**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** InternalCondoms | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** 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 internal condoms.

Internal condoms provide a physical barrier that lines the vagina and partially shields the perineum, which blocks the sperm from entering the genital tract. Internal condoms do not contain spermicidal agents. In typical use, 21 out of 100 people who use an internal condom will experience an unintended pregnancy within the first year of use. Currently, FC2® is the only internal condom available in the U.S.; which is available now by prescription.

The internal condom is the only vaginal barrier method that provides pregnancy prevention and protects against sexually transmitted infections (STIs)/sexually acquired HIV with consistent and correct use. The internal condom is also approved for use during anal sex to protect against STIs/ sexually acquired 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 risk conditions for using this method. This method may not be appropriate for clients who are not comfortable touching their genitals or who may have problems with inserting the internal 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 internal condoms:
	1. Internal condoms may be initiated at any time.
	2. Instruct client on how to insert the internal condom:
* In squatting, leg-up, reclining or lithotomy position, compress inner ring and introduce into vagina guiding sheath high into vagina until outer ring rests against vulva. Rotate inner ring to stabilize device in vault.
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 hormonal 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.
4. Dispense supplies.

**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 internal 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 internal condom for contraception.
1. Managing problems:
2. Recurrent vaginal or vulvar irritation, without signs of infection, may indicate an allergy or sensitivity to the product; suggest trying another contraceptive method.
* If symptom persists after discontinuing the method, reevaluate for other etiologies (e.g. STI exposure, yeast vaginitis, or bacterial vaginosis).

**CLIENT EDUCATION:**

1. Advise client to use the internal condom every time vaginal intercourse occurs.
2. Make sure the internal condom is in proper place before the penis enters the vagina.
3. Ensure that the penis does not slip between the vagina and the outer surface of the condom.
4. Ensure that the outer ring does not get pushed into the vagina.
5. Instruct the client that the internal condom may be inserted up to 8 hours before intercourse.
6. The internal condom may be removed any time after intercourse and disposed into a waste container.
7. Advise the client not to use the internal condom along with an external condom; the friction between the two may cause breakage.
8. Advise the client that the internal condom is a single use only device and a new condom must be used for every act of intercourse.
9. Advise the client to call the clinic with any questions or concerns regarding contraceptive methods.

**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>

Cates, W. & Harwood, B. 2011. Vaginal Barriers and Spermicides, In Deborah Kowal (Ed) *Contraceptive Technology*, 20th Ed. Pg 391-407. Ardent Media: Atlanta, GA

T., Stone, K., Steiner, M., Warner, L., & Cates, W. 2014. Female condoms. Retrieved September 5, 2014 from <http://www.uptodate.com/contents/female-condoms?source=search_result&search=female+condoms&selectedTitle=1~18>