2014

Social Solutions

Female Condom Acceptability Study

Draft report submitted to UNFPA Suriname

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
BOG	Bureau for Public Health (*Bureau voor Openbare Gezondheidszorg*)
CARICOM	Caribbean Community and Common Market
CARISMA	Caribbean Social Marketing Programme for HIV & AIDS Prevention
CCP	Comprehensive Condom Programme
CSE	Comprehensive Sexuality Education
EDSC	English- and Dutch-speaking Caribbean
e.g.	For example (*exempli gratia)*
ETO	Basic Technical Education (*Eenvoudig Technisch Onderwijs*)
FBO	Faith Based Organization
FC	Female Condom (as designed by the Female Health Company)
FC1	First-generation female condom
FC2	Second-generation female condom
FDA	Food and Drugs Administration
HAVO	General Secondary Education (*Hoger Algemeen Voortgezet Onderwijs*)
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma Virus
Ibid.	As previous (*ibidem*)
IPPF	International Planned Parenthood Federation
LBGO	Lower Vocational Education (*Lager Beroepsgericht Onderwijs*) (old name)
LGBT	Lesbian, Gay, Bisexual, Transgender
MOH	Ministry of Health
MSM	Men having Sex with Men
MSM+	Men who have Sex with Men and living with HIV
MULO	More Extensive Lower Education (*Meer Uitgebreid Lager Onderwijs*)
MZ	Medical Mission (*Medische Zending)*
NAP	National AIDS Programme
NBCCS	New Beginnings Consulting and Counseling Services
NGO	Non Governmental Organization
PANCAP	Pan-Caribbean Partnership against HIV & AIDS
PATH	Program for Appropriate Technology in Health
PSI	Population Services International
RGD	Regional Health Service (*Regionale Gezondheidsdienst*)
SMU	Suriname Men United
SRH	Sexual and Reproductive Health
SRD	Suriname Dollar
SRO-CAR	Sub-Regional Office for the Caribbean
STI	Sexually Transmitted Infection
SZF	State Health Insurance Fund (*Staats Ziekenfonds*)
UNFPA	United Nations Population Fund
UK	United Kingdom
US	United States
VCT	Voluntary Counselling and Testing
VDRL	Venereal Disease Research Laboratory
VOJ	General Junior Secondary Education (*voortgezet onderwijs op junioren niveau*)
VOS	General Senior Secondary Education (*voortgezet onderwijs op senioren niveau*
VWO	Continued Scientific Education (*Voortgezet Wetenschappelijk Onderwijs*)

WHO	World Health Organization
WHR	Western Hemisphere Region Inc.
YAG	Youth Advisory Group (of the UNFPA)
YAM	Youth Advocacy Movement (of the Lobi Foundation)

Summary

This report presents the result of a study on the acceptability of female condoms in the Caribbean country of Suriname. In 2006, the Suriname Ministry of Health through the EC/UNFPA Joint programme for Reproductive Health launched a national campaign to promote the female condom in Suriname. Since then, the UNFPA has continued to provide the FC2 to the Ministry of Health as part of its contribution to Comprehensive Condom Programming. The aim of the present study is to identify the variables impacting the use of female condoms, and present them to programme leaders and policy makers.

The study combined desk research, survey work and interviews with experts from governmental, non-governmental and international organizations. A total of 64 persons were surveyed, among whom eighteen female sex workers. Study limitations included the small sample size, non-random sampling, and use of a pre-designed questionnaire.

The Female Condom is a disposable, often prelubricated device that is both a contraceptive and a barrier against Sexually Transmitted Infections (STIs). Different designs and brands of female condoms exist but only the FC2 has been approved by the WHO and US FDA. Female condom acceptability studies in other countries provide evidence that social marketing, education on proper use, and improved user skills increase uptake and acceptability. Earlier recorded disadvantages of the female condom included the relatively high cost, complexity of insertion, discomfort (pain from the inner ring) and fear of the possibility that it might slip into the vagina. Reported benefits included: it is strong and less likely to burst than the male condom, it is well lubricated, it gives a natural feeling, and it made women feel empowered, more protected and relaxed.

In Suriname, female condoms are purchased and imported by the UNFPA, which delivers most FC2 to the central information centre for health promotion and HIV prevention LIBI! of the National AIDS Programme (NAP). LIBI! distributes female (and male) condoms to NGOs and government organizations, as well as to individuals who visit the desk. Most organizations that are involved in SRH activities have included the female condom in outreach and awareness activities; some specifically focusing on high risk groups (e.g. sex workers, MSM and people living with HIV/AIDS). FC2 are liberally distributed, for free, and there is little monitoring of where they end up, whether they are actually used, and how they were experienced by users.

The survey sample consisted of 23 men and 41 women, and was diverse in terms of age and educational, professional and ethnic backgrounds. All respondents but one had exclusively had heterosexual sexual contacts in the past year. Stakeholder interviews suggest that use of the female condom by MSM is uncommon in Suriname. Being in a stable relationship had little effect on the number of casual sexual contacts. Among respondents with a stable partner (excl. sex workers), 17.9 percent had sex with one casual partner and 32.1 percent with more than one in the past year (N_{total}=28). Among persons without a stable partner, 22.2 percent had sex with one person and just over half (55.5%) with more than one in the past year. Men were more likely than women (excl.sex workers) to have multiple stable partners and to engage in multiple casual sexual relationships.

Virtually everyone knew that using a condom is the best way to prevent Sexually Transmitted Infections (STIs) when one is sexually active. In total 42.2 percent of respondents reported using condoms consistently in the past year, with sex workers being more likely than others to consistently

use condoms (66.7% versus 32.6%). There is a general tendency to not use a condom with a stable partner, and (sometimes or consistently) use a condom with casual partners and, for sex workers, with clients. Women were more likely than men to report that they decided about condom use when having sex.

The main mentioned benefits of the female condom were that it provides better protection, that it – like the male condom- protects against unwanted pregnancy and STIs, that you can insert it in advance, and that the man does not need to wear a condom. Mentioned disadvantages included that it was uncomfortable/painful, was difficult to insert/use, can slip of, and gave an unpleasant feeling during sex. Sex workers appeared more likely than others to have used the female condom. A significant proportion of persons who had used the female condom had not used it in the past year, and many others had only used it once in this period. Only two interviewees used the female condom consistently when having sex. Among respondents who had used the female condom, the majority (60%) had used it with a stable partner. Forty percent of female condom users judged it uncomfortable and 8.6 percent found it only a bit comfortable (N_{total}=35). The largest share of those who used the female condom would use it again (74.3%) and recommend it to a friend (69.4%; N_{total}=35). Reasons to not use it again or not recommend it to others included that it was uncomfortable, it took too much effort, and required one to stay focused on it to prevent it from slipping away.

Just under half of respondents had first heard about the female condom from a counsellor or outreach worker (43.8%; N_{total}=64). The second and third most common sources of information were, respectively, a partner/friend (14.1%) or the media (10.9%). Virtually no-one found it difficult to buy condoms. Female condoms, however, have small distribution figures and are hardly available at Suriname's commercial market. Close to one third of respondents did not know where to find a female condom (32.8%).

The researchers conclude that given the high level of reported sexual risk behaviour, promotion of *consistent* condom use is important. Female condoms largely serve the same purpose of male condoms, but several respondents found them uncomfortable and they are much more expensive. Notwithstanding the listed disadvantages, it is concluded that the female condom should remain part of SRH outreach activities in order to increase the available choices in contraceptives and barrier methods. Requesting payment from the general population for over-the-counter condoms and better monitoring will reduce waste and allow health professionals to obtain better insights in the acceptability of male and female condoms.

The researchers recommend improvement of supply chain management. The distribution of female condoms should become demand-driven and based on monitored distribution criteria. The female condom must be presented as part of a broader SRH strategy, as one of the available methods for protection against pregnancy and STIs. Awareness activities should include men and be culturally sensitive. These activities should emphasize consistent use, particularly during casual sex. Both outreach workers and the target population must be properly educated on use of the female condom.

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1. Introduction

1.1 Study relevance, aims and objectives

This study describes the acceptability of female condoms among men and women, including female sex workers, in Suriname. A study on female condom acceptability is relevant because low condom use had been identified as one of the major factors impeding the control and prevention of HIV in the Caribbean region. Condoms, both male and female, are currently the only available and most effective technology to prevent HIV and other sexually transmitted infections, as well as unintended pregnancies, among sexually active people. They are inexpensive, cost-effective, their use does not require assistance of medical personnel, and they can be used by anyone who is sexually active.

In 2006, the UNFPA Sub-Regional Office for the Caribbean (SRO-CAR) spearheaded the introduction of the second-generation female condom (FC2) in the English- and Dutch-speaking Caribbean (EDSC). Later the promotion of the female condom was incorporated into the Comprehensive Condom Programme (CCP) which is a comprehensive approach to improving universal access to condoms in countries.

The female condom is seen as an important tool in the reduction of HIV transmission among women and girls, as it gives women power and control over condom negotiation and use. The uptake and use of the female condom have increased dramatically in some countries in the Caribbean with more and more countries beginning to purchase female condoms using national budgets. However, in many countries, increased use of the female condom has been credited to novelty of the product and targeted promotion with sex workers. In many cases, female condom use decreased significantly after initial introduction and try-out, particularly in the general population.

Research is key to understanding barriers to condom use, to devise strategies to counter and/or address these barriers, and to effectively bolster the promotion and sustained use of the female condom. In this context, the aim of the present study is **to make evidence on the variables impacting the use of female condoms available to programme leaders and policy makers**. The specific objectives are to:

- Investigate female condom use among different population groups in Suriname
- Make available to policy makers and programme managers data that describe factors that support and prevent the use of female condoms
- Propose recommendations for enhancing effective programming for female condoms based on the findings of the investigation.

Similar female condom acceptability surveys will be conducted in Barbados, Belize, and Guyana.

1.2 Methods

Information was obtained using a combination of desk study, survey work and interviews with experts from relevant governmental, non-governmental and international organizations.

1.2.1 Desk study

Desk study involved the analysis of existing reports and studies about female condom uptake and acceptability in Suriname and other countries. The researchers aimed to particularly consult studies with a focus on the Caribbean region but few studies were found on female condom acceptability in Caribbean countries. Most studies concerning this topic were conducted in various African countries,

where the female condom has apparently been more widely promoted (e.g. Deniaud 1997; Ezire 2013; Napierala et al. 2008; Valens and Joseph 2013; Welsh 2001). Given the comparability of findings from studies that were conducted in a wide variety of settings (urban and rural; women, men and couples; commercial sex workers and others), we suspect that the lessons learned from the consulted African studies also apply to Suriname. The consulted data sources are listed in the Literature list.

1.2.2 Survey

A total of 64 persons were interviewed, among whom 23 men and 41 women. The UNFPA had posed sample requirements with regard to the gender division, age groups, share of respondents involved in Commercial Sex Work, and the share of female condom users. In order to comply with these requirements, survey respondents were recruited in a variety of ways from different locations. Respondents included:

- People from the researchers' personal network who indicated that they had used the female condom
- Representatives of SRH organizations who were approached for this study, and who indicated that they had used the female condom
- Sex Workers who were hustling in the streets
- Sex Workers who visited the dermatological service HIV testing and counselling centre as part of their regular control program
- Clients of the dermatological service HIV testing and counselling centre who indicated that they had used the female condom
- Men and women who were hanging out at the "Waterkant" on a random afternoon/early evening
- Men and women in night life, on a random Friday night.
- Men and women in the community of Nieuw Aurora (district of Sipaliwini)

By interviewing persons from this wide variety of locations and in different contexts, the researchers aimed to represent the diversity of experiences with regard to the female condom. Because the sample was non-random, the results cannot be extrapolated to the Suriname population at large.

1.2.3 Expert consultations

The researchers consulted representatives from government organizations , NGOs and international organizations, as listed in Table 1.

Table 1. Consulted organizations

Organization	Tasks/Mission
(Semi) government	
Ministry of Health, National AIDS Program (NAP)	Coordination of all HIV related activities carried out by other organizations
Ministry of Health, LIBI!	Central information centre for health promotion and HIV prevention Main task is to refer persons to other services Distributor of free male and female condoms for NGO's and individuals
Ministry of Health, Dermatological Service	Free VCT service and free tests for other STI's can be done in the health clinic. Distributor of free male and female condoms

Organization	Tasks/Mission
Medical Mission (phone consultation)	Providing primary health care services in the interior
Public Health Service (BOG) (only e-mail)	Development and execution of public health policy, focussing on health control, research and education.
NGOs	
Stichting Lobi	Promoting the quality of life in Suriname, by improving the health of particularly women and children. Main working area is Sexual and Reproductive Health Distributor of free male and female condoms
Youth Advocacy Movement of the Lobi Foundation	Strengthen SRHR among youth.
Suriname Men United (SMU)	Reduce HIV transmission among homosexual men and other Men who have Sex with men (MSM) by promoting a healthy lifestyle. Provision of gay-safe condoms and lubricant, information and awareness, research and data collection, counselling. Distributor of free male condoms
Stichting He & HIV	Improve the acceptance and equal rights of MSM+ through education and sensitization. Distributor of free male condoms
Stichting Liefdevolle Handen	Provides guidance to women with psychosocial problems in general and to sex workers and drug addicts in particular. Distributor of free male and female condoms
Double Positive	Provide (psycho-social) assistance, care and guidance, to women and young girls living with HIV/AIDS, and their environment. Distributor of free male and female condoms.
Firms	
New Beginnings Consultancy & Counseling Services (phone consultation)	Specialized in the design of health programs and the provision of technical assistance as a partner of the Ministry of Health. Main goal is reducing stigma and discrimination. Distributor of free male and female condoms.
International Organizations	
UNFPA	Promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. Imports male and female condoms for distribution by partner organisations.
UNFPA Youth Advocacy Group (YAG)	Supports the UNFPA in issues regarding their mandate. Their vision is that it is important that youth make adequate choices and have the appropriate skills and information.

1.2.4 Study limitations

Due to the **small study sample** and **non random sampling** method the findings cannot be generalized to the Suriname population at large. Notwithstanding this limitation, stakeholder consultations suggest that general trends have correctly been recorded and interpreted. For example, even though the exact figures may have been different with a larger sample size, we have no reason to believe that perceived and experienced benefits and disadvantages of the female condom reported in this study would have been different.

Because this study is part of a larger project with similar studies being executed in different Caribbean countries, the researchers were provided with a **standard questionnaire**. A few questions in the questionnaire were, in the researcher's opinion, not relevant or poorly phrased. For example, one of the questions asks about religion of the respondents, but it is unclear why this question had to be asked if there is no follow-up question concerning the possible impact of religion on condom use. Nevertheless, with the addition of a couple of extra questions we believe the survey covered all relevant topics.

2. Desk review

2.1 What is the female condom

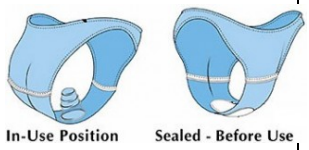
The Female Condom is a disposable, often pre-lubricated device that is both a contraceptive and a barrier against Sexually Transmitted Infections (STIs). The female condom was developed in the 1980s, when the Female Health Company started production of the first female condom (FC1) made of polyurethane (Schilling et al. 1991). By 1991, the FC1 was launched worldwide and by 1993 the FC1 was approved by the US Food and Drugs Administration (FDA). By 1996, the FC1 was adopted by public organizations and Ministries of Health around the world, particularly in low-income countries where HIV/AIDS figures were highest and the demand for women initiated prevention methods was largest. The largest purchasers of the FC1 were non-profit organizations.

In response to complaints that the FC1 was too expensive, the Female Health Company developed second generation female condom (FC2). FC2 was approved by government and regulatory bodies around the world in 2005 (Female Health Company 2013). FC2 is made from synthetic nitrile, which is less likely to make potentially distracting crinkling noises. The fact that the FC2 does not contain natural rubber latex may be an added benefit for couples that have allergic reactions to the natural rubber latex in male condoms. An additional advantage is that the FC2 is cheaper than FC1 (though more expensive than the average male condom), and it is hoped that the lower cost will enhance acceptability. The World Health Organization (WHO) has cleared FC2 for bulk procurement by U.N. agencies (WHO 2007) and the United Nations Population Fund (UNFPA) has incorporated the female condom into international programming.

In addition to the FC female condoms, various other types of female condoms have been marketed that vary in design, material and international approval (Table 1)[1]. The only female condom that has been approved by both the WHO and the US Food and Drugs Administration (FDA) as a safe and effective device for preventing pregnancy and HIV/STIs is the FC2. As a result, the FC2 is the only female condom that has been approved for bulk procurement for public sector programmes.

[1] Information about the different types of female condoms was obtained from Preventionnow.net (http://www.preventionnow.net/female_condoms/products/) and the website of the Cervical Barrier Advancement Society (http://www.cervicalbarriers.org/information/otherFemCondom.cfm)

Table 2. Different types of female condoms on the market

Name	FC1 and FC2	VA w.o.w.® Feminine Condom (Reddy Female Condom)[2]	Natural Sensation Panty Condom®	Silk Parasol Female Panty Condom	The Woman's Condom (in development)
Manufacturer	Female Health Company, UK	Medtech Products Ltd., India	Natural Sensation, Colombia	Silk Parasol Company, US	PATH, international
Image					
Appearance	A sheath with flexible rings on each end to aid insertion and hold the condom in place	A pouch attached to a rounded triangular opening and a sponge to secure it inside a woman's vagina	Is designed to be worn like an undergarment and contains a replaceable panty liner made of thin synthetic resin that stretches like a male condom	Is designed to be worn like an undergarment, providing a complete barrier both internally and externally	Polyurethane pouch that is partially enclosed in a capsule to aid insertion. The capsule dissolves in the vagina which releases the pouch, and the condom is then secured in the woman by foam pads
Material	FC1: polyurethane FC2: nitrile (synthetic latex)	Natural rubber latex	Reusable cotton and nylon	Biodegradable latex	Pouch, foam and ring made of polyurethane; Dissolving capsule made of polyvinyl alcohol.
WHO approval	Yes, 2006 (FC2)	Under review	No	No	Under review
USFDA approval	Yes, 2009 (FC2)	No	No	No	currently being tested
CE mark[3]	No	Yes	Yes	No	No

[2]This female condom is marketed under the V Amour brand name in Africa and L'amour in South America. It is also approved for distribution in Brazil, Europe and India.
[3] European Union consumer health requirement

2.2 Availability of the female condom in the Caribbean

Starting in 2006, the UNFPA Sub-Regional Office for the Caribbean (SRO-CAR) spearheaded the introduction of the second-generation female condom (FC2) in the English- and Dutch-speaking Caribbean (EDSC). In 2009, UNFPA donated just under a million male condoms (997,520) and 209,000 female condoms to seven Caribbean countries[4], as part of an 18 month comprehensive condom programming (CCP) project designed to introduce the female FC2 condom into the markets (Wedderburn 2010). These condoms were distributed by the Ministries of Health (MOHs), National AIDS Programs and NGOs focusing on HIV/AIDS. It was expected that the CCP would raise the profile of the female condom and increase uptake (Wedderburn 2010).

The sexually active population in the Caribbean, however, has not en masse started using female condoms. A 2012 study on the condom market in the Eastern Caribbean reports:

> Male condoms are by far the product of choice in the Eastern Caribbean. Female condoms, while available at retailers and clinics, have failed to catch on. These condoms were not cost effective for retailers and were not as attractive to younger consumers. During field research in summer of 2012, multiple public clinics in Trinidad and Tobago were found to be distributing expired female condoms – some expired by over a year. Similarly, in the commercial sector, female condoms are not widely available, and where they are available, the low demand results in female condoms that expire on shelves. (Euromonitor International 2012b: 11)

In 2006, the Suriname Ministry of Health in collaboration with UNFPA launched a national campaign to promote the female condom, consisting of an information and a distribution component (Caffe and Caffe 2008). The 10,000 female condoms procured for this campaign were distributed within 3 months, almost 100% requested by women. Based on the promising initial response, a more sustainable second phase was initiated, consisting of the development of a distribution network of approximately 140 outlets, including pharmacies, primary care clinics, NGO's, escort services, and motels/lodgings. Through this network 94,000 female condoms were distributed during a fourteen month period (ibid.). There is no information about actual use and user satisfaction.

A few years later, in 2011, a Suriname market survey reported that only very small numbers of female condoms were found in visited outlets (Verhage et al. 2011a). This survey estimated the number of available condoms at 5.8 per capita/yr. The free and commercial market segments were equal in size, with respectively 1.2 million and 1.6 million (virtually only male) condoms being distributed/sold. The most recent import of female condoms is dated December 2013, when 10000 female condoms were imported and sent to Medical Mission (4000) and LIBI! (6000). The cost of this import was US$ 5,700 for the female condoms and US$ 2,300 freight; or US$ 0.80 per female condom. At present, UNFPA covers all expenses related to the import of female condoms and their distribution to the various organizations.

Also in other Caribbean countries, female condoms are not widely distributed. In 2009-2010 in Jamaica, the UNFPA provided 300,200 female condoms for free distribution through relevant

[4] Trinidad and Tobago (T&T), Sint Maarten, Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Vincent and the Grenadines.

government agencies and NGOs in Jamaica, versus 6.2 million male condoms (Verhage et al. 2011b). It was observed that demand for female condoms was low (ibid.). Moreover, female condoms were procured for USD 0.585 per piece; almost 20 times the price of male condoms (see also WHO 1997). In 2012 in the Dominican Republic, no female condoms were found to be available (Euromonitor International 2012a).

Between 2006 and 2012 in Haiti, the Caribbean Social Marketing Project for HIV and AIDS prevention and sexual health promotion (CARISMA) promoted national coverage of the female condom as a means to improve sexual and reproductive health in general and to reduce the rate of HIV infection (2006-2009). Despite these efforts, demand and use of the female condom in Haiti have failed to meet expectations. For example, by the end of 2010 Population Services International (PSI) Haiti had inventory of over 162,000 pc of its Reyalite female condom brand (FC2). Through the first nine months of 2011, only 50,000 were successfully distributed (Euromonitor International 2012c).

2.3 Acceptability, benefits and disadvantages of the female condom

2.3.1 Female condom acceptability

Early studies of female condom acceptability reported high acceptability rates, ranging from 37% to 96% (Hoffman et al. 2004). However, these studies typically examined only short-term acceptability: Women were shown the condom and asked to try it and report one or two months later on their willingness to use it in the future (see, for example, Napierala et al. 2008; Schilling et al. 1991).

Fewer intervention studies have tracked patterns of female condom use over a substantial period - between six months and one year-while also examining overall levels of protection (Hoffman et al. 2004). These longer term studies suggest that use of the female condom may lead to a small increase in the level of protected sex among high-risk populations such as sex workers and clients of STI and HIV clinics (ibid.). A study among sex workers in Antigua, for example, found that the number of sex workers reporting using a female condom with a client had increased from 10% in 2008 (baseline) to 52% in 2010 (PSI Research Division 2010). The Antigua study also reported an overall increase likelihood of sex workers using a female condom with a client from the period 2008 to 2010. Research in sub-Saharan Africa suggests that acceptability may actually be established quicker among sex workers than among other women (Deniaud 1997).

Studies in the general population have found that it has been difficult to motivate sustained use of the female condom. In Nigeria, for example, researchers found repeated use of the female condom to be very low. Only three out of ten persons who ever used female condoms intended to continue using it (Ezire 2013). Similar conclusions were drawn in a study in Kenya, where few women participants in an intervention program used the female condom (consistently) over a longer period of time (Welsh 2001). Nevertheless, among the women who did use the female condom 80% liked the devices very much or fairly well at both 6- and 12 month interviews. Among women who had used both the male and the female condom, about 3 times as many preferred the female condom to the male condom (ibid.).

Existing studies provide evidence that social marketing and education on proper use increase uptake and acceptability, particularly among first-time users (Deniaud1997; Ezire 2013; Napierala et al. 2008; Valens and Joseph 2013; Vijayakumar et al. 2006). In Zimbabwe, for example, women (ages 16-48)

who participated in a female condom intervention project received counselling about HIV/AIDS and safer sex, as well as participatory female condom demonstrations (Napierala et al. 2008). The participants also followed sessions on resolving relationship problems and learned about condom negotiation. While very few women had ever used the female condom prior to participating in the program, after two months reported use of the female condom had greatly increased and 27% of women stated that the female condom was their preferred method for pregnancy and/or HIV prevention. Vice versa in Nigeria, it was found that a poor first experience with the female condom was a major reason for discontinuing use (Ezire 2013). First use experience, in turn, was influenced by what users were told and the skills they had in wearing a female condom. The Nigeria study concluded that in order to increase repeated use, first-time users must be well informed and supported (ibid.). This implies, among others, that outreach workers must be adequately trained to effectively communicate the benefit of the use of female condom and skills on how to it, while addressing and taking away fears and myths concerning the use of female condom (Napierala et al. 2008).

In a related fashion, several studies report that acceptability increases as women gain skills in applying the female condom. A review of studies on female condom use and acceptability in several African countries concludes that: “initial negative perceptions of the device are often replaced with a more positive reaction after several uses. The experience gained with use reduces the technical problems” Deniaud (1997). A similar conclusion is drawn from a study in Kenya, which finds that the proportion of women who reported problems using female condoms diminished from the 6- to the 12-month visits, suggesting that female condom acceptability is affected by condom use skills (Welsh 2001)

Actual-use studies suggest that the female condom is not going to be acceptable to all women, nor to all men. A short-term randomized cross-over trial among US women in a steady relationship who tested both male and female condoms, for example, concluded that the male condom was preferred over the female condom among both women and their partners (Kulczycki 2004). Moreover, various African studies suggest that men find the female condom less acceptable than do women, and that male objection is an important reason for non-use (Deniaud 1997; Welsh 2001). Also sex workers may experience difficult negotiations with clients who refuse to use the female condom (Deniaud 1997). These findings suggest that acceptability of the female condom may be different for different population groups, depending on their gender, relationship status, socioeconomic position and other factors. The present Suriname study supports this conclusion.

2.3.2 Disadvantages

Incorrect use of the female condom may, like incorrect use of the male condom, result in the female condom not providing protection against a sexually transmitted infection and pregnancy. Failure rates for the female condom are slightly higher than those for male condoms. The incident pregnancy rate within the first year has been estimated at 5% for perfect use, as compared to 3% for the male condom, and 21% for typical use as compared to 15% for the male condom (Napierala et al. 2008). Other studies, however, found the contraceptive efficacy of the FC female condom in the same range as those of other barrier methods (Hoffman et al. 2004). The perception that the female condom provides a lesser level of protection than the male condom may deter some couples from using it (Valens and Joseph 2013).

The CARESMA condom marketing study in Jamaica identified possible determents of the female condom:

- Too much handling required at the point of use compared with other available contraceptive methods
- Inadequate promotion of this contraceptive method when compared with the male condom
- Relatively high cost of the female condom in the private sector.
  (Verhage 2011b)

Meanwhile earlier research in Jamaica pointed to additional variables impacting the sustained use of the female condoms including novelty, accessibility, cost, smell, and condom skills (Verhage et al. 2011b).
Nigerian researchers who conducted focus groups with men and women who had used the female condom found that the experiences of most of the participants, especially the women, were negative. Factors that discouraged repeated use of the female condom included those listed in Jamaica:

- Perceived complexity (difficulty of insertion),
- The time it takes to complete the insertion process, male condoms are faster to use than female condoms,
- Discomfort experienced in the process of use like pains from the inner ring,
- Fear of possibility that it might slip inside the vagina,
- Intimidation as a result of the size of the FC, and
- Price; it is too expensive

(Ezire et al. 2013)

Similar objections to the FC1 or 2 were voiced in other studies (e.g. Deniaud 1997; Naidu 2013) and, as we will see later, also in Suriname. With regard to the complexity of use, women in a South African study found it unpractical that that unlike with male condoms, to wear the FC the woman has to assume a certain position. For this reason, FCs cannot be worn at any moment and at any place (Naidu 2013).

The Nigerian researchers also observed resistance to change and fact that it is a “new” product. In addition, participants mentioned “lack of social support from friends and community members as a key factor why people initially use the female condom and then stopped” (Ezire et al. 2013: 211). Low availability of -and poor access to- female condoms also has been pointed out in several studies as a factor that deters couples from using this contraceptive device (Euromonitor International 2012a,b,c; Naidu 2013; Valens and Joseph 2013). Indeed, also in Suriname we find that as compared to male condoms, female condoms are relatively difficult to find – particularly at night time and in weekends.

Among women in Zimbabwe, two main complaints about the female condom were that it was “uncomfortable” and that it was not dependable (Napierala 2008). In Kenya, partner objection was an important reason to reason for not using female condoms (Welsh 2001). It he US, Schilling et al. (1991) found that the most common objections to using the female condom were its large size, possible messiness and inconvenience, and the belief that insertion would be uncomfortable and difficult. A random trial among patients from a US reproductive health clinic listed the following

complaints about the female condom: difficult insertion, pain or discomfort during intercourse (for both partners), and experience of burning, itching or irritation (Kulczycki 2004).

In South Africa, even women who favoured the freedom and agency potentially offered by the female condoms complained about the design of FCs, which "is not compatible with their bodies, raising concerns and appealing for a change in design, shape and size" (Naidu 2013). The fact that the FC is "unlike the male condom, a very generic 'one size fits all'" was felt as a limiting factor and not reflective of the diversity in female bodies and preferences. An undesirable scent, complexity of insertion, noisiness, and fear of the FCs getting lost in the body further dissuaded women from using the female condom (Naidu 2013).

The Female Health Company, which fabricates the FC2, acknowledges that "the following events are rare but can occur when using the FC2:

- Discomfort during insertion;
- Pain after insertion, before sex;
- Discomfort during sex;
- Burning sensation, rash or itching"

(Female Health Company 2013; World Health Organization 2007)

The Women's Condom, which was recently developed by the Program for Appropriate Technology in Health (PATH), has changed the design in response to some of the above complaints. According to its website, the material is "softer and thinner" and the inner ring has been replaced by "four small dots of soft, absorbent foam". PATS' new female condom model also facilitates insertion by adding "a rounded cap to the end of the condom, which gathers the condom pouch together until after insertion. Once the condom is inserted, the tip dissolves in less than a minute for most women."[5] The PATH Women's Condom is presently tested by the WHO.

2.3.2 Benefits

Female condoms are the only currently available female-initiated method of HIV and sexually transmitted infection (STI) prevention (Napierala et al. 2008). Proponents assert that the female condom provides women with more independent protection and is an "empowering tool against sexually transmitted diseases and unwanted pregnancies" (Naidu 2013, see also Deniaud 1997). Moreover, there is evidence from multiple studies that introduction of the female condom alongside the male condom increases the rate of protected sex acts (ibid.).

In an early acceptability study, Latin-American and Afro-American women from vulnerable populations in the US expressed preference for the female condom over the male condom for the following reasons: it would enable women to have control over their own protection; it would be safer than a male condom; and the use of the female condom would be less embarrassing than asking a man to use a condom (Schilling et al. 1991).

In a Nigerian study, married couples who had become regular users of the female condom provided the following benefits of the female condom:

[5] See PATH website: http://www.path.org/projects/womans_condom.php

- The female condom is an effective way to prevent pregnancy and sexually transmitted (STIs) without any concern about side effects, unlike other contraceptive methods such as pills and injectables.
- The female condom enabled women to meet the sexual needs of her spouse irrespective of whether she was menstruating or breastfeeding (named by women).
- If female condom is properly used, it gives a natural feeling as if one is having sex without a condom.
- Some also felt the female condom is better lubricated and so reduces pains that may occur as a result of the woman not being properly lubricated.
  (Ezire et al. 2013)

In South Africa, the few women who favoured the female condom indicated that it made them feel empowered, more protected and relaxed. It was also commented that the female condom was stronger and less likely to burst than the male condom (Naidu 2013). Women who participated in a female condom intervention program in Zimbabwe believed that the female condom can be used more consistently than male condoms (Napierala et al. 2008)

3. Organizations

This chapter provides information about the relevant organizations that are distributing (female) condoms and/or providing HIV & AIDS services and counselling[6]. Some of these organizations were named by respondents as places where to go to if they have medical questions or complaints regarding sexual and reproductive health or named as the place where they can find free (female)condoms (see Chapter 4). Summary information about these organizations is provided in Table 1.

National AIDS Programme

The national AIDS Programme (NAP) in Suriname resides under the Ministry of Health and has a two-tier policy. One focal area of the NAP is its treatment programme, which focuses on the improvement of all aspects of treatment of people living with HIV and AIDS. These aspects include improving the quality of health care and training of family doctors and nurses in HIV testing and care. A second focal area is the prevention programme, which has as its aim to better inform society about HIV and AIDS, to more openly discuss sexuality, and to combat the stigmatization of people living with HIV. The NAP is not an implementing organization but coordinates all HIV related activities carried out by other organizations.

LIBI!

The LIBI! Information centre is a government information centre for health promotion, which disseminates different health information materials. One of the main tasks of LIBI! is to refer clients to national information services for HIV, Non Communicable Diseases, Chronic Care, Tuberculosis, Cancer. The Centre also informs on issues such as implementation of the Tobacco Law and

[6] General information is also based on studies on Comprehensive Sexuality Education (2013) and PANCAP Mapping (2012), both submitted by Heemskerk & Duijves

Alcoholism. The distribution of condoms and lubricant is also part of the LIBI! information centre program activities.

To improve access to health education material, LIBI! develops and prints brochures and pamphlets. In addition, the Centre collects information and promotional materials from various other organizations concerning health related matters, which subsequently are made available by and within the centre. Furthermore, LIBI! takes parts in health awareness fairs where both male and female condoms and the use of lubricant are promoted.

LIBI! staff have observed that female condoms are seldom requested (S. Bleau, Coordinator LIBI!, pers. com 4 December 2014). It also has been experienced that in cases where the female condom is offered as a tool for the prevention of pregnancies and STIs, women complained that insertion of the female condom took more time than putting on a male condom and was inconvenient.

A representative of LIBI! underlined the need for more publicity around the benefits of the female condom, and for more awareness (Ms. Bleau, Coordinator LIBI!, pers. com.4 December 2014). In her vision, use of the female condom can strengthen women in their freedom to determine when, where and how they want to protect themselves. Acceptance can be increased through social marketing of the female condom. Awareness should be focussed on expansion of available choices rather than on the female condom as a means of prevention.

Between August 2012 and October 2014, LIBI! received 100.000 female condoms from the UN. By July 2014, 74.997 female condoms had been distributed, among which about 1800 to the general public (Ms. Bleau, Coordinator LIBI!, pers. com. 4 December 2014). The remaining condoms had been donated to various organizations. LIBI! Does not know what happened with the (female) condoms after distribution – either to organizations or to individuals. There are no monitoring activities to check whether the various organizations have distributed female condoms; how many and to whom. Neither have there been efforts to investigate where the distributed condoms have ultimately ended up, whether or not they have been used, and how clients have experienced these condoms.

During the validation meeting stakeholders expressed concern about the limited control on the distribution of free male and female condoms. For example, it was noted that individuals who present themselves at the LIBI! counter can take away boxes of free condoms, but they are not held accountable for what happens with them.

Department of Dermatology

The Dermatology Service (popularly known as “Derma”) is an executive organisation that falls directly under the Ministry of Health. The department offers free Voluntary Counselling and Testing (VCT) services and free tests for other STI's in the health clinic. Medications for the treatment of STI's are available against payment but the Dermatology Service does not extend HIV medication. After being diagnosed with HIV, the patient is redirected to a general practitioner.

Sex workers from registered clubs, mostly migrants, come by every six weeks for their obliged STI test and counselling when necessary. At this moment five clubs (from two owners) are registered, and the -Brazilian, Jamaican, Venezuelan and some Colombian- sex workers from these club take part in the health program. The head of the HIV/AIDS counselling and testing department explained that new sex workers of these clubs must come over for an overall check up (Ms. Hordijk, pers. com. 28

November 2014). This includes a screening for STIs, a VDRL (Venereal Disease Research Laboratory) test and a skin examination. An HIV test is recommended but not obligatory.

When sex workers visit the Dermatology Service they receive 30 male condoms, 6 female condoms and 30 sachets of lubricant. Sex workers who are not familiar with the female condom receive information on how it should be used. Other sex workers can, like any other person, on their own account visit the Dermatology Service for a free HIV and/or STI test. No doctor's prescription is required. There is no mechanism to register whether sex workers actually used the female condoms they received and if not, what they did with them.

The Department of Dermatology does not organize sessions concerning HIV/AIDS and condom use on its own initiative, but this can be arranged on request.

The consulted head of the HIV/AIDS counselling and testing department indicated that the female condom is not very known by Suriname women (Ms. Hordijk, pers. com. 28 November 2014). During counselling employees of Derma explain how to use this type of condom and distribute them. Every client receives six condoms. Female condoms are not distributed to the general public, except when they are asked for. Because most clients do not return to the clinic, the Dermatology Service receives no feedback about experiences with the female condom..

Foundation Regional Health Service (RGD)

The Regional Health Service is a parastatal organization subsidized by the government for the provision of primary health care services to the coastal population of Suriname. Its services are in the first place directed to the approximately 120,000 poor and very poor (*on- en minvermogenden*) who are registered with the Ministry of Social Affairs. These registered poor are issued a medical assistance card, which they use to obtain free medical attendance at one of the RGD clinics or associated hospitals. Some 25,000 others who are covered by the State Health Insurance Fund (SZF) choose RGD doctors as their primary physicians. In addition, individuals with private health insurance sometimes choose RGD doctors as their health care providers.

The Foundation Regional Health Service did not respond to our request for input for this study

Medical Mission

The Medical Mission Primary Health Care Suriname (*Medische Zending, MZ*) is a private, non-profit organization that acts as an umbrella organization for three religious organizations that have undertaken to provide medical services to the population of the interior. Besides the RGD, they are the other key component in the national primary healthcare system. The districts under the administration of MZ are sparsely populated but cover about 80% of the landmass of the country and possess some of the poorest infrastructure in the country. Altogether the MZ operates 57 health posts, which are VCT sites as well.

Health care is provided by health workers, the majority of whom originate from local communities. These health assistants have a diploma recognized by the Ministry of Health and fall under the

inspection of nursing and caring professions. HIV counselling is part of their curriculum and regular refresher courses take place.

Overview of FC2 received

Year	Received by MZ head office
2011	8000
2012	1000
2013	4000

Source: Medical Mission 2014, provided upon request

The distribution of female condom (FC2) took place in 2012 and 2013. In 2012 54 MZ clinics received a total of 7,893 female condoms and in 2013, 39 MZ clinics received a total of 3,644 female condoms. A representative of MZ explains that the female condom is not popular in use at places were no specific programs are implemented for the promotion of FC2. In general, in communities where MZ is active, men are typically dominant in decision making about contraceptive use (Ms. Meerberg, pers. com. 28 November 2014).

An assistant physician at the medical post in the village of Ladoani in the Upper Suriname River region indicated that female condoms are not commonly distributed (Ms. Chotkoe, pers. com. 2 December 2014). The post serving the village of Nieuw Aurora and surroundings has a large supply of male condoms that are distributed frequently, from the post and from the houses of employees. However, in the 8 weeks working at this clinic, the consulted assistant physician had only seen one or two female condoms (ibid.). During neonatal consultations she informed the mothers about contraception, with the female condom being one of the options. Employees are well aware of the female condom and capable to provide information. It is unknown if culture plays a role in the acceptance of the female condom but generally, area residents appear very open to listen to and talk about sex education (ibid.).

A health assistant at the medical post in Marchallkreek explained that she provides monthly education sessions about sexuality and contraceptives. In addition, the topic is discussed during neonatal consultations (Ms. Eiflaar, pers. com. 3 December 2014). During these sessions the health assistant distributes male and female condoms, which she obtains from the Medical Mission office in Paramaribo. Her experience is that women of the village do not use the female condom. Some explained that they are afraid the condom will get stuck inside. Men are of the opinion that the male condom is better. Nevertheless, the consulted health assistant voiced the opinion that it is important to also distribute female condoms during education (ibid.).

Public Health Office (Bureau Openbare Gezondheidszorg, BOG)

The BOG is the national institute for preventive health care, and focuses on promoting and monitoring the health of Suriname's population. The organisation works on public health prevention and control of specific diseases through policy development, epidemiological surveillance, health education, research, laboratory diagnostics and public health intervention.

BOG does not provide clinical HIV services and counselling and does not distribute condoms. Nevertheless, in its role as health policy maker, the organisation included the female condom as an option in the "decision making tool" (DMT) for family planning.

Lobi Foundation

The Lobi Foundation (1968) is an NGO, which has as its mission to promote the quality of life in Suriname by improving the health of particularly women and children. This mission is executed by promoting responsible parenthood and reproductive health, and is based on respect for human life, human dignity and strengthening of the family.

The main working area of the Lobi Foundation is Sexual and Reproductive Health, which is approached through the principle: “Sexuality is a key element in the life of every human being; therefore each individual must be able to express his/her sexuality in a pleasant and responsible way” (Lobi website: http://www.lobisuriname.org/). Comprehensive Sexuality Education (CSE) is inherent in all activities of the Lobi Foundation. The foundation has clinics in Paramaribo, Lelydorp, Moengo and Nickerie. The first two clinics are VCT sites.

The organization does not pro-actively travel to the interior for outreach and/or medical services but when invited, health workers from the organization also travel outside of their regular service areas. The organization has a mobile unit for counselling and testing outside of the regular VCT locations. Lobi Foundation has an oral agreement with MZ, arranging that Lobi will not work in the MZ areas.

Lobi Foundation distributes (male and female) condoms. There is no special attention paid to the female condom; it is offered as another option in the range of contraceptives. Negative experiences that have been shared with Lobi Foundation are the insertion time and the disturbing sound. One of the advantages of the female condom is the fact that women can decide themselves to protect themselves. A physician at Lobi Foundation explained that during awareness sessions, educators also discuss positive traits of the female condom, such as that it can have a stimulating effect during intercourse (Drs. Slijngard, pers. com. 28 November 2014). Use of the female condom during anal sex is also discussed during awareness.

Some years ago the female condom was sold for Srd 5 (~US$ 1.50) but nowadays the Lobi Foundation distributes male and female condoms for free. In the year 2011, 46,878 male condoms were sold and 3,095 female condoms were handed out (Heemskerk & Duijves 2012). In recent years approximately 3000-4000 female condoms have been distributed annually (Ms. Breidel, educator at Lobi Foundation, pers. com. 14 November 2014).

Youth Advocacy Movement (YAM) of the Lobi Foundation

The YAM (2001) is the youth group of Lobi Foundation. The Suriname YAM is part of the international YAM network, which was established by the International Planned Parenthood Federation, Western Hemisphere Region Inc. (IPPF/WHR). The various YAM groups represent youth interests within organizations that provide information and raise awareness about SRH in the East Caribbean region. The mission of YAM Suriname is to strengthen SRHR among youth. YAM Suriname counts 23 members, among whom 14 are regularly active. The members are aged 17 to 25.

Suriname Men United (SMU)

Suriname Men United (SMU) is a Foundation which is dedicated to the well being and health of Men who have Sex with Men (MSM). SMU provides information with the aim to prevent the spread of STIs and HIV.

The organisation executes outreach activities for MSM. These activities primarily focus on education about STIs, HIV education, the distribution of condoms and lubricant, and education about condoms. The female condom is not part of SMU's outreach activities. The chair of SMU indicated that he is not aware of the use of female condoms by MSM (Mr. Van Emden, pers.com. 17 Nov 2014).

Foundation He+HIV

The Foundation He+HIV was founded in 2009, and focuses on care and support of Men who have Sex with Men and living with HIV (MSM+). The mission of the organisation is to improve the acceptance and equality of MSM+ through education and sensitizing. Besides, they focus on reducing stigma and discrimination of homosexuality and HIV in society and they promote a healthy lifestyle of MSM+.

The Chief Executive Officer at Foundation He+HIV stated that he is not aware of use of the female condom by MSM (Mr. Colom, pers. com. 28 November 2014). During a recent capacity building training, none of seven (MSM) participants had ever used the female condom.

Foundation Liefdevolle Handen

Liefdevolle Handen (Loving Hands) was founded in 2009 and is connected to the Evangelical/Gospel church (*Volle Evangelie*). This Faith Based Organization (FBO) provides guidance to women with psychosocial problems in general and of sex workers and drug addicts in particular. In addition, the Foundation supports women with bereavement, abused females and mothers with maladjusted children.

Outreach -including condom distribution and information provision- is among the strategies employed in the area of HIV prevention. Three times a week in the morning and three times a week by night the employees go into the streets, to clubs and massage salons to deliver these services in Paramaribo. Every now and then they distribute condoms and deliver information in the districts of Commewijne and Brokopondo as well. During outreach attention is given to different themes (e.g. syphilis, HPV infection) and when necessary the use of both male and female condoms is demonstrated with a dildo and a model vagina (Figure 1). Women are the primary target group. Men are included but not actively targeted. Per month, the organization distributes about 200 male condoms and 50 female condoms, including lubricant. The target group has expressed challenges in use of the female condom especially regarding inserting the commodity. The foundation leaves the choice to the target group; there is no specific promotion of the female condom.

During the UNFPA validation meeting for the present report, representatives of *Liefdevolle Handen* revealed some women experienced discomfort from the ring inside the condom and from insertion (Ms. Bromet and Ms. Barrington, pers. com. 28 November 2014). The organization explains that it

would be good to increase women's knowledge on the female condom, emphasizing the fact that women can protect themselves through the use of this condom.

Figure 1. Demonstration of the insertion of the female condom by a peer educator of Stg. Liefdevolle Handen.

Foundation Double Positive

Foundation Double Positive was founded in 2009. The main activity of the foundation is to provide (psycho-social) assistance, care and guidance, to women and young girls living with HIV/AIDS, and their environment. That guidance is provided by buddies, peer counsellors and social workers. The organization has approximately 250 persons in its database.

Double Positive staff members provide trainings, also in the interior. In addition, they visit schools, and health fairs. Once a the month, information concerning HIV/STI's is given in the maternity ward of 's Lands Hospital. At every occasion male and female condoms and lubricant are distributed. Use of both types of condoms is also demonstrated with a dildo and a model vagina.

Female condoms are not often used by females. Women leave it to men to take care of the condom explains Ms. Verdies, peer counsellor at Double Positive (pers. com. 28 October 2014). Women are too little aware of the advantages and men are not familiar with this type of condom. Ms. Verdies noted that one of her clients, an MSM, had problems with rupturing of condoms when he was doing sex work. He was advised to use the female condom, without the ring, for anal sex.

New Beginnings Consulting and Counseling Services

Established in 2007, the consultancy firm New Beginnings Consultancy and Counseling Services (NBCCS) is specialized in the design of health programs and the provision of technical assistance as a partner of the Ministry of Health. In addition NBCCS supports companies, schools and organizations concerning coaching and counselling in the field of health.

Among its various services, NBCCS provides Christian health and family life education and faith based counselling. The firm delivers outreach in Paramaribo city, in rural districts and in gold-mining areas. Its outreach workers distribute approximately 2250 condoms and 1000 sachets of lubricant per month. New Beginnings Consultancy and Counseling Services incorporates the NGO Chances For Live.

NBCCS has stopped the distribution of female condoms because nobody was interested (Mrs. Kambel, director NBCCS, pers. com. 27 October 2014). The NBCCS director experienced that in general, sex workers do not like this type of condom and the male condom is easier to apply, smaller, and easier to carry. Moreover, sex workers have tricks to put on the male condom which is not possible with the female condom (ibid). The NBCCS director also pointed at the risk of re-use of this type of condom.

During consultations with NBCCS, it was indicated that some MSM make use of the female condom. Hence during trainings attention is also paid to the use of the female condom by MSM. At present NBCCS focuses on condom promotion and negotiation strategies for specific groups (Mrs. Kambel, director NBCCS, pers. com. 27 October 2014).

United Nations Population Fund (UNFPA)

UNFPA is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programs to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

The overall objective of the UNFPA Country Programme in Suriname, as part of its regional strategy, is to contribute to the reduction of poverty and to improve the quality of life of the people by promoting sexual and reproductive health and rights; gender equality and equity by integrating population related factors into development strategies and plans.

UNFPA started its cooperation in Suriname in 1985 by supporting projects in the area of adolescent health, data collection and capacity building for population programmes. In 2003 its liaison office was opened in Paramaribo with the objective of strengthening the organization's capability for stepping up program delivery in the country.

UNFPA does not distribute female condoms itself. The imported stock is sent to the National AIDS Program (LIBI!), which is responsible for the distribution of condoms. (Virtually) all organisations that distribute female condoms in Suriname obtain their stock from LIBI!. Once or twice a year UNFPA receives a report from NAP with number of condoms that have been distributed and a list of organisations that received condoms (e.g. hospitals, brothels, foundations). More detailed data is not available.

Youth Advisory Group (YAG) of the UNFPA

The youth group of UNFPA, the Youth Advocacy Group (YAG) Suriname, is a diverse group of six to ten young Suriname adults (aged 20 to 25) who support the UNFPA in issues regarding their mandate. The group contains representatives of different sub groups such as adolescent mothers and men who have sex with men (MSM), and is chaired by a male and a female chair person who are annually re-elected. Under the auspices of UNFPA, YAG members participate in workshops and attend international meetings. In addition, the group can suggest ideas for activities to UNFPA. The YAG Suriname has been involved in peer education about sexuality since its establishment in 2010, and has always discussed sensitive topics in the area of sexuality.

The YAG provides closed and open SRH information sessions to promote condoms. In 2013, YAG youth received peer education training, and the program was started up in 2014. Open sessions feature a display table with a dildo and a model vagina to demonstrate correct use of the male and female condom. A problem with demonstration of the female condom is that you cannot see inside. The ring has to be placed against the opening of the uterus – that has to be explained in words. These sessions take place in public places, such as shopping malls or the city-centre. The information is rather basic as people are passing by.

During the closed sessions, a group is invited to an agreed location. The information provided is more extensive, about safe sex, and people tend to ask more questions. Reactions to the information tend to be very good. In 2014, 6 closed sessions and 5 open sessions were performed. In the annual planning for 2014, it has been foreseen that two sessions will be held monthly.

In order to conduct information sessions at schools (e.g. MULO), approval must be obtained from MINOV, because condom use is not part of the curriculum. During the sessions it appears that many youth have heard about the female condom, but very few ever used it. So far only two youngsters who were part of the sessions indicated that they had used it and liked it. The male condom is better known; you cannot find the female condom at the Chinese corner store. Some sex shops feature female condoms but they are to hand out for free, not for sale. The YAG chairperson stated that Surinamese are conservative and do not easily try new things. Therefore it will take a while before the female condom will gain in popularity (Ms. Kromosoetoe, pers. com. 29 October 2014). One perceived disadvantage of the female condom is that it takes some effort to insert it. Besides, the distribution of the female condom should be more equal to that of the male condom; if the female condom is more widely available more people may try it out of curiosity (ibid.).

4. Results

4.1 Demographic profile

Respondents were on average 32.8 years of age; the youngest was 18 years old and the oldest interviewee was 64 years. Surveyed women (N=41) were on average slightly older than men (N=23), but the difference was small (33.4 yr vs. 31.8 yr). Fourteen respondents were younger than 25 years of age, 28 were between the ages 24 and 34, 11 persons were between 35 and 44 years old, and the remaining 11 persons were 45 years of age or older (Figure 2).

Three quarters of the survey sample consisted of Surinamese (73.4%), 21.9 percent were Guyanese, and the sample included one Brazilian, one Venezuelan, and one person from the Dutch Antilles (Figure 3). All but one of the Guyanese were sex workers, as well as the Brazilian and the Venezuelan. The largest group of survey respondents consisted of Creoles (42.2%), followed by persons of mixed ethnic heritage (26.6%), Maroons (25%), East Indians or Hindustani (3.1%) and Javanese (3.1%).

In terms of religion, the largest group of survey respondents consisted of Roman Catholics (28.1%), followed by members of various evangelical denominations such as the Moravian Church[7] (21.9%), the Anglican church (1.6%), and the *Volle Evangelie* (14.1%) Other people self-identified as general Christian (18.8%) and smaller numbers of survey respondents were Rasta, Hindu, Muslim or Atheist.

[7] In Suriname this church is known as EBG

Figure 2. Age groups of survey respondents

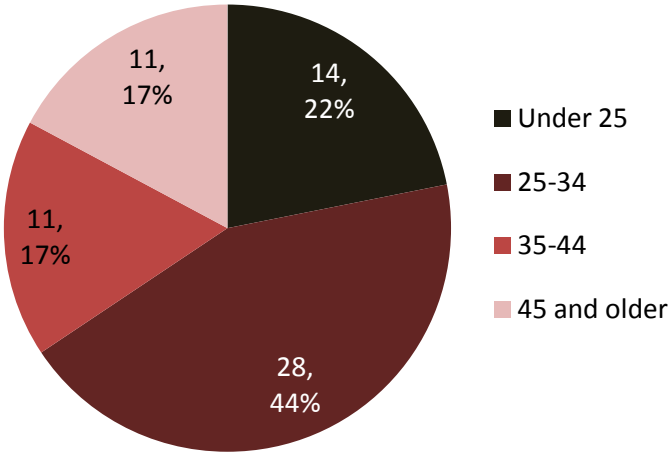
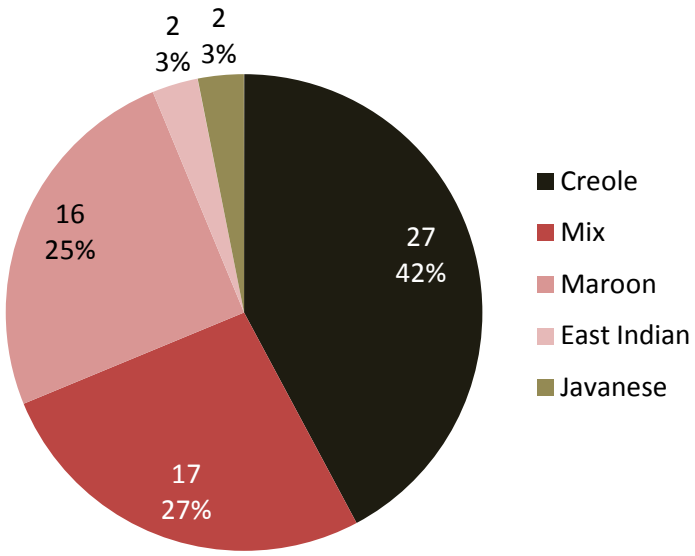


Figure 3. Ethnic background of the survey respondents



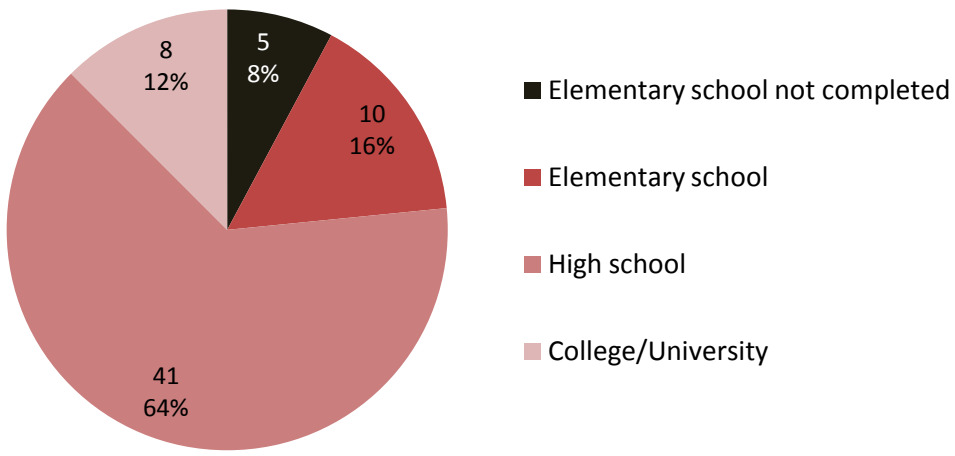
Five persons in the survey sample had only a few years of elementary school (7.8%) and another 10 persons (15.6%) had completed elementary school but no more advanced diploma (Figure 4). Close to two thirds of the sample had a high school diploma, among whom 26 persons (40.6%) a diploma at the VOJ (Continued Education at the Junior level)[8] level or equivalent and 13 (20.3%) a VOS (Continued Education at the Senior level)[9] equivalent diploma.

Survey respondents performed a wide variety of professions including housewife/mother (5 pers.), student (6 pers.), teacher (5 pers.), public worker (4 pers.) construction worker (4 pers.) and health worker (4). Other professions that were listed by just one or two persons included: gold miner. Call agent advisor, musician, technician, a job in the hospitality/tourism sector, fisher, social worker, cook, a job at the Counter Terrorism Unit, and entrepreneur. Seven interviewees worked in an

[8] In Suriname, VOJ included school such as MULO, LBO, ETO, etc.
[9] In Suriname, VOJ schools include school such as HAVO, VWO, Lyceum, etc.

organization within the SRH and HIV/AIDS sector. The sample included 18 sex workers (28.1%), including 13 Guyanese, 3 Surinamese, one Brazilian and one Venezuelan. Six sex workers reported that in addition to performing sex work, they also run a small business.

Figure 4. Educational background of the survey respondents



4.2 Sexual profile of the respondents

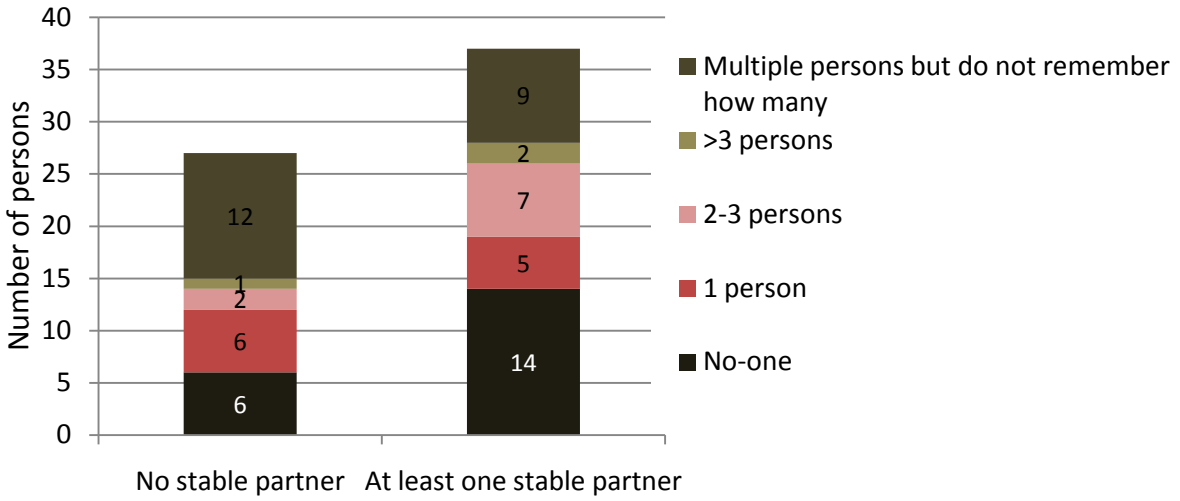
Of the 64 survey respondents (41 female, 23 male), 42.2 percent did not have a stable partner. A little over half of the survey respondents had one stable partner (53.1%), and smaller numbers of respondents had two (1 person) or more (2 persons) stable partners. Sex workers were a little less likely than others to be involved in a stable relationship, but the difference was small (resp.50% versus 60.9%)

All but one respondent had been involved in heterosexual sexual contacts only in the past year. Of the 41 women in the sample, three reported no sexual contact in the past year, thirty-five had only had sex with men, and the three remaining women had been involved in sexual activity with both women and men. One woman, a sex worker, had been sexually active with both women and men. All 23 surveyed men had only been sexually active with women in the year preceding the interview.

According to representatives from the UNFPA, Lobi Foundation and New Beginnings Consulting and Counseling Services (NBCCS), the female condom is also used by Men who have Sex with Men (MSM) for anal sex. However, the chair of Suriname Men United (an interest group for MSM in Suriname), the Chief Executive Officer of He & HIV (an interest group for HIV-positive men in Suriname) and the owner of a gay club in Paramaribo were not familiar with this phenomenon. Furthermore, during a He & HIV capacity building training for MSM living with HIV, all seven participants indicated that they had never heard of use of the female condom by MSM. Also transvestite sex workers who were hustling in the streets and various MSM who were approached in a gay bar in Paramaribo reported that they had never heard of MSM using the female condom, and they wondered how this could work. Hence we conclude that even though it is possible that there are men who use the female condom when they have sex with other men, this is not common behaviour in Suriname. Because the MSM we approached did not feel that the female condom was applicable to them, we did not interview them.

Whether or not someone has a stable partner does not appear to have a strong effect on the number of casual sexual contacts (Figure 5). Among those with at least one stable partner, 37.8 percent did not have sex with casual contacts in the past year, versus 22.2 percent of those without a stable partner. Among interviewees with a stable partner, 13.5 percent had had sex with one person who was not the stable partner in the past year, and almost half with more than one (48.6%). Among persons without a stable partner, 22.2 percent had had sex with one person, and just over half (55.5%) with more than one. The presence of sex workers in the sample affects these numbers. Nevertheless, also if we exclude sex workers from the sample, we find that 17.9 percent of persons with a stable partners had one sexual contact with a non-stable partner in the past year, and 32.1 percent with more than one non-stable partner (N_{total}=28).

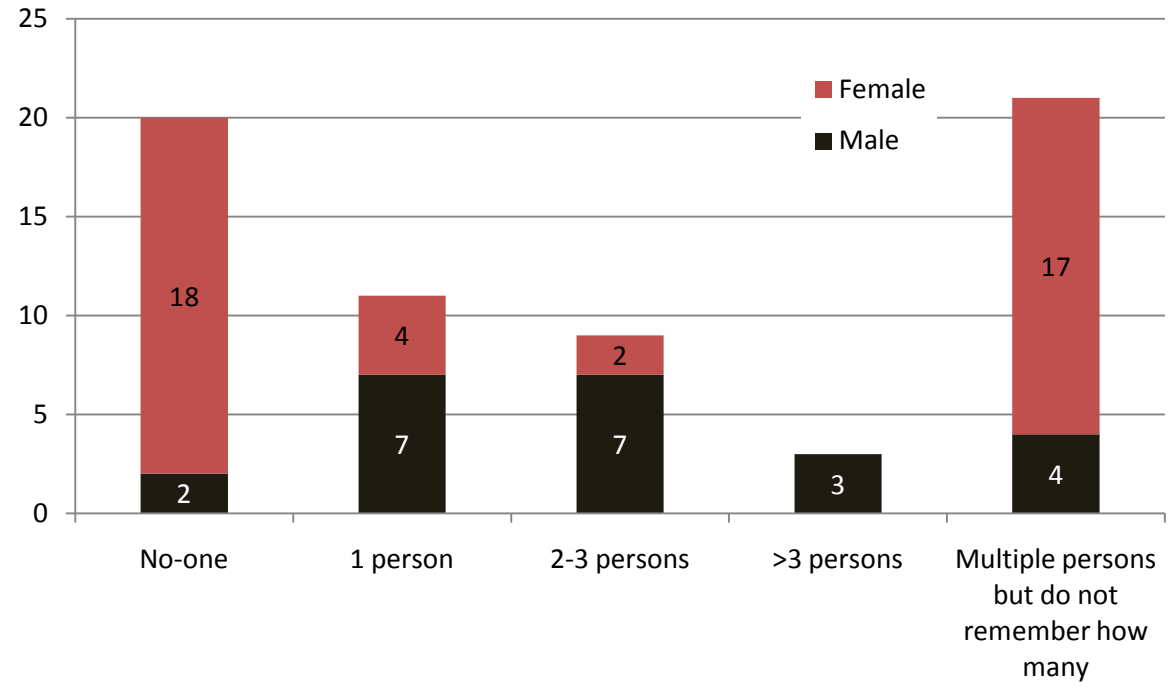
Figure 5. Number of persons who are not a stable partner with whom the interviewee had sexual contact in the past year, by whether or not the person has a stable partner



Gender affects the likelihood that a person has multiple partners. In the total sample, we find that 43.9 percent of women (N=41) did not have any casual sexual contacts in the past year, versus 8.7 percent of men (N=23). Furthermore, four women (9.8%; N_{total}=41) and seven men (30.4%; N_{total}=23) reported that they had had one casual sexual contact in the past year.

In the complete sample the findings are convoluted by the presence of sex workers who have sexual contact as a profession. When we exclude sex workers from the sample we find that men are even more likely than women to engage in casual sexual relationships. All 17 women who reported that they had multiple sexual contacts but did not know how many, were sex workers. Without sex workers, there are no women who reported that they had more than two to three casual sexual contacts in the past year. Only one woman who was not a sex worker reported that she had had more than one casual sexual contact in the past year, versus more than half of surveyed men (56.5%; N_{total}=23).

*Figure 6. Number of non-stable sexual partners in the past year, by gender**



* The data include sex workwers, which are largely responsible for the large number of women with multiple casual sexual contacts

4.3 Use of condoms

When asked about the best way to prevent Sexually Transmitted Infections (STIs) when one is sexually active virtually everyone named using a condom (96.9%). Two persons named being monogamous/loyal, and another two referred to not having oral sex. Other answers were only mentioned once, including: washing/hygiene, not kissing, sexual abstinence, HIV testing, more support for sex workers, using the contraceptive pill, and using two condoms- her and his.

In total 42.2 percent of respondents reported using condoms consistently in the past year (Figure 7). Others used condoms seldom (4.7%), once in a while (14.1%), or often (9.4%). Seven women and one man reported that they had not used condoms during sexual activity in the past year. All seven women were reportedly monogamous; they had one stable partner and did not have any casual partners. The man in question did not have a stable partner and reported one casual sexual partner.

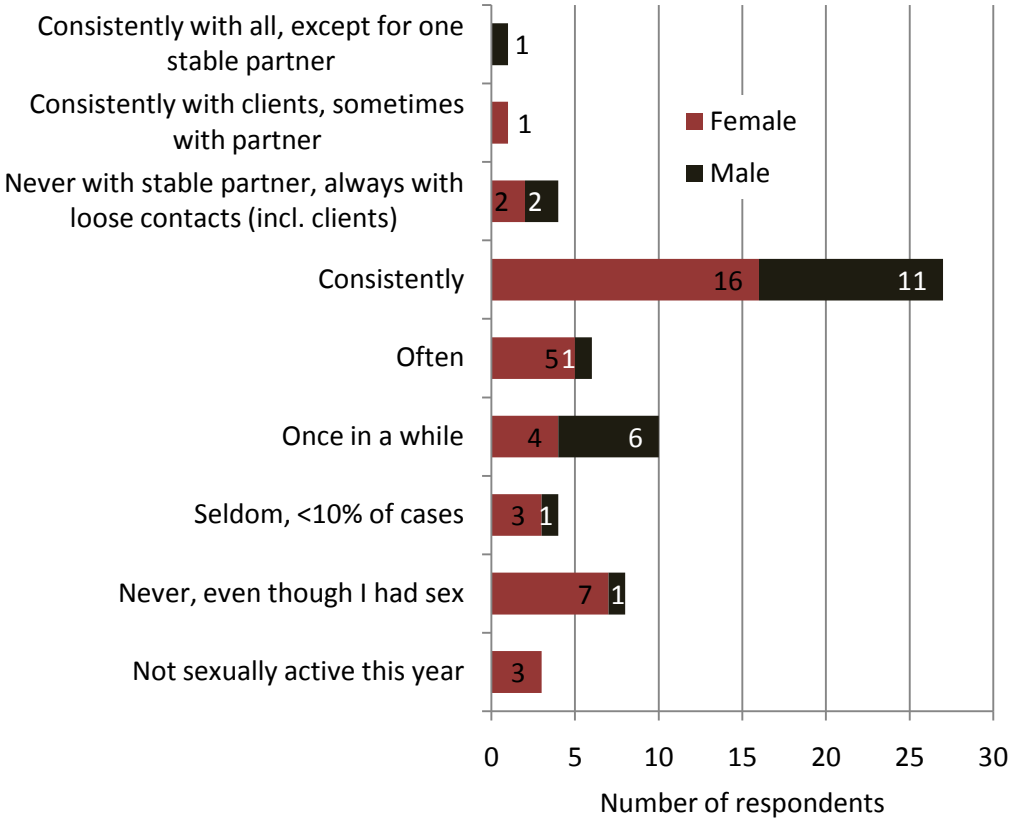
Two thirds of sex workers (66.7%) versus one third of other respondents (32.6%) had consistently used a condom in the past year. Sex workers who had not consistently used a condom in the past year indicated that they consistently used condoms with clients (and casual partners) but not with a stable partner.

The results further suggest that also other persons use condoms selectively; they do use them in some occasions or with some partners, but not with others. There seems to be a tendency to not use a condom with a stable partner, and (sometimes or consistently) use a condom with casual partners. Indeed, of those persons who did have sex AND who used a condom (N=53), one third (32.1%) only used a condom when having sex with a casual partner (incl. sex worker clients). Another 9.4 percent

of respondents used condoms only with their "stable casual partner". In addition, seven out of the eight persons who had not used condoms during sexual activity in the previous year were in a stable relationship.

The above, however, is no rule of thumb and the sample included also persons who do not fit this pattern. For example, 28.3 percent of those who had used a condom in the previous year reported that they had used condoms with their stable partner(s) (N_{total}=53). Six persons (9.5%) had used condoms with both stable and casual partners (N_{total}=53).

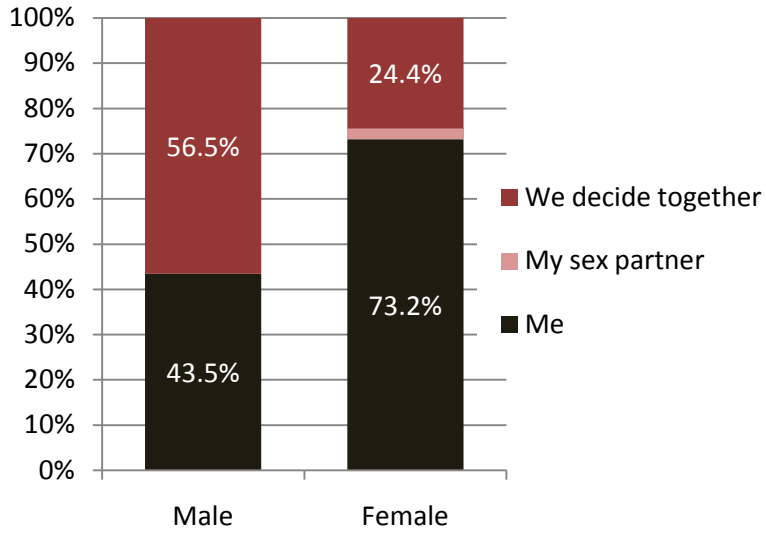
Figure 7. Consistency of condom use in the past year, by gender



The main reasons to use a condom are the prevention of pregnancy (4.7%), the prevention of SOAs/HIV (37.5%), or a combination of those two (48.4%) (N_{total}=64). Less common reasons to use a condom were to experiment (1 person), to maintain bodily fluids (1 person), protection of the partner by someone who is HIV-positive (2 persons), or to protect oneself in general (4 persons).

Women appeared stricter than men when it comes to deciding about condom use (Figure 8). Close to three quarters of women reported that when they were having sex, they were the ones to decide about condom use (73.2%; N_{total}=41). About a quarter of women said that the decision on whether or not to use a condom was made together with the sex partner (24.4%), and only one person left the decision to the sex partner (N=41). Among men, 43.5 percent reported that they were the ones to decide about condom use while just over half of men reported that this decision was made together with their sex partner (56.5%; N_{total}=23). All but two sex workers indicated that they were the ones deciding about condom use. The two other sex workers would decide together with the sex partner.

Figure 8. Who decides to use a condom when having sex, by gender



4.4 Opinions of the female condom

All respondents, regardless of their personal experience with the female condom, were asked about the perceived benefits and disadvantages of this type of condom. As benefits, respondents mainly referred to protection against pregnancy and STIs, whereby some believed the female condom offered better protection (23.4%) while others were of the opinion that it served the same function as the male condom (17.2%) (Table 3). Other important benefits in the eyes of survey respondents were that the female condom can be placed in advance (9.4%), that the man does not need to wear a condom (6.3%), that the woman has more power of decision-making (6.3%) and that it protects women (6.3%). For example, one woman responded: "[the female condom] is my thing. I wear it before the man can complain about the condom." Other advantages were mentioned by less than 4 persons. In addition, 15 persons did not know any advantages (23.4%) and four persons were of the opinion that the female condom does not have any advantages (6.3%; N_{total}=64).

Table 3. Perceived benefits of the female condom (N=64)

Perceived benefits of the female condom	Nr	%
Provides better protection	15	23.4%
Same as male condom; protection against pregnancy and STIs	11	17.2%
You can place it in advance so no need to interrupt sexual activity	6	9.4%
Man does not need to wear a condom	4	6.3%
It gives women power of decision making	4	6.3%
It protects women	4	6.3%
No advantages	4	6.3%
Flexible, supple, feels good	3	4.7%
It always fits	2	3.1%
Firmer than the male condom; does not easily rip	1	1.6%
Can bring it in as part of foreplay	1	1.6%
Less painful than the male condom because it is better lubricated	1	1.6%
Don't know	15	23.4%

Respondents also listed a variety of perceived disadvantages of the female condom, the main ones being that the female condom is painful/uncomfortable in use (20.3%) and difficult to insert and/or use (14.1%). These and other perceived disadvantages are listed in Table 4. Some women indicated that they removed the ring out of the condom in order to prevent that it might hurt. A SRH expert indicated that this ring is only a tool for insertion of the condom and its removal does not affect reliability of the condom (Dr. Slijngard, physician at Lobi Foundation, pers. com. 28 November 2014).

Table 4. Perceived disadvantages of the female condom

Disadvantage	Nr	%
Don't know	15	23.4%
Painful/uncomfortable	13	20.3%
Difficult to insert/use (when you are not used to it)	9	14.1%
Can slip off	4	6.3%
No disadvantages	4	6.3%
Person or partner does not like the feel of it during sex	3	4.7%
Same as male condom	3	4.7%
Scary	2	3.1%
Dry	2	3.1%
Seems complex	2	3.1%
Feels unsafe	2	3.1%
Men are not familiar with it/do not trust it	2	3.1%
Man complains that he does not feel anything/that it is a burden	2	3.1%
Can get stuck	2	3.1%
Annoying sound	1	1.6%
Hard to find	1	1.6%
You need to hold it otherwise the outer ring slips inside	1	1.6%
You cannot see if it ruptures	1	1.6%
If the man is rough the penis can go beside it	1	1.6%
Don't know how to use it	1	1.6%
Large/feels as a bag	1	1.6%

Just over half of the respondents had actually used the female condom (51.6%; N_{total}=64). Twenty-three women from the sample had used it (56.1%; N_{total}=41), and an additional two women had inserted the female condom to experiment, but they had not actually used it with a partner. Among men, 10 out of 23 had used it (43.5%; N_{total}=23). The results suggest that the female condom is relatively more often used among sex workers than among the general population. Thirteen of the seventeen sex workers in the sample had used the female condom, versus 20 of the 45 persons who were not sex workers. Because we made a conscious effort to interview persons among whom at least half had used the female condom, these figures are not representative for the general Suriname population. In a random sample, the difference in user rates of the female condom between sex workers and the general population would most likely be much higher.

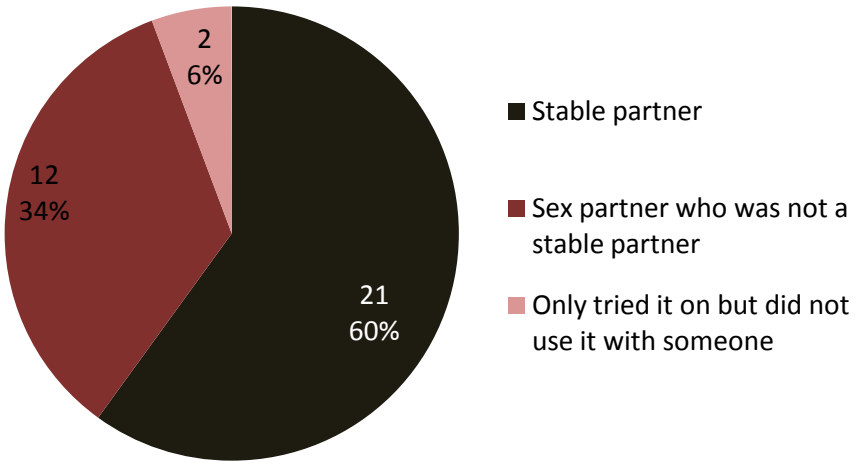
Among those who had used the female condom, the most mentioned reason to do so the first time was curiosity/try it out (74.3%, N_{total}=35). Three persons indicated that they themselves were providing outreach services and awareness activities, and they wanted to have a first-hand

experience before talking about it with others. In addition, five persons said that they used the female condom because they were of the opinion that it was safer than the male condom (14.3%; N_{total}=35). One person added that male condoms rupture easily. One woman proclaimed that she used the female condom just because she found it nice, and one other person because men sometimes refuse to use a condom.

Women and men who had used the female condom were asked how often they had used it in the past three years. A large share of respondents reported that they had not used it at all in this past period (40%: N_{total}=35). Others had just used it only once (6 persons, 17.1%) or two to three times (4 persons, 11.4%). On the other hand, there were also respondents who had used the female condom four to ten times (1 person), ten to twenty times (8 persons, 22.9%) or consistently (2 persons, 5.7%) in the past three years.

The most recent time that the female condom was used, most people had used it with a stable partner (60%; Figure 9). These were often persons who just wanted to try it out. Twelve other persons had used the female condom with someone who was not a stable partner the last time they had used it (34.3%) and two persons had just tried it on but not actually used it to have sex.

Figure 9. Person with whom the female condom was used the last time the respondent used it (N=35)



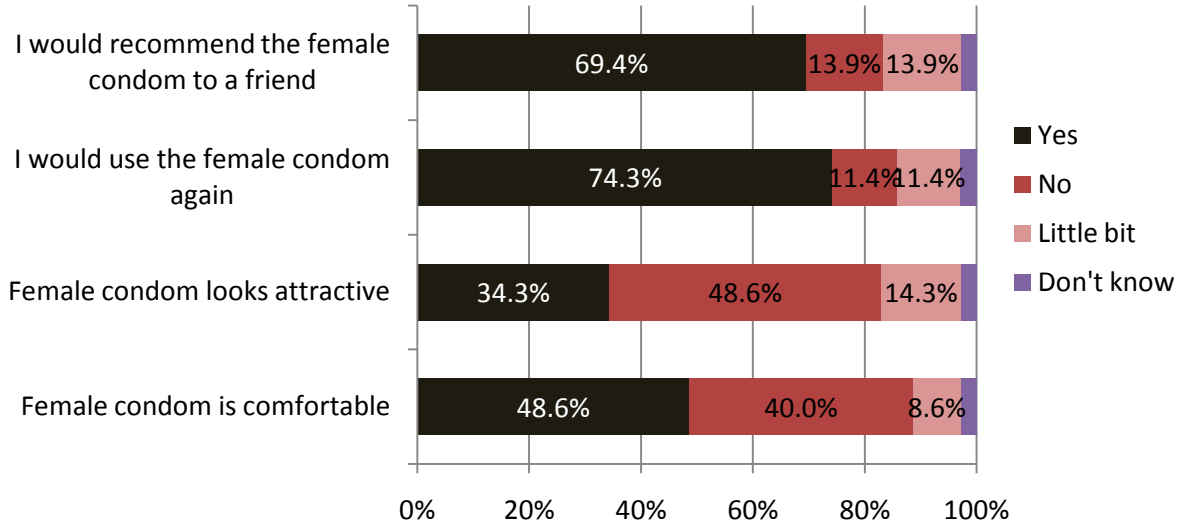
Among those who had used the female condom, almost half had found it comfortable. On the other hand, 40 percent of female condom users judged it uncomfortable and 8.6 percent found it only a bit comfortable (N_{total}=35; Figure 10). Only a third of respondents with experience with the female condom were of the opinion that it looked attractive (34.3%) while about half of them judged it as being unattractive looking (48.6%; N_{total}=35). Another 14.3 percent of respondents who had used the female condom found it just a little bit attractive looking.

The largest share of those who used the female condom would use it again (74.3%) and would recommend it to a friend (69.4%). Four persons responded that they might use the female condom again and five would possibly recommend the female condom to a friend. Four other respondents said that they would not use it again, and five persons would definitely not recommend it to others (Figure 10).

Reasons to not use it again or not recommend it to others included:

- It hurts,
- It takes too much effort
- You have to stay focused on it because otherwise it slips away
- It is not comfortable

Figure 10. General opinions of the female condom among those who had used it at least once (N=35)



4.5 Availability of, and access to, female condoms in Suriname

When asked where they first heard about the female condom, the largest group of respondents indicated that they had been informed by a counsellor or outreach worker (43.8%; N_{total}=64) (Figure 11). As we described in the previous chapter, various organizations in Suriname are involved in information provision, awareness raising, promotion and demonstrations of both female and male condoms. The second and third most common sources of information were, respectively, a partner/friend (14.1%) or the media (10.9%; N_{total}=64). Information sources grouped under "other" included "anyone", colleague sex workers, in Guyana, sexual education program, sisters, and in short stay hotel.

Hardly anyone was ashamed or found it difficult to buy condoms. A wide variety of (male) condoms is available in corner stores, typically right at the cashier desk, and condoms can be taken for free at different locations such as selected pharmacies and sexual and reproductive health (SRH) clinics. In total 96.9 percent of survey respondents conveyed that they had no problems buying condoms. Only two persons (3.1%) responded that they "sometimes" found it difficult or felt ashamed to buy condoms.

Female condoms, however, have very small distribution figures and are hardly available at Suriname's commercial market. Hence they are more difficult to obtain than male condoms, and close to one third of respondents did not know where to find one (32.8%). People who did know

where to find a female condom most often mentioned the pharmacy/drugstore (26.6%), Stg. Lobi[10] (20.3%) and "derma[11]"(18.8%) (Table 5).

Figure 11. Places where respondents first were informed about the female condom (N_{total}=64)

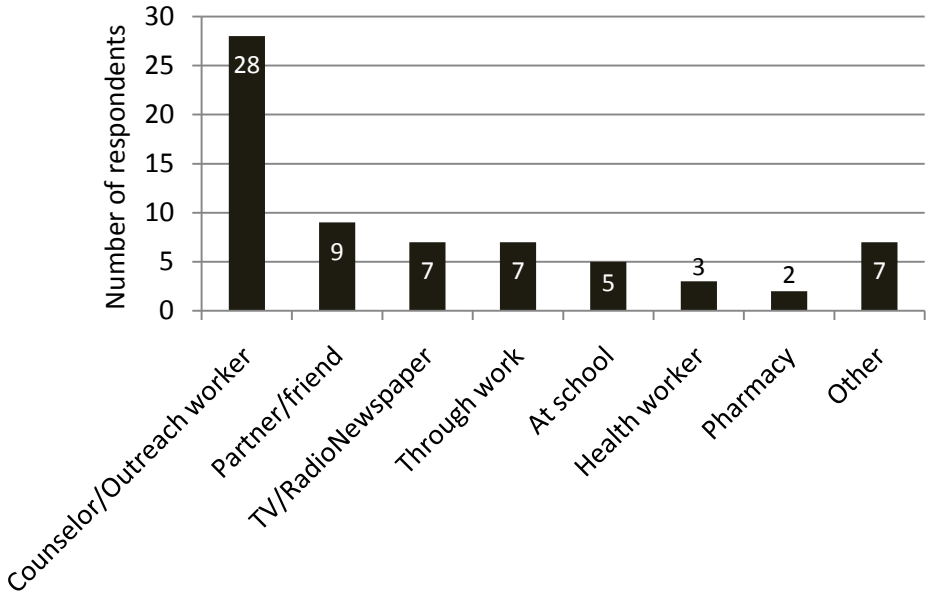


Table 5. Locations where one can find a female condom according to respondents (N=64)

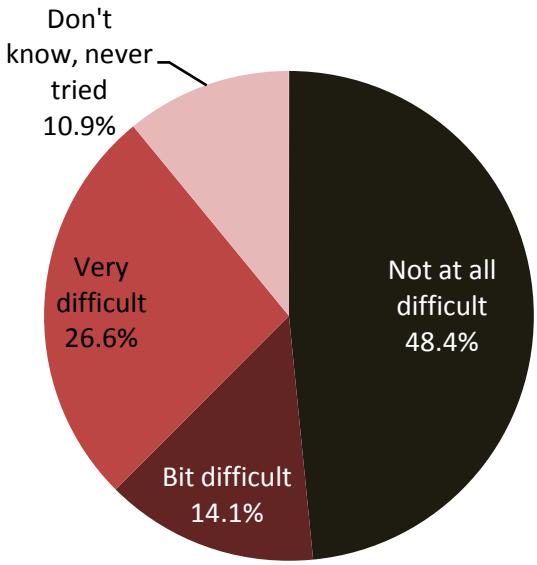
Location	Nr	%
Don't know	21	32.8%
Pharmacy/Drugstore	17	26.6%
Stg. Lobi	13	20.3%
Dermatological Service (Derma)	12	18.8%
LIBI!	7	10.9%
Clinic/General practitioner	6	9.4%
At work (Professional institution that works on SRH)	3	4.7%
Hospital	2	3.1%
Maxi Linder	1	1.6%
Sex shop	1	1.6%

[10] Stg. Lobi is a Suriname foundation which promotes responsible parenthood and improved sexual and reproductive health

[11] "Derma", as Suriname's dermatological service is popularly named, is a government health centre which – among others- performs free HIV testing and counseling.

Close to half of respondents reported that they did not find it difficult at all to find a female condom if they needed one. On the other hand, 14.1 percent of respondents said they found it a bit difficult, and 26.6 percent found it very difficult. One out of every nine persons answered that they could not tell because they had never tried to buy a female condom (Figure 12). Women were more likely than men to report that finding a female condom was very difficult (resp. 30.8% vs. 20.0%), and slightly less likely to state that finding one was no problem at all (46.2% vs. 52.0%).

Figure 12. Answers to the question: "How difficult is it to obtain a female condom?"



Respondents also were asked how long it would take them to obtain a female condom if we would ask them to find one. This question was part of the Caribbean survey format and we found it problematic because the ease of finding a female condom depends on the time of the day. During the day, female condoms can be obtained at many pharmacies and health institutions that are closed at night time. Hence people who were interviewed at night time sometimes responded that it would only be the next morning that they would be able to get a female condom (e.g. >1 hour). If we would have interviewed the same person in day time he or she would probably answer differently.

Keeping this limitation in mind, we found that just over a quarter of respondents indicated that they would be able to find a female condom within 10 minutes. Among them were four persons who worked at a location whether the female condom was distributed, and so they could take them from work. Another 21.9 percent said it would take them less than an hour, and 4.7 percent estimated that they would take between one and three hours to find a female condom. In addition, just over a quarter of surveyed persons indicated that it would take them a day or more to find a female condom (26.6%). Two of these persons believed that the female condom was not available in Suriname and thought they would have to go abroad to obtain one. Others indicated that they did not know/never tried (17.3). Two persons conveyed that it would depend on the pharmacies, because some shut down at night (3.1%).

With regard to the promotion of the female condom, interviewees named a wide variety of possible strategies, including:

- Outreach/demonstrations/information sessions
- Make it more attractive looking/change the design
- Advertisement through the media and on billboards
- Clearly explain working and benefits/make sure women understand how to use it well
- Involve schools in outreach and awareness activities
- Actively involve men in outreach activities
- Provide tips on ways to make insertion more exciting

It was mentioned that the message in outreach and information sessions should be that the female condom provides a tool for women to protect themselves independently of men.

Three respondents were of the opinion that the female condom should not be promoted at all.

5. Conclusions

This report analyzed acceptability of the female condom among men and women, including female sex workers, in Suriname. The aim of the present study was **to make evidence on the variables impacting the use of female condoms available to programme leaders and policy makers**. The specific objectives were to:

- Investigate female condom use among different population groups in Suriname
- Make available to policy makers and programme managers data that describe factors that support and prevent the use of female condoms
- Propose recommendations for enhancing effective programming for female condoms based on the findings of the investigation.

Our first conclusion is that despite the plethora of outreach and awareness activities about responsible and healthy sexual behaviour, sexual risk behaviour continues to be the norm, particular among men. Having multiple casual sex partners is common, even among men with a stable partner – or more than one. Among women (excluding sex workers) such behaviour was rare though, and particularly women with (a) stable partner(s) were unlikely to involve in casual sexual relationships. MSM were not part of the study sample as use of the female condom in this community appears not to be widespread in Suriname.

Respondents were well aware that using of a condom is the best way to protect oneself against STIs and unwanted pregnancy. However, this knowledge does not necessarily translate to responsible sexual behaviour. In fact, the inconsistent and selective use of condoms is worrisome. The results suggest a tendency to not use a condom with a stable partner and use one with casual partners, though in many cases respondents deviated from this rule of thumb. It is hopeful that a majority of respondents, particularly women and sex workers, expressed that they decide about condom use when they have sex. On the other hand, there are also persons, albeit just a few, who reported that they leave the decision about whether or not to use a condom in the hands of the sex partner. Such behaviour poses a health risk.

Given the observed sexual risk behaviour, promotion of the *consistent* use of condoms - to date the only effective protection against STIs including HIV/AIDS- seems pertinent. The question next arises what role the female condom can play in these efforts.

A second conclusion from this study is that few respondents perceived an added value of the female condom while, on the other hand, we recorded important disadvantages. We find that, like the male condom, the female condom is generally valued for protection against unwanted pregnancy and STIs. The most important mentioned added benefit of the female condom was that it offers better protection against HIV/STIs, mainly because it is less likely to tear and the condom partly covers the outside labia. Similar benefits were mentioned in female condom acceptability studies in various African countries. Other benefits that were recorded in foreign studies, such as women's empowerment and the possibility to insert the female condom some time prior to intercourse, were rarely mentioned by Suriname respondents.

Also with regard to disadvantages of the female condom, opinions offered by respondents in Suriname did not differ much from those reported in other countries in the Caribbean region and Africa. Interviewees named discomfort or pain as a result of the ring that needs to be inserted, complexity of insertion and use, and fear that the female condom might slip off as main disadvantages. Some surveyed sex workers explained that the female condom was actively promoted within their communities in the Caribbean region. However, in part due to unfamiliarity of clients with this type of condom, all interviewed sex workers preferred the male condom.

Outside of the sex workers' community it was much more difficult to find persons who had used the female condom, which leads us to believe that its use in the general population is uncommon. Most interviewees who had used it had tried it out of curiosity and to know what it is like. Many of them tried it only once.

An additional disadvantage of the female condom that surfaced during the validation meeting with stakeholders is its price. At USD 0.80/piece, the female condom is several times more expensive than the male condom. At present the UNFPA bares this expense. However, the UN will not continue to pay for free female condoms forever, and health policy makers must consider this in planning their HIV/AIDS prevention strategies for the years to come.

Given its high acquisition cost and the relatively small number of persons who like and consistently use the female condom, one might wonder whether this device should be promoted at all. After all, those who use the female condom as a preferred anti conceptive know where to get it, while those who never used it generally did not really care. Why not just focus on the male condom, which largely serves the same purpose, is more widely accepted, and is more cost-effective?

Based on stakeholder consultations, we content -as a third conclusion- that it is important to include the female condom in SRH outreach activities, to broaden the range of available methods to prevent pregnancy and STIs. The shared opinion was that people should have a choice of contraceptives and barrier methods, and the female condom should be one of the available choices.

At present, different governmental and non-governmental organizations distribute and give information about female condoms, both through active outreach activities and by presenting them on a counter. Stakeholders expressed their concern about the (too) liberal distribution of free female condoms. It was observed that there is limited monitoring of where the (female) condoms end up and whether they are actually used, which may lead to wasteful usage.

The researchers conclude that condom promotion efforts should focus on creating demand rather than on reaching a certain target number of female condoms that are distributed. Both governmental and non-governmental organizations can play a pivotal role in informing the public about the wide range of available contraceptive methods and about ways to protect oneself from STIs including HIV/AIDS. Both male and female condoms must remain readily available at no cost for high risk groups such as sex workers and persons living with HIV/AIDS. For other sections of the population, however, asking a small fee for condoms that are distributed over the counter and improved monitoring of condom distribution would not only reduce waste, but also improve insights in male and female condom acceptability.

6. Recommendations

Based on our study results and input gathered during the validation meeting with stakeholders we present recommendations aimed at enhancing the acceptability of female condoms. Our recommendations are organized in two sections; Distribution and Awareness. "Distribution" refers to recommendations aimed at more efficient and cost-effective ways of distributing female condoms. "Awareness" focuses on ways to improve the awareness of sexual behaviour and (female) condom use.

Some recommendations can be qualified as "Quick wins" because they are viewed as something that can be done with little effort and in a relatively short period of time. We have marked these recommendations with a QW sign.

Distribution

- Work demand driven. Distribution criteria need to be developed and implemented to guide who receives free condoms (the target groups) and how many, to ensure better targeting of scarce resources. Target groups for free male and female condoms should be the lowest income clients and high risk groups (e.g. sex workers, HIV+ persons). QW
- Make people who are not part of specific target groups pay a small fee for the female condom. After a pilot period wherein everybody had the opportunity to try the female condom for free, it should be a possibility to sell female condoms, possibly at a subsidized price. Such a policy can prevent people from taking the condom 'just because it's free'. QW
- Improve supply chain management processes at NAP/LIBI! to improve the efficiency and targeting of free condom supplies. For example, organizations that receive free condoms may be asked to fill out a short survey to gain inside in condom use. Data should be digitally processed and analyzed by LIBI! on a structural basis.
- Pending WHO approval, make new designs of the female condom, which have replaced the inner ring with (more comfortable) foam pads, available in Suriname.
- During data collection, the term 'condom' should be separated in male condom and female condom. QW

Awareness

- Focus awareness not mainly on females. QW Results showed that some men are not aware of the female condom, do not trust it etc. Attention should also be paid to cultural sensitivity. In some communities men determine whether or not a condom will be used.
- Given the high rate of teenage pregnancies, involve parents and schools in HIV/condom awareness activities through age-appropriate, fun and creative outreach activities.
- The female condom should be presented as one of many methods to prevent pregnancy and/or prevention of STIs. It is an alternative method that may suit some people but not others. Give insight in the pro's and con's of the female condom which can help persons to make a suitable choice. QW
- Focus awareness not only on condom use in general, but focus on the consistent use, in particular with casual sexual partners. QW
- Make sure counsellors at the various organizations are educated and trained in (female) condom use and that they have access to necessary tools (model vagina with inside look). Capacity should be built to effectively communicate the benefit of the use of female condoms and skills on how to use female condom. QW
- Make sure the product is not just given out without proper education on how to use it. In order to prevent unsatisfied users which ultimately will make female condom programming unsuccessful. QW

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