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LETTERS

Further testing of female condoms

Madam,

Changes in behaviour and barrier methods of contraception remain the only ways of slowing the sexual transmission of HIV. The female condom represents a new and potentially important addition to the existing choices. Bounds et al's[1] preliminary study of 24 married or cohabiting couples found 63 per cent of the men and 79 per cent of the women reported the effect on sexual pleasure to be no different or better than the male condom. Because the female condom is made of polyurethane, a material more durable than rubber, and covers a larger surface area, it may provide better protection than a standard latex condom. In addition, early reports on the US made WPC-333 female condom (similar to the one used by Bounds et al) suggest that the risk of female exposure to seminal fluid is less when WPC-333 is used as compared to a male condom.[2]

We have tested the US-made WPC-333 female condom to determine if the female condom might be an acceptable method of protection from STDs for high-risk female sex workers.[3] Twenty massage parlour workers in Khon Kaen, Thailand, were trained by nurses to use the female condom and supplied with 20 unlubricated devices each. They also were provided with a supply of lubricant and their regular supply of male condoms. The participants were instructed about the risk of AIDS and advised that they could use the female condom as an alternative method of protection to the male condom. The decision of which device to use, if any, was left to the participant.

Participants were interviewed two weeks later. They reported using the female condom alone in a total of 78 (32 per cent) of 247 episodes of vaginal intercourse, of which eight episodes were in conjunction with the male condom. The male condom was used in 90 (35 per cent) episodes. Two thirds of the volunteers reported no aversion to the female condom, while one third disliked it. Mechanically, the female condom performed well. No rips or tears were reported during intercourse, and no woman reported severe pain. The most common objection to the 17 cm device for these Thai women was that it was too big. Also, the need to lubricate the condoms made their use messy and inconvenient. Nineteen participants said the female condom was less convenient to use than the male condom, and six said it was less convenient to use than the male condom, and six said it was less comfortable. Most of these problems can be overcome by shortening and pre-lubricating the condoms. One other objection was difficulty inserting (15 per cent), a problem which may have been due to lack of experience with inserting the condoms.

While the participants' own general assessment of the condom was fairly positive, most discontinued using the device because of male partner objection. Ten respondents reported that all partners with whom they used the female condoms objected to their use; eight said reactions were mixed; and two said all partners with whom they tried them reacted positively. Eighteen of 20 participants said they would advise other sex workers to try these female condoms.

We are now preparing to repeat this study at the same site, using 15 cm pre-lubricated female condoms. Revised instructions will be provided by the manufacturer, and each participant will be required to practise inserting at least two of the devices before initiating the study.

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