system

Condoms move through multiple supply system before they get to their final point of sale or distribution, from manufacturers to quality control, and from donors to governments and the private sector, female condom are subject to particular standards of storage, logistics, and purchasing. Procurement policies of both donors and developing country governments are often inconsistent and uncoordinated, resulting in wasted resources and inadequate supplies (Rodrigo et al, 2005). Limited distribution systems, particularly in rural areas, constrain their availability and complicate access. In Ireland, for example, prevention information and commodities are primarily in urban areas and on the East Coast, while rural areas are poorly served (Carlos et al. 2005). In Romania, widen differences in condom availability by residence, type of outlet and region of the country. Condom are widely available in pharmacies and supermarkets (over 80

percent) and service station (over 60 percent), but are only available in about 40 percent of hotels and only 25 percent of all retail outlets sell them in rural areas (Daly et al, 2005). Diversifying points of distribution can help address issues around condom supply and access, for example, providing free condoms to clients at HIV-treatment and voluntary counseling and testing centers. In addition to providing condoms in health settings and making them available in supermarkets and pharmacies, condoms should be distributed to non-traditional outlets such as hotels, clubs, taxi stands, and by peer educators. 104 in South Africa, community group recommended supplying condoms in ''spaza shop'', informal businesses in township and poorer areas (Kieran et al, 2005)

2.4 USEFULNESS OF FEMALE CONDOM

The 1995 Fourth World Conference on Women in Beijing articulated a bold framework for achieving women's empowerment with a strong focus on women's human rights, sexual and reproductive health, and gender equality. Fifteen years after Beijing, access to prevention information and services remains an urgent health and human rights issue for women. Today HIV/AIDS is the leading cause of death for women of reproductive age globally, and approximately 215 million women in developing countries who wish to prevent or postpone pregnancy have an unmet need for modern here contraceptives. (WHO,2009).

Oftentimes a lot of men either are uncomfortable with or outright refuse to put on a condom, therefore using a Female condom that the woman inserts inside of her actually gives her the power to make the decision for herself to protect her own and their partners' sexual health. When used correctly, female condoms have been proven to protect both partners from the majority of STD's and prevent women from unplanned pregnancies (Singh et al, 2009).

A brand of female condoms can be inserted up to 8 hours before intercourse which means that it can be put on the knowledge of the partner.

Since female condoms are made out of polyurethane and nitrile, they are less likely to cause an allergic reaction than latex condoms.

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1. STUDY DESIGN

This study was a Descriptive cross sectional survey.

3.2 STUDY POPULATION

The study was carried out in Ibadan North Local Government area, which is one of the five LGA within Ibadan metropolis, Ibadan the capital city of Oyo state is regarded as the city in West Africa. The headquarters of the local government is Bodija. As a result of accommodation problems the local government headquarter is temporary accommodated at quarter 87 at GRA at Agodi, were the secretariat is located. Ibadan North Local Government consists of 12 administrative wards and 14 localities. The local government area is made up of people from different social, religious and cultural background, professional, artisans, both unemployed and employed. Majority of dwellers are Yoruba while there are also Igbo, Edo, Fulani, Efik, and Ibibio among others. The 2006 National Population Commission (NPC) census figures for Oyo state is 5,589,589 while Ibadan North Local Government area has a population of 69,655 women of child bearing age. The local government area is made up of communities with varied socio-economic classes with some high brow area and also some very poor communities.

3.3. INCLUSION CRITERIA

a. Participants must be married women between the age group of 15-49 years.

b. Participants must reside in Ibadan North Local Government Area.

3.4. SAMPLE SIZE

The minimal sample size for this study will be estimated using lesile kish formula for cross sectional studies

$$n = \frac{Z^2 pq}{d^2}$$

Where Z = standard normal deviate set at 1.96

P= Proportion of married women who had awareness of female condom (13%) in Nigeria (NDHS, 2008)

q= 100-P = 87%

d= Level of precision set at 0.05

$$N = \frac{1.96^2 \times 0.13 \times 0.87}{0.05} = 174$$

Non response rate set at 10%

$$\frac{100 \times N}{100-r} = \frac{100 \times 174}{100-10} = 193$$

3.5. SAMPLING TECHNIQUE

Two stage sampling methods were used. At stage one simple random sampling method was used to select two (2) health facilities out of the ninety four (94) registered health facilities in Ibadan North Local Government Area. In this stage, all health facilities were listed and a simple random sampling method (balloting) was used to select the health facilities which included Adeqyo hospital and Association of family for reproductive health (AFRH). At stage two, a systematic random sample technique was used to select the study participants. In this method, the first participant was selected at random while the women were seated in the reception hall of the hospital. Then; the other participants were selected at regular intervals according to their sitting position on each clinic day. At the end, 193 respondents were selected from the two family planning health facilities in Ibadan North Local Government Area.

3.6. DATA COLLECTION

Data was collected using a well structured questionnaire. Questions based on the study objective were asked consisting of Socio-demographic characteristics of research participants, knowledge (opinion) about female condom use, perception and attitude toward female condom utilization.

These questions were adopted from the questionnaire used for the national HIV/AIDS and reproductive health survey conducted in 2007 (NARHS, 2007).

3.7. DATE MANAGEMENT / ANALYSIS

Data collected was managed and analyzed using SPSS version 15.0. Frequency distribution tables which were generated from the required variables and chi-square tests were used to determine the statistical significance of cross tabulation between various qualitative variable with level of significant see at ($P<0.05$).

The perception question was determine from the questionnaire, and it was recode as follows strongly agree = 5, agree=4, uncertain=3, disagree=2, strongly agree=1, and the mean score was approximately 46, those with poor perception were those that scored less than 46(<46) and those with good perception was those that scored greater than equal to 46(≥46) from question 15-28.

3.8 LIMITATION OF THE STUDY

The study depends largely on the ability of the respondents to remember and give accurate information. Hence information bias was experience with the respondents

CHAPTER FOUR

4.0 RESULTS

Table 1 shows the social Demographic Characteristics of the women. The mean age of the respondents was 32.4 ±6.6 years. Most (96.9%) were Yoruba and 93.5% were currently married. Many (42.5%) respondents were into trading / business. Almost (99.5%) the respondents had ever attended at least primary school. Almost half (47.7%) had tertiary education, less than 57.5% were Christian and 48.2% of the respondents had at least 3-4 children.

Table 1: Socio-demographic characteristics of respondents

Variables	Frequency	Percentage
Age group		
<25	19	9.8
25-34	104	54.3
≥35	69	35.8
Ethnicity		
Yoruba	188	96.9
Igbo	5	2.7
Marital status		
Currently married	180	93.3
Living with sexual partner	12	6.2
Religion		
Islam	78	40.4
Christianity	111	57.5
Occupation		
Civil servant	22	11.4
Teacher	25	13.0
Trading	82	42.5
Self employed/artisan	35	18.1
Others	27	14.0
Attend school		
Yes	192	99.5
No	1	0.5
Education status		
Primary	18	9.3
Secondary	81	42.0
Tertiary	92	47.7
No of children		
1-2	90	46.6
3-4	93	48.2
5-6	8	4.1

Table 2 shows respondents awareness of female condom. Majority (67.8%) of respondents had ever heard of female condom, however, Many (66.3%) of the respondents had never seen a female condom. Few (33.7%) respondents who had seen a female condom describe that female condom looks like nylon with rings at both ends.

Table 2: Awareness of female condom

Variable	Frequency	Percentage
Ever heard about female condom		
Yes	131	67.8
No	62	32.1
Ever seen a female condom		
Yes	65	33.7
No	128	66.3
Description of what female condom looks like		
A rubber with soft rings	14	7.2
It is like latex rubber with rings at ends 1 open other is close	10	5.0
It is like nylon, with rings at both ends	20	10.3
It is latex rubber with rings at ends, which is removable and larger than male condom	6	3.1
It is like rubber tube with rings at the ends	15	7.7

Table 3 shows the perception of women towards female condom. Almost half of the respondents (41.5%) were uncertain about the effectiveness of female condom to protect against ~~unplanned~~ pregnancies, followed by those who agreed (30.6%). Very few disagreed with protective effect of female condom against unplanned pregnancies (2.1%). About one third of respondents (33.7%) believed that female condom protects against STIs, followed by (39.9%) who were uncertain about the ability of female condom to protect against STIs. Majority of the respondents were uncertain about the female condom been easy to use (76.2%), female condom reducing sexual pleasure (76.7%), female condom having side effects (80.9%) and female condom being easier to negotiate with husbands (75.6%). More than half of the respondents agreed that female condom empower women to negotiate safer sex with husbands (66.8%), and believed that women use female condom when they suspect infidelity (55.4%). About half of the respondents were uncertain on the efficacy of female condom to function as an effective barrier method to control and plan family better (54.9%).

Table 3 shows perception of women towards female condom

Variable	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Total
FC protect against unplanned pregnancy	50(25.9)	59(30.6)	80(41.5)	4(2.1)	1(0.5)	193(100)
FC protect against HIV	44(22.8)	65(33.7)	77(39.9)	5(2.6)	2(1.0)	193(100)
FC protect against STI	44(22.2)	66(33.7)	82(39.9)	3(1.6)	1(0.5)	193(100)
FC is easy to use	16(8.3)	16(8.3)	147(76.2)	11(5.7)	3(1.6)	193(100)
FC is cheaper than other FP methods	17(8.8)	12(6.2)	155(80.3)	8(4.1)	1(0.5)	193(100)
FC reduces sexual pleasure	9(4.7)	15(7.8)	148(76.7)	18(9.3)	2(1.0)	193(100)
There are side effect when using FC	2(1.0)	8(4.1)	157(80.9)	14(7.3)	11(5.7)	192(100)
FC empower women to negotiate safer sex with husband	20(10.4)	40(20.7)	129(66.8)	3(1.6)	1(0.5)	193(100)
Women use FC when they suspect infidelity with husband	36(18.7)	46(23.8)	107(55.4)	2(1.0)	2(1.0)	193(100)
Women should say no when their husband want to use force to have sex with them	20(10.4)	45(23.3)	98(50.8)	13(6.7)	17(8.8)	193(100)
FC is a barrier method which women use to control and plan family better	34(17.6)	49(23.4)	106(54.9)	2(1.0)	2(1.0)	193(100)
It is possible to use FC without husband knowing	6(3.1)	20(10.4)	109(56.5)	26(13.5)	32(16.6)	193(100)
It felt good	6(2.6)	14(3.1)	7(3.6)	9(4.7)	3(1.6)	39(100)
It made noise	5(2.6)	16(8.2)	3(1.6)	7(3.6)	7(3.6)	38(100)
It slipped out	3(1.6)	13(6.7)	8(4.1)	8(4.1)	6(3.1)	38(100)
It pained me when I use it	1(0.5)	10(5.2)	4(2.1)	14(7.2)	9(4.6)	38(100)

The attitude of the respondents to female condom use is presented in table 4. Majority (60.1%) agree that female is unfavorable, 69.4% would not recommend female condom to other women, and 34.3% agreed that female condom protects against STIs and unwanted pregnancies.

Table 4: Attitude towards female condom

Variable	Frequency	Percentage
Female condom is favorable or not favorable when discussed with husband		
Favorable	36	18.7
Not favorable	116	60.1
Would recommend female condom to other women		
Yes	54	27.8
No	134	69.4
Reason for recommending female condom		
Female condom protect STI and unwanted pregnancy	64	34.3
I will not recommend it because I have not seen or used it.	54	27.8
It has no side effect	7	3.6

Table 5 shows the prevalence of female condom use. Only few 18.1% respondents had ever used female condom, while majority 81.9% respondents had not used a female condom

Table 5: Prevalence of female condom use among married women

Have you ever used a female condom	Frequency	Percentage
Yes	35	18.1
No	158	81.9

Table 6 below shows the prevalence of female condom use among the respondents, on the cross tabulation only education showed Significant relationship with ever use of female condom (p=0.002).

Table 6: Ever use of female condom and socio demographic use

Variables	Ever use female condom		Total	X^2	P-value
	No n (%)	Yes n (%)	N (%)		
Age group					
<25	17(89.5)	2(10.5)	19(100)	4.728	0.094
25-34	90(85.7)	15(14.3)	105(100)		
≥35	51(73.9)	18(26.1)	69(100)		
Ethnicity					
Yoruba	153(81.8)	34(18.2)	187(100)	0.234	0.890
Igbo	5(80.0)	1(20.0)	6(100)		
Marital status					
Currently married	149(82.8)	31(17.2)	180(100)	1.959	0.162
Living with sexual	8(66.7)	4(33.3)	12(100)		
Religion					
Islam	68(87.2)	10(12.8)	78(100)	2.858	0.091
Christianity	86(77.5)	25(22.5)	111(100)		
Occupation					
civil servant	18(81.8)	4(18.2)	22(100)	0.823	0.935
Teacher	21(84.0)	4(16.0)	25(100)		
Self employed	30(85.7)	5(14.3)	35(100)		
Trader	66(80.5)	6(19.5)	72(100)		
Others	21(77.8)	6(22.2)	27(100)		
Education status					
Primary	16(88.9)	2(11.1)	18(100)	7.146	0.002
Secondary	72(88.9)	9(11.1)	81(100)		
Tertiary	68(73.9)	24(26.1)	92(100)		
No of children					
1-2	73(81.1)	17(18.9)	90(100)	0.249	0.883
3-4	77(82.8)	16(17.2)	93(100)		
5-6	7(87.5)	1(12.5)	8(100)		

Table 7 shows the relationship between perception of women towards female condom and socio demographics, only education shows significant relationship with female condom use ($p<0.001$).

Table 7: Association between perception of women towards female condom and socio demographic characteristics

Variable	Perception of women towards female condom		Total	X^2	P-value
Age group	Poor	Good			
<25	9(47.4)	10(52.6)	19(100)	2.420	0.298
25-34	63(60.0)	42(40.0)	105(100)		
≥35	34(49.3)	35(50.7)	69(100)		
Ethnicity					
Yoruba	103(55.1)	84(44.9)	187(100)	0.061	0.806
Igbo	3(50.0)	3(50.0)	6(100)		
Religion					
Islam	49(62.8)	29(37.2)	78(100)	0.949	0.330
Christianity	54(48.6)	57(51.4)	111(100)		
Occupation					
Civil servant	8(36.4)	14(63.6)	22(100)	5.856	0.210
Teacher	13(52.0)	12(48.0)	25(100)		
Self employed	24(68.6)	11(31.4)	35(100)		
Trader	45(54.9)	37(45.1)	82(100)		
Others	14(51.9)	13(48.1)	27(100)		
Education status					
Primary	14(77.8)	4(22.2)	18(100)	17.529	<0.001
Secondary	54(66.7)	27(33.3)	81(100)		
Tertiary	36(39.1)	56(60.9)	92(100)		
No of children					
1-2	47(52.2)	43(47.8)	90(100)	1.605	0.448
3-4	52(55.9)	41(44.1)	93(100)		
5-6	6(75.0)	2(25.0)	8(100)		

Relationship between ever use of female condom and attitude of women towards female condom is presented in table 8. On the cross tabulation, attitude showed a significant relationship with ever use of female condom ($p<0.001$).

Table 8: Ever use of female condom and attitude of women towards female condom

Variables	Ever use of female condom		Total	x^2	P-value
Attitude	No n (%)	Yes n (%)			
Poor	125(97.7)	3(2.3)	128(100)	63.835	<0.001
Good	33(50.8)	32(49.2)	65(100)		

Table 9 shows cross tabulation of female condom use and perception of married women. A significant relationship was found between perception of married and female condom use ($p<0.001$).

Table 9: perception of married women and female condom use

Variable	Female condom use		Total	X^2	p-value
Perception	No n (%)	Yes n (%)	N (%)		
Poor	99(93.4)	7(6.6)	106(100)	21.060	<0.001
Good	59(67.8)	28(32.2)	87(100)		

The logistic regression showed on table 10, perception of married women showed significant relationship with use of female condom among married women (OR: 6.71; 95% CI 2.76-16.32). Secondary education was not significantly related with female condom (OR: 1.00; 95% CI 0.20-5.08).Similarly, tertiary education showed an insignificant relationship with use of female condom (OR: 2.82; 95% CI 0.60-13.20).

Table 10: Logistic regression of female condom use on perception and education of women towards female condom use

Variable	Odd ratio (OR)	95% CI for OR	P-value
Perception			
Poor	1		
Good	6.71	2.76-16.32	<0.001
Education			
Primary	1		
Secondary	1.00	0.20-5.08	1.000
Tertiary	2.82	0.60-13.20	0.187

CHAPTER FIVE

5.0 DISCUSSION

This study explores the awareness, attitude, perception, and factors affecting the use of female condom among married women.

This study shows the distribution of women age 15-49 years. Almost (93.3%) of the women are currently married. The ethnic composition of the sample indicates that majority (96.9%) of the respondents were Yoruba and is one of the ethnic groups in Nigeria. This is similar to observation of National Population Census (2006), indicates that majority of dwellers who live in Ibadan are Yoruba.

Almost (99.5%) respondents attended school which Provide an overview of the relationship between women level of education and use of female condom, this study revealed women that attend tertiary education (47.7%) were more likely to use female condom than those who attend other form of education. This is align with a study carried out by Olunike et al, 2010.Her study found that user of female condoms were more likely to have a higher education compare to non users who do not attend school.

On awareness, more than half (67.8%) of the respondents have heard about female condom. This is in line with a study conducted by Okunola (2010) which shows that over 80% women had awareness of female condom as a form of modern contraceptive and majority of them learnt about it through the mass media and family planning clinics. However, this is contrast with NARHS (2007) finding which gives the awareness of female condom use to be 13.0% and NDHS 2008 report to be 14.7%

Most 69.4% of the respondents would not recommend female condoms to other women, because they have never used or seen a female condom (27.8%), and (60.1%) of Women said it was not favorable to use female condom because their husbands do not allow them to use it when they discuss it with their husbands. This study agrees with UNFPA 2005 survey which revealed that attitude of women towards the use of female condom depends on reaction of the women's regular partner or husband. At the same time, some women cited that their partner's lack of acceptance on female condom use was the reason for discontinuous use of the method.

However, the fact that many respondents have not use female condom, most of the female condom users are face with problems related to attitude of partners (Greener et al 2002). Women find it difficult to negotiate female condom use with the husband because of cultural norms, men acceptance as decision makers in key family issues which hinder women attitude and usage, shows negative attitude towards female condom use (Marth et al, 2010).

The study revealed that prevalence of female condom use is 18.1%, which is slightly higher than a study by Okunola (2010), which revealed that only 11.3% of married women had ever used a female condom. This is contrast to the report by NDHS 2008 which gives prevalence of female condom at 0.2 percent. These maybe as a result of respondents being married women who have previously attended family planning clinic were given a female condom free of charge.

False rumors, myths and reputations about female condom are quite common and widespread among the study population. Similarly there are indications that female condom is faced with an image problem. Less than tenth (8.2%) respondents said female Condom makes noise when they use it and 6.7% said it slipped out during sexual intercourse. This is in accordance with short term acceptability study on prevalence of female condom use among women. It was revealed that a proportion of users find it difficult to insert female condom, and 35-50% feel discomfort during sexual intercourse has been associated with less consistent use of female condom (UN 2001). In contrast, across the world however, concerns exist primarily among men, about whether female condom reduces the sensation and enjoyment of sex and affect sexual performance

Many people also expressed their distrust for Female condom with sayings like, "sex with condom is like eating candy with its cover"; "sex with female condom is like wearing blanket in a hot day"," Sex with Female Condom is equivalent to not having intercourse at all".

The recognition given to female condom as a widely accepted mode for control of HIV/AID (33.2%), STIs (34.0%) and unplanned pregnancies (30.4%), by the study participants, revealed that women can be empowered through the use of female condom.

This is in line with a UNAIDS 1997 exploratory qualitative investigation in 4 countries which included South Africa, Brazil, Ghana, Zimbabwe, explained the role of women ~~empowerment~~ to use female condom, to protect their reproductive health ,make decision and negotiate protection with husband. They further summarize that female condom will be most successful in enhancing sexual communication among couples who uses female condom for protection (Kathmandu et al 2002).On contrast WHO/UNAIDS 1997, encourage the introduction of female condom as a method of preventing unplanned pregnancies and infection as an additional tool in respond to the needs of women sexual and reproductive health. This perceived a positive perception toward female condom use.

5.1 CONCLUSION

The study revealed that nearly a third of the respondents in the study, indicated that husband influence and cultural norm are reason for discontinues use of female. This together with the widespread rumors and inadequacy of information about female condom have resulted in serious imposition on the use of female condom for the prevention of HIV/AIDS (as observed from the low awareness of female condom use among the study population), People's perception about the effectiveness of female condom in preventing HIV infection has been found to be diverse. Most people believe that if properly used female condom is effective in protecting from HIV infection. Contrary to this, a considerable proportion of people particularly those that were involved in the qualitative study present convincing argument for doubting the effectiveness of female condom like: problems in properly wearing female condoms, tear and breakage of condom during use. Similarly, the survey result indicated that only a third of those who attended health education session about female condoms came across with information on how to use female condoms. This is a clear indication on how lack of awareness about female condoms affects people perception and its utilization.

5.2 RECOMMENDATION

The findings of the study have evidently shown that there is low awareness and utilization of female condom. The following programmatic actions are recommended with respect to the finding of the study;

Government and donors should scale up cost, budget, policy and programmatic actions promoting gender equality in the national response to HIV/AIDS. This include to support the empowerment of women and sexual minorities and to increase their ability to negotiate female condom use.

Religious leaders should promote a more comprehensive prevention approach that include the right to people to access complete ,accurate evidence base information about HIV prevention including sexuality and life skills educations on female condom use.

There is need to maximize the level of awareness of female condom use among the rural women and those with low level of education about HIV/AIDS, sexually transmitted infections

REFERENCES

Adeokun, L. Mantell, J.E., Weiss,E., Delan o, E.G & Jagha, T. (2002). Promoting dual protection in family plaining clinic in Ibadan Nigerian. *Int. family planning perspective.* 28(2): 87-95.

Alan Gutmacher Institue (AGI) and the campaign against unwanted pregnancy (CAUP),(2002-2003),Community –based survey.

Alarape , A.I,Olapegba,P.O & Chovwen,C.O.(2008). Condom use among student :The influence of condom self –efficacy, social norms and affective attitude towards condom. *J.C. social science*: 17(3):237-241

Anne Philpott (2006). Promoting protection and pleasure: amplifying the effectiveness of barriers against sexually transmitted infections and pregnancy, *The Lancet* 368(27).

Andrzeji, K., (2004). Socio-cultural context of condom usewithin marriage in Rural Lebanon. *Stud. Family Plan.* 35(4): 246-260.

Association de lutte contre le SIDA (ALCS), Monitoring the Implementation of the UNGASS Declaration of Commitment (2006)

Asociación Atlacatl Vivo Positivo, *Monitoring the Implementation of the UNGASS Declaration of Commitment*: El Salvador Country report (2006)

Bauni, E.K. and J. Obonyo, 2003. The low acceptability and use of condoms within marriage. *Afr. Popul.Stud.*, 18(1): 51-65.

Condon use in Nigeria; Iyaji Ajeoh and Ogbuke Martha Uchenna.Department of sociology-Kogi State Nigeria. Country Report (2005)

Christopher Murray and Alan Lopez, eds ,Health Dimension of sex and reproduction vol.3,Global burden of Disease. Boston Harvard University Press,(1998):280.

Carl Haub and Britt Herstand, family planning worldwide 2002 Data sheet (Washington Dc population reference Bureau, 2002).

Country Report (2006) [hereinafter El Salvador UNGASS Report]

Deanna Kerrigan, et al., Environmental-Structural Interventions to Reduce HIV/STI Risk Among Female Sex Workers in the Dominican Republic, 96 *American Journal of Public Health* (2006)

Deliege .D. (2003). A new female condom, women's opinion. *Archivesof public Health* 61:249-269.

Engender Health,(2002). Contraceptive Sterilization:Global Issues and Trends. Engender Health, New York.

El Salvador UNGASS Report. For example, 48 Fest, an initiative of the Staying Alive Foundation (http://eu.staying- alive.org/48fest/index.html).

Global Campaign for Microbicides, Addressing Questions and Common Misperceptions about Microbicide Clinical Trials (FactSheet #18) (undated)

Gardener, G., D.B. Richard and D.U. Ushma, (1999) .Closing the Condom Gap. Population reports, SeriesH, Number 9 Baltimore: Population Information Program, John Hopkins University school of Public Health.

Green, E., (2001). The Impact of Religious Organization in Promoting HIV/AIDS Prevention. Christian Connections for International Health Forum, 11: 2-5.

Hoke,TheresaHatzell,P.Feldblum,K.VanDamme,M.D.Nasution,T.W.Grey,E.L.Wong,LRalimanonjy,L.Ramharimala and A.Rasamindrakotroka. (2007) Temporal trends in sexually transmitted diseases prevalence and condom use following introduction of the female condom in Madagagascar sex workers *international Journal of STD& AIDS* 18.461-466.

Human Rights Watch, Access to condoms and HIV/AIDS information: A Global health and human rights concern (2004).

Hillier, L.L.H. and D. Warr, (1998). When you carry Condoms all the Boys think you want it: Negotiating Competitive Discourses about Safe Sex. J. Adolesc.,21(1): 15-29.

ICASO, A Call for Political Leadership: Community Sector Recommendations for the UN Political Declaration on HIV/AIDS (2006)

International HIV/AIDS Alliance and Reproductive Health Matters, Emerging Issues: Condom policy and programming, (2006).

Jamaican AIDS Support (JAS) Monitoring the Implementation of the UNGASS Declaration of Commitment: Jamaica Country Report (2005) [hereinafter Jamaica UNGASS Report]

JOHN. A.ROSS AND William L.Winfrey (2002),`Umet need' for contraceptive in the developing World and The formal Soviet union, An update estimate`International family planning perspective 28,No .3.

Knodel, J. and P. Anthony, 1996. Prospects for IncreasedCondom use within Marriage in Thailand. Int. Family Plan. Perspective., 5(3): 97-102.

L O Omo-Aghoja,[1] V W Omo-Aghoja,[2] C O Aghoja,[3] F E Okonofua,[4] O Aghedo,[5] C Umueri,[6] R Otayohwo,[7] P Feyi-Waboso,[8] E A Onowhakpor,[1] and K A Inikori[9]

Department of Obstetrics and Gynaecology, College of Health Sciences, Delta State University, Abraka, Nigeria

Department of Oral and Maxillofacial Surgery, University of Benin Teaching Hospital, Benin

Corresponding Author: Dr. Lawrence Omo-Aghoja E mail: eguono_2000@yahoo.com , Email: losuakpor@gmail.com

Morocco Country Report (2005) [hereinafter Morocco UNGASS Report]

Mitsuynaga T M.Larse UM and Okonofua F.E (2005). Risk factors for complication of induced abortions in Nigeria, *Journal of women's health*, 14(16):515-528.

Monjok, E, smesny, A ; Ekabua, E.J & Essien E.J. (2010). Contraceptive practices in Nigerian ; Literative review and recommendation for future policy decision, Open access *journal of contraception* (1); 9-22

Mellors, S. Monitoring the Implementation of the UNGASS Declaration of Commitment: South Africa country report (2005).

Mantell JE et al., Introducing the female condom through the public health sector: experiences from South Africa, *AIDS Care,* 2000, 12(5):589-601.

Mantell JE and Weiss E, Dual protection against unwanted pregnancy and HIV/STDs, *Sexual Health Exchange,* 1999, No. 3, p. 8; and Mantell JE, Weiss E and Scheepers E, The female-initiated protection paradigm: promoting dual protection within family planning services, unpublished manuscript, 1997.

Miller R et al., *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services,* New York: Population Council, 1997

National Population Commission, *Nigeria Demographic and Health Survey 1999,* Calverton, MD, USA: ORC/Macro, 2000.

Nigeria UNGASS Report by Singo and Abanihe (1994)

National HIV/AID and reproductive Health Survey. NARHS.(2007).

National demographic and health survey NDHS,(2007).

Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), Monitoring the Implementation of the UNGASS Declaration of Commitment: Nigeria Country Report (2005) [hereinafter Nigeria UNGASS Report]

NAZ Foundation International, The impact of social, legal and judicial impediments to sexual health promotion, and HIV and AIDS related care and support for males who have sex with males in Bangladesh and India (2005)

Olúnike, A; Aboderin, M & Otegbeye, T.(2010).for sexual pleasure, Nigeria women snub female condom. Retrieved from http .//.www.online Nigeria.com. Accessed on 8/12/2010.

Oye-Adenira BA.et al (2005), Community based survey of unwanted pregnancy in southwestern, *African Journal of reproductive health*,(1(;133-141

Q.f.odumoşu ,A.Ajala.E.Nelson –Twąkor.& s.k Alonge.(1999). Unmet need for contraception among married man in urban Nigeria, Nigeria institute of social and economic research (niser) Ibadan,Nigeria.

Population Action International, Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card (2002)

PITA Foundation, Monitoring the Implementation of the UNGASS Declaration of Commitment: Indonesia Country Report (2006)

Sexually transmitted diseases in A.O.Osoba (1995). DSSepartment of medical microbiology unverisity college hospital lbadan Nigeria

UNAIDS, Practical Guidelines for Intensifying HIV prevention (2006)

Unmet need for family planning; Recent trends and their Implications for program (2003) population bureau, Lori Ashford.

United nations (1995), Maine (1981), Omran (1984); The ICPD program of action draws attention to survey evidence indicating that some 120 million (MWRA),married women of reproductive age.

United nation population fund (2005).

Westoff and Ocha (1991), reproduced in World Population profile (1994)

World Health Organization review for clinical trail (2011)

World Health Organization and UNAIDS; Joint Surveillance Report. November (1998).

Questionnaire

Dear respondents,

I am a postgraduate student in the department of epidemiology, Medical Statistics and Environmental Health (EMSEH), University of Ibadan, conducting a research on the perception and attitude towards utilization of female condom among married women age of 15-49 years in Ibadan North Local Government Area, Oyo State. Please respond correctly to the best of your knowledge and with all sincerity to this questionnaire, your name is not needed to assure you of our unshakable confidentiality. Thanks for dedicating your time and granting us audience.

Serial Number .....

Name of Health Facility .....

Section A: Socio demographic characteristics

1. What is your age? .....
2. What is your ethnicity? .....
3. What is your Marital Status? 1. Currently Married 2. Living with Sexual partner 3. Separated 4. Divorced 5. No response
4. How long have been living continuously in this city/town/village? .....
5. What is your religion? 1. Islam 2. Protestant 3. Catholic 4. Traditional 5. No religion
6. What is your occupation i.e. what kind of work do you do? .....
7. Have you ever attended school? 1. Yes 2. No
8. What is the highest level of school you attended? 1. Quaranic 2. Primary 3. Secondary 4. Tertiary

9. How many children do you have? .....

10. How many children do you intend having in your whole life? .....

Section B: AWARENESS, PERCEPTION, ATTITUDE AND UTILIZATION OF FEMALE CONDOM

11. Have you ever heard of female condom before? 1. Yes 2. No

12. Have you ever seen a female condom before? 1. Yes 2. No

13 If yes, please describe what it looks like? .....

14. Have you ever used a female condom before ? 1. Yes 2. No

Please tick if you agree or disagree with the following.

	Strongly agree	Agreed	Uncertain	Disagree	Strongly disagree
	1	2	3	4	5
15. Female condom protects against unplanned pregnancies					
16. Female condom protects against HIV/AIDS					
17. Female condom protects against STI					
18. Female condom is easy to use					
19. Female condom is easily available And accessible					
20. Female condom is cheaper than Other FP method					
21. Female condom reduces sexual pleasure					
22. There are side effects when using female condom					

23. Female condom empower women To negotiate safer sex with their Husband					
24. It is easier to negotiate female condom use with Husband					
25. Women should use female condom when they suspect infidelity with their husbands?					
26. Women should say no if their husband want to use force to have sex with them?					
27. Female condom is a barrier method which married women use to control and makes then plan their family better.					
28. It is possible to use a female condom without your husband knowing					

If you ever used female condom before, please tell me your experience when last you used it

29. If felt good					
30. It made noise					
31. it slipped out					
32. It pained me when I was using it					
33. Others specify					

34. When discussing female condom with your partner, would you say it is .....

1. Favorable 2. Not favorable

35. Would you recommend female condom to other married women?

1. Yes 2. No

36. What is your reason for recommending female condom to other married women?

.....

35. Would you recommend female condom to other married women?

1. Yes 2. No

36. What is your reason for recommending female condom to other married women?

.....