



# Sexually transmitted infections: condom distribution schemes

NICE guideline

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## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline should be read in conjunction with PH3.

## Overview

This guideline covers condom distribution schemes. The aim is to reduce the risk of sexually transmitted infections (STIs). In addition, these schemes can provide a good introduction to broader sexual and reproductive health services, especially for younger people, and help prevent unplanned pregnancies.

NICE has also produced guidelines on [contraceptive services for under 25s](#) and on the [physical health of people in prison](#).

## Who is it for?

- Local authority commissioners of services for those most at risk of STIs
- Providers of condom distribution schemes
- Practitioners working in specialist and general services for groups at high risk of an STI
- People who use or are considering using condom distribution schemes, their families and carers, and the general public

NICE worked with Public Health England to develop this guidance.

## Recommendations

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline was developed as a result of a review of NICE guideline PH3 (published February 2007). See the original NICE [guideline](#) and [supporting documents](#).

### 1.1 Targeting services

- 1.1.1 Provide a range of [condom distribution schemes](#) (also known as condom schemes) to meet the needs of different local populations, based on needs assessment, consultation and sexually transmitted infection (STI) rates. Target those most at risk. Include [multicomponent schemes](#), [single component schemes](#) (free condoms) and [cost-price sales schemes](#).
- 1.1.2 Provide condom schemes as part of existing services that are likely to be used by those most at risk. This could include services provided by the voluntary sector (such as advice projects and youth projects), school health services and primary healthcare (including GP surgeries and community pharmacies).
- 1.1.3 Ensure links exist between condom schemes and local sexual and reproductive health services. For example, consider:
- Providing condoms with information about local sexual health services.
  - Displaying posters and providing leaflets advertising local sexual health services where condoms are available.
- 1.1.4 Publicise condom schemes to people most at risk of getting an STI. For example:
- Put posters and leaflets in places used by those most at risk.
  - Advertise on geospatial social networking apps (used to find local sexual partners) or websites (such as the [NHS condom locator](#)) and social media.

## 1.2 *Multicomponent schemes for young people in health, education, youth and outreach settings*

### Service organisation

- 1.2.1 Provide tailored multicomponent condom schemes in preference to other types of condom scheme for young people aged up to 16 and others for whom there is a duty of care.
- 1.2.2 Consider extending tailored multicomponent condom schemes to include all young people up to the age of 25.
- 1.2.3 Integrate these schemes into broader services for young people, for example, as part of young people's sexual and reproductive health services (see NICE's guideline on [contraceptive services for under 25s](#)).
- 1.2.4 Offer pathways into other services including: sexual and reproductive health, alcohol and drug, mental health and partner violence services, as needed.
- 1.2.5 Ensure services:
- meet the Department of Health's [You're Welcome](#) criteria for young-person-friendly services
  - are confidential
  - are sited in settings accessible to young people for example, in health, education, youth and outreach settings and in a range of geographical areas
  - are accessible by public transport
  - are available at convenient times for young people (for example, after school, college or university and at weekends).
- 1.2.6 Ensure the safety of young people by:
- Assessing the [competence](#) of those under 16, and others for whom there is a duty of care, before providing them with condoms.

- Being alert to signs of child sexual exploitation or abuse, including intimate partner violence. See [Spotting the signs of CSE proforma](#) (British Association for Sexual Health and HIV and Brook) and NICE's guideline on [child maltreatment](#).
- Agreeing with the young person how they will use the scheme. This should take into account their age and circumstances and include an agreement that after a specified number of visits they will discuss their relationships and condom use again.

1.2.7 Consider providing a range of condom types (for example, latex-free) and sizes, female condoms and [dental dams](#). Include lubricant as well as condoms if they need or want it.

## Information and advice

1.2.8 Tailor information and advice according to the young person's needs and circumstances, including their sexual identity and whether or not they are having sex or are in a relationship.

1.2.9 Discuss the effect that alcohol and drugs can have on decision-making and their ability to consent.

1.2.10 Teach young people to use condoms effectively and safely (using education, information and demonstrations) before providing them.

1.2.11 Provide information about emergency contraception and [post-exposure prophylaxis](#) so that young people know what to do and where to go in the event of a condom failure.

## 1.3 *Single component schemes*

### Free condoms

1.3.1 Consider distributing free condoms (with lubricant) to people at most risk of STIs through:

- Commercial venues (including [sex-on-premises venues](#)), [public sex environments](#) and other places where people are at more risk of getting an STI.
- Local businesses that people most at risk of STIs may use, for example, some community pharmacies.



- Voluntary and community organisations that work with those at most risk, for example, sexual health charities.
- Other settings, such as universities and further education settings.

1.3.2 Provide information next to supplies of condoms (the information should be in line with NICE's guidelines on [behaviour change: general approaches](#) and [behaviour change: individual approaches](#)). This could include information about:

- sexual and reproductive health
- reliable sources of further information (for example, [NHS Choices](#))
- other condom schemes (including [multicomponent schemes](#))
- local sexual health services, including HIV testing services
- what to do in the event of a condom failure.

1.3.3 Ensure supporting information is sensitive to the environment where it is displayed, for example in terms of language and the images used.

### Cost-price sales schemes

1.3.4 Sell cost-price condoms to the wider population using websites run by existing health and wellbeing services, or larger-scale online condom sales schemes.

1.3.5 Provide information about using condoms and about sexual and reproductive health at the point of sale (see recommendation 1.3.2).

### *Terms used in this guideline*

This section defines terms that have been used in a specific way for this guideline. For general definitions, please see the [glossary](#).

### Condom distribution schemes

Mainly referred to as 'condom schemes' in this guideline. The term refers to all schemes that provide free or cost-price condoms, female condoms and dental dams, with or without lubricant. This includes schemes that also offer advice, information or support.

### **Cost-price sales schemes**

These schemes provide cost-price condoms and, if appropriate, lubricant. They include community schemes that provide cost-price condoms to sex workers and online services.

### **Multicomponent schemes**

These schemes distribute free condoms with or without lubricant, together with training, information or other support.

### **Single component schemes**

These schemes provide or distribute free condoms and if appropriate, lubricant. This includes online services for specific groups or areas of the country, and distribution schemes in public places.

## Putting this guideline into practice

NICE has produced [tools and resources](#) to help you put this guideline into practice. Another resource that may be helpful is Brook and Public Health England's guide to [C-Card condom distribution schemes](#).

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

- 1. Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
- 2. Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
- 3. Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.
- 4. Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.
- 5. Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. For **very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our [into practice](#) pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) *Achieving high quality care – practical experience from NICE*. Chichester: Wiley.

## Context

In 2015 there were approximately 435,000 new diagnoses of sexually transmitted infections (STIs) in England. Most were among heterosexual people under 25 and men who have sex with men ([Sexually transmitted infections and chlamydia screening in England: 2015](#) Public Health England). In the UK as a whole, 6,095 people were diagnosed with HIV in 2015 ([National HIV surveillance data tables](#) Public Health England). Over half of these were men who have sex with men (3,320). In the heterosexual population a disproportionate number of diagnoses were among [black Africans](#).

Condoms can protect against many STIs including HIV, chlamydia and gonorrhoea. They offer less protection against STIs transmitted by skin-to-skin contact, such as genital herpes and warts. In the UK in 2011, the cost of treating STIs (excluding HIV) was estimated at £620 million ([Unprotected nation](#) Family Planning Association).

Cost can be a major barrier to condom use, particularly for poorer people ([Barriers to condom use](#) Sakar 2008). Social norms and religious and cultural beliefs can also prevent people from using them because of stigma or embarrassment.

## *Current practice*

Some condom schemes only provide free or cost-price condoms. Others combine this with information or support. The C-Card scheme is probably the most widespread UK scheme. Local authorities commission these and define who is eligible. Typically they focus on people aged 13 to 24 (see [C-Card condom distribution schemes](#)).

## *Policy and commissioning*

This guideline will help local authorities and the NHS reduce STIs, a key objective in [A framework for sexual health improvement in England](#) (Department of Health).

Local authorities are responsible for commissioning and delivering all community and pharmacy contraceptive services. See [Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV](#) (Public Health England). NHS England commissions contraception schemes provided as an additional service under the GP contract, and sexual health services in prisons.

## *More information*

You can also see this guideline in the NICE Pathway on [preventing sexually transmitted infections and under-18 conceptions](#).

To find out what NICE has said on topics related to this guideline, see our web pages on [HIV and AIDS](#), [sexually transmitted infections](#), [contraception](#) and [sexual health: general and other](#).

See also the [evidence reviews](#) and information about [how the guideline was developed](#), including details of the committee.

## The committee's discussion

Evidence statement numbers are given in square brackets. For an explanation of the evidence statement numbering, see the [evidence reviews](#) section.

### *Background*

This guideline supplements existing NICE guidance on [contraceptive services](#). The committee agreed that although the focus of the guideline is on sexually transmitted infections (STIs), [condom distribution schemes](#) may lead to wider benefits, such as preventing unplanned pregnancies or getting young people involved with health services. It agreed that people should be advised to use condoms to reduce the risk of STIs in addition to their chosen method of birth control.

The committee noted that there is often a substantial overlap between condom schemes that just provide or sell condoms and [multicomponent schemes](#) that provide additional training, advice, information or support. For example, a multicomponent scheme for young people may also sell cost-price condoms to other groups.

The committee did not examine evidence about condom schemes in prisons or other detention centres because these were excluded from the scope. The committee noted that NICE's guideline on the [physical health of people in prison](#) addresses this.

### *Overview of the effectiveness evidence*

The committee expressed its concern about the quality of the evidence on condom schemes in the UK. Much evidence dated from the 1990s and most was from the US (little was identified from the UK). In many cases, key statistics and intervention details are missing from the papers. Limited evidence was available on how the components of schemes influenced effectiveness or cost effectiveness. No evidence was identified on the effectiveness and cost effectiveness of the C-Card scheme, which is commonly used with young people in the UK.

Most of the evidence that was available focused on condom schemes for HIV prevention, whereas current UK schemes focus on preventing a broad range of STIs and unwanted pregnancies [ES1, ES2, ES3, ES4, ES5, ES6, ES7, ES8].

The committee did not make any recommendation based on ES8, which compared sexual risk taking after different types of condom provision, because there were no statistically significant differences that could inform or enhance a recommendation.

The committee discussed a paper submitted during the consultation process. It had not been published in a peer-reviewed publication and did not meet the inclusion criteria for the review. It claimed that some condom schemes increased teenage pregnancy rates in the US during the 1990s ([The incidental fertility effects of school condom distribution programs](#) Buckles and Hungerman 2016). The committee noted that, because there were extensive methodological issues with the paper, no clear conclusions could be drawn.

## Outcomes

Most included studies reported intermediate outcomes, such as intention to use condoms, condom use at last intercourse or attitudinal measures. Few reported STI outcomes – those that did were poor quality studies.

The committee was aware that the focus of this guideline was condom provision to prevent STIs and that avoiding pregnancy was outside the scope. But it was also clear that increasing condom use would help avoid some pregnancies. Indeed, many of the proxy measures mentioned are as relevant to preventing pregnancy as to STI prevention.

The costs of these avoided pregnancies were included in the economic analysis. In addition, the review database was checked to ensure that no studies with pregnancy outcomes alone had been overlooked and the committee was confident that a body of evidence had not been missed.

The committee was aware of a recently published meta-analysis indicating that: 'interventions increasing the availability of, or accessibility to, condoms were shown to be efficacious in increasing condom use behaviours and that condom schemes provide an efficacious means of HIV/STI prevention'. Although most papers in the meta-analysis did not meet the inclusion criteria for this guideline (for example, two-thirds were in Africa or Asia) the committee was reassured that this review supported its conclusions<sup>[1]</sup>.

## Unintended consequences

The included studies clearly showed that condom schemes do not increase levels of sexual activity among young people, nor do they reduce the age at which young people become sexually active [ES1, ES5].

## Key gaps in the evidence

The committee was clear that an understanding of behaviour change must underpin condom schemes, but there was no specific evidence on the techniques used to deliver any of the evaluated



schemes. The committee agreed that schemes should be delivered in line with NICE's guidelines on [behaviour change: general approaches](#), [behaviour change: individual approaches](#) and [patient experience in adult NHS services: improving the experience of care for people using adult NHS services](#).

The committee discussed the importance of collecting data from UK-based condom schemes. An expert told the committee that one of the largest sources of evidence could be existing C-Card schemes. Many of these undertake regular, extensive monitoring and evaluation of their programmes, as recommended in the C-Card guidance [EP1].

The committee agreed that a standardised approach to assessing the effectiveness of local schemes would be extremely beneficial and enable a national evidence synthesis to explore the effectiveness of C-Card schemes in STI prevention. It agreed this should be strongly reflected in the research recommendations.

The committee discussed the possibility that online services could address some equity issues for people in rural areas. But the evidence was poor so the committee made a research recommendation on this.

Some GP surgeries provide condoms as part of their reproductive health role, but the committee questioned whether they would want to get involved in condom schemes aimed specifically at preventing STIs. Stakeholder comments reassured them that GPs might be interested in delivering such schemes. The committee agreed that this approach could be particularly useful for GP practices used by those most at risk, for example, in universities. But because there was little evidence, the committee made a research recommendation on this.

## *Targeting services*

The discussion below explains how we made recommendations [1.1.1 to 1.1.4](#).

The committee agreed that people are most at risk of STIs if they are involved in higher rates of risky sex (for example, they may have multiple partners or frequently change partners). There may be more people involved in such activities in some groups than others, but this does not mean that everyone in the group is necessarily at high risk. For example, men who have sex with men are the highest risk group for STIs and HIV, but this does not mean that every person in that group is at high risk.

The committee agreed that a person's behaviour was the key determinant of their risk, so recommendation 1.1.1 refers to 'those most at risk'.

The committee discussed the importance of integrating condom schemes with broader services, not just sexual and reproductive health services but, for example, general practice, young people's services, education, school nursing and pharmacies. It recognised that areas needed to plan their own mix of the different types of condom scheme recommended in the guideline based on local need.

The committee discussed evidence that a small media campaign had been effective in raising awareness of syphilis and condom use. Members agreed that advertising and publicity were a key component of effective condom schemes [ES6, EP1, EP2].

## Cost effectiveness

The committee heard expert testimony on the cost effectiveness of condom schemes. This showed that they are most cost effective and sustainable if they target people at most risk of STIs and are embedded into existing services. It was also told that: "Commissioning is currently taking place within the context of a challenging economic climate. Local authority budgets, in particular, are reducing, which results in less funding available for prevention work ... [such as] for condom and lube schemes."

The expert noted that commissioners need to work collaboratively and commission services for communities of people who share a common interest, belief or other characteristic, not just communities linked by geographical area. Another expert told the committee that in recent years some schemes have been commissioned to cover multiple local authority areas. Examples include the [Come Correct](#) scheme in London, which is funded by more than 20 local authorities. This enables local areas to buy into a pre-designed scheme and potentially benefit from economies of scale [ES10, EA, EP1, EP2].

## Inequalities

The committee recognised that targeting schemes at different population groups or geographical areas could lead to inequalities (for example, people living outside cities may not have access to city-based services). It also noted the lack of evidence of effectiveness for some groups, for example, people with learning disabilities. For this reason, the committee kept its recommendations as broad as possible.

It also agreed that, although the evidence for selling condoms at cost price was lacking, it could help offset some of the potential inequalities generated by targeted schemes. It agreed that web-based postal systems, in particular, might help to overcome inequalities related to geographical isolation or stigma [ES7]. But, based on the economic modelling, these schemes would need to be very low cost.

### *Multicomponent schemes for young people in education, youth and outreach settings*

The discussion below explains how we made recommendations [1.2.1 to 1.2.11](#).

The committee was aware that young people under 16 need to be assessed as competent to consent to sexual intercourse before providing them with condoms. Either they should have parental permission or they should demonstrate that they can understand and appraise the nature and implications of condom use. This includes understanding the risks of not using them, and alternative courses of action. As a result, the committee agreed that if there are concerns about a young person's competency to consent, [multicomponent schemes](#) are more appropriate than [single component schemes](#), even though they are much more costly.

The committee was aware that multicomponent schemes also provide information and training (both in terms of education and hands-on training or demonstration) so 'condom naive' young people can take responsibility for using them effectively. But it was unclear from the evidence exactly what mix of components made multicomponent schemes more or less effective, so the committee was unable to make firm recommendations about their exact content [ES1, ES2, ES3].

No evidence of effectiveness was identified for the C-Card scheme, the most common multicomponent scheme in the UK. The committee agreed this is a key gap because most of these schemes provide condoms to young people up to the age of 25 – and because young people aged 16 to 25 have one of the highest rates of STIs. It also agreed that, in lieu of this evidence, the C-Card [best practice guidance](#) is helpful.

On balance, members agreed that multicomponent condom schemes should consider providing their service to young people up to the age of 25 [EP1].

### **Cost effectiveness**

The economic analysis used a model scheme that provided education, condoms (using a credit card type C-Card) and telephone counselling, because these are common elements. Effectiveness data

came from a multicomponent scheme for school students (aged 17) who were 1.23 times more likely to use a condom than students in a school without a scheme. It cost £0.48 per person per year, calculated from cost data from 4 UK C-Card schemes. This included costs for: condoms and lubricants, staff time for training and administration, website, advertising and the C-Card.

STIs included in the model were chlamydia, gonorrhoea, HIV and syphilis. STI diagnosis rates were used to judge the initial prevalence of these STIs. STI incidence in the model was influenced by initial prevalence, transmission rates, sexual activity levels and condom failure rates, as well as condom use. The incidence of each STI was associated with a quality-adjusted life year (QALY) loss and a cost.

For a target population aged 13 to 18, the model showed a condom distribution scheme prevented 1,373 STIs. This led to savings on STI-related costs of £758,947. Each person gained 17 QALYs. The scheme cost £1,538,499 and the incremental cost effectiveness ratio (ICER) of using condom schemes to prevent STIs only was £45,856.

The committee was clear that increasing condom use would also help avoid some pregnancies, so an economic analysis was conducted on preventing pregnancies for a population aged 14 to 18. This used an economic model from NICE's guideline on [contraceptive services for under 25s](#). The model assumed that all pregnancies in this age group were unintended and that increased condom use would either delay or prevent pregnancy, as well as preventing STIs.

The committee noted that for a population of 100,000 people aged 14 to 18, increasing condom use by 22% would lead to pregnancy-related savings of over £11 million. This would make condom schemes highly cost saving.

Analysis conducted for a target population aged 13 to 25, considering the effect of condom schemes on STIs only, resulted in an ICER of £17,411. Condom schemes were more cost effective for this broader age group because the rates of both sexual activity and STI prevalence were higher. In this age group, an analysis of the effect of increasing HIV prevalence to 0.19% (the UK average) showed that this would make the condom scheme cost saving. So it would be more effective and cost less than not providing a scheme. A scenario analysis considered that training provided by multicomponent schemes may reduce condom breakage. This reduced the ICER to £14,469, potentially demonstrating the importance of including training in condom schemes.

The committee noted a threshold analysis in which effectiveness (relative risk of condom use) and cost per person in the target population were varied. This suggested that schemes can be cost effective even without considering pregnancy effects, as long as costs and condom use effects can

be balanced. If a scheme did not achieve any change in condom use it would not be cost effective because it would accrue the cost for no health benefits.

Additionally, the committee heard that the use of static models and short time horizons are likely to have underestimated the cost effectiveness of schemes.

## *Single component schemes*

The discussion below explains how we made recommendations [1.3.1 to 1.3.5](#).

The committee discussed the challenges of making sure condoms are available to the widest possible audience, while ensuring schemes are cost effective by targeting populations most at risk of an STI. It also discussed the transition for young people from multicomponent to [single component schemes](#).

The committee was aware that young people under 16 might also use single component schemes. It agreed that there was no way to prevent this. But it was clear that multicomponent schemes are the best option for them and for anyone over 16 for whom there is a duty of care (for example, if they have special educational needs or disabilities).

It agreed that providing condoms freely to people most at risk of STIs is important, although it is better if this takes place in the context of broader information provision or education, especially for young people. One expert told the committee that:

*"...free condoms and lube within locations (including gay bars, clubs and saunas) should be maintained. It is appropriate to provide free condoms and lubricant targeted at gay, bisexual and other men who have sex with men, due to them shouldering a disproportionate burden of HIV and other STIs.*

*"Furthermore, condoms and lube available within bars, clubs, saunas and other settings provide important visibility, helping to increase social norms of condom and lube usage.*

*"Ensuring that they are free reduces one of the barriers for people accessing condoms and lube, [that is] cost. This is particularly important given the fact that addressing social determinants is an important aspect of HIV prevention." [ES6, EP2]*

The committee noted the lack of published evidence about the effectiveness of single component condom schemes, but it also noted the range and flexibility of these schemes. In addition, it noted that the cost effectiveness evidence for them was compelling. As a result, the committee did

recommend these schemes but, because of the lack of published evidence, could only make this a 'consider' recommendation.

## Cost effectiveness

The committee noted that specific cost and effectiveness data were not available for condom schemes aimed at adults most at risk of STIs. Cost effectiveness analysis was conducted for 2 groups that include people most at risk of HIV: men who have sex with men, and [black Africans](#). This showed that distributing free condoms to people at most risk is highly cost effective or cost saving, even with high scheme costs and relatively small effects. That is because, among people most at risk of an STI, a small increase in condom usage can avert numerous HIV cases, saving £100,000 and 4.5 QALYs per case [EA].

### *Men who have sex with men*

For groups of men who have sex with men, in populations with a low HIV prevalence (using diagnosis rates, average 0.05%), the committee noted schemes would be cost effective or cost saving with a cost per person per year up to:

- £5 if they increased condom use by 4%
- £10 if they increased it by 6%
- £15 if they increased it by 8%.

For populations with a medium to high HIV prevalence (average 5 to 9%), schemes costing up to £15 per person per year would be cost effective or cost saving if condom use increased by 2% [EA]. If a scheme did not achieve any change in condom use it would not be cost effective because it would accrue the cost for no health benefits.

### *Black Africans*

The committee noted economic evidence supporting large-scale condom distribution among black Africans. It noted that for black African populations with a low HIV prevalence (average 1.46% for men and 3.84% for women), schemes that increased condom use by at least 8% would be cost effective or cost saving if the cost per person per year was less than £15. With medium HIV prevalence (average 1.79% for men and 4.55% for women), schemes would be cost effective or cost saving at up to:

- £5 per person per year if they increased condom use by 2%

- £10 if they increased it by 4%
- £15 if they increased it by 6% [ES9; EA].

If a scheme did not achieve any change in condom use it would not be cost effective because it would accrue the cost for no health benefits.

### *Cost-price sales schemes*

The committee noted that cost-price sales schemes may encourage more of the general population to use condoms, and it may be possible to deliver these at a low cost. This could help people who might not be regarded as most at risk to get low price condoms and so help offset any potential differential impact resulting from this guideline.

### **Cost effectiveness**

The committee agreed that programmes selling condoms at cost or reduced price, particularly large-scale programmes such as a national web-based scheme, could be cost effective. They would have the added advantage of diminishing some of the potential inequalities in service provision as a result of specific targeting of condom schemes – possibly reaching people who would not otherwise be able to access schemes. This was particularly felt to be the case for web-based postal schemes [ES7].

The committee considered the cost effectiveness of condom schemes for the general population. It noted that when using diagnosis rates for HIV prevalence, condom schemes would have to increase condom use by 20% and cost less than £0.20 per person per year. It noted that any reduction in unplanned pregnancies would increase the cost effectiveness of schemes.

In an analysis that increased HIV prevalence to an average of 0.19%, schemes that cost £5 per person would be cost effective if they increased condom use by more than 50%.

The committee discussed the fact that ICERs are higher for the general population because of the relatively low prevalence of STIs, and that schemes targeting those most at risk would be more cost effective.

In an analysis that increased HIV prevalence to 0.4%, condom schemes costing up to £2 per person per year would be cost effective if they increased condom use by 10%. Those costing £5 would be cost effective if they increased use by 24%. If a scheme did not achieve any change in condom use it would not be cost effective because it would accrue the cost for no health benefits.

If cost-price sales schemes can recover any administrative costs, through charging for condoms and postage and packaging, they could be cost-neutral.

## *Evidence reviews*

Details of the evidence discussed are in [evidence reviews, reports and papers from experts in the area](#).

The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from.

**Evidence statement (ES) number 1** indicates that the linked statement is numbered 1 in the evidence review. **EP1** indicates that expert paper 'C card distribution scheme' is linked to a recommendation. **EP2** indicates that expert paper 'LGBT Foundation condom & lube distribution scheme' is linked to a recommendation. **EA** indicates that the recommendation is supported by the economic analysis 'A model to evaluate the cost effectiveness of condom distribution (CD) schemes'.

If a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

**Recommendation 1.1.1:** EA; EP1; IDE

**Recommendation 1.1.2:** EA; EP1; IDE

**Recommendation 1.1.3:** ES6; EP1

**Recommendation 1.1.4:** ES6; EP1, EP2

**Recommendation 1.2.1:** ES1, ES2, ES3, ES4

**Recommendation 1.2.2:** EA; IDE

**Recommendation 1.2.3:** EA; IDE

**Recommendation 1.2.4:** IDE

**Recommendation 1.2.5:** ES1, ES2, ES3, ES4; EP1; IDE



**Recommendation 1.2.6:** ES1, ES2, ES3, ES4; EP1; IDE

**Recommendation 1.2.7:** EP1, EP2; IDE

**Recommendation 1.2.8:** ES1, ES2, ES3, ES4; EP1; IDE

**Recommendation 1.2.9:** IDE

**Recommendation 1.2.10:** ES2, ES3, ES10; IDE

**Recommendation 1.2.11:** IDE

**Recommendation 1.3.1:** EA; EP2; IDE

**Recommendation 1.3.2:** EA; EP2; IDE

**Recommendation 1.3.3:** EP2; IDE

**Recommendation 1.3.4:** EA; ES7; IDE

**Recommendation 1.3.5:** EP2; IDE

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<sup>[1]</sup>Charania MR, Crepaz N, Guenther-Gray C et al. (2011) Efficacy of structural-level condom distribution interventions: a meta-analysis of U.S. and international studies, 1998-2007. *AIDS and behavior* 15: 1283–97.

## Recommendations for research

The guideline committee has made the following recommendations for research.

### *1 What measures would make up an effective, standardised approach to evaluation of condom distribution schemes?*

How can we develop a standardised framework to evaluate condom schemes and what would be included in that evaluation?

#### **Why this is important**

Hundreds of condom schemes in the UK are collecting data on usage. But the focus is on the number of condoms distributed and number of users. UK-specific evidence on the effectiveness and cost effectiveness of schemes, using standardised frameworks for data collection and evaluation, would support outcome-based commissioning. It would also allow comparison of the effectiveness and cost effectiveness of different models of condom provision and support local learning. High level area or national datasets would enable more rigorous analysis of the effectiveness and cost effectiveness of different types of scheme.

### *2 How can the effectiveness and cost effectiveness of condom schemes in the UK be improved for people at most risk of STIs?*

How can we ensure the effectiveness and cost effectiveness of the C-Card and other UK-based condom schemes for preventing sexually transmitted infections (STIs) and unintended pregnancies among groups at high risk? What are the essential components of an effective scheme?

#### **Why this is important**

We did not identify any UK-based comparative studies on condom schemes. Information about the essential components needed and how these schemes can be tailored for, and targeted at, different population groups is needed. In addition, information is needed on their impact on STI rates. Based on such data, more effective and cost effective condom schemes can be introduced.

### *3 What behaviour change techniques are most effective as part of a condom distribution scheme?*

What combinations of behaviour change techniques can be used to help condom schemes increase condom use among different high risk groups?

#### **Why this is important**

Many evaluations have been published on behavioural interventions to increase condom use. But the effectiveness of these interventions in the context of condom schemes has not been measured. In addition, many of these studies examined 'intention to use' condoms rather than actual use. Using an established taxonomy of behaviour change techniques to identify the most effective combinations could increase the effectiveness of schemes.

### *4 How can digital technologies be used to increase access to, and uptake of, condom schemes?*

Can digital technologies such as web-based schemes increase access to, and uptake of, schemes among people who live in areas without a face-to-face condom scheme or who would prefer to remain anonymous?

#### **Why this is important**

There is a potential equality issue inherent in providing targeted condom schemes. Increasing access for broader at-risk populations (for example, in rural areas) would help to offset the potential differential effects of these schemes.

### *5 Can GP practices deliver effective and cost effective condom schemes to reduce STIs?*

Can condom schemes be effective and cost effective in GP practices to reduce STIs? Can they be delivered in ways that are acceptable to GPs and other practice staff? In addition, how can the impact of such schemes be maximised?

#### **Why this is important**

Many GPs are interested in delivering condom schemes, and this could have a number of benefits. For example, the UK network of GP practices could improve delivery in rural areas and to other

populations with poor access to services or who do not use existing services. Conversely, some people might be reluctant to get free condoms from their local GP.

## Glossary

### *Black Africans*

The term 'black African' includes anyone who identifies themselves as black African, whether they are migrants from Africa, African descendants or African nationals.

### *Competence*

In this guideline, competence refers to an assessment of whether a young person has maturity and understanding to make decisions and provide consent. This is sometimes called 'Gillick competence' and may be applied through 'Fraser guidelines' (see section 6 of Brook and Public Health England's [C-Card condom distribution schemes](#)).

### *Dental dam*

A thin, square piece of rubber that is placed over the labia or anus during oral-vaginal or oral-anal intercourse.

### *Post-exposure prophylaxis (PEP)*

A month-long course of drugs that can prevent HIV infection after the virus has entered a person's body. The sooner PEP is started, the more likely it is to work. A course of PEP needs to start within 72 hours of exposure otherwise it is unlikely to work.

### *Public sex environments*

Public areas where people go for consensual sexual contact (both same sex and opposite sex).

### *Sex-on-premises venues*

This term is used for commercial venues, as opposed to public spaces and parks, where men who have sex with men can meet and have sexual relations on site. A similar term, 'on-premises club', is used by heterosexual swingers to describe a sex club where non-commercial sexual activity takes place.

For a glossary of public health and social care terms see the Think Local, Act Personal [Care and Support Jargon Buster](#).

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## *Accreditation*

