Sexually transmitted infections: condom distribution schemes

NICE guideline

Draft for consultation, August 2016

This guideline covers condom distribution schemes as a way of preventing many sexually transmitted infections (STIs). They can also provide a good introduction to broader sexual and reproductive health services, especially for younger people, and help prevent unplanned pregnancies.

Who is it for?

- Local authority commissioners of sexual health services and other services for groups at high risk of STIs.
- Providers of condom distribution schemes .
- Practitioners working in sexually transmitted infection (STI) prevention, or in broader sexual and reproductive healthcare.
- Practitioners who work with or support young people and other groups at high risk of STI.

It may also be relevant for:

- Condom manufacturers.
- People who use or are considering using condom distribution schemes, their families and carers, and the general public.

This guideline will supplement NICE guideline PH3 (published February 2007).

This guideline contains the draft recommendations, information about implementing the guideline, context, the guideline committee's discussions and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the

scope, and details of the committee and any declarations of interest.

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Contents

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.

1.1 Targeting services

1.1.1 Provide a range of condom distribution schemes (also known as condom schemes) to meet the needs of the local population, based on local needs assessment, user consultation and local sexually transmitted infection (STI) prevalence rates. This includes multicomponent schemes, single component schemes (free condoms) and cost-price sales schemes. Target these schemes at high-risk groups, for example, men who have sex with men and young people aged 16 to 24. See section 1.2 for schemes suitable for young people and section 1.3 for schemes suitable for adults.

1.1.2 Include condom schemes in services already provided for, or used by, high-risk groups. For example, services provided by the voluntary sector, school health services and community pharmacies.

1.1.3 Ensure links and referral pathways exist between the different types of condom scheme and local sexual and reproductive health services. For example, consider:

- providing condoms in packs that include 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 at high risk of getting an STI. For example, advertise on geospatial social networking apps, websites (such

as the NHS condom locator) and social media, or use posters and leaflets.

1.2 Multicomponent condom distribution schemes for young people in education, youth and outreach settings

1.2.1 For young people up to the age of 25, provide tailored, multicomponent condom schemes in preference to other types of condom distribution scheme.

1.2.2 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).

1.2.3 Ensure the schemes include the following components:

- Assess the competence of young people under 16, and others for whom there is a duty of care, before providing them with condoms.
- Teach young people to use condoms effectively and safely (using education, information and demonstrations) before providing them with condoms.
- Give young people lubricant as well as condoms if they need or want this. Consider providing a range of condom types (for example, latex free) and sizes, female condoms and dental dams.
- Agree a review process for young people using the condom scheme.
- Take into account young people’s age and circumstances. After they have made a specified number of visits to get condoms, allocate time to talk to them again about their relationships and condom use.
- Look out for any signs of child sexual exploitation or abuse (see BASHH and Brook's Spotting the signs of CSE proforma and NICE's guideline on child maltreatment).
- Offer pathways into other services such as pregnancy testing or chlamydia screening.

For further information on best practice see Brook and Public Health England’s C-Card condom distribution schemes.

1.2.4 Ensure services are young person-friendly. Deliver schemes that:

- are confidential
- are in settings that are accessible to young people (for example, in education, youth and outreach settings; in a range of geographical areas; and accessible by public transport)
- are available at times that are convenient for young people (for example, after school, college or university and at weekends)
- meet the Department of Health's You're Welcome criteria for young person-friendly services.

1.3 Condom distribution schemes for adults

Free condoms ('single component' schemes)

1.3.1 Consider distributing free condoms (with lubricant) to men who have sex with men and other high-risk groups through:

- commercial venues (including sex on premises venues), public sex environments and other places where people at high risk of STIs may gather
- voluntary and community organisations that work with people at increased risk, for example, sexual health charities
- local businesses that may be used by people at increased risk of STIs, for example, community pharmacies.

1.3.2 Display supporting information next to supplies of condoms. This could include information about:

- sexual and reproductive health (in line with NICE's guidelines on behaviour change: general approaches and behaviour change: individual approaches)
- reliable sources of further information (for example, NHS Choices)
- local sexual health services.

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

Cost-price sales schemes

1.3.4 Sell cost-price condoms to the wider population using existing sexual and reproductive health services websites, or large-scale national schemes (for example, Freedoms).

1.3.5 Ensure information about using condoms and about sexual and reproductive health is available 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.

Black Africans

Throughout this guideline the term ‘black African’ includes anyone who identifies themselves as black African, whether they are migrants from Africa, African descendants or African nationals. Black African communities encompass diverse population groups, including people:

- from a range of cultural, ethnic and faith backgrounds
- who may have a range of sexual orientations
- whose knowledge or understanding of English may be limited.

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).

Condom distribution schemes

Mainly referred to as ‘condom schemes’ in this guideline. It 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 cheap condoms and lubricant, if appropriate. This includes community schemes that provide cost-price condoms to sex workers, or online services that offer cost-price condoms.

High-risk groups

Groups at high risk of STIs (including HIV and *Chlamydia trachomatis*) may be involved in higher rates of risky sex (for example, they may have multiple partners or frequently change partners). Nationally, the highest levels of STIs are among men who have sex with men, and young people aged 16 to 24. The highest levels of HIV are among men who have sex with men and among black Africans living in the UK. Locally, other population groups may also be identified as high risk. These can be identified using Public Health England’s sexual and reproductive health profiling tool.

Multicomponent schemes

These schemes distribute free condoms with or without lubricant, together with training, information or other support. They include: the C-Card scheme for young people (for details see Brook and Public Health England’s C-Card condom distribution schemes), the use of peer educators, and schemes that distribute free condoms, lubricant and advice to men who have sex with men.

Single component schemes

These schemes provide or distribute free condoms and lubricant, if appropriate. This will include 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.

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 2014, there were approximately 440,000 new diagnoses of sexually transmitted infections (STIs) in England. Most were among heterosexual people aged under 25 and men who have sex with men (Sexually transmitted infections and chlamydia screening in England: 2014 Public Health England). In the UK as a whole, over 6,000 people were diagnosed with HIV in the same time period (National HIV surveillance data tables Public Health England). Over half of these were men who have sex with men (3,360). In the heterosexual population, 1,223 diagnoses were among black Africans.

Condoms can protect people against many STIs including HIV, chlamydia and gonorrhoea (Condom fact sheet in brief Centers for Disease Control and Prevention). 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 additional information or support.

The C-Card scheme is probably the most widespread condom scheme in the UK. Local authorities commission these schemes and define who is eligible, but typically they focus on those aged 13 to 24 (see C-Card condom distribution schemes).

Policy and commissioning

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

Since April 2013, local authorities have been 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 (Brook and Public Health England). NHS England commissions contraception schemes provided as an additional service under the GP contract. It also commissions sexual health services in prisons.

More information

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.

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 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 use condoms to prevent 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 schemes were excluded from the scope. The committee noted that NICE's guideline on the physical health of people in prison (expected to publish in November 2016) will address this issue.

Overview of the effectiveness evidence

The committee expressed its concern about the quality of the evidence on condom schemes. Much of it dated from the 1990s and most was from the US (little evidence from the UK was identified). 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 interventions were identified on the effectiveness and cost effectiveness of the C-Card scheme, which is commonly used with young people in the UK. In addition, much of the evidence focused on condom schemes for HIV prevention, whereas current UK schemes focus on preventing a broad range of sexually transmitted infections (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.

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 for the prevention of STIs and that a focus on avoiding pregnancy would be out of the scope of the guideline.

None of the included or excluded studies reported pregnancy outcomes, but the committee was clear that increasing condom use would help avoid some pregnancies, and indeed many of the proxy measures mentioned above are as relevant to pregnancy prevention as to STI prevention. The costs of these avoided pregnancies were included in the economic analysis.

The committee was reassured by further investigation by the reviewers that not searching for papers evaluating condom schemes using pregnancy outcomes did not mean that a block of evidence had been missed.

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 available evidence

Although the committee was clear that an understanding of behaviour change must underpin these schemes, there was no specific evidence on the behaviour change 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 C-Card schemes currently in operation. A large number of these schemes will be undertaking extensive monitoring and evaluation of their programmes on a regular basis, 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 the potential for 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.

Targeting services

The discussion below explains how we made recommendations 1.1.1 to 1.1.4 and is linked to evidence statements 7 and 10, the economic analysis and expert papers 1 and 2.

The committee discussed the importance of integrating condom schemes with broader services, not just sexual and reproductive health services but, for example, young people's services, education, school nursing and pharmacies. It recognised that local areas needed to plan their own mix of the different types of condom schemes recommended in the guideline based on local patterns of need [EP1, EP2].

Cost effectiveness

The committee heard evidence on the cost effectiveness of condom schemes that showed that such schemes are most cost effective and sustainable if they target people at high risk of STIs and are embedded into existing services. The committee heard from one expert 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. There is therefore a trend of reduction in funding for condom and lube schemes".

The expert noted that commissioners need to work collaboratively and understand the need to commission services for communities of identity, not just geographical communities. Another expert told the committee that in recent years some schemes have been commissioned over larger footprints (multiple local authority boundaries).

Such examples include the Come Correct scheme in London, which is funded across more than 20 local authorities. This enables local areas to buy into a pre designed scheme, enabling added value and the potential to benefit from economies of scale [ES10, EA, EP1, EP2].

Inequalities

However, it also recognised that targeting schemes either by population group or geographical area could lead to inequalities, for example, because people living outside cities may not have access to them. It also noted the lack of evidence relating to some groups, for example, people with learning disabilities. For this reason, the committee kept its recommendations broad where possible. It also agreed that even though the evidence for selling condoms at cost prices was lacking, as long as this could be done in a very low cost way then it would help to offset some of the potential inequalities that could be generated by targeted schemes. It agreed that web-based postal systems for condom distribution especially might help to overcome inequalities related to geographical isolation or stigma [ES7].

Multicomponent condom distribution schemes for young people in education, youth and outreach settings

The discussion below explains how we made recommendations 1.2.1 to 1.2.4 and links to evidence statements evidence statements 1 to 4 , expert paper 1 and the economic analysis.

The committee was aware that providing condoms to young people under 16 required that the young person be assessed to ensure that either they have parental permission, or they demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of condom use. This includes understanding the risks of not using them, and alternative courses of action.

The committee agreed that if there are concerns about a young person's competency to consent to sexual activity, multicomponent schemes are more appropriate, even though they are much more costly. That's because they assess the competence of the young person before admitting them to the scheme. The committee noted that assessment of competence is discussed in detail in the C-Card condom distribution schemes best practice guidance.

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. It was unclear from the evidence [ES1, ES2, ES3] exactly what mix of components made multicomponent schemes more or less effective though, so the committee was unable to make firm recommendations about the exact content of these types of schemes.

Cost effectiveness

The economic analysis used a model scheme that provided education, condoms (via a credit card type C-card) and telephone counselling, because these are common elements. The scheme was cost effective using these elements [EA]. See below for more details of the economic analysis.

The committee agreed that integrating multicomponent schemes into other services might make them more cost effective and more sustainable. But it also noted that cost effectiveness is related to the local prevalence of STIs, HIV and unplanned pregnancies – and that better targeted schemes will be more cost effective [EA, EP1].

Although education and training is a key aspect of multicomponent schemes, members noted that the cost effectiveness modelling showed that this is unlikely to have a major impact on rates of condom failure. However, the committee did agree that high quality condom schemes could be a good introduction to the broader range of sexual and reproductive health services, especially for young people. 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 in the evidence. It agreed that in lieu of this evidence being available, the best practice guidance in C-Card condom distribution schemes is helpful [EP1].

The committee discussed the cost effectiveness analysis of condom schemes for young people. This used effectiveness data from a multicomponent scheme for school students, who were 1.23 times as likely to use a condom compared with students in a school without a scheme. The scheme involved education, a card entitling the students to free condoms, and access to telephone counselling. The

scheme cost £0.48 per person per year. This was calculated from cost data from 4 UK C-Card schemes, which included costs of condoms and lubricants, costs of staff time for training and administration, website costs, advertising costs and costs of the C-Card. STI diagnosis rates were used to judge the prevalence of STIs included in the analysis.

The committee noted that the scheme was cost effective in the base case analysis, for a target population aged 13 to 24. It:

- prevented over 5,000 STIs
- resulted in 55 quality-adjusted life years (QALYs) gained
- had an incremental cost of £957,622 (the incremental cost effectiveness ratio [ICER] was £17,411 per QALY).

The committee noted that effectiveness evidence was for students aged 14 to 18 and may not be directly applicable to those aged 18 to 25, but because there was no specific evidence for this older age range the data was extrapolated to include them.

The committee noted that the ICER of £17,411 was likely to represent an upper bound, and that condom distribution schemes were more cost effective or cost saving in scenario analyses.

A scenario analysis considered that training from multicomponent schemes may reduce condom breakage. This reduced the ICER to £14,469, demonstrating the importance of the inclusion of training in condom distribution schemes.

In scenario analyses, using the same cost and effectiveness criteria, condom schemes were more cost effective in young people over 16 because they were more sexually active and STI prevalence was higher. 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 conventional care.

An economic analysis was also conducted on studies of a population aged 14 to 18 in relation to preventing pregnancies. It assumed that all pregnancies in this age group were unintended and that increased condom use would either delay or prevent

pregnancy, in addition to 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.

Additionally, the committee heard that the use of static model and short time horizon likely underestimated the cost effectiveness of condom distribution schemes.

Condom distribution schemes for adults

The discussion below explains how we made recommendations 1.3.1 to 1.3.4 and links to evidence statements 5 to 7, evidence statement 9, expert papers 1 and 2 and the economic analysis.

The committee discussed the balance between making sure that condoms are available to the widest possible audience and ensuring schemes are cost effective by targeting populations at high risk of an STI.

It agreed that providing condoms freely to people in high-risk groups is important, although it is better if this takes place in the context of broader information provision or education. 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 MSM 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, cost. This is particularly important given the fact that addressing social determinants is an important aspect of HIV prevention" [ES6, EP2].

Cost effectiveness

It also agreed that programmes, particularly large-scale programmes (such as a national web-based scheme) to sell condoms at cost or reduced price, could be cost effective. They would have the added advantage of diminishing some of the potential inequalities in service provision as a result of very specific targeting of condom

schemes – possibly reaching people who would not otherwise be able to access condom schemes. This was particularly felt to be the case for web-based postal schemes [ES7].

The committee noted that specific cost and effectiveness evidence were not available for condom schemes for adults at increased risks of STIs. Cost effectiveness analysis was conducted for 2 groups with increased risk of HIV: men who have sex with men, and black Africans. This showed that distributing condoms for high-risk groups is highly cost effective or cost saving, even with high scheme costs and relatively small effects. In a high-risk population, a small increase in condom usage can avert a number of HIV cases, saving £100,000 and 4.5 QALYs per case. See below [EA].

Men who have sex with men

For groups of men who have sex with men, where HIV prevalence is low (using diagnosis rates, average 0.05%), the committee noted schemes costing up to:

- £5 per person per year would be cost effective or cost saving if they increased condom use by 4%
- £10 per person per year would be cost effective or cost saving if they increased condom use by 6%
- £15 per person per year would be cost effective or cost saving if they increased condom use 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].

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].

General population

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. Delivering these schemes could help people who might not be regarded as high risk to obtain low price condoms and this would help to mitigate any differential impact of this guideline. One of the experts told the committee that providing condoms and lube is particularly important because addressing social determinants is an important aspect of HIV prevention [EP2].

Cost effectiveness

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 high-risk populations 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%.

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: EP1; IDE

Recommendation 1.2.4: ES1, ES2, ES3, ES4; EP1; 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

Gaps in the evidence

The committee's assessment of the evidence and expert comment on condom schemes identified a number of gaps. These gaps are set out below.

1. What do different groups and populations need from condom distribution schemes and how can they be engaged in services?

(Source: committee discussions)

2. Should schemes include female condoms, dental dams and lubricant?

(Source: committee discussions)

Recommendations for research

The guideline committee has made the following recommendations for research.

1 How effective and cost effective are multicomponent condom distribution schemes aimed at young people and adults at high risk in the UK?

How effective and cost effective is the C-card and other UK-based multicomponent condom schemes at preventing sexually transmitted infections (STIs) and unintended pregnancies among young people and adults 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 multicomponent condom distribution schemes. Information about the essential components of these schemes and how they can be tailored and targeted for different population groups would lead to more cost effective and acceptable provision. Information about their impact on STI and unintended pregnancy outcomes, as well condom use at last intercourse, consistent condom use or intention to use condoms is important to rigorously evaluate schemes.

2 What behaviour change strategies are most effective as part of a condom distribution scheme?

What behaviour change techniques can be used with condom schemes to increase condom use among different high-risk groups?

Why this is important

Many evaluations of behavioural interventions to increase condom use have been published. But no evidence was found that measured the effectiveness of these interventions in the context of condom schemes. In addition, many of these studies examined intention to use rather than actual use of condoms. Using effective behaviour change interventions as part of a scheme has the potential to increase its effectiveness.

3 How can local condom distribution schemes best be evaluated?

How can a standardised framework for the evaluation of condom schemes be developed and what would be the components of that evaluation?

Why this is important

There are hundreds of condom schemes in the UK, all of which are collecting data about the number of condoms distributed and number of users. A standardised framework for data collection and evaluation would provide UK-specific evidence on the effectiveness and cost effectiveness of schemes. High level area or national datasets would also enable more rigorous analysis of the effectiveness and cost effectiveness of different types of condom scheme.

4 Can digital technologies increase access to and uptake of condom distribution schemes?

Can digital technologies, for example, web-based postal 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 differential effects of these schemes.

Update information

This guideline is an update of NICE guideline PH3 (published February 2007).

See the original NICE guideline and supporting documents.

Glossary

Geospatial social networking apps

Smartphone applications that people can use to search for sexual partners, based on geographical proximity.

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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