**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** External Condoms | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** March 2017, January 2018, January 2019, **January 2021** |
| **References:** U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016; U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016; Contraceptive Technology, 20th Ed |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; and Contraceptive Technology, 20th Ed.

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in their use of external condoms.

The external condom is a thin sheath that fits over the erect penis. It works as a barrier to stop sperm from getting into the vagina. External condoms are made from 3 types of materials: latex, natural membrane, and synthetic. When used consistently and correctly, external condoms reduce both the risk of pregnancy and of acquiring most sexually transmitted infections (STIs). With typical use, 18 out of 100 people who use external condoms will experience an unintended pregnancy within the first year of use.

Latex condoms when placed on the penis before any genital contact, and used throughout intercourse, greatly reduce the risk of STIs that are transmitted primarily to or from the penile urethra. Latex condoms will provide protection against STIs that are transmitted skin-to-skin to the extent of the areas that are covered by the condom.

Condoms made from natural membrane contain small pores that may permit the passage of viruses (hepatitis B, herpes simplex, and HIV), which may not provide the same level of protection against STIs as latex condoms.

Use of condoms lubricated with the spermicide nonoxynol-9 (N-9) is no longer recommended because of their higher cost, shorter shelf life, and lack of additive benefit as compared with other lubricated condoms. Concerns have also been raised about genital ulceration and irritation resulting from high-frequency use of vaginal spermicidal N-9 products and potential for facilitating transmission of STIs including HIV.

**STANDARD:**

(**insert AGENCY name**) MDs, NPs, PAs, DOs, NDs, and RNs may provide information, counseling, and supplies to any client who requests this contraceptive method.

There are no U.S. MEC category 4 risk conditions for using this method.

Latex allergy is listed as a U.S. MEC category 3 risk conditions for the use of latex condoms. Any client who has an allergy to latex should not use a latex condom, and instead should use a synthetic condom.

**PROCEDURE:**

1. Follow ***Core Reproductive Health Services*** ***Clinical Practice Standard***.
2. Each client will receive client instructions regarding warning signs, common side effects, risks, use of method, alternative methods, use of secondary method, and clinic follow-up schedule. Document the client’s education and understanding of the method of choice.

**PLAN:**

1. Initiation of external condoms:
	1. External condoms may be initiated at any time.
	2. Instruct client on how to use a condom:
* The package should be opened carefully to avoid damage; any package that shows signs of damage, or deterioration (brittleness, stickiness, or discoloration) should not be used. Check expiration date on package.
* Before any genital contact, place condom on tip of the erect penis with rolled side out.
1. If condom does not roll it is probably inside-out, remove and discard condom.
* Unroll condom all the way to the base of the erect penis.
* Immediately after ejaculation, hold the rim of the condom and withdraw the penis while it is still erect.
* Throw away the used condom in a waste container, do not flush down toilet.
1. The decision to offer and dispense future-use EC should be made on an individualized basis and should include shared decision making between the provider and the client. The practice of offering and dispensing future-use EC to *all* clients has had no impact on unintended pregnancy rates. Data shows that clients who had EC available at the time of unprotected intercourse either didn’t take it at all or took it incorrectly. Additionally, the practice of providing EC to all clients represents a significant cost to the agency. Clients *requesting* (those that self-identify that they need or want) EC for future use and those using less reliable methods of contraception (tier 3 methods) might benefit most from having future-use EC made available.
	1. Instruct the client to wait 5 days after the administration of Ella® before initiating combined oral contraceptives. Recommend the use of a barrier method of contraception with all subsequent acts of intercourse that occur within the next 14 days.
2. Review client’s history and access of recommended health screenings. Send a Release of Records for past health screenings, if performed elsewhere.
3. Offer and schedule a Reproductive Health Well Visit with the prescribing provider if the client has not had one within the past 12 months.

**ROUTINE FOLLOW-UP:**

1. The recommendations listed below address when routine follow-up is recommended for safe and effective continued use of contraception for healthy clients. Although routine follow-up is not necessary for the use of external condoms as either a contraceptive method or when used for protection against STIs, recommendations for follow-up might vary for different users and different situations. Specific populations such as adolescents, those with certain medical conditions or characteristics, and those with multiple conditions may benefit from more frequent follow-up visits.
2. Advise client to return at any time to discuss side effects or other problems, or if the client wants to change the method being used.
3. At other routine visits, healthcare providers should do the following:
* Assess the client’s satisfaction with their contraceptive method and ask whether the client has any concerns about method use; and
* Assess any changes in health status that would change the appropriateness of using the external condom for contraception.

Managing Problems:

1. Clients sensitive or allergic to natural rubber latex may experience irritation, allergic contact dermatitis, and/or systemic anaphylactic symptoms. Consider recommending synthetic condoms and refer for allergy skin testing.
2. If allergic reaction occurs only after exposure to latex condoms and not after other latex products, the reaction may be related to brand-specific condom attributes such as spermicides, lubricants, perfumes, local anesthetics, and/or other chemical agents added during manufacturing process. Recommend trying different brands of latex and synthetic condoms.
3. Advise client to contact a healthcare provider if they or their partner experience a severe allergic reaction while using latex condoms or spermicides.

**CLIENT EDUCATION:**

* + - 1. Provide the client information on all contraceptive methods; it is important that the client understands all options available to decrease risk of pregnancy.
			2. Advise the client to use the external condom with every act of anal, vaginal, and oral intercourse.
			3. Advise the client to use the condom during the entire sexual act.
			4. Advise the client to use a new condom for each act of intercourse.
			5. Discuss with the client that water-based lubricants can be used with latex condoms; avoid using oil-based lubricants.
			6. Advise clients to consider using EC for prevention of pregnancy if condom slips or breaks during intercourse.
			7. Advise the client that condoms should be stored in a cool and dry place, out of sunlight.
			8. Inform the client latex condoms should not be used beyond their expiration date or more than 5 years after the manufacturing date.

**REFERENCES:**

Centers for Disease Control and Prevention. 2016. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

Centers for Disease Control and Prevention. 2016. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>

Warner, L. & Steiner, M. 2011. Male Condoms, In Deborah Kowal (Ed) *Contraceptive Technology*, 20th Ed. Pg. 371-389. Ardent Media: Atlanta, GA

Stone, K., Steiner, M., Warner, L. & Cates, W. 2014. Male condoms. <http://www.uptodate.com/contents/male-condoms?source=search_result&search=male+condom&selectedTitle=1~150>