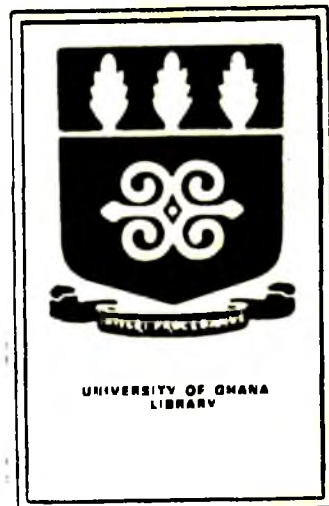


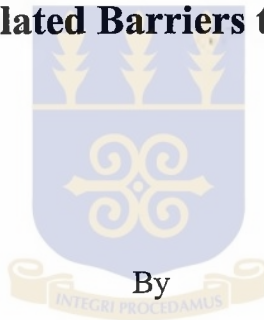


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Institute of African Studies
University of Ghana, Legon

**From the Point of Sales:
Purchase-Related Barriers to Condom Use**



By
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Submitted to the University of Ghana, Legon
In partial fulfilment of the requirements for the
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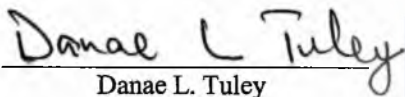
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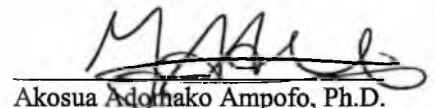
Declaration

I, Danae L. Tuley, declare that this thesis is an original work. Except where otherwise stated and proper citation given, all of the information presented here is based upon personal findings through field study and personal observation. Dates, facts, and figures are correct according to the source and publication dates listed in the “Works Cited” section at the end of this thesis, or are based upon data collected during the course of the study, as outlined in the chapter entitled “Methodology”.



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Dedication and Acknowledgements

This study is dedicated to my mother. Not only is she the inspiring, creative woman with whom I proudly share my birthday, but she is also the one person who believed in me enough to allow me to follow a dream, even at her own expense. That dream led me to Ghana, where I was able to learn a lot about life, both the good and the bad. While this study is a tangible sign of my achievements and the obstacles I overcame, the memories of my year here are what I hold dearest.

Though sceptical about my coming to Ghana, I must also thank my father for his support. Though he may not have understood my reasons for wanting to take this course and he was constantly worried about my well being, he allowed me to explore and learn for myself. I hope that he is proud of what I have accomplished here and will continue to be proud of me, wherever I may end up.

This study would have not have become a reality without the support and help of Michael. Not only did you support me emotionally while writing this, but you also bent over backwards to help me with data collection and as my liaison with the university after I left Ghana. There are no words to express exactly how grateful I am. I hope you know this already.

I also acknowledge the support and assistance of other friends and loved ones here in Ghana. You welcomed me as one of your own, but also recognized my limitations as a foreigner and offered helping hands on numerous occasions. Your help was invaluable, and so is your friendship.

Thank you also to my advisors, Dr. Akosua Adomako Ampofo and Mrs. Delali Badasu, for helping me to complete this study on time. I appreciate your advice and the extra time you gave me.

And of course, I acknowledge the blessings bestowed upon me by God. He not only gave me the strength to be successful in the completion of this course, but also provided many miracles along the way. For His continuing guidance I am truly grateful.

Table of Contents

Title Page	
Declaration	
Dedication and Acknowledgments	
Table of Contents	
List of Tables	
Abstract	
List of Terms and Acronyms	
Chapter 1: Introduction	1
Statement of Problem	1
Research Questions	4
Objectives of the Study	5
Justification of Study	6
Chapter Breakdown	7
Chapter 2: Literature Review	9
Literature Review	9
Chapter 3: Methodology	25
Methods of Data Collection	25
Method of Analysis	31
Field Experience and Limitations of the Study	32
Chapter 4: Barriers to Condom Use	36
Cultural Barriers	36
Knowledge Barriers	36
Prevention Choice and Frequency of Condom Use	39
Chapter 5: Barriers Related to Purchase	42
Addressing Areas for Change	42
Placement of Condoms	43
Product and Price	46
Comfort Level of Condom Purchase	50
Point of Purchase	51
Chapter 6: Summary and Conclusion	53
Summary and Conclusion of Study	53
Recommendations	56
Works Cited	
Appendix A: Questionnaire for Sexually Active Ghanaians in Accra	
Appendix B: Retailer Questionnaire	

List of Tables and Figures

Table 2.1: Pregnancies Per 100 Women During First Year of Condom Use	17
Table 2.2: The Impact of Bamako, Mali Multimedia Campaign on Contraceptive Use.	23
Table 3.1: Breakdown of Questionnaire Respondents.	27
Figure 4.1: Distribution of Perceived Barriers to Condom Use.	39
Figure 4.2: Reported Frequency of Condom Use.	40
Table 5.1 Condom Buying Atmospheres of Different Accra Condom Retail Shops.	48
Figure 5.1 Buying Tendencies of Condom Users.	49

Abstract

Consistent condom use is one of the best ways of stopping the spread of HIV/AIDS and other sexually transmitted diseases (STDs) throughout Ghana. Unfortunately, barriers exist that keep people from using condoms during sex. These barriers range from cultural and religious barriers to barriers resulting from the undesired or lack of sensation condoms provide. This study looks at perceived barriers to condom use in general, but then takes a closer look at those barriers related to condom purchase. These include ease of purchase, brand availability, product display, and condom cost. One hundred sexually active Ghanaians were surveyed about their perceived barriers and condom buying habits. Six different condom retail shops in Accra were also interviewed and observed for insight as to why Ghanaians may not use a condom simply because they are uneasy about buying them. The findings showed that while retail shop owners are hesitant to provide self-service condoms due to theft risks, Ghanaians would be more likely to use condoms if they were sold out in the open and not behind a counter.

List of Terms and Acronyms

AIDS: Acquired Immune Deficiency Syndrome

access: The obtain ability or the ability to acquire and use condoms.

barriers to condom use: Anything that prevents a person from using a condom.

comfort level: Refers to the extent to which customers are comfortable shopping for or buying condoms.

condom: A sheath, usually made of latex, that prevents sperm, as well as some sexually transmitted diseases, from entering the vagina. Unless otherwise stated, the term condom refers to the male, latex condom.

cultural barriers: A barrier to condom use relating to culturally accepted norms or expectations (e.g. religion, tradition, etc).

educational barriers: When an absence of knowledge prevents one from using a condom (e.g. not knowing that AIDS is fatal, thinking AIDS can be cured).

GDHS: Ghana Demographic and Health Survey (Unless otherwise specified, references are from the most recent edition, 1998.)

GSMF: Ghana Social Marketing Foundation

HIV: Human Immunodeficiency Virus

LSM: Living Standards Measure

NGO: Non-Governmental Organization

non-traditional retailer (outlet): Any condom sales outlet that is not a chemists or a pharmacy.

patriarchy: A recognized rule or domination by men within a particular society or group of people.

PPAG: Planned Parenthood Association of Ghana

Prophylactic: A device, such as a condom, that slows the course of an illness of disease.

purchase-related barrier: Anything relating to the sale of condoms that prevents one from buying them (e.g. embarrassment in approaching sales staff, lack of available brand selection, or unknowledgeable sales staff).

self-service: A condom purchasing environment where sales staff are not required for customers to pick up or analyse condom packages (e.g. on a store shelf or next to the cash register).

STD: Sexually Transmitted Disease (Also known as STI: Sexually Transmitted Infection)

style: In the context of this study refers to a particular condom product produced by a condom manufacturer distinguished by size, colour, flavour, texture, etc. (e.g. Durex Featherlite or Choice Strawberry).

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNICEF: United Nations Children's Fund

UNPOP: United Nations Population Division

WHO: World Health Organization

Chapter 1: Introduction

Statement of Problem

Condom use dates back more than 3,000 years where illustrations of the contraception method were created in Egypt. In the 17th Century, they were already being used to prevent the transmission of sexually transmitted diseases (STDs) during war. During World War I, social hygienists fought to prohibit condoms because they thought that anyone who risked getting an STD deserved the consequences of their actions. At that time, doctors were allowed to prescribe condoms to men in order to protect themselves from syphilis and gonorrhoea through pre-marital and extra-marital sexual intercourse, but women could not obtain condoms for the same purpose or to prevent unwanted pregnancies. The sexual revolution of the 1960s in America curbed condom use because men no longer had to turn to prostitutes for sex. The pill could easily prevent pregnancy and the prevalent STDs were easily treated. Within the next twenty years, the need for condoms became apparent with the discovery of HIV/AIDS (Knowles 1999).

Today condoms are the most successful way of preventing AIDS, which is a pandemic in Africa. But, while most Ghanaians say they know about AIDS (Measuredhs.com 20 Sep. 2002), according to UNAIDS/WHO, more than three percent of Ghanaians are HIV positive (2000: 3) and the numbers continue to grow. A UNAIDS/WHO report stated that there are 340,000 Ghanaians living with AIDS, of which 330,000 are adults (2000: 3). This does not include the many more who have contracted other less fatal STDs that can still have serious consequences such as cancer or infertility.

The concentration of HIV cases among adults supports the belief that transmission is taking place mostly through sexual intercourse. A deadly disease that now plagues up to a third of the population of Southern African countries such as Botswana and South Africa has

appears still not scared Ghanaians into avoiding sexual promiscuity and using protection, given the rising number of cases. A study of women in Sub-Saharan Africa reported that by age 20, only 17% were not yet sexually active (Upadhyay & Robey 1999). If such high-risk behaviour continues to prevail, it will not be long before Ghana's infection rates match its southern African counterparts.

Condoms, aside from being the most successful way of preventing HIV and STD transmission, are also one of the safest methods of contraception, considering that only a severe allergy to latex medically deters their use (Hatcher et al. 1997). If Ghanaians know about AIDS, but are still having sexual intercourse, then condom use should be consistently high. However, UNICEF/UNPOP reported that between 1990 and 1999, the total contraception prevalence rate in Ghana was only 22% (UNAIDS/WHO 2000: 8). More specifically, according to the Ghana Health and Demographic Survey 1998, only 2.7% of women and 8.2% of men currently use condoms as a form of prophylactic or contraception.

These statistics and many Ghanaian's apathetic attitude towards condom use shocked me as a Westerner when I first came to the country. They continue to do so today. But while I know that without a significant increase in the numbers of consistent condom users AIDS cases will continue to increase, I have also learned that the problem is more complex than originally seen. Ghana, like other developing countries, faces many obstacles in terms of education, health care, contraception accessibility, and accurate data collection that significantly add to the problem of adequate condom use. In this way, AIDS becomes a multi-facetted problem that needs to be dissected and addressed by both individuals and organizations such as governmental, non-governmental, and media before it can be solved.

One of the major dimensions of the AIDS problem in Ghana and throughout Africa is cultural barriers and the gender-power dynamics that exist. In some African countries, women are more than seven times as likely to contract the AIDS virus as their male

counterpart (“Africa: Gender Inequality... 2003). Largely responsible for this is the attitude that for men, a desire for sex is “beyond their control” and the failure of many men to consider sex a “consensual activity” (*AIDS and Men* 1999). The gravity of the situation was recently summed up by United Nations Secretary-General Kofi Annan, a Ghanaian, who stated, “Violence, abuse and intimidation often make it impossible for women to protect themselves against the virus...It will require a bold transformation in men’s attitudes and behavior so that women become their equal partners” (“Men and Violence are Barriers...” 2004).

The AIDS problem is also very different in urban and rural parts of the country. In the rural environments, questions of adequate awareness and accessibility are raised. It seems, however, there is less room for excuse for not using condoms in the cities where even the non-educated are surrounded by anti-AIDS and pro-condom campaigns that plaster the airwaves, billboards, and backs of buses. Ghanaians are not changing their behaviour towards condoms, even though the messages about risks of HIV are prevalent.

As already mentioned, HIV/AIDS has already infected a large number of people in Ghana. The fact that there is no cure amplifies the need to slow the spread of the disease as quickly as possible. AIDS can have a significant impact on the development and the economy of Ghana. People who are sick are not able to work and feed themselves or their family. It brings about high medical costs to those who cannot afford it and do not have access to any form of insurance scheme. When AIDS patients die, they may leave behind financial debts as well as children who may be rejected by other family members due to the nature of the parent’s death.

While research into the economic ramifications as well as other aspects of the disease is not lacking, the problem continues not only to exist, but also to grow. Ghanaians have their own justifications for non-condom use, which vary according to level of knowledge,

circumstance, and perceived risk (Adomako Ampofo 1999). However, room exists for finding out exactly why fewer than 10% of Ghanaians use condoms during sexual intercourse. More can also be done to understand what would encourage people who engage in this risky sexual behaviour to take a simple precaution to significantly reduce their chances of acquiring the deadly disease. Until that understanding is achieved and the statistics of consistent condom users significantly increases, studies such as this one that seek to examine barriers to condom use and condom buying are relevant.

Research Questions

It became apparent after reviewing existing studies and conducting a small pilot study of my own, that the main problem that needed to be addressed was not the numbers of people who use condoms, but what exactly deters others from buying and using condoms on a regular basis. A survey I conducted among 30 young people on the University of Ghana and Ghana Institute of Management and Public Administration (GIMPA) campuses, revealed that 60% of sexually active respondents who reported a barrier to condom use indicated that something related to purchasing (e.g. cost, availability, ease of purchase) deterred them from using a condom, compared to 40% who reported that it was a lack of sensation from the condom that deterred them from using it¹.

Though the pilot study was very small in size, it helped me to frame the issues for the ensuing study. While little other than education about the severity of HIV/AIDS can convince people to ignore their perceived lack of sensation, I felt that the other barriers were

¹ The study was part of a quantitative research project for the Research Methods II class at the Institute for African Studies at the University of Ghana, Legon, Spring 2002. The project looked at reported condom use based on sex, barriers to condom use, and an exposure to Western environment or peers. Data was collected by distributing a survey of nineteen questions to 30 young adults on the University of Ghana, Legon and GIMPA campuses. Respondents were chosen by a non-probability sample.

an area that needed to be looked at more closely. The responses of the pilot study brought about many questions.

- Who buys condoms and where?
- What brands do they buy?
- What is involved in buying a condom?

By asking these questions, I set out to uncover problems and solutions that other social scientists and scholars had not looked at when tackling the condom question.

Objectives of the Study

Based on the above justifications for this study, the overall objective of the study is to find out the barriers to condom use among sexually active Ghanaians in Accra. More specifically, the study was designed to achieve the following objectives:

- To find out how condom retailers and condom distributors meet customers' needs for availability of preferred condom brands.
- To find out how condom retailers and condom distributors meet customers' needs for affordable condoms.
- To find out how condom retailers and condom distributors meet customers' needs for convenient retail shop locations.
- To find out if condom retailers and condom distributors meet customers' needs for comfort level of condom purchase.
- To make recommendations based on this study for policy makers, condom retailers, condom distributors, and non-governmental organizations (NGOs).

Justification of Study

Contraception and AIDS prevention are popular topics. Many studies have been redone and re-examined numerous times. However, gaps exist where new studies could be beneficial. From the literature found, contraception in general has been studied in-depth, but not prophylactics. Most of the barriers relating strictly to pregnancy prevention such as cultural, educational, and perceived health-risk barriers are well understood. Many of the studies still look at condoms primarily as a contraceptive and focus more on married couples. Those that do address condoms from the HIV/AIDS prevention perspective overlook barriers related to the purchasing itself.

Alternatively, many studies that do recognize the AIDS aspect of contraception use, ignore married couples as needing protection against AIDS. Such studies tend not to go beyond the so-called high-risk groups such as commercial sex workers and their clients. Research is often limited by beliefs that sex should not be openly discussed and that the average person is not at risk. Large barriers to condom use, such as religious opposition, poor access in rural areas, and a general dislike of the 'unnatural' condoms, becomes the primary excuse as to why people do not protect themselves when engaging in high-risk behaviour.

It would seem likely that these are major barriers are important factors in the increasing rate of HIV-infection in Ghana. Social factors, while important to the increasing rates of infection, are difficult to change. However, there are other less daunting barriers, such as access and cost, which have a potential to be more easily alleviated, if proper attention is given to them. From the existing research looked at for the basis of this study, those that mentioned barriers such as cost or quality pertained to rural areas where access is not very high. Such studies do not focus on where access is highest and then attempt to bring prevalence to a similar level.

Therefore, this study was designed to look at the more minor barriers to condom use in Ghana, in an area where availability is at its highest, Accra. By focusing on the areas that are easier to change, rather than larger barriers such as cultural norms and expectations, improvements in condom use will be more forthcoming. When smaller improvements are made, the acceptance of condoms will be more easily integrated.

While the larger barriers tend to receive more attention, there is also a need to uncover other barriers. This study first intends to find out what prevents Ghanaians in Accra from using condoms and what they perceive as being a deterrent to protecting themselves from STD infection. The focus will then shift to those barriers specifically related to purchasing condoms. Lack of ease in actual condom purchase will be the central concern. However, brand availability, retail shop location, and cost will also be looked at as contributors to purchase barriers.

These barriers will be examined from all levels of condom purchase and sales, from the consumer, up through the retailer, to the distributor. Doing this will provide a wider platform for analysis of why people are not buying and using condoms. In turn, data collected will be a source of insight to both those involved in condom sales and purchase, but also the social scientists eager to learn why condom prevalence in Ghana is so low.

Chapter Breakdown

To accomplish the objectives stated, the ensuing chapters will be devoted to the following areas:

Chapter II Literature Review: A review of existing literature that addresses related topics such as the evolution of contraceptive methods in Ghana, cultural and other barriers to condom use, and condom education and its effectiveness.

Chapter III Methodology: An outline of the study including methods of data collection, respondents, methods of analysis, and the limitations the methodology and other factors posed.

Chapter IV Barriers to Condom Use: This chapter addresses barriers to condom use from a more general standpoint. These include cultural and educational barriers. This chapter also addresses reported condom use.

Chapter V Barriers Related to Purchase: Stemming from the previous chapter, this chapter looks specifically at the reported barriers to condom use that are specifically related to purchasing. Placement of product, brand availability, and the perceived comfort level of purchasing condoms are the main topics discussed in this chapter.

Chapter VI Summary and Conclusion: This chapter summarizes the findings of the study and then makes specific recommendations for diminishing barriers to condom use and increasing condom prevalence rates.

Chapter 2: Literature Review and Conceptual Framework

Literature Review

Barriers to condom use can be quite numerous and stem from many areas of society. Society also forms the basis for how, when, and what kinds of condoms are sold. Therefore, it is necessary to take a broader view of condom purchase and use in Ghana.

Risk Taking and Condom Use

When so few sexually active people in Ghana are using a condom to protect themselves from a disease that they admit to knowing about, psychological reasoning becomes an area focussed upon in HIV-related research. Founded in the 1950s when people had a similar apathy towards personal health, Rosenstock's Health Belief Model is concerned with the non-engagement in preventive health measures. The motivation to undertake or ignore preventive health can be grouped into three categories: individual perceptions (one's own perceived severity of or susceptibility to an illness), modifying behaviours (demographic variables or perceived threat), or the likelihood of action (how likely is a person to undertake a preventive measure). The limitations of the model are that factors outside of health beliefs such as special influences, cultural factors, or previous experience can also influence behaviour (Brown 1999). In terms of condom use, if one does not perceive that they are susceptible to AIDS or they belong to a demographic group such as a particular religion that rejects condom use, they are less likely to use condoms.

Similarly, the Theory of Reasoned Action by Ajzen and Fischbein claims that intention is the most important determinant of whether or not one engages in positive health behaviour. One with an intention to engage in certain behaviour is more likely to engage in that behaviour than one without an intention. Again, social norms and personal approval affect the likelihood of having an intention or adopting certain behaviour. (Ajzen & Fischbein

1975) Those who have an intention to use a condom will probably do so, permitting availability or mutual acceptance by the partner. Some people claim that there is a social norm that condoms imply infidelity (Dodoo & Adomako Ampofo 1998; Schoepf 1997), therefore, the intention to engage in preventive behaviour will be reduced. As mentioned, the availability of condoms can also affect the likelihood of engaging in preventive health behaviour. Unfortunately, in Sub-Saharan Africa, where AIDS is a significant concern, access and availability must be improved to meet the region's needs (Adomako Ampofo 1999; Schoepf 1997).

The Introduction and Evolution of Contraceptive Methods in Ghana

Family planning was first looked at nationally in 1969 when a population policy was introduced to help curb high population growth rates. The following year, a national family planning programme was launched, focussing on providing couples with access to modern methods of contraception (Badasu 2001). While the programme was successful in bringing awareness of contraception, 25 years later, the programme needed to be revised. This happened for two reasons. First, there has been a significant change in socio-economic conditions since 1969, and second, new threats such as HIV/AIDS change the focus of contraception method choice (PIP 1995). With the discovery of AIDS, the focus shifted from preventing births to preventing deaths, as well as a focus on condoms as a dual purpose contraceptive/prophylactic. However, after 25 years of attention entirely given to contraception, it is difficult to now alter people's views on method choice and the benefits of condom use.

To assist in the shift in contraceptive focus, social marketing was introduced. Social marketing attempts to positively alter consumer behaviour and personal welfare through the 4Ps— Product, Price, Place, and Promotion. Beyond the 4Ps, social marketing considers planning and distribution and undertakes market research in areas that benefit personal and

national well-being. This approach fits in well with an increasing need to combat the spread of AIDS. By the mid 1990s, social marketing organizations maintained 54 programmes in 50 countries, helping to contain the spread of AIDS (Piotrow et al. 1997). Social marketing organizations are continuing to undertake research and educate people in how to protect themselves from HIV and other STDs spreading rapidly throughout the world.

In the ten-year span that the GDHS has measured contraceptive use, considerable improvements in condom use have been reported. Knowledge of condom use between 1988 and 1998 nearly doubled from 48.5% to 86.8%. Current use among women rose from .3% to 2.8% over those same ten years (Measuredhs.com 20 Aug. 2002). The earlier surveys, however, address condom use as a contraceptive, making it difficult to determine earlier attitudes toward condom use in terms of AIDS prevention. However, if financial support of condom and AIDS prevention does not improve, those statistics may not continue to increase. These improvements show that a continuing financial investment in prophylactic education is merited.

Financing the Condom Need

Though the United Nations General Assembly committed itself in June of 2001 to increasing access to HIV-related commodities (condoms, diagnostic measures, and drugs), a large gap still exists between what is needed and the current financial commitment (Chapman, Barraclough, & Richens 2001). The situation was not helped when American President George W. Bush proposed an end to U.S. federal aid to family planning centres abroad (IPPF 2001). Unfortunately, it will be the poorest countries, also those suffering most from HIV/AIDS that are hardest hit by reductions or insufficient increases in monetary donations.

In Sub-Saharan Africa, by the year 2005, the annual requirement of male condoms for STD/HIV prevention will be 1,146,329,472 pieces (Chapman, Barraclough, & Richens 2001:

- 5). Unfortunately, cost estimates will only increase, making it difficult to keep up with demand. Aside from inflation, part of the reason that costs are increasing is that the need for male condoms is increasing, as there is currently the largest ever generation of young people aged 15-24 (IPPF 2001). Estimated commodity needs, which includes condoms, will rise from US\$208 million in 2000 to US\$709 million by 2005, where donor support will remain virtually the same. These estimated costs consist only of the cost of delivering commodities onto a ship and do not include the fees for delivery, storage, and other costs that would add an additional one-third on top of the above costs (Chapman, Barraclough, & Richens 2001:
- 6). With a 26% reduction in funding in the year 2000 alone (IPPF 2001), even the most accessible areas for condom purchase in Ghana will have difficulty meeting the needs of condom users throughout the country.

The Impact of the Spread of AIDS

The spread of AIDS is a unique problem in the development of African nations. If it is not curtailed, the effects on national development can be detrimental. Four main factors make HIV different than other more common diseases.

1. AIDS is always fatal. Though drugs exist that delay the onset of AIDS, they are not a reality in developing countries like Ghana due to their high cost.
2. HIV/AIDS unlike other diseases affects mostly adults. Thus, instead of being the people who contribute the most to the development of the country, they are rather the ones slowing down development and raising the health care costs. When adults with AIDS finally die, they also leave behind children who are often ostracized, even by those family members who should be taking them in.
3. HIV can have a long incubation period of ten years or more. This characteristic is uniquely responsible for both the increase in HIV cases, but also a decline in economic development. When symptoms are not visible until long after initial

infection, many people unknowingly pass along the disease to others. When the disease finally takes hold, a victim can suffer for years creating high monetary and social costs that are not prevalent with other diseases (William 1999: 47).

Unlike diseases that result from mal-nutrition or poor access to health care, AIDS is not more prevalent among those from a lower socio-economic background. AIDS kills both the rich and the poor and at present, no amount of money can buy a cure. In Africa, men with a higher economic and social status tend to have more partners and thus have a higher infection rate. The opposite is true of women of the same class who tend to have fewer sexual partners and are less at risk. If higher income results from higher economic output, then there is a much greater economic loss from both illness and death caused by AIDS (William 1999).

Looking at STDs and their Implications on the AIDS Spread

While HIV is a sexually transmitted disease and alone affects about three percent of the population, there are other serious diseases affecting even more Ghanaians, which both perpetuate the spread of HIV and have their own potentially fatal affects. Many STDs such as gonorrhoea, syphilis, and herpes are quickly spreading throughout Sub-Saharan Africa. In 1995, there were 333 million new cases of curable STDs reported worldwide, 20% of which came from Sub-Saharan Africa (Messersmith et al. 2000). Some have no cure and can lead to serious illnesses like cancer or infertility. But if having a non-fatal STD was not deterrent enough of high-risk behaviour, statistics show that having an STD increases the AIDS transmission risk from two to nine times (Messersmith et al. 2000).

STD prevalence and condom use to prevent STDs were measured in a study in an Anglophone West African country, Nigeria. Nineteen percent of the respondents in the survey reported ever having an STD. The study was further divided into different risk categories. In the high-risk (promiscuous) category, 57% reported ever having an STD, while 22% of sex worker clients reported ever having one. In general, men who patronize

commercial sex-workers, have a greater tendency to use condoms. In the high-risk category, 51% had used a condom to prevent an STD and 86% of sex-worker clients had done the same. While these numbers are still too low and do not reveal consistent condom use, the numbers of low-risk condom users are much lower, 28%. For this study, low-risk does not refer to abstinent men, but rather a mean number of five sexual partners in their lifetime, with a mean age of 33.9 (Messersmith et al. 2000). This result perpetuates the idea that people who are not promiscuous or sex-worker clients are invincible in relation to STD risk.

A study among Ugandans revealed how serious an increase in STD cases can be in terms of contracting AIDS. Of more than 500 who were questioned, three in ten reported having had genital ulcers, a common symptom of other diseases such as herpes and chancroid (Morgan et al. 2002). People with genital ulcers are more likely to be HIV positive because the virus is more easily passed on when there is an open sore through which it can pass into the blood stream. According to the study, 38% (43% of men, 30% of women) of the Ugandans of those with genital ulcers had engaged in sexual intercourse while symptomatic, but only 16% (15% of men, 19% of women) of them had disclosed the condition to their partner (Morgan et al. 2002).

Whether HIV positive or not, exposing a sexual partner during an outbreak of genital ulcerations puts them at great risk for acquiring whatever STD they may have. Because some of these causes such as herpes have no cure and cause severe discomfort, for which relief is often only achieved through expensive medication, as well as increase risks for cancer and infertility, infected persons have a moral obligation to notify potential partners of the risks involved with any sexual contact. Sometimes, infected persons underestimate the severity of the symptoms, particularly at the early stages. Often, however, sufferers are uncomfortable with seeking professional treatment. In the Ugandan study, where respondents were observed

over several months and privy to free treatment and advice, only 12% of those who reported genital ulcers sought any treatment (Morgan et al. 2002).

The importance of this study is to show not only a growing need for awareness about other STDs, but also the growing need for condoms. It shows how people knowingly conceal their health status and put others at risk. Though we do not know whether those who deceived partners were in lasting and monogamous or casual sexual relationships, it still shows that anyone is in danger of infection. It is also likely that whether or not the genital ulcer sufferers were HIV positive or not, their potential sexual partner could not sense their condition and thus proceeded with the high-risk contact. This shows that one generally cannot differentiate between who is HIV positive and who is not simply by looking at them. Condoms, therefore, are a necessity in all sexual relationships that are not monogamous between two people who tested positive, but also those who tested negative for all possible STDs. However, just as seeking medical care for suspected STDs may not be socially accepted, some social systems and gender inequalities within them perpetuate high-risk sexual behaviour.

Social Systems and Gender Issues

High condom use is linked to an idea known as informed choice. Informed choice is made up from both an access to information and being supplied with choices where one can apply that information. The success of an informed choice is based upon social policy and community and gender norms (Upadhyay & Robey 1999). Just as cost and availability can be barriers to condom use, so too can social standards that have been passed from one generation to the next, regardless of the need for change.

African women are expected to bear multiple children in order to accommodate for the demands of lineage heads and the need to produce heirs. A large family is also still needed to provide free labour in the form of farming or selling goods to provide an income.

Some lineage heads who want as many children as possible are opposed to family planning, whether condoms or female methods of contraception (Adongo et al. 1998). In patrilineal societies in Ghana, such as the Ewe and the Dagomba, a husband has exclusive rights over his wife's sexual services, which was supported by the lineage heads (Aidoo 1985).

Among some societies, polygamous marriages and extra-marital affairs are looked at as a way of ensuring offspring. From this tradition has come an increasing acceptance of male promiscuity and non-monogamous relationships both before and during marriage. A husband's infidelity is often not sufficient grounds for divorce and wives do not always have a say when their husband decides to take on a second wife (Aidoo 1985). This leniency for multiple partners, with or without the presence of modern or traditional contraceptive methods, does significantly increase the risk of infection for women who themselves are monogamous. This practice, combined with the lack of trusted and available health care providers, creates a dangerous perpetuation of a disease that always kills.

Gender roles play a significant role in how and how quickly the HIV virus and other diseases are spread. In general, contraception is generally reported as either equal in use or more prevalent among women than men (Roudi & Ashford 1996; Bawah et al. 1999). If pregnancy is the only risk from sexual intercourse, then female methods such as contraceptive pills or intrauterine devices (IUD) are usually sufficient. However, these methods in no way prevent the spread of STDs. Such diseases require a barrier method of contraception, which both blocks the exchange of bodily fluids and contact between the genitals (Hatcher et al. 1997).

While contraception might be a further benefit of condom use, they are the safest and most reliable means of preventing STDs from spreading. Mention of condoms almost universally refers to the traditional male latex condom. Currently, a female condom is on the market, but is not as popular partly due to lack of availability. Despite advantages such as

pre-intercourse insertion and an ability to be used with oil-based lubricants, the *Femidom*, as it is sometimes called, is not as widely available as its long-time male counterpart, is more costly, and it is more difficult to use, allowing for spillage or accidental contact (Gardner, Blackburn, and Upadhyay 1999).

As it is commonly used, there are approximately 21 pregnancies per 100 women during the first year of female condom, showing that semen, which may also contain HIV, is passing from the man into the woman. With the male condom, there are only 14 pregnancies per 100 women. However, when female condoms are used correctly and consistently, the figure drops considerably to five pregnancies per 100 women. Male condoms used correctly and consistently result in only two fewer pregnancies with three pregnancies per 100 women (Hatcher et al. 1997).

Table 2.1: Pregnancies Per 100 Women During First Year of Condom Use

	Female Condom	Male Condom
As Commonly Used	21	14
Used Correctly and Consistently	5	3

Source: Hatcher, Robert A. et al. *The Essentials of Contraceptive Technology*.

Pregnancy, though not the same as STD transmission, shows the failure rate of the device and is sometimes easier to test. The statistics show that the *Femidom* has a potential for success if better education is achieved, but is still not the most effective method. Because of the uncertainties and greater risks of the female condom, men take most of the responsibility for condom use.

Patriarchal values are still innate in African countries such as Ghana (Aidoo 1985). Men often feel that is their decision alone to decide if a condom will be used. Among many Africans, the use of condom implies a lack of trust or an insinuation of an infected partner. Women who request that a condom be used are sometimes accused of engaging in high-risk

behaviour such as promiscuity or commercial sex work (Schoepf 1997; Adomako Ampofo 1999).

Many women live in fear of being beaten if they refuse sex to their husband or insist on condom use with any sexual partner (Bawah et al. 1999; Adomako Ampofo 1999). Among Ghanaians, 43% of men and 33% of women approved of wife beating if the wife refused to have sex with her husband (Heise, Ellsberg, & Gottemoeller 1999). Men who might accept a chance of infecting their partner, still may refuse to use condoms because they see condoms as loss of control over women and license for them to practice infidelity (Bawah et al. 1999; Schoepf 1997).

Women, who turn to commercial sex work for economic survival, even if they recognize a need for condoms, are often unable to negotiate condom use with clients. Even when rates for sexual services are low, clients sometimes feel that they own the woman for that period of time and can beat women who insist they wear a condom. Women are sometimes able to significantly increase their earnings if they offer their services without requiring that a condom be used (Adomako Ampofo 1999). At the opposite end of the economic scale, women who are married to powerful businessmen or politicians and know of their husband's infidelity, still have little leverage in ensuring that their husband's high-risk behaviour does not have fatal repercussions for them (Schoepf 1997).

Unfortunately, parents' and other adults' behaviour can have an extremely adverse effect on younger generations who are becoming or thinking about becoming sexually active. Adolescents in Zimbabwe reasoned that condoms are unnatural, reduce pleasure, and show a lack of respect or trust in the partner. Like adults in similar studies, girls who introduced or carried condoms were considered 'easy' and not suitable for marriage (Gage 1998). In Sierra Leone and Swaziland, young people had adopted the patriarchal attitudes of their elders. In Freetown, Sierra Leone, 59% of university students, an age group that should be

contraception savvy, saw the man as being responsible for issues relating to safe sex and many thought that women should not even know about sex (Gage 1998). Girls in Swaziland expressed an acceptance of partner's demands for sex, obedience, and submission. And, both boys and girls saw boys as having the "natural right" to make more demands in sexual relationships (Gage 1998: 163).

Gradually, younger generations are contributing to a change in gender inequalities and negative social traditions, allowing for the positive autonomy needed for Ghanaians to make wise choices about their reproductive health. This trend is more common in urban areas where modern and foreign influences are more prevalent. But where societal obstacles are not the sole reason for low condom use, other barriers are still keeping the majority of sexually active Ghanaians from turning to condoms.

Access to Contraceptives

Poor access to contraception methods such as condoms would indisputably lead to low consumption. Therefore, poor access has often been the excuse for the fast spread of HIV throughout Sub-Saharan Africa. However, access to contraception has increased considerably since the discovery of the virus, even though the numbers of casualties continues to rise. A study examined the relationship between contraception access and prevalence based on statistics from 64 developing countries in 1982, 1989, 1994, and 1999. In 1994 and 1999, the mean prevalence in 'high access' developing countries was only 44%. At the lowest level of mean availability, condoms had the highest level of availability at 40% (Ross et al. 2002: 32).

Between 1982 and 1994, the number of countries with uniformly high access to the four methods reviewed (condom, pill, IUD, female sterilization) rose from 9 to 23. Correspondingly, the number of countries with uniformly low access dropped from 23 to 9 (Ross et al. 2002: 32). Countries were categorized for access and prevalence as either very

low, low, medium, or high, according to 1999 data. While most countries tended to be equal in status in prevalence and access (e.g. very low in both prevalence and access, or high in both prevalence and access), Ghana revealed the greatest imbalance in the relationship between prevalence and access. In the very low prevalence category, no countries were listed as high access. However, only one country, Ghana, showed medium access to contraception, but very low prevalence (Ross et al. 2002). With a medium-level access, low prevalence of condom use in Ghana cannot be blamed solely on a lack of availability. This shows that social costs are a greater barrier than poor access.

Education and Misconceptions about AIDS and Condoms

Targeting both the infected and uninfected is extremely important so that those with HIV do not spread the disease to others and those without it protect themselves from acquiring it. While both groups are important, some organizations tend to focus on the healthy. A World Bank publication argued that since AIDS is spreading very rapidly in developing countries and there is no foreseeable cure to this fatal disease, governments and NGOs will have more impact if they put most of their resources into targeting the not yet infected, rather than the already infected who have little to gain from behavioural change (William 1999).

Monitoring the effectiveness of information campaigns can be difficult, as can knowing what type of programme to implement. Sometimes, the most effective methods are impractical. Before HIV reached the magnitude it has, a “quick, forceful intervention [was] likely to be the most efficient mechanism, in resources used, for limiting the spread of an infectious disease.” The reason that this technique was not successful in stopping the spread of HIV was that over two decades ago when the virus was first discovered, no one knew how serious it would become (William 1999).

When that window of opportunity started to close due to a delay in understanding about exactly how the virus is transmitted, it left room for the rumours and misinformation that are still spreading. A study of the decision-making process among the youth (to be discussed below), revealed that some teenagers in South Africa thought that AIDS was either an attempt to reduce Africa's large population or a fictitious disease that is "America's idea to discourage sex" (Gage 1998). Others in all parts of Africa see AIDS as being restricted to commercial sex workers, those who are extremely promiscuous, or people who have sex with partners showing visible signs of having AIDS (Adomako Ampofo 1999; Gage 1998; Schoepf 1997)

A 1999 analysis of family planning programmes, however, showed that Ghana rated above average in all areas of the index. Ghana scored an average of ten points above the grand average of developing countries and an average of eight points above the scores of Anglophone Africa in the areas of Policy, Services, Evaluation, and Method Availability ("The Family Planning..." 2001). Two areas of concern are immediately apparent with an index of family planning efforts. The first is that praising programme efforts may weaken further effort in a battle that is far from won because people may feel that the situation is no longer a concern.

The second potential problem is one that pertains to many studies of condom use. Even where condom use is isolated in studies determining family planning or contraception use tendencies, particularly in qualitative studies, they often fail to look independently at condom use as a contraceptive and condom use as a barrier to STD transmission. Condom use as a contraceptive might be replaced with another method if a preferred method is discovered, in the absence of available condoms, or if there is no longer a need for contraception. Those who use condoms but do not acknowledge their importance in

preventing STD infection may eventually be in as great of risk as those who never used a condom.

The Effectiveness of Multimedia Campaigns

Establishing the dual benefits of condom use within a community is an important area of focus for family planning campaigns. Often, these occur in the form of multimedia campaigns, which can be both memorable and understood by all members of the community, regardless of educational level. Determining exactly how effective such campaigns are is near impossible. To determine an approximate effectiveness, a control group must be studied before *and* after the campaign's commencement. This stipulation immediately limits which programmes can be measured for future improvements.

One such study of a multimedia campaign took place for three months in the 900,000-inhabitant city of Bamako, Mali. The campaign consisted of television spots and songs on the radio and informed about methods, male sexual responsibility, health and economic advantages to family planning, communication between spouses, and the misconception that Islam prohibits family planning (Kane et al. 1998). This particular study showed a definite correlation between exposure and contraception use. The baseline (pre-exposure) rate of condom use among men, aged 15 to 49 was 15.5%. Post intervention rates rose to 18.4% (Kane et al. 1998: 315).

The study probed deeper and found a further correlation between the number of interventions seen and those currently using modern contraception, which for men would refer to condom use (Table 2.1). In all instances, the greater the number of interventions seen, the higher the number using modern contraception. While these results may not be standard for multimedia campaign impact, they are a positive sign and may mean that many lives were saved.

Table 2.2: Impact of Bamako, Mali Multimedia Campaign on Contraception Use

Number of interventions seen	Men currently using modern contraception	Women currently using modern contraception
0	11.1%	2.6%
1-2	18.3%	8.1%
5-7	40.7%	16.3%
All (10)	67.7%	23.7%

Source: Kane, Thomas T. et al. "The Impact of Family Planning Multimedia Campaign in Bamako, Mali". *Studies in Family Planning*. Volume 29[3]. Sept 98. pp309-323.

Problems in Educating Young People About Condom Use

Expensive media campaigns are not the only means of educating the population about reproductive health. Such programmes might not even be necessary if micro methods were more prevalent. Where decreased sensation is a common excuse for not using a condom by people who have experienced sexual intercourse both with and without a condom, early education is necessary so that people start with and always continue to use them.

Many parents and adolescents say that they would prefer that parents supply information about reproductive health. Despite this ideal educational environment within the home, the reality is that parents are often misinformed, confused or embarrassed and do not end up being the source of their children's knowledge (Hughes & McCauley 1998). While little study has been done on parental education of contraceptive use, such education seems to be limited to morality and abstinence. The result of this insufficient instruction is that adolescents turn to their peers for information—peers who also tend not to have any formal instruction (Gage 1998).

Case studies from Senegal and South Africa revealed that adolescents who sought other means of advice were declined assistance. Respondents reported approaching clinics for help, only to be refused information and turned away. Because of the experience of their peers, others are afraid to visit the clinics and only do so when they are already pregnant or have an STD (Gage 1998). Unfortunately, health care workers and family planning advisers are keeping information from young people who they might feel are too young to know the

realities of contraception. In Uganda, only 39% of family planning advisers explained if a method protected against STDs. The rate was even lower in Zimbabwe, where only 10% provided that information (Upadhyay & Robey 1999: 10).

Awareness Programs and Social Marketing

Sex and AIDS education are often left out of formal education and neglected by parents and health care workers because they feel that talking about sex and ways to protect oneself against pregnancy and STDs promotes sexual activity and promiscuity. This assumption has been shown to be false. Of 53 studies of programmes of sexual education programmes reviewed by UNAIDS, 22 of them showed some delay in sexual activity or a reduction in the number of partners, pregnancies, or the STD rate. A further unspecified 27 studies showed that the programmes neither increase nor decrease sexually activity. Only three of the studies showed any increase in such behaviour (Upadhyay & Robey 1999:16).

Some organizations have dedicated a considerable part of their efforts to other ways of reaching the youth. Social marketing makes a business out of condom use and organizes subsidies from donor organizations for condom retailers (Gardner, Blackburn, and Upadhyay 1999). The Ghana Social Marketing Foundation (GSMF) International is a private organization established in 1993 in response to “emerging public health and other developmental needs in developing countries” (GSMF 1). GSMF’s efforts to inform extend beyond traditional multimedia campaigns of billboards and television commercials. The organization has transcended traditional boundaries to reach particular groups such as the youth. *Things We Do For Love*, a television drama about and for young people, and *Speakeasy*, a radiobroadcasted open-forum, allows for both young people and their parents to discuss important topics such as reproductive health and sexual activity (GSMF 11). Hopefully, innovations in reproductive health education such as these will allow for a better understanding HIV/AIDS, but also other STDs and the risks associated with sexual activity.

Chapter 3: Methodology

As the previous two chapters have discussed, I wanted to know what the barriers to condom use are, particularly those related to condom purchase. Because existing literature has not specifically answered all the questions I had asked, it became necessary to go beyond such sources and conduct my own study. This required a diversified study that covered all areas of condom retail—from the distributors down to the consumers. Not only was gathering information from various sources necessary for understanding the broader picture of condom sales and purchase, it was also necessary to use the different sources to cross-check or verify each other, a method also known as triangulation.

Methods of Data Collection

To adequately investigate the questions I had asked, three key groups needed to be consulted for information. To determine perceived barriers and areas of change needed, I consulted sexually active Ghanaians in Accra. To understand deterrents related to sales and the consumer reactions to buying condoms, I consulted the condom retailers. I also saw a need to gather information from the distributors of the different condom brands.

The study was carried out from a qualitative perspective because it allowed for a better understanding of the extent to which barriers exist and how people feel about buying condoms, rather than just numbers of users. My methods of data collection focussed primarily on a survey, interviews, and personal observation.

Respondents were chosen according to the method of data collection. For the interview, respondents were more specifically targeted because of their specific levels of knowledge. For instance, at GSMF, only a couple of people were able to offer enough information about this aspect of family planning and reproductive health. Several visits were

made before the interview actually took place and the interviewee was selected through a chain of recommendations from staff that I encountered.

Questionnaire: The questionnaire was a valuable tool for information collection from potential condom users of the general public. Although it is a quantitative method, the figures collected through the questionnaire were a necessary contribution to the triangulation method used to verify my data. Given the small size and time constraints of the study, one hundred sexually-active Ghanaians in Accra were asked questions pertaining to their condom buying habits, their preferred brands and retailers, the extent of their condom use, and their feelings about how condoms are displayed and sold, and the extent to which that inhibits buying (Appendix A). This method allowed for comparisons between the retailers and their impressions of condom buying and the actual consumers' needs and views.

For the questionnaires, a more precise method of respondent selection was necessary. My target population for the questionnaire was all sexually active Ghanaians in Accra. A convenience sample was used due to the large size of the target population. All sexually active people were potentially qualified to answer the questions in the questionnaire. To represent this population, a sample size consisting of one hundred respondents was formed. Every third customer leaving four centrally located chemists and pharmacies were approached to fill out a questionnaire. This method, however, provided a higher proportion of men. Part of the reason for this variation was the willingness to participate, as well as fulfilling of the requirement of having had sexual intercourse at least once.

Questionnaires for this study were assistant-administered. There were three reasons behind turning to research assistants to help with gathering this data. For one, the size of the study was quite large for one or even two people, particularly as I was also involved in more in-depth interviews. Second, because sex and condom use is culturally not an open topic of discussion, it seemed even more difficult getting people to consider answering questions

when they were approached by a foreigner using the insider/outsider approach. I had seen many times how local people liked to give an impression of morality and responsibility to foreigners, while a local data collector might have less of a barrier to overcome. The final reason was my inexperience with the local languages. I felt that for those respondents who did not completely understand a question on the questionnaire or did not speak English at all, a Ghanaian would be more likely to assist with such problems. Research assistants also had their limitations because some gathered data from non-sexually active people, which made it necessary to later collect replacement questionnaires from others who did fit the profile. Some of the assistants also allowed respondents to leave without having filled in the questionnaire in its entirety.

Most of the respondents who took part in the questionnaire are men. This is a result of the method of selection, but also willingness to answer questions, and fitting the criteria of having had sexual intercourse before. Of the 100 respondents, 73 are men and 27 are women. Their ages range from 18 to 36 years. They have a variety of professions ranging from teachers to computer software programmers. Most of the respondents (70) are either married, engaged, or in some form of committed relationship. The remaining 30 respondents do not consider themselves as being in a committed relationship.

Table 3.1: Breakdown of Questionnaire Respondents

	Married	Other Committed Relationship	Not in Relationship	Currently Sexually Active
Women(27)	3	16	8	21
Men (73)	14	37	22	64
Total (100)	17	53	30	85

Source: Author's field work, June 2002.

Interview: Two types of interviews were used to gather information in this study. The set-question-closed-ended-answers technique was used for gathering information from condom retailers. This method entails posing set questions to every respondent. This was necessary because comparable data was needed from all retailers in order to make comparisons, though a simple questionnaire would have limited free response. The interviews were very informal because they were conducted on the shop floor during working hours when employees had time in between helping customers. In cases where more than one employee was nearby, they collectively answered questions. This seemed to help in cases where one employee did not remember experiences or had not personally sold many condoms.

In the retail sector, six retailers in different socio-economic areas of Accra were selected for data collection. The six were broken up according to percentages of distribution given by GSMF. For instance, because approximately two-thirds of brands are sold in pharmacies or at chemical shops, two of each (total: 4) were selected for observation and interviews. Alternatively, approximately one-third of brand distribution goes to filling stations and supermarkets, so only one of each of these types of retail shops were selected. Though I have been told that condoms can also be purchased at markets and other types of vendors, none were listed on the distribution figures from GSMF, nor did any of the questionnaire respondents list that they bought condoms from such places. Therefore, none were looked at for inspection. The following is a breakdown of retail shop type and location in Accra:

- Pharmacies: Osu and Ring Road Central
- Chemical Shops: Legon and Mile Seven
- Filling Station: Legon
- Supermarket: 37

Respondents in the retail shops ranged in age from 28 to 42. Pharmacists had a relevant university degree. Other respondents ranged from completion of junior secondary school to some university education. For interviews in pharmacies, it was the pharmacist on duty that I was most interested in interviewing. This selection process was based on the fact that the level of knowledge about condoms and other health care related products was higher than other workers in the shop. In the case of one pharmacy, even though others were visible in the shop, it was the pharmacist who immediately approached me on the shop floor to see what I was in need of.

For all other retailer interviews, the person working nearest to where condoms were sold was the person that I approached with my set of questions. Generally, chemical sellers, like pharmacists, were positioned behind the counter with the other medicines. For the non-traditional retailers, I also tended to approach the person nearest to the condoms. Since condoms in filling stations are located nearest to the cash register, I interviewed the person working at the cash point, assuming that he or she would know more about actual sales and the comfort level of those who do buy condoms.

In the supermarket, however, where condoms are sold on the shelves amidst hundreds of other items, the nearest person is usually a cleaning assistant or shelf replenisher of little education, probably to junior secondary school level. Instead, I approached the manager on duty. While exact condom sale figures were not available, I figured he or she would know how often they replenish and whether or not people buy many condoms from them at one time. Personal observation was an invaluable form of input at the pharmaceuticals aisle at the supermarket.

Condom distribution in Ghana is almost completely undertaken by GSMF. Not only do they import, subsidise, and distribute condoms, they carry out research in family planning

and reproductive health, as well as extensive behavioural change campaigns using different forms of multimedia. In general, GSMF is the foremost authority on condom retail in Ghana.

Due to the importance of the interview with GSMF, I used the in-depth, open-ended response method of interviewing. This allowed the respondent to offer as much information as he had on any topics he found beneficial to my study. Though my visit to GSMF was more formal, the interview was less planned. The main reason for this was my own naïveté as to the organization's complete functions and to what extent it could offer assistance. I intended a first visit to be more like a meeting of colleagues where I could gather general information and seek guidance. A follow-up visit would more formally address GSMF as a business and seek information about strengths and weaknesses. After several cancellations and failed attempts to get an interview, it became necessary to gather as much information from the first willing respondent I met. While the questions had not been defined prior to the visit, it became necessary to build on knowledge the interviewee imparted and gather as much information as possible at that time due to the delay in setting up this meeting. Considering the limited time period for collecting data and the sufficient amount of information obtained from the interview, a follow-up interview was not requested.

Personal Observation: This aspect of the study centres around pharmacies, chemists, and other types of condom retailers. Though it is important to talk with the people who sell condoms day in and day out, observation is another important means of understanding both the problems and the solutions. Originally, the intention was to observe people buying condoms, but, as mentioned earlier, with less than ten percent of sexually active Ghanaians using a condom as a means of contraception, finding people in the act of purchasing their condoms was not as easy as originally anticipated. Some of the retailers even mentioned that only around six or seven customers per day purchase condoms.

Observation became necessary for another reason other than observing customers. Condom sellers, particularly the pharmacists and chemical sellers, tended to be very optimistic about condom sales and the level of comfort that customers have about buying condoms. While it is difficult to say whether or not the situation really is that way, at least at those particular retailers, personal observation was also a necessity. As a potential condom user, even one who is probably more comfortable with the idea coming from a less traditional society, I was able to see how the method of display and the availability appealed to me and whether or not I would feel comfortable buying condoms if I needed them. Also, though my questions were slightly different than an actual customer, having to approach the sales people to ask intimate questions about condoms helped me to realize the comfort level, approachability, and knowledge of the sales people.

Method of Analysis

When all of the questionnaires were completed, the answers were entered into a spreadsheet programme and tabulated. Not all questions applied to all respondents. Some question's percentages were tabulated based on a sub group of respondents to which the question applied. For instance, condom retailer's comparisons were divided between male and female responses. Questions about barriers to condom use were also only focused on the respondents who listed that they perceived a barrier to condom use. This was also the case for brand preference where reasons for brand preference were only tabulated amongst those who listed that they had a preferred brand.

Retailer responses were much easier to compare. Before approaching any of the retailers, a chart was created with a column for every retailer involved (Appendix B). Categories on the top portion of the chart were areas that I could observe on my own, such as the type of retailer (pharmacy, supermarket, etc.); the number of brands sold; whether or not

the female condom was available; or if condoms are sold on a shelf, the counter, or behind the counter. Some of these questions were later clarified once a conversation with the retailer had begun, such as the complete number of brands for sale if all brands were not noticeable from initial observation, something not always obvious. Other categories such as the most popular brand, the comfort level, peak sales times, and price range required assistance from sales staff. From the chart, all data could easily be compared both between the responses of all of the retailers and also with the responses from the customer questionnaire.

Field Experience and Limitations of the Study

Any study that asks questions that seem to have been overlooked or looked at from different angles in previous studies poses a significant challenge. The questions that I have asked could easily fuel a number of future studies. And, because this was only intended to be a small project, I certainly hope that I or other social scientists will continue to probe into these kinds of barriers to condom use.

While limitations in scope and size were unavoidable, there were other limitations that this study faced. I became interested in low statistics of condom use early on in my visit to

Ghana. As a Westerner, I could not help but be alarmed by the low reported condom use, as well as the daunting rates at which HIV/AIDS is spreading. The focus of my project was transformed many times and it was only during a small research project during the second semester of coursework that I began to focus on the idea of barriers to condom use specifically. My small pre-study survey helped me to focus on the perceived barriers that potential condom users have.

Also, while I had visited and observed condom retailers many times, it was not until after lectures had ceased that it was suggested by one of my lecturers that I visit and spend

time with condom retailers to get a better picture of people's reactions to buying condoms. This suggestion led to a significant restructuring of my study, which in turn required a new methodology. While it may have seemed too late to make such changes, I considered the suggestions valuable enough to do so. Therefore, condom use barriers related to purchase became the prime focus of my research.

Though the size limits of this thesis restricted any extensive data collection, time limits became even more of a barrier. My research of existing data looked mostly at numbers of condom use and AIDS statistics in general, with a few pieces of scholarship discussing barriers. Most that mentioned barriers, related more to the fact that respondents claimed some sort of barrier that kept them from using condoms. When specific barriers were mentioned at all, they tended to be issues of poor access in rural areas. While this is a problem, I was more anxious to look at where condom use is highest and then find out why, even there, it is still very poor.

From the beginning of this project, I knew that GSMF would be a critical source and a necessary first stop in data collection. Though the information I eventually collected was very valuable, the study was significantly delayed by cancelled appointments by GSMF staff and misdirection of appropriate staff to interview. The interview, as predicted, was the necessary first step. I had not been aware of exactly how large a part GSMF played in condom distribution, nor the areas they had and had not yet researched. Once this information was finally gathered, I could proceed confidently with the remainder of my study.

The personal attribute that delayed me the most was my extreme shyness. It has always been an impediment in countries where language is not such a barrier and I am not seen as a complete outsider from first glance. In Ghana, however, that obstruction was multiplied many times. Unfortunately too, it was worsened rather than improved by having

stayed here for the better part of the year, due to continual reminders of my differences. No matter where one comes from, condom use is delicate subject for which approaching people about them takes considerable courage. Though time was not on my side, I was even further delayed by a task that evoked considerable fear in me.

After reviewing the data, some other problems were also noticed. When distributing a questionnaire, simplicity and conciseness is very important. Though a draft of the questionnaire was distributed to advisors, colleagues, and others, a need for certain additional related questions were not noticed. Generally, areas that would have brought additional necessary information and clarity were not realized until tabulating data or answering questions based upon what had been gathered. For instance, further questions about tendencies for non-monogamous relationships would have been helpful, as would information about socio-economic status, aside from just profession. Also, some respondents claimed that they use monogamy as their means of preventing STDs, but also claimed that they always use a condom. If this is true, one would assume that this is because they use the condom as a contraceptive and not for STD prevention. Doing so means that they may not use condoms consistently if contraception needs change. Without further questions, however, it was difficult to know what the respondents reasoning for condom use are.

Finalizing the study became another great obstacle when I was asked fourteen months after submitting the research to make additions. While many of these suggestions would have been very positive contributions, they were not necessarily possible at that late date after I had separated from Ghana, my materials, and the bulk of the study for nearly a year a half. Exactly four months were given for the completion of the study once a panel of advisors officially approved this topic and the topics of my colleagues. While some work was done prior that approval, the majority of problem formulation, research, data collection,

calculations, and writing was done after that point as some changes were suggested then. I hope that readers will take this into consideration when reading this.

Chapter 4: Barriers to Condom Use

Sexual intercourse is probably the most intimate act two people can perform together. Sexual intercourse between two people has been taking place since people first appeared on the earth. Until recently, aside from the risk of unwanted pregnancy, couples have basically been able to have sex as they saw fit. They were open to a variety of contraceptive methods from the traditional withdrawal method to the modern and discrete Norplant implants were available to them. Suddenly, in the last twenty years, people are being told that sex can kill them. While certain STDs have been in existence for centuries, talking about risks related to sex suddenly does not exclusively mean pregnancy.

Cultural Barriers

In Ghana, culture is the biggest barrier to high condom use, according to GSMF. According to them, sex and thus condom use is not considered acceptable amongst those who are not married. Other studies indicate that some people believe condoms are for casual sex, or outside of marriage and therefore they do not use a condom with their partner (Adomako Ampofo 1999; Schoepf 1997). For those who are married, they are expected to remain faithful to their partner. They reported that Ghanaians are quite religious and, living in small communities, they know other people's personal affairs, which leads to a low prevalence of condom use. However, premarital sex and extra-marital affairs are still prevalent. GSMF also confirmed the belief that women who take an interest in their health and buy condoms are labelled as "bad girls" rather than the responsible individuals that they are.

Knowledge Barriers

A lack of knowledge about HIV/AIDS and its transmission and prevention can also be a barrier to condom use. For example, people who believe that AIDS can always be recognised by outward appearance or those who believe that traditional medicines can either prevent or cure STDs, will not necessarily use a condom (Adomako Ampofo 1999). Such

attitudes represent an incomplete education about HIV/AIDS and other STDs and portray how a lack of knowledge can be a barrier to condom use.

Where condoms are used, they are not necessarily used correctly. Condoms have a dual function. GSMF said, however, that most Ghanaians do not understand condom's second function and use them primarily to protect against pregnancy. This is a major problem because, without a desire to also combat the spread of STDs, condoms may not fulfil that duty. Since the introduction of condoms into Ghana, they have been sold as a contraceptive. It is only recently since the concern over AIDS that their purpose has broadened. Even though numerous campaigns and educational programmes and policies have been implemented, they are still not doing enough to create a behavioural change towards the dual-function method.

If someone is using a condom to prevent pregnancy, there is a chance that they change methods or refrain from using the condom during times of low risk of pregnancy or when a child is desired. During these times, such people are susceptible to contracting STDs. In the survey of sexually active respondents, 14% [12 out of 85 (9m/3w)*] were using condoms, but not for the purpose of preventing STDs. Using condoms solely as contraception also shows a lack of updated knowledge. A lack of knowledge can be the most dangerous element of all in the spread of AIDS.

Lack of knowledge, while a barrier on its own, further perpetuates other barriers. Many, either through experience or from hearsay, believe that condoms take away from the pleasurable sensation that comes from sexual intercourse. Thirty percent [22 out of 73 (13m/9w)] of the survey respondents reported that a decreased sensation was a major barrier to their condom use (Table 4.1). While some truth may exist to this fear, it is the lack of

* Breakdown of men and women respondents. m= men w= women

knowledge that lets people walk away from protecting themselves. According to GSMF, different types of condoms are available and the right type can alleviate some of the lack of sensation. Taking the time to learn your partner's desires and needs can also make up for any decreased feeling.

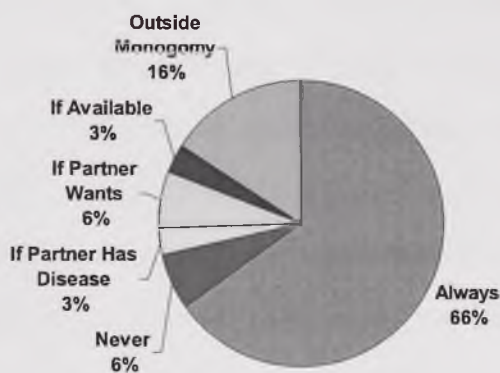
A further 17% [12 out of 73 (3m/9w)] of the respondents said that they do not always use a condom because of disapproval by their partner, while six percent [4 out of 73 (2m/2w)] say they use condoms only when a partner wanted to. These figures are higher than the findings of the *GDHS* where 2.4% of women who approved of contraception said that their partner did not. Twenty-six percent [19 out of 73 (8m/11w)] reported discomfort in buying was a major barrier, and 40% (6 out of 15) of the women who reported barriers said that, as a woman, they feel that men should buy condoms.

None of the women who responded to a question about who buys the condoms reported that they were responsible for purchasing them, though some were currently sexually active and not in a committed relationship. All of these responses suggest that those women are not taking responsibility for their personal health. This lack of information is most risky where people do not realize that condoms are a requirement and not a luxury for those with any risk of contracting a STD. Except in cases of rape, condoms are always a choice, but without an understanding that STDs can and do kill people of all kinds, they are not achieving the popularity they require.

6% [5 out of 94 (3m/2w)] reported that they never use a condom, even though over half (3 out of 5) of those who never use one are not in a committed relationship but are sexually active.

The lack of awareness extended further into respondents justifications for not always using a condom. Three percent [3 out of 94 (3m/0w)] said that they only use a condom if their partner has a disease. Considering that for most STDs, the infected person usually does not even know if they are infected for a period of up to even ten years, relying on a suspected knowledge of a partner's state of health is extremely naïve. Considering that female condoms are not as widely used as the traditional male condom, condom use required the approval of a male partner for use, which can be a barrier to its utilisation.

Figure 4.2 Reported Frequency of Condom Use



Source: Author's field work, June 2002

A further three percent [3 out of 94 (3m/0w)] said that they only use a condom if there is one available. However, nearly a third [29 out of 88 (23m/6w)] of the respondents said that they only buy single condoms to get them through the evening. Without planning ahead, there is an obvious chance that condoms will not be available when a need for them presents itself.

The 16% [14 out of 94 (8m/6w)] of the non-married respondents who claimed that they only use a condom when having sex outside of a monogamous relationship may appear

to be responsible about their sexual behaviour. Even within the sanctity of marriage, however, it is extremely possible, particular in a society that does not consider male infidelity as serious as female infidelity (Aidoo 1985), that one may not know if their partner is not mutually faithful and putting his or her partner at an unknown risk. Most couples do not get tested for STDs and only know they have one when symptoms develop.

Chapter 5: Barriers Related to Purchase

Some barriers are so extensive, so deeply buried within a culture, that they are difficult to change. Others, however, are not so deeply rooted and could be more easily changed. Buying a condom can be a frightening enough experience that it is sometimes enough to deter a person from using a condom. Other potential users are not persistent enough to buy a condom if too much effort is involved in finding a retail shop when one is needed. Even with deadly diseases such as AIDS spreading across the globe; the simplest of deterrents or the slightest discomforts, can keep a person from protecting themselves.

Addressing Areas for Change

GSMF is the primary distributor of condoms in Ghana. With this job comes a large responsibility for understanding the sales market and what changes need to be made. Condoms are not just a commodity, they are a lifeline to people who engage in high-risk sexual behaviour. They are goods that come with many cultural implications and restrictions. Because of the connotations linked with condom use, simple advertising and sales tactics are not enough.

While considerable work is left to be done in the area of increased consumption, GSMF is making headway in increasing awareness and meeting the needs of condom users and potential users. An interview with the Research, Monitoring, and Evaluation Department at GSMF outlined what the organization does and its intentions for the future. Already, they have significantly widened the price range of condoms so that they are accessible to all economic groups. While more expensive condoms such as Durex are quite popular, there was previously a void in the lower end of the price spectrum. Ghanaians are grouped into ten Living Standard Measures (LSM), one representing the lowest living standard and ten representing the highest. Most condom users fall into the lower five living standard groups, rather than the highest living standard groups. According to GSMF, more than 20% (the

largest category) of condom users fall into the LSM 2 group. LSM 3 produces the second largest group of condoms users with 16.81%. Only 8.85% of condom users belong to LSM 10. This shows a definite need for broadening the condom market to include lower costing alternatives.

According to GSMF, other organizations like the Ministry of Health (MOH) and the Planned Parenthood Association of Ghana (PPAG) supply highly subsidized condoms to parts of the community. However, without any brand name or promotion behind them that appealed to consumers and encouraged them to purchase them, they were not filling the gap they were intended for, according to GSMF. In response, GSMF gave a brand name to an unbranded condom from the USA, naming it Champion. Champion condoms retail for approximately one hundred cedis and are sold individually. GSMF explained that Champion condoms are sold for less than the most common good, the water sachet, which sells for two hundred cedis. At that price, those with little or no income can buy one or two as necessary, while others might be encouraged to buy one, two, or five thousand cedis worth to have available. However, while Champion condoms are of good quality, GSMF explained that some people do not trust a low costing condom for that fact alone. According to Piotrow *et al.*, people prefer or appreciate products more if they pay more money for them, regardless of quality (1997). No matter what the selection, however, condom sales will not be high if consumers cannot get to or properly view what is available. Condom placement is just as important as product range.

Placement of Condoms

Placement of condoms within the shop, from the findings of the study, seems to be based primarily on economic background of the clientele and the level of trust that the store has with those who enter the shop. For instance, the only retail shop in the study where condoms were sold predominately from an aisle amongst other products was a store selling

mostly higher-priced Western imports at the area of Accra known as 37. Employees are within view of the sales location. There, customers are allowed to spend unlimited time reading boxes and comparing prices if necessary, and are not in the way of other customers waiting to purchase other items. And, because, according to the manager on duty, a large number of the customers there are from or have lived in Western countries, buying condoms at their leisure from the shelf is completely common and acceptable.

From personal observation, the second most accessible position for condom browsing and purchase was at an upper class franchised pharmacy in Osu where, from observation, most of the customers were also foreigners or wealthy Ghanaians. Here, a very accessible display rack was placed to the right of the cash register where one could easily see all brands and styles available, though prices were only available on request, still requiring the consumer to approach the sales staff for information. The area was set up in a way that allowed browsers room to peruse available brands even if other customers had approached the cashier to pay. The pharmacist working at the time of the visit was happy with the location of the condoms and felt they were very conducive to easy purchase.

Other classes of retail shops, however, have a different approach to selling condoms. For them, selling condoms from unsupervised shelves is theft waiting to happen. All of those retailers who keep all or some of their brands behind the counter named theft problems as the primary reason for doing so. Most of them displayed some of their selection on the counter where people could pick up packages and inspect them. Not displaying all brands in this manner, however, allowed for a great deal of misconception about the extent of the selection. If one does not know the entire selection, they may refrain from purchasing if their preferred brand does not appear to be for sale.

At a Legon chemical shop, for instance, two brands were displayed on the sales counter, the lowest price Champion brand and a much higher priced, non-subsidized

Protector brand. Someone who might not trust the Champion brand because of its extremely low price, and is not prepared to spend 28,000 cedis for the six-pack of Protector condoms, might immediately leave the shop, assuming that the shop does not have a condom to suit them. Only after asking the chemist, did it become apparent that three other brands of middle range prices were also for sale.

The Ring Road Pharmacy displayed its condoms in a variety of places as well. Most were in a glass case visible immediately after entering the shop. However, the different brands and varieties were crowded into a small space so that one could not see most of the wide selection without serious inspection or assistance from the pharmacist. Other brands were hidden amongst other items in different shelves along the back wall of the store. Champion condoms were sold from a plastic container situated next to other plastic containers of toffees. The pharmacist did report, however, that some customers used the toffees as a means of approaching the area where the condoms are sold where they could then point discretely at the brand they wished to purchase. This shows that if customers need and excuse to purchase condoms, fear might be a barrier to their purchase of condoms.

The same was the case for a Legon-area filling station shop. Upon first impression, it seemed that only one brand of higher priced condoms were for sale. A few seconds later, two more brands were discovered amongst the sweets and other low priced items available near the register. Eventually, with the help of the sales clerk, six different brands were uncovered both on and behind the counter. The area was very cluttered and, particularly since some of the condoms were flavoured, it was difficult to decipher which were condoms and which were sweets. Not only would the difficulty in finding the condoms be a deterrent for potential customers, but they might also see the arrangement as a lack of seriousness in selling a health-related items, especially since, as GSMF noted, people tend to trust chemists and pharmacists more as a source of purchasing condoms.

Of the sexually active Ghanaians surveyed, approximately two-thirds said that they buy condoms from a pharmacy, with the remainder from chemical sellers, filling stations, or their partner buying the condoms. However, according to figures provided at GSMF at GSMF, 62% of male condoms are sold in chemical sellers, with only around 30% sold in pharmacies. This finding shows that perhaps more research needs to be undertaken among preferred retailers.

Aside from product placement being a potential barrier, so too is the location of the retail shop itself. It is important that condoms are easily available so that use is ensured. Nearly one-third of respondents [25 out of 85 (22m/3w)] said that there is not condom retail shop within easy walking distance of where they live. Thirteen percent of respondents [9 out of 73 (9m/0w)] also claimed that lack of availability of condoms was a significant barrier to condom use.

Product and Price

The brands and ranges of condoms being sold in the retail shops visited for this study spanned from five to fifteen. The number of condom types for sale correlated with both the class of the retail shop as well as whether it was an established chain or not. Upper class retail shops and chain stores tended to provide access to a wider variety of brands. The upper class retail shops were the only retail shops that carried the larger condom multi-packs, such as the Durex 12-packs, which were generally duplicates of Durex styles sold in 3-packs.

Though none of the respondents favoured it as contraceptive or prophylactic, the female condom was available at most of the retail shops and the impression of sales was mixed. The price for the female condom ranged from 300 to 600 cedis, which is a large price range considering that it is a product that is subsidized and imported solely by GSMF. In the Osu pharmacy, female condom sales were reported as high, while in the Legon filling station, the shop assistant said sales were relatively low. However, these reports corresponded with

traditional male condom sales as reported by the retailers. The Ring Road pharmacist reported that customers did not like using the female condom at all, which may explain its hidden position amongst the rest of the condom selection in the shop.

The range of condoms for sale is also an important area for inspection. As mentioned above, the range was between five and fifteen different brands, styles (such as ribbed or coloured), or quantities. However, at the supermarket, the range of 15 styles only included three different brands. While all three brands are generally considered to be the best quality available in the country, consumers who do not prefer those three brands would find no solace in the range of different condom sizes, colours, and textures available. Both the Legon chemical shop and the Legon filling station, however, sold five or six different brands.

The size of condom selection is of little importance if the brands being sold do not correlate with what consumers want. Thirty percent of respondents [22 out of 73 (14m/8w)] said that a perceived lack of quality condoms prevents them from using one, while twenty-six percent of respondents [19 out of 73 (16m/3w)] said that cost was a major barrier for them (see Table 4.1). Again, these findings are much higher than those from the *GDHS*, which reported that point eight percent of women and point nine percent of men saw cost as a barrier to their condom use. To relieve these barriers, many condom users stick to a one brand that they like or trust. Good quality, according to 68% [52 out of 76 (43m/9w)] of those who had a favourite brand, was the reason that they were consistent in using a particular brand.

According to the survey, approximately half of the respondents said that Gold Circle, a lower-priced GSMF subsidized brand sold in packages of four, was their brand of choice. However, only two of the retail shops visited carried that brand. The statistics provided by GSMF also showed that, in their target area, Gold Circle condoms were only sold in pharmacies and at chemical shops and had only the fourth largest coverage area of retail

shops among all brands sold in Ghana. The highest coverage of condoms was Champion singles, followed by Champion containers, which was only a preferred brand of approximately one-fifth [15 out of 76 (12m/3w)] of the sexually active respondents. Panther had the third largest availability of the retail stores visited and one retail shop claimed that it was the most popular of the five brands they carried, but it was not even mentioned as a favourite brand of respondents.

Table 5.1: Condom Buying Atmosphere of Different Accra Condom Retail Shops

	Self-service Yes/No	% of Women Buyers*	Price Range (¢)	Multiple Purchase rating out of 10*	Total Styles Sold
Osu (Ph)	Yes	30%	100- 25,000**	9	15
37(S)	Yes	n/a	300- 18,900**	8	15
Legon (Ch)	Partial	30%	200- 28,000**	5	5
Legon (F)	Partial	40%	100- 53,000**	3	6
Mile Seven (Ch)	No	25%	100- 21,000**	4	6
Ring Rd. (Ph)	1/16 of brands	20%	250- 25,000**	3	16

* As reported by pharmacist or other condom retail shop

† 1-10 scale rating tendency to buy multiple condoms during single purchase as reported by retailer.

** multipack

Ph= Pharmacy Ch= Chemical Seller

F= Fuel Station

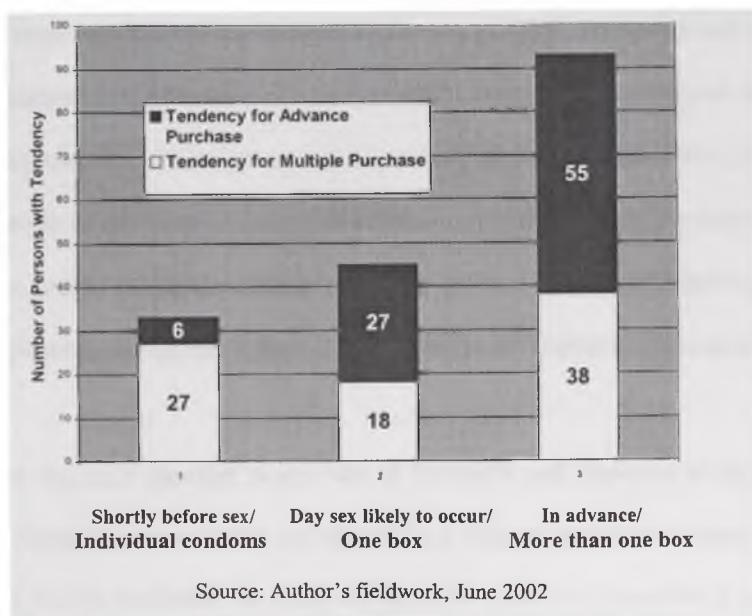
S= Supermarket

Source: Author's fieldwork, June 2002

Approximately two-thirds [58 out of 88 (44m/14w)] of those surveyed also stated that they buy multiple boxes of condoms at one time. This figure does not necessarily match the personal observations of the condom retail shops who tended to relate that except in the case of Champion condoms where people often buy one thousand cedis or more at a time, or with the upper class retail shops where people buy multiple packs of Durex, regardless of the cost, multiple purchases are not too common. In general, the impression of the retailers was that consumers buy one box, usually of three condoms, which may not allow for a surplus of condoms for future use. Again, this data suggests that a larger study is necessary.

A similar discrepancy was found within the area of advanced purchase, or buying a condom and keeping it for any occasion that one might have sex. Again, nearly two-thirds [58 out of 88 (44m/14w)] claimed that they buy condoms in advance when doing other purchasing. Seven percent [6 out of 88 (3m/3w)] admitted that they buy their condoms shortly before sex is likely to occur. All of the condom retail shops were quick to report that late evening, usually between five o'clock and midnight, was the time period of most condom sales. The Legon chemist reported experience where customers reporting stomach pains or other illnesses, came to the door after closing, only to request condoms when they are allowed in to make an after-hours purchase. Last-minute purchasing can lead to non-use of condoms if the potential user is not successful in acquiring the condom. The Osu Pharmacist told how, while evening sales were high, they were highest between ten and the closing time of midnight because other local retail shops were already closed by this time.

Figure 5.1: Buying Tendencies of Condom Users



Comfort Level of Condom Purchase

The findings of this study pertaining to ease of purchase of condoms were mixed. Almost half [48% or 42 out of 88 (33m/9w)] of the respondents said that they usually buy condoms where they are sold behind a counter and they must ask a clerk for assistance. More than half [52% or 46 out of 88 (34m/12w)] said that if they currently buy condoms where they are sold out in the open, they would not be hesitant to buy them from a retail shop where they were sold behind the counter if they needed to buy them. These two findings would imply a reasonable ease of consumers with buying condoms. Some of the retailers, particularly in the upper class areas, echoed this comfort level, even if their estimated sales figures did not. This could imply a couple of things: the respondents were not answering truthfully, comfort level for buying condoms is higher at upper class retailers or locations, or other factors of the demographic makeup of the responding group such as age or education are responsible for the increase comfort level.

Other responses by the respondents showed a level of discomfort and a desire for change. Respondents could indicate as many as nine barriers as they perceived affected their condom buying and use. While some listed as many as five barriers, 26% [19 out of 73 (10m/9w)] percent of the barriers came under the category of discomfort in buying condoms. If more than a quarter of the respondents are either hesitant to buy or do not buy a condom because of an uneasy feeling when buying them, then more attention to condom retail needs to be paid.

Despite the high reported usage rate of condoms and tendency to buy from full-service retail shops, the respondents did agree that a change in sales technique would alter their tendency to buy condoms. As many as 86% [73 out of 85 (56m/17w)] admitted that they would be more likely to “buy and use [condoms] if condoms were sold more from shelves where you did not have to get help from a salesperson in order to buy them.” Though

the question was addressed to those who do not always use condoms, many of those who had indicated that they always use a condom also answered that they would be even more likely to buy condoms if it is sold in a self-service location. While it is unclear as to their reason for this, one could assume that even those who always use a condom would feel more at ease about doing so if purchasing them was less awkward.

Point of Purchase

Aside from pricing, GSMF also looked at the types of retail shops that sold condoms and expanded the market to reach what GSMF referred to as “non-traditional” outlets. Apparently, however, hesitancy of customers has provided a barrier prohibiting the successful implementation of this project. Originally, according to GSMF, condoms were solely available from pharmacies and chemical shops. Just as people trust them to provide correct and adequate medication, they trust pharmacists and chemists to meet their contraceptive and STD prevention needs. This was also the finding in this study where almost all of the respondents [61 out of 88 55m/6)] bought most of their condoms from a pharmacy. While most people purchase condoms without consulting a pharmacist, according to GSMF, they are hesitant to buy condoms from non-traditional retail shops such as supermarkets and filling stations. Because this came up after the questionnaire was administered, the respondents were not asked about this issue raised by GSMF.

As someone who is completely accustomed to what is here considered non-traditional retail shops, it did not immediately seem apparent to me that one might be hesitant to buy from a filling station. However, after trying to interview shop clerks with little formal education about brands available, it became very apparent to me that many people might receive insufficient help when buying from a filling station. While chemical shop employees may not have a pharmaceutical degree, they and the pharmacists were considerably more helpful and easy to talk to and seemed to know their products much better than other condom

retailers. This difference in mannerism and knowledge could certainly be considered a barrier, particularly if one has no other options but to buy from a filling station, but then leaves empty-handed because they do not feel at ease with the service or fully understand what is available.

To combat this problem, GSMF is looking at training programmes for other retailers. The training would supposedly include knowledge about the condoms themselves including product expiration and benefits of different condom types, as well as proper behaviour such as not staring at customers who are buying condoms. This training will hopefully allow for increased comfort in shopping at non-traditional outlets, allowing for an increased number of retailers. One area of non-traditional sales that GSMF is not seriously considering at this time is, however, vending machines. Though they are extremely popular in public restrooms in more developed countries where condom use is more prevalent, thus allowing for after-hour and private condom purchasing, GSMF has concluded that vending machines are too big of a target for theft and vandalism.

Chapter 6: Summary and Conclusion

Summary and Conclusion of Study

This study was created as a means of looking at barriers, particularly those related to purchasing, which keep Ghanaians from protecting themselves from infection of the deadly AIDS, as well as other STDs. In more economically developed countries, condoms have become second nature for many and a great awareness of the threat of HIV/AIDS prevents many from even considering having sexual intercourse without a condom. However, when sexual intercourse, condom use, and all matters related to the topic are not openly discussed and many traditions and cultural practices dictate how, when, and with whom sex takes place, consistent condom use is compromised. Traditions which promote polygamy, gender inequality, and forced marriage of young girls to much older men, as well as place pressure on couples to produce several children, further impede positive change in the fight against AIDS.

With many cultural-related restrictions and unwillingness to discuss sexual and reproductive health, barriers are already in place that prevent adequate condom use among Ghanaians. As with other areas of positive development in an economically poor nation, lack of adequate education is a constant impediment to implementing change and making it a readily accepted idea. Where people are educated and understand the presence of AIDS and the new purpose of condoms, there is a presence of behavioural change to match that knowledge. However, many more people do not experience that formal education and are left open to the rumours that they hear on the street. Lack of education and thus a lack of fear of STDs is a significant cause of poor condom use rates.

Without a significant element of fear present within the general population, many sexually active Ghanaians, according to the findings in this study, are swayed by ideas that

condoms significantly decrease their sexual pleasure. Others are too easily convinced that proper protection is the decision of their partner. Women, according to the *GDHS*, are not consistently using condoms and 40% of the women surveyed in this study said that they feel that as a woman, condom purchase is up to their male partner. For women who are engaging in sex with a casual partner, leaving this decision to others can be deadly.

Condoms were not traditionally created as a barrier to the transmission of STDs. It is more commonly known as a contraceptive and many people use condoms solely for that purpose. Despite numerous campaigns by organizations such as GSMF and Johns Hopkins University Center for Communication Programs (JHU/CCP) where messages like “Abstain from Sex, Be Faithful Together, Use Condom Every Time” attempt to change behaviour, condoms are first seen as contraception by many Ghanaians. In the survey conducted, 14% reported that they always use a condom, but did not list it as their method of STD prevention in their relationship. Where condoms are not used purposefully for STD protection, their effectiveness becomes non-existent when contraceptive needs change.

For this study, however, one more specific barrier to condom use was studied. From previous, smaller studies and a review of existing data, it became obvious that unease in purchasing is a significant obstacle in appropriate condom use. A comparison with Western sales methods and techniques brought about questions about how much purchasing barriers prevent condom use. The comparison and earlier studies brought about many questions such as the following: Who buys condoms and where? What brands do they buy? What brands are being sold and do they correlate with what consumers want? What is involved in buying a condom? Are they sold in a manner in which people feel comfortable purchasing them?

Unlike barriers such as decreased sensation from a condom, which is difficult to change, it was perceived that insight into barriers related to purchase so that they might eventually be alleviated. Sexually active Ghanaians in Accra, the most developed city in

Ghana with the highest condom accessibility, were asked a variety of questions about their condom use and buying habits. Six different retail shops were visited for interviews and personal observations about their condom sales, selection, and condom buyer comfort level. A more in-depth interview was also conducted with GSMF, the major condom importer and promoter of good reproductive health in Ghana.

Most of the retail shops kept at least a portion of their condom selection in a full-service area, which they attributed to high theft risks. Those retailers who did sell all of their condoms in self-service areas catered for wealthier customers who already tend to have better knowledge about condoms and their uses. It is the retail shops that are not self service who are not only discouraging customers from being able to pick up condom packets and read about what they are buying, but also encouraging a higher discomfort in the actual purchasing of the condom. Brands kept behind the sales counter are often difficult to see, which may prevent a potential customer from making a purchase if they perceive that the selection is low or that their brand of preference is not available.

The condom selection tended to be wider in retail shops considered as 'upper class'. Brands and styles spanned from five to fifteen. However, one retail shop with a range of fifteen condom styles only carried three different brands of the male condom. Respondents also listed their brand of choice, of which the most popular did not correlate with distribution figures provided by GSMF or the selection in the retail shops.

Most of the respondents claimed that they make multiple purchases of condoms at one time, which did not seem to match the information from many of the chemists, except for the lowest priced brand sold in singles. On the opposite end of the scale, customers tended to make multiple purchases or buy large quantity packages of the most expensive brands at the upper class retail shops. Again, most respondents claimed that they buy condoms in advance

and not at night right before sex is likely to occur. The retailers, who all saw late evening as by far the busiest time of condom sales, did not support this opinion.

Approximately half said that they currently buy condoms where they are not self-service, with approximately the same figure claiming that if they do purchase from a self-service retail shop, they would not be hesitant to buy from a non self-service retail shop if condoms were needed. However, over a quarter of respondents who saw a barrier to their condom use, said that discomfort to purchasing kept them from using condoms. Additionally, nearly all of the respondents said that they would be more likely to buy and use condoms if they were sold from the shelves and did not require the help of a salesperson.

GSMF is reportedly taking on some of the obstacles prohibiting healthy condom sales. They have recently expanded the range of condoms to include all price ranges. The organization has also been trying to expand the range of retail shops, past the traditional pharmacies and chemical sellers to the filling stations, supermarkets, and others. Because people tend to trust pharmacists and chemists more, they are also trying to provide training for the non-traditional retail shops so that customers will feel more comfortable shopping from them.

Recommendations

The following are areas already being addressed by government, civil society, retailers, and distributors, but according to the findings of this study, should be improved upon and continued.

- The continuation of multimedia behavioural change campaigns to emphasize the dual purpose of condoms.

- A more aggressive condom-related education programme within the school system so that children are comfortable with the idea of condoms before they start having sexual intercourse.
- A broadening by GSMF of distribution of condom brands among traditional and non-traditional retail outlets.
- More research in preferred brands of condoms and the reasons for preferred brands. This will aid in correct distribution as well as the addition of new brands of condoms with similar features.
- A comparison of barriers to condom use among the different regions of Ghana.

The study also brought about specific concerns relating to condom use barriers. Below are my specific recommendations based upon the findings of this study:

- **A more in depth look at barriers to condom use in future editions of the *Ghana Demographic and Health Survey*.** Only the most recent edition of GDHS looked in-depth at condom use as a means of STD prevention. However, barriers such as those indicated in this study have not been analysed.
- **A comparative study by GSMF of retail shops that were full service but later became self-service, and how condom sales and perceived ease of purchase were affected by this change.** Such a study, based on my personal observations and the findings of this study, would show that changes in sales approaches and methods would improve the customer's likelihood to buy condoms. However, a detailed 'before-and-after' study would be required to convince many people that such changes are extremely beneficial.
- **The continuation and expansion of non-traditional retailer training so that condom users will feel equally at ease purchasing from non-traditional**

outlets as they do chemist shops and pharmacies. GSMF indicated in the interview that their efforts to train non-traditional outlet's sales people are still in the early stages. My personal observations that pharmacists and chemists offer better customer assistance, and the study's findings revealing tendencies to trust pharmacies and chemists more for condom purchase, show that GSMF should indeed continue and increase their training.

- **An attempt by retail shops to locate condoms in accessible, visible locations where customers can examine packages at their leisure.** The findings of this study revealed, particularly in the interviews with condom retailers, that accessible condoms make people instantly more comfortable with buying them. Though theft is a concern, the success that Western countries have had by placing condoms in the open and the destigmatisation that ensued, should be an incentive for Ghanaian retailers to at least experiment with forms of self-service condom sales.
- **The implementation of vending machines in restrooms where Ghanaians can purchase condoms discretely at any time.** With over a third of the respondents claiming that condoms are not sold within walking distance and over a quarter stating that discomfort from purchasing condoms can keep them from buying, vending machines are a likely solution to these problems. Brands of condoms such as Champion are inexpensive enough to be purchased with coins. Though theft and vandalism are concerns, locations that might be considered as lower-risk such as hotels and more formal eating establishments could be used as trial locations to measure the success of vending machines. Again, as happened in the West when condoms were moved from behind the counter to self-service

locations on the sales shelves and when condom vending machines became common, the stigmatisation of condoms was significantly reduced.

Vending machines have also traditionally been a successful way for different organisations to earn money by purchasing the vending machine and the contents at wholesale prices and then selling them in the machines. Business owners and other groups might value the introduction of condom vending machines as a new form of fundraising. The fact that GSMF has avoided the idea due to their perceived vandalism risks is ignoring a potentially invaluable sales outlet.

Hopefully, these recommendations and this study will inspire policy makers and organizations such as GSMF, as well as retailers of condoms to further probe into the barriers that condom purchasing can create. If even one person is inspired to conduct a further study, decides to consistently use condoms, or positively adjust the way that they sell condoms to customers, then this study is a success. Though AIDS and STDs require a significant amount of further understanding and education before the entire problem can be eradicated, as long as people have an interest in finding a solution, there is hope. This study is a contribution to that hope.

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Appendix A: Questionnaire for Sexually Active Ghanaians in Accra

This survey is an essential part of research being done for a Masters Degree from the Institute of African Studies at the University of Ghana, Legon. This research looks at condom use, brand preference and what prevents people from or makes them uncomfortable buying condoms. Thank you for taking the time to complete this brief survey. All answers are kept confidential and anonymous, meaning your name will not be asked and none of your personal details will be used in the study. Please answer all of the questions in full.

1. What is your age? _____
2. What is your sex? Male/ Female
3. What is your profession? _____
4. What is your marital status?
a) married b) never been married c) divorced d) separated
5. If not married, are you currently in a relationship? Yes/ No
If yes, how long? _____
6. Have you ever had sexual intercourse? Yes/No
7. Are you currently sexually active? Yes/ No
8. Do you know that HIV/AIDS is a fatal disease with no cure? Yes/ No
9. Do you know that other sexually transmitted diseases (STDs) such as gonorrhea and syphilis can cause infertility and cancer and are often not curable? Yes/ No
10. If you are sexually active, what do you do to protect yourself from contracting AIDS and other STDs?
a) use condom b) withdrawal method c) stick to one partner
d) don't sleep with people who have disease e) local medicine
f) other (please specify) _____
11. How often do you use a condom?
a) Always b) Never c) If person appears to have disease
d) Only if partner wants to use e) If one is available
f) Only if having sex outside monogamous (faithful) relationship
12. Who provides condoms in your relationship? You/ Your partner/ Either
13. Do you have a preferred brand? Yes/ No If so, what is it?
a) Gold Circle b) Champion c) Durex d) other

14. What is the main reason for using that brand of condom?
a) low cost b) good quality c) widely available d) other
-
15. What prevents you from using a condom? (Circle all that apply)
a) high cost b) lack of good quality c) don't like feel of using condom
d) partner doesn't approve of condom e) don't need because am married/engaged
f) don't need because partners not infected g) don't feel comfortable buying them
h) lack of availability i) as a woman, feel that men should buy condoms
j) other
-
16. Where do you usually buy condoms?
a) chemist b) pharmacy c) petrol station d) market place
e) grocery store f) other _____
g) partner buys condom
17. Are condoms sold within easy walking distance of your home?
18. When you or your partner buys condom, do you buy...
a) individual condoms to last the evening b) one box
c) more than one box to have on hand
19. Do you or your partner usually buy condoms
a) shortly before sex is likely to occur (eg on the way home) b) the day sex is likely to occur
c) when doing other shopping, regardless of possibilities of sex
20. Where you usually purchase condoms, are the condoms located...
a) behind a counter where you must ask a clerk for assistance
b) out in the open where you can select or read packaging at your own leisure
21. If you usually purchase condoms where they are sold out in the open, would you be hesitant to purchase them from places where they are kept behind the counter, even if you needed them? Yes/ No
22. If you don't always use condoms, would you be more likely to buy and use them if condoms were sold more from shelves where you did not have to get help from a salesperson in order to buy them? Yes/ No

Appendix B: Retailer Survey**RETAILER**

	#1	#2	#3	#4	#5	#6
Type of Retailer (P, C, F, S)						
On Shelf, Counter, or Behind						
# of Brands, Types						
Female Condom? Yes/ No						
Most Popular Sold						
Number bought at one time						
Comfort Level 1-10						
% of Women Buyers						
Peak Sales Times						
Reasons for not Self-Service						
Price Range						