Women and Healthy Living in Canada

Fact Sheet Number 5 Fall 2012

CONDOM USE

Most women in Canada who are at risk of acquiring sexually transmitted infections use condoms. However, many women find it difficult to negotiate safer sex and condom use with their partners, pointing to a need for greater sexual equality for women.

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex-and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

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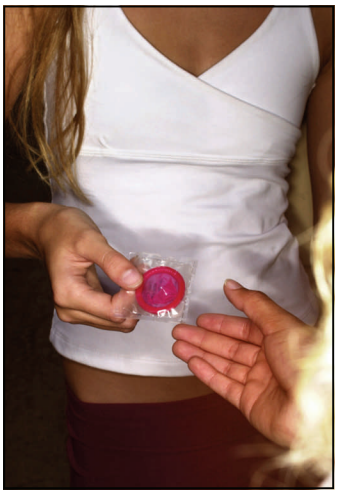
Condoms are widely available and inexpensive contraceptives that also provide the best available barriers to sexually transmitted infections (STIs), such as chlamydia, gonorrhea, syphilis and HIV [1]. Preventing STIs is critical because viral and incurable infections (as well as the occurrence of bacterial STIs) have been steadily increasing in Canada [2]. Condoms are the only barrier protection against HIV transmission during vaginal and anal intercourse [1]. Male condoms are most commonly available and used for mutual protection in vaginal and anal intercourse and are sometimes used by partners for oral sex. When used correctly, male condoms are 87%-98% effective in preventing pregnancy. Female condoms have been available for some time in North America and are the most effective women-controlled prevention against STIs.

Sex-and gender-based analysis

Sex–and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. ***Sex*** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. ***Gender*** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.



3. ***Diversity*** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. ***Equity*** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [3].

Sex issues

Fewer than half of women report using condoms as their primary form of contraception, although 31% of women aged 18-19 and 34% of women aged 20-24 reported using condoms as their birth control of choice [4]. Young males (15-24) were less likely to report using a contraceptive. About one-third of young adults in Canada have had sex with more than one partner in the past year [2, 5]. In Canada, fewer than 35% of women at any age between 15 and 49 who were at high risk for STIs (users with more than one sexual partner in the past 12 months) reported using a condom during the last time they had sexual intercourse [4]. In every age group, women were less likely to report using a condom during last intercourse than men. For females, but not for males, earlier first intercourse was associated with reduced likelihood of using condoms [2, 5].

Gender issues

Condoms as the primary choice for contraception declines as women get older, which presumably coincides with women being in more stable relationships where the risk of disease transmission is lower. Despite their effectiveness as contraceptives and in preventing STIs and HIV/AIDS, many women considered high risk for STIs do not use condoms, particularly after the age of 25. Women may not be able to negotiate safer sex and condom use because men decide whether or not a male

condom is used. Power differences and potential or real threats of violence may prevent women from protecting themselves [6, 7]; condom use can often be a point of contention between partners [8]. Female condoms have not been well received by women because they are difficult to use and expensive [9].

Diversity issues

Young women with more education and more income were more likely to report regular use of condoms. Condom use declines dramatically with age. Women over 30 years with more than one sexual partner in the past year were half as likely to use condoms as women aged 15 to 29 years [2, 4]. Older women may be more likely to believe that they are not at risk from unprotected sex. Fewer women used condoms in 2002 (18%) than in 1995 (25%) [10]. The decline in condom use was not accompanied by increased abstinence nor was it balanced by corresponding numbers of women and their partners testing for STIs. However, the prevalence of sexually transmitted infections - including chlamydia, gonorrhoea, syphilis and HIV/AIDS - has increased [2, 4, 10]. A survey of injecting drug users found that women varied in their use of condoms, depending if their sexual encounters were with regular partners, casual partners or paying clients [11]. Women in the sex trade, women who engage in survival sex and others who are vulnerable to poverty and violence are disproportionately likely to acquire HIV although specific rates of condom use in these populations is unknown.

Equity issues

Women with more education have a greater likelihood of using condoms during high-risk encounters, particularly women with at least some post-secondary education [3]. Researchers have found that young women and men were less likely to engage in risky behaviour if they were motivated to pursue their education [12]. As noted, women's ability to negotiate condom use can be compromised by threats of violence and other power differences with their partners. Early tests of an "Invisible Condom", an applicator with spermicidal gel, have been favourable [13]. If it becomes commercially available it may be an effective contraceptive and preventative for women whose male partners refuse to wear a male condom [13].

Critique

Survey data available on contraceptive use, and condom use specifically, are limited, despite the fundamental importance to individual and population health. The Canadian Community Health Survey asked about contraceptive use among 15-24 year olds but only asked high-risk survey respondents under 50 years of age about condom use [14]. Given that condom use declines with age, while the risks of unprotected sexual intercourse remain unchanged across the life span, it would be valuable to ask about unprotected high-risk sex among all respondents [2, 4]. Other limitations to the survey include that respondents may only have replied about male condom use, "sexual intercourse" was not defined in the question, and respondents who are asked about personal behaviour may not be fully forthcoming about high risk behaviour [15].

FOR MORE INFORMATION

BC Centre of Excellence for Women's Health:
www.bccewh.bc.ca

Atlantic Centre of Excellence for Women's Health:
www.acewh.dal.ca

Prairie Women's Health Centre of Excellence:
www.pwhce.ca

The Source:
www.womenshealthdata.ca

La Source:
www.lasourcesantedesfemmes.ca

SGBA e-learning resource:
www.sgba-resource.ca

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