Sexually transmitted infections: condom distribution schemes

Consultation on draft guideline
Stakeholder comments table

05/08/16 – 16/09/16

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ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
PH1	[office use only]	Brook	Full	General		We fully support all three recommendations in this guideline. Easy access to condoms remains important to improving the sexual and reproductive health of young people and other high risk groups. For young people and young men in particular, condom distribution schemes can be a bridge into sexual and reproductive health services. Cuts to public health funding will be the main challenge to implementing these recommendations. We hope that the very clear evidence of cost-effectiveness presented in this guideline will help overcome that challenge. We also have extensive experience of establishing and coordinating condom distribution schemes which is reflected in the C-Card condom distribution schemes guide authored by Brook for PHE and referenced in this guideline.	Thank you for this comment.
2	[office use only]	Brook	Full	4	9	Brook recommends that condom distribution schemes are available to all young people and not restricted to those aged16 and above. Staff must be trained and supported to decide if under 16s can access condoms based on assessments of risk and competence to consent.	Thank you for this comment. The updated guideline had been re-worded to be clear that multicomponent schemes (section 1.2) should be provided in preference to other schemes for young people up to 16 and others for whom there is a duty of care, and considered for other young people up to age 25.
3	[office use only]	Brook	Full	5	5-7	We agree that condom distribution schemes for young people should be multi-component including information and education for young people as well as training for professionals delivering the scheme. Multi-component schemes provide young people with the opportunity to discuss health and wellbeing issues with trained staff, in a confidential environment, as well as learn how to protect their sexual and reproductive health.	Thank you for this comment.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
4	[office use only]	Brook	Full	5 6	4 4	Health settings should also be included here, eg SRH and GUM services, to increase accessibility and encourage young people into such services. Community pharmacies are another location that may improve accessibility to young people, particularly in rural areas.	Thank you for this comment. Health settings have been added in line with your comment.
5	[office use only]	Brook	Full	5	11-28	We would recommend also providing information about emergency contraception so young people know what to do and where to go in the event of a condom failure	Thank you for this comment. What to do and where to go in the event of a condom failure has been added later in section 1.2 of the guideline recommendations.
6	[office use only]	Brook	Full	7	25-27	Gillick competence and Fraser guidelines apply to assessing the competence of young people under 16.	Thank you for this comment. The hyperlink takes readers to the glossary where competence is defined and links to further information are provided.
7	[office use only	Brook	Full	10	17	Data is now available for 2015	Thank you for this comment. The 2015 data has been added to the context section of the guideline and the link updated.
8	[office use only]	Brook	Full	11	19	'Making it work…' was authored by MEDFASH for Public Health England not by Brook.	Thank you for this comment. The reference to Brook has been removed.
9	[office use only]	Christian Medical Fellowship	Short	General		CMF is, of course, in favour of measures that will reduce the transmission rate of STIs. However, we question the validity of the orthodoxy which claims that the key to achieving this goal is more and better-targeted condom provision. Our contention is that evidence suggests condom distribution without behaviour change has had little effect to date, and that to do more of the same is unlikely to produce a different outcome and may even lead to an increase in teen pregnancy. A rigorous new	Thank you for this comment. Although this paper would not have met our inclusion criteria, we are pleased to see that its conclusions support the recommendations that encourage the support of condom provision with interventions that aim to change behaviour, see updated recommendations 1.2.7 and 1.3.2 in particular.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						study (2016) by a pair of Notre Dame economists found that school districts that instituted condom distribution programs in the early 1990s saw significant increases in the teen-fertility rate.[1] That increase was only partially offset in settings where counselling was provided alongside condoms. The same study also found that sexually transmitted diseases (STDs) increased in counties with condom-distribution programs, suggesting that condom-distribution programs encourage sexual risk taking. The researchers suggest that risk-taking may be offset by counselling programmes: 'Because counselling programs commonly promote abstinence and other safe sexual practices, counselling might discourage risky sexual activity that otherwise would be condoned by the presence of condoms in schools' (p19) We advocate a shift in focus from policies aimed at reducing the risks associated with sexual activity to those which are aimed more directly at reducing the level of sexual activity. CMF's view is that we cannot deal effectively with teenage sex and its legacy of sexually transmitted disease without challenging the widely promoted idea that teenage relationships are incomplete without sex. Teenagers need help and support in crossing the border between childhood and adulthood - affirmation from peers, family and friends, accurate information about sex and its consequences and assurance that virginity is good and that saying 'No' is OK	This guideline does not compare condom schemes to other methods of STI prevention (for example abstinence), but rather is focussed on how to distribute condoms in the most cost- effective way.
10	[office use only]	Christian Medical Fellowship	Short	5	8-10	The priority that local sexual health clinics appear to work to is 'safe sex' rather than 'fulfilling relationships'. We do not believe it is inevitable that young people 'will have sex anyway'. Better, surely, to encourage long-term satisfaction rather than immediate gratification, and having the courage to postpone sexual debut rather than succumb to cultural and peer pressures. Towards this goal, the importance of parental and media influences	Thank you for this comment. This guideline does not compare condom schemes to other methods of STI prevention (for example abstinence), but rather is focussed on how to distribute them in the most cost-effective way. However, studies in the reviews that compared abstinence and condom distribution schemes found no difference between groups

[1] http://www3.nd.edu/~kbuckles/condoms.pdf

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						should not be underestimated. Teenagers are more likely to save sex when their parents communicate the importance of doing so.[2] Much evidence points to the effectiveness of maternal involvement in sex education, but the presence of a father is also an important factor in teenagers saving sex until adulthood.[3] Health professionals should ignore the role of parents only as a last resort, not as standard procedure. The Bailey Review findings on the commercialisation and sexualisation of childhood in our culture, and the role of the media in promoting it, are also relevant here.[4] A key factor in the Ugandan success in reducing HIV rates so dramatically during the 1990s was a community wide, mass media communication of messages to achieve the desired outcomes of abstinence and being faithful, in addition to condom use.[5] The Learning and Teaching Scotland (2010) resource[6] highlighted that, '*while important, combining sexual health services and education does not, alone, effect real change. Action is also needed that focuses on improving self-esteem, motivation and achievement. Having a sense of a positive future is argued to play a critical part in achieving positive sexual health and well-being. Parental, family and media influences are also important'*.	in the number of people who had sex (Schuster, 1998 and Furstenberg , 1997).
11	[office use only]	Christian Medical Fellowship	Short	5	general	CMF does not support condom distribution schemes to young people but, if they are to occur, then multicomponent schemes are preferable, linking distribution with education and information that emphasize the 'save sex' message and its benefits, not simply the 'safe sex' message.	Thank you for this comment. The committee agree that multi-component schemes are preferable for young people and have recommended these. Further emphasis has been given to the need

[2] Dilorio C, Kelley M, Hochenberry-Eaton M. Communication about sexual issues: mothers, fathers and friends. *J Adolesc Health* 1999;24:181-9.
[3] McNeely C, Shew ML, Beuhring T, Sieving R, Miller BC, Blum RW. Mother's influence on the timing of first sex among 14 and 15 year-olds. *J Adolesc Health* 2002;31:256-65.
[4] https://www.gov.uk/government/news/bailey-review-of-the-commercialisation-and-sexualisation-of-childhood-final-report-published
[5] Joseph Roundtree Foundation. *"Planned" teenage pregnancy* 2006 www.jrf.org.uk/bookshop/eBooks/9781861348753.pdf.
[6] SPICe Briefing Teenage Pregnancy 22 January 2013. http://scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_13-03.pdf

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						The latter is in any case a misleading term. Sex is not 'safe' when it is dependent on condoms that may sometimes be faulty and are always dependent on correct use.[7] It is not safe when condoms do not protect against HPV, HSV or chlamydia.[8] [9] Indeed the term may give young people a false sense of security such as to put them at greater, not lesser, risk. It is not 'safe' when the likely emotional and psychological costs are factored in. Information about the risks of intercourse under the influence of drugs or alcohol should be included. Sex in such settings is much more likely to result in unplanned pregnancy or transmission of STIs.[10] [11]	for assessment of competence of those under 16 and continued engagement with young people using the scheme in section 1.2 of the guideline. To note that the guideline does not include the term 'safe sex'.
12	[office use only]	Christian Medical Fellowship	Short	5	general	In a recent survey of almost 5,000 15 year olds in NI, 14% were sexually active. But those 15 year olds themselves, when asked, considered that 60%-70% would be sexually active. Education of young people should let them know that not everyone of their age is sexually active and that those who are often regret it.[12] This will lend courage to those young people whose deepest instincts are to save sex for later but who feel intimidated by the thought that 'everyone is doing it' and that they can't afford to be different. The importance of empowering young people by teaching techniques to resist pressure is not highlighted in the guidance as an area that requires equality with providing information on contraception and STIs. In our view, this needs to be remedied. There are numerous organisations providing high quality sex education that recognises the importance of 'saved' sex (ideally saved for marriage, but at the very least for a committed loving	Thank you for this comment. The provision of sex education is outside the scope of this guideline, which is focussed on the provision of condom distribution schemes.

[7]9.Fu H et al. *Fam Plann Persp* 1999; 31:56-63
[8] 20.www.naid.nih.gov/dmid/stds/ condomreport.pdf
[9] 23.Wald A et al. *JAMA* 2001; 285:3100-6
[10][10] Deardorff J et al. Early puberty and adolescent pregnancy: the influence of alcohol use. *Pediatrics* 2005; 116:1451-6
[11] Yan A et al. STD-/HIV-related sexual risk behaviors and substance use among U.S. rural adolescents. *Journal of the National Medical Association* 2007; 99:1386-94
[12] Dickson N et al. First sexual intercourse: age, coercion, and later regrets reported by birth cohort. *BMJ* 1998; 316:29-33

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						relationship) as well as 'safer' sex (which usually equates to using a condom). Their websites[13] contain links to a wealth of resources which when combined give a truly comprehensive sex education package.	
13	[office use only]	Christian Medical Fellowship	Short	5	12	Assessment of competence must be more than a box-ticking exercise by those whose priority is simply to ensure safe sex. Intercourse with an under-aged girl is still a criminal offence, notwithstanding Home Office advice.[14] Consideration should be given to whether a 13 year old girl has sufficient emotional and psychological maturity to consent. Evidence exists suggesting sex experience before confidentiality, empathy and trust have been established can hinder and may destroy the possibility of a solid permanent relationship.[15] Sabia found a link exists between early experience of sex and depression in teenage girls.[16] Routine provision of condoms cannot be in the best interests of young teenagers.	Thank you for this comment. Recommendation 1.2.5 contains details of how condom providers should act to protect the safety of young people. This includes assessing competence (using the Gillick/Fraser framework), agreeing a review process that takes into account the young persons age and circumstances, repeated discussions about their relationships and condom use and assessment of any signs of exploitation and abuse. The committee discussion section also includes further consideration of the issues around safeguarding for young people accessing condom distribution schemes.
14	[office use only]	Christian Medical Fellowship	Short	6	2	Parental involvement should normally be sought, and invariably so where younger teens are involved. Fraser guidelines permit proceeding without parental knowledge, but Lord Fraser also stated in his ruling that: 'Any important medical treatment of a child under 16 would normally only be carried out with the parents' approval' and it should be: '…most unusual for a doctor to advise a child without the knowledge and consent of parents on contraceptive matters.' [17] DH guidance states that: 'The duty of confidentiality is	Thank you for this comment. Parental involvement is an important part of the assessment of competence - one of the criteria in the Fraser guidelines addresses this point: "Could the young person be persuaded to inform his or her parents or carers that they are seeking contraception?". This issue is highlighted in the committee discussion

[13] www.loveforlife.org.uk; www.evaluate.org.uk; www.oasisuk.org/article.aspx?menuid=865; www.lovewise.org.uk; www.lifeuk.org./education/relationships; www.challengeteamuk.org; www.damaris.org/savingsex; http://www.love2last.org.uk/

[14] Home Office, Children and Families: *Safer from Sexual Crime* – The Sexual Offences Act 2003, London: Home Office Communications Directorate, 2004. Read more at http://www.fpa.org.uk/factsheets/law-on-sex#fupXTiyb1kEwl7B8.99

[15] Calderone, M, quoted in Collins R. A physician's view of college sex. *JAMA* 1975; 232:392

[16] Sabia J, Rees D. The effect of adolescent virginity status on psychological well-being. *Journal of Health Economics* 2008; 27:1368-1381

[17] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL). bit.ly/2aYvtBH

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						not absolute. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow locally agreed child protection protocols.'[18]	section of the guideline.
15	[office use only]	Christian Medical Fellowship	Short	5	14	Information about contraception should be given in the context of lessons about mutual worth, respect for self and others, freedom from peer pressures and the courage to resist cultural trends and make one's own decisions in line with one's most deeply held instincts. The likely emotional cost of saying yes to sex early in a relationship only for it all to 'end in tears' should be considered. Contraception cannot protect the heart! Regret at surrendering cheaply something of such worth is ubiquitous. A number of research studies have shown that teenagers often regret the age when they started having intercourse, and over 40% of teenagers in the UK give peer pressure as the reason for first intercourse.[19] *Sex education should focus on values, not simply on technicalities*. There is considerable evidence that simply increasing the availability of contraception to teenagers without accompanying education on the importance of saving or delaying sex leads to more sexually transmitted infections (and unplanned pregnancies) rather than fewer.[20] [21] Paton found that where there was an emergency birth control scheme operating, STI rates for under 16s increased by 12%. Young people aged 16-24 were the most affected group, accounting for 50-65% of all newly-diagnosed STIs in the UK in 2007.[22]	Thank you for this comment. The committee felt that the recommendations in 1.2 did emphasise the need for tailored information, assessment and continued engagement with young people using condom distribution services to enable discussion of the issues that have been raised.

[18] *Best Practice Guidance For Doctors And Other Health Professionals On The Provision Of Advice And Treatment To Young People Under 16 On Contraception*, Sexual And Reproductive Health, DH, Gateway Reference Number 3382, 29 July 2004. bit.ly/2ayXnOM
[19] *'Teenage Sex'*, Trevor Stammers, CMF File 37, 2008. http://www.cmf.org.uk/publications/content.asp?context=article&id=2184
[20] http://www3.nd.edu/~kbuckles/condoms.pdf
[21] Paton D. Random behaviour or rational choice? Family planning, teenage pregnancy and sexually transmitted infections. *Sex Education* 2006;6:281-308
[22] http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1216022460726

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						Easier access to condoms reduces the perceived cost of sexual activity and makes it more likely (at least for some teenagers) that they will engage in sexual activity. This phenomenon, sometimes known as 'risk compensation',[23] results in an increase in the very thing it is trying to prevent and in this context will trend towards an increase in rates of STIs.	
16	[office use only]	Christian Medical Fellowship	Short	5	27	It must be made clear that condoms do not effectively protect from the risk of chlamydia, herpes and HPV, even when used consistently and competently. In one study, among clients with known exposure, 13.3% of consistent condom users were diagnosed with *C trachomatis* infection compared to 34.4% of inconsistent condom users.[24] The figures are worse for HPV and Herpes, condoms providing little or no protection.	Thank you for this comment. The wording has been clarified in the landing page for the guideline which states that condoms protect against 'many' sexually transmitted infections.
17	[office use only	Department of Health	Full	General	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for this comment.
18	[office use only]	Devon Youth Service]		P15	16plus	We agree that multicomponent schemes are the most flexible and appropriate for young people. We have found the CCard scheme helpful and useful. The ability to assess competence is crucial.	Thank you for this comment.
19	[office use onl	Devon Youth Service]		P5	24	Really pleased to see the reference to CSE in Devon C card scheme first meeting this is covered it would be good to know that any adopted scheme considers these risks.	Thank you for this comment.
20	[office use only]	Family Education Trust	Full	General	General	Guidance issued by the Centers for Disease Control and Prevention states that: 'Abstinence or mutual monogamy with an uninfected partner is the most reliable way to avoid acquiring and transmitting' STIs (Ref 3). Yet the NICE draft guideline makes no reference to the value of promoting the benefits of abstinence or mutual monogamy with an uninfected partner as the most effective ways of preventing STI transmission.	Thank you for this comment. This guideline focuses specifically on condom distribution schemes and the scope of the guideline did not cover sexually transmitted infection prevention more widely and therefore has not looked at the broader evidence.

[23] http://en.wikipedia.org/wiki/Risk_compensation

[24] Niccolai L et al. Condom effectiveness for prevention of Chlamydia trachomatis infection. *Sex Transm Infect*. 2005 Aug; 81(4): 323–325.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
21	[office use only]	Family Education Trust	Full	General	General	The draft guideline makes several references to the provision of condoms to adolescents as young as 13. While it refers to 'the competency to consent' and the need to assess whether a young person has the necessary maturity and understanding to provide consent, it omits to note that young people under the age of 16 are below the legal age of consent to sexual intercourse. The draft guideline also omits to consider the possibility that condom schemes catering for under-16s may have the effect of condoning unlawful sexual activity. Professor David Paton has noted that during the months following the Court of Appeal's ruling in favour of Victoria Gillick in December 1984, attendances by under-16s at family planning clinics decreased by over 30 per cent, but concerns that there would be a corresponding rise in the under-16 conception and abortion rate did not materialise. This suggests that confidential contraceptive provision may increase the likelihood that some young people under the age of 16 will become sexually active when they might not otherwise have done so (Ref 4).	Thank you for this comment. The C-Card guidance from Brook and PHE (see https://www.brook.org.uk/about-brook/c-card-guidance), states that "The law is clear that young people can be provided with condoms" (p.21) The committee considered evidence that showed that condom schemes do not increase levels of sexual activity among young people. Please see the committee discussion section of the guideline for how the committee considered the evidence and made recommendations.
22	[office use only]	Family Education Trust	Full	4	14	We question the appropriateness of including condom schemes in school health services. Where condoms are provided to pupils under the age of 16 on school premises, the impression is given that the school is countenancing unlawful sexual activity and restraints against underage sex are removed. Since there is evidence that school–based interventions are made more effective by parental involvement (Ref 5), the guidance should stress the importance of schools consulting with parents about contraceptive advice offered on school premises. At present there is only a single passing reference to parents in the draft guideline.	Thank you for this comment. The C-Card guidance from Brook and PHE (see https://www.brook.org.uk/about-brook/c-card-guidance), states that "The law is clear that young people can be provided with condoms" (p.21). The committee did not find any evidence to suggest that parental involvement in condom distribution schemes made them more effective.
23	[office use only]	Family Education Trust	Full	5	17-18	What young people 'want' and what they 'need' are not necessarily the same thing. Young people under the age of 16 may 'want' lubricant and condoms, but they do not 'need' them any more than a young person under the age of 17 'needs' car keys in order to facilitate his or her desire to engage in unlawful activity.	Thank you for this comment. The use of the word 'need' in the recommendation is in reference to anal intercourse. Condom failure rates in anal intercourse are much higher in the absence of water based lubricants.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
24	[office use only]	Family Education Trust	Full	5	24	Looking out for signs of child sexual exploitation or abuse is necessary, but one of the sad consequences of taking a relaxed attitude towards underage sexual activity is that all too often it has been assumed that young people are demonstrating maturity simply by virtue of seeking contraception and cases of exploitation have gone undetected. As serious case reviews in Rochdale, Rotherham and Oxfordshire have demonstrated, victims of sexual abuse were deemed to be making 'a lifestyle choice' and 'having consensual sexual intercourse when in fact they were being raped and abused by adults' (Refs 6-8). In this context, condom distribution schemes may be part of the problem rather than a solution. We are concerned about the implications of the draft guideline for child protection with regard to the way that it undermines the protective principles that lie at the heart of the law on the age of consent.	Thank you for this comment. The committee were very clear about the importance of safeguarding young people and have therefore included this within the recommendations for section 1.2.There is also additional information on safeguarding in the committee discussion section of the guideline.
25	[office use only]	Family Education Trust	Full	6	2	In the case of young people under the age of 16, we question the commitment to confidential contraceptive services. Confidentiality policies undermine the role of parents who continue to bear the legal responsibility for the care and protection of their children. There is also evidence that such confidentiality policies may prove counterproductive. In the United States teenage conception and abortion rates have declined more rapidly in areas where mandatory parental notification laws have been in place, prohibiting the supply of contraception and emergency hormonal birth control to underage young people without the involvement of parents (Ref 9). Studies have also found that high levels of perceived parental supervision are associated with a reduced incidence of STIs (Ref 10). **References** 1. Richens J, Imrie J, Copas A, 'Condoms and Seat Belts: The Parallels and the Lessons', *The Lancet*, 2000, 355, 400-4. 2. Cassell MM, Halperin DT, Shelton JD, Stanton D, 'Risk compensation: the Achilles' heel of innovations in HIV prevention?'	Thank you for this comment. The role of parenting per se is outside the scope of this guideline. Parental involvement is an important part of the assessment of competence. This issue is highlighted in the committee discussion section of the guideline.

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						BMJ 2006, 332, 605-7 3. *CDC Health Information for International Travel 2016, Chapter 3.* 4. Paton, D., 'The economics of family planning and underage conceptions', *Journal of Health Economics* 21 (2002) 207-225. 5. Blake S, Simkin S, Ledsky et al., 'Effects of parent-child communications intervention on young adolescents' risk for early sexual intercourse', *Family Planning Perspectives* 2001, 33, 52-61. 6. Rochdale Borough Safeguarding Children Board, *The Overview Report of the Serious Case Review in respect of Young People 1,2,3,4,5 & 6*, December 2013; Rochdale Borough Safeguarding Children Board, *The Overview Report of the Serious Case Review in respect of Young Person 7*, December 2013. 7. Alexis Jay OBE, *Independent Inquiry into Child Sexual Exploitation in Rotherham 1997–2013*, August 2014. 8. Alan Bedford, *Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F, approved by the Oxfordshire Safeguarding Children Board*, 26 February 2015. 9. Levine P B, 'Parental involvement laws and fertility behavior', *Journal of Health Economics*, 2003: 22, 861-78. 10. Bettinger JA, Celentano DD, Curriero FC et al., 'Does parental involvement predict new sexually transmitted disease in female adolescents?' *Arch Pediatr Adolesc Med* 2004, 158, 666-70.	
37	[office use only]	Family Planning Association	Full	6	9	We would also recommend that young people are consulted in the design of these services, so that they truly reflect the needs of young people.	Thank you for this comment. The first recommendation in the guideline refers to local needs assessment and user consultation. Implementation issues are linked to from the 'Putting this guideline into practice' section of the guideline.
38	[office use only]	Family Planning Association	Full	General	General	Although it is positive to see young people and men who have sex with men targeted, it is important to ensure that condom distribution schemes remain accessible to people who fall outside of risk groups. We welcome the recognition of the importance of widespread information provision and education	Thank you for this comment. To note that the guideline has broad recommendations about condom provision and sale. However, the highest prevalence groups for sexually transmitted infections are men who have sex with men and young people from 16 – 24. The economic analysis indicated that for schemes to be most cost effective they need to be targeted towards higher prevalence populations.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
39	[office use only]	Greater Manchester Sexual Health Commsioners	Main doc	P5	Line 11	general comment re safeguarding – we feel this section needs strengthening to indocate that the contact point will meet the immediate need for contraception while also ensuring safeguarding needs are met.	Thank you for this comment. The guideline committee discussed safeguarding and the issue raised. The recommendation on safeguarding in section 1.2 of the guideline was strengthened and made clearer but the committee considered that the decision to meet immediate needs for contraception should remain with the accountable person. Therefore specific reference to this is not made in the recommendation.
40	[office use only]	Greater Manchester Sexual Health Commsioners	Main doc	C card		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**. Is this really a strong enough base from which to design a condom distribution scheme? It would be useful to evaluate the experience of using C card schemes from young people's perspective and see if in the digital world today for young people is c card still relevant, or is it a barrier to condom use?	Thank you for this comment. The committee discussed this issue and agreed to prioritise how to evaluate condom distribution schemes to ascertain their effectiveneness in the research recommendations.
41	[office use only]	Greater Manchester Sexual Health Commsioners	Main doc	Normalisation of condom use		The whole document would be strengthened by an every contact counts approach to condom distribution – the role of the school nurse, the GP, the sexual health clinic.	Thank you for this comment. The committee did not identify any specific evidence on an Every Contact Counts approach to condom distribution that met the inclusion criteria for the evidence reviews.
42	[office use only]	Hertfordshire County Council	Guidelines	5	14 General	How do you define 'teach' - shown a short film, information/instructions provided in a leaflet, one to one discussion with youth worker? The guidelines do not reflect why and how young people want to access information. We will be undertaking our own young people's consultation on CDS to identify is we are meeting their needs. What was learnt from the PHE 'rise above' campaign?	Thank you for this comment. This guideline is about providing condom distribution schemes. No evidence was identified relating to young people's information needs from condom schemes that met the inclusion criteria for this work. We are aware that there is more information on the detail of C-Card schemes in the best practice document produced by Public Health England, which is flagged for information within section 1.2 of the guideline.

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43	[office use only]	Hertfordshire County Council	Guidelines	5	30	If there is a lack of evidence on C-CARD schemes (page 16, line 23), why is this seen as 'best practice' and the only approach recommended for under 25 years? . C-CARD is mainly aimed at under 18's. What about support for 18-25 years?	Thank you for this comment. The updated guideline is clearer on the age groups to which the different condom schemes should be targeted. C-Card schemes are a type of multicomponent scheme and the committee considered that other kinds of multicomponent scheme were effective. For this reason, they concluded that C-Card schemes were likely to be effective. There is duty of care to provide multi-component condom distribution schemes for people up to the age of 16 but the committee agreed they should also be considered for people up to the age of 25. Additional reasons for recommending schemes to young people are in the discussion section of the guideline. The updated guideline is clearer that multicomponent schemes are not the only approach recommended for under 25s. Recommendation 1.3 recommends distribution of free condoms to high-risk groups (16-24 year olds are the second highest risk group in England) and recommends selling cost-price condoms (to the local population.
44	[office use only]	Hertfordshire County Council	Guidelines	5	general	There is no reference or consideration to use single component schemes (free condoms via community settings, health services, online) with young people especially those who are high risk, over 16's or those who will not access multi component schemes e.g. C-CARD. Example: 1) If our services are working with young gay men (18- 25) in an outreach setting (e.g. night club, public sex environment), are we expecting staff to only offer a multicomponent scheme, and not distribute at point of contact?? 2) During Fresher week at the local university, is any distribution of condoms only limited to a multicomponent schemes? Could a single component method be used with a recommendation to signpost/encourage young people to	Thank you for this comment. The updated guideline is clearer on the age groups to which the different condom schemes should be targeted. The recommendations and the discussion in the updated guideline are clearer that schemes are not mutually exclusive (i.e. an individual who is 18 may be able to access a multicomponent schemes, single distribution scheme or buy cost price condoms. However, there is duty of care to provide multi-component condom distribution schemes for people up to the age of 16 but the committee agreed they should also be

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						access multicomponent schemes and other sexual health services? The guidelines do not offer any flexibility with high risk groups 16-25 years. This restricts access especially when providing opportunistic sexual health interventions.	considered for people up to the age of 25
45	[office use only]	Hertfordshire County Council	Guidelines	6	3	We support the need to provide condoms in a range of settings working with high risk groups e.g. Pharmacies providing EHC. However, we are unable to fund services to provide multicomponent schemes (C-Card), limiting the number of CDS for over 18 year olds e.g. pharmacies, GP's. This is reflected in the attendance data we collect for C-card, which shows poor uptake for those aged 17+ years.	Thank you for this comment.
46	[office use only]	Hertfordshire County Council	Guidelines	6	10	Is adult defined as over 25?	Thank you for this comment. The reference to adult in single component schemes has been removed from the updated guideline. The guideline does not define adult. The recommendations and the discussion in the updated guideline are clearer that schemes are not mutually exclusive (i.e. an individual who is 18 may be able to access a multicomponent schemes, single distribution scheme or buy cost price condoms. However, there is duty of care to provide multi-component condom distribution schemes for people up to the age of 16 but the committee agreed they should also be considered for people up to the age of 25.
47	[office use only]	Hertfordshire County Council	Guidelines	8	26	Does NICE support online schemes? Would they recommend this for young people over 16 who fall within a high risk group e.g. MSM, black African? How do they recommend appropriate targeting and safeguarding? Based on these recommendations are you suggesting current online schemes do not provide condoms for those under 25 years?	Thank you for this comment. Recommendation 1.3 recommends cost-prices sales of condoms via online schemes. The committee did not see any evidence relating to free condom provision via online schemes and so has not made a recommendation about this. A research recommendation has been made about digital technologies. The recommendations have been rewritten to ensure that they do not imply that people under age 25 are ineligible from accessing single component schemes.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
48	[office use only]	Hertfordshire County Council	Guidelines	12	14	We support the need to target the most at risk groups highlighted e.g. MSM, Black African, 16-24 year olds.	Thank you for this comment.
49	[office use only]	Hertfordshire County Council	EQIA	1	1.1	Age: If you are stating a different need amongst younger adults compared to young people, why is not reflected in the guidelines? There needs to be consistency with language. How do you define a younger adult? We believe that only recommending one approach for all under 25's impacts on an individual's access to services and how they are treated. The needs of a 15 year old at school are different from a 22 year old living in sheltered accommodation.	Thank you for this comment. This is a misinterpretation of what was intended. The recommendations and the discussion in the updated guideline are clearer that schemes are not mutually exclusive (i.e. an individual who is 18 may be able to access a multicomponent schemes, single distribution scheme or buy cost price condoms. However, there is duty of care to provide multi-component condom distribution schemes for people up to the age of 16 but the committee agreed they should also be considered for people up to the age of 25.
50	[office use only]	Hertfordshire County Council	EQIA	5	3.2	If those living in rural areas might not be able to access multi-component schemes and schemes that did not providing education and support to young people and vulnerable groups would be inappropriate – what is the alternative? As a harm reduction measure, surely some access to condoms would be a better alternative than not to offer any? Does this not increase risk?	Thank you for this comment. This is reflected in the equality impact assessment for the guideline and in the committee discussion. However, the evidence the committee considered did not provide a solution to this issue, which will need to be tackled locally. Section 1.1 of the guideline recommends including condom schemes in existing general services, for example through primary care and pharmacy which may help to address inequity. People may be able to access condoms online too, for example (see section 1.3 of the guideline). A research recommendation has also been made about digital technologies.
68	[office use only]	Middlesbrough Council No nominated lead as far as we are aware			1.1.1	Boys and young men should be really mentioned as a separate targeted group.	Thank you for this comment. None of the evidence that the committee saw indicated that boys and young men should be mentioned as a separate group within in the recommendations.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
69	[office use only]	Middlesbrough Council No nominated lead as far as we are aware			1.2.3	No mention of Delay discussions in distribution which is surprising considering schemes should be promoting that young people are less likely to have sexual activity under the age of 16; and first time sex for both boys and girls is 16 (Wellings et al)	Thank you for this comment. The committee discussed encouraging delay of sexual activity in young people. They agreed that recommendations in section 1.2 of the guideline do cover this, in particular the need to tailor information and advice according to a young person's needs and circumstances.
70	[office use only]	Middlesbrough Council No nominated lead as far as we are aware			Not referenced	I am not aware of guidance available on the promotion of flavoured condoms for young people, are NICE able to provide any evidence base to the use of Flavoured condoms for use for penetrative (Anal/Vagainal) intercourse and should schemes be promoting flavoured condoms for the acts or only be promoting for oral sex. This has came up as a potential point of conflict between two schemes operating in the Middlesbrough area so was after further feedback or evidence on the matter.	Thank you for this comment. No evidence relating to flavoured condoms was identified during the production of this guideline.
71	[office use only]	[Northern Health & Social Care Trust]	Full	5	23	Additional consideration: in the scheme which we are involved in we consider CSE issues but also alcohol/drug issues and how this impacts a person's ability to consent, increase vulnerability etc. We have found that in terms of training the scheme operators consent is something that we have had train on thoroughly not just in terms of age which is the notion where we have found those we train default to. Not to assume heterosexuality so to ensure that scheme operator can ensure they are given the right information to higher risk groups. We have also had examples where scheme operator assumed sexuality activity of a service user where this was not yet the case…. So guidance should suggest not to assume this and have young person feeling awkward or close down a conversation and to normalise people attending prior to sexual activity. Ensure that we use the opportunity provided by the scheme so that young people know they can delay or abstain from sexual activity even if they have been previously active.	Thank you for this comment. The committee discussed the points raised and added an explicit reference to drugs and alcohol to the recommendations. The guideline will also be published as a pathway that will link to other NICE guidelines on the issues raised.
72	[office use only]	Nottingham University Business	Full	12	7-8	No evidence at all is provided that "condom distribution schemes may lead to … preventing unplanned pregnancies". It is quite inappropriate for recommendations to be based on such an	Thank you for this comment. The committee considered evidence that showed that condom distribution schemes increase

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		School				evidence-free assumption. Indeed, the most recent evidence [Buckles and Hungerman, 2016 – discussed below] suggests that condom distribution schemes may increase teen births. Reference: Buckles, K.S. and D.M Hungerman (2016), 'The incidental fertility effects of school condom distribution programs', *NBER Working Paper* 22322, June.	condom use. Increased condom use, even taking into account condom failure will lead to decreased conception. The economic modelling work undertaken for this guideline demonstrated that when pregnancy is taken into account, condom distribution schemes are cost saving.
73	[office use only]	Nottingham University Business School	Full	13	6-7	A paper published subsequent to the Draft [Buckles and Hungerman, 2016] provides direct evidence on the impact of condom distribution programmes in schools on teenage STIs. Although this study was published after the cut-off point for the Review, given the lack of evidence in existing studies on these outcomes, it is essential that the Evidence Review is updated to examine its findings. The Economic Evaluation and Draft Recommendations are likely to need revising given that the study finds gonorrhoea rates for women increased following condom provision. Reference: Buckles, K.S. and D.M Hungerman (2016), 'The incidental fertility effects of school condom distribution programs', *NBER Working Paper* 22322, June.	Thank you for this comment. The committee discussed this paper. It had not been published in a peer-reviewed publication and did not meet the inclusion criteria for the review.
74	[office use only]	Nottingham University Business School	Full	13	10-17	The assertion that "the committee was clear that increasing condom use would help avoid some pregnancies" is misleading and should be deleted. In the first place, the issue is not whether "condom use" prevents pregnancies but whether condom distribution schemes prevent pregnancies. It is possible that condom use prevents pregnancies but that condom distribution schemes do not, either because they do not increase condom use and/or because they induce an increase in risk taking sexual behaviour which cancels out any beneficial effect of increased condom use. Second, the Evidence Review reports no research to support the assertion that condom use (or condom distribution schemes) do in practice reduce teen/unwanted pregnancies. Third, a paper published subsequent to the Draft [Buckles and Hungerman, 2016] provides direct evidence on the impact of	Thank you for this comment. The committee saw no evidence that supported the theory that condom distribution scheme increase the number of unintended pregnancies. The committee discussed the Buckles paper. It had not been published in a peer-reviewed publication and did not meet the inclusion criteria for the review.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						condom distribution programmes in schools on teenage fertility and finds that, overall, condom promotion schemes increased teen births. Given that this is apparently the only study looking at pregnancy outcomes it is essential that the Evidence Review, Economic Evaluation and Recommendations are updated to consider its findings. Reference: Buckles, K.S. and D.M Hungerman (2016), 'The incidental fertility effects of school condom distribution programs', *NBER Working Paper* 22322, June.	
75	[office use only]	Nottingham University Business School	Full	13	19-21	The statement that "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" does not adequately reflect the strength of the evidence presented in the Evidence Review. ES1 discusses one paper [Guttmacher et al, 1997] which examines rates of sexual activity and finds no significant difference in sexual activity between intervention and control group. The data from this paper comes from 1991 and the methodology is weak in that there is no comparison of relative changes before and after the condom promotion scheme. This study is given the weakest possible quality grading. ES5 discuss two relevant papers. One paper [Kirby et al, 1999] reports no difference in onset of sexual activity but lower rates of sexual activity amongst the intervention group. Crucially, however, this study reported that condom promotion also led to a significant reduction in condom use at last sex, relative to the control group. This study is also based on data from over 20 years ago and is given the weakest possible quality grading. A second paper [Schuster et al, 1998] reports no significant change in sexual activity or its onset before and after intervention. The paper is given an intermediate quality rating [+], despite the fact that no control group is used. Again, the data in this paper is over 20 years old. Regarding Kirby et al (1999), it is misleading to report this as finding evidence that condom schemes do not increase levels of sexual activity without making clear that this is in the context of a scheme	Thank you for this comment. Guttmacher find there is no difference in sexual activity between intervention and control. Kirby et al find no difference in mean age of first intercourse and a (non-significant decrease in amount of sexual activity). A decline in condom use does not necessarily correlate to whether condoms increase or decrease sexual activity. Schuster, notes no change in sexual activity, The paper mentions (in the discussion) a change in "sexual activities other than vaginal intercourse", but casts doubt on these being caused by the condom distribution scheme. The Buckles paper reference notes that "The majority of the empirical evidence on this question finds that condom programs did not increase teen sexual activity; examples include Martinez-Donate et al. (2004), Blake et al. (2003), and even the above Kirby et al. (1999). Wretzel et al. (2011) show that a condom availability program lowered STI rates in one school district.(p.5)" After reconsidering this evidence and using their expertise in the area, the committee

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						which actually reduced condom use, i.e. had the opposite effect to that intended. Clearly this is within the definition of an "unintended consequence" and should be reported as such. Regarding Guttmacher et al (1997) and Schuster et al (1998), these do not provide evidence that "condom schemes do not increase levels of sexual activity". Rather they suggest that there is not sufficient evidence to conclude that levels of sexual activity increase. Put another way, not rejecting a null hypothesis of no effect is not the same as finding positive evidence of no effect. A further and crucial point, noted below, is that ES5 discussion ignores findings from one of the papers [Schuster et al, 1998] that some forms of sexual activity increased significantly following intervention. The Evidence Review needs to be revised to reflect this. Given these points a more appropriate statement relating to Unintended Consequences based on the Evidence Review would be something like this: "The evidence on whether condom schemes have unintended consequences is weak and out of date. Those studies which do exist provide mixed evidence on whether condom schemes increase levels of risky sexual activity. There is some evidence that condom schemes can reduce the rate of condom use."	remained of the opinion that condom schemes do not increase sexual activity among young people.
76	[office use only]	Nottingham University Business School	Full	13	19-21	The section on unintended consequences should clarify the state of knowledge regarding unintended consequences for men who have sex with men (MSM) and for the general population. ES6 reports one study in which condom distribution in London commercial gay venues had an effect on some measures of condom use (e.g. to be carrying condoms whilst out in gay venues) but that "There was no statistically significant change in frequency of unprotected anal intercourse". The implications of this study for inferences about unintended consequences should be considered	Thank you for this comment. The committee were content with the statement as it stood and the support which it provided to the development of recommendations.
77	[office use only]	Nottingham University Business	Full	17	27-29	It is highly unsatisfactory to rely on an economic analysis which "assumed that … increased condom use would either delay or prevent pregnancy". The Evidence Review makes clear that there is	Thank you for this comment. The committee discussed the Buckles paper. It had not been published in a peer-reviewed publication and

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		School				no evidence to support this assumption. Indeed, a more recent study by Buckles and Hungerman (2016) suggests condom distribution may have the opposite effect. Simply to assume an effect and calculate the cost savings is meaningless. At the very least, the economic evaluation should attempt to model scenarios in which condom distribution leads to (i) a decrease condom use; (ii) no change in condom use; (iii) an increase in risky sexual activity amongst young people; (iv) an increase in the number of teenage pregnancies. Reference: Buckles, K.S. and D.M Hungerman (2016), 'The incidental fertility effects of school condom distribution programs', *NBER Working Paper* 22322, June.	did not meet the inclusion criteria for the review. The committee saw no evidence that condoms distribution schemes decrease condom use, increase risky sexual activity or increase the number of teenage pregnancies and therefore these scenarios were not considered in the economic model. More information about the evidence the committee considered is discussed in detail in the committee discussion section of the guideline.
78	[office use only]	Nottingham University Business School	Full	19	12-23	The Statement should be revised to emphasise that the Evidence Review did not find good evidence that condom distribution schemes increased condom use for men who have sex with men (MSM). The Economic Evaluation should report the cost effectiveness of scenarios in which condom distribution leads to (i) a decrease condom use; (ii) no change in condom use; (iii) an increase in risky sexual activity amongst MSM.	Thank you for this comment. The committee saw no evidence that condoms distribution schemes decrease condom use or increase risky sexual activity and therefore these scenarios were not considered in the economic model. More information about the evidence the committee considered is discussed in detail in the committee discussion.
79	[office use only]	Nottingham University Business School	Full	20	5-26	The Statement should be revised to emphasise that the Evidence Review did not find strong evidence that condom distribution schemes increased condom use in the general population. The Economic Evaluation should report the cost effectiveness of scenarios in which condom distribution leads to (i) a decrease condom use; (ii) no change in condom use; (iii) an increase in risky sexual activity amongst the general population.	Thank you for this comment. The committee saw no evidence that condoms distribution schemes decrease condom use or increase risky sexual activity and therefore these scenarios were not considered in the economic model.. More information about the evidence the committee considered is discussed in detail in the committee discussion.
80	[office use only]	Nottingham University Business School	Evidence Review	General	General	A paper published subsequent to the Draft [Buckles and Hungerman, 2016] provides direct evidence on the impact of condom distribution programmes in schools on teenage fertility and STIs. Although this study was published after the cut-off point for the Review, given the lack of evidence in existing studies on these outcomes, it is essential that the Evidence Review is updated to incorporate the findings.	Thank you for this comment. The committee discussed the Buckles paper. It had not been published in a peer-reviewed publication and did not meet the inclusion criteria for the review. The committee did not see any evidence that indicated that condom distribution schemes increase teenage pregnancies or increase sexual transmitted

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						Reference: Buckles, K.S. and D.M Hungerman (2016), 'The incidental fertility effects of school condom distribution programs', *NBER Working Paper* 22322, June.	infections. More information about the evidence the committee considered can be found in the committee discussion section of the guideline.
81	[office use only]	Nottingham University Business School	Evidence Review	28	ES5	In the discussion of Schuster et al (1998) it is stated "there was no difference in onset of, or increase in sexual activity". This statement needs amending to reflect the fact that Schuster et al report significant increases in several forms of sexual activity, most particularly as reported by females.	Thank you for this comment. Schuster reports an increase among women of non-vaginal sexual activity, which the committee regarded as a positive outcome. This is reported in the discussion section of the paper.
82	[office use only]	Nottingham University Business School	Health Economics Report	General	General	The economic evaluation is deficient in that no attempt is made to model the effect of behaviour change arising from condom distribution schemes. The evidence is too weak to exclude the possibility that condom schemes can increase risky sexual activity. Given how crucial this factor may be in evaluating cost effectiveness, the economic evaluations for young people, MSM and the general population should include scenarios in which there are such unintended consequences.	Thank you for this comment. The committee reconsidered the evidence and did not agree with the conclusion that condom distribution schemes may increase risky sexual activity. Therefore, they were of the view that the approach to the economic modelling was appropriate.
83	[office use only]	Nottingham University Business School	Health Economics Report	General	General	Given that the evidence on the effect of condom distribution schemes on condom use is mixed with some studies finding that condom use decreases, all the economic evaluations should include scenarios in which condom use (i) does not change and (ii) goes down following condom distribution schemes.	Thank you for this comment. The committee did not agree with the conclusion that condom distribution schemes may decrease condom use. Therefore, they were of the view that the approach to the economic modelling was appropriate.
84	[office use only]	[Royal College of Nursing]	General	General	General	The Royal College of Nursing welcomes the opportunity to review and comment on this draft guidance. The RCN invited members who work with and care for people using sexual health services to review and comment on the draft document on its behalf. The comments here include the views of our members.	Thank you for this comment.
85	[office use only]	[Royal College of Nursing]	General	General	General	The draft guidance seems comprehensive and helpful. The guidance is clear guidance and well underpinned by the evidence.	Thank you for your comment.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
86	[office use only]	[Royal College of Nursing]	General	General	General	We would welcome greater acknowledgement of Pre-Exposure Prophylaxis (PrEP) and how condoms are still the first line response for the prevention of HIV. It would be beneficial in this guidance to make this. The concern is that PrEP may be seen as the "magic bullet" in terms of HIV prevention from those at risk.	Thank you for this comment. PrEP is outside the scope of this guideline, which is only about provision of condom distribution schemes.
87	[office use only]	[Royal College of Nursing]	General	General	General	In relation to contraception and sexual health it should be made more explicit that condoms should ideally be used alongside other forms of contraception such as Long-Acting Reversible Contraception (LARC) or oral contraception, encouraging young people to "double dutch" to protect against pregnancy and STIs.	Thank you for this comment. The guideline is hyperlinked to the NICE contraceptive services guideline (see https://www.nice.org.uk/guidance/ph51). However the contraception is outside of the scope of this guideline, which focusses on condom distribution to prevent STIs.
88	[office use only]	[Royal College of Nursing]	Short version	4	8 - 11	*Section 1.1*: It needs to be acknowledged that young people below age of 16 are having sexual relationships and will need to be able to seek free family planning and condoms.	Thank you for this comment. Young people under 16 are included specifically in the recommendations in section 1.2 of the guideline. The text of the first recommendation in section 1.1 has been changed to refer to those at most risk too, which would include young people.
89	[office use only]	[Royal College of Nursing]	Short version	4	22	*Section 1.1*: Also suggest advertise in General Practitioners (GPs) surgeries, community centres, hospitals and drop in centres.	Thank you for this comment. Several references to health services have been added to the updated guideline, in particular in section 1.1 of the recommendations.
90	[office use only]	[Royal College of Nursing]	Short version	5	27	*Offer pathways to other services such as pregnancy testing or chlamydia Screening*: These are generally considered as level one services. It may be helpful to include pathways to general practice or wider sexual health.	Thank you for this comment. The need for pathways into other services is addressed in the recommendations in section 1.2 of the guideline.
91	[office use only	[Royal College of Nursing]	Short version	8	29	*Putting this guideline into practice:* The link to "Tools and Resources" appears broken.	Thank you for this comment. The tools and resources will not go live until the guideline is finalised. This link will be activated then.
92	[office use only]	[Royal College of Nursing]	General	General	General	It would helpful to have advice on who leads on the schemes recommended in this guidance. The schemes are often contracted within Sexual Health Services, or sit within Public Health Services at local authorities – the latter is probably more appropriate, although must be appropriately resourced.	Thank you for this comment. Service delivery is outside of the scope of this guideline. Different organisations may need different approaches to implementation, depending on their size and function.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
93	[office use only]	[Royal College of Nursing]	General	General	General	It would be helpful to have guidance on negotiating regional or national contracts with condom suppliers for cost efficiencies and consistency. This would be a cost benefit to the NHS.	Thank you for this comment. This is outside of the scope of this guideline.
94	[office use only]	Royal Pharmaceutical Society	Targeting services	Page 4	Line 14	Pharmacists have played a core role in public health services for sexual and reproductive health. Independent pharmacist prescribers, medicines management pharmacists and the use of patient group directions (PGDs) highlight how clinical skills of a pharmacist in hospital and the community are utilised to prescribe or supply medicines are being used to a greater extent.	Thank you for this comment. The committee agree that pharmacies have an important role to play therefore they flagged community pharmacy services as a key venue for condom distribution in the recommendations in section 1.1 of the guideline.
95	[office use only]	Royal Pharmaceutical Society	Condom distribution schemes for adults	Page 6	Line 20	A greater willingness by the public to consult pharmacists on sensitive issues such as sexual health and an increased availability of private consultation areas in community pharmacies allows pharmacist to be accessible to the wider public. Harnessing these skills and accessibility presents significant opportunities for the prevention of sexually transmitted infections.	Thank you for this comment. The committee agreed that pharmacies have an important role to play and therefore there are several references throughout the guideline, in particular in the recommendations in section 1.1 of the guideline.
96	[office use only]	Royal Pharmaceutical Society	Targeting services	Page 14	Line 17	The Royal Pharmaceutical Society Sexual Health Toolkit http://www.rpharms.com/support-resources-a-z/sexual-health-toolkit.asp is a toolkit to support the integration of pharmacy and pharmacist in to services that promote better patient sexual health.	Thank you for bringing this toolkit to our attention. We will flag it up with our implementation colleagues at NICE. It may also be suitable to put this forward for inclusion on the NICE shared learning database. We would encourage you to look into this further on the NICE Into Practice webpage.
97	[office use only]	The National LGB&T Partnership	Full	General	General	We are concerned that by excluding to mention by name any other high-risk groups at risk of getting an STI, including HIV, beyond Men who have Sex with Men (MSM) and black African communities, commissioners and service providers won't consider the needs of other groups when commissioning or delivering condom distribution schemes. This includes: - trans women (who were found to be at equal highest risk of HIV acquisition in the UK by PHE) - trans men (who may or not also be MSM) and non-binary people. It is expected that trans people are up to four times more likely to be HIV positive than the national average, as based on research in the USA (Grant, Mottet et al, 'National Transgender Discrimination Survey Report on Health and Health Care', 2010). No substantial data has	Thank you for this comment. The guideline recommendations no longer refers to high risk groups, but instead talks about those most at risk. As outlined in the committee discussion section, the committee wanted to emphasise that even though a person may be in a high prevalence group for sexually transmitted infections, it is behaviour that influences whethers a person is at high risk.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						been collected regarding the sexual health of trans people in the UK, but comparable data from the USA evidenced that 14.3% of trans young people are thought to be HIV positive, which is the highest rate of any youth group in the USA. - lesbian and bisexual women. The vast majority of women who have sex with women (WSW) engage in sexual practices which could result in the transmission of STIs and very few of these women use barrier protection (LGBT Foundation, Beyond Babies and Breast Cancer, 2013). - black & minority ethnic (BME) MSM. Evidence suggests that this group are an even higher risk group than either MSM or black Africans, and should be a target population in their own right. There has been an increase of new HIV diagnoses in those who are among other and mixed heritage MSM, a 100% increase in black Caribbean MSM from 2005-2014 and a 126% increase in black African MSM in the same period (PHE, Black and Minority Ethnic Men who have Sex with Men, 2016).	
98	[office use only]	The National LGB&T Partnership	Full	4	23	Briefly explain 'geospatial social networking apps'; these include gay dating sites such as Grindr, which is a good opportunity to advertise to targeted groups actively seeking to have sex.	Thank you for this comment. The updated recommendation section 1.1 states that 'advertise on geospatial social networking apps (used to find local sexual partners).
99	[office use only]	The National LGB&T Partnership	Full	5	17-19	It's very encouraging that the guidance considers the use of female condoms and dental dams. An alternative option is to provide information on how to make a dental dam out of a condom which is a cost effective way of providing an inclusive service (i.e. everyone can take condoms and decide how they use them dependent on the type of sex they want to have, rather than being dictated by assumptions based on gender presentation). Over Manchester Pride in 2016, LGBT Foundation provided three sexual health postcards to accompany loose condom and lubricant packets, explaining: how to make a dental dam out of a condom; how to use a condom; and how to access STI and HIV testing.	Thank you for providing this information.
100	[office use only]	The National LGB&T Partnership	Full	6	21-27 (section 1.3.2)	In addition to providing additional information about sexual and reproductive health, schemes can supply additional information on a broader range of associated health issues with signposting to	Thank you for this comment. This is outside the scope of the current guideline which is concerned with condom distribution to prevent

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						additional brief advice or services, around for example substance misuse support. This is particularly important when looking at the broader determinants of health, which is something Public Health England are moving towards in their MSM work.	sexually transmitted infections.
101	[office use only]	The National LGB&T Partnership	Full	7	3	Language and imagery should also be inclusive. For example, supporting guidance on how to use a condom could discuss use of a condom over penis, prosthetic or sex toy, rather than exclusively assuming condoms are only for use on a penis. Imagery should be similarly inclusive; for example, demonstrative pictures could use images of condom use on a prosthetic.	Thank you for this comment. No evidence relating to the content and imagery and language for targeted condom distributions schemes was found, therefore the committee were unable to make a specific recommendations on this. However, the need to fully consider the needs of different populations accessing condom distribution schemes is highlighted in the equality impact assessment form'
102	[office use only]	The National LGB&T Partnership	Full	8	16-17	It's correct and important to address the fact that MSM and black African communities have the highest levels of HIV in the UK. It's also worth stating that trans women, alongside MSM, are at the highest risk of acquiring HIV in the UK (PHE, 2014). It's thought that at least 1% of the population identify as gender variant (GIRES, 2011); whilst little research has been done into the disproportionate HIV burden in the UK trans community, comparable research from the USA (UNAIDS 'The Gap Report' 2014) highlighted trans women as being 49 times more likely to acquire HIV than all adults of reproductive age. By excluding this high-risk group, the guidance runs the risk of missing an opportunity to encourage condom distribution schemes to consider how to reach out to trans communities whom might not otherwise access sexual health services or support.	Thank you for this comment. The guideline recommendations no longer refers to high risk groups, but instead talks about those most at risk. As outlined in the committee discussion section, the committee wanted to emphasise that even though a person may be in a high prevalence group for sexually transmitted infections, it is behaviour that influences whethers a person is at high risk.
103	[office use only]	The National LGB&T Partnership	Full	15	6-10	An additional inequality is that as discussed above, exclusive imagery and language for targeted condom distribution schemes means that cis (i.e. non-trans) people are unlikely to access the schemes. Unless commissioners and service providers are made aware that trans communities are a group at high risk, it is unlikely that they will consider how best to be inclusive of these groups.	Thank you for this comment. No evidence relating to the content and imagery and language for targeted condom distributions schemes was found, therefore the committee were unable to make a specific recommendations on this. However, the need to fully consider the needs of different populations accessing condom distribution schemes is highlighted in the equality impact assessment form'

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
104	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	General		Whilst there is a major emphasis on prevention of sexually transmitted infections with condoms within the document, it must not be forgotten that condoms remain a very widely used method of contraception in the UK.	Thank you for this comment. The committee acknowledge this in the committee discussion section. However, the scope of this guideline was focussed on condom distribution schemes for sexually transmitted infection prevention.
105	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	22	7	Female condoms are only infrequently used in the UK and are not relevant for inclusion in research on condom distribution schemes. Similarly for dental dams. Uptake of lubricant in the MSM community is relevant and important.	Thank you for this comment. The committee were aware that female condoms are used less frequently in the UK. However, they did think that they could be relevant to the UK setting and therefore wanted to include them within the guideline recommendations and research recommendations.
106	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	4	15	It is essential that condoms given out in schemes in schools, voluntary agencies and pharmacies link to local sexual and reproductive health services – inclusion of written information, posters and Q readers about access to these services is essential.	Thank you for this comment. Tailored information and advice that should be given as part of multi-component condom distributions schemes in recommendations in section 1.2 of the guideline.
107	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	5	12	Training of all staff who work in young people's services to be familiar with assessment of competence and child protection is essential. This includes non-clinical staff such as receptionists as well.	Thank you for this comment. Staff training is outside of the scope of this guideline.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
108	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	General		Including a list of current condom distribution schemes mapped to regions across England would be helpful and interesting. Whilst this might well change with time it would raise awareness for professionals in terms of local availability and the need to improve local services.	Thank you for this comment. This issue was addressed to one of the committee expert testimony providers who confirmed that such a list does not exist.
109	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	General		Including some basic costs of condoms, discounts available for large bulk purchases and schemes would be helpful to set this context for this guideline.	Thank you for this comment. There will be a costing report associated with this guideline. This comment has been passed onto colleagues preparing the report.
110	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	15	5	Concern over inequalities and differences between urban and rural communities is a very significant factor.	Thank you for this comment. The committee shared your concern. This is reflected in the equality impact assessment for the guideline and in the committee discussion. However, the evidence the committee considered did not provide a solution to this issue, which will need to be tackled locally. Section 1.1 of the guideline recommends including condom schemes in existing general services, for example through primary care and pharmacy which may help to address inequity. People may be able to access condoms online too, for example (see section 1.3 of the guideline). A research recommendation has also been made about digital technologies.
111	[office use only]	Clinical Effectiveness Unit (CEU) of the UK Faculty of Sexual and Reproductive Health	Full	General		Research should include an attempt at comparison of multicomponent condom distribution and voluntary sector schemes for young people.	Thank you for this comment. Although the guideline committee did not prioritise comparison of condom schemes from different sectors, the committee set a series of research questions that would include voluntary sector schemes.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
112	[office use only]	[University of Southampton, The Centre for Sexual Health Research, Psychology Dept.]	Full	General	General	I'm surprised that any reference to condoms as effective prevention of unplanned pregnancy as well as STI transmission has still not been included despite several comments in the last consultation on this guidance. Condoms are men's only reversible method of preventing pregnancy – all others rely on women's methods. Condoms are the only method of reducing transmission of most STIs for both men and women.	Thank you for this comment. The committee discussion section does refer to pregnancy prevention and the costs of avoiding unintended pregnancies were included in the economic evaluation. However, the scope for the guideline is the provision of condom distribution schemes for the prevention of sexually transmitted infections. NICE has already produced guidelines on contraceptive services for young people (see https://www.nice.org.uk/guidance/ph51) and condoms are incorporated into that guideline, which is hyperlinked from the current guideline.
113	[office use only]	[University of Southampton, The Centre for Sexual Health Research, Psychology Dept.]	Full	5	Section 1.2	I thought that multicomponent condom schemes would be for all high-risk groups: YP, MSM, African and people from other countries with high STI prevalence (esp. GC, syphilis and HIV). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534601/hpr2216_stis.pdf In terms of triage for high-risk in GUM, people in high-risk groups also include substance misusers, sex workers, people with bisexual partners, those with multiple partners, sex tourism, etc.	Thank you for this comment. The recommendations and the discussion in the updated guideline are clearer that schemes are not mutually exclusive (i.e. an individual who is 18 may be able to access a multicomponent schemes, single distribution scheme or buy cost price condoms). However, there is duty of care to provide multi-component condom distribution schemes for people up to the age of 16 but the committee agreed they should also be considered for people up to the age of 25. The committee saw no evidence to suggest that multicomponent schemes were more effective than other schemes for groups other than young people, and they are very costly compared to single component schemes (free condom distribution). Triage in genitourinary medicine is outside the scope of this guideline.
114	[office use only]	[University of Southampton, The Centre for Sexual Health Research,		5	17-19	It's really good to give lubricants and a variety of sizes and types of condoms – this could be encouraged more? Breaks, slips and abandonment of condoms (and subsequent mistrust/dislike of condoms) can be reduced by first identifying the right size, shape and feel of condom for an individual.	Thank you for this comment. The need to provide a range of condom types and sizes is highlighted in the recommendations in section 1.2 of the guideline.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		Psychology Dept.]				Ideally people could also be encouraged to practice with a few on their own to identify best fit and feel, before using them in a high-pressure 'heat of the moment' situation. Refs. Sanders, et al. 2012. Condom errors and problems: a global view. Sexual Health, 9, 81-95 http://www.ncbi.nlm.nih.gov/pubmed/22348639 Emetu et al. 2014: http://www.ncbi.nlm.nih.gov/pubmed/24456514	
115	[office use only]	[University of Southampton, The Centre for Sexual Health Research, Psychology Dept.]	Full	9	4	'Changes should be implemented as soon as possible' – could this be upgraded to 'urgent'? During the course of our condom study we have noticed reductions in provision of condoms to universities, colleges, youth centres, young people advisory centres, health centres and many other points of usual access due to cuts in health promotion/ public health funding in recent years. (In Southampton and Coventry, but hear from others at conferences and other networking that this pattern is seen in other parts of the country). We are not able to identify any peer reviewed publications to cite as evidence of this – these are very recent trends and are more likely to be only locally recorded by commissioners and service providers. Also in recent years, we've been witnessing rises in STIs (particularly in young people) and antibiotic resistance. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534601/hpr2216_stis.pdf	Thank you for this comment. The highlighted sentence is standard text on implementation within the NICE guideline. However, the committee were mindful of the current financial climate and the resource impact of recommendations have been considered. A linked resource impact report will be published alongside the guideline.
116	[office use only]	[University of Southampton, The Centre for Sexual Health Research, Psychology Dept.]	Full	9	20-23	It might be good to mention that commissioners assessing local high-risk groups could look for more current trends through discussions with virology and microbiology rather than just HPA data that often lags a year + behind. Also to remember that data may be missing because of lack of testing – it's getting harder to test as access to clinics is increasingly difficult and postal testing is limited in acceptability. Plus testing of all relevant body sites of infection isn't always possible – time, costs, accurate history taking.	Thank you for this comment. The highlighted sentence is standard text on implementation within the NICE guideline. However, the committee have tried to reflect these issues more in the language used in the recommendations, in particular in section 1.1 of the guideline.
117	[office use only]	[University of Southampton, The Centre for	Full	10	Context lines 20-24	PHA 2015 Report figures quoted on this page: 6000 new HIV in 2014: of which 3360 MSM; 1223 black Africans – remainder 1417 - A bigger number than black Africans and maybe important to	Thank you for this comment. These figures have been updated in the guideline.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		Sexual Health Research, Psychology Dept.]				acknowledge? It might be worth acknowledging the undiagnosed estimates in this report as well (page 9) – this is an important motivation for condom use.	
118	[office use only]	[University of Southampton, The Centre for Sexual Health Research, Psychology Dept.]	This form	Questions on page 1		Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Multi-Component and Single-Component CDSs – how to ensure all high-risk groups can access MC-CDSs – this is challenging enough even in a clinic setting	Thank you for answering this question
119	[office use only]	[University of Southampton, The Centre for Sexual Health Research, Psychology Dept.	This form	Questions on page 1		What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) http://www.ncbi.nlm.nih.gov/pubmed/24456514	Thank you for answering this question
85	[office use only]	Public Health England	5	27-28		Consider how the target group(s) prefer to access services, e.g. via on-line services, take into account the views of potential users Condom schemes should also offer pathways into contraception services especially those that can offer Long Acting Reversible Contraception (LARC).	Thank you for this comment. The committee considered how target groups may want to access services . While no specific evidence about online services was identified, the committee considered that it was covered by the recommendations in sections 1.1-1.3 of the guideline and these allowed enough flexibility to allow local areas to deliver multi-component schemes to best meet the needs of their population.
86	[office use only]	Public Health England	6	12-20		Distribution of free condoms through other channels including internet should also be considered.	Thank you for this comment. The distribution of cost-price condoms through other channels is considered in the recommendations in section 1.3 of the guideline. A research recommendation on the use of digital technologies to support access and uptake of condom distribution schemes has also been made in the guideline.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
87	[office use only]	Public Health England	6	21-27		Display of information on local and internet HIV testing services should also be recommended in section 1.3.2.	Thank you for this comment. The committee have added a reference to HIV testing services in recommendation 1.3.2 in line with your comment.
88	[office use only]	Public Health England	10	8-10		Please note that for specialist contraceptive services, condom distribution can be included in Sexual and Reproductive Health Activity dataset (SRHAD) data submissions.	Thank you for this information.
89	[office use only]	Public Health England	10	17-28		The context should also note that condom distribution schemes will contribute to pregnancy prevention. Condoms are an important and widely used method of contraception, even though it is not the most effective.	Thank you for this comment. This information is contained at the beginning of the committee discussion section within the guideline.
89	[office use only]	Royal College of General Practitioners	Short	General	General	We are concerned that this guidance is not also directed at NHS England or Clinical Commissioning Groups but also those who are also responsible for providing contraceptive services and within which provision of condoms is an integral part.	Thank you for this comment. This guideline is aimed at • 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. This information will appear on the guideline 'Landing page' on the NICE website.
90	[office use only]	Royal College of General Practitioners	Short	General	General	Current strategies for commissioning are shifting away from the provision of specialist sexual health services towards general practice. Therefore we recommend that general practice as a distinct and highly accessed setting, with specific commissioning needs, is recognised in the guidance. The particular importance (and potential) of condom provision in general practices in deprived areas, or those distant from young peoples' or specialist services, might be highlighted.	Thank you for this comment. The updated guideline includes a reference to general practice in recommendations in section 1.1. The updated guideline also includes a research recommendation on whether GP practices can deliver effective and cost effective schemes for preventing sexually transmitted infections.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						We are concerned that the guidance needs, overall, to give more specific consideration to the general practice setting which differs from other settings in some important ways. 1. There is the potential to take opportunistic approaches in those attending for other reasons, who may or may not have given their sexual health a single thought. 2. Attendees from across the spectrum of risk use general practice, including those at risk, but not in recognised risk groups (e.g. heterosexual people with very risky behaviours but who are over 25 years old). 3. General practice can provide integrated holistic care, so it is not possible tease out condom provision and advice from (for example) cervical screening; alcohol reduction advice or viral hepatitis testing (unless open provision of condoms at reception is taken as the only 'mode' of involvement). 4. Attendees at general practice gain some confidentiality, because they might be there for any number of reasons (skin problems, advice on weight, asthma etc.) – many of our service users, particularly the young and the HIV positive, value this 'cloak'. Many practices already provide condoms. Many practices are already participating in C Card schemes. Such involvement can be commissioned, and sometimes links with training in risk assessment and sexual health promotion, (and other relevant training) for staff (e.g. as in SHIP training). Condom provision can occur: 1) **within consultations**: using targeted sexual health promotion conducted EITHER with people (e.g. young people) opportunistically assessed as at risk when they consult for unrelated reasons OR when people were in any case seeking sexual health or contraception advice (arguably the smaller, and arguably the lower average risk, group!). 2) **at reception** – this can either be 'unlocked' for individual repeat attenders who have already been assessed and advised (e.g. by giving them a C Card) AND/OR can be open for anyone who requests them. **Despite the acknowledged lack of evidence, guidance should attempt to distinguish the comparative benefits of these options for commissioners.**	

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						There is potential for greatly increased involvement of practices with risk assessment and condom provision – and the C Card scheme. **To support high quality provision – and expansion - of such services: a) there must be training relevant to the setting (notably in risk assessment as well as the more standard components of care); and b) adequate funding of services (through contracted services, financial incentives or both).**	
91	[office use only]	Royal College of General Practitioners	Short	4	12-14	**Condom schemes for high risk groups** General practice is a service used by high risk people: 1.Young people, including those at high risk, access general practice at scale – and may not be accessing other services [example Refs: Green *Where do sexually active female London students go to access health care?* STI 2012; Saunders *'Where do young men want to access STI screening?* STI 2012; Woodhall *Is chlamydia screening and testing in Britain reaching young adults at risk of infection?* (NATSAL) STI 2016; Sonnenberg *Prevalence, risk factors and uptake of interventions for STIs in Britain* NATSAL Lancet 2013.] 2. People from high prevalence countries (particularly Africans), access general practice at scale. [See for example Leber *Promotion of rapid testing for HIV in primary care* Lancet 2015 – the majority of HIV positives identified in this setting were African]. 3. Men who have sex with men are (overwhelmingly) registered with and access general practice [eg Metcalfe *Don't ask, sometimes tell* Int J STD AIDS 2015] – their individual risk however may or may not be assessed. 4. There is very limited evidence about the use of general practice by female sex workers, but see older work by Jeale: general practice will be highly accessed by this group, however their risk may or may not be recognised by clinicians. NB There is a need for more research into utilisation of general practice by those at risk of sexual health problems (see research recommendations, below).	Thank you for this comment. GP surgeries have been added to the list of examples in the updated guideline and a research recommendation has been added that addresses condom distribution schemes to prevent sexually transmitted infections in general practice.
92	[office use only]	Royal College of General Practitioners	Short	5-6	General	**Section 1.2** The scale of access by young people of general practice services should be reflected in this section - particularly, but not solely, there	Thank you for this comment. No evidence was found on the effectiveness of delivering condom distribution schemes from GP

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						localities lack other options OR (better?) the guidance should specifically bring in a section about provision of condoms in general practice (a section which addresses any relevant risk group).	practices. However, the guideline committee considered this feedback and added a reference to general practice in the recommendations in section 1.1 of the guideline. Further information on committee deliberations on this point can also be found in the committee discussion section.
93	[office use only]	Royal College of General Practitioners	Short	5	11	Although we agree that this is best practice, it is time consuming to do well. Whilst some practices are already providing this service, often using practice nurses, general practice is of course under extreme pressure at present. It is unlikely that practices will take this on anew, to the standards given, without training appropriate to the setting and also funding (see end of comment 2, above).	Thank you for raising this issue.
94	[office use only]	Royal College of General Practitioners	Short	5	16	Teaching should also incorporate the efficacy of condoms as contraceptives and in reducing STI transmission and what to do if the condoms breaks.	Thank you for this comment. The committee did not consider any evidence about what should be taught to people using condom schemes. There is more information in PHE /Brook best practice guide on C card schemes which is included for information in the guideline. A bullet point about knowing what to do in the event of condom failure has been added to the updated recommendations.
95	[office use only]	Royal College of General Practitioners	Short	5	19	We are concerned that some readers will not understand the term "dental dam" and we thought it would be useful if a definition could be included in the glossary.	Thank you for this comment. A definition of dental dams has been added to the glossary in the updated guideline.
96	[office use only]	Royal College of General Practitioners	Short	5	27	Service users should also be directed to pathways offering contraceptive services including emergency contraceptive.	Thank you for this comment. The updated guideline has been amended to reflect that multi-component condom distribution schemes should include pathways into other services. Please see section 1.2 of the guideline recommendations.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
97	[office use only]	Royal College of General Practitioners	Short	6	27	It would also be beneficial to include information regarding online services.	Thank you for this comment. Section 1.3 of the guideline recommendations flags the provision of information on reliable sources of further information (giving the example of NHS choices). Section 1.3 of the recommendations also references using the internet for distribution of cost-price condoms. A research recommendation has also been made on digital technologies.
99	[office use only]	Royal College of General Practitioners	Short	7 (likely 6)	27	Information regarding what to do if a condom breaks or if a person has unprotected sexual intercourse would be helpful.	Thank you for this comment. Information about emergency contraception and what to do and where to go in the event of a condom failure has been explicitly added to section 1.2 of the guideline recommendations.
100	[office use only]	Royal College of General Practitioners	Short	7	5	There is a concern that this recommendation advocates that condoms should only be provided free to adults under 25 years and MSM and other high risk groups that have yet to be identified. Condom provision in many practices is currently to a wide population. Whilst the concept of risk groups is of great utility to commissioners and to public health, in consultations assumptions must be avoided and it is the risk of the individual that matters. Thus, whilst clinicians may be more likely to discuss sexual health with people in a risk group that is apparent to them (e.g. a young person), in fact individual young people, or MSM - or women in their 30s - may be at zero, medium, high – or future – risk. See Green and Metcalfe above and also Mercer *Changes in sexual attitudes and lifestyles in Britain through the life course and over time* NATSAL Lancet 2013. If the provision of condoms must be restricted, it should rather – in the general practice setting – be restricted to individuals thought to have need (whether to prevent pregnancy, STI - or both). As acknowledged in the guidelines, cost is a barrier to use of condoms therefore restricting free condoms to particular groups is likely to result in reduced usage.	Thank you for this comment. The guideline now makes clear that there is duty of care to provide multi-component condom distribution schemes for people up to the age of 16 but the committee agreed they should also be considered for people up to the age of 25. The guideline recommendations in section 1.1 now also state those most 'at risk' rather than risk groups based on sexually transmitted infection rates. The updated guideline recognises that risk will be defined by a person's behaviour. Recommendation 1.3 recommends distribution of free condoms to those most at risk and recommends selling cost-price condoms to the general population.
101	[office use only]	Royal College of General Practitioners	Short	8	12	Risk 'groups' are not, as a whole group, involved in risky sex… Suggest rewording from: 'Groups at high risk of STIs (..) may be involved in higher rates of risky sex..' to	Thank you for this recommendation. The committee discussed this feedback and have changed the wording to 'those at most risk', which better reflects that risk is associated

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						'Groups at higher average risk of STIs… are groups which [may] have a higher than average proportion of individuals involved in risky sex…' Every risk group has individuals in it at zero risk of STI – overlooking this a) normalises risk-taking b) leads to missed opportunities for positive reinforcement to individuals of their healthy choices c) undermines sexual health promotion messages. [Understandably, those working in specialist sexual health services do not tend to come across individuals at no risk ref Green, above].	with behaviour.
102	[office use only]	Royal College of General Practitioners	Short	9	28	Putting this guideline into practice The wording given does emphasise the need for flexibility, however condom provision is probably best implemented across an area or a number of practices, with support and relevant education, rather than leaving each individual practice to solve problems and implement in isolation (which could be inefficient in many ways). It would make most sense to take an integrated approach to sexual health care provision, i.e. not focus solely on condom provision or C Cards.	Thank you for this comment. The highlighted section is standard text on implementation within the NICE guideline. Service delivery is outside the scope of the current guideline but the committee were of the view that the need for flexibility in terms of condom provision is reflected in section 1.1 of the guideline recommendations.
103	[office use only]	Royal College of General Practitioners	Short	10	25	It would be useful to include the benefits of condoms against pregnancy.	Thank you for this comment. This issue is included in the first section of the committee discussion in the guideline. With the pathway for this guidance, it will also be clearly linked to existing NICE guidance on contraceptive services. Pregnancy was also included as an outcome within the health economic modelling for the guideline.
104	[office use only]	Royal College of General Practitioners	Short	10	25	We are concerned that some readers will not know about the benefits of dental dams and this should be described here.	Thank you for this comment. A definition of dental dams has been added to the glossary.
105	[office use only]	Royal College of General Practitioners	Short	12	9 & 10	Generalisation, suggest change from: "People should use condoms to prevent STIs in addition to their chosen method of birth control" to "People who are, or may be, at risk of STI should use condoms in addition to their method of birth control". Couples stop using condoms for a range of good and bad reasons and it is generally not helpful to imply that all couples should simply	Thank you for this comment. The committee did not feel that the suggested wording improved the clarity of the guideline. Therefore no change was made to the guideline..

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						use condoms for as long as they are using contraception: it is best for practitioners to be open about this and ready to discuss – again people in long term mutually monogamous relationships will be much more commonly seen in the GP setting than in an STI clinic.	
106	[office use only]	Royal College of General Practitioners	Short	14	15 to 19	Targeting services If it doesn't have its own section, general practice should be mentioned here as the largest of all potential services that could be included.	Thank you for this comment. The updated guideline has been amended to include a reference to General Practice. This is in section 1.1 of the recommendations.
107	[office use only]	Royal College of General Practitioners	Short	14	21	Although, we acknowledge that local authority budgets are reducing and this had led to the targeting of high risk groups is the most cost effective, it is well established that condom and contraceptive services are still cost effective in preventing STIs and unwanted pregnancies in the general population. Nevertheless, there is potential for nurses and doctors in general practice to identify and provide condoms for people at high risk of STI and/or unwanted pregnancy on an opportunistic basis.	Thank you for raising this issue.
108	[office use only]	Royal College of General Practitioners	Short	15	5	Inequalities General practice has unequalled geographical coverage. Practice teams know and work with – and are often involved in ongoing and support of – its patients with learning disabilities.	Thank you for raising this issue. The committee were keen for general practice to be involved in condom schemes and they added general practice as an example within the recommendations and included a research recommendation on general practice. Further detail of their discussion is included in the committee discussion section of the guideline.
109	[office use only]	Royal College of General Practitioners	Short	20	12	General population / cost effectiveness One of the difficulties of cost benefit evaluation of the general practice setting, is that using condom provision as a way of bringing up the topic of sexual health opportunistically, may well lead to other health benefits. Examples include increased targeted STI testing; opportunistic contraceptive care; detection of alcohol or mental health problems; sexual health promotion advice etc. These are the benefits where condom provision is linked to clinical care and risk assessment (rather than commissioning solely provision at reception). So hard to do cost benefit.	Thank you for raising this issue.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
110	[office use only]	Royal College of General Practitioners	Short	22	9	**Research recommendations:** We strongly support the listed research recommendations. However currently the recommendations do not mention general practice, although this setting is huge scale, highly accessible, not necessarily comparable with other settings – and, probably, the most difficult in which to conduct evaluation. Understandably, sexual health or e.g. youth health specialists and academics not familiar with the GP setting tend not to include – or be aware of – such research as there is (some of which we have referred to here). Some specialist providers – also operating at primary level, and possibly currently under threat – may see general practice as a competitor, and may overlook evidence as to the massive scale of service access and use that there is in general practice. Finally, all primary level providers (including GPs) hear negative tales about other primary level services – by people seeking an alternative. Great care is comparatively invisible: no service should solely be judged by its bad stories; we all hear more bad stories than good about other providers. In fact general practice is by far the largest provider of contraceptive care, and is holding its own in STI testing (see Woodhall and also Sonnenberg, above). We have given evidence that it is readily accessed by many people in risk groups. However you will note from the publications we cite that we have sometimes had to draw evidence from research that did not have general practice as its primary focus - so close reading is required. However the publications given here should not be taken as comprehensive, there are many more with relevance. We would be keen to see research which can much better characterise: Who, in risk groups, is accessing general practice? Of these, what proportion are not using alternative relevant services? (population level research, such as NATSAL, could give some answers – to a degree NATSAL provides useful information, as above). In general practice, can the use of risk assessment through sexual history taking impact positively on a) targeted provision of condoms b) increased repeat visits for collection of condoms c) other relevant aspects of health care.	Thank you for this comment. The research recommendations could be applied to range of settings, including general practice. A specific research recommendation aimed at GP practices is included in the guideline.

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						How could the cost effectiveness of condoms, implemented with training, best be evaluated in the GP setting?	