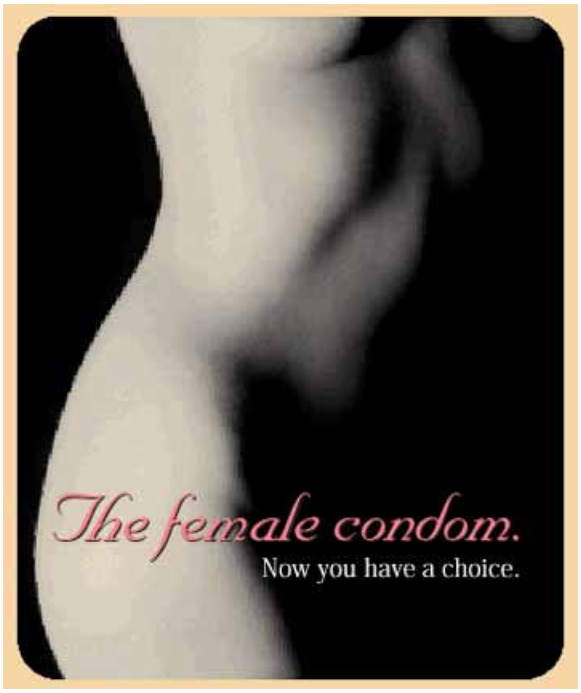
Female Condom



Teaching and Counselling Guide for Health Care Providers

Toronto Public Health

The Female Condom Teaching and Counselling Guide was compiled by the Female Condom Education and Training Committee, 2001:
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NOTE: Sections of this guide were adapted with permission from the teaching guide created by Female Health Company (FHC). Email Address www.femalehealth.com

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Introduction

This Teaching and Counselling Guide has been written to assist you, the health provider, in incorporating the female condom into existing pregnancy, sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention programs. The female condom is a barrier method of contraception that also provides protection from STDs/HIV. This method offers women an additional safer sex option.

This Guide addresses:

- Content and messages for educators, counsellors and service providers to ensure the most effective use of the female condom.
- Information needs of clients on how to use the female condom and what to expect when using it.

Background

In the fall of 2000, Toronto Public Health (TPH), in collaboration with several community partner agencies, embarked on a pilot study to assess the acceptability of the female condom with women at high risk for STDs including HIV and unintended pregnancy. The Executive Summary of the Female Condom Project can be found in *Appendix A*. The study determined that the female condom is an acceptable method of protection for English speaking, culturally diverse, low income women who were also at risk for STDs/HIV and unintended pregnancy in the City Toronto.

This Guide provides an overview of the lessons learned from the study, which was conducted in two community health centres, two TPH sexual health clinics and three community agencies.

It includes key findings from the study, including what factors contribute to the successful use of the female condom, information from other research studies, and information provided in the Female Health Company Teaching Guide.

Key research findings for counsellors and educators included (Gillis, 2002; Hardwick, 2002a):

1. Education and counselling sessions provided by trained service providers, either in **individual or group formats**, were effective in introducing the female condom to women at high risk for STDs/HIV and unintended pregnancy.

2. Education and counselling sessions, accompanied by the provision of unlimited numbers of free male and female condoms, increased the percentage of protected sex acts by at least 20% (Hardwick, 2002b).

3. Women aged 25 and older had greater likelihood of continued use of the female condom.

4. Practice inserting the female condom before using it with a partner was found to be an **essential factor** for continued use.

5. Service providers trained to provide education and counselling to women on how to use the female condom reported an increase in knowledge, a more positive attitude and enhanced skill in counselling clients on the use of the female condom (Macpherson, McWatt, Lappan-Gracon & Hardwick, 2002).

Summary

As with all methods of birth control and STD/HIV prevention, different methods are used and required at different times in women's lives. Given the cost of the female condom, the intent is not to replace male condoms, but rather to augment the range of protective choices available to women, especially women for whom the male condom is not appropriate.

The way in which the female condom is presented to potential users is also essential to its acceptance. Some service providers may think the method is too complex, doubt its efficacy, assume the product will not be widely accepted or just dislike the method. These biases must be addressed up front. Negative attitudes towards the female condom by service providers are a major barrier to use (Latka, 2001). Service providers with positive attitudes toward the female condom may make the best counsellors and advocates for the female condom.

This Guide is intended to support counsellors and educators in communicating effectively about the need for and use of the female condom with their clients. Your comments about this Guide can be submitted to:

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Background Information

Women's Sexual Health Practices

Women's Contraceptive Use

Women have a long history of determining their sexual outcomes by using a variety of devices to control both their fertility and their exposure to sexually transmitted diseases (STDs). The use of contraceptive devices from the late nineteenth century on has caused a dramatic reduction in the number of births in the Western World. The fact that contraception was illegal in Canada until 1969 did not deter women in their attempts to control their reproduction and to protect themselves from STDs.

While there are currently a number of birth control choices available to women in Canada, the only effective method of preventing chlamydia, gonorrhoea or HIV has historically been the male latex condom. However, male condom use has been inconsistent, and has been difficult for women to control or enforce. In order for women to better protect themselves from unwanted pregnancy and sexually transmitted disease, they need access to methods they have more control over. These must include methods that do not require prescription by a physician, that are immediately reversible, produce no side effects, are non-systemic, affordable and, most importantly, prevent both pregnancy and STDs, including HIV. The female condom addresses this need (World Health Organization and UNAIDS, 1997).

Women, Unintended Pregnancy and Exposure to STDs

Unintended pregnancy and exposure to sexually transmitted diseases including HIV challenge women's reproductive rights and sexual health. The number of unintended pregnancies in Canada is substantial. The 1998 Canadian Contraception Study found 28% of women responding reported having had an unplanned pregnancy (Fisher, Boroditsky, & Bridges, 1999: 172).

Untreated STDs can result in serious conditions such as pelvic inflammatory disease, infertility and cancer of the cervix. Diagnosis and treatment of STDs is complicated by the lack of symptoms for many diseases as well as women's anatomy. Since most of a woman's genitalia are inside her body, she is not able to actually observe the changes that may alert her to the presence of a STD.

Rates of sexually transmitted diseases, including HIV, have increased steadily in recent years among women aged 15 to 44 in Toronto (Toronto Public Health, 2002). HIV-positive women in Ontario most often report that their exposure to the virus was as a result of being from an HIV-endemic country and/or having sex with HIV-positive men (Remis, Major, Wallace, Schiedel, & Whittingham, 2001).

Since women with a STD are at an increased risk of contracting and transmitting HIV, prevention of all sexually transmitted diseases is necessary to prevent HIV transmission (World Health Organization, 2000; Hitchcock, 1996).

Individual behaviour is not the only indicator for risk of unintended pregnancy/STD/HIV. TPH analysis indicates that people living in poverty tend to have a higher incidence of STD while high-income areas tend to have the lowest rates (Toronto Public Health, 2001; Hardwick and Patychuk, 1999). To be successful, prevention strategies must address the determinants of health and not solely individual behavior. Although an overall reduction in STD rates is important, efforts must be directed at decreasing the rates of STD/HIV in low-income women in particular.

Summary

When clients think about prevention, many are primarily concerned about pregnancy prevention. They may not realize their STD/HIV risk. The counsellor's challenge is to provide education about and access to protection against both pregnancy and STD/HIV. The female condom is unique because it is the only female barrier method that offers protection from both unintended pregnancy and HIV/STD. The high cost of the female condom, however, prevents its accessibility to the population that may benefit the most from its protective qualities: poor women.

What is the Female Condom?

The female condom is a loose fitting polyurethane sheath about 6.5 inches long with a flexible ring at each end. Polyurethane is a soft, thin, supple plastic which is stronger than latex. Polyurethane also conducts heat, so sex can feel very sensitive and natural with the female condom.

The female condom acts like a strong, thin second skin between partners. It adheres to the wall of the vagina during intercourse for barrier protection against HIV/STD transmission and unplanned pregnancy.

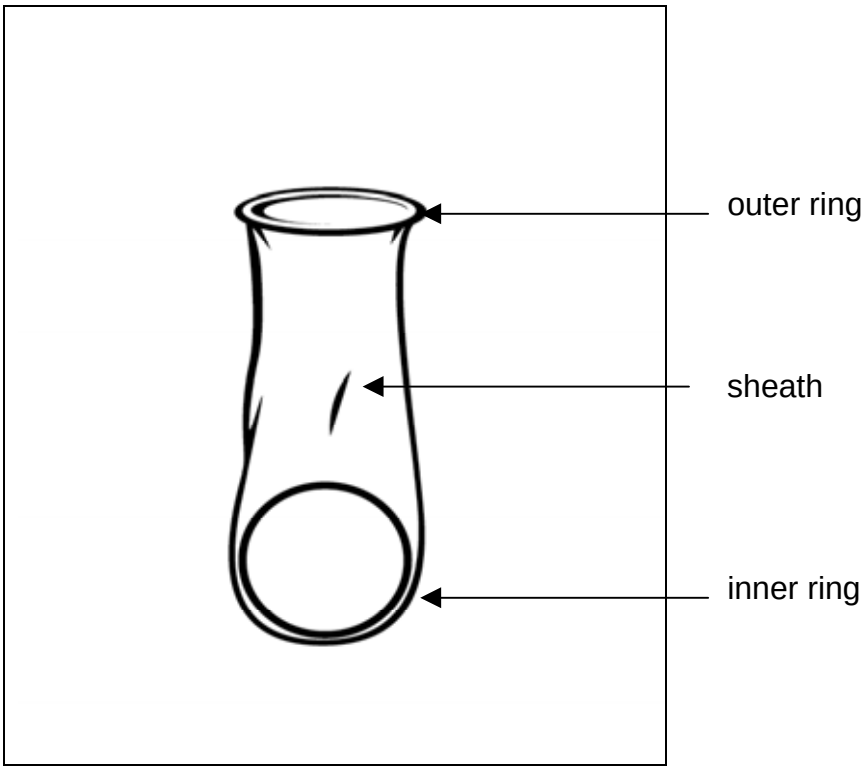


Figure 2: Female Condom

The floating inner polyurethane ring is firmer than the outer ring. The inner ring is used to insert the female condom and helps keep the female condom in place. It is designed to slide in place behind the pubic bone, acting like an anchor for the condom.

The outer ring is soft and remains on the outside of the vagina during insertion and sexual intercourse. It covers the area around the opening of the vagina (the vulva), and also may provide some protection for the labia and urethra from STDs such as herpes and human papiloma virus (HPV).

The female condom is pre-lubricated with silicone, the same lubricant used on male latex condoms. It is water based and does not contain spermicide. The female condom is compatible with spermicide should women wish to use it for added pregnancy protection. It is important, however, that women be aware that spermicide can increase the risk of HIV transmission as it is a mucosal irritant. For more information about lubricant, see *Lubricant is the problem solver for the female condom.*

Service providers should be prepared for a range of initial reactions to the female condom. Some people react negatively to its size and shape. Women often need some time to adjust to the idea of its use especially if they have no previous experience with insertion devices such as tampons.

Introducing this method with humour and reassurance that other couples have successfully used the female condom helps to decrease any potential negativity. See *Counselling Checklist, How to Use the Female Condom,* for some suggestions on how to introduce the female condom.

Almost all the women in our study gave the female condom a try. The more they used it, the more they liked using it and preferred it to the male condom. Of the participants who completed the study 36% preferred the female condom to the male condom and another 33% like having the choice of both (Hardwick 2002a, 2002b).

Getting women to try the female condom despite its appearance, providing enough female condoms for women to practice inserting it before using it for sex, and supporting them by offering follow-up proved to be key factors in its ongoing successful use.

Benefits of the Female Condom

Many women and men can't or won't use a male condom. There are many reasons for this, including men's loss of erection or sensation, inability to negotiate condom use, both partners' allergies to latex and denial of personal risk of STD/HIV and pregnancy.

The female condom is not made of latex and can therefore be used by individuals with a latex allergy. It is made out of polyurethane that conducts body heat and provides more sensitivity. All types of lubricant can be used. The female condom has a strong safety record, does not alter the vaginal flora and covers more of the female genitalia than does the male condom, potentially providing increased protection against some STDs.

Female condoms, while they require co-operation from the male, do not require the type of initiative a male condom does. In other words, the female condom does not require an erect penis for insertion or withdrawal. A woman can put the female condom in, either minutes or hours before sex. She can take the initiative because she is the one responsible for inserting the condom.

Additionally, since the female condom may be inserted ahead of time, interruptions or timing issues during the sex act are eliminated. This may lead to more spontaneity and intimacy for couples.

Each client needs to decide what method is most appropriate for her or him. Offering the female condom as an additional risk reduction strategy within a hierarchy of options can increase the usage and acceptability of both the male and the female condom. The female condom is a method that is unfamiliar to many men and women, but with counselling and practice it may be an alternative choice that leads to an increase in protected sex acts.

Table 1:

Comparison of Male and Female Condoms

Male Condom	Female Condom
❑ Worn by a man	❑ Worn by a woman
❑ Latex	❑ Polyurethane
❑ Fits snugly on penis	❑ Fits into vagina: conforms to her body
❑ Does not heat to body temperature	❑ Will heat to body temperature if inserted at least 20 minutes prior to intercourse
❑ Lubricant: - use water based only - do not use oil based - may include spermicide	❑ Lubricant: - use water or oil based - no spermicide included
❑ Requires erect penis for insertion and withdrawal - timing is crucial	❑ Does not require erect penis for insertion or withdrawal - does not require immediate withdrawal - can be inserted 8 hours prior to intercourse
❑ Semen is contained in condom	❑ Semen may not be contained in condom post ejaculation. If semen leaks out but the female condom is still properly in place, protection is not compromised

Who Can Use the Female Condom?

Women who:

- are concerned about unintended pregnancy and STDs/HIV
- have a partner that can't or won't use male latex condoms
- are menstruating
- have a retroverted uterus
- have had a hysterectomy
- are peri and post menopausal
- are allergic/sensitive to latex
- have a partner allergic /sensitive to latex
- have experienced female circumcision as long as two fingers can still be inserted into the vagina

Who is Most Likely to Use the Female Condom?

Women who:

- like having choices in pregnancy/STV/HIV prevention methods
- are dissatisfied with their present form of pregnancy/STD/HIV prevention methods
- are age 25 years and older
- are comfortable touching their genitals
- are able to access free female condoms through clinics, health centres and women's groups
- are well supported by their health care provider
- are able to negotiate safer sex
- have sex with co-operative partners

Will the Female Condom Protect Me?

Prevention of Unintended Pregnancy

- The female condom is estimated to be 95% effective when used consistently (every time) and correctly (FHC no date).
- The female condom is estimated to be 75%-82% effective in typical use (FHC, no date).

Prevention of HIV and STD Transmission

- The female condom is estimated to reduce the risk of HIV infection for each act by 97.1% when used consistently (every time) and correctly (FHC, no date).
- In vitro studies show that the female condom provides an effective barrier to passage of microorganisms including HIV. Passage of a bacteriophage smaller than hepatitis B, the smallest virus known to cause an STD, and one-fourth the size of HIV, is blocked by the female condom (FHC, on date).
- Recent results of a controlled study of STD transmission in sex-trade workers in Thailand showed that when the choice between either the female and male condoms were available, the rate of STD transmission was reduced by one-third when compared with the STD transmission rate in a similar group with access solely to the male condom (Fontanet, Saba, Chandelying, et al., 1998). These findings suggest that the female condom, where available, provides an additional measure of protection against STD transmission and HIV infection.

Safety

The female condom has a strong safety record. The use of a female condom does not alter vaginal flora and does not cause measurable skin irritation, allergic reactions or vaginal trauma. As with the male condom, the female condom, if it is used properly, offers excellent protection from unplanned pregnancy/ STDs/HIV.

In typical use however, clients can experience difficulties with insertion, removal, and some mechanical problems while using the female condom during sexual intercourse. Some mechanical problems such as noise and appearance are barriers to use due to aesthetics and nuisance factors but some mechanical problems are barriers to effectiveness. Safety is compromised if mechanical problems result in women's exposure to semen, putting them at risk of STD/HIV and unintended pregnancy (Macaluso, Lawson, Hortin, et al., 2003). See *Mechanical Difficulties* for more information.

Re-Use of the Female Condom: Risk Reduction

Toronto Public Health recommends that a new male or female condom be used for every act of intercourse where there is a risk of unintended pregnancy or STD/HIV infection.

In our consultations with community agencies, it became apparent that some women would need to reuse the female condom due to its high cost. Given the diversity of personal circumstances for many women, female condom reuse may still be a safer and a more feasible option than no condom at all for women who cannot or do not access new condoms.

Toronto Public Health does recognize the need for risk-reduction strategies. We suggest agencies refer to the World Health Organization's draft protocol for safe handling and preparation of female condoms intended for reuse if their clients require information on condom reuse. This protocol is based on the best available evidence, but has not been extensively studied for safety and has not been evaluated for efficacy in human use. WHO continues to support research on female condom reuse and will disseminate relevant information, study results and guidelines for policy makers as additional data on reuse become available (World Health Organization, 2002).

For the most up-to-date information on FC Reuse Protocals visit the WHO website:

www.who.int/reproductive-health/rtis/reuse.en.html

How Acceptable is the Female Condom?

Until recently, little has been known about the use of the female condom in North American women, unlike in developing countries where the female condom has been widely distributed and evaluated. Studies in those countries, among many different cultures show that on average, 50% to 70% of women found the female condom to be acceptable (FHC, 2000). The TPH Female Condom Pilot study also supports this finding (Gillis, 2002; Hardwick, 2002a). We determined that the female condom was acceptable to culturally diverse, English speaking, low-income women, at high risk for unplanned pregnancy/STD/HIV in the City of Toronto.

Previous research has reported that the use of the female condom did not interfere with a sensitive and pleasurable sexual relationship (FHC Guide, 2000). When the female condom was available to women, the number of acts of protected intercourse increases (Artz, Macaluso, Brill, & Kelaghan, 2000; Gillis, 2002; Hardwick, 2002a, 2002b; Latka, Gollub, French, & Stein et al., 2000; Sly, Quadangno, Harrison, Eberstein, Riehman, & Bailey, 1997).

The way in which the female condom is presented is essential to its acceptance, both by service providers and potential users (Artz et al, 2000; Latka, 2001; Latka, et al, 2000). Service-providers often have initial negative reactions to the female condom and given that little research about its use in North America has been available, educators, pharmacists and service-providers have not promoted it to their clients. When accompanied by client assessment, counselling and support, introduction of this method to women has the potential to increase protection from unplanned pregnancy/STD/HIV without compromising their sexual pleasure and intimacy.

Summary

The female condom has been demonstrated to be safe and effective, with high acceptability among women and men, and provides significant protection against the transmission of STDs/HIV and unintended pregnancy. Most importantly, the availability of the female condom leads to an increase in the overall number of protected sex acts when it is promoted along with the male condom.

Counselling and Teaching Clients

Women may be attracted to the female condom due to dissatisfaction with other methods of preventing STDs/HIV and unintended pregnancy. Each method has significant advantages and disadvantages. An important part of the service-provider's role is providing clients with information they need to choose the best method for their individual circumstances.

Such counselling is likely to include information regarding:

- male and female reproductive anatomy,
- STD/HIV transmission
- all available safer sex / birth control methods,
- safer sex negotiation and relationship communication

as well as an assessment of:

- cultural approaches to birth control and STD/HIV prevention
- risk for STD/HIV and unplanned pregnancy
- partner response and acceptability of different methods
- risk for partner/family violence
- ability to pay for contraceptive/safer sex devices

The style in which the counselling is done is as important as the information that is exchanged. The use of open-ended questions can determine client's knowledge level. Setting the tone is key. Humour, maintaining a non-judgmental attitude, using plain language and encouraging client participation all enhance learning. Using teaching aids such as videos, pelvic and penis models, diagrams and print materials are all helpful in teaching sessions.

Introducing the female condom can be done in group or one-to-one sessions (Gillis, 2002). The information in this Guide can be adapted to either situation. Regardless of the setting, the environment as well as the tone and style of the counselling done will affect how clients receive the information.

Group sessions offer a friendly setting where women can share information and ideas, offer emotional support and provide examples of success stories. Research has identified peer support as a key ingredient in supporting women's efforts to implement risk reduction strategies (Gollub, Savouillan and Coruble, 1998; Mwakizha 1996). On average, group sessions are likely to be longer than individual sessions due to the interaction of group members. Approximately 60 minutes is needed to introduce and discuss the female condom with a group.

Not all women are comfortable in group settings or are able to attend. With one-to-one sessions, service –providers can tailor the message to fit the needs of the client. One-to-one sessions vary in length, depending largely upon the client‘s pre-existing knowledge base. For example, if the client has used tampons or diaphragms in the past, she may require less explanation about inserting the female condom than the woman who is uneasy about touching herself. Each clinical setting is different, and time constraints may vary. Counsellors need to be aware, however, that women will require ongoing support and follow-up in order for this method to be successful.

Best practices to ensure female condom use

- Review of female anatomy and physiology
- Assessment of comfort level: ability to use tampons, to insert own fingers in own vagina, to look at own genitals in mirror, etc
- Review of birth control and safer sex methods using a hierarchy of options
- Provide counselling in either individual or small group sessions with other women providing peer support
- Ability to follow up with clients within a month for support
- Tips for insertion and emphasis on importance of practice
- Offer insertion check
- Discuss negotiation and communication skills
- Provide male and female condoms as well as water-based lubricant
- Provide 5-10 female condoms so women may practice insertion prior to use for sex

Inserting the Female Condom

Insertion

Difficulty with insertion is one of the most common barriers to use, as cited in the previous literature and in the findings of our study. Service providers need to be able to spend time with clients to both explain the steps of insertion and to reassure them that it may take several attempts before they can use this method confidently with a partner for sex.

Women's knowledge of their anatomy and enough opportunity to practice are important indicators for success. One of the key findings in our study is that insertion practice – first without a partner and then with them is an important factor in increasing acceptability of this method. Some women, who were very comfortable both with their partner and with vaginal insertion devices such as tampons and diaphragm, did not practice privately before using it with a partner. In retrospect, they identified that practicing without a partner was a major step that they should not have skipped.

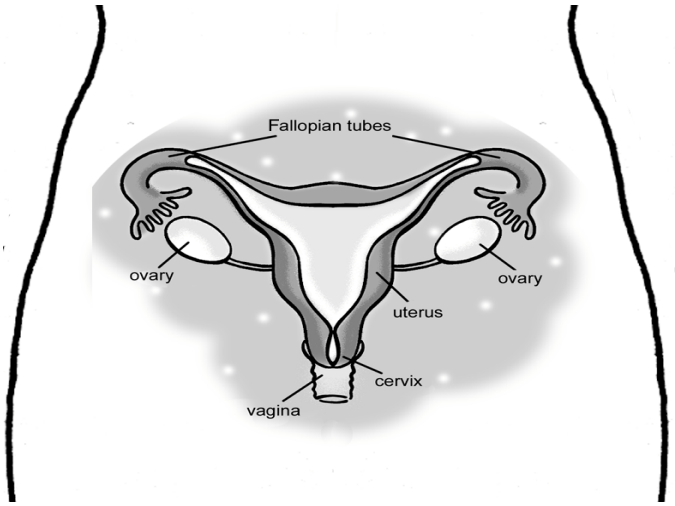
Service providers should strongly encourage all women; even those who feel confident, to practice on their own before using the female condom for sex (Gillis, 2002). We recommend that service providers give "counselled" women at least 5-10 female condoms initially, as practice is essential. Distributing fewer female condoms to clients for general use is of limited benefit. Note: women can reuse the "practice condom" more than once.

The ability to insert the female condom up to eight hours prior to intercourse is often seen as an advantage to women who have difficulty negotiating safer sex, or for couples who find taking time out to put on a male condom decreases spontaneity and pleasure.

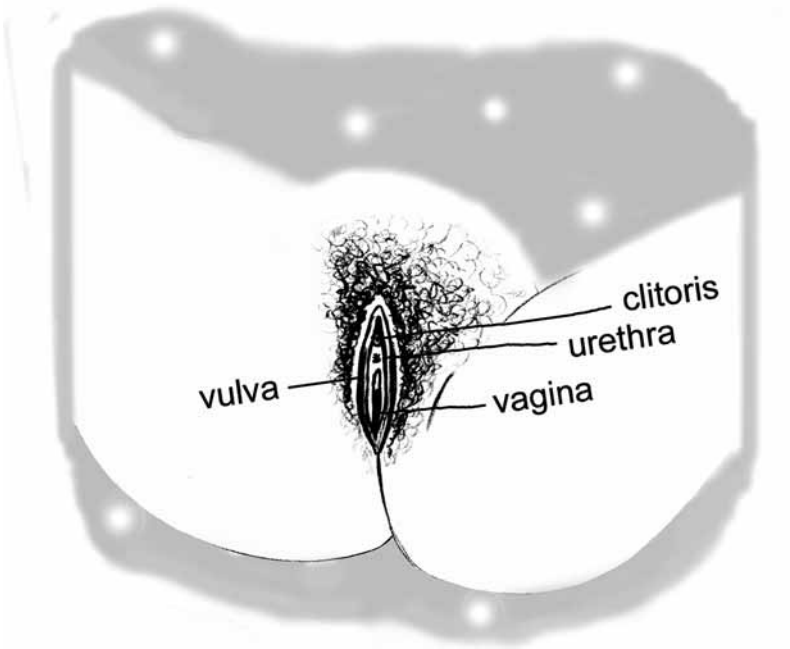
Women in our study, who did insert it earlier, wore the condom for 2-4 hours. Two women did not like getting lubricant from the female condom in their underwear. One woman reported that urinating with the female condom was messy. Most women agreed that insertion 20 minutes before intercourse helped with many of the common problems of the condom but few women were interested in inserting the female condom too long before intercourse (Gillis, 2002).

Although early insertion of the female condom may allow women greater control over negotiating sexual risk reduction, educators need to be aware of the disadvantages of early insertion that may dissuade women from employing this strategy.

Women's lack of knowledge regarding their internal sexual anatomy is not only a barrier to female condom use but also to their sexual development. Providing general information about their sexual body parts is important for supporting women's successful use of the female condom as well as their efforts to have control over their own sexual health.



Organs

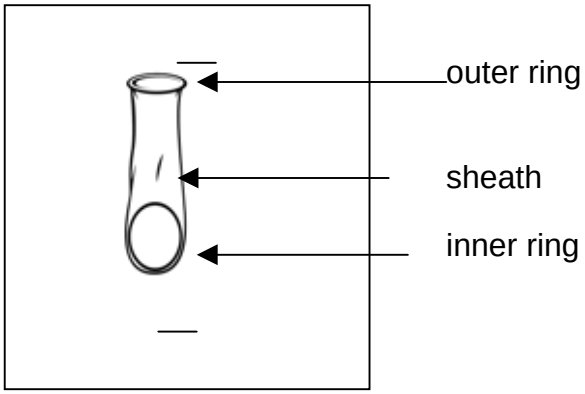


Vulva

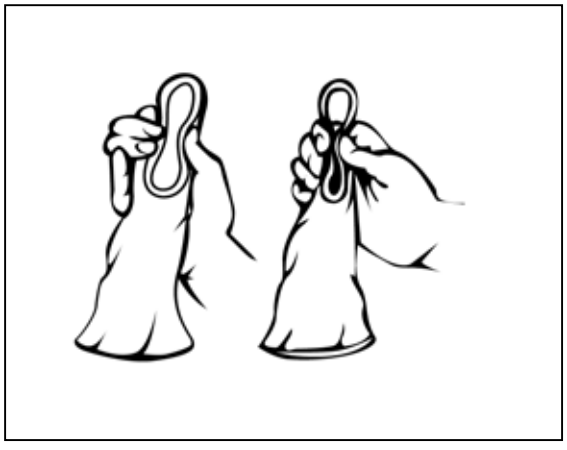
Insertion Checks

Given that difficulty with insertion is one of the most common barriers to use, providing women with insertion checks by either a physician or a nurse practitioner can increase women's confidence in this method.

The following diagrams illustrate the steps necessary to insert, use and remove the condom:

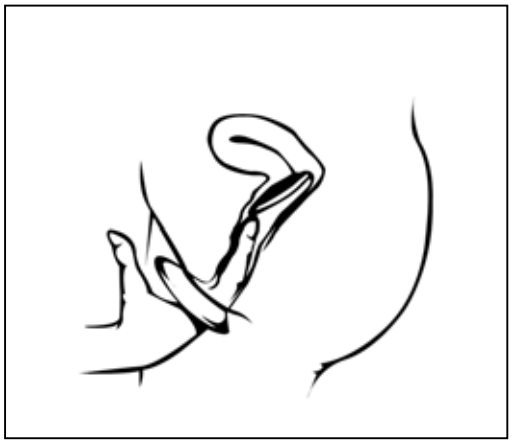


1. Look at the condom and make sure it is completely lubricated outside and inside. Add more lubricant as needed.



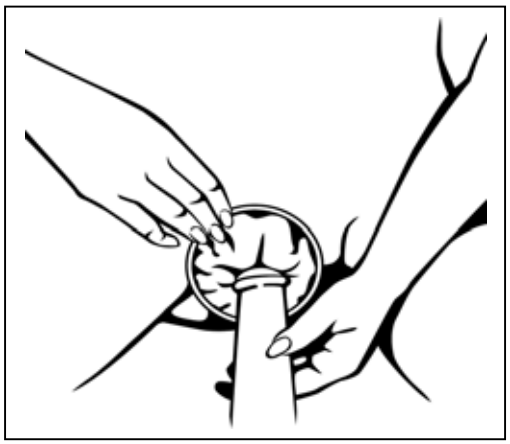
2. With one hand squeeze the inner ring.

3. With the other hand, separate the outer lips of the vagina.

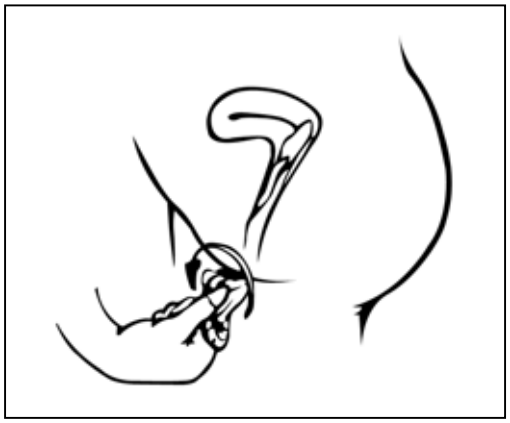


4. Push it up the vagina as far as it will go. The inner ring will sit comfortably over the cervix.

5. The outer ring should remain visible on the outside of the vagina.



6. When both partners are ready, simply guide the penis into the female condom.



7. Twist the outer ring and gently pull the condom out.

8. Throw the condom in the garbage and NOT in the toilet.

Steps for inserting, using and removing the female condom

1. Be careful when you open the package that you do not tear the condom.
2. Choose a position that is comfortable: squat, raise one leg, sit …Look at the condom to be sure it is completely lubricated on the outside and the inside.
3. While holding the condom at the closed end, grasp the soft, flexible inner ring and squeeze it with the thumb and middle finger, or thumb and second finger, so it becomes long and narrow.
4. With the other hand, separate the outer lips of the labia.
5. Gently insert the inner ring completely into the vagina. Feel the inner ring go up and move into place.
6. Next, place the index finger on the inside of the condom, and push the inner ring up as far inside as it will go. The inner ring should be behind the pubic bone. Be sure the sheath is not twisted. The outer ring remains outside of the vagina.
7. The condom is now in place and ready for use with a partner. The sheath loosely lines the vaginal wall.
8. Gently guide the penis into the sheath's opening with your hand, making sure the penis is not slipping between the outside of the sheath and your vagina. Use enough lubricant so that the condom stays in place during sex. If the condom is pulled out or pushed in, there is probably not enough lubricant. Add more to the shaft of the penis and reinsert.
9. To remove the condom, twist the outer ring and gently pull it out. Try to do this before standing up to avoid semen spillage.
10. Throw the condom out in the garbage—do not flush it down the toilet.

Mechanical Difficulties

Noise, slippage, spillage, and discomfort are common barriers to use (Choi, 1999). Our findings were consistent with the literature. It is important that service providers are knowledgeable about the following common mechanical problems that can affect safety, sexual pleasure and trust in the effectiveness of this method:

- The female condom rides on the penis (female condom sticks to the penis like a loosely fitting male condom
- The female condom comes completely out of the vagina (slippage)
- The outer ring is pushed inside the vagina (invagination)
- The penis enters outside the condom (penis misrouting)
- Semen spills on the woman's body (spillage)
- Condom breakage * rare with the female condom

Some of these mechanical problems are related to anatomy. Women with large vaginal fundus size report more mechanical problems and experience increased risk of exposure to semen, especially when their partners have relatively small penises. Couples who have very active intercourse have also reported more mechanical problems than when they have less active intercourse (Lawson, Macaluso, Duerr, et al., 2003).

The majority of women who encountered difficulties were able to resolve them with practice, by developing innovative techniques, and/or by problem solving with peers and counsellors**.** For example, one participant in our study reported that the female condom broke or tore. She had long artificial nails at the time. She was able to overcome this by having her partner insert the condom with his penis (Gillis, 2002).

Spillage and slippage were larger barriers to use for women using it for sex work than those using it for sex in general (Gillis, 2002). Sex workers did not like any exposure to semen even if the semen had no direct entry into their body. Unlike the male condom that contains semen, it can seep out of the female condom during removal or in certain sex positions.

Spillage, slippage or dislodgement of either the penis or the female condom was a factor in different sexual positions. Most women agreed that the easiest position was lying face to face with the man on top. Sex workers were cautious about using the female condom in sexual positions, such as “doggy style” where the women is on her hands and knees and is entered from behind. Clients could more easily slip their penises between the condom and the vaginal wall without women’s knowledge (Gillis, 2002).

Discomfort was mainly a factor in sexual pleasure. See *Female Condom and Sexual Pleasure.* Making sure the condom is inserted properly, adding lubricant and rearranging the inner ring may improve comfort.

Complaints that the condom is noisy can usually be overcome with more lubricant or by allowing more time for the condom to warm to body temperature. It is important to note that noise can be a major barrier if couples are experiencing a lack of privacy due to crowded living conditions. Disposal can also be a problem when privacy is an issue (Gillis, 2002).

Lubricant is the problem solver for the female condom:

Because oil-based lubricants will not cause damage to the sheath, any type of lubricant can be used with the female condom, including petroleum jelly, baby oil, or lotions. However, use **water-based lubricants** whenever possible with the female condom as oil based lubricants may damage vaginal flora.

Most problems people have in using the female condom can be fixed by adding more lubricant to the inside of the female condom or to the penis.

- If there is not enough lubricant on the inside of the condom or the outside of the penis, the condom may be pushed inside of the vagina during sexual intercourse. Inform clients that if this occurs more lubricant is needed on the outside of the penis or on the inside of the condom.

- If there is not enough lubrication on the inside of the female condom between the penis and the female condom, the female condom can adhere to the penis when the man withdraws. To avoid this, put a few drops of lubricant on the inside of the condom as well as on the outside of the penis to reduce friction between the surfaces.

- If the condom is pulled out of place, extra lubricant is needed either inside the condom or on the outside of the penis.

- If the female condom “squeaks” add more lubricant.

Female Condom and Sexual Pleasure

A fundamental ingredient of good sexual health is women's sense of entitlement to sexual pleasure (Gillis, 2002). Having access to risk reduction methods that do not interfere with sexual pleasure for women and their partners are indicators of continued use of these methods.

It is important for service providers to understand how the female condom either increases or decreases sexual pleasure. Given the benefits of the female condom as already discussed**,** many of the aspects of the female condom enhance intimacy, spontaneity and increase sensation.

For the women in our study the female condom neither heightened nor diminished sexual pleasure (Gillis, 2002). Some women identified that initially the "work" of insertion interfered with their enjoyment but with experience and practice they relaxed and enjoyed the sex, especially as they grew to trust its effectiveness as a method. Some women found sex with the female condom more pleasurable than with the male condom while for others the problems of slippage and irritation from the rings (outer and inner) caused the sex to be less pleasurable (Gillis, 2002).

Women's sense of control over their bodies is another indicator of sexual health. Their ability to initiate sex contributes to this sense of control. This was evidenced in our study. For several women the female condom was a catalyst for sex given that the act of insertion was a signal to partners of their interest in having sex (Gillis, 2002).

Whether or not the female condom enhanced or decreased sexual pleasure also depended on how women like sex--e.g. hard, fast with friction, deep or with clitoral stimulation. Generally the experience was different both among women and also with different kinds of men (e.g. penis size and age of man). In general the participants' comments reflected that intercourse with the female condom was not unpleasant but differently pleasurable (Gillis, 2002). Part of the service providers' role in introducing the female condom is to discuss the diversity of experience related to sexual pleasure and the female condom.

Aesthetics

Feeling sexually appealing is important in the sexual health of women. One of the chief complaints about the female condom is its lack of aesthetic appeal, in particular the outer ring that hangs out of the vagina. Although this will not be a barrier to use for all women, service providers need to consider strategies for eroticizing female condom use, just as has been done for the male condom (Gillis, 2002).

Negotiating Female Condom Use with Male Partners

In our study we assumed that male opinion and reactions to the female condom would be important factors in determining women's levels of usage and acceptability of the female condom (Gillis, 2002). Service providers should explore male reaction with their clients as part of their assessment. We did not speak directly to the male partners of the women in our study but we did ask participants for their partners' reactions.

Few women had difficulty getting their male partners to try the female condom but not all received an enthusiastic response. The female condom aesthetically repelled several men, while others had a litany of complaints. For the majority of men however, there were advantages and disadvantages to each method (Gillis, 2002).

Penman-Aguilar, et al. (2002) found that many men were willing to try the female condom, depending on the promotional strategies that their female partners used. The most successful women used a variety of strategies tailored to their particular situation. For example, use of a video depicting couples (like them) who were successfully using the female condom, information from an authoritative source such as sexual health clinics and eroticizing the insertion by encouraging their partners to help with the insertion.

We encourage the inclusion of men in the discussion about the use of the female condom if possible. When talking with men, advise them that many men have tried the female condom and liked it. Men may have questions about the female condom. For example, men might ask about its size. Remind them that the female condom is designed for the women's body, not theirs.

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Emphasize the positive for men:

The female condom:

- Can be inserted ahead of time so there are no interruptions to "spoil the mood"
- Is not tight or constricting to the penis
- Is made of polyurethane, conducts heat so it may feel more natural and sensation is not dulled
- May be a good alternative for men who are unable to maintain an erection with the male condom
- Any kind of lubricant may be used
- Men do not have to withdraw right after ejaculation, which may lead to more intimacy

The female condom may also work better with some men than others. Among the factors that contribute to its use are age, penis size, the ability to maintain an erection, as well as the many factors associated with male arousal. Service providers need to consider that although different methods work for different women, the same can be said of men. A woman who had previously been unsuccessful with the female condom may be successful using it with a new or different partner.

Although this method is female initiated, most men will be aware of this device because the outer ring is visible. Given the lack of familiarity and lack of aesthetic appeal, many women may feel more comfortable using the female condom with a known or well-trusted partner (Gillis, 2002). However, women are more likely to feel at greater risk for an STD/HIV from a casual partner or a partner that they "do not know" (Fisher et al.1999). This paradox may pose a significant barrier to consistent use. Women in new relationships may require additional strategies to introduce the female condom. Counsellors need to assist women in identifying when they are likely to use the female condom and if not, what other safer sex options would be used.

Negotiating Female Condom Use

Including negotiation techniques in the counselling may lead to greater acceptability of the female condom. Women who have difficulty negotiating safer sex may benefit from group education sessions with other women. In peer support groups women can offer each other emotional support, explanations of male behaviour and examples of success stories in negotiating safer sex. They can learn strategies, language and tools that empower them in ways that educators and service provides cannot (Gillis, 2002). Service providers can provide the necessary support, information, resources and facilitation that contribute to the success of such groups.

In one to one sessions in clinic settings, service providers will need to provide opportunities for their clients to practice negotiation and responding to negative reactions. This may involve providing:

- opportunities for role plays
- information on how to introduce the female condom
- information on when to introduce the female condom
- information on how to make the female condom sexy and fun
- pamphlets, videos and information for partners

Summary

In general, different methods work with different couples at different times in people's lives. The female condom may not be the best method for women with a disparity between vagina and penis size or if having very active sex due to the mechanical problems that can occur. As well, women may be uncomfortable approaching their partner about the female condom for a variety of reasons. After assessment and counselling, if women feel that this method is not going to be successful, other methods of protection will need to be explored.

For safety, we strongly advise women not to trick their male partners by using the female condom without their prior knowledge.

Conclusion

Service providers trained using this Teaching and Counselling Guide have successfully introduced the female condom to women in the TPH Female Condom Pilot project. We hope that this Guide continues to provide counsellors and service providers with the background information, knowledge and skills needed to communicate effectively about the need for and use of the female condom. This Guide is intended to augment the range of protective choices available to women and to facilitate the incorporation of the female condom into existing prevention/safer sex options.

The following *Counselling Checklist* is intended to be a user friendly guide to ensure service providers include the content and messages that need to be communicated to foster the most effective use of the female condom. For more information regarding the distribution of the female condom, contact Barbara Macpherson at Toronto Public Health at 416-338-0904; bmacpher@toronto.ca.

Female Condom 1:1 Counselling Checklist	
Counselling Topic	**Tips for Counsellors**
1. Client-specific issues	
❑ Assess sexual/reproductive health in general; history of contraceptive use	❑ Present FC within a hierarchy of choices
❑ Assess tampon/diaphragm/douching/ other intra-vaginal practices of the client– discuss how these relate to female condom use	❑ FC more successful with women who are comfortable touching themselves ❑ FC more successful with women over 25
❑ Assess knowledge of STDs & mucosal immunity	❑ Review mucosal immunity & HIV/STD prevention - see Appendix B ❑ Remind clients that not all STDs have symptoms ❑ Explain women's increased risk
❑ Assess current level of knowledge, familiarity and skill with the female condom and draw on this experience during the rest of the session	
2. Basic Female Anatomy	
❑ Location and overview of labia, vagina, clitoris, pubic bone, cervix, uterus, anus and urethra	❑ Reproductive system is a "closed pouch" – nothing will float up and away and get lost ❑ Point out difference between the vaginal opening, urethra and anus ❑ Explain how you can pee or defecate with female condom in place if necessary ❑ Vagina is a strong muscle built for childbirth; female condom should not harm the vagina

Female Condom 1:1 Counselling Checklist	
Counselling Topic	**Tips for Counsellors**
3. How to Use the Female Condom	
❑ Aesthetics	❑ Be prepared for initial negative reactions due to aesthetics–use humour. Some think it is visually unappealing (hangs out of vagina) → discuss how couple can eroticize safer sex with the female condom
❑ Overview of how it works: 2 rings, one inside as an anchor, one outside to protect	
❑ Size - looks big but built to line the vagina. Not supposed to fit tightly on the man	❑ Size - compare FC to unrolled male condom (same length) Compare FC to stretched out male condom (male condoms can be as big when it needs to be)
❑ Material – made of polyurethane, review advantages: stronger, transfers heat, can use any kind of lubricant, inserted in advance ❑ Insertion - see inserting the female condom description and diagrams	❑ Material - allow for "hands on " experience-suggest client feel and taste difference between latex and polyurethane. Compare properties ❑ Insertion – Insert at least 20 minutes prior to intercourse to allow it to heat to body temperature ❑ Stress importance of practice prior to use for sex ❑ Provide enough male, female condoms and lube for practice and sex
❑ Use - woman needs to guide penis into centre of the FC to prevent penile mis-routing	❑ Use - use penile model with pelvic model to demonstrate penile mis-routing. Discuss different sexual positions and potential for mis-routing ❑ Explain how it can be used for oral sex ❑ Do not use a male and female condom together—friction can cause dislodgement of FC
❑ Removal – after ejaculation, twist outer ring closed, gently pull out and dispose, do not flush down toilet	❑ Removal - Explain that after ejaculation semen may seep out into the sheets ❑ Use a new FC for every new sex act ❑ Disposal – may need to discuss how to discreetly dispose of FC if couple living in shared accommodation.

Female Condom 1:1 Counselling Checklist	
Counselling Topic	**Tips for Counsellors**
4. Negotiation with a Partner	
❑ Discuss FC requires male co-operation	❑ May require counsellor to role play with client
❑ Stress importance of not tricking partner	❑ See Negotiating Use with Male Partners
5. Advantages of the FC	
❑ Under a woman's control - no need for male erection	❑ Discuss sexual pleasure, using diagrams show how ring may stimulate clitoris
❑ Some couples say sex feels more natural	
❑ Some women say outer ring is stimulating	
❑ Covers more of outer labia – more STD protection	❑ Partners may be able to enjoy sex more if they have confidence that the FC won't break
❑ Stronger than the male condom	
❑ Help prevent both pregnancy & STDs	
6. Mechanical Difficulties	
❑ Difficulty with insertion	❑ Slippery and tricky to insert; practice at leisure before using for sex
❑ Invagination during sex	❑ Outer rings get pushed inside vagina with thrusting - use more lubrication.
❑ Slippage	❑ Condom riding out during sex - use more lubrication
❑ Spillage	❑ Twist rings and remove condom right after ejaculation & while still lying down
❑ Noise	❑ More lubrication
❑ At first couple may be unsure they are using it correctly	❑ Practice
❑ Inner ring may be uncomfortable to either partner	❑ Rearrange inner ring to make sure it is inserted properly ❑ Reinforce need for lubrication to make it work properly ❑ Refer to Appendix C, Q&A

Female Condom 1:1 Counselling Checklist	
Counselling Topic	**Tips for Counsellors**
7. Checking for female condom insertion	
❑ Offer the opportunity for women to insert the female condom in private, then to discuss their experiences	❑ Requires an area of privacy—may not be appropriate for a group education session ❑ Offer video viewing
❑ Offer onsite nurse practitioner or physician checks that the female condom has been inserted behind the pubic bone.	❑ Not all settings may have a nurse or doctor available.
❑ If not possible or appropriate – client describes process	❑ Client verbally describes steps of insertion and demonstrates knowledge of: - inner and outer rings - safety qualities of the sheath ❑ Client demonstrates two positions for insertion standing with leg raised and squatting ❑ Client demonstrates appropriate application of the lubricant. Be specific about where & how much ❑ Client demonstrates correct grasp of the inner ring ❑ Client is able to verbalize position and manually identify vaginal orifice and pubic bone ❑ Client inserts the inner ring behind the pubic bone, pushes the sheath in with the forefinger and checks insertion ❑ Client is able to verbalize the importance of gently holding the outer ring against her body during penetration and guiding their partner's penis into the condom ❑ Client removes the female condom using the twist technique

Female Condom 1:1 Counselling Checklist	
Counselling Topic	**Tips for Counsellors**
8. Provision of Safer Sex Supplies	
❑ Provide as many female and male condoms and water based lubricant as the client will need until the next visit including enough for practice.	❑ Offer male condoms as well in the event that they decide not to use the female condom and to provide more choices ❑ Assess client's knowledge of male condom application. Review and demonstrate as needed. Ask if client and/or partner allergic to latex ❑ Ask how many female condoms & male condoms the client thinks she needs ❑ Provide water based lubricant
❑ Offer follow-up visit	❑ Explore need for follow-up ❑ Provide AIDS and Sexual Health InfoLine number: 416-392-2437 or 1-800-668-2437 ❑ Give a female condom pamphlet
9. Closure	
❑ Reinforce key points.	❑ Do not use the female condom with a male condom. Either condom may break due to friction ❑ Do not remove the inner ring for vaginal intercourse. It is used to insert the female condom and keeps it in place in the vagina ❑ You can put in the female condom up to 8 hours prior to having sex – it won't hurt you or stop you from going to the bathroom. Most couples put it in just before having sex ❑ More lubricant solves most problems. ❑ Use a new female condom every time you have sex –if not realistic, refer to WHO reuse guidelines ❑ Emphasize the importance of practice and patience. It may take a couple of insertion attempts before the FC feels easy to insert

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APPENDIX A

Female Condom Pilot Project Final Report

Executive Summary

> ***"So it was just a matter of when you do use it, you're in control. It's kind of like you decide you know. They come and fish around but usually when you put it in, the intention is already there to have sex. So yeah, I like using the female condom." (Pilot Project participant)***

With assistance from our community partners, TPH was able to design and implement a social marketing campaign, develop educational resources and health promotion materials, document effective strategies and conduct a pilot study with women aged 18 to 45 at risk for STDs/HIV and unplanned pregnancy. Key findings of the study include the following:

- There was increased knowledge and awareness of the female condom as a barrier method.
- 36% of participants who completed the study stated that they preferred the female condom to the male condom.
- An additional 33% wanted to have the choice between male and female condoms.
- There was a 20% increase in the percentage of sex acts protected by either the male or the female condom.
- Technical difficulties with insertion are a barrier to use but with practice and support, many women and couples are able to overcome these difficulties.
- A key ingredient for successful use of the female condom is practice – both privately and with partners.
- Women 25 years and older were more likely to use the female condom than women under 25.
- Cost is a barrier to use. No participant could pay the current retail pharmacy price for the female condom.

- 78% of participants who completed the study felt it offered greater control over their sexual health.

- Many participants recognized that female condoms require male compliance.

- The female condom neither heightened nor decreased sexual pleasure for most participants.

- Comparisons between the male condom and female condom were mixed – the majority of participants stated there were advantages and disadvantages to both methods.

Many women were attracted to the study due to dissatisfaction with their present method of birth control and STD/HIV prevention. This supports frontline workers' experience that women's options in this area are limited. Different contraception and STD/HIV protection methods are needed at different times in people's lives. While there is no perfect method, women are eager to find new ways to protect themselves and maintain their sexual health.

Given the increase in STDs, including HIV, and perinatal transmission of HIV, TPH needs to strengthen its prevention efforts by increasing the number of barrier protection choices available to women. Providing women with a choice of methods appears to increase the number of protected sex acts.

Few women are familiar with the female condom. Despite high rates of STD/HIV and unplanned pregnancy in our pilot study population, health care providers had not discussed this method with their clients prior to this project. It is important that service providers receive education and training about the benefits of this method as well as the factors that contribute to initial and ongoing use. Thus, the findings of this study will be included in future TPH sexual health service provider training events and resources.

Providing education and counselling sessions, either in a group or individual format, along with free unlimited quantities of both male and female condoms and water-based lubricant, significantly increased the percentage of sex acts that were protected by either the male or female condom. Providing the female condom with an educational and counselling component was key to the success of this method. Educators needed to be familiar with the broad range of problems that women experience when learning to use the female condom, such as slippage, noise, discomfort, and spillage and be able to provide detailed education, counselling and ongoing support.

Given that poverty and social inequality are associated with higher rates of chlamydia, gonorrhoea, and unplanned pregnancy (Hardwick and Patychuk, 1999; Toronto Public Health, 2001) and that cost is a major barrier to use, TPH should

provide female condoms to community agencies for free distribution to their clients. Women at highest risk due to socio-economic reasons are least able to purchase the female condom or indeed any other methods of birth control or STD/HIV prevention. As a result, we have concluded that it is both prudent and equitable for TPH to provide female condoms as well as male condoms.

Language was a barrier to all aspects of the Female Condom Pilot Project. Although there were a few media interviews in some language-specific newspapers and radio programs, the poster, pamphlet and educational materials used in the project were developed in English only. We are therefore unable to generalize the findings of this pilot study to women whose command of English did not allow them to participate. It is important that we continue to consult and partner with community agencies that service diverse populations in order to identify health concerns and develop strategies to address these concerns.

APPENDIX B

Mucosal Immunity

The term mucosal immunity describes the status of the immune system at the mucous membrane level, which is very important in determining chance of infection. The presence of a STD in one partner has been shown to influence both the infectivity and the susceptibility in transmission of HIV. For example, an infection in the vagina can cause an increase in the production of white blood cells to the surface of the genital mucous membranes. These are the cells that HIV infects. If a woman is then exposed to HIV, her risk of acquiring the virus is much greater and may increase from 3 to 50 times. Keeping mucosal tissue healthy is a very important way to prevent HIV infection.

There is also some empirical evidence to show that women, because they are biologically the receptive partner during penile-vaginal intercourse, are at higher risk than heterosexual men of sexually transmitted diseases including HIV (WHO, 2000). It is estimated that if a man has gonorrhea, there is a 70% chance that his female partner will acquire the infection on a one time exposure. If a woman has gonorrhea, the chance that her male partner will become infected is about 30%. After sexual intercourse, semen can remain in the vagina for up to 2 days, while men are exposed to the fluids in the vagina only for the duration of intercourse. Thus in any single act of penile-vaginal intercourse, the woman's exposure is greater than her male partner's.

The probability of transmission of HIV from an infected person to an uninfected person after exposure depends on three factors:

- **Virulence:** This refers to the amount of virus present and is often referred to as viral load or viral dose. The amount of viral dose depends on the type of fluid (i.e semen, blood, breast milk, and vaginal juices), the clinical stage of HIV infection of the person to whom you are exposed, and the presence of STD(s).
  Viral dose is increased in the primary and symptomatic stages of HIV.
  Viral dose is increased if the person is HIV/STD co-infected.
  Viral dose **may** be decreased by antiretroviral therapies.* During antiretroviral therapy, serum RNA levels may be low or undetectable but viral load may still be high in semen, vaginal fluid and breast milk.

- **Exposure:** This refers to how a person is exposed, the number of times they are exposed, the length of time of the exposure and the chance that their partner is infected with HIV. Exposure can be receptive or insertive

- **Resistance**: This refers to resistance at the mucosal level and depends on the health of the mucous membranes. Inflammation and or infection increases the numbers of white blood cells at the mucosal level, which increases the number of cells, that are targeted by HIV.

The more white blood cells present, the easier it is for HIV to infect. Vaginal inflammation and or infection can be caused by the presence of STDs, spermicide use, douching with perfumed soaps, vaginal fisting, vigorous, prolonged and or dry intercourse, etc.

The combination of all three of these factors together determines the likelihood of STD or HIV transmission during a single sex act. It also explains why an individual may have multiple exposures to HIV and not become infected; if viral load is low, exposure is limited and resistance is high. Another individual may have only one exposure to HIV and become infected: if viral load is high, exposure is extensive and resistance is low.

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APPENDIX C

The following section has been taken with permission from the Female Health Company Website, 2001. Some information has been altered slightly to reflect the findings of our study and Toronto Public Health recommendations. These changes have been noted in the text. Please check www.femalehealth.com for up-to-date common questions and answers. We also recommend that you call the AIDS and Sexual Health InfoLine: 416-392-2437 or 1-800-668-2437**.** The InfoLine is able to provide counselling in different languages.

Common Questions about the Female Condom (FC)

Q. Is the FC effective?

A. When used correctly every time, the FC's failure rate in a 6-month pregnancy efficiency study was 3%. When women used it only sometimes or not at all during the same study, the failure rate was 12%. Based on these results, the annual failure rate is 5% for correct, consistent use, and 21% with a range of 18%-25% when used sometimes.(It's important to note that the FC's failure rate is comparable to other barrier contraceptives. And as with all other condoms, it doesn't work unless you use it.)

Q. Is it easy to use?

A. If you read the instructions carefully to understand how the FC works, you can expect it to be very easy for you. (About 95% of the women in Female Health Company studies said they understood the instructions easily and felt they could use the FC.) Sometimes it takes two to three times to become familiar with it and comfortable using it. But after the newness wears off, many find the female condom to be very natural and quite pleasurable because it is warm and smooth.

Q. When am I supposed to insert the FC?

A. The FC can be inserted right before sex, or up to eight hours ahead of time. Insertion 20 minutes prior to intercourse will help overcome many of the mechanical problems in using the female condom (Gillis, 2002).

Q. Can the penis be used to place the FC in the vagina?

A. In the Toronto Public Health (TPH) study, one women successfully inserted the female condom this way (Gillis, 2002). However the FHC does not recommend this method. The FC is designed to be inserted with the inner ring acting as an anchor, holding the condom in place behind the pubic bone.

Q. Does the outer ring get pushed inside during sex?

A. No. The outer ring should remain in the place on the outside of the vagina at all times. If there is not enough lubricant on the inside of the condom or on the outside of the penis, the condom may go inside of the vaginal canal. If this happens, STOP immediately, remove the condom, and insert a new one. Use more lubricant on the outside of the penis and on the inside of the condom.

Q. Will the ring on the outside hurt?

A. No. The outer ring is very soft and flexible. Also, some women have reported that the outer ring can actually enhance pleasure, as it can rub against the clitoris and increase stimulation. Some women and their partners may find the ring irritating (Gillis, 2002).

Q. Does the inner ring need to fit snugly around the cervix?

A. The FC inner ring does not have to fit around the cervix. The inner ring is anchored by the pubic bone to keep it in place and the sheath adheres to the vaginal wall lining. Furthermore, the ejaculate is captured inside the sheath.

The FC sheath adheres to the vaginal wall, lining it as if it were a second skin as it conforms to the natural inner contours. It's the woman's natural lubrication combined with the lubricant on the outside of FC sheath that causes the female condom to adhere.

The inner ring is used primarily for insertion, although it does help keep the female condom in place once the ring is past the pubic bone. Be sure the inner ring is pushed up as far as it will go past the pubic bone and that you use enough lubricant so that the penis slips easily in and out of the condom.

Q. Can the man feel the inner ring?

A. Most men do not, although some have reported that they do feel that it is there. Because the inner ring is not attached to the sheath, it can move subtly, allowing the penis to move freely inside the woman.

Q. Why is the FC inner ring not attached to the sheath?

A. So that the inner ring can slip into place easily and lodge under the cervix. Once in place, the inner ring is out of the way of the penis during sex.

Q. Why does the FC adhere to his penis when he withdraws?

A. If there is not enough lubrication on the inside of the female condom between the penis and the female condom, it can adhere to the penis when he withdraws. To avoid this, put a few drops of lubricant on the inside of the female condom as well as on the outside of the penis to reduce friction between the two surfaces. If the condom is pulled out of place, STOP having sex, take a new condom, add extra lubricant to the inside of the condom and the outside of his penis, and insert the new condom.

Q. Can I use the male condom and the female condom at the same time?

A. **No,** because neither one will work properly. The material used in condoms rub together, friction between them could cause the male condom to be pulled off or the female condom to be pushed in. If either the female condom or the male condom is used properly and carefully, no additional barrier should be necessary.

Q. Can I urinate while wearing the FC?

A. Yes, you can urinate while the FC is in place. The FC covers a portion of the outer vagina, or labia, but can be moved aside for urination. Gently move the ring which forms the outer edge to the side or back. After urinating, check with your finger to be sure the inner ring is in place past the pubic bone. If you cannot feel it, it's in place. Most women insert the FC about 20 minutes or less before having sex, so urination is usually not an issue.

Q. Can I use the FC during my period?

A. Yes, but under this circumstance, we do not recommend inserting it very far in advance of intercourse.

Q. Can the FC be used if I have a retroverted uterus?

A. Yes, because it lines the vaginal wall, covering the cervix along the way.

Q. I have had Female Circumcision. Can I use the FC?

A. Yes, you can use the FC if you can have sex or insert two fingers inside the vagina. Remember, the FC does not need the external genitalia to hold the condom in place. Once inserted in the vagina the FC's inner ring will keep the FC in place by sliding behind the pubic bone, acting like an anchor for the condom.

Q. Can the FC be used if the woman has had a hysterectomy?

A. Yes. The FC fits inside the vaginal wall by adhering to it. Because the FC sheath is lubricated, inside and out, and because the vaginal wall is already moist, the sheath clings to the inner vagina, conforming to its natural contours and lining the inner vagina like a second skin. Carefully follow the instructions for insertion and be sure to use enough lubricant so that there is no friction, so that the penis slips easily in and out. It is always a good idea to practice inserting the FC all by yourself a few times before you use it with your partner, so you are confident when using it for sex.

Q. Can the FC be used soon after childbirth? Can a woman who has had an episiotomy use the FC?

A. Preliminary studies show that the FC can reduce pain for women who are sensitive to sex, and that it is helpful for women who have recently given birth or had an episiotomy.

Q. Can a pregnant woman use the FC?

A. Yes, the FC can be used by a pregnant woman.

Q. Can the FC be used with a urinary tract infection?

A. If you have an infection, you should discuss using the FC or other device with your physician before using it during sex. Preliminary studies show that the FC does not increase the incidence of urinary tract infections, and that it is not damaged by oil-based medications.

Q. Does the FC protect the man's scrotum from condyloma?

A. If inserted properly, the FC covers part of the labia. Therefore, during intercourse, the scrotum may not touch the labia, so protection is increased.

Q. What are the ingredients in the FC's lubricant?

A. The FC is prelubricated with silicone, the same lubricant as used male latex condoms. In addition, a 4-oz. bottle of glycerin-based lubricant is enclosed in the box of FC. The lubrication enables a smooth entrance for the penis into the vagina. The instructions give details on how and when to use extra lubricant. The extra lubricant is water based and does not contain spermicide.

Q. What kind of lubricant can I use with the FC?

A. Because the FC is made from polyurethane, oil based lubricants will not cause the sheath to disintegrate. Therefore, you can use water or oil based lubricants with the female condom. Toronto Public Health recommends that you use water-based lubricants to protect the normal vaginal flora.

Q. Why don't you put spermicide in your lubricant?

A. We do not put spermicide in the FC lubricant because some women are sensitive to nonoxynol-9, and become irritated using it, causing them to be more vulnerable to STDs. Women have the option whether to use a spermicide with the female condom.

Q. Can I use spermicidal foam, gel or film with the FC ?

A. You can use nonoxynol-9 with the FC, but recent studies have shown that spermicide use can increase HIV transmission (Centers for Disease Control, 2000). Toronto Public Health recommends that women at risk for HIV infection should not use spermicides. For more information visit the WHO website**:** **www.who.int/reproductive-health/rtis/nonoxynol9.hmtl**

If you do decide to use a spermicide, put the spermicide inside of the vagina before inserting, or cover the outside of the condom with the spermicide, whichever is preferable. You can use spermicidal foam, gel or film with the FC. No clinical studies have been completed to demonstrate the added effectiveness when using a spermicide with the female condom (FHC, no date).

Q. Can the FC be used along with a diaphragm?

A. No, because the FC inner ring lies in the same place the ring of the diaphragm ring goes.

Q. Can the FC be used along with an IUD?

A. Yes.

Q. Why is the FC more expensive than male latex condoms?

A. The FC is made of polyurethane, which is a thin, strong, sensitive plastic that is much more costly than latex. In addition, the manufacturing process is very expensive. Polyurethane offers many advantages. For example, it rarely rips or tears, and can be used with any lubricant – water based or oil based, including spermicidal lubricant containing nonoxynol-9. In addition, polyurethane transmits heat once it is inside the body, so you can hardly feel it during sex.

Q. What is the benefit in using the FC instead of the male condom?

A. The FC offers an option for women. Especially for women whose partner can't or won't use the male condom or women who are sensitive/allergic to latex.

Q. Do FCs come in sizes or flavours?

A. No, the FC only comes in one size. It's designed to fit into a woman's body, not onto a man's penis. The lubricant that comes with the FC is water based and unflavoured.

Q. My partner is 13 inches, will he fit the FC?

A. If he fits into you, he will be able to fit into the FC. You will probably need a lot of extra lubricant though. The lubricant (either water or oil based) will make entry easier.

Q. Male condoms don't fit my partner because he is too big. If I take the inner ring out of the FC, can he use the FC on his penis?

A. No. The female condom was designed to be worn by a woman, not a man. That inner ring helps to hold the female condom in place by the woman's pubic bone. If a partner has difficulty with penetration, just remember to use more lubricant. Put lubricant on the penis and on the inside of the FC, enter slowly, and enjoy!

Q. Can the FC be used during oral sex?

A. Yes. Using scissors, cut the FC along the seam and place the female condom over your vagina or over your partner's mouth. Be careful to keep the condom between your partner's mouth and your vagina throughout the oral sex act. Use a new "whole" female condom if you begin intercourse and follow the instructions for insertion.

Q. Can the FC be used for anal sex?

A. The Female Condom has been licensed by Health Canada for vaginal intercourse. While there is limited research on the effectiveness of the female condom for anal intercourse, it can be considered a method of risk reduction for anal intercourse. If used for anal intercourse, the inner ring must be removed to prevent any damage to the rectum/anus (Toronto Public Health, 2003).

Q. If I have an orgasm and my partner has not ejaculated; do I need to put a new condom in if we continue to have sex?

A. As long as he doesn't withdraw, you can continue! Once he has had an orgasm (and ejaculated), you will need to insert a new female condom before your next sex act. Remember to remove the female condom prior to standing up, to avoid spilling.

Q. Can we have sex in a variety of positions?

A. Yes. The FC will work in different sexual positions. As long as you have inserted the FC properly and ensure the outer ring remains outside your vagina, the FC will protect you no matter what sexual position you choose! Be sure to use enough lubricant so his penis slips in and out, regardless of position. We recommend lying down to remove the FC to avoid spilling.

Q. Will using the FC inhibit foreplay?

A. As you become more familiar with having sex using the FC, inserting the FC can actually become a part of foreplay.

Q. Can I wash the FC out after having sex and re-use it?

A. Just like a male condom, the FC can only be used one time. Studies evaluating reuse have not been completed.

Toronto Public Health recommends that you refer to Female Condom Reuse Protocols on the WHO website; **www.who.int/reproductive-health/rtis/reuse.en.html**

APPENDIX D

The following agencies contributed to this project:

AIDS Committee of Toronto

Black Coalition for AIDS Prevention

Crossways Clinic

Immigrant Women's Health Centre

Lakeshore Area Multi-service Project (LAMP)

Lawrence Heights Community Health Centre

Maggie's: Toronto Prostitutes' Community Service Project

Scarborough Sexual Health Clinic

South Asian Women's Centre

Two-Spirited People of the First Nations

Voices of Positive Women

Warden Woods Community Center

Women's Health in Women's Hands

Youth Link Inner City

APPENDIX E

Female Condom Teaching Resources

Item	Source	Cost
• Female Condom Poster • Female Condoms • Female Condom Pamphlets • TPH FC Research Document	Toronto Public Health Barbara Macpherson Health Education Consultant Toronto Public Health 416-338-0904 bmacpher@.toronto.ca	No cost
Penis Models	Any condom novelty shop.	Yes
• Clear Plastic Female Pelvic Model • Female Reproductive Anatomy Charts	Jannsen-Ortho Drug Rep in your area. Customer Service (416) 382-4949	Pending on Rep
• FC Video • Dry FC • Educational Materials	Female Health Company 1-800-884-1601 www.femalehealth.com	$35.00 plus shipping

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