

25 April 2001
Original version submitted

Brief report on the effect of providing single versus assorted brand name condoms to hospital patients: a descriptive study

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Condom distribution to hospital patients: the effect of providing single versus assorted brand name condoms on acquisition

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Abstract

Objectives. This study examined condom acquisition by persons in a hospital setting when single versus assorted brand name condoms were provided.

Methods. Condom receptacles were placed in exam rooms of two clinics. During Phase 1, a single brand name was provided; for Phase 2, assorted brand names were added. Number of condoms taken was recorded for each phase.

Results. For one clinic there was nearly a two-fold increase in number of condoms taken (Phase 1 to Phase 2); for the second clinic there was negligible difference in number of condoms taken.

Conclusions. The provision of assorted brand name condoms, over a single brand name, can serve to increase condom acquisition. Locations of condoms and target population characteristics are related factors.

Public health professionals promote condom use as a means to prevent the spread of hepatitis B, HIV and other sexually transmitted diseases among persons at risk for these diseases. [1-3] Condom distribution, a strategy for increasing condom availability, is a principal component of risk reduction interventions targeting these persons and condom availability has been enhanced via the application of social marketing principles. [4-6]

With the establishment of effective condom distribution systems, public health professionals are then challenged to encourage the use of these systems by those at risk. Condom distribution setting, condom cost and provision of a variety of condoms are all factors that may influence people to acquire condoms. [7-11]

There are a wide variety of condoms on the market, with at least 70 types differing by brand name, size, texture, thickness, color, flavor, scent, lubrication level and lubrication type. [12] The range of condom properties offered suggests that manufacturers are not only responsive to matters related to condom utility, they are also seeking to satisfy user's particular preferences. Among condom users, condom acceptability is influenced by characteristics such as shape, size and amount of lubrication. [13-15] These and other potentially desirable characteristics can vary from one brand name to another. The current study examines condom acquisition when single versus assorted brand name condoms was made available to persons within a hospital-based condom distribution system.

Methods

Setting and Procedures

This study was conducted from January to May of 1997 at the Alaska Native Medical Center located in Anchorage, Alaska. The medical center is an Indian Health Service facility serving Alaska Natives, American Indians and other non-Native American beneficiaries. Prior to this study, the Outpatient Pharmacy and Women's Health Clinic distributed a single brand name

condom. These clinics offered the LifeStyles[®] lubricated condom, which is listed in the General Services Administration formulary. For this study, we established condom distribution locations in the Internal Medicine Clinic (IMC; open weekdays, 8-6 PM) and Emergency/Urgent Care Clinic (ECC; open 24 hours a day, 7 days a week).

Condom receptacles, open-topped clear plastic containers (4 x 10 x 7 in), were placed in 5 IMC and 6 ECC exam rooms. Receptacles were wall-mounted with the opening 58 in from the floor, an unreachable distance for most children. Characteristics of the clinic exam rooms (i.e., room size and amount of furnishing) influenced placement of the receptacles. Exam rooms in the IMC were large and it was often necessary to mount receptacles amongst or over existing furnishings. Exam rooms in the ECC were small and contained few furnishings, allowing us to mount receptacles in conspicuous locations.

For Phase 1 (1/23/97 to 3/17/97; 54 days) receptacles were filled with known quantities of LifeStyles[®] lubricated condoms. For Phase 2 (3/18/97 to 5/6/97; 50 days), we continued providing LifeStyles[®] lubricated condoms and added known quantities of assorted brand name condoms, including Love Gasket[®], Maxx Plus[®], Ramses[®], Fiesta[®], lubricated and mint-flavored Sheik[®], Kimono[®] and Gold Coin[®].

To familiarize patients with the new distribution locations, we provided LifeStyles[®] lubricated condoms for a 30-day period prior to beginning Phase 1. During the study period, IMC and ECC receptacles were monitored and replenished with condoms on a biweekly basis. In addition, a supply of patient education pamphlets pertaining to disease prevention and condom use techniques was also maintained.

Data Analysis

Only clinic visits by patients aged 14 years and older were included as we reasoned that a majority of them would be less motivated or unable to take condoms. Paired samples *t* test and chi square analysis was used as appropriate.

Results

Table 1 illustrates sex and age of patients and a description of visit reasons by clinic for the overall study period. During this time 6000 females and 3578 males were seen at the IMC and ECC; patient sex was significantly associated with clinic attendance ($\chi^2_1 = 7.5, P = .006$). The mean age for females (39.8 years) was not significantly different than that of males (40.2 years). Patients seen at the ECC were significantly younger (mean = 37.9 years) than those seen at the IMC (mean = 49.3 years; $t_{9576} = -26.89, p < .001$). Among IMC patients, reasons for visits were generally chronic or maintenance in nature (e.g., diabetes) and visits among ECC patients were generally acute or episodic.

For the IMC there was slight increase in number of condoms taken from Phase 1 to Phase 2 (285 vs 286). For the ECC there was nearly a two-fold increase in number of condoms taken from Phase 1 to Phase 2 (3565 vs 6067).

Discussion

Study findings suggest that provision of assorted brand name condoms, over a singular brand name, will serve to increase condom acquisition. Patients were often unattended in the exam rooms giving them opportunity to take condoms in private, a condition favorable to improving acquisition rates. [7] Substantial increases in condom acquisition, however, were specific to only one of the two distribution locations. This increase may be due to the ECC patient's younger age and their degree of sexual activity or it may be due to the higher volume of patient visits to this clinic. In addition, data from both phases showed that IMC patients acquired far fewer condoms than ECC patients did, a finding that may be attributable to condom receptacle placement. Receptacles in the ECC were highly visible and accessible. In the IMC the receptacles were, in cases, located behind equipment making access more difficult.

The offering of assorted brand name condoms may appeal to persons in several ways. Merely the uniqueness of the packaging (e.g., wrapper color or design), condom brand name (e.g., Love Gasket[®] or Maxx Plus[®]), or condom style (e.g., flavored or colored) may induce

people to take them. In addition, as previously stated, shape, size and amount of lubrication can influence condom acceptability. Those who find these characteristics acceptable may see them identified on the condom label or they may infer them from the brand name. Lastly, people may have familiarity with or loyalty to a particular brand name or they may simply be interested in experimenting with new ones.

An intended outcome of this study was the formation of a strategy for improving condom accessibility and acquisition, with the hopeful goal to increase their use, among a population having members who demonstrate low rates of condom use and high rates of sexually transmitted disease. [16-18] Therefore, we did not attempt to collect additional patient-specific data given concerns that methods for doing so, such as, obtaining of informed consent, conducting focused interviews and observing condom taking behavior would negatively impact its potential benefit. Consequently, we were unable to determine who took condoms and whether the condoms were used, given away, or even sold or destroyed. In consideration, we limited statistical analyses to patient demographics and number of condoms distributed. However, we contend that the increased number of free condoms taken from the hospital is likely to have resulted in increased availability and usage in the community.

Results of our study suggest that programs maintaining a condom distribution system should offer a variety of brand name condoms to their participants. We note that before beginning this study we conducted no research to support our decision to purchase and distribute one brand name over another. However, we did have anecdotal reports from female patients, who were known to trade sex for money or drugs, that they preferred flavored or nonlubricated condoms for oral sex. Thus, we suggest that program administrators survey their target population to evaluate the acceptability of particular brand names or condom styles. Alternatively, programs could closely monitor

condom inventories and subsequently provide brand names that have higher demand.

Explicating the relationship between brand name preference, condom distribution

location and condom use is a topic for future research.

Acknowledgements

The authors wish to thank Brian McMahon and Cheryl Bowie for their support and assistance with conducting this study. The authors also thank Beth Trubatch, Andrea Fenaughty and Dana Lindemann for their effort on earlier drafts of this manuscript. Financial support for this study came from the Viral Hepatitis Program, Alaska Native Medical Center.

The use of condom brand names in this manuscript is for identification purposes only. Contributing authors, those who were acknowledged, the Viral Hepatitis Program and the Alaska Native Medical Center do not have any affiliation with the manufacturers or distributors of named products and their mention does not imply endorsement.

Table 1. Number of Patient Visits, Sex and Age of Patients, and Primary Reason for Visit by Clinic for the Overall Study Period

	No. of Patient Visits*	<i>n</i> (%)
Internal Medicine Clinic	2444	
Sex		
Female		1043
(60)		
Male		702
(40)		
Age		
14-28		228
(13)		
29-43		457
(26)		
44-58		506
(29)		
59-73		400
(23)		
74-88		148
(8)		
≥89		6
(<1)		
Primary Reason for Visit		
Liver, Heart, Lung or Other Exam		642 (26)
Hypertension		301
(12)		
Esophagus Disorder		125 (5)
Emergency/Urgent Care Clinic	12 528	
Sex		
Female		4957
(63)		
Male		2876
(37)		
Age		
14-28		2456
(31)		
29-43		2945
(38)		
44-58		1507
(19)		
59-73		705
(9)		
74-88		213
(3)		
≥89		7
(<1)		
Primary Reason for Visit		
Upper Respiratory Disorder		1293 (10)
Inner Ear Disorder		789 (6)
Acute Pharyngitis		753 (6)

*Values include multiple visits by a single patient.

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8 May 2001
Reviewers' reports

Brief report on the effect of providing single versus assorted brand name condoms to hospital patients: a descriptive study

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Deborah Cohen

The data presented are very limited but are fascinating. The main shortcoming of the study has to do with the limited findings and interpretation of the findings. The authors need to describe how the IMC and ER are different (or similar) Do patients need appointments to visit the IMC? Is the ER (presumably) walk-in? If this is the case, then the patients served are apt to be extremely different. There is a lot of data showing that ER patients tend to be extremely high risk, and are more like the type of people who do not plan for the future and are impulsive. Therefore, the ER is probably the best place in any locality in which to provide HIV risk reduction interventions due to the population and high volume. This is extremely important. Although it is recognized that ERs attract high risk people, very few interventions are actually scheduled in an ER. The increase in condom uptake when new varieties were made available, underscores that the ER population is more likely to try new things (in a sense take more risks) than the IMC population. The paper would benefit from authors obtaining more data about the ER and IMC population-maybe they could get hold of discharge diagnoses. The ER population might actually be going there because of STD or HIV related symptoms, whereas the IMC might have more chronic conditions like Diabetes, which might limit their sexual risk taking behaviors.

If the intervention is still ongoing, perhaps some qualitative interviews might be done with patients to understand the findings better. Or a description of the history of the program would be useful-is it still in existence? If not, why not?

Unless there is more substance to be added to the paper, I would recommend revising as a brief letter, rather than as an article.

Ruth Garside

This is a paper whose findings are important to those with closely related research interests which can be accepted without revision. The quality of written English is acceptable for publication.

Competing interests: None declared.

This study examined uptake of condoms freely provided in two hospital settings and compared the uptake when a single brand condom was offered to when assorted brands were offered. The authors conclude that offering assorted brands can substantially increase uptake in some settings. This is a useful finding for all health care providers who are trying to encourage condom use to prevent the spread of STIs and as contraception. The limitations of the study are acknowledged by the authors and reasons why only one location showed a substantial change explored. The study is described in sufficient detail to allow replication and comparison with related analysis.

Please answer the following questions

Have you in the past five years received reimbursements, fees, funding, or salary from an organisation that may in any way gain or lose financially from the publication of this paper? If so, please specify.

I was supported by a one off grant during 1997/98 to undertake research about condom shape by Ansell Ltd. who manufacture Lifestyles® condoms.

Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this paper? *No*

Do you have any other financial competing interests? *No*.

Are there any non-financial competing interests you would like to declare in relation to this paper? *No*