

INFLUENCE OF AGE, EDUCATION & SOCIO-ECONOMIC BACKGROUND ON THE USAGE OF FEMALE CONDOM IN IKENE LOCAL GOVERNMENT AREA OF OGUN STATE,

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ABSTRACT

The study examined the influence of socio-economic background, age difference and educational status on the acceptability of female condom among the females in Ikenne Local Government of Ogun State. Sample consisted of three hundred females randomly selected from the local government with an average age of 34.98 and a standard deviation of 5.53. An adopted instrument titled “Female condom usage (FCU) “was used in gathering data. Three hypotheses were formulated and tested at a level of 0.05 significance. Data was analyzed with the use of Multiple Regression and Independent t-test. Results showed that, socio-economics, educational background and age grouping are statistical significant and contributed 22.8% to the usage of female condom. While socio-economic status and age were found to be best contributors to the usage of female condom and the two age grouping were not significant to the usage of condom. On the basis of these, it was recommended that: The public health crusaders, social workers and counselors should create more awareness in the usage of female condom. Sex education should be inducted in teachers’ training programme and be taught in schools. School libraries and other resource centers should also be stocked with books that talk about female condom.

Key Words – Socio-economic background, age, education & female condom.

Introduction

Patterns of adolescents’ use of contraception are important concerns. “A sexually active teenager who does not use contraception has a 90% chance of pregnancy within one year” (Source?). About 20% of sexually active adolescents become pregnant yearly, and 78% of these

pregnancies are unplanned. One third of the unplanned teenage pregnancies end in abortion. Helping teenagers use contraception when they become sexually active is important to help reduce the number of unplanned pregnancies, therapeutic abortions and sexually transmitted infections. Throughout the United States, the overall percentage of teenagers using contraception at first intercourse has increased during the 1980s. STIs represent a global health problem, with an estimated 300 million new cases annually (WHO, 2002). These include the rapidly growing HIV epidemic as well as syphilis, chlamydia, gonorrhoea and herpes. Without including HIV figures, STIs cause 230,000 deaths each year, and many more people suffer pain, infertility and indignity (Langill and Delaney, 2000). There is no other product on the market apart from condoms that give adequate protection against STIs. Despite this, only 20 per cent of risky sex acts were protected by condom use. (Bankole, Darroch & Singh, 1999).

The female condom is a strong, soft, transparent polyurethane sheath which, when inserted in the vagina before sexual intercourse, provides protection against most sexually transmitted infections, including HIV, and pregnancy (WHO, 2002). It forms a barrier between the penis and the vagina, cervix and external genitalia. It is stronger than latex, odourless, causes no allergic reactions, and may be used with oil-based and water-based lubricants. It can be inserted prior to intercourse, is not dependent on male erection, and does not require immediate withdrawal after ejaculation.

When used correctly and consistently, condoms are a reliable method of preventing pregnancy, and have no medical side effects. According to World Health Organization (2005), the male condom is 98% effective, and the female condom 94% effective when used according to instructions. Yet, there is huge unmet need for effective contraception in the developing world. About 150 million women actively want to use family planning, but they are left to choose whether to have children, when to have children, and how many to have. This is physically and psychologically very damaging. The gap between the need for contraceptive supplies and the funds available to purchase them is projected to reach hundreds of millions of dollars by 2015.

Having control over their own fertility is a pre-requisite for a woman's empowerment. Condoms are a tool for women to plan their families and are therefore a gateway to empowerment (Lindberg, Ku & Sonenstein, 2005). Empowered women have a much better chance of protecting themselves against HIV and of keeping their children healthy. However, the facts are stark, women are particularly vulnerable to HIV because they are disempowered, often unable to negotiate safe and pleasurable sex lives. Women and girls make up almost 57% of all HIV positive people in sub-Saharan Africa, and 76% of young people (aged 10-24 years) living with HIV in the region are female. In most other regions women and girls represent a rapidly increasing proportion of people living with HIV (Miller, 2002).

South Africa is one of the few countries in the world where the national Family Planning Programme has played a central role in introducing the female condom. Preliminary data from the first 18 months showed that around 80% of female condom acceptors were also using hormonal contraceptives, indicating a desire for dual protection; most said they used the female condom to protect themselves from HIV and other STIs. The female condom serves to complement rather than substitute for the male condom. A significant proportion of women reported also using male condoms but said that the female condom allowed them to protect themselves in situations where men could not be persuaded to use a male condom. Family planning providers saw the female condom as an important addition, giving women more choice and offering protection from both pregnancy and STIs. Barriers to integrating the female condom

into clinic activities included lack of time to provide counseling on dual protection and use of the female condom. The success of the pilots is attributed to phased introduction, comprehensive training of providers, reliable supplies, and a national barrier methods task force that include government and NGO stakeholders. The programme will be expanded to 249 sites by the end of 2006, and a study evaluating the effect of female condom distribution on use of dual protection is currently being finalized. Certainly in South Africa the female condom has taken off to a greater degree than elsewhere in the world. A study showed that female condom procurement figures have risen from 1.3 million in 2002 to 2.4 million in 2005. For example, the mining company Impala Platinum in Rustenberg is poised to pilot the female condom amongst 3,000 of its miners. The popularity of the female condom has resulted in the demand exceeding the supply (Lindberg, Ku & Sonenstein, 2001).

Finally, the current cost of the female condom is prohibitive for the majority of women at risk of HIV infection as well as health program directors with tight budgets. Its unit price to developing country governments ranges from 57 cents to 70 cents, compared with between 3 cents and 5 cents for the male condom. This high cost affects programming, which in turn affects use rates. Donors spend only an estimated 5 cents on purchasing female condoms for every dollar they spend on male condom programming.

Female Health Company, the leading manufacturer of female condoms, recently announced that it will offer a large-volume discount on its second-generation female condom. However, the volume purchased must be quite large to qualify for the discount, 60 million to 120 million at 38 cents each, and fewer than 60 million at 60 cents each. (In 2003, between 10 million and 12 million female condoms were sold.)

Another option—reuse after disinfecting the female condom with a bleach and water solution—could decrease the method's overall cost, but the practice may not be practical in the situations where most women live. Meanwhile, some agencies are exploring the development of cheaper female condom products that use latex instead of polyurethane and involve lower production costs.

The research has been carried out in view of importance of female condom usage. It is equally important to note that from the literature, research have not been conducted in Nigeria. For this reason, the following hypotheses were tested:

1. There is no significant combined contribution of socio economic background, age and educational background on female condom usage
2. There is no significant relationship contribution of each of socio-economic background, on age and education and female condom.
3. There is no significant difference in the age grouping (20-29) and 40-49 years and female condom usage

METHODOLOGY

The study made use an expo- facto descriptive survey research design. It was decided that this design would be the best for collecting the information useful enough to establish facts sought by the study, since none of the variables was manipulated.

Sample

The study sample was drawn from the population of female (married and single) within the Ikenne Local Government of Ogun state, Nigeria. It consisted of three hundred female randomly selected. The ages of the women were first stratified into 20-30, 31-40 and 41-50 ranging from 20-50years. The mean age was 34.98years. Also, the educational status, socio-economic and age grouping were taken in to consideration. (If the sample was drawn from Ikenne LG alone, why is the title, South West and not Ikenne or Ogun State. More LGs are required to retain the South West title)

Instrumentation

An adapted questionnaire was used to collect data for the study. The questionnaire titled “Female Condom Usage” (FCU) has two major sections. Section A sought demographic data while section B contained items measuring attitudes, usages and comfortability of female condom. To ensure the validity and reliability of use in Nigeria, it was given to expert in health education, test and measurement experts in one of the private owned universities in Nigeria. The test- retest method was also used to obtain the reliability co-efficient at an interval of three weeks of administration on some females outside the scope of study. The alpha coefficient gave 0.87. Likert scale format of strongly agree = 5 points, agree = 4 points, neutral =3 points, disagree = 2 points, and strongly disagree = 1point. Some of the items in the such? include, “I am interested in learning how to use the female condom correctly” the female condom predicts are from STDS including HIV; ‘I believe that I could make female condom use for fun and erotic.

Procedure:

The Researchers personally visited some designated places to administer the questionnaires. Apart from soliciting for their cooperation, the respondents were informed of the purpose of the study and the need for factual and objective response. Participants filled the questionnaire at individual pace and the completed copies were retrieved.

Data analysis

The statistical tool used in the study was multiple regression and independent t-test. All analysis was carried out at 0.05 probability level.

Results

Hypothesis 1: There is no significant combined contribution of socio economic background, age and educational background on female condom usage.

Table 1: Multiple regressions (enter) showing the combined contribution of the socio economic background, age and educational background on female condom usage.

R = .481 R ² = .231 Adjusted R ² = .228 Std error of estimates = 4.22619.					
ANOVA					
Model	Sum of square	Df	Mean square	F	Sig.
Regression	1027.9629	3	342.6543	4.793	.009
Residual	21161.2085	296	71.4905		
Total	22189.1714				

- a. Predictors educational status, age and socio-economic background
- b. Dependent variable; female contraceptive

Table 1 shows that the multiple regression coefficient between the independent variables (socio-economic background, on age and education) and dependent variable (female condom) equal 0.481. The R square equals 0.231 while adjusted R square 0.228. This implies that the independent variables contribute 23.1 percent to the variance in the usage of female condom. However, when adjustment was made for other factors, the contribution becomes 22.8%. Further effort to test the significance of the linear relationship between the socio-economic background, on age and education and female condom using Analysis of Variance produced F-ratio value of 4.793 (p <0.05). This means that there is significant linear relationship between the socio-economic background, on age and education and female condom.

Hypothesis 2: There is no significant relationship contribution of each of socio-economic background, on age and education and female condom

Table 2: Coefficient of Multiple Regression showing the magnitude of contribution

Model	Unstandardized co-efficient		Standardized co-efficient	T	Sig
	B	Std error	Beta(β)		
Constant	50.007.709	22.92905		13.481	.000
Social economic background	4.425	2.058	.556	12.151	.000
Age	6.506	7.142	.223	7.911	.006
Educational status	.703	4.136	.011	1.696	.523

- a. Dependent variable: Female condom

Table 2 presents the co-efficient showing the proportion of each of socio-economic background ($\beta = 0.556$, $t = 12.151$, $p < 0.05$), age ($\beta = .223$; $t = 7.911$; $p < 0.05$) and educational status ($\beta = .011$; $t = 1.696$; $p > 0.05$) to the usage of female condom. The above table shows that social-economic status and age grouping made significant contribution to the prediction of contribution. In terms of magnitude of contribution, socio-economic status made the most significant contribution, followed by age and educational status made the least contribution of the female condom usage.

Hypothesis 3: There is no significant difference in the age grouping 20-29 and 40-49 years and female condom usage

Table 3: Independent t-test of ages (20-29years) and (40-49years) and female condom usage.

Age of the respondents	N	\bar{x}	Standard deviation	Df	T	t-crit	p
20-29	86	24.13152	4.6714	186	.074	1.96	NS
40-49 years	102	22.791241	5.23456				

As revealed in table 3, the result shows that there is no significant age difference in the usage of female condom. The computed t- value of 0.74 is less than the critical f-value of 1.96 at 0.05 level of significance. This implies that the usage of female condom is not being affected by the age grouping, hypothesis is therefore accepted.

DISCUSSION

The result presented in table 1 shows that there is significant relationship between the demographic variables (socio-economic background, age and educational status) and female condom usage. In other words, socio-economic background, age and education status contribute positively to usage of female condom. It shows that the combined contribution is 22.8% which also shows a significant figure f – ratio of 4.793 at the level of 0.05. This finding agrees with the study of Adekun, Mantell & Weiss (2002) that socio-economic and education status contribute significant to the usage of female condom.

The result in table 2 reveals two out of the three independent variables are general determinants of usage of condom. The result shows that socio-economic status and age are good determinants. Further more, socio-economic status shows to be the best determinant as beta value is 0.556 and t-value of 12.151 is significant at 0.05, this was followed by age which shows a beta value of 0.223 at a t- level of 7.911, which is also significant at 0.05 levels. However, educational status was seen to be a bad determinant of the usage of female condom. This finding lends support to the finding of Holmes, Levine & Weaver (2004) that says the higher the level of socio-economic background, the greater the chance of adopting new device because of exposure. Age

might also become device features in the fact that, family who tends to control their family size result of the use of inceptor by suiting the family unit. The young one might not give it a much attention because of the shyness in using it within our locality. Educational status is not making a significant fervent input, but this might be due to the fact that sex-education is not being taught in Nigeria schools (This is not completely true, sex education is being taught from junior secondary level). Also, talking about sex is looked upon as a taboo in the geographical area of the study. Hence, no much education and awareness have been made. (are sure of your facts?)

Recommendation

Based on the findings of this study, the following recommendations are made;

The health practitioners, social workers and counselors should create more awareness in usage of female condom. Also, sex education should be introduced in teachers' training programme and be taught in schools. School libraries and other resource centers should be stocked with books that encourage use of female condom.

ADD THE SUBSIDIZATION OF FEMALE CONDOM FOR WOMEN BY GOVERNMENT

CONCLUSION

The study adds to a growing body of literature documenting strong support for the acceptability and usage of female condom in Nigeria. Since the findings showed that socio-economic background, age and education are determinants for usage of female condom. It is therefore necessary that educating the masses to arouse the level of awareness must be a priority. Moreover, the crusade must also be taken to classroom especially to students of higher learning.

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