Consumer Preference Study of the Female Condom in a Sexually Active Population at Risk of Contracting AIDS

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Abstract

To determine the acceptability of the female condom among commercial sex workers in Khon Kaen, Thailand. Twenty sex workers from a massage parlor and 21 from a brothel were trained in the use of the female condom. The voluntary participants were instructed about the risk of HIV and advised that they could use the female condom as an alternative method to the male condom for protection. The female condom was used in 28.4 per cent and 17.8 per cent episodes of sex in each site during the two weeks. Continuation of use of the female condom increased from 0 per cent in the first group to 43 per cent in the second group. The reasons for discontinuing its use were that it was inconvenient and because of their partners' objection. More users said they liked the female condom even though more thought it was difficult to insert and it did cause pain. However, they would recommend it to others and most felt that other women would want to try it. The participants also saw the advantage of the female condom as a back-up method in case of clients' refusal to use the male condom but all prefered the male condom if there was a choice.

Key word : HIV/AIDS, Female Condom, Sex Worker

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Condoms are a highly effective means of preventing human immunodeficiency virus (HIV) transmission and their use is increasing in many parts of the world. Currently, the only widely available effective method to prevent heterosexual transmission of HIV is the use of male condom. How-

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ever, even where HIV prevalence is high, as is the case in some developing countries, condom promotion projects, involving constant condom availability and regular counselling, have been unable to attain levels of use above 70 per cent except in limited targeted populations[1,2].

AIDS is now a leading cause of death among women in developing countries[3]. Women of all ages are biologically at a higher risk than men for contracting HIV[4]. The majority of these infections are transmitted through vaginal intercourse; the presence of other STD infections can substantially increase women's chances of becoming infected with HIV[5]. Data from studies around the world have highlighted the need for female-controlled prevention methods. Non-consensual sex, fear of violence, economic dependence, and inability to negotiate male condom use restrict prevention options for many women[6]. Although the female condom requires male cooperation, it does not require male initiative. Most importantly, use of the female condom reduces the number of unprotected acts of sexual intercourse, thereby decreasing the risk of pregnancy and increasing protection against transmission of STDs, including HIV.

The world's first female condom (Reality, Femidom, and Femy are all registered names for the female condom) became available to the public in 1992. For five years prior to its introduction in 1992 and continuing since then, clinical studies have been conducted to evaluate efficacy, acceptability and safety. Additional studies addressing operational issues such as introduction strategies, education, marketing, and distribution programs, are increasing trial, acceptance and availability of the female condom particularly to at-risk populations.

Objective

To determine if the female condom might be an acceptable method of protection from STDs/HIV for sexually active populations at risk of contracting AIDS.

Methodology

During the two weeks of the study, forty-one sex workers in Khon Kaen (20 from a massage parlor as the trial I group and another 21 from a brothel as the trial II group) were trained to use the female condom. Subjects in each trial group worked in the same establishment and were selected randomly to voluntarily participate in a two-week study of the female condom. Their employer gave full support and cooperation for the study. The participants were instructed about the risk of HIV and advised that they could use the female condom as an alternative method of protection to the male condom. (They were also provided their regular supply of male condoms). The decision of which device to use, if any, was left to the participant. Furthermore, only women currently using contraception were eligible to participate in this study.

As a pre-test, four women who were not part of the 41 subjects were trained in the use of the female condom and given a supply of ten female condoms each and told to try using the condom for one week. The purpose of this pre-test was to gather practical information to enhance the content of the training instruction. In addition, the pre-test was an exploratory step to determine that, in fact, the female condom could be used by this high-risk group.

During a period of three hours before they began to work, the volunteers were given an overview by the investigators of HIV/AIDS and how it can be prevented. Next, the female condom was described to them, then the participants split into eight groups of five to learn more about the female condom and practice inserting the condom by using a full scale pelvic model. At the end of the small group sessions, each participant was given a Thai-language pamphlet on how to insert and remove the condom and a supply of ten female condoms. The participants were informed that they would be interviewed on their experience after the first and second weeks. They were told how to obtain a resupply of condoms and all women were instructed not to reuse the condom and to return any unused supply.

Participants were interviewed at their place of employment by the investigators who conducted the group training. These investigators were skilled in conducting in-depth interviews, especially with high-risk population such as the 41 subjects.

RESULTS

1. Sample Characteristics

The subjects in Trial II were distinctly younger and less educated than the Trial I group. In the former, almost all were under age 25 and none had secondary school or higher education. More

participants in the first trial used the injectable contraceptive but the pill was the most common method for both groups (Table 1).

2. Use of the Female Condom

The twenty volunteers of the first trial group had 247 acts of sexual intercourse during the two-week study period and they reported using the female condom alone in a total of 70 or 28.4 per cent of episodes. In the second trial group, the number of sexual encounters was 744 and the female condom was used in 132 or 17.8 per cent of episodes. Thus, use of the female condom in the second trial (132) was greater than in the first (70) but the rate of protection with this method was lower (28.4: 17.8). It is most noteworthy that the participants in Trial II used either the female condom or the male condom in 100 per cent of episodes of sex during the two weeks. In both groups no participants used the condom during menses. All douched after using the condom and none reused the female condoms. Continuation of use of the female condom increased from 0 per cent in the first trial to 43 per cent in the second trial. Among those who stopped using the condom in the second trial, the major reason was personal discomfort. This is in contrast to the first trial where subjects discontinued use mostly because of their partners' objection (Table 2).

3. Participants reaction to the female condom

More users in the second trial said they "liked" the female condom even though more thought it was difficult to insert and more experienced pain than the Trial I users. More users in

Table 1. Characteristics of sample population.

	Trial I (N=20) %	Trial II (N=21) %
1. Age (years)		
16-20	15.0	19.0
21-25	25.0	76.0
26-30	30.0	5.0
31-35	30	0.0
Total	100.0	100.0
2. Education		
No education	5.0	14.3
Primary school	70.0	85.7
Secondary school	20.0	0.0
Junior college	5.0	0.0
Total	100.0	100.0
3. Method of current contraception		
Pills	90.0	76.2
Injectable	10.0	23.8
Total	100.0	100.0

Table 2. Using the condom.

Participants' reaction	Trial I (N=20) %	Trial II (N=21) %
1. Use of condom by number of episodes of intercourse ( )		
- female condom only	(70) 28.4	(132) 17.8
- male condom only	(82) 33.2	(612) 82.2
- both condoms	(8) 3.2	0.0
- no condoms	(87) 35.2	0.0
Total	(247) 100.0	(744) 100.0
2. Reused condoms	0.0	0.0
3. Discontinued before 2 weeks	100.0	57.1
Reason for discontinued use of the female condom:		
- discomfort to self	30.0	83.0
- discomfort for client	50.0	23.8
- inconvenient	55.0	33.3
- decreased enjoyment	30.0	0.0
- partner objected	75.0	14.0
- out of supplies	65.0	0.0

Trial II complained that the outer ring interfered with intercourse than Trial I users. These differences between the two groups may reflect the different level of concern for client satisfaction in the two groups of participants or differences related to coital frequency or clients insistence during intercourse. 95 per cent of the Trial II users reported that both inner and outer rings stayed in place during intercourse compared to two-thirds of Trial I users (Table 3).

The female condom was not difficult to remove and almost all respondents felt competent in using it. It did cause pain in the majority of users and, possibly for this reason, all prefered the male condom if there was a choice.

Table 3. Participants' reaction to the female condom.

Participants' reaction	Trial I (N=20) %	Trial II (N=21) %
Liked the condom	50.0	71.0
Disliked the condom	35.0	28.6
Condom was well lubricated	95.0	90.5
Always easy to insert	50.0	14.3
Inner ring interfered with intercourse	30.0	81.0
The condom stayed in place	70.0	95.2
Outer ring interfered with intercourse	35.0	19.0
Outer ring stayed in place	65.0	95.2
The condom ripped	5.0	0.0
The condom was easy to remove	100.0	85.7
Know enough to use properly	95.0	95.2
The condom caused pain	35.0	81.0
The male condom is more convenient	95.0	100.0

4. Male clients' reaction to the female condom

It has already been stated that the male clients of the Trial I and Trial II users were different populations and, thus, were not strictly comparable. In addition, the reactions of clients were based on the assessment of the sex worker. The data showed that male satisfaction with the female condom was high: 81 per cent of the volunteers reported that some of their clients liked the female condom while only 19 per cent reported that all clients disliked the female condom. This positive response occurred even though virtually all the clients of Trial II participants could see the condom and could feel the inner ring during intercourse (Table 4).

Table 4. Male clients' reaction to the female condom.

Clients' reaction	Trial I (N=20) %	Trial II (N=21) %
Client could see the condom	100.0	95.3
Some liked the condom	50.0	81.0
All disliked the condom	50.0	19.0
Client could feel inner ring	50.0	95.2

5. General view and recommendation of the female condom

The general view of both trial I and trial II was high: 90 per cent would recommend it to others and most felt that other women would want to try it. Inexplicably however, less than half of the users in the second trial indicated that they would like to use the female condom in the future. The implication of this set of responses is that the female condom is an acceptable option to avoid STD/HIV but it is not a desirable option in practice. (Table 5-6)

DISCUSSION

In the first trial group, the female condom was used in 28.4 per cent of episodes. Two-thirds of the twenty 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. Eighteen of 20 participants (90%) said they would advise other sex workers to try these female condoms, thirteen of them said the female condom was less convenient to use than the male condom, and six said it was less comfortable, and it bothered them to insert the condom by themselves. Most of them reported that it was too long and too wide; also, the need to lubricate the condoms made their use messy and inconvenient.

In the second trial group, twenty-one volunteers evaluated the female condom during 132 acts of coitus (17.8% of episodes). Seventy-one per cent of the participants liked the condom while four of them (nineteen per cent) reported that all of their clients disliked the condom. 95 per cent of the users reported that the condom stayed in place during intercourse. It is not difficult to remove, almost all respondents felt competent in using it and 90 per cent would recommend it to others. Nevertheless, less than half of the users would like to use the female condom in the future. The reasons for dis-

Table 5. Participant's perceptions of the condoms.

	Trial I (N=20) %	Trial II (N=21) %
1. Percent who believed that the female could prevent:		
Gonorrhea	90.0	100.0
Syphilis	90.0	100.0
HIV	90.0	100.0
2. Percent who believed that the male condom could prevent:		
Gonorrhea	90.0	95.2
Syphilis	90.0	95.2
HIV	85.0	95.2
3. Would advise others to use the female condom	90.0	90.5
4. Others could learn to use the female condom:		
from the pamphlet alone; training was not necessary.	50.0	57.1
I feel I could train others how to use the female condom.	90.0	81.0
I thought others will use it.	90.0	95.2
I would like to use the female condom in the future.	65.0	47.6

Table 6. Additional comments relating to the experience expressed by the participants and their clients.

When asked to add comment relating to their own experience with the female condom, the users responded as follows:
- The condom should be reduced in size
- Inner ring should be thinner and softer
- It was accepted if used only once a day but might cause pain if used more often than that
- It caused a compressed feeling inside
- It caused pelvic pain after intercourse

Additional comments relating to the experience expressed by their clients included the following statements:
- The condom was too big
- Feeling pain and scraping of genitals
- The man's genitals pushed against the inner ring
- Liked the condom because of the loose sensation (more than with the male condom)

continuing use were that it was inconvenient and that it hurt. The female condom does cause pain in the majority of users. This trial of a female condom found that structural problems remain with regard to the inner ring, size and the spread of the lubricant to the outside of the condom which make it difficult to handle and insert.

Studies in different countries and cultures showed that 50 per cent to 93 per cent of male and female participants found the female condom to be acceptable[7-9]. The most common concerns expressed about using the female condom included difficulty to insert, noise, aesthetics, and size of the inner ring. Most women who liked the female condom said they were likely to use it when it became generally available. Women found that insertion became easier with repeated use. Most importantly, when the female condom was available as one of several options, the number of acts of unprotected intercourse decreased.

Preliminary results of a large study including more than 1,600 low-income women in Philadelphia demonstrated that, when offered a variety of preventive options, 87 per cent chose the female condom. The study also showed that availability of the female condom resulted in an overall reduction in the number of unprotected acts of intercourse [10]. An inner city study of high-risk women found that the ability to use a preventive method, which they could control, was an important feature influencing their choice of HIV prevention methods [11]. In a UK study of 148 women using female condoms, 69 per cent of the women and 45 per cent of their partners found it to be acceptable, 22 per cent of the women said they would use it regularly, and an additional 61 per cent said they would

use it sometimes[12]. A Japanese study showed the overall utility, including acceptability, to be 72 per cent[13] Three-quarters of US and Latin American women participating in a 6- month contraception study said they liked the female condom, and 51 per cent said they would continue to use it[7]. A 2-phase study in Malawi assessed the acceptability of the female condom by 157 participants. In phase 1, sixty-six per cent of participants liked the female condom very much and another 31 per cent liked it fairly well. In phase 2, only 2 participants found the female condom to be unacceptable. Among males, 71 per cent liked the female condom better than the male condom[14]. Other studies of the female condom in Senegal[15], France[16], South Africa[17], Zambia[18], Venezuela[19], Zimbabwe [20] and the United States[21-23] demonstrated comparable acceptability rates ranging from 50 to 70 per cent.

Among sex workers and their clients in various countries, investigations showed the accept-ability rates of the female condom were generally similar to, or higher than, other study populations [15,16,19,23,24]. A study in Uganda found that 90 per cent to 100 per cent of sex workers, 90 per cent of urban women, and 100 per cent of rural women liked the female condom very much or fairly well [25]. A descriptive study assessed intention to use the female condom by 148 sexually active women from three US methadone centers. Of 139 high-risk women who had never used the female condom, 32 per cent indicated they intended to use it in the future[26].

An *in vivo* study comparing male and female condoms established that the breakage rate during use of the female condom was much lower than the breakage rate for the male condom. The risk of exposure to sperm from tearing or movement was 2.7 per cent for the female condom and 8.1 per cent for the male condom[27]. Actual breakage tears during use of the female condom were less than 1 per cent compared with over 8 per cent recently reported for the polyurethane condom[28].

According to efficacy in prevention of STDs/HIV, the design of the female condom offers an extra measure of safety to women that the male condom does not. Because the outer ring of the female condom partially covers the external genitalia the female condom may be particularly beneficial in preventing infections caused by genital ulcer pathogens, such as herpes and chancroid[29]. Furthermore, the female condom covers the vaginal mucosa, and thus may provide better protection from STDs than diaphragms, sponges, and caps that cover the cervical mucosa only[30]. *In vitro* studies have shown that the female condom provides an effective barrier to passage of microorganisms including HIV[31-33]. The female condom blocked passage of a bacteriophage smaller than hepatitis B, the smallest virus known to cause an STD, and one-fourth the size of HIV. One study of STD reinfection rates in 104 sexually active women with documented trichomonas and or chlamydia infection demonstrated that none of the 54 participants who consistently used the female condom were reinfected[32]. Non-compliant users and the control group had trichomonas reinfection rates of 14.7 per cent and 14 per cent, respectively. Three noncompliant users were reinfected with chlamydia[34]. Our study showed that 90 and 100 per cent of participants in the first and second trial group believed that the female condom could prevent those infections.

There are many obstacles ahead, however, including the cost of the device, the current level of donor support, unexplored research questions and lack of familiarity with this new product. But there are many positive signs as well. Research already indicates it offers some protection from STD/HIV. Many women and men like it and will use it when it is available. They will also use it when they have enough support from their peers. Social marketting projects have found that men and women will continue buying the product if it is available and affordable.

SUMMARY

These two acceptability trials have demonstrated that even sex workers with minimal education can be easily trained to insert and remove the female condom. Continued demand for the female condom after the research supply was exhausted, is also an indication that they would continue to use the female condom but on a limited basis. The participants in the second trial saw the advantage of the female condom as a back-up method for clients who refused to use a male condom. From the condom use data in the second trial, approximately 18 per cent of brothel clients did not object to the

women using their own protection. Further research is urgently required to determine whether as high (or higher) levels of compliance and protection can be achieved in other brothel populations. Without the availability of a female condom, unprotected intercourse and disease transmission could have occurred. If this pattern is typical, then the female condom, as currently developed, could already play a significant role in the prevention and control of HIV infection in Thailand.

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การศึกษาการยอมรับการใช้ถุงยางอนามัยสตรีในกลุ่มประชากรที่เสี่ยงต่อการติดเชื้อเอ็ชไอวี

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ได้คัดเลือกหญิงบริการทางเพศจากสถานบริการอาบอบนวด 20 คน และจากซ่องโสเภณี 21 คน ในจังหวัดขอนแก่นเพื่อศึกษาการยอมรับและความพอใจในการใช้ถุงยางอนามัยสตรี พบว่ามีการใช้ถุงยางอนามัยดังกล่าวร้อยละ 28.4 ของการมีเพศสัมพันธ์ในกลุ่มแรก และร้อยละ 17.8 ในกลุ่มหลัง ผู้ใช้ให้ข้อคิดเห็นว่าขนาดของถุงยางอนามัยสตรีที่นำมาให้ใช้นี้กว้างและยาวเกินไป อีกทั้งไม่สะดวกในการใช้ แต่ถ้าชายคู่นอนไม่คัดค้านตนเองเต็มใจที่ใช้ เมื่อเปรียบเทียบกับถุงยางอนามัยบุรุษถ้าเลือกได้จะเลือกใช้วิธีหลังมากกว่า ผู้ชายส่วนใหญ่ให้ความเห็นว่าไม่น่าสนใจและลดความรู้สึกทางเพศ อย่างไรก็ดีผู้ใช้เห็นว่าถุงยางอนามัยสตรีจะเป็นที่ยอมรับในกลุ่มสตรีที่มีโอกาสเสี่ยงต่อการติดเชื้อโรคติดต่อทางเพศสัมพันธ์สูง ถ้าคู่นอนไม่คัดค้านและรูปแบบเหมาะสมกว่านี้ เพราะอย่างน้อยก็เป็นอีกวิธีหนึ่งที่อาจเป็นทางเลือกใช้ของสตรีที่มีอำนาจต่อรองต่ำและพยายามหาวิธีป้องกันตัวเองในสถานการณ์ที่โลกกำลังเผชิญกับโรคที่ยังไม่อาจรักษาได้เช่นโรคเอดส์ในปัจจุบัน

คำสำคัญ : เอ็ชไอวี/เอดส์, ถุงยางอนามัยสตรี, หญิงบริการทางเพศ

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