

ATTITUDES TOWARDS FEMALE CONDOM USAGE AMONG ADULT FEMALE IN IMO STATE UNIVERSITY, OWERRI, NIGERIA

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Abstract. The study was to determine the attitude of female condom among adults' female in Imo State University, Owerri, using cross-sectional form of descriptive survey research design. 180 copies of questionnaire returned out of 200 copies were analyzed using descriptive statistic of frequency count, normative percentage and grand mean; as well as inferential statistics of chi-square (χ^2). The level of significant was fixed at ≤ 0.05 . Appropriate degrees of freedom were worked out. Result from the research shows that attitude towards FC shows that 77.8% of respondents responded yes in different variable as shown above while 22.2% respondents responded no, when subjected to chi-square analysis. The calculated $\chi^2=2901.4$ is greater than the tabulated 9.488, indicating that significant number of respondents had good attitude toward FC. Research has shown that the concept of female condom use among women is very poor but some of the respondent's have taking positive measures to ensure they remain safe by ensuring the use of male condom even if they would not use female condom. The will power among women in FC use is weak, this could be cultural eliminated by the help of society and men especially. The psychosexual factors were female empowerment, more options for contraception and disease prevention, discomfort with vaginal insertion, and condom use norms. The interpersonal factors included: enhanced communication, relationship status, partner preferences, and partner objections.

Keywords: *female condom, attitude, adult female, Imo State*

Introduction

A female condom (FC) (also known as a femidom) is a device that is used during sexual intercourse as a barrier contraceptive to reduce the risk of sexually transmitted infections (STIs-such as gonorrhea, syphilis, and HIV, though its protection against them is inferior to that by male condoms)(Trussell, 2011) and unintended pregnancy. FC was invented by Hessel (1992), it is worn internally by the female partner and provides a physical barrier to prevent exposure to ejaculated semen or other body fluids. Female condoms can be used by the receptive partner during anal sex. The female condom is a thin, soft, loose-fitting sheath with a flexible ring at each end. They typically come in various sizes. For most vaginas, a moderately sized condom is adequate; women who have recently given birth should try a large size first. The FC2 female condom is a nitrile sheath or pouch 17 cm (6.7 in) in length. At each end there is a flexible ring. At the closed end 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.

This ring acts as a guide during penetration and stops the sheath from shifting during intercourse. There is a silicone-based lubricant on the inside of the condom, but additional lubrication can be used. The condom does not contain spermicide. The inner ring at the closed end of the sheath is used to insert the condom inside the vagina and to hold it in place during intercourse. The rolled outer ring at the open end of the sheath remains outside the vagina and covers part of the external genitalia. The (FC1) female condom was first made from polyurethane. The second generation female condom is called the FC2 and is made from synthetic nitrile (Trussell, 2011) (this material change was announced in September 2005, and full transition of the product line to FC2 was done by October 2009). The newer nitrile condoms are less likely to make potentially distracting crinkling noises. FC2 was developed to take the place of FC1, providing the same safety and efficacy during use, but at a lower cost. It is hoped the nitrile condoms will also allow for significant reductions in female condom pricing. FC2 is manufactured by The Female Health Company. The World Health Organization (WHO) has cleared FC2 for purchase by U.N. agencies and the UNFPA (a U.N. agency) has incorporated the female condom into national programming (UNPFA, 2006).

They are sold under many brand names, including *Reality*, *Femidom*, *Dominique*, *Femy*, *Myfemy*, *Protectiv* and *Care*. The original version of the FC female condom (brand names included *Reality*, *Femy* and *Femidom*), was made of polyurethane. As this was a relatively expensive material, the makers of the FC female condom released the FC2 version made of the cheaper nitrile material. Large-scale production of the FC2 began in 2007. The condom was approved by the FDA in March 2009. Production of the original FC condom has now stopped. A recent version of the female condom is made from natural latex, the same material used in male condoms. This condom does not make the noises some experience with plastic condoms. This type of female condom is manufactured by Medtech Products Ltd, India. It is sold under various brand names, including *Reddy*, *V Amour*, *L'amour*, *VA WOW Feminine condom*, and *Sutra*. One more clinical trial is required before it can be considered for FDA approval in the United States. The global health nonprofit Program for Appropriate Technology in Health (PATH) has also developed a female condom tailored for use in developing countries. The Woman's Condom is manufactured by Shanghai Dahua Medical Apparatus in China and is in early introduction. Research suggests that the FC2 female condoms are a cost-effective method of HIV prevention even at low levels of use. The literature has shown that the cost-effectiveness would increase significantly at higher levels of use.

A study conducted by Dowdy et al. (2006), Chair of the Department of Health, Behavior and Society at Johns Hopkins University's Bloomberg School of Public Health, examined the projected public health impact that the FC2 female condom would have at different levels of use in two developing countries: South Africa and Brazil. The study concluded that FC2 use would generate significant cost savings at all levels of implementation by preventing thousands of HIV infections and saving millions of dollars in health care costs. FC2 Female Condom gives women control and choice over their own sexual health; women can protect themselves (responsibility of preventing STIs) when their partner does not want to use a male condom; female condoms may provide enhanced sensation for men as compared to male condoms (Sadaty, 2020). FC2 is hypo allergenic and is safe to use with people who are allergic to rubber latex; FC2 may be inserted hours before intercourse; female condoms are not dependent on the

penis being erect for insertion and does not require immediate withdrawal after ejaculation; FC2 is not tight or constricting; FC2 is highly lubricated and the material warms to body temperature (PATH, 2005), they are easy to access (relative to methods requiring a visit to a medical provider) and can be purchased in drugstores and some supermarkets, they can be purchased without a prescription, they may enhance sex and sexual play for both partners - the condom's external ring may stimulate the clitoris and/or penis during vaginal intercourse, they are not dependent on a male partner to maintain his erection in order to stay in place, female condoms as a family planning tool has the above advantage over other methods of birth control (McIntyre, 1998). The external genitals of the wearer and the base of the penis of the inserting partner may be more protected (from skin-to-skin transmitted STDs such as herpes and HPV) than when the male condom is used. Some disadvantages to the female condom include: it may cause irritation of the genital area in people of both sexes (including irritation of the vagina, vulva, penis, or anus). It may slip into the vagina or anus during vaginal intercourse or anal intercourse, it may reduce sensation during intercourse.

Objective of the study

The main purpose of the study was to determine the knowledge and attitude of female condom among adults female in Imo State University, Owerri. In specific terms, the objectives of the study include; (1) to determine the level of attitude toward female condom exhibited adults in Imo State University, Owerri; and (2) to determine the influence of age and marital status on the attitude on female condom characterized by adults female in Imo State University, Owerri.

Significance of the study

Results of the study would reveal level of knowledge and attitudes of adult female toward female condom. Specifically, result of the study would be significant to adults (male /female), Public health officers, health counselors, health educators, curriculum planners, medical personnel (clinician, nurses, pharmacist and clinical laboratory scientist) and researchers in assessing levels of knowledge and attitude of respondents about female condoms. The Center for Health and Gender Equity's Prevention Now! Campaign promotes the use of male and female condoms as a means of preventing the spread of HIV/AIDS; reducing instances of unintended pregnancy, unsafe abortion, and other unsafe outcomes of unprotected sexual intercourse; promote the sexual and reproductive health and rights of all persons; and expand choices for those living with HIV/AIDS. Results of the study would motivate public health workers toward identifying gap and palliative measure to promote the use of female condom in this locality. Health counselors would through the results of the study develops and adapts effective client counseling method on the best healthy sex life style to adopt. Health educators, curriculum planners and researchers would be able to identify gaps in knowledge that can aid in the development of health education and health promotion concepts that can be utilized in the community to address the deficiencies. These would increase the knowledge of the public locally about female condom.

Research questions

The following research questions gave direction to the study; (1) What is the influence of marital status on the attitude of female condom exhibited by adults female

in Imo State University, Owerri? (2) What is the influence of age on the attitude toward female condom exhibited by adult's female in Imo State University, Owerri? (3) What is the level of attitude toward female condom exhibited by of adults' female in Owerri metropolis?

Hypothesis

The following null hypotheses were postulated for the study: (1) There is no significant difference among adults female of various marital status in Imo State University, Owerri on their attitude of female condom. (2) There is no significant among different age group of female adults on their level of their attitudes toward female condom. (3) There is no significant difference on the level of attitude on female condom exhibited by adults' female in Imo State University, Owerri.

Scope of the study

The study was delimited to the level of attitude on female condom among adults' female (18-70years) in Imo State University, Owerri. It was delimited to independent variables of ages, levels of education and occupational status. It was further delimited to adults (18-70years) in Owerri. It involved young adult age (18-40), middle adult (41-65) and older adult above 65years. It was delimited to the use of structured interview guide as the main instrument for data collection. Finally it was delimited to the use of descriptive statistic of frequency and percentage as well as inferential statistic of chi square at 0.05 level of significant for data analysis.

Materials and Methods

A cross-sectional form of descriptive survey research design was used for this study. This is because descriptive studies are used when the characteristics of a population are either unknown or partially known (Hennekens et al., 1987), this justified the use of similar design in a study of similar nature.

Study area

Imo State was created on February 3, 1976 out of the old East Central State by the then regime of General Murtala Mohammed. Abia State was carved out of Imo State in the state creation exercise of 1991. It has Owerri as its capital and largest city. Other major towns are Okigwe, Oguta, Nkwere, Orlu, Mbaise, Mbano, Mbieri, Ideato, Awo-Idemili, Ohaji, Obowo, Ngor-Okpuala, Uzoagba, Emekuku, Orodio, Mgbidi. Situated in south eastern Nigeria, Imo State covers an area of 5,530 square kilometres. Imo State last known population is 715800 (year 2015). This was 0.393% of total Nigeria population. If population growth rate would be same as in period 2006-2015 (+16.04%/year), Owerri population in 2016 would be 830 613 Imo State shares boundaries with Enugu and Ebonyi States to the north, Anambra State to the west, Rivers State to the south and in the North and Rivers State to the South, Cross River and Akwa Ibom States to the east. The inhabitants of Imo State are Igbo. The official language of the state is Igbo alongside English. Imo State has a rich cultural heritage. Imo State derives its name from Imo River, which takes its course from the Okigwe/Awka upland. It lies within latitudes 4°45'N and 7°15'N, and longitude 6°50'E and 7°25'E. The vegetation is tropical rain forest. Imo State indigenes are predominantly Christians of different

denominations, but mostly Catholicism. Some people in the state still practice traditional religions. The State is blessed with abundant natural resources. These include crude oil, lead, zinc, white clay, fine sand, limestone and natural gas in commercial quantities. The state also produces agricultural produce such as palm produce, cocoa and rubber. The main staple crops are yam, cassava, cocoyam and maize. There are many traditional festivals observed in the State. Each community has different festivals celebrated in honor of ancient deities or to mark an important event in the history of the area.

Sample, sampling techniques and data collection

The accessible population of the study consisted of an estimated two thousand (2,000) adults (female) (18-70 years) adults in Imo state university. The sample for the study consisted of 200 (two hundred) adults' females randomly drawn areas in Owerri metropolis. Ten percentage (10%) of the accessible population was used as sample size, Fernandez et al. (2006) opined that if the population is in few thousand 10% will be appropriate as the sample size. The main instrument for data collection consisted of structured questionnaire. The structured questionnaire was in three sections A and B. Section A, was made up of three questions on demographic data (age, sex and marital status). Section B, contained thirteen (5) questions on the knowledge of attitudes on female condom (FC) hypertension. All the five (5) questions were closed ended. Data collected were analyzed using descriptive statistic of frequency count, normative percentage and grand mean; as well as inferential statistics of chi-square (χ^2). The level of significant was fixed at 0.05. Appropriate degrees of freedom were worked out

Validity and reliability of the instrument

The draft of the structured questionnaire was approved by the research supervisor and validated by three lecturers in Department of Public Health of Imo State University, Owerri. The validators were requested to examine the content of the instrument in line with the objectives of the study to ascertain clarity and ability to elicit appropriate responses for the study. Modifications were made following validators comments. Split-half method was used in establishing the reliability of the instrument. Twenty (20) copies of the instrument were distributed once to twenty adults in Aladimma area in Owerri metropolis. A result of the single administration was divided into two equal halves using odd and even numbers. Cronbach alpha correlation co-efficient will be used in ascertaining the correlation co-efficient. Using cronbach alpha correlation 0.91 was obtained. This showed a high positive correlation and thus regarded as reliable as shown.

Results and Discussion

The 180 questionnaire returned out of 200 questionnaire were analyzed using descriptive statistic of frequency count, normative percentage and grand mean; as well as inferential statistics of chi-square (χ^2). The level of significant was fixed at 0.05. Appropriate degrees of freedom were worked out. The *Table 1* shows the distribution of respondents based on the respondents, which shows that married without another sex partner is 112 (62.2%) respondents, married with other sex partner are 5 (2.8%)

respondents, single without sex partner with 23 (12.8%) respondents and single with one or more sex partner are 40 (22.2%) respondents.

Table 1. Distribution of respondents on the bases of marital status.

Category	Total number of frequency	Percentage
Married without another sex partner	112	62.2
Married with other sexual partner	5	2.8
Single without sex partner	23	12.8
Single with one or more sex partner	40	22.2
Total	180	100

Table 2 shows the attitude toward FC based on marital status of the respondents. On FC been used for family planning among the respondents across married without another sex partner (97.3% or 109 respondents), married with another sex partner (100% or 5 respondents), single without sex partner (87% or 20 respondents) and single with one or more sex partner respondents (62.5% or 25 respondents), respectively. On FC preventing unwanted pregnancy among the respondents across married without another sex partner are 96.4% (108 respondents), married with another sex partner are 100% (5 respondents), single without sex partner are 91.3% (21 respondents) and single with one or more sex partner respondents are 32.5% (13 respondents), respectively. Whether FC use prevent HIV transmission the respondents across married without another sex partner are 80.4% (90 respondents), married with another sex partner are 100% (5 respondents), single without sex partner are 65.2% (15 respondents) and single with one or more sex partner respondents are 70% (30 respondents), respectively.

Table 2. The attitudes on FC based on their marital status.

Marital status	Married without another sex partner N (%)		Married with another sex partner N (%)		Single without sex partner N (%)		Single with one or more sex partner N (%)		Total
	Y	N	Y	N	Y	N	Y	N	
Do you know FC can be used for family planning?	109 (97.3)	3 (12.7)	5 (100)	0 (0)	20 (87)	3 (13)	25 (62.5)	15 (37.5)	180 (100)
Do you know that used of FC continuously can prevent unwanted pregnant.	108 (98.4)	4 (1.6)	5 (100)	0 (0)	21 (91.3)	2 (8.7)	13 (32.5)	27 (66.5)	180 (100)
Do you know that FC use can prevent HIV transmission?	90 (80.4)	22 (19.6)	5 (100)	0 (0)	15 (63.2)	8 (26.8)	30 (75)	10 (25)	180 (100)
Do you know that FC can prevent sexually transmitted disease (STD)?	100 (89.3)	12 (10.7)	5 (100)	0 (0)	23 (100)	0 (0)	40 (100)	0 (0)	180 (100)
Do you know that FC does not cause any form of pain or disease when used during sex.	50 (44.6)	62 (55.4)	5 (100)	0 (0)	1 (4.3)	22 (95.7)	35 (87.5)	5 (12.5)	180 (100)

Notes: $\chi^2=2729.2$, $\chi^2 0.05=19.675$ at $df=11$, $p<0.05$

On FC use prevent STD in the respondents across married without another sex partner are 100 respondents (89.3%), married with another sex partner are 5 respondents (100%), single without sex partner are 23 respondents (100%) and single with one or more sex partner respondents are 40 respondents (100%), respectively. When asked if FC use does not causes pain or disease during sex, the respondents across married without another sex partner are 50 respondents (44.5%), married with another sex partner are 5 respondents (100%), single without sex partner are 1 respondent (4.3%)

and single with one or more sex partner respondents are 35 respondents (87.5%), respectively. When subjected to chi-square, the calculated 2729.2 was greater than the tabulated 19.675, indicating that there is significant good attitude toward FC by respondents.

The *Table 3* shows the frequency of respondents in different age group. In age 18-25 years had 60 respondents (33.3%), 26-35 years had 56 respondents (31.1%), 36-45 years had 40 respondents (22.2%) and finally 46 years and above had 24 respondents (13.3%).

Table 3. Distribution of respondents based on their age group.

Age group (years)	Number of respondents in frequency	Percentage
18-25	60	38.3
26-35	56	31.1
36-45	40	22.2
46 and above	24	13.3
Total	180	100

The attitudes toward FC across different group variables are shown in *Table 4*. On FC been used for family planning among 18-25 years respondents are 50 (83%) of them said yes, among 26-35 years respondents are 47 (83.4%) responded yes, in 36-45 years respondents are 29 (72.9%) said yes while among 46 years and above respondents are 21 (87.5%) said yes. On FC preventing unwanted pregnancy among 18-25 years respondents are 60 (100%), among 26-35 years respondents are 49 with 87.5%, in 36-45 years respondents are 32 with 80.0%, and lastly among 46 years and above respondents have 24 or 100%. Whether FC use prevents HIV transmission in 18-25 years respondents are 51 with 85.0%, among 26-35 years respondents are 45 with 80.4%, in 36-45 years respondents are 30 with 75%, and lastly among 46 years and above respondents are 15 with 62.5%. On FC use prevent STD in 18-25 years respondents are 97 (95%) of them said yes, among 26-35 years respondents are 54 (96.4 %) responded yes, in 36-45 years respondents are 37 (92.5%) said yes, and lastly among 46 years and above respondents are 15 (62.5%) said yes. When asked if FC use does not causes pain or disease during sex among 18-25 years respondents are 37 with 61.7% of them said yes, among 26-35 years respondents are 31 with 55.4% responded yes, and lastly among 46 years and above respondents are 14 with 58.3% said yes. When subjected to chi-square, the calculated 2827.4 was greater than the tabulated 19.675, indicating that there is significant good attitude toward FC by respondents.

Table 4. The attitudes on FC based on the different age group.

Age group	18-25		26-35		36-45		46 and above		Total
	Y	N	Y	N	Y	N	Y	N	
Do you know FC can be used for family planning?	50 (83)	10 (17)	47 (83.4)	9 (16.6)	29 (72.5)	11 (36.5)	21 (87.5)	3 (22.5)	180 (100)
Do you know that used of FC continuously can prevent	60 (100)	0 (0)	49 (87.5)	7 (32.5)	32 (80)	8 (20)	24 (100)	0 (0)	180 (100)

unwanted pregnant.									
Do you know that FC use can prevent HIV transmission?	51 (85.5)	9 (24.5)	45 (80.4)	11 (19.6)	30 (92.5)	10 (17.5)	15 (62.5)	9 (37.5)	180 (100)
Do you know that FC can prevent sexually transmitted disease (STD)?	57 (95)	3 (5)	54 (96.4)	2 (13.6)	37 (92.5)	3 (7.5)	15 (62.5)	9 (37.5)	180 (100)
Do you know that FC does not cause any form of pain or disease when used during sex.	37 (61.7)	23 (38.3)	31 (55.4)	25 (44.6)	0 (0)	40 (100)	14 (58.2)	8 (41.7)	180 (100)

Notes: $\chi^2=2827.06$, $\chi^2_{0.05}=19.675$ at $df=11$, $p<0.05$

In a similar research conducted by Fernandez et al. (2008), indicated that assessing the acceptability of the female condom in a sample of young heterosexual Spanish couples. The sample was made up of 45 couples (90 participants) from Spain. The age range was from 19 to 42 years. The study was carried out in the three stages: pre-trial, post-trial, and follow-up (one year later). Before the intervention, 88 participants (97.8%) had heard about the female condom, although 73 participants (81.2%) claimed to know very little about the method, and barely one third had seen one. The appraisals after the trial period reveal differing levels of satisfaction with the method, with no significant differences found by gender. Those participants who used a greater number of condoms during the trial period pointed out more positive points about the method, but also more negative points. Of the 17 couples who continued to participate in the follow-up stage (one year after the trial stage), only one (5.9%) still used the female condom. However, 10 men (58.8%) and 8 women (47.1%) expressed a willingness to use it in the future, and 12 women (70.6%) and 11 men (64.7%) had told friends and acquaintances about FC.

Hart et al. (1999) discovered that the female condom, while being perceived as an improvement over the male condom, was recognized as having limited value because of the need to agree its use prior to sex taking place. Women like the fact that it could be inserted some time before, and left in place sometime after, sexual intercourse, that it was effective for multiple instances of intercourse, and that men would be unaware that it was being employed. Female-controlled methods to prevent sexually transmitted infections, including HIV, and to increase reproductive choice, hold the promise of ceding some control over sexual and reproductive health to women. Hirky et al. (2003) reported the female condom attitudes and experiences among HIV-positive heterosexual women and men. The study described attitudes toward and experiences with the female condom of 89 HIV-positive individuals (n=56 women; n=33 men) reporting heterosexual behavior. Most respondents (n=78) had seen or heard of the female condom. However, relatively few (n=14 women; n=5 men) had used it at least once. Reactions from both women and men across user groups, regardless of favorable or unfavorable attitude or experience with the female condom, centered around a similar set of factors: aesthetics, difficulties with the male condom, male partner reaction, beliefs about efficacy, and lack of training.

Meekers and Richter (2005) in a research Factors associated with use of the female condom in Zimbabwe that were conducted to assess factors associated with ever-use of the female condom and consistent use (always or often) with marital and regular non-marital partners. Perceived ease of use and affordability of the product and prior use of the male condom were associated with men's and women's ever-use. Consistent use with marital partners was negatively associated with reporting multiple partners in the past year (odds ratio, 0.3) and positively associated with using the device for pregnancy

prevention (5.4) and previously using the male condom (8.0). Consistent use with regular no marital partners was associated with numerous variables, including perceived ease of use (1.9) and effectiveness for STI prevention (3.8), low HIV risk perception (2.4), and use for pregnancy (2.9) and STI (2.3) prevention. Perceived affordability and ease of use may encourage couples to try the female condom but may not lead to consistent use.

Francis-Chizororo and Natshalaga (2003) conducted a research of acceptability and perception among rural women in Zimbabwe of FC. The findings show that very few women had used the female condom prior to the survey. Several women (93%) liked the condom especially young women aged 20-39 years (83%), compared to older women aged 40 years and above (11%). Both women and men liked the dual role of contraception and protection against STIs including HIV/AIDS played by the female condom. Most women (98%) felt that it is important for women to have their own condom. However, both men and women pointed out that it will be difficult to introduce the female condom in married situations due to the stigma associated with condoms in general. Over 80% of women said they will have to seek permission from their partners to use the female condom. Women had problems with inserting the condom and were concerned with lubrication, size and appearance, and how to dispose of used condom. Regarding cost, 77% felt that the female condom is too expensive given that the male condom can be obtained free from health centres. The cost of the female condom could hinder its continued use and would encourage women, especially commercial sex workers, to re-use it. Respondents still require more information relating to side effects (45%), effectiveness in STIs prevention including HIV/AIDS (44%), proper use (43%) and cost (32%).

Bogart et al. (2000), in a study (AIDS knowledge to investigate factors influencing intentions of Hispanic adults to use the female condom) used the theory of planned behavior (TPB). A total of 146 persons (75 women and 71 men; mean age 27 years) recruited from community-based organizations completed an anonymous survey regarding intentions to use the female condom and their main sex partner. The TPB model had greater predictive utility for women's, than for men's, female condom use intentions. For men, attitudes and norms did not predict female condom use intentions, but greater AIDS knowledge was related to lower intentions to use the female condom, above and beyond the TPB constructs. Perceived behavioral control, operationalized as self-efficacy, significantly increased the predictive utility of the TPB model for women's female condom use intentions but not for men's.

In another related research by Buck et al. (2005), in Zimbabwe, reported that adult HIV prevalence is over 25% and acceptable prevention methods are urgently needed, where sixty-eight Zimbabwean women who had completed a barrier-methods study and 34 of their male partners participated in focus group discussions and in-depth interviews to qualitatively explore acceptability of male condoms, female condoms and diaphragms, reported nearly half of women and some men preferred male condoms because they are effective and limit women's exposure to semen, although they reportedly detract from sexual pleasure and carry social stigma. Female condoms were least preferred because of obviousness and partial coverage of outer-genitalia that interfered with sexual pleasure. Bull et al. (2003), in a research Knowledge of attitudes toward and stage of change for female and male condoms among Denver inner-city women, surveyed 198 young women (15-25 years old) living in the inner city of Denver about their knowledge of attitudes toward and practices regarding female and male

condoms. Most (75%) women had ever considered using male condoms; 32% had ever considered using female condoms; and use of either was sporadic. Research findings suggest that African Americans and younger women are more likely to contemplate using female condoms. It can be deduced that lack of knowledge and positive attitudes toward female condoms in this sample suggest that programs designed to raise awareness and knowledge of female condoms while improving their image are needed.

Conclusion

Result obtained from the study shows that the awareness of FC and attitude on FC is very poor and its availability is very scarce. FC remains the best sex barrier/protective and very tolerable with painless side effect if used properly, the implication is the increase in STD and unwanted pregnancy among women due to low patronage of FC. In recommendations, author opined that these findings underscore the need for additional research and comprehensive education efforts aimed at both technical use and communication skills-building in order to realize the potential of the female condom as an alternative barrier method, and female condoms should be offered to adolescents as an additional choice rather than as replacements for male condoms. In suggestion for future study, further research is needed to assure access, availability of female condoms and male participation in their use in Nigeria.

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Conflict of interest

The author confirms there are no conflict of interest with any parties involved in this research.

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