Contraception

Original research article

Acceptance and use of the female condom among women with incomplete abortion in rural Tanzania[☆]

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Abstract

Background: This study describes the outcome of a postabortion care intervention aimed at introducing the female condom as a means of preventing women from having unwanted pregnancies and sexually transmitted infections (STIs)/HIV.
Methods: Postabortion contraceptive counseling and services were offered to 548 women admitted to the Kagera Regional Hospital for incomplete abortion. The counseling included information about STI/HIV and the use male or female condom. In total, 521 (95%) women accepted contraception.
Results: Contraceptive use was assessed 3 months after abortion among 475 (91%) women. The female condom was accepted by 201 of 521 (39%) and was used by 158 of 521 (30%). Women who had experienced an unsafe abortion, had attended secondary school or earned an income were more likely to accept the female condom. The women were generally satisfied with the method, and the majority intended to use it again.
Conclusion: Postabortion care programs provide an excellent entry point for introducing the female condom as a contraceptive method for the prevention of both repeat unwanted pregnancies and STI/HIV infection.
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Keywords: Abortion; Contraception; Female condom; Postabortion care; Unsafe

1. Introduction

In the early 1990s, the female condom was developed as an alternative to the male condom to enable women to have greater control over their fertility and increased protection from disease. Studies have proven that the female condom, when used consistently and correctly, provides contraceptive efficacy in the same range as other barrier methods [1,2]. It has further been documented that compliant use of the female condom is effective in preventing sexually transmitted infections (STIs) [3,4]. Experiences in Brazil, Ghana, Zimbabwe and South Africa, where the female condom has

been actively promoted, suggest that effective programs can generate demand. In these countries, the female condom has been promoted and distributed through public sector and social marketing projects, and this approach has led to a sixfold increase in the number of female condoms distributed [5]. However, in many countries, uptake has been lower than anticipated, demonstrating that successful implementation will not be as straightforward as was hoped [5]. Some of the problems encountered in relation to the distribution of the female condom are the high price of the female condom (US$2) and the need for a comprehensive training of service providers [5].

At present, the female condom is the only alternative to the male condom as a protective means against both pregnancy and STI/HIV. This fact underscores the urgency to continue promoting female condoms alongside male condoms in family planning. Such linkage between reproductive health programs and STI/HIV prevention efforts is in line with a growing trend acknowledging that reproductive health care

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has a central role to play in the fight against the HIV epidemic [6]. Postabortion care programs may serve an important entry point for promoting the use of female condoms. This approach is justified by two Tanzanian studies, which found that 50–60% of women admitted for incomplete abortion had had an unsafe abortion [7,8]. Women having unsafe abortion comprise a vulnerable group that is at increased risk of experiencing both repeat unwanted pregnancy and HIV infection [9,10]. Furthermore, a recent study in Dar es Salaam [11] documents a comparably higher HIV prevalence rate among women admitted with complications after an unsafe abortion than among the general population. Counseling about HIV and promotion of male and female condoms should therefore be considered essential parts of postabortion contraceptive counseling, especially in countries with high HIV prevalence rates.

The present study describes the outcome of a postabortion care intervention aiming to introduce the female condom as a means to prevent women from having unwanted pregnancies and STI/HIV.

2. Method

2.1. Study population

Data were collected among women admitted for incomplete abortion at the Kagera Regional Hospital (KRH) during the period November 2002–June 2003. A total of 548 women were admitted to the hospital during the study period, and they were all provided with contraceptive counseling and counseling on STI/HIV. Part of the counseling focused on the use of the female condom and the benefits of using double protection to avoid both unwanted pregnancies and STI/HIV. The women were asked to choose between the following contraceptive methods: oral contraceptive, medroxyprogesterone injection, male condom and female condom. In total, 521 (95%) women accepted contraception and were provided with a contraceptive method of their choice. The women who accepted contraception were asked to return for follow-up after 1 month and after 3 months. At 1 month, 448 of 521 (86%) returned for follow-up, and 475 of 521 (91%) returned for the 3-month follow-up.

2.2. Socioeconomic characteristics

In order to assess if socioeconomic status influenced decisions about the female condom, information was obtained about marital status, educational level and employment.

2.3. Pregnancy situation

The women were interviewed by the use of a previously described empathetic approach [8]. According to this approach, the classification of unsafe abortion or spontaneous abortion is based on the outcome of a confidential dialogue conducted under strict privacy during which the woman shares her experience regarding her present pregnancy. Only women who reveal having had an illegally induced abortion were classified as having a history of unsafe abortion.

2.4. Acceptance of the female condom

Women who left the hospital with the female condom after contraceptive counseling were defined as accepting the female condom, and women who refused to receive it were defined as rejecting the female condom. The women who accepted the female condom were provided with 10 female condoms before discharge from the hospital and were interviewed about condom use at 3-month follow-up.

2.5. Statistical analysis

Data were recorded using the software Epi Info, version 6.04, for Epidemiology and Disease Surveillance (CDC, Atlanta, GA, USA). Statistical analyses were carried out with the Statistical Package for the Social Sciences (SPSS for Windows, version 12.0). A nested case–control design, using the group of women who accepted the female condom (cases) as dependent variable versus women who rejected it (controls), was applied. The associations between acceptance of the female condom and socioeconomic and reproductive characteristics are presented as odds ratios (ORs) with 95% confidence intervals (95% CI). To adjust for possible confounding between analyzed risk factors, multivariate logistic regression was performed. Firstly, all covariates with $p \le .20$ in univariate analyses were included

Table 1
Socioeconomic characteristics of the study population

	Unsafe abortion (n=234) [n (%)]	Spontaneous abortion (n=287) [n (%)]
Age (years)		
−19	59 (25.2)	39 (13.6)
20–24	82 (35.0)	86 (30.0)
25–30	50 (21.4)	82 (28.6)
30–34	23 (9.8)	41 (14.3)
35+	20 (8.5)	39 (13.6)
Marital situation		
Married	113 (48.3)	252 (87.8)
Single	85 (36.3)	17 (5.9)
Divorced/widowed	36 (15.4)	18 (6.3)
Previous births		
0	105 (44.9)	75 (26.1)
1–2	83 (35.5)	120 (41.8)
3–4	32 (13.7)	63 (22.0)
5+	14 (6.0)	29 (10.1)
Education		
None	17 (7.3)	17 (5.9)
Standard 1–7	177 (76.3)	218 (76.2)
≥Form 1	38 (16.4)	51 (17.8)
Occupation		
Housewife	121 (54.0)	221 (79.2)
Schoolgirl/servant/ petty trader	39 (17.4)	6 (2.2)
Employed	24 (10.7)	32 (11.5)
Farmer	19 (8.5)	15 (5.4)
Unemployed	21 (9.4)	5 (1.8)