Debate on female barrier methods – why they may (will) not be effective (at this rate)

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Biomedical Interventions for HIV Prevention

Vaginal Diaphragm

Provider issues:

- training for fitting and counselling: ' Providers and counselors must be trained and comfortable when talking about sexuality, foreplay, intercourse, self-examination of the genitals and interaction of the couple before and during intercourse……' (Bulut et al 2001)
- provider bias: diaphragm users are older, better educated women (and therefore don't mention to younger women). Providers describe the ideal diaphragm user as someone who is responsible, has self-control and is comfortable touching her body (Mantell et al 2003)
- Relegated for contraception – major rehabilitation by proactive providers and trainers would be needed (MD/RN)

Vaginal Diaphragm

User issues:

- After fitting, need for instruction on how to put it in place (leave in for 6 hours after sex)
- Low cost over time (can be used 3 years), messy, has to be washed and stored. Some evidence that new diaphragm-like products may be more acceptable (Bird et al 2004)
- Some evidence men aware

Female Condom

- FC costs about **27 times more** than MC (plus programme costs)
- cost (product and programme support) through social marketing programmes: US$1.80/unit compared to US$0.93/unit for MC (PSI 2004)
- cost per couple-year protection (CYP) based on product and programme costs, numbers sold, amount of programme income generated: US$90 for FC and $2.40 for MC. (Why? 2004 PSI sold under 2 million FC and 867 million male condoms)
- FC2 unit price is 0.60 at current volumes (down from 0.68 for FC1).To reduce to 0.38 requires sales 60 million; global sales and bulk purchasing will have to increase more than fourfold over 2005 sales (14 million)
- To get to really significant price reductions, sales would have to be 200-300 million - even then price would be around US$0.22
- Lost time and resources on the reuse issue when a cheaper product is needed!
- Ridiculously low marketing expenditure and promotion

Female condom- South Africa case study (7years)

Reported lack of demand, low usage and little impact BUT impact assessments have shown:

- Lack of trained staff in place to both promote use and to pass on training in FC promotion to their colleagues at all levels.
- Lack of efficient monitoring and data collection system – so no info on impact. Rumours of 'slippage' (i.e. selling to the private sector);
- Lack of promotion materials, campaigns, media coverage; lack of IEC skills and materials for counselling/training (vaginal models, flip charts)
  No focus on counselling/FC promotion with men

- Lack of logistical management. No formal procurement plans, inventory, monitoring and projections of potential need for supplies
- No integration into HIV, STI or FP services: no policies, protocols, strategies, guides for providers on how to integrate FC into services

Getting HIV prevention and treatment commodities and services (and female barrier methods) to where they are needed: a long, long way to go!

Champions for hire?

Where are the champions? Male circumcision is discussed openly now but female barrier methods???

- e.g. Stephen Lewis spoke about laughing with fellow 'circumcisees' - he never mentioned female barrier methods (or the male condom)
- Female condom – it's in the **yuck zone** with the diaphragm – you can bet these will never be effective!

Moving forward – don't listen to Mitch and don't jump to conclusions that female barrier methods will take off and become effective on their own!