Review Article

Barriers and Self-Control-Experiences of Using a Female Condom among Brothel-Based Female Sex Workers in a Western Indian City: A Qualitative Study

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Abstract

Background and Objectives: Female Condom (FC) is a dual protection contraceptive, aimed both, towards the prevention of pregnancyas well as STIs/HIV in women. The National AIDS Control Programme, implemented by the State agency, therefore seeks to popularize its acceptance and usage among Female Sex Workers (FSWs), as an option to male condoms, to adopt safe sex with clients and to reduce the incidence of STIs/HIV. The objective of this study was to document the knowledge and first hand experiences of FC use amongst brothel based Female Sex Workers (FSWs) of a city in western India. **Methods:** The study is a subsection of a mixed methods doctoral study. The data was extracted from qualitative design. In-depth interviews with FSWs were administered. FSWs were selected from the brothels using a purposive sampling method. A total of twenty in depth interviews were administered. **Interpretations:** The study reflected the advantages and limitations of the use of FC. The FSWs were found to have low knowledge about FC. In some instances such as dealing in ebriated clients and in intimate relations, the FSWs thought that, it gave self-control to protect from unsafe encounters. But the cost attached to it as compared to the availability of free male condoms, different serious misconceptions including fear of FC getting trapped inside the vagina during use, increase time in client's ejaculation were challenges in use. **Conclusion:** The study reveals the positives and challenges experienced in using FC among brothel based FSWs. There is a need to strengthen the promotion of usage of FCs in FSWs through the Targeted Interventions (TI) of National AIDS Control Organization (NACO) to improve the knowledge and to reduce different road blocks that would impede the use of FCs among FSWs.

Keywords: Experiences; Female condom; Female sex workers; Knowledge

Introduction

Male and Female Condoms (MC, FC) are equally effective both inpreventing unintendedpregnancy and prevention of transmission of sexually transmitted infections, inclusive of human immunodeficiency virus, when used consistently and correctly. [1] As compared to MC, FC imparts greater control over the sex acts to the woman. [2] It was invented in 1984and was specifically endorsed for usage in FSWs,a high risk group for STIs/HIV, with a view to empower the FSW, to negotiate its use. The United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV and AIDS (UNAIDS) and World Health Organization (WHO) collaborated for free distribution of FC in 23 countries including India. [3] There is evidence of moderate to high acceptability and use of FC among FSWs of Turkey, Central America, Costa Rica, Côte d'Ivoire, Thailand, and Zimbabwe. [1,4-6] Studies in Kenya, Thailand, and the United States proved that the prevalence of STIs declined by the same percent in women, who were given FC or MC, in comparison to those given only MC. [7-9] In Madagascar, prevalence of STI among FSWs, declined by 13%, a year after FC was added to the distribution of MC. [10] Similarly, a study carried out on usage of FC/MC by FSWs of Thailand, revealed, that as compared with groups offered only MC, the group offered either MC /FC, had a 24% reduction in the rate of new STIs. [11] In India, pilot research carried out in the early years after introduction of FC, showed a high acceptability of FC as an alternative safe sex method to MC, among FSWs in five states. Its use was found to be beneficial, especially with clients reluctant to use MC. [11,12] Literature review highlighted barriers of cost, misconceptions, complexity in use, and clients' unacceptability affecting the use of FC. [1] There is therefore a need for aggressive promotion of FC to override the financial benefits offered by distribution of free MCs in this critical population. In comparison to the

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prevalence of 2.2% of HIV at the national level, the prevalence of HIV among FSWs was above 18%. [9] Therefore, in 2007, Hindustan Latex Family Planning Promotion Trust (HLFPPT), a national 'not for profit' health services organization introduced a campaign to promote FC among FSWs-'Targeted Interventions' (TI) in India. [9] The campaign intended to bring improved decision-making and autonomy in condom use. FSWs were trained for correct insertion and use of FC. [12] The present study documents the knowledge and first-hand experiences of FC use among brothel-based FSWs in western India.

Methods

To gain insight into FSWs experience of using FC a qualitative design was used. A descriptive approach was adopted in which the experiences were elucidated. This helped to understand participants' perceptions about use of FC.

Participants and study setting

The study area is ared light area of Pune, situated in the heart of the city and is surrounded by a large numbers of commercial establishments. It has a total of 333 brothels, where around 2500 FSWs reside. [8] Number of residents of FSWs in each brothel varies from 5 to 10. However, this is a floating number, as the FSWs often migrate between cities and brothels within the same city, in their quest for a better life. Considering the accessibility of this focus group and the sensitivity of the research study, the study was conducted within the brothels, where an in depth interview was conducted with the FSWs. The participants were recruited using a purposive sampling technique using these inclusion criteria:

- FSWs having knowledge about FC and those who have used it for some time
- Those willing to consent and devote substantial time

The study concluded at 20th respondent after reaching a theoretical saturation, which indicates that, based on the data that has been collected or analysed, further data collection and/or analysis is unnecessary. [13]

Ethical consideration

Approval to the study was sought from the Independent Ethics Committee of Savitribai Phule Pune University before initiating the study. The Informed Consent Form (ICF) was translated in Hindi as majority FSWs speak and understand Hindi. Within the brothel, the ICF was read and explained to all FSWs. In case the FSW was literate, a written informed consent was obtained. In case, the FSW was illiterate, thumb impression of the respondents was obtained in the presence of colleague FSW, who also signed as an impartial witness.

Data collection

The semi structured interview had open-ended questions on knowledge, source of information and training as regards use of FC, its distribution and availability, experiences about its use and challenges. The study period was April 2013-September 2015. The in depth interviews were conducted over 30 minutes-60 minutes. Two interviews, took more than 60 minutes as the FSWs solicited with the clients who approached them during the process. The use of open-ended questions helped the respondents to describe their experiences in detail; probes were used to encourage the participants to tell more without asking any leading questions. The interviews were not audio taped, instead transcribed verbatim by the first author. All measures were adopted to maintain confidentiality in collection and storing of the data.

Data analysis

The interviews were translated into English. Analysis used inductive approach. [14] The transcripts were read several times to identify categories and themes. The researcher read all the transcripts. After discussion, a coding frame was developed and the transcripts were coded. If new codes emerged, the coding frame was changed and the transcripts were re-read according to the new structure. This process was used to develop categories, which were then conceptualized into broad themes after further discussion.

Interpretations

Characteristics of the respondents

As per Table 1, most (35%) of the respondents were in the young age group of 28 years-32 years. 80% were illiterate. 35% of the respondents were from West Bengal. 25% and 10% of the respondents were deserted/separated and widowed respectively. 15% were *Devadasis.

Theme 1

FC is a good option as it boasts self-control and eases the struggle to negotiate MC: Before FC was introduced; FSWs struggled to negotiate use of MC by the client. The FC gave the FSW a new found hope, a sense of self control and an option

Table 1: Distribution of respondents by socio demographic profile (qualitative=20).

Variable	Qualitative (n=20)	
	n	%
Age in years		
18-22	2	10
23-27	6	30
28-32	7	35
33-37	3	15
38-42	1	5
Above 42	1	5
Literacy status		
Illiterate (cannot read and write)	16	80
Literate (can read and write)	4	20
Civil status		
Unmarried	4	20
Married	6	30
Deserted/Separated/Divorcee	5	25
Widow	2	10
*Devdaasi	3	15
Geographic residence		
Maharashtra	2	10
Nepal	1	5
West Bengal	7	35
Karnataka	6	30
Andhra Pradesh	3	15
Others	1	5

to MC. The FSWs were now confident to talk about FC with their clients. The respondents confided that putting a MC on the client's penis was a filthy experience for the FSW and hence very much loathed by FSWs (though enjoyed by some clients!). This unpleasant experience and practice could now be done away with completely. The red light area witnesses' high numbers of clients during night, majority of the clients come in an inebriated state and do not want to use condoms, increasing the risk of unsafe sex. In such scenarios, FC acts as a weapon to shield such encounters.FSWs expressed that in intimate relationships with lovers' and regular partners, where an emotion of possessiveness and love becomes a barrier to use of condom, they have started using FC that has been accepted and enjoyed by both the client as well as the FSW. The one thing that was most liked by FSWs was that it could be inserted well in advance prior to the start of the sex work business. This gives them a feeling of freedom and security and a confidence to convince the clients' about condom use. Secondly, with the FC inserted they were willing to go with clients outside the brothels such as lodges or any other place of client's convenience for sex. This reflected an increase in the income as they would charge high for going outside the brothels. All FSWs shared that with FC, they feel protected and very much in control of the sex acts. A few FSWs, negotiating high rates even revealed that they have now convinced their clients for use of FC regularly.

Theme 2

As compared to MC, most of the FSWs had their first exposure to FC: Some were knowledgeable about theFCbut possessed some grave mythstoo**.**All the FSWs were aware of all the facets of use of MC; however, respondents shared that first exposure to FC happened only due to the promotional/ awareness sessions organized by the NGOs. FSWswere either invited to the office of the NGO or staff from the NGO visited the brothels. The NGO representatives oriented them about FC, showed leaflets to demonstrate insertion and removal, and then distributed FCs freely. The sessions were followed by visits to check the use and replenish the stock of the FC. However, the campaign slowly subsided with time. Just as the FSWs were getting accustomed for using FCs, the program came to an abrupt end. The NGOs stopped the free distribution of FCs and instead started selling it at Rs. 3/- per piece. Some colleagues who were key opinion leaders in the brothels were not keen to train the FSWs about use of FCs, because they themselves lacked the required knowledge and skills to teach about FC use. Further, few FSWs, who were peer educators lost their interest and motivation to train FSWs regarding use of FC; consequently, the FSWs lost on avenues to have their queries (regarding FC use) addressed.

Misconceptions: The data revealed that FSWs were frightened about the insertion of FC as they thought it may get trapped inside the vagina and get lodged deep inside the uterus. The reason for this belief is that it has to be inserted inside the vagina before use which is terrifying as compared to male condom which is fitted externally on to the penis of the clients and hence remains outside the body. One particular respondent shared that she was shocked when she came to know about her colleague's experience of removal of the uterus (hysterectomy) because of the use of FC. This discouraged her to even think about FC as undergoing surgery for using a condom is intimidating. The FSWs voiced that the size and look of FC is scary."I tried using a female condom but remembered one friend from the red light area of Mumbai who shared her experience of having had to undergo a hysterectomy. She felt (that) it was because of the use of FC. Her uterus had to be removed. After I heard her experience, I am scared of using FC" 21 years old FSW. The FSWs revealed their inability to decide whether FC can be reused or not. They believed that the price paid for the FC should be worth it and FCs is affordable only if it is reusable. However, they honestly acceptedthat they do not have any knowledge about reuse of FC. Some FSWs complained of Lower Abdominal Pain (LAP) after the insertion of the FC during use. After that they started fearing that the insertion would bring pain always. So were reluctant to use the FC.

Theme 3

The different barriers refrained the FSWs from accepting the FC for continuous use with clients and Cost of FC: FSWs are reluctant to buy the FC because they get male condoms free. FSWs are reluctant to use the FC because they have to buy the FC at Rs. 3/- a piece. As per the prevalent practices of the red light area, FSWs' have to surrender 50% of their daily income to brothel owners/ managers, for food and other expenses. Apart from these expenses they have to send money to their dependent family members regularly. There are empty days when they don't get even a single client and hence no income. With this context why would they prefer to buy condoms? Though the price is meagre, yet every rupee (paisa) saved matters, considering that FSWs in red light area come from a lower socio economic background. Further, availability of male condoms for free and ease of purchase precludes use of FC. "Initially they distributed FC free of cost, later they started with social marketing of condoms by selling it at the cost of Rs. 3/-; instead you get male condoms free still". A 30 year old FSW.

Use of FC increases the time required for the client to ejaculate. This affects time spent with the client, who in turn increases the time by which the FSW is ready for the next client: FSWs desire to earn more money by entertaining more number of clients. They practice skills that ensure clients' satisfaction in a short interaction (wherein the clients ejaculates fast and release them quickly), and then they are ready for a new client. A few of them attribute long sexual encounters with the use of FC, which could also be painful. They further shared that the interference of FC during sexual intercourse does not give pleasure to the clients and delays the time of ejaculation. Longer sex acts adversely affect their earnings during peak hours and during festival days when the business is booming with fast new clients. Time spent in the sex act becomes a critical factor then. Other reasons for delay for the FSWs could be the time required for removing the FC and that for inserting a new one.
Sex work during menstruation: Specific clients' fancy sex during menstruation that constrains FSWs' to practice safe sex work during menstruation. Such men seeking the pleasure of the moistness of internal organ during sexual encounters may not like the structural interference of the FC, so the clients in such situation would not permit the

use of FC. Apart from this barrier, the insertion of the FC during this period would painful and may increase bleeding. **Clients' attitudes towards FC use:** Some clients are not willing to use condoms (male/female), because of the belief that it reduces pleasure. Secondly, the bigger size of the FC threatens and scares them and their clients from continuing the physical act. So, they are not willing to accept and use the FC during paid sex.

Discussion

Self-control in using FC

It is evident that biology, inequalities in gender roles, accepted societal sexual norms access to resources and decision-making power put women at greater risk of infection than men. Women because of lack of information about sexual and reproductive health neglects the risks associated with sexual behaviors. Even recognizing their vulnerability does not make them powerful to protect themselves. Women who receive information and counselling, and who learn to use the FC, can protect themselves even if their partners refuse to use a male condom. [6] This is true with FSWs too as they are more vulnerable and powerless to negotiate male condoms with clients. Research studies reflected that FSWs' acceptability of FC was high because it granted them self-control to protect against STIs/HIV. [6]

Knowledge about FC

Study's finding about low knowledge is supported in research studies among FSWs of Ankara, Turkey, and Thailand. [4,15] There aare different myths among FSWs including FC being slipped or trapped inside the vagina that has been reported in research articles of Uganda, Malawi, and Zimbabwe. [16-18] FSWs' fear of undergoing hysterectomy because of use of FC is a newly discovered myth that needs to be explored further. This could be the result of low levels of knowledge about FC. The present HIV prevention program is inclined more towards promotion and distribution of male condoms than FC. The strategies need to be restructured to bring FC at forefront. Peer education showed to improve the knowledge, acceptance and utilization of FC in Indonesia. [12] It should be enhanced in India's HIV prevention program too. The myths should be targeted with dedicated efforts to increase correct knowledge about FC.

Cost of FC

Cost attached to the FC becomes a concern at the background availability of free male condoms. Similar issue was found in FSWs in Nepal. [5] In contrast a study in China showed that FSWs charging low fee ≤ 30 RMB per client showed high acceptability towards FC. [19] The policy makers should strive hard to subsidize the cost of the FC. They should think in terms of purchasing the FC in bulk for getting a huge discount and other cost effective options that are under consideration. [11]

Clients' attitude towards FC

Clients' refusal to accept FC because of its strangeness, size, concerns about prevention efficacy towards STI/HIV, reductions in sexual pleasure has been found in many studies. [4,17-20] The overall picture that is emerging from studies is that of non-acceptance of FC by clients. This could be a disappointing factor for FSWs to use FC. [17,21] A few studies have reported clients' acceptance of the FC because of its soft texture and lubrication and seeking pleasure as part of foreplay. [21,22] However, this aspect was not found in this particular study. Present study's clients' dislike about the use of FC during menses is in contrast with a study of Brazil, where the FSWs' enjoy them during periods. [23]

Challenges in use of FC

The primary physical barrier experienced by FSWs across the globe is of difficulty in the insertion of FC, research studies among FSWs of China, Cote d' Ivoire, Thailand, Zimbabwe, Costa Rica, Swaziland, Uganda, Central America have documented the same. [1,10,11,17,20-24] Difficulty in insertion because of a lack of privacy is corroborated in a program review report by HLFPPT in India. Finding longer ejaculation time because of the use of FC is new; have to be further explored with research in this area.Some FSWs have reported lower abdominal pain after using FC that could be because of pain due to inner ring uro genital symptoms as side effects. [22] The lower abdomen pain might worsen if the FSWs have symptoms of STIs. These could be the different possibilities for the lower abdomen pain that has to be explored by further research. These types of experiences might further deter women from using FC. [25-28]

Limitations

The biggest limitation of a qualitative design is lack of generalizability or representativeness. The study finding cannot be applied to FSWs from other regions. The findings have emerged from in depth interviews with FSWs only. Data triangulation in terms of interviews with brothel owners and clients is not attempted. That would have added different perspectives towards the experiences shared by the FSWs.

Conclusion

Introduction of FC among FSWs was projected to promote the use of condom and simultaneously provide protection from STI/HIV. Importantly, it empowers the female partner. This is especially important in case of FSWs negotiating successful use of condoms with clients. The objectives of this study were to document the knowledge and first-hand experiences of FC use among brothel-based FSWs in western Maharashtra. It identified the plus points and the negatives of FC use in the population. It also unearthed certain myths and misconceptions about FCs which preclude its universal usage. The same were due to ignorance about facts of FC. The FSWs voiced out the feeling of self-control in using the condom especially with unwilling clients and in intimate relations. Cost, a lack of privacy, physical adjustments was found to be the main hurdles in use. It is evident that initial use is troublesome unless it is continuously practiced. Continued use was commonly associated with adequate support during adoption phase. It is therefore crucial to support the population more intensively in the initial phase. The findings recommend amendments in the health promotion of FC in the TIs. Continuous health messages with the application of innovative communication media: use of flip charts, posters, patient information brochures and demonstration on models (insertion of FC) training the FSWs

on correct usage is recommended strongly. In contrast to male condoms, FC comes with a price tag, subsidization and efforts to make it free would ensure accessibility. The involvement of male clients in health promotion would help in changing their attitudes. Although FC has been introduced in many countries, their supply and uptake is inadequate. Greater investment by the private and public sectors and support from the donor are urgently needed to make the FC an affordable option. While new FC products being developed offer more choice and may overcome some of the problems reported by current users, these products face financial and regulatory barriers that slow their path to market. Advocacy for the female condom, from the community level upwards, is needed to stimulate demand and increase access and availability. Research that provides more data on the method's impact and cost-effectiveness will help promote the female condom. The female condom is not a promise on the horizon but an effective, female-initiated method available now that can protect women from pregnancy and STIs. It is an important technology that needs to be given a more prominent role in reproductive health programs and included in STI/HIV and pregnancy prevention efforts worldwide.

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