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Reproductive and Sexual Health

Targeted Condom Access for Disease and Pregnancy Prevention

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NAVY AND MARINE CORPS PUBLIC HEALTH CENTER

PREVENTION AND PROTECTION START HERE

This document does not establish Department of Navy policy. It is intended to help leaders and medical professionals understand and apply targeted condom access as a disease and unplanned pregnancy strategy.

Comments are encouraged and may be forwarded to:

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EXECUTIVE SUMMARY

Targeted condom access is one important component of a comprehensive sexually transmitted infections (STI) and unplanned pregnancy prevention effort.

Navy Medicine has promoted sexual responsibility and condom access for many decades, with the goal of reducing the incidence of sexually transmitted infections and unplanned pregnancies among Sailors and Marines.

STIs, including HIV – the virus that causes AIDS - are a major public health threat. Military members are at risk of exposure to STIs. Each year, about 100 active duty Sailors and Marines newly infected with HIV, and thousands more were infected with other STIs. In 2012, 2 of 3 (64%) of pregnancies among surveyed enlisted Sailors were unplanned.

Abstinence from sex and long-term mutual monogamy are the most effective means of preventing STIs. For people who decide to have sex outside a monogamous relationship, proper use of latex condoms reduces the risk of acquiring or spreading many STIs, and reduces the chance of unplanned pregnancies.

However, in 2008, less than half of surveyed unmarried active duty Sailors and Marines wore a condom the last time they had sex. Barriers to consistent condom use may include limited access or limited experience. Condom access efforts may enable some Sailors and Marines to overcome these barriers. Among American in general the rates of condom use are significantly lower among young adults than among adolescents. This suggests that sexual health promotion efforts should focus on the maintenance of condom use as individuals transition to adulthood and as they enter into a range of both short- and long-term relationships.

Condom distribution programs do not hasten the onset of sexual intercourse, nor increase sexual activity. Condom access efforts conducted by military commands should not be interpreted as encouraging sexual activity. Rather, condom distribution efforts encourage and enable safer behavior.

Although Sailors and Marines can and should buy condoms if they want to use them, making condoms easy to get, at strategic times and places, may increase the likelihood that people who choose to have sex will do so with a condom, rather than without a condom. A study of the sexual behavior of deployed enlisted male sailors who had multiple sex partners suggests that Navy prevention efforts can positively influence condom use in foreign ports.

Navy medical guidance regarding condom access is cited in BUMEDINST 6222.10, Prevention and Management of Sexually Transmitted Diseases: *"...Educational programs and materials; (e.g., condoms and pamphlets), should also be made discretely available in community sites such as barracks, clubs, individual commands, medical facilities, and health and wellness enters....Condoms...can also be made available without charge in clinics, sick bays and aid stations."*

Often an emotionally-charged issue, targeted condom distribution efforts require thoughtful planning and leadership courage. Access strategies should be sensitive to community concerns and perceptions. Specific examples are discussed herein.

Leadership support is essential.

**Frequently Asked Questions
about
Targeted Condom Access for Disease and Pregnancy Prevention**

What does the scientific literature tell us about structural-level condom distribution interventions?

A recent meta-analysis (Charania et al, 2010) of structural level condom distribution programs and studies found that interventions which increased condom availability, accessibility and acceptability improved condom use, condom acquisition/condom carrying, delayed sexual initiation among youth and reduced sexually transmitted infections (STI). Interventions were efficacious for many groups including youth, adult males, commercial sex workers, clinic populations and populations in areas with high STI incidence. The authors concluded:

“Given the urgency of the HIV epidemic, making condoms more universally available, accessible and acceptable, particularly in communities or venues reaching high-risk individuals, should be considered in any comprehensive HIV/STD prevention program”

Do the Navy and Marine Corps promote access to condoms?

Yes, in a thoughtful, targeted fashion. The objective is to reduce unprotected sex and thereby, reduce the incidence of sexually transmitted infections (STIs) and unplanned pregnancies. Navy medical guidance regarding condom access is cited in BUMEDINST 6222.10, Prevention and Management of Sexually Transmitted Diseases: “*Educational programs and materials (e.g. condoms and pamphlets) should also be appropriately available in community sites such as barracks, clubs, individual commands, medical facilities and health and wellness centers*”.

Examples of targeted access efforts include, but are not limited to, stocking condoms in some authorized minimum medical allowance lists (AMMALS) for Navy ships, and free condom access in some clinical settings and health fairs. Other opportunities include condom access in conjunction with the mandatory all-hands GMT/NMT-type and command-orientation-type sexual health lectures for Sailors, and the mandatory annual *Semper Fit* HIV-STI prevention lectures for Marines.

A study of the sexual behavior of deployed enlisted male sailors who had multiple sex partners suggests that Navy prevention efforts can positively influence condom use in foreign ports. (Norris E, Phillips R, Statton M, Pearson T, 2005).

Are sexually transmitted infections (STIs) a problem?

Yes.

Sexually Transmitted Infections (STIs), including HIV are a major public health threat. The American Social Health Association (1998) estimated that there are 15.3 million new cases of sexually transmitted disease in the United States each year, at an annual direct medical cost of \$8.4 billion.

Military members are at risk of exposure to STIs. Since 1999, about 100 active duty Sailors and Marines became infected with HIV each year. From 1985 through 2011, at least 5,800 active duty Sailors and Marines have been infected with HIV, most of whom have been lost to the service (NMCPHC 2012). In 2011, at least 5,000 active duty members were infected with Chlamydia, gonorrhea or syphilis (NMCPHC 2011). Although the incidence of Human Papillomavirus Virus (HPV) is unknown, 205 active duty female Sailors and Marines were diagnosed with cervical cancer from 2001-2005 (HPV is believed to cause 90% of cervical cancer). The estimated healthcare cost of these cases was \$5.4 million (NEHC 2007). From 2004-2009, there were 16,923 STI-related medical encounters with sailors and marines (AFHSC 2010).

Where do Sailors and Marines become infected with STIs?

Military members are infected with STIs, including HIV within the continental U.S. (CONUS) and abroad. Navy surveillance data indicate a high percentage of reported STIs are acquired in the CONUS. For example, the Atlantic fleet reported 97% of STIs were acquired CONUS (Schibly, 1998). Based on HIV subtypes, it seems a significant proportion of HIV infections among service members are probably acquired in CONUS (Brown, Newby, Ray, Jackson, & Burke, 1996; Brodine et al, 1995). STI frequency may be higher CONUS due to the fact that most military personnel spend most of their time in CONUS.

Sailors and Marines are also at risk for STIs while deployed overseas. For example, four of five servicemen infected with non-B HIV subtypes reported sex with prostitutes in overseas ports (Brodine et al., 1995). A 1991 study of self-reported behavior among 1744 shipboard male Sailors and Marines during a six-month deployment found “high levels of risk behavior for the transmission of STIs” including an overall prostitute contact rate of 42%, and a “new STI” infection rate of 10% (Malone et. al., 1993). Another 1992 study of 2072 male shipboard Sailors and Marines found an overall prostitute contact rate of 42% during all previous overseas deployments. This study also reported an increased risk of infection with hepatitis B among members with a history of short deployments to the South Pacific region (9.8% positive for anti-HBc) and among members with a history of longer duty in the Mediterranean and South Pacific (19.4% and 17.3% positive, respectively) (Hawkins et al, 1992).

Are unplanned pregnancies a problem?

Yes.

Unplanned pregnancies among active duty Sailors continue to be of concern. In 2010, 2 of 3 (64%) pregnancies among surveyed enlisted female Sailors unplanned. In other words, only 36% were intended. The national *Healthy People 2010* objective is to increase the proportion of pregnancies that are intended to 56% (DHHS 2012).

In 2005, 35% of surveyed male enlisted Sailors and 18% of female Sailors said “when a birth control method is not available, I believe you just have to take a chance and hope a pregnancy does not occur”. (Uriell Z. 2006).

How can STIs and unplanned pregnancies be prevented?

Abstinence from sex, or long-term mutual monogamy, are the most effective means of avoiding STIs.

For people who decide to have sex outside a monogamous relationship, proper use of latex condoms reduces the risk of acquiring or spreading many STIs, and reduces the chance of unplanned pregnancies.

People may further reduce risk by having sex with fewer people, and by not trading money for sex.

Do condoms work?

STIs. Yes – male latex condoms reduce risk, but do not eliminate risk (Holmes K, Levine R, Weaver M, 2004). According to the CDC (2003):

“Latex condoms when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases. While the effect of condoms in preventing Human Papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.”

“Condoms can be expected to provide varying levels of protection from different STDs. There is no one definitive study about condom effectiveness for all STDs. Several studies have demonstrated that condoms can reduce the risk for HIV, chlamydia, gonorrhea, and trichomoniasis, and may protect against herpes and syphilis. However, because not all studies have demonstrated protective effects, the body of evidence is considered inconclusive. Data are lacking regarding the degree of risk reduction for chancroid and genital Human Papillomavirus. The lack of data about condom effectiveness indicates that more research is needed – not that latex condoms don’t work.”

Regarding female condoms, there is very little data available about the female condom’s effectiveness against STIs. However, a recent study (Thamban et al, 2004) of male and female condom use among 869 women over a 6-month period concluded that

“Overall, failure rates were low enough to conclude that the 2 devices, when used correctly and consistently, should provide equivalent protection against STDs.”

Pregnancy. Yes. According to Hatcher et al (2011), the percentage of women experiencing an unplanned pregnancy during the first year, using only “chance” as their form of contraception, is 85%. With condoms, this percentage is reduced to:

Pregnancy Prevention Failure Rates for Male and Female Condoms

	With typical use	With perfect use
Male condoms	18%	2%
Female condoms	21%	5%

How are condoms used “correctly”

Studies indicate that a significant proportion of sexually active young Americans do not use condoms correctly. Mistakes include putting the condom on after some penetration has occurred, using petroleum-based lubricants with latex condoms, and failure to leave a reservoir at the tip of the condom.

For facts about correct condom use, please see the **attached SHARPFact** fact sheet Condoms and their use in preventing STIs.

Do Sailors and Marines Use condoms?

Condom use among Sailors and Marines has been increasing since 1998, according to a recurring DoD study of self reported health behaviors. In 2008, less than half of surveyed unmarried active duty Sailors and Marines wore a condom the last time they had sex.

Condom Use at Last Sexual Encounter Among Active Duty Unmarried Military Members

	Male	Female
Sailors	48%	34.5%
Marines	42.2%	26%
Soldiers	45.1%	38.1%
Airmen	45.7%	34.7%

(Note: the national Healthy People 2020 objective is not less than 60.7% for men and 38% for women)

The low level of condom use among unmarried female Sailors and Marines is a situation that deserves attention. HIV, syphilis and gonorrhea in female active duty members are very low. But, we do see about 2,000 Chlamydia infections in these women each year. What is it that prevents unmarried active duty women from insisting on condom use? How can we help our women have condoms where are when needed, help them feel confident and comfortable bringing up the subject of condom use with a partner, and help them insisting on condom use?

What prevents people from using condoms to protect themselves?

Barriers to consistent condom use may include limited access, experience, comfort or skills in condom use.

Some adults are embarrassed about buying condoms (Bracket K., 2004). Researcher Dr. Kimberly P. Brackett asked students at the University of Florida to purchase condoms and then write a paper about their experience. Embarrassment was prevalent among the 78 men and 176 women; many reported this was the first time they had purchased condoms. While the men reported less embarrassment than the women, the study found that both groups often used like strategies when making their purchase. For example, almost one-fifth said they sought out a clerk of the same sex. Both men and women reported trying to conceal the condoms or buying additional items to distract attention. Men and women alike said they scanned the store for other customers while purchasing the condoms; women were more likely to wait for other customers to leave.

Some people feel condoms ruin the mood or reduce sensitivity. Condom access efforts may enable some Sailors and Marines to overcome these barriers by demonstrating that there are many types of condoms. Condoms can be “fun”, rather than ruining the mood while other condoms may actually increase sensitivity. By informing people about the variety of condoms available, condom access efforts may help people overcome their dislikes about condoms.

People may not know how to bring up the subject of condom use with a partner. They may not be certain how to use a condom correctly. Although no studies have been conducted, anecdotal information suggests Sailors and Marines may use an “access” opportunity to ask questions about how to correctly use condoms and how to negotiate condom use with their partner.

Getting condoms they can try may also help some people overcome anxiety about using condoms for the first time.

Alcohol intake may serve as a barrier to correct and consistent condom use.

Is cost a barrier to condom use?

Data are sparse. However, studies in civilian populations in the U.S. have shown that increased condom access results in increased condom use. People who had access to free condoms were more likely to use condoms than were people who paid as little as 25 cents for a condom (Cohen et al 1999a; Cohen et al 1999b; Cohen and Farley 2004).

Why should the Navy and Marine Corps give away condoms – can't people buy them?

Sailors and Marines can and should buy condoms if they want to use them. Condoms are sold in every NEX and Marine Corps Exchange, not to mention many commercial establishments. Condoms can also be purchased over the internet.

But, in some foreign deployment locations, purchasing condoms may be inconvenient or impossible. Making condoms easy to get, at strategic times and places, may increase the likelihood that people who choose to have sex will do so with a condom, rather than without a condom.

Some people may be too embarrassed to be seen buying condoms. These people may be more likely to accept and use free condoms they can get inconspicuously in a clinic or on a ship, for example.

Also, making condoms available in small quantities at health promotion events may increase the likelihood a person will ask about them (and learn how to use them correctly and consistently), and may increase the likelihood that some people who are presently having unprotected sex will try them, and adopt them into their lifestyle.

Another barrier to buying condoms may be the location of condoms in the store. For example, some stores lock condom displays or position them behind the counter (to prevent theft). Many studies have demonstrated that people are often embarrassed to purchase condoms. If the customer must also ask the store clerk for help, some will be less likely to purchase them. The best location is one which is inconspicuous. Let's make condom access easy for our people. Where are condoms displayed in your exchange store? Can your local health promotion, preventive medicine or public health professional work with your exchange to increase accessibility of condoms to customers?

Who pays for “free” condoms?

Non-medical commands may purchase condoms for targeted issue, such as stocking of condoms in authorized minimal medical allowance lists.

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DoD policy prohibits distribution of over-the-counter contraceptives (including condoms) to individual beneficiaries for the purpose of family planning (Title 32: National Defense; PART 199—CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS);199.4; which states “Basic program benefits; (3) *Family planning*. The scope of the CHAMPUS family planning benefit is as follows: (B) *Exclusions*. The family planning benefit does not include the following: (1) Prophylactics (condoms)”. See https://www.hnfs.net/common/benefits/benefits_limitations_exclusions.htm.)

Do condom access efforts increase sexual activity?

No. Scientific research on this question has been primarily focused on adolescents and young adults. The evidence clearly suggests that condom distribution programs do not lead to earlier or more frequent sexual behavior (Franklin et al 1997, Wellings et al 1995, Kirby 1994). Condom availability has been shown to reduce STIs and pregnancy among adolescents (Wolk and Rosenbaum, 1995) and in some case to even decrease sexual activity (Blake et al, 2003; Seller et al., 1994). The evidence also shows that condom access decreases the frequency of unprotected sex and contributes to decreases in disease and pregnancy (Jemmott et al 1998) (Shafii et al 2007).

Do condom access efforts in military commands imply that sexual activity is encouraged or condoned?

No. Just as easy access to earplugs does not imply that people should expose themselves to loud noise, condom access does not imply people should have sex. By making access to earplugs and condoms easy, it is implied that safety is desired and expected. Condom access made easy by military commands should not be interpreted as encouraging sexual activity. Rather, targeted condom access efforts acknowledge risk and encourage and enable safer behavior to reduce that risk.

Why should I order condoms without spermicide?

Condoms with spermicides have a much shorter shelf-life than do condoms without spermicides.

Condoms with spermicides are no more effective than condoms without spermicide in preventing STI transmission (CDC 2002, 2003) or pregnancy (Hatcher et al 1998). In fact, the use of spermicide is not considered a reasonable choice of contraceptive when there is potential exposure to HIV, because frequent use of spermicides may theoretically irritate vaginal tissue and increase susceptibility to HIV infection (Hatcher et al 1998). The FDA warns that non-oxynol 9 (N9) spermicide should not be used for anal sex or by anyone infected with HIV (See the FDA labeling requirement for N9 at <http://www.fda.gov/bbs/topics/NEWS/2007/NEW01758.html> .

Is there a specific “Navy Issue” condom?

No. But SHARP recommends ordering directly from condom manufacturers or order through the federal supply system using NSN 6515-00-117-8416. This is a non-spermacidally lubricated male latex condom.

Commands may order condoms using National Stock Numbers or they may order directly from condom manufacturers or distributors. All the major brands have websites which provide ordering information and prices. There are many stock numbers in the federal supply system. The actual brand one receives through the supply system may vary, depending on recent periodic purchases made by the Defense Supply System. Notice that some are lubricated with spermicide (and have a much shorter shelf-life than do condoms without spermicides):

Some Navy authorized medical allowance lists (AMALS) include condoms. In February, 2005, an AMMAL change request was initiated to replace all male condom NSNs with 6515-00-117-8416 (lubricated male condom). While it appears this change has been made, as of January 2007 it seems that NSN 6515-01-260-6721 is being used by the Seabees, Specwar, Military Sealift Command, Naval Cargo Handling Command and EOD. SHARP has recommended NSN 6515-01-260-6721 (unit package quantity 36) be replaced by NSN 6515-00-117-8416 (unit package quantity 144). NSN 6515-01-260-6721 is non-lubricated. This is acceptable, but is inferior to the non-spermacidally lubricated NSN 6515-00-117-8416, because the user may add an inappropriate lubricant, like vaseline or baby oil, which will cause the condom to break. Additionally, the user may dislike the experience of a non-lubricated condom and therefore be less likely to use one in the future. While we can be encouraged that about 50% of unmarried male active duty sailors and marines report that they did use a condom the last time they had sex (2005 data), a large body of evidence informs us that a significant proportion of young American men do not use condoms correctly -- including inappropriate use of lubricants.

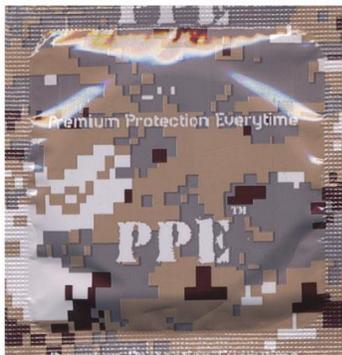
Anecdotal reports of condom breakage may have raised concerns among some Sailors and Marines about the quality of “Navy issue” condoms. A likely cause of quality degradation is improper storage (see Weiss, Olson and Brodine, 1992), such as leaving cases exposed to temperature extremes.

What is a “condom keychain”

SHARP purchases a condom keychain / compact as one mechanism to teach Navy medical professionals to teach their patients and populations about correct and consistent condom use. Each contains 2 male condoms and an information card. The front side of the card tells the reader how to get information from SHARP. The reverse side explains the advantage of abstinence or mutual monogamy for risk elimination, and explains that latex condoms reduce risk.



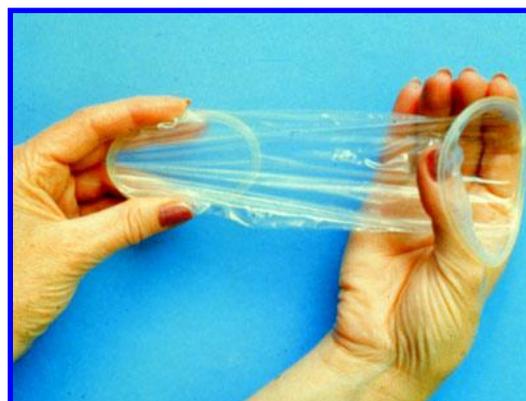
A condom container may promote correct and consistent condom use by people who choose to engage in sex outside a monogamous relationship because it (1) provides a discreet way to carry condoms and thus have them when needed, (2) protects the condoms from damage, (3) contains two condoms to facilitate replacement if the first tears or falls off, and (4) provides brief prevention information and the SHARP website address for those who want more information. Commands that are interested in purchasing this product may contact SHARP.



Another product which may appeal to our population is the “**PPE**” camouflage condom. This condom is available through commercial distributors and through the military supply system (NSN 6515-00-117-8416). Contact SHARP for more information.

What is the female condom?

The female condom is a polyurethane condom worn by a woman. The NSN is 6515-01-485-7192. You can through condom distributors. Please see the attached fact sheet [Female Condoms](#).



How can a command conduct a successful condom access effort?

Condom access and education opportunities include:

- National Condom day (February 14th; Valentines Day)
- National STD Awareness Month (April)
- National Teen Pregnancy Prevention Day and Month (May 5th)
- World AIDS Day (December 1st)
- Men's Health Month (April)
- Women's National Health Week (May)
- Women's Health Month (Oct)
- General Military Training (GMT) on sexual health
- Semper Fit STD prevention training
- Navy Military Training (NMT) on sexual health
- Health fairs
- Safety stand-downs
- Liberty briefings
- Pre-deployment briefings
- Annual women's health examination
- Annual preventive health assessment (men and women)
- Health care provider offices, health promotion, preventive medicine, laboratory waiting area, pharmacy, sick call waiting areas
- Treatment for sexually transmitted disease
- Requests for a "conscience" check

Suggested rules of thumb:

- Keep your leaders informed of your condom access strategy – avoid surprises.
- Because it is often an emotionally-charged issue, targeted condom distribution efforts require thoughtful planning and leadership courage. Access strategies should be sensitive to community concerns and perceptions.
- Get buy-in from community stakeholders including chaplains, clinical department heads, women's health experts, health promotion, preventive medicine, local "A" school commanders, and enlisted leaders.

Note about chaplains:

Chaplains are essential partners in sexual health promotion. They deliver value-based messages and provide individual counseling which supports responsible behavior. These services, which typically focus on risk elimination through abstinence and fidelity, compliment the comprehensive medical message that also include abstinence and monogamy plus additional options for risk

reduction. Together, Chaplains and medical professionals may reach the most people and do the most good. For example, in the words of Reverend James Goebel, CHC, USN:

“It is often believed that safe sex practices such as the use of condoms should be regarded as taboo to those who advocate abstinence. Abstinence is always the best policy, because it is the only sure and safe way to prevent pregnancy and sexually transmitted infections. However, the reality is that many people do not choose the best method, because they either feel pressured or feel that they have lost the ability to choose. Perhaps then the only solution is to offer a package, which includes both the condom along with helpful literature outlining the benefits of abstaining from sex until marriage when they can share themselves with that person who can give the greatest sense of intimacy and pleasure.” (note – the SHARPFact Sheet “Safer Options Reduce Risk” on the SHARP website discusses all of these options).

A fully-scripted, “all-hands”, value-based, PowerPoint lecture written by and for Chaplains may be accessed from the SHARP website.

- Anticipate community sources of “complaints” or concerns, in coordination with stakeholders. Although pediatricians often have condoms for patient education, your general promotion activities may minimize potential complaints by avoiding waiting areas that may include children. Buy-in from building “owners” can help prevent conflicts later. Let people voluntarily choose to take or ask about condoms – don’t “force” condoms on people by placing condoms onto trays in galleys, etc. People should feel they are free to engage or not.
- Thoughtfully devise a strategy, in coordination with stakeholders, which targets the segment of your population you believe to be at risk. Strategies for condom access may be:
 - universal access: for example, some commands may require every Sailor leaving a ship at every liberty port to take condoms from a bowl on the quarterdeck before disembarking. This strategy has the advantage of ensuring that every Sailor who will have sex has condoms available – even those that would not have taken condoms for fear of being seen taking them (fear of “discovery” or embarrassment). Another advantage is that all Sailors will have condoms to give to shipmates at risk. A disadvantage is that some Sailors may feel insulted. Issuing condoms and earplugs may help assuage concerns about the “message” being sent by leaders who adopt this universal access policy.
 - inconspicuous access: Customers may discreetly access condoms, i.e. without asking for permission and without being observed. For example, many preventive medicine offices, health promotion offices, shipboard medical spaces, and adult-patient clinical settings have condoms available in a place that patients may help themselves inconspicuously. Retail store make condom access “inconspicuous” by positioning condoms in a place where the customer does not need to ask for assistance to select them. Restroom dispensers are another example of “inconspicuous” access
 - educational opportunity access: for example, condoms offered to interested viewers of a sexual health display, at which a health professional or non-medical volunteer peer educator stands by to answer questions. Settings may be in a clinician’s office, at a health fair, or at a health display in a barracks, galley, or “A” school break room. These can be important awareness and knowledge-building events.

- Sexual health promotion efforts should not be perceived as just “pushing condoms”. Wherever you make condoms accessible, include a comprehensive prevention message that includes the fact that abstinence and monogamy can eliminate risk, and condoms reduce risk. Consider using the attached *SHARPFact* factsheet “Choosing Safer Options Reduces Risk”.
- Every clinician, counselor or educator tasked to speak with patients or clients about sexual health, should have condoms available for people who say they want to try them. Stock these clinical settings with a variety of condoms for patient education. Just having samples visible may generate patient questions and productive risk reduction discussions.
- Teach health care providers to speak with their patients about correct and consistent condom use. Many clinicians are not comfortable or experienced in this skill. Consider making this an in-service training for providers. Ask SHARP for help.
- Be prepared for occasional misuse of “free” condoms. For example, a bowl of free condoms may disappear from a clinic and reappear as “balloons” taped to the ceiling of a barracks hallway. Help leaders understand that these occasional events are expected, and each may be used as another opportunity to educate. Rather than focusing on preventing a recurrence by limiting access and punishing perpetrators, consider maintaining the same level of inconspicuous access and engaging perpetrators as partners in promoting sexual health among their peers.
- Don’t forget that many military members acquire their sexually transmitted infection while in the U.S. – condom access and sexual health education isn’t just a “deployment” concern.
- For females who decide to have sex, help them know it is OK for females to get and carry condoms and insist on their use. It is their right and responsibility to protect their health.
- If you invite your local public health office or family planning partners to participate in health fairs, remember they may bring along condoms and messages appropriate for their populations. These messages may be focused to some extent on men who have sex with men and injecting drug users. Discuss these issues with your partners and stakeholders and decide which products and messages are appropriate for your Navy/Marine Corps health promotion effort.

For advice or support, contact NMCPHC SHARP

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ATTACHMENTS

CDC Fact Sheet: Condom Distribution as a Structural-level Intervention

SHARPFAC: Condoms and their Use in Preventing STDs

Fact Sheet: Female Condoms

SHARPFAC: Choosing Safer Options Reduces Risk

CDC Fact Sheet on Male Latex Condom

Condom Distribution as a Structural Level Intervention

October 2010

Scientific Support for Condom Distribution

Individual-level and group-level risk reduction interventions are effective in increasing condom use and reducing unprotected sex. These types of interventions, however, focus on an individual's personal risk and do not address barriers beyond the individual, such as not having access to condoms. Structural-level interventions are particularly attractive in HIV prevention efforts because they are designed to address external factors that impact personal risk for HIV. A recent meta-analysis (www.springerlink.com/content/b587252154332991/fulltext.pdf), reviewing the scientific literature on structural-level interventions aiming to increase the availability, accessibility, and acceptability of condoms, found that:

- Structural-level condom distribution interventions or programs (CD programs) are efficacious in increasing condom use, increasing condom acquisition or condom carrying, promoting delayed sexual initiation or abstinence among youth, and reducing incident STIs.
- Interventions that combined CD programs with additional individual-, group- or community-level activities showed the greatest efficacy. One possible reason for this is that these different modalities address different behavioral determinants as well as other prevention needs of individuals in affected communities.
- CD programs were efficacious in increasing condom use among a wide range of populations, including youth, commercial sex workers, adult males, STD clinic patients, and populations in high risk areas.

CD programs have been shown to be cost-effective and cost saving. It was estimated that one state-wide CD program led to saving millions of dollars in future medical care costs by preventing HIV infections.

Programmatic Considerations for Condom Distribution

Programs should consider implementing CD programs in their communities. As resources and capacity warrant, programs should also consider integrating a CD program with other HIV prevention strategies and health care services as part of a comprehensive HIV prevention approach.

Those interested in designing and implementing a CD program should consider including these elements:

- Provide condoms free of charge.
- Conduct wide-scale distribution.
- Implement a social marketing campaign to promote condom use (by increasing awareness of condom benefits and normalizing condom use within communities).
- Conduct both promotion and distribution activities at the individual, organizational, and environmental levels.
- Target: 1) individuals at high risk, 2) venues frequented by high-risk individuals, 3) communities at greatest risk for HIV infection, especially those marginalized by social, economic, or other structural conditions, or 4) the general population within jurisdictions with high HIV incidence.
- Supplement the CD program with more intense risk reduction interventions or other prevention or health services for individuals at highest risk. Integrate CD program activities within other community-level intervention approaches to promote condom use and other risk reduction behaviors.
- Establish organizational support for condom distribution and promotion activities in traditional and non-traditional venues.
- Conduct community-wide mobilization efforts to support and encourage condom use.



Additional Resources:**CDC HIV and AIDS**

www.cdc.gov/hiv
Visit CDC's HIV and AIDS Web site.

CDC-INFO

**1-800-CDC-INFO or
1-800 (232-4636)**

cdcinfo@cdc.gov

Get information about personal risk, prevention, and testing.

CDC National HIV Testing Resources

www.hivtest.org
Text your ZIP code to KNOW IT or 566948
Locate an HIV testing site near you.

CDC National Prevention Information Network (CDC NPIN)

1-800-458-5231
www.cdcpin.org
Find CDC resources and technical assistance.

AIDSinfo

1-800-448-0440
www.aidsinfo.nih.gov
Locate resources on HIV and AIDS treatment and clinical trials.

For more information, visit the CDC HIV and AIDS Web site at www.cdc.gov/hiv.

Important issues to consider while planning and designing a CD program are:

- Develop a process for identifying and engaging appropriate community partners.
- Identify who plans, implements, manages, and provides resources to support a CD program.
- Identify obstacles to reaching members of vulnerable or hard-to-reach populations and strategies to overcome them.
- Calculate the costs and determine the scale of a CD program.
- Identify the laws, policies, or practices that may support or hinder a CD program.
- Define programmatic objectives, key indicators for measuring performance, and how these data will be collected. Key indicators to consider are:
 - Number of condoms distributed.
 - Number of agencies, venues, or settings where free condoms are distributed.
 - Estimated number of audience impressions from campaign messages.

Snapshots of Existing CD Programs**New York City Department of Health & Mental Hygiene (NYC DOHMH)**

- The NYC DOHMH distributes free condoms and water-based lubricants to partnering organizations through their Web site **www.nyccondom.org**.
- Partners include traditional public health agencies (e.g. clinics, hospitals, CBOs, shelters), schools, and businesses (e.g. health clubs, bars, barbershops, clothing stores, hotels).
- Distribution grew from 5.8 million free condoms in 2004 to 17.3 million in 2006 to over 40 million in 2009.
- Since 2007, DOHMH has branded, packaged, and distributed its own “NYC Condom” to appeal to the local community.
- Social marketing campaigns are conducted annually and include TV and subway ads, web banners, and posters. Ad designs are tailored to particular communities within NYC.

- The NYC DOHMH website also provides information on where to obtain free condoms, the importance of condom use, how to correctly use condoms, and other HIV/STD resources in the city.

District of Columbia (DC) Department of Health: HIV/AIDS, Hepatitis, STD, & TB Administration (HAHSTA)

- HAHSTA distributes free condoms and lubricants to partnering organizations and to any DC resident through their Web site **www.doh.dc.gov/condoms**.
- More than 300 traditional partners and hundreds of other local businesses (e.g. clubs, laundromats, convenience stores, beauty shops, nail salons, barber shops, liquor stores) provide free condoms to the community.
- Distribution grew from 500,000 free condoms in 2007 to 3.5 million in 2009.
- The social marketing campaign includes customized condom packages, dispensers, information cards, stickers, t-shirts, and posters/decals to promote condom use and emphasize condom availability at participating locations.
- HAHSTA's Web site provides information on where to obtain free condoms and how to correctly use condoms.
- Youth-specific condom promotion and education campaigns have been developed to work with youth-serving CBOs and schools.
- Social media are being used to promote condom use and to identify locations that provide free condoms by zip code.

Next Steps

CDC has identified additional examples of condom distribution programs implemented in various settings that may be useful to agencies interested in initiating or augmenting their condom distribution programs. Those examples, along with additional resources, will be included in a *Condom Distribution Toolkit* that CDC intends to publish in early 2011.

Condoms and STDs:

Fact Sheet for Public Health Personnel



Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of STD transmission. To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many infected persons may be unaware of their infections because STDs are often asymptomatic or unrecognized.

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies.



Sexually Transmitted Diseases, Including HIV Infection

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.

There are two primary ways that STDs are transmitted. Some diseases, such as HIV infection, gonorrhea, chlamydia, and trichomoniasis, are transmitted when infected urethral or vaginal secretions contact mucosal surfaces (such as the male urethra, the vagina, or cervix). In contrast, genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical and empirical basis for protection. Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases are transmitted. Condoms block transmission and acquisition of STDs by preventing contact between the condom wearer's penis and a sex partner's skin, mucosa, and genital secretions. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or HPV because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing risk of STD transmission among condom users with nonusers who are engaging in sexual intercourse. Accurately estimating the effectiveness of condoms for prevention of STDs,



however, is methodologically challenging. Well-designed studies address key factors such as the extent to which condom use has been consistent and correct and whether infection identified is incident (i.e., new) or prevalent (i.e. pre-existing). Of particular importance, the study design should assure that the population being evaluated has documented exposure to the STD of interest during the period that condom use is being assessed. Although consistent and correct use of condoms is inherently difficult to measure, because such studies would involve observations of private behaviors, several published studies have demonstrated that failure to measure these factors properly tends to result in underestimation of condom effectiveness.

Epidemiologic studies provide useful information regarding the magnitude of STD risk reduction associated with condom use. Extensive literature review confirms that the best epidemiologic studies of condom effectiveness address HIV infection. Numerous studies of discordant couples (where only one partner is infected) have shown consistent use of latex condoms to be highly effective for preventing sexually acquired HIV infection. Similarly, studies have shown that

condom use reduces the risk of other STDs. However, the overall strength of the evidence regarding the effectiveness of condoms in reducing the risk of other STDs is not at the level of that for HIV, primarily because fewer methodologically sound and well-designed studies have been completed that address other STDs. Critical reviews of all studies, with both positive and negative findings (referenced here) point to the limitations in study design in some studies which result in underestimation of condom effectiveness; therefore, the true protective effect is likely to be greater than the effect observed.

Overall, the preponderance of available epidemiologic studies have found that when used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV infection and reduce the risk of other STDs.

The following includes specific information for HIV infection, diseases transmitted by genital secretions, genital ulcer diseases, and HPV infection, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.



HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS

HIV infection is, by far, the most deadly STD, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. The ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of HIV.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as urethral and vaginal secretions, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate that the consistent use of latex condoms provides a high degree of protection.

Other Diseases transmitted by genital secretions, including Gonorrhea, Chlamydia, and Trichomoniasis

Latex condoms, when used consistently and correctly, reduce the risk of transmission of STDs such as gonorrhea, chlamydia, and trichomoniasis.

STDs such as gonorrhea, chlamydia, and trichomoniasis are sexually transmitted by genital secretions, such as urethral or vaginal secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against diseases such as gonorrhea, chlamydia, and trichomoniasis by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of STDs such as chlamydia, gonorrhea and trichomoniasis.



Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Consistent and correct use of latex condoms reduces the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. Condom use may reduce the risk for HPV infection and HPV-associated diseases (e.g., genital warts and cervical cancer).

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/secretions. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are covered (protected by the condom) as well as those areas that are not.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms provide limited protection against syphilis and herpes simplex virus-2 transmission. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers associated with increased condom use in settings where chancroid is a leading cause of genital ulcers.

Condom use may reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer) and may mitigate the other adverse consequences of infection with HPV; condom use has been associated with higher rates of regression of cervical intraepithelial neoplasia (CIN) and clearance of HPV infection in women, and with regression of HPV-associated penile lesions in men. A limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer, nor should it be a substitute for HPV vaccination among those eligible for the vaccine

Selected References are available at:

www.cdc.gov/condomeffectiveness/references.html



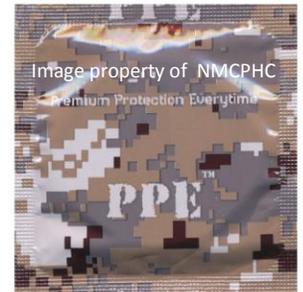


FACT SHEET – 12 July 2012 CONDOMS

Introduction

With nearly 1 million Americans infected with HIV, most of them through sexual transmission, and an estimated 19 million cases of other sexually transmitted infections (STIs) occurring each year in the United States, effective strategies for preventing these diseases are critical.

Refraining from having sexual intercourse with an infected partner is the best way to prevent transmission of HIV and other STIs. But for those who have sexual intercourse, the correct and consistent use of latex condoms during sexual intercourse - vaginal, anal, or oral - can greatly reduce a person's risk of acquiring or transmitting HIV infection. Use of latex condoms reduces the risk of acquiring or transmitting other STIs, including diseases transmitted by genital secretions (such as gonorrhea, chlamydia, and trichomoniasis) and, to a lesser degree, genital ulcer diseases (such as genital herpes, syphilis, and chancroid). Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases (such as genital warts and cervical cancer).



Condoms must be used consistently and correctly to provide maximum protection. Consistent use means using a condom with each act of intercourse. Correct condom use includes all of the following steps:

- Use a new condom for each act of vaginal, anal, or oral intercourse.
- Put on the condom on before any penetration.
- Hold the tip of the condom as you unroll it, leaving space at the tip of the condom.
- You can buy lubricated condoms. If you feel you need to add lubrication to a latex condom, use only water-based lubricants, which may be purchased at any NEX, MCX or pharmacy. Oil-based lubricants, such as petroleum jelly, cold cream, hand lotion, or baby oil, can weaken the condom and cause it to break.
- After ejaculation, hold the condom firmly at the base and withdraw while erect, to keep the condom from slipping off.

Myths About Condoms

Misinformation and misunderstanding persist about the effectiveness of condoms. The Centers for Disease Control and Prevention (CDC) provides the following updated information to address some common myths about condoms. This information is based on findings from recent studies.

Myth #1: Condoms frequently break. Some have questioned the quality of latex condoms. Condoms are classified as medical devices and are regulated by the Food and Drug Administration. Every latex condom manufactured in the United States is tested for defects before it is packaged. During the manufacturing process, condoms are double-dipped in latex and undergo stringent quality control procedures. Several studies clearly show that condom breakage rates in this country are less than 2 percent. Most of the breakage is likely due to incorrect usage rather than poor condom quality. Using oil-based lubricants can weaken latex, causing the condom to break. In addition, condoms can be weakened by exposure to heat or sunlight, or by age, or they can be torn by teeth or fingernails.





FACT SHEET – 3 June 2014

CHOOSING SAFER OPTIONS REDUCES RISK

Introduction

Over 1 million Americans are infected with HIV, most of them through sexual transmission. As many as one-fourth of these people don't even know they are infected. One in four cases of HIV infection in the U.S. now occurs in a women. Most infected women and some infected men were infected by heterosexual contact. HIV is spread between men and women. In fact, women in the U.S. and around the world are becoming increasingly affected by HIV. Over 6000 active duty sailors and marines have been infected with HIV. An estimated 19 million new sexually transmitted infections (STI), including HIV, occur each year in the United States. Experts estimate that one in four Americans will become infected with a sexually transmitted disease in their lifetime. Effective strategies for preventing these diseases are critical.

How can we reduce our risk of getting one of these diseases? What are the options?

Abstain from sex or delay sex

Refraining from having sexual intercourse with an infected partner is the best way to prevent transmission of HIV and other STIs. People can choose to not have sex. People can also decide to wait, or delay sex, until a later time in their life. They may choose to have personal relationships that do not involve sex.

Choose Outer-course vs. Intercourse

Outer-course is non-penetrative contact, such as massaging, hugging, and kissing. Non-penetrative contact vs. intercourse can eliminate transmission risk for HIV and most (though not all) STIs.

Monogamy is sex between two people, who only have sex with each other, as part of a long-term relationship. If neither partner is infected, there is no risk of disease transmission. A series of short-term relationships is not as safe because of the increased risk that one of those partners will be infected.

Use Condoms and other barriers

Although not as safe as abstinence or monogamy, the correct and consistent use of latex condoms during sexual intercourse - vaginal, anal, or oral - can greatly reduce a person's risk of acquiring or transmitting many STIs, including HIV infection. In fact, recent studies provide compelling evidence that latex condoms are highly effective in protecting against HIV infection when used for every act of intercourse. A variety of male condoms are available. Female condoms and oral barriers are also available. Condoms can reduce both the risk of pregnancy and the risk of disease transmission. Put the condom on before any vaginal, anal, or oral contact.

Condoms can be expected to provide different levels of risk reduction for different STIs. There is no one definitive study about condom effectiveness for all STIs. Several studies have demonstrated that condoms can reduce the risk of acquiring chlamydia, gonorrhea, trichomoniasis, syphilis, chancroid, herpes, Humanpapilloma Virus (HPV) and cervical cancer.

Condoms for Women. The "FC2" female condom™ is lubricated and disposable. The lubricant is non-spermicidal. One study of this condom as a contraceptive indicates a failure rate of 21-26 percent in 1 year among typical users; for those who use the female condom correctly and consistently, the rate was approximately 5 percent. Unlike the male condom, the female condom™ protects the external female





genitalia because its outer edge remains outside the vagina during sex – resulting in less skin-to-skin contact. If a male condom cannot, or will not be used, consider using a female condom.

Reduce the number of sexual partners

Many people who are infected with an STI don't know it, and you can't tell just by looking at them. The more people a person has sex with, the more likely it is that one (or more) will be infected with an STI. Though not as safe as abstinence or monogamy, reducing the number of people a person has sex with can reduce risk by reducing the number of potential exposures.

Do not have sex with “high-risk” people

You can't tell if potential partners are “high risk” just by looking at them. People who may be at higher risk of having a sexually transmitted infection include those who trade sex for money or sex for drugs, because they may have sex with many other people. Other people who may be at higher risk are people who share needles, because this activity can result in HIV, Hepatitis B and Hepatitis C infections, which can then be spread sexually. Non-monogamous men who have sex with men are also at higher risk of being infected with HIV and Hepatitis B because the risk of transmitting these viruses is greater with receptive anal intercourse than with vaginal or oral intercourse, and because some of these men may have many sex partners. Having sex with a person who is more than 5 years older than you can also involve increased risk. Though not as safe as abstinence or monogamy, avoiding sex with “high-risk” people can reduce risk of exposure to a sexually transmitted infection.

Other things that can reduce the risk of infection with HIV or other STDs are:

Consider HIV Pre-Exposure Prophylaxis (PrEP)

PrEP is daily medication used for HIV prevention by people at very high risk of getting HIV. Ask your doctor if PrEP may be right for you.

Do not share needles or “works”

The safest thing a person can do is to not inject (non-prescription) drugs. For people who do continue to inject drugs, use a new, sterile needle from a reliable source each time. HIV and other viruses can be spread whenever needles are contaminated with blood - even small quantities of blood which may not be visible to the naked eye. This is true of all needles – including needles used for steroids, tattooing or body piercing. If sterile needles cannot be used, disinfect needles and syringes before and after each use.

Stay sober - Use of drugs or alcohol can affect sexual behavior because of reduced inhibitions and clouded judgment. Stay in control – stay sober.

Get tested for HIV and syphilis every year if you are a man who sex with men or a person who has unprotected sex with multiple partners. **Get tested for chlamydia every year** if you are a women under the age of 25 or, if older than 25, you have unprotected sex with multiple partners.

Where can I get more information? Your medical care provider should be consulted if you think you may have been exposed to any sexually transmitted disease. CDC provides information through their National STD Hotline at (800) 227-8922 and their National AIDS Hotline at (800) 342-AIDS (2437).



Myth #2: HIV can pass through condoms. A commonly held misperception is that latex condoms contain "holes" that allow passage of HIV. Laboratory studies show that intact latex condoms provide a highly effective barrier to sperm and micro-organisms, including HIV and the much smaller hepatitis B virus. Natural membrane or animal skin condoms, are not recommended for STI prevention. They contain natural pores in the membrane through which HIV and other STIs may pass.

Preventing HIV Infection and Other STIs: Recommended Prevention Strategies

Abstaining from sexual intercourse is the most effective HIV prevention strategy. For individuals who are sexually active, the following are highly effective:

- Having intercourse only with one uninfected partner
- Using latex condoms correctly from start to finish with each act of intercourse

Condoms for Women. The **female condom** or vaginal pouch has recently become available in the United States. A small study of this condom as a contraceptive indicates a failure rate of 21-26 percent in 1 year among typical users; for those who use the female condom correctly and consistently, the rate was approximately 5 percent. Although laboratory studies indicate that the device serves as a mechanical barrier to viruses, further clinical research is necessary to determine its effectiveness in preventing transmission of HIV. If a male condom cannot be used, consider using a female condom.

Plastic Condoms. A polyurethane male condom was approved by FDA in 1991 and is now available in the United States. It is made of the same type of plastic as the female condom. The lab studies show that the new polyurethane condoms have the same barrier qualities as latex. Lab testing has shown that particles as small as sperm and HIV cannot pass through this polyurethane material. A study of the effectiveness of this polyurethane condom for prevention of pregnancy and STIs is underway. The new polyurethane condoms offer an alternative for condom users who are allergic to latex. Also, polyurethane condoms can be made thinner than latex, have no odor, and are safe for use with oil-based lubricants.

Spermicides. In one study, of women at very high risk of exposure to HIV infection, researchers found that the women who used Nonoxyol-9 (N-9) gel had become infected with HIV at about a 50% higher rate than women who used a placebo gel. Further, the more frequently women used only N-9 gel (without a condom) to protect themselves, the higher their risk of becoming infected. Simply stated, **N-9 did not protect against HIV infection and may have caused more transmission.** Women who used N-9 also had more vaginal lesions, which might have facilitated HIV transmission. While N-9 will not offer any additional protection against HIV, a condom lubricated with N-9 is clearly better than using no condom at all. The protection provided by the condom against HIV far outweighs the potential risk of N-9. If given the choice, **condoms without N-9 may be a better option for HIV prevention.**



Where can I get more information?

Your medical care provider should be consulted if you think you may have been exposed to any sexually transmitted disease. CDC provides information through their National STD Hotline at (800) 227-8922 and their National AIDS Hotline at (800) 342-AIDS (2437). For further information regarding your sexual health, visit the SHARP Home Page at <http://www-nehc.med.navy.mil/hp/sharp>.

This information adapted by the Sexual Health and Responsibility Program (SHARP), Navy and Marine Corps Public Health Center from material developed by the Centers for Disease Control and Prevention

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Information about FC2[®] Female Condom and Its Use.

FC2 female condom has the same design and instructions for use as the FC1 female condom. The material has been changed to improve affordability, while maintaining the high quality, reliability and features of FC1. FC2's sheath, with its outer ring, is made from a synthetic nitrile. Insert FC2 prior to sexual intercourse to provide protection against HIV/AIDS, other STIs and unintended pregnancies. The inner ring aids insertion and helps to secure the device in place during intercourse while the softer outer ring remains outside the vagina.



FC2 female condom

- Is a new second generation female condom made of synthetic nitrile. It was designed to improve affordability, particularly in large volumes, while maintaining the high quality, reliability and features of the original FC1 female condom.
- Has been shown in studies to be comparable to FC1. These assessments include preclinical safety studies of the new material and a direct comparison study evaluating efficacy in terms of failure rates (rips, tears and slippage).
- Is, with FC1, the only female-initiated protection method invented and approved since the advent of the HIV/AIDS epidemic.

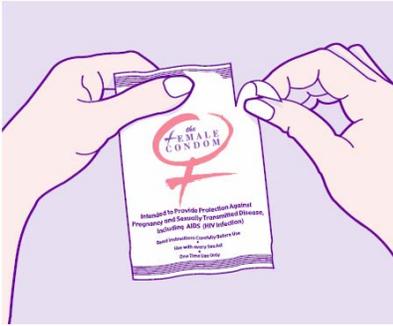
Like FC1, FC2

- Provides women and men with an additional choice to protect themselves against HIV/AIDS, other STIs and unintended pregnancies.
- Forms a barrier between the penis and the vagina, cervix and part of the external genitalia, thereby providing additional protection.
- Is strong, hypoallergenic and, unlike latex, may be used with both oil and water-based lubricants.
- Is not dependent on the male erection, does not require immediate withdrawal and is not tight or constricting.
- Has passed a stringent technical review process conducted by WHO including safety, quality and clinical data.
- Received FDA approval for distribution in the United States.

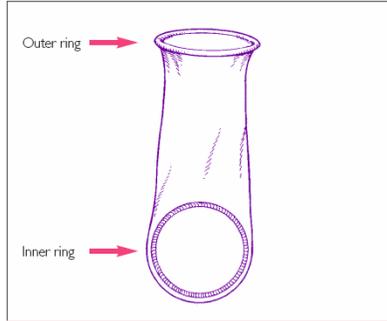
The Female Health Company
515 North State Street, Suite 2225
Chicago, Illinois 60654
Tel: + 1 312 595 9123
Fax: + 1 312 595 9122
Email: info@femalecondom.org
www.femalehealth.com



FC2 female condom is not difficult to use but it may take some practice to become comfortable with it. Women should practice inserting and removing it prior to using it for the first time during sexual intercourse. Insertion becomes easier with practice — try it at least 3 times before making any decisions about future use.



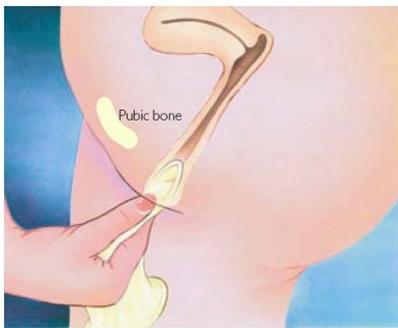
1. Open the package carefully by tearing the notch on the top right of the package. Do not use scissors or a knife to open.



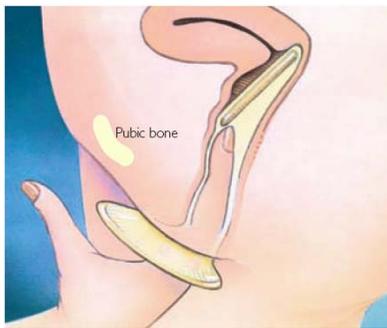
2. The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to hold the sheath in place during intercourse.



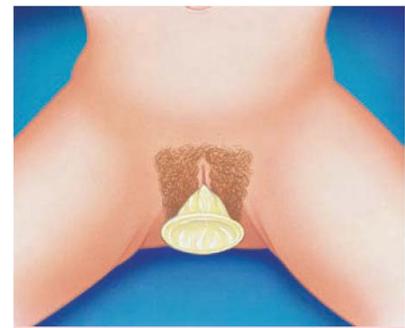
3. Hold the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and middle finger so it becomes long and narrow.



4. Choose a position that is comfortable for insertion – squat, raise one leg sit or lie down. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.



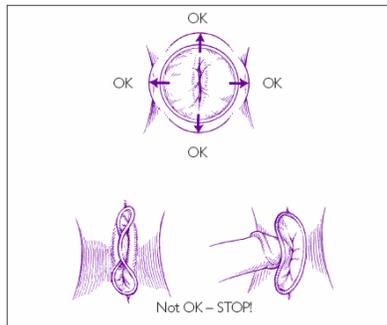
5. Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.



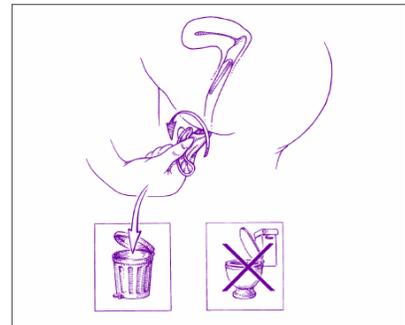
6. FC2 female condom is now in place and ready for use with your partner:



7. Gently guide your partner's penis into the sheath's opening using your hand to make sure that it enters properly.



8. Be sure that the penis is not entering on the side, between the sheath and the vagina wall.



9. To remove the condom, twist the outer ring and gently pull the condom. Wrap the condom in the package or in a tissue and throw it in the garbage. Do not put in the toilet.

- Natural rubber latex condoms for men are highly effective at preventing sexually transmitted infections, including HIV/AIDS, if used correctly.
- If you are not going to use a male natural rubber latex condom, you can use the FC2 Female Condom to help protect yourself and your partner.
- The FC2 Female Condom only works when you use it. Use it correctly every time you have sex.
- Before you try the FC2 Female Condom, be sure to read the directions and learn how to use it correctly.