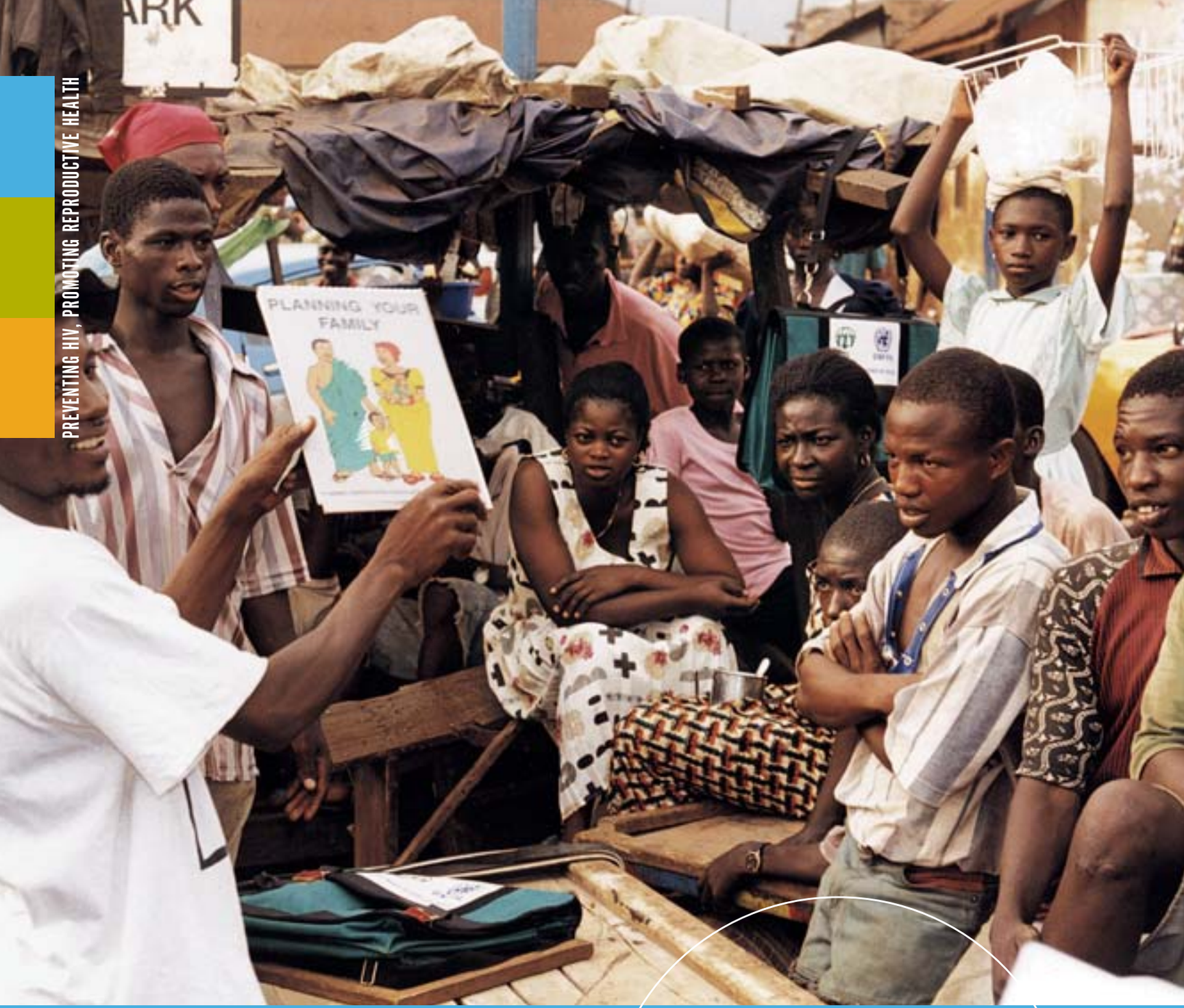
PREVENTING HIV, PROMOTING REPRODUCTIVE HEALTH



CONDOM PROGRAMMING FOR HIV PREVENTION

AN OPERATIONS MANUAL FOR PROGRAMME MANAGERS

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EXECUTIVE SUMMARY

Condoms play a special role in combating the spread of HIV/AIDS because they are presently the only devices that protect against sexually transmitted HIV. However, high costs to users, limited availability and accessibility, and negative perceptions of condoms have created a gap between the number of condoms distributed and the amount needed for populations to protect themselves from HIV/STIs. Improved condom programming can help close the gap in condom supply and use, and reduce the spread of HIV.

The goal of condom programming is to ensure that sexually active persons at risk of HIV/STIs are motivated to use condoms, have easy access to quality condoms, and can use them consistently and correctly. It addresses the supply of and demand for condoms as well as the political, sociocultural, and economic environment. This manual outlines a seven-step process to improve the effectiveness of existing condom programmes or to create a new condom programme. It is designed to give managers practical and specific advice on condom programming.

STEP 1. UNDERSTAND CONDOM CLIENTS AND THE ENVIRONMENT. In order to decide which client groups to target, managers must investigate potential client groups,

their risk of HIV infection, and the barriers discouraging them from using condoms. A condom needs assessment gathers epidemiological, sociocultural, and behavioural information on potential client groups and on the broader sociocultural and political environment.

STEP 2. ASSESS PROGRAMME AND CREATE ACTION PLAN.
A small staff team can conduct a rapid assessment of a condom programme's existing capabilities, including the supply and distribution of condoms; providers' attitudes, knowledge, and skills; organisational support; service quality; and condom promotion. Based on this information and the needs assessment conducted in Step 1, managers can decide which issues—including barriers to condom use, adverse circumstances in the environment, and programme weaknesses—must be addressed for condom use to rise and subsequently create an action plan.

STEP 3. PROCURE HIGH-QUALITY CONDOMS AND MANAGE THE PIPELINE.
In order to maintain a reliable and consistent supply of quality condoms, managers should review and strengthen every element of the logistics system, including data collection about distribution and stock levels, product selection, forecasting condom needs, procurement, inventory management, storage and transportation, and resupply distribution outlets.

STEP 4. EXPAND DISTRIBUTION SYSTEMS.
Managers can increase access to condoms and reach new client groups by using multiple distribution channels, increasing the number and types of outlets supplying condoms, and matching those outlets to clients' needs. Potential distribution channels include commercial sales, social marketing, community-based distribution, and workplace promotion as well as the health care system. Using nontraditional outlets and changing policies and service practices at health facilities to make them condom-friendly can expand access to condoms.

STEP 5. PROMOTE CONDOMS AT DISTRIBUTION POINTS.
Managers should provide individual client counselling at condom distribution points—whether health facilities, retail shops, or nontraditional outlets—and, where this is not possible, display and distribute educational materials, such as posters and leaflets, instead to give condom clients essential information on how to use condoms correctly. To improve counselling, there is a need to train providers and focus supervision on condom service delivery.

STEP 6. PROMOTE CONDOMS AT THE COMMUNITY, DISTRICT, AND NATIONAL LEVELS.
Behaviour change communication—including peer education, community education, school-based education, and mass media campaigns—can increase knowledge, shape attitudes, and change behaviours among potential condom clients and throughout the broader community. Condom promotion efforts can extend their reach by working with STI, HIV prevention, reproductive health, and refugee health programmes. They also need to create a supportive political and sociocultural environment; raise awareness of HIV/AIDS; place condom programming on the political agenda; and make condom promotion socially acceptable via advocacy to political, religious, community, and business leaders.

STEP 7. MONITOR PROGRAMME PROGRESS AND EVALUATE OUTCOMES.
Managers need to make sure monitoring and evaluation systems include key condom indicators so they can detect and fix problems, assess programme performance, and decide which activities to expand or stop. A complete monitoring and evaluation system measures inputs (the number of people trained in condom counselling and distribution), outputs (the availability and quality of condoms), outcomes (changes in condom use and sexual behaviour), and impacts (changes in HIV and STI rates).

ACRONYMS

AIDS	acquired immunodeficiency syndrome
BCC	behaviour change communication
CBD	community-based distribution
HIV	human immunodeficiency virus
IDP	internally displaced person
IPPF	International Planned Parenthood Federation
JSI	John Snow, Inc.
LMIS	logistics management information system
NGO	nongovernmental organisation
PSI	Population Services International
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization

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INTRODUCTION

SLOWING THE HIV/AIDS PANDEMIC

Since the early 1980s, more than 60 million people have been infected with human immunodeficiency virus (HIV), and more than 20 million people have died from the resulting disease, acquired immunodeficiency syndrome (AIDS). There were an estimated 5 million new infections in 2003 alone—the vast majority in developing countries (Joint United Nations Programme on HIV/AIDS [UNAIDS], *Report on the Global HIV/AIDS Epidemic 2002*. Geneva: UNAIDS, 2002). Of the 45 million new HIV infections projected to occur between now and 2010, two-thirds could be prevented by strengthening and broadening prevention strategies ((Stover J et al., "Can we reverse the HIV/AIDS pandemic with an expanded response?" *Lancet* 2002;360:73–77).

HIV has four major modes of transmission:

- Unprotected sexual intercourse with an infected person;
- Transfusions of infected blood;
- Transmission from mother to child during pregnancy, labour, delivery, or breastfeeding; and
- Injections with contaminated needles.

Therefore, to combat the spread of HIV, prevention programmes must use a combination of strategies. Promoting safer sexual behaviours, increasing condom use, diagnosing and treating sexually transmitted infections (STIs), and offering voluntary counselling and testing (VCT) all help limit transmission through unprotected sexual intercourse. Ensuring the safety of the blood supply prevents transmission through blood transfusions. Offering VCT and condoms to pregnant women and their partners, treating pregnant women with short courses of antiretroviral drugs, using safe delivery practices, and counselling new mothers on infant feeding options can prevent HIV infection in pregnant women, mothers, and their newborns. Encouraging sterile injections, promoting safer sex practices, and offering drug abuse treatment helps minimise transmission among injecting drug users.

In many areas, however, HIV is primarily spread through unprotected sexual intercourse, so safer sexual practices are key to controlling the epidemic. To reduce the sexual transmission of HIV, many programmes follow a three-pronged approach that encourages abstinence, faithfulness to a single sexual partner, and condom use.

Condoms play a special role because they are currently the only devices that protect against sexually transmitted HIV. Consistent and correct

condom use reduces the risk of heterosexual transmission of HIV by about 80 percent (Weller S and Davis K, "Condom effectiveness in reducing heterosexual HIV transmission." *Cochrane Database of Systematic Reviews*, 2001)—and also protects against other STIs which may contribute to HIV transmission. Active promotion and use of male condoms has been proven to slow the spread of HIV, and the promotion of female condoms has increased the number of protected sex acts.

Because male and female condoms prevent pregnancy as well as infection, they offer people the convenience of dual protection. Condom use can also help fulfil the unmet need for contraception in developing countries, where more than 100 million married and some 8 million unmarried women of reproductive age want to space or limit births, but lack access to contraceptive methods (Ross J and Winfrey W, "Unmet need for contraception in the developing world and the Former Soviet Union: an updated estimate." *International Family Planning Perspectives* 2002;28:138–143).

Given its importance in both preventing the sexual transmission of disease and protecting against unwanted pregnancy, condom programming is an essential part of reproductive health services for both men and women. Policymakers and programmers should consider how best to use condom programming to complement and reinforce the full range of reproductive health interventions, including STI services, HIV prevention, family planning, and maternal and child health care.

ELEMENTS OF CONDOM PROGRAMMING

Condom programming is a strategic approach to ensure that sexually active persons at risk of HIV/STIs are motivated to use condoms, have access to quality condoms, and can use them consistently and correctly. Thus condom programming must address both the supply of and demand for good quality condoms (see Figure 1) as well as the environment, which is the critical operating framework through which access to and use of condoms is ensured.

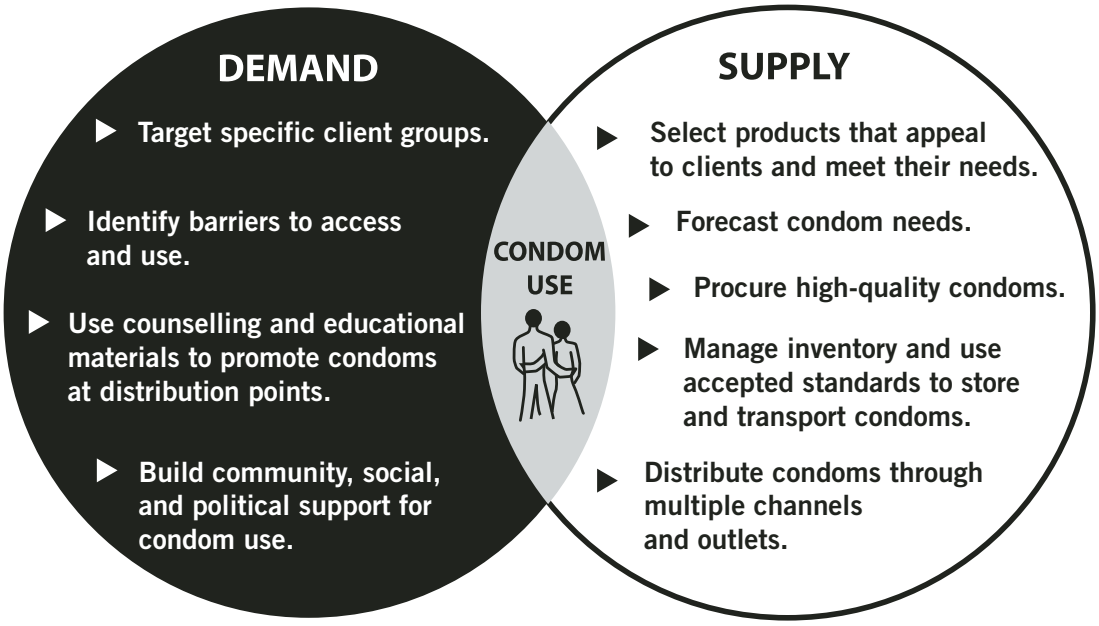


Figure 1. Elements of condom programming.

On the supply side, condom programming must select products that appeal to clients, forecast condom needs, procure sufficient quantities of high-quality male and female condoms, manage inventories, and distribute condoms—all with the goal of giving clients easy and confidential access to affordable condoms when and where they need them.

On the demand side, condom programming must assess the needs of different user groups, identify and remove barriers to condom access and use (such as myths, perceptions, dislikes, and fears), promote consistent and correct condom use at service-delivery outlets and in the larger community, and build support for condom use within the broader sociocultural environment. Here the goal is to motivate women, men, and youth who are at risk of HIV to use condoms.

The surrounding political, sociocultural, and economic environment is critical to the success of these efforts. Social norms, institutional capacity, service accessibility, and public policy all have an impact on individual choices, gender roles, and the understanding of sexuality and disease. Limited resources and infrastructure, including health services, may constrain efforts to promote condoms. Therefore condom programming also must work towards an environment that supports the goal of safe, responsible, and consensual sexual relations and programme activities designed to reach that goal.

THE CONDOM GAP

According to the Joint United Nations Programme on AIDS (UNAIDS), the 6 to 9 billion male condoms distributed each year constitute as little as one quarter of what is needed if all populations are to protect themselves from HIV and other STIs (UNAIDS, *Report on the Global HIV/AIDS Epidemic 2002*. Geneva: UNAIDS, 2002; UNFPA: *Condom Availability & Programming*. UNFPA, 2001). Worldwide, the demand is expected to be almost twice as high by 2015. The gap in protection is especially large in developing countries. In sub-Saharan Africa, for example, the 724 million condoms distributed by donor agencies and regional country governments in 1999 amounted to less than 5 condoms annually per man aged 15 to 59 years (World Bank, *Confronting AIDS: Public Priorities in a Global Epidemic*. Washington, D.C.: World Bank, 1997).

A similar supply gap exists for female condoms. Although the current annual global market for the female condom is about 10 million units, average annual donor support for the female condom in the developing world ranged from none to just over 100,000 condoms between 1996 and 2000 (excluding supplies for well-developed female condom programmes in Ghana, South Africa, Uganda, and Zimbabwe) (Gardner R, Blackburn R, and Upadhyay U, "Closing the condom gap." *Population Reports*, Series H: Barrier Methods 1999:1–36).

Production capacity is not responsible for this gap. Condom manufacturing capacity is underutilised and could expand greatly before reaching its limit. Rather, high costs to users, limited availability and accessibility, and negative perceptions of condoms all contribute to the gap. Many programmes do not reach potential users with preventive messages that help them to change their behaviour.

USING THIS MANUAL

Improved condom programming can help close the gap in condom supply and use, and reduce the spread of HIV. This manual is designed to give managers practical and specific advice on condom programming. The seven-step approach outlined here (see Figure 2) gives managers a pathway to improve the effectiveness of existing condom programmes or to create a new condom programme:

- Steps 1 and 2 guide managers through a needs assessment process so they can decide which client groups to target and then create an action plan tailored to those groups.
- Steps 3 and 4 describe how to improve the supply and distribution of condoms.
- Steps 5 and 6 describe how to promote demand for condoms—both at distribution points, such as clinics and shops, and throughout the community and the nation.
- Step 7 helps managers assess the progress of their efforts.

Managers of all kinds of programmes—whether public or private, national or local—will find this manual useful, although some topics and exercises may be irrelevant or overly demanding for smaller, simpler programmes. The manual also can benefit managers working at lower levels of an organisation as well as those at the top, especially where decentralisation has given district and local managers greater responsibility for decision making.

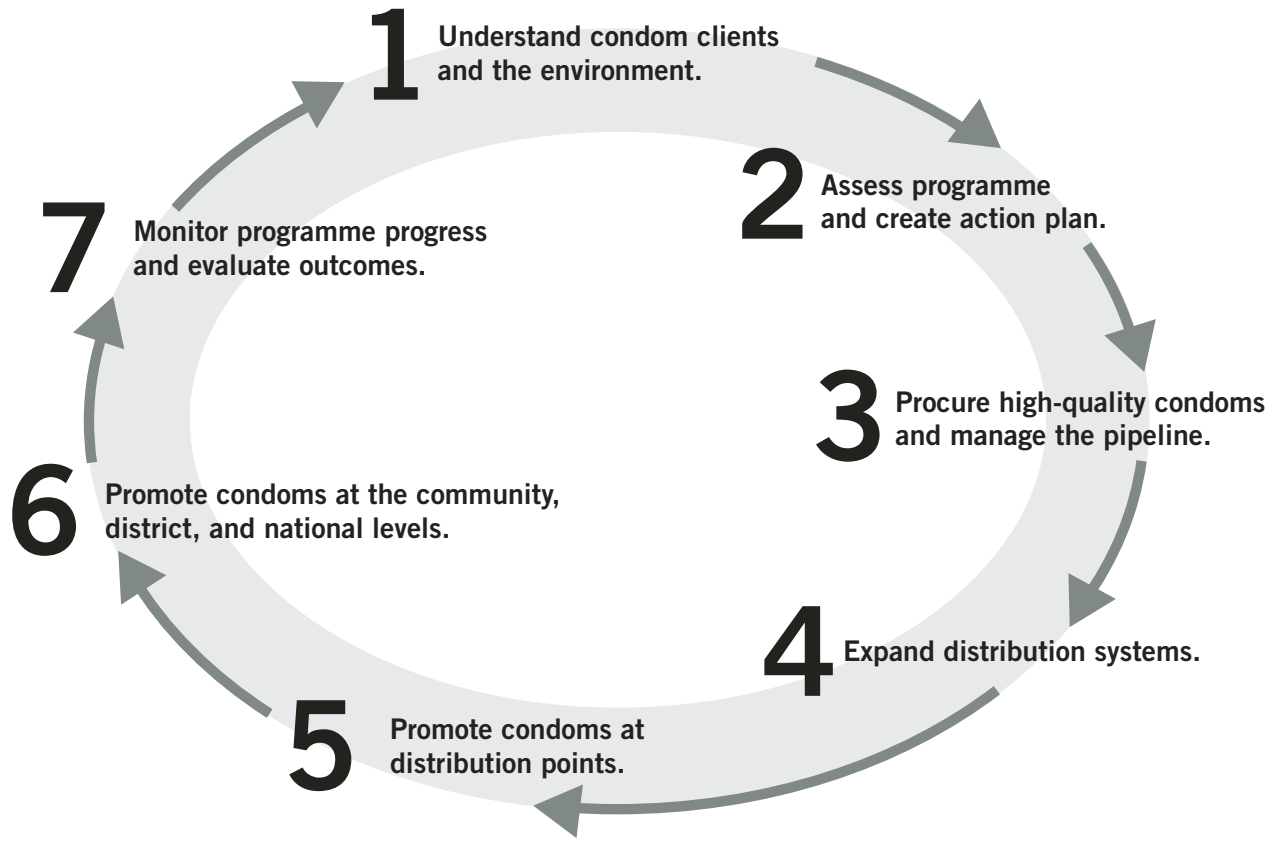


Figure 2. Seven steps for condom programming for HIV prevention.

Because every situation is unique, however, managers should be flexible in how they employ the manual. Depending on an organisation's capabilities, the environment in which it operates, and the manager's responsibilities, he or she should select which portions of the manual to use. Managers also are encouraged to customise the forms and exercises to reflect local circumstances, for example, by filling in items of local importance in the spaces left in the worksheets.

Complementary guidelines to help service providers understand the goals of condom programming and take an effective part in condom promotion are available in *Condom Programming for HIV Prevention: A Manual for Service Providers,* which is available from the headquarters and local offices of the United Nations Population Fund (UNFPA) and is also posted at its website *(www.unfpa.org)*. Concerning procurement, there is also *The Male Latex Condom: Specification and Guidelines for Condom Procurement* (December 2003), which is published by the World Health Organization, UNFPA, UNAIDS, and Family Health International. It is available on the WHO website *(www.who.int/pub/en/)*.

STEP 1.

UNDERSTAND CONDOM CLIENTS AND THE ENVIRONMENT

KEY ACTIONS

- *Identify potential client groups.*
- *Decide which client groups to target.*
- *Identify barriers that discourage condom use.*
- *Gather information on clients and environment with a condom needs assessment.*
- *Analyse the results.*

In order to design effective condom programming, managers must understand the local situation and its challenges. A condom needs assessment gathers epidemiological, sociocultural, and behavioural information so that managers can decide which client groups to target with condom programming. They learn about each client group's situation, including the circumstances that put the clients at risk of HIV infection and the barriers that discourage them from using condoms. The needs assessment also helps managers understand the broader sociocultural and political environment and how it will help or hinder their efforts. Without a supportive environment, even the best condom programming efforts are unlikely to achieve the desired effect. The results of this needs assessment directly contribute to the action plan created at the end of Step 2 (see page 30).

This manual is designed to help managers assess needs within the geographic area and populations of interest of a specific programme. Another, complementary publication, *Rapid Needs Assessment Tool for Condom Programming,* can help top policymakers assess the current status of condom programming throughout a country, identify potential client groups and barriers that discourage condom use, map the political and social environment, and set national priorities. It is available from the United Nations Population Fund (UNFPA) headquarters and local offices around the world, as well as on its website *(www.unfpa.org)*. The first step in this national assessment is a review of existing research and documents identifying sexual and other practices that influence HIV transmission, the incidence and prevalence of infection, and current policies related to condom promotion and distribution. Next are in-depth interviews with programme managers revealing the extent of current condom programming activities and identifying pressing needs for improvement. The *Rapid Needs Assessment Tool for Condom Programming,* then helps policymakers generate recommendations for action and identify what further resources, training, technical assistance, and funds are needed.

IDENTIFY POTENTIAL CLIENT GROUPS

Reproductive health needs and concerns vary, depending on a person's gender, life stage, risk factors, and other circumstances. The first step in a condom needs assessment is to identify all of the population groups in the local area who may be at risk of HIV infection and in need of condoms. It is essential to look beyond those people currently using condoms and consider groups who may

have been overlooked by HIV-prevention programmes or who are difficult to reach.

Client groups frequently singled out by condom programmes include:

Women. In most developing countries, women are at higher risk of HIV infection than men, largely because of gender norms that give them little control over the nature and timing of sex and little power to negotiate with men over safer sex, use of condoms, or sexual concerns (see Appendix for "Gender and Condom Programming" fact sheet). They are more likely than men to live in or be vulnerable to poverty, are more likely than men to experience coerced sex or rape, and are more likely to have to sell sex to survive. Women may be reluctant even to suggest condom use for fear their partners will suspect them of infidelity and perhaps react violently. In addition, HIV is more easily transmitted from men to women than from women to men.

Men. Although men have access to condoms and the power to use them, they are more likely than women to engage in risky sexual behaviours and less likely to seek preventive medical services. Part of the problem is social norms that associate masculinity with risky behaviours, such as engaging in extramarital affairs and visiting sex workers (see Appendix for "Gender and Condom Programming" fact sheet). Certain groups of men—including the clients of sex workers, migrant workers, and the military—may act as a bridge between core groups of infected individuals and the general population.

Married couples. Promoting condoms to couples in stable relationships poses a special challenge. Married people may not believe their spouses are putting them at risk of infection, they may believe condoms are only for sex workers and casual partners, they may view condoms as a relatively ineffective contraceptive method, or they may want to have children.

To overcome these barriers, programmes must promote condoms to stable couples as a method of dual protection that can space births while also protecting the family's health (see Appendix for "Protecting Against Both HIV and Pregnancy" fact sheet). Condom programming that addresses married couples has the additional advantage of fostering open communication between partners, which can help build relationships that are equal and safe.

Youth. In developing countries, about half of all new HIV infections occur in people between the ages of 15 and 24 years. Many youth become sexually active at an early age, often because of sexual abuse, early marriage, or sexual activity due to poverty. Social norms, however, may limit their access to information about how HIV is transmitted and to condoms. Orphans and street youth are particularly vulnerable to exploitation.

Adolescent girls face some special risks: they are physiologically more vulnerable to HIV infection than adult women, they may engage in sex work because of poverty or because they are forced to, and they may be sought out for sex by older men, who are more likely than younger men to be infected with HIV. In some regions, myths such as "having sex with a virgin will cure AIDS or other STIs" put young girls at even greater risk.

GUYANA: TARGETING ADOLESCENTS

One group of young people in Guyana is at especially high risk for HIV/STI infection. These "limers," as they are locally known, hang out along the sea wall, at fast food restaurants, and at minibus stops. Investigations into transmission patterns found that minibus drivers and conductors, who are idolised by both the young men and young women, contribute to HIV risks by having casual, unprotected sex with the young women. Therefore, the Guyana Youth HIV/AIDS STI project enlarged its focus to address minibus drivers along with the young women who are sexually involved with them. The project distributes information on HIV/STI prevention and condoms at minibus stops and sea wall parties. It also has developed rap messages to be played on the minibuses along with the pop music,

Continued: Guyana: Targeting Adolescents

since the adolescents and drivers consider rap music a meaningful and credible source of information.

Source: International Planned Parenthood Federation (IPPF), *Learning from the Field: Experiences in HIV Prevention from Family Planning Associations Worldwide*. London: IPPF, 2002.

Refugees and internally displaced persons (IDPs). Refugees and IDPs face multiple risks. They live in settings where the social systems guaranteeing law and order and the cultural norms governing sexual behaviour are severely disrupted. Rape, sexual assault, and domestic violence are common, and sex may be traded for scarce goods or security. Their movement between and within countries also may bring them in contact with populations with higher levels of HIV. At the same time, access to health care, including condoms, is often poor—because of the dangers of armed conflict, the limited resources of relief agencies, and distrust of foreign health care providers.

Men away from home. Men who live apart from their family—such as soldiers, miners, truck drivers, and migrant workers—are at greater risk for becoming infected with HIV. Away from their regular partners and the social controls of home, these men often seek casual or commercial sex, have multiple partners, or use alcohol or other substances that lead to risky behaviour. The mobility of these men makes them more difficult to reach and contributes to the spread of HIV/AIDS from region to region and group to group.

Sex workers and their clients. Economic pressures, fear of violence by clients, lack of condom negotiation skills, and fatalistic attitudes may discourage sex workers from using condoms with clients. Trusting relationships discourage them from using condoms with boyfriends and regular clients. At the same time, the illegal and stigmatised status of commercial sex work may compromise sex workers' access to health services, including HIV prevention. Prevention efforts need to address all of the stakeholders involved in sexual transactions, including clients and brothel owners as well as sex workers themselves. Female condoms may offer sex workers greater control over HIV prevention if clients find them more acceptable than male condoms.

INDONESIA: EXPLORING BARRIERS TO CONDOM USE BY SEX WORKERS

Before launching a safe sex programme for sex workers in Batam, the Indonesian Planned Parenthood Association (IPPA) conducted focus group discussions and interviews with sex workers and their clients. This needs assessment found that many factors discourage sex workers from using condoms, including:

- The need to earn enough money to support dependents (the sex workers lose money by rejecting clients who refuse to use condoms);
- Myths and misconceptions about how to prevent HIV/STIs and about condoms;
- Inadequate negotiation skills;
- Peer pressure in the form of ridicule, belittling comments, and competition among sex workers; and
- A habit of not using protection when having sex with boyfriends.

The assessment also explored sex workers' and clients' preferences for different types of condoms as well as where to locate drop-in centers and clinics for sex workers. Understanding sex workers' needs and circumstances helped IPPA design an effective intervention to reduce barriers to condom use.

Source: International Planned Parenthood Federation (IPPF), *Learning from the Field: Experience in HIV Prevention from Family Planning Associations Worldwide*. London: IPPF, 2002.

Men who have sex with men. HIV is easily transmitted between men, and this mode of transmission is widespread in Latin America and parts of Asia. However, cultural prohibitions about same-sex encounters make it difficult to reach this population. Fear of violence, stigmatisation, and distrust of health care providers may prevent men

from seeking information and counselling about how to prevent infection.

Injecting drug users. In some parts of the world, intravenous drug use is a major mode of HIV transmission. Drug users who share contaminated needles may inject HIV directly into the bloodstream. Once infected, drug users can transmit HIV to their sexual partners—and they are unlikely to remember precautions, such as condoms, when they are high.

People living with HIV/AIDS and their partners. When individuals first learn that they are infected with HIV, they may be too shocked and distressed to be concerned about the need for safer sex. However, encouraging people with HIV to avoid transmitting the infection to others—by notifying their partners about their status and consistently using condoms—is essential in limiting the spread of AIDS. Even if both partners in a couple have HIV, condom use is still important: preventing reinfection with HIV and other STIs can help maintain their immunity.

DUAL PROTECTION

This manual focuses on condom programming to prevent HIV infection, but sexually active couples also need protection against unwanted pregnancy. Condoms are unique because they provide "dual protection"; that is, they simultaneously protect against both infection and pregnancy (see Appendix for "Protecting Against Both HIV and Pregnancy" fact sheet).

Condom programmes should incorporate the concept of dual protection from their inception. Managers should consider potential clients' need for pregnancy prevention as well as their risk of infection when they decide which client groups to target, and they should design programme activities that actively promote condoms as a method of dual protection.

DECIDE WHICH CLIENT GROUPS TO TARGET

Effective condom programming focuses its energy and resources on key client groups. This allows managers to tailor interventions to clients' needs, concerns, and special circumstances, making them more likely to increase condom use and reduce HIV transmission. When deciding which client groups to target (see Worksheet 1), managers should consider the following factors:

- HIV transmission patterns;
- Clients' access to condoms and information about HIV;
- Organisational expertise, resources, and objectives;
- Ease of reaching client group; and
- Humanitarian concerns.

HIV transmission patterns. Managers must understand the levels and patterns of HIV infection in their community. HIV levels typically rise first in groups who engage in high-risk behaviours; some examples are sex workers, refugees, port workers, and injecting drug users. Only later do HIV levels rise in the general population. By gathering data on HIV incidence, as well as prevalence in the general population and in potential high-risk groups, programmers can determine who is most at risk of HIV and which stage the HIV/AIDS epidemic has reached (see Figure 3). These categories are dynamic, and managers may have to change strategies as the epidemic moves from one stage to another and patterns of transmission shift. Because incidence data reveal current patterns of transmission, they are more important than prevalence data for planning prevention efforts.

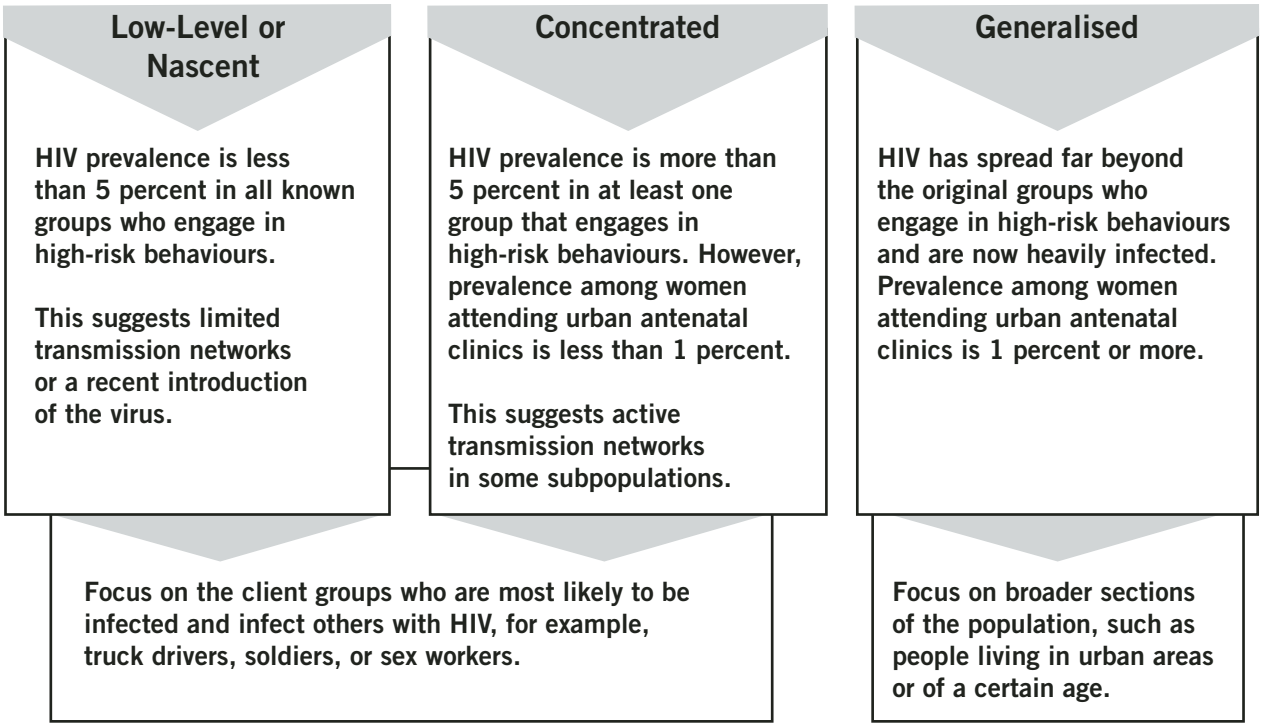


Figure 3. Condom programming strategy for HIV epidemic levels.

Another critical question is which routes of HIV transmission are important locally. Condoms are effective only against sexual transmission of HIV. Different strategies are needed when HIV is being transmitted from mother to child, via the blood supply, or through needle sharing by drug users.

Clients' access to condoms and information about HIV. Potential client groups are in greater need of condom programming interventions when they know little about HIV/AIDS and have limited access to condoms and HIV-prevention counselling.

Organisational expertise, resources, and objectives. Condom programmes are more effective when they build on existing resources, expertise, and experience and fit an organisation's objectives. For example, a youth organisation active in poor urban areas may be ideally equipped to design condom programming for out-of-school youth. In contrast, a family planning and reproductive health service-delivery organisation is more likely to succeed if it targets HIV-prevention services to adult women and married couples.

Ease of reaching client group. If a programme's resources are limited or its funding is short-term, it makes sense to target a client group that is relatively easy to reach and influence. This strategy is cost-effective; that is, the programme will reach more people and have a greater impact on HIV transmission at a lower cost. It also increases the likelihood that a programme will finish implementing planned activities and demonstrate visible results before funding runs out.

Humanitarian concerns. Some marginalised groups, such as refugees driven from their homes by war, deserve special consideration for humanitarian reasons.

WORKSHEET 1: DETERMINE WHICH CLIENT GROUPS TO TARGET				
POSSIBLE TARGET AUDIENCES	CHECK IF:			RANK GROUPS IN ORDER OF PRIORITY FOR TARGETING
	GROUP EXISTS LOCALLY	PREVALENCE OF HIV IS >5% OR INCIDENCE IS HIGH RELATIVE TO REST OF POPULATION	GROUP'S NEEDS MATCH ORGANISATIONAL CAPABILITY	
Sexually active women				
Sexually active men				
Married couples				
Youth, girls				
Youth, boys				
Migrant workers				
Men away from home: _____ (specify group, for example, truck drivers)				
Military				
Sex workers, female				
Sex workers, male				
Clients of sex workers				
Refugees				
Internally displaced persons				
Injecting drug users				
Men who have sex with men				
People living with HIV/AIDS				
Other:				
Other:				

Note: In this worksheet and others, there are blank spaces at the bottom in which locally important information (here, client groups) can be entered so that the worksheets are as relevant as possible.

IDENTIFY BARRIERS THAT DISCOURAGE CONDOM USE

After deciding which client groups to target, the next step is to assess which barriers make it difficult for them to get condoms and discourage them from using condoms. Barriers to condom use take many forms:

Limited access. Lack of a nearby outlet with convenient hours prevents some potential clients from getting condoms. Others want to avoid a potentially embarrassing face-to-face request for condoms.

Cost. Some clients cannot afford to buy condoms at full price, but clients may value and be more likely to use condoms if they pay at least a nominal fee for them. Expense is a bigger concern for female condoms, which on average cost US$.60 each to procure compared with US$.03 per male condom.

Concerns about partner. Some people worry that if they suggest using condoms, their partners will assume they are confessing to, or accusing their partner of, illicit sex or HIV infection. Other people do not use condoms because they trust their partners—whether that partner is a spouse or a regular partner outside marriage.

Limited knowledge. Some people may not realise that condoms prevent disease as well as pregnancy, and they may not know how to use condoms.

Myths, perceptions, dislikes, and fears. Widespread rumours and misinformation may convince potential clients that condoms are ineffective, unsafe, limit sexual pleasure, or are associated with promiscuity. Clients also may have valid reasons for disliking condoms.

Gender norms. Women have difficulty negotiating condom use where social norms give men power over sexual decisions and practices—and condom use requires the cooperation of both partners (see Appendix for "Gender and Condom Programming" fact sheet).

Stigma. People engaged in socially objectionable sexual activities, such as unmarried young people and sex workers, may be reluctant to seek counselling on how to prevent infection.

Religious beliefs. Some religious groups prohibit all forms of contraception, including condoms. Religious opposition to sex outside marriage may discourage sex education, HIV counselling, and the distribution of condoms to young people.

Cultural practices. Certain cultural practices may discourage condom use. Where dry sex (which takes place after using drying agents to make the vagina dry, hot, and tight) is commonly practiced, couples may worry that condoms will interfere with sexual pleasure. Programmers are concerned that increased friction and the chemical effects of drying agents make condoms more likely to break.

Providers' attitudes and skills. Providers may not discuss or recommend condoms to clients because they feel uncomfortable talking about sexuality, think clients will be offended, are biased against unmarried youth engaging in sex, or believe condoms to be less effective than other family planning methods. They also may lack the technical and communication skills to promote condoms effectively. Family planning providers may view condoms purely as contraceptives and downplay their ability to prevent infection. Other providers are biased against the female condom, considering it appropriate only for single women and sex workers.

GATHER INFORMATION ON CLIENTS AND ENVIRONMENT WITH A CONDOM NEEDS ASSESSMENT

A condom needs assessment gathers epidemiological, sociocultural, and behavioural information about targeted client groups to answer key questions about HIV risks and barriers to condom use (see text box on following page).

KEY QUESTIONS ON TARGETED CLIENT GROUPS

HIV risks

- What is the prevalence of HIV within this client group?
- What makes this group vulnerable to HIV infection? Consider sexual behaviours, gender norms, mobility, etc.
- How does this group contribute to HIV transmission in the larger community?
- How knowledgeable is this group about HIV/AIDS, male condoms, and female condoms? Where do they get their information?
- How many group members currently use male and female condoms? How consistently?

Barriers to condom use and services

- Does this group have easy access to affordable male condoms? To female condoms? If not, why?
- Which myths, perceptions, dislikes, and fears about male condoms are common in this group? About female condoms?
- What condom programmes already serve this group? Are condom services available, accessible, and appropriate to this group?
- Do programmes promote condoms for HIV prevention, contraception, or both?
- How difficult is it to reach this group? Consider all possible obstacles, including geography, language, social stigma, and mobility.
- Will social norms, religious beliefs, or political sensitivities make it difficult to offer services to this group?

Equally important is understanding the political, legal, social, and economic context in which any proposed condom programme will operate and in which individuals will make choices about HIV prevention (see Key Questions). Leadership support may determine whether condom programmes are implemented and how many resources they receive. Government regulations may enhance or limit the availability of and access to condoms. And public policies, media policies, and social norms may decide how vigorously and how widely condoms are promoted. To avoid duplicating efforts and wasting resources, managers also should investigate what condom services and products are already offered by the Ministry of Health, HIV/AIDS and family planning organisations, nongovernmental organisations (NGOs), social marketing organisations, and commercial condom distributors, as well as which client groups they serve.

KEY QUESTIONS ON THE POLITICAL, SOCIAL, AND SERVICE ENVIRONMENT

Access

- Are there import restrictions, duties, or tariffs that limit the number of male and female condoms imported or increase their price?
- Is the female condom approved for use?
- Do licensing or prescription requirements limit the sale of condoms to certain types of outlets?
- Do legal restrictions or social norms prevent adolescents, unmarried women, or other groups from buying condoms?
- Are condom vending machines and displays of condoms for self-service purchase allowed?
- Does resistance from community leaders and concern about public reaction limit the number and types of settings in which condoms are sold?

Promotion

- Is public discussion of safer sex and condoms socially acceptable?
- Is condom advertising permitted?
- Does government policy support sex education in the schools?
- Do mass media managers support or resist condom promotion?

Public support

- Have political, community, or religious leaders spoken out publicly about the need for HIV prevention and the importance of condoms? Have they spoken out against condoms?

Continued: Key Questions on the Political...

- How much money does the government budget for HIV-prevention activities?
- Do public-sector programmes promote and distribute condoms?
- Is condom use in the sex industry regulated?

Existing condom programmes

- What services and products do other organisations promoting condoms offer?
- Which client groups do these programmes target?
- What plans do other organisations have to expand condom programming?

To answer key questions on targeted client groups and the political, social, and service context, managers should first gather and analyse information already available online (see text box right). The health ministry and international organisations, such as UNAIDS, are good sources of epidemiological data on HIV levels. International organisations, government departments, and NGOs are likely to have conducted studies of clients' knowledge, attitudes, and risk behaviours. Also of interest are evaluations of prior HIV-prevention programmes in the public, private, and NGO sectors. Broader social, economic, and political studies can provide important background information on the status of women, migration patterns, the labour market, and other relevant factors. Medical databases can help locate academic studies relevant to the region.

Existing information may not provide all the answers. Collecting new data allows condom programmers to update existing data, fill in any gaps, focus on the local situation, and investigate specific issues of interest. Common approaches to collecting condom programming information include community forums and public meetings, key informant interviews, focus groups, surveys, and observation of service delivery. Some methods require substantial expertise, time, and resources; others are far less complicated. For example, interviews with key informants, such as the heads of existing condom programmes, and discussions with members of targeted client groups can produce important insights relatively quickly and easily.

ONLINE SOURCES OF INFORMATION ON HIV/AIDS

COUNTRY FACT SHEETS

Synergy Project. Country profiles.
www.synergyaids.com/summaries.asp

UNAIDS/WHO. Epidemiological fact sheets by country.
www.who.int/emc-hiv/fact_sheets/ or
www.unaids.org/hivaidsinfo/statistics/fact_sheets/index_en.htm

SURVEY DATA

HIV/AIDS Survey Indicators Database.
www.measuredhs.com/hivdata/start.cfm

Behavioral Surveillance Surveys (BSS).
www.fhi.org/en/aids/wwdo/wwd12a.html

Demographic and Health Surveys (DHS).
www.measuredhs.com

Multiple Indicator Cluster Surveys (MICS).
www.childinfo.org/MICS2/Gj99306m.htm

Reproductive Health Surveys (RHS).
www.cdc.gov/nccdphp/drh/logistics/global_rhs.htm

Sexual Behavior Surveys (SBS).
www.cpc.unc.edu/measure/data/data.html

GENERAL INFORMATION

Joint United Nations Programme on HIV/AIDS (UNAIDS).
www.unaids.org

United Nations Population Fund (UNFPA): Preventing HIV/AIDS.
www.unfpa.org/hiv/index.htm

World Health Organization (WHO): HIV Infections.
www.who.int/health_topics/hiv_infections/en/

ANALYSE THE RESULTS

The next step is to synthesise all of the information collected, draw conclusions, and identify key issues for programme managers. This information, together with the results of the programme assessment conducted in Step 2, will be used to develop an action plan to improve condom programming for targeted client groups (see page 30).

Review all of the information gathered on the client groups that the programme intends to target with condom programming. Enter key points into Worksheet 2a.

WORKSHEET 2A: COMPILE INFORMATION ON TARGETED CLIENT GROUPS **(see worksheet 1, page 12)**

	FIRST CLIENT GROUP TARGETED:	SECOND CLIENT GROUP TARGETED:
Prevalence of HIV, trends over time, and transmission routes (if available)		
Risk factors that make group vulnerable to infection		
Current levels of knowledge about HIV prevention		
Current usage of male and female condoms		
Accessibility and affordability of male and female condoms		
Myths, perceptions, dislikes, and fears about male and female condoms		
Relevant social norms, religious beliefs, and political sensitivities		
Other barriers to condom use		
Condom programming efforts currently directed to this group		
Practical obstacles to reaching group with condoms and information		
Other		

Consider all of the information entered in Worksheet 2a. What are the greatest obstacles and challenges for condom programming for each client group? Are there any positive trends that programme managers can build upon? In Worksheet 2b, list up to four specific issues—whether negative or positive—that managers must consider when designing condom promotion and distribution activities for these client groups.

Review all of the information gathered on the social, political, and service environment in which the programme operates. Enter key points into Worksheet 3a. (page 18)

WORKSHEET 2B: KEY ISSUES FOR TARGETED CLIENT GROUPS

	FIRST CLIENT GROUP:	SECOND CLIENT GROUP:
1		
2		
3		
4		

WORKSHEET 3A: COMPILE INFORMATION ON ENVIRONMENT

	POLICIES, LAWS, REGULATIONS, SOCIAL NORMS, SERVICES, ETC.	ANY DIFFERENCES BETWEEN MALE AND FEMALE CONDOMS?
Import restrictions, duties, tariffs on condoms		
Licensing and prescription requirements		
Government and donor subsidies and financial support		
Legal status and regulation of commercial sex industry		
Restrictions on advertising and promoting condoms		
Limits on sex education and condom promotion for youth		
Restrictions on condom distribution		
Political leaders' attitudes and actions		
Religious leaders' attitudes and actions		
Community leaders' attitudes and actions		
Mass media managers' attitudes and actions		
National condom programmes		
Local condom programmes		
Other		

Consider all of the information entered in Worksheet 3a. Which aspects of the social, political, and service environment pose the greatest obstacles to condom programmers? In Worksheet 3b, list up to four environmental issues—whether negative or positive—that should be considered when designing promotion and distribution activities for male and female condoms.

WORKSHEET 3B: KEY ISSUES IN ENVIRONMENT

	MALE CONDOMS:	FEMALE CONDOMS:
1		
2		
3		
4		

STEP 2.

ASSESS PROGRAMME AND CREATE ACTION PLAN

KEY ACTIONS

- *Organise an assessment of programme capabilities.*
- *Assess supply and distribution of condoms.*
- *Assess providers' attitudes, knowledge, and skills.*
- *Assess organisational support for condom services.*
- *Assess quality of services.*
- *Assess condom promotion in the community and to its influential members.*
- *Develop an action plan for condom programming.*

Assessing a programme's capabilities can help managers develop an action plan to improve the effectiveness of current condom programming, especially its ability to reach a selected client group. Alternatively, an assessment can help managers of all kinds of organisations—including health and development NGOs, businesses, and the military—plan how to add condom programming to existing activities.

ORGANISE AN ASSESSMENT OF PROGRAMME CAPABILITIES

Two or three carefully selected staff members can conduct an assessment of an organisation's strengths and weaknesses in condom programming in a matter of days. The assessment team should reflect the breadth of the programme. Managers should select people with different perspectives and experiences, who have expertise in administration, service provision, and daily operations.

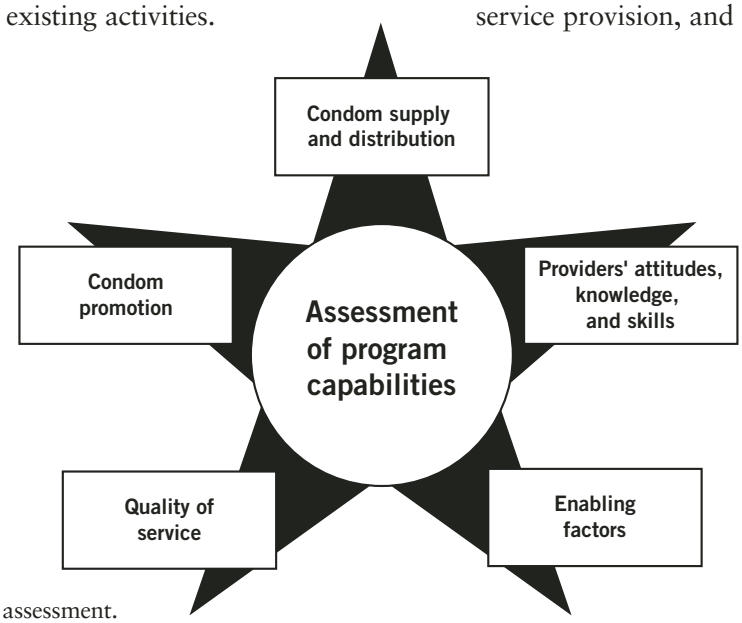


Figure 4. Areas for assessment.

The assessment team should work together to complete the five worksheets below, which cover areas critical to condom programming, as outlined in Figure 4. Members of the assessment team will be able to rate many items by drawing on their own knowledge of the programme. Sometimes, however, they may not know the correct response or they may disagree. In these cases, they should gather additional information, for example, by interviewing other staff members or clients, checking records, observing service delivery, or inspecting supplies and equipment.

Because programme support for male and female condoms can vary dramatically, even within the same organisation, the rating guides require two responses for each item—one for male condoms and the other for female condoms.

Once the assessment of programme capabilities is complete, managers should work with the assessment team to develop an action plan based, in part, on its results and, in part, on the assessment of the targeted client groups and environment conducted in Step 1.

ASSESS SUPPLY AND DISTRIBUTION OF CONDOMS

Clients need to have ready access to a consistent and affordable supply of condoms. Some programmes procure and distribute condoms themselves; others rely on outside suppliers, such as social marketing programmes, pharmacies, or the public health system, to make condoms available. Whoever acts as supplier is responsible for the proper storage and distribution of the condoms. Start this part of the assessment by making a list of all sources of male and female condoms in the community and how much they charge for each type (see Worksheet 4a). Keep this list in mind when completing the rating guide opposite. If more than one client group is targeted, fill out a separate rating guide for each.

WORKSHEET 4A
CONDOM SUPPLY AND DISTRIBUTION FOR _____ (fill in specific client group [refer to worksheet 1 page 12])

Part 1. List different sources of condoms in the community and how much each charges for male and female condoms. List either the average cost or a range of costs.

CONDOM SOURCE	COST OF MALE CONDOM	COST OF FEMALE CONDOM

Part 2. Rate how frequently each issue poses a problem for the targeted client group.
1 = not a problem 2 = sometimes a problem 3 = often a problem

MALE CONDOMS	FEMALE CONDOMS	
		Shortages of condoms
		Stockouts of condoms
		Oversupply or wastage
		Inadequate storage facilities
		Limited availability of free condoms
		Limited availability of low-cost (subsidised) condoms
		Limited availability of condoms at full, commercial price
		Inconvenient locations or hours at condom distribution points
		Lack of privacy and confidentiality during transaction
		Clients do not know where to go to get condoms they can afford
		Summary score (total of individual ratings)

Add up the ratings for the individual items to create two summary scores for the supply and distribution of male and female condoms. These may range from 10 to 30. A total score of 20 or higher (for male condoms, female condoms, or both) suggests that condom supply and distribution poses a barrier to effective condom programming and should definitely be included in the condom programming action plan.

Examine the ratings assigned to individual items. Ratings of 3 suggest that the targeted client group faces serious obstacles in getting or affording condoms. Of those items rated 3, which problems most hinder clients' access to condoms? Which problems does the programme have the expertise and resources to address? Considering both the importance of the problems and the feasibility of solving them, list three priority items for action in Worksheet 4b.

WORKSHEET 4B: ACTION ITEMS FOR CONDOM SUPPLY AND DISTRIBUTION		
	MALE CONDOMS	FEMALE CONDOMS
1		
2		
3		

ASSESS PROVIDERS' ATTITUDES, KNOWLEDGE, AND SKILLS

Effective condom programming ensures that providers have positive attitudes, accurate knowledge, and good counselling skills. Start this part of the assessment by listing everyone who interacts directly with condom clients—or consider what groups of people might take on that responsibility in the future. Typical provider categories include doctors, nurses, other health care workers, counsellors, peer educators, community-based distributors, teachers, and pharmacists. Also consider alternative providers such as retail sales clerks, youth group coordinators, leaders of self-help groups and trade unions, and postmasters. Complete separate rating guides for each category of providers (see Worksheet 5a).

WORKSHEET 5A: ATTITUDES, KNOWLEDGE, AND SKILLS OF _____ (Fill in specific provider group)		
Rate how strong this type of provider is in the following areas. *1 = strong 2 = inconsistent 3 = weak*		
MALE CONDOMS	FEMALE CONDOMS	
		Experienced in serving condom clients
		Holds favourable attitudes towards condom use
		Has nonjudgemental, respectful attitude towards all clients regardless of age, marital status, and sexual practices
		Feels comfortable discussing sexuality
		Has accurate knowledge of HIV/AIDS, condoms, and other technical matters and can respond to myths, perceptions, dislikes, and fears
		Knows how to assess HIV/STI risks of individual clients
		Knows how to counsel condom clients who have problems (for example, insertion for female condoms, breakage or slippage for male condoms)
		Knows how to demonstrate condom use
		Knows how to teach condom negotiation skills
		Has good interpersonal communication and counselling skills
		Summary score (total of individual ratings)

Add up the ratings for the individual items to create two summary scores for providers' attitudes, knowledge, and skills. These may range from 10 to 30. A total score of 20 or higher (for male condoms, female condoms, or both) suggests that providers' abilities pose a barrier to effective condom programming and should definitely be included in the condom programming action plan.

Examine the ratings assigned to individual items. Ratings of 3 suggest that providers lack essential attitudes, knowledge, and skills needed to serve the targeted client group. Of those items rated 3, which weaknesses most limit providers' ability to serve condom clients? Which problems does the programme have the expertise and resources to address? Considering both the importance of the problems and the feasibility of solving them, list three priority items for action in Worksheet 5b.

ASSESS ORGANISATIONAL SUPPORT FOR CONDOM SERVICES

Condom providers need continuing support from their organisation in order to do a good job. Start this part of the assessment by briefly describing the settings for existing or proposed condom programming activities. Some possibilities are health clinics offering facility-based counselling on HIV prevention; schools offering sex education to students; retail stores selling condoms; venues such as theatres, stadiums, and streets that host community mobilisation activities; and events such as youth festivals. Complete separate rating guides for each setting (see Worksheet 6a).

WORKSHEET 5B: ACTION ITEMS FOR PROVIDERS' ATTITUDES, KNOWLEDGE, AND SKILLS

	MALE CONDOMS	FEMALE CONDOMS
1		
2		
3		

WORKSHEET 6A: ORGANISATIONAL SUPPORT AT _____ (Fill in specific setting)		
Rate how strong the programme is in the following areas. *1 = strong 2 = inconsistent 3 = weak*		
MALE CONDOMS	FEMALE CONDOMS	
		Is there a private place to talk to individual condom clients?
		Are condom posters; brochures; and other information, education, and communication (IEC) materials posted where clients can see them?
		Are there handouts on condoms for clients to take home?
		Do providers have essential job aids, such as HIV risk assessment charts, counselling guidelines, reference materials, and penis models?
		Do programme guidelines, policies, and protocols support the use of condoms for dual protection?
		Are programme guidelines, policies, and protocols gender- sensitive?
		Does preservice training cover HIV/STIs and condoms?
		Does refresher and in-service training cover HIV/STIs and condoms?
		Is there regular supervision of condom programming?
		Do supervisors possess the knowledge, skills, and job aids they need to assess and give feedback on condom programming?
		Summary score (total of individual ratings)

Add up the ratings for the individual items to create two summary scores for organisational support for male and female condoms. These may range from 10 to 30. A total score of 20 or higher (for male condoms, female condoms, or both) suggests that lack of organisational support in a given setting poses a barrier to effective condom programming and should definitely be included in the condom programming action plan.

Examine the ratings assigned to individual items. Ratings of 3 suggest that limited facilities, supplies, training, supervision, or support pose obstacles to providers serving condom clients. Of those items rated 3, which problems most hinder providers' ability to serve condom clients? Which problems does the programme have the expertise and resources to address? Considering both the importance of the problems and the feasibility of solving them, list three priority items for action in Worksheet 6b.

WORKSHEET 6B: ACTION ITEMS FOR ORGANISATIONAL SUPPORT		
	MALE CONDOMS	FEMALE CONDOMS
1		
2		
3		

ASSESS QUALITY OF SERVICES

Thorough preparation and good organisational support does not guarantee the quality of services delivered. The best way to judge the actual quality of care delivered is to observe interactions between clients and providers. Another option is to interview clients after they buy condoms or receive counselling. This kind of exit interview is valuable because it reveals the client's perspective on the care received, but it is necessarily subjective and cannot assess the technical quality of care. To complete this rating guide (Worksheet 7a), the assessment team must consult with supervisors who routinely observe client-provider interactions or conduct their own observations and exit interviews.

WORKSHEET 7A: QUALITY OF SERVICES AT _____ (Fill in setting)

Observe client-provider interactions, interview clients, or both. Rate the actual quality of care delivered to condom clients in each area. (Not all areas will apply to each setting.)
1 = good 2 = inconsistent 3 = poor

MALE CONDOMS	FEMALE CONDOMS	
		Waiting times are brief
		Clients have auditory and visual privacy during counselling
		Clients are treated in a respectful, nonjudgemental manner
		Providers give accurate and complete technical information and answer client's questions
		Providers discuss sexual practices and assess the client's personal risk factors for HIV/STIs
		Providers tailor counselling to client's needs and circumstances
		Providers are sensitive to gender issues
		Dual protection and dual method use (that is, using condoms along with another family planning method) are discussed
		Providers give hands-on demonstration of condom use
		Providers teach condom negotiation skills
		Summary score (total of individual ratings)

Add up the ratings for the individual items to create two summary scores for the quality of care offered to clients interested in male and female condoms. These may range from 10 to 30. A total score of 20 or higher (for male condoms, female condoms, or both) suggests that poor quality of care poses a barrier to effective condom programming and should definitely be included in the condom programming action plan.

Examine the ratings assigned to individual items. Ratings of 3 suggest that lapses in quality of care pose a serious obstacle to clients deciding to use condoms and learning how to do so correctly. Of those items rated 3, which problems most hinder clients from adopting and using condoms? Which problems does the programme have the expertise and resources to address? Considering both the importance of the problems and the feasibility of solving them, list three priority items for action in Worksheet 7b.

ASSESS CONDOM PROMOTION IN THE COMMUNITY AND TO ITS INFLUENTIAL MEMBERS

Behaviour change communication (BCC) is an educational strategy for promoting improvement in health status. It serves two purposes for condom programming. When directed to potential clients and their families, it can promote demand for condoms in the community. When directed to influential members of society, it can advocate for a supportive political and social environment. Complete Worksheet 8a to evaluate the programme's behaviour change communication strategy.

WORKSHEET 7B: ACTION ITEMS FOR QUALITY OF SERVICE

	MALE CONDOMS	FEMALE CONDOMS
1		
2		
3		

WORKSHEET 8A: CONDOM PROMOTION

Rate how strong the programme is in each area.
1 = strong 2 = inconsistent 3 = weak

MALE CONDOMS	FEMALE CONDOMS	
		There is a BCC strategy in place to promote demand for condoms among the targeted client group(s)
		There is a BCC strategy in place to promote condoms among gatekeepers important for the targeted client group(s)
		Peer educators and community-based distributors are trained to promote condoms (if applicable to target client group)
		Condoms are promoted at formal and informal community gatherings
		Condoms are promoted in the mass media, including broadcast and print media
		Media and messages are selected to fit the target client group(s)
		Condom programming is linked with other HIV-prevention and reproductive health programmes that serve targeted client group(s)
		Advocacy efforts are directed at political leaders
		Advocacy efforts are directed at religious leaders
		Advocacy efforts are directed at community and/or business leaders
		Summary score (total of individual ratings)

Add up the ratings for the individual items to create two summary scores for the promotion of male and female condoms. These may range from 10 to 30. A total score of 20 or higher (for male condoms, female condoms, or both) suggests that weakness in promotion and advocacy are a barrier to effective condom programming and should definitely be included in the condom programming action plan.

Examine the ratings assigned to individual items. Ratings of 3 suggest that the programme is not effectively using behaviour change communication to encourage condom use and advocate for a supportive environment. Of those items rated 3, which ones have the greatest potential to promote demand for condoms and create a favourable social and political environment? Which activities does the programme have the expertise and resources to undertake? Considering both the importance of the problems and the feasibility of solving them, list three priority items for action in Worksheet 8b.

WORKSHEET 8B: ACTION ITEMS FOR CONDOM PROMOTION

	MALE CONDOMS	FEMALE CONDOMS
1		
2		
3		

DEVELOP AN ACTION PLAN FOR CONDOM PROGRAMMING

With the information collected in Step 1 and in Step 2, programme managers can develop an action plan to create, expand, or improve condom programming for targeted client groups. Managers must begin by identifying key problems that limit condom use among targeted client groups and deciding what needs to change at the individual, community, national, and programme levels. Then they can select feasible and effective interventions to bring about the changes desired and, ultimately, increase correct and consistent condom use.

The action planning process begins by sharing the results of the assessments of the client groups, barriers to condom use, sociocultural and political environment, and programme strengths and weaknesses (compiled in Worksheets 2 through 8) with everyone involved in designing and managing condom programming. With their input, programme managers decide which issues—including barriers to condom use, adverse circumstances in the environment, and programme weaknesses—must be addressed for condom use to rise. Special attention should be given to the action items listed in Worksheets 4b through 8b.

Managers then set an objective for each issue; that is, they specify the change that the programme wants to bring about. For example, if the problem is lack of access to affordable condoms, the desired change might be having nontraditional outlets, such as barbershops and gas stations, sell condoms at low, subsidised prices.

The final step is to select interventions that can bring about the changes desired. The information provided in the rest of the operations manual can help managers create a list of potential interventions, from which they can select the activities most likely to prove effective and feasible.

Target Clients	Assess Needs	Plan for Action
Identify key client group(s) to be focus of condom programming [Step 1, Worksheet 1]	Assess HIV risks of targeted client group(s) [Step 1, Worksheet 2] Assess barriers to condom use [Step 1, Worksheets 2 and 3] Assess sociocultural and political environment [Step 1, Worksheet 3] Assess programme strengths and weaknesses [Step 2, Worksheets 4-8]	List key issues: *Which problems must be addressed to increase condom use?* Set objectives: *What changes—at the individual, community, national, and programme levels—do managers want to bring about?* Select interventions: *What actions can managers take to bring about desired changes? [Steps 3-6]*

Figure 5. Developing an action plan.

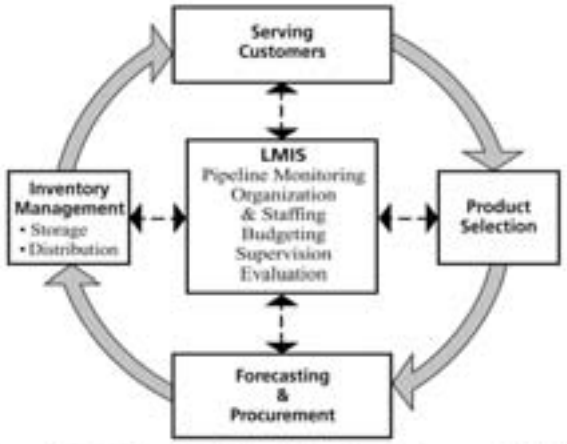
STEP 3.

PROCURE HIGH-QUALITY CONDOMS AND MANAGE THE PIPELINE

KEY ACTIONS

- *Select products that meet clients' needs.*
- *Collect and report essential data.*
- *Forecast condom needs in the way that best fits the programme.*
- *Procure condoms according to national and international standards and specifications.*
- *Manage inventory, storage, and transportation systems.*
- *Establish reliable systems to resupply distribution outlets.*

A Logistics Management Information System (LMIS) is the engine that drives the entire logistics cycle. Collecting and reporting logistics data about condom distribution and monitoring stock levels is critical for making informed decisions about product selection, forecasting, procurement, and inventory management. To ensure a reliable and consistent supply of condoms—and thus avoid shortages, stockouts, and oversupply—quality monitoring must occur at every stage so that all elements of the system operate effectively.



Source: Adapted from Family Planning Logistics Management (FLPM)/ John Snow, Inc.: *The Logistics Handbook: A Practicle Guide for Supply Chain Managers In Family Planning and Health Programs.* Arlington, Virginia, FPLM/John Snow, Inc. 2002.

Figure 6. Logistics cycle. (LMIS = Logistics Management Information System)

An LMIS can be developed for a wide variety of health commodities, including both female and male condoms. Unless there is a well-functioning logistics system in place, condoms will not reach clients and the programme will fail to meet its goal. As the motto for John Snow, Inc.'s DELIVER logistics project puts it, "No Product? No Program."

This section guides HIV-prevention programme managers in strengthening logistics systems, thereby improving service quality and overall programme impact. This section does not address factors outside of the in-country logistics system such as financing, national policies, regulatory controls, or advocacy. For more detailed information on contraceptive logistics systems, see Step 3 in the Resources section (pages 84).

SELECT PRODUCTS THAT MEET CLIENTS' NEEDS

Clients are more likely to use condoms—and use them consistently—if the products offered are attractive as well as functional. Therefore, it is important for programmes to identify the condom preferences of users and potential users. (See Step 1 about user needs.) Managers should decide on what kinds and how many types of condoms to stock based on the needs of targeted client groups, the features that clients find appealing, the

comparative cost of different products, and the logistical challenges posed by stocking and distributing multiple condom types.

Managers should consider stocking the following kinds of condoms, but only if brands that meet international quality standards are available:

- ***Female as well as male condoms.*** The female condom offers women greater control over condom use and also has some advantages for men. (See Appendix for "Female Condoms" fact sheet.)
- ***Multiple condom sizes.*** Adolescents may find standard size male condoms too large, which can lead to slippage, and men with large penises may find them too small, which can cause discomfort and breakage. Appropriate condom sizes also vary among populations.
- ***Different designs.*** Men may appreciate certain design options, such as the roomier fit of "baggy" condoms or the increased friction of condoms with extra room at the tip.
- ***Plastic condoms.*** Plastic condoms offer men increased sensation, a less restrictive fit, thinner feel, lack of odour, and the ability to use oil-based lubricants.
- ***Colours and scents.*** Couples may find the novelty of different colours and scents appealing.

Programmes should **not** distribute condoms lubricated with nonoxynol-9, which can increase the risk of HIV infection in some women by causing inflammation and abrasions in the vaginal wall, nor should they distribute condoms made out of natural membranes, which do not protect against HIV/STIs. (See Appendix for "Male Condoms" fact sheet and the *WHO/CONRAD Technical Consultation on Nonoxonyl-9* posted at *www.who.int/reproductive-health/rtis/N9_meeting_report.pdf.*)

In addition to selecting appropriate products, programme managers also should consider how they are packaged. Attractive packaging can encourage people to buy condoms and even give them greater confidence in the quality and reliability of the products inside. Because manufacturers also are responsible for packaging condoms, packaging decisions are an integral part of the procurement process.

COLLECT AND REPORT ESSENTIAL DATA

Once the decision is made about what types of condoms to procure, it is up to the programme manager to ensure that they are available at all times and at all distribution points. To do this effectively, the manager must be able to collect, organise, and report the information that will be used in making decisions about the procurement process.

At a minimum, programme managers need three essential data items to make the decisions for managing logistics systems:

- ***"Stock on hand"*** is the quantity of usable stock available at all levels of the system. Items that are unusable because of deterioration and expiry are not counted as stock on hand, but as losses. Programmes should be sure to count stock available at the central, regional, district, and service-delivery levels. Condom forecasts based on central-level stock balances alone will lead programmes to order too much product and are likely to result in overstocking and product losses due to expiration.
- ***"Rate of consumption"*** is the average quantity of stock dispensed to users during a particular period of time. Consumption estimates should be based on quantities actually dispensed to end users, rather than on quantities issued to the lower level. Collecting this data is not always possible or practical in programmes with multiple and unique distribution points. In such cases, distribution data should be gathered at the lowest practical level in the system.
- ***"Losses and adjustments"*** are the amounts of stock removed from the pipeline for any reason (loss, damage, expiration) other than consumption by clients or distribution to a lower level in the system.

Although logistics managers may collect and use other data, these three pieces of information are essential to operate a condom logistics system. This information is kept account of in stockkeeping records (which track the quantity of products stored in a single facility), transaction records (which track the movement of products as they are ordered, issued, received, dispensed, or transferred), and consumption records (which track the number of products dispensed to clients). Quantities should always be recorded as individual pieces, not a larger unit such as packing cartons or boxes. This is especially important for condom programmes that receive commodities from more than one manufacturer or donor, as carton and box sizes are not standard among manufacturers.

The data in these records are then gathered into summary LMIS reports, which are routinely submitted on a monthly or quarterly basis. This same basic report can be used at all levels of the logistics system, from the distribution points to the central supply warehouse. It lists the beginning stock balance, consumption, ending stock balance (usable stock on hand), and the quantities requested. An aggregate summary report, which includes the condom stock balances from multiple regions, districts, and clinics, provides the basis for forecasting and procurement decisions at the central level.

In practice, some of this information may be unavailable or incomplete. In many systems, the percentage of distribution points reporting back up the supply chain is low. Therefore, one of the most important decisions facing logistics managers is determining at what level logistics data should be aggregated for decision making.

FORECAST CONDOM NEEDS IN THE WAY THAT BEST FITS THE PROGRAMME

At the national level, condoms are procured in bulk from manufacturers and donors to provide sufficient stock to resupply and, in new programmes, fill the pipeline on a long-term basis. These procurements are based on aggregated national programme estimates that take into account consumption patterns from all levels and facilities in the distribution system, such as clinics, social marketing programmes, and community-based distribution systems (see Step 4).

Forecasting the quantity of condoms needed can be difficult, especially for new condom programmes that lack historical data on programme growth and commodity consumption. The goal is to get as close to the mark as possible by considering the stage of the epidemic (see Figure 7) and by using a combination of four different data sources on condom consumption.

Logistics data. Forecasts based on logistics are highly accurate if consumption patterns remain relatively stable and programme changes are taken into account by forecasters. Optimal forecasts are made using data on the quantities of condoms dispensed at the lowest level in the distribution system. When this is not possible, the forecaster should then use data from the next level up in the system, or from the lowest level in which there is confidence in the accuracy of the data.

The advantages to this method are that the data measure actual distribution levels and consumption trends, and that capacity constraints in the system are taken into account, since the basis of the forecast is actual system capacity. Disadvantages are that logistics data cannot measure actual demand nor system capacity if there have been stockouts or oversupplies in the period when the forecast was made. Forecasts prepared from logistics data also may not be appropriate if condom supplies have not been able to meet demand. Conversely, if excessive supplies have been distributed to outlets, or improperly managed, then a population-based forecast method should be used until logistics systems improvements can be made.

Client population data. Population-based forecasting techniques serve as a good starting point for new programmes because reasonably accurate forecasts can be based on the size of the population the programme will be serving. Instead

of preparing forecasts for the general population, however, forecasters should project needs for the specific client groups targeted by the programme. They need to establish the number of condoms required to protect each member of the client group over a specific period of time—typically the number of condoms required to protect a full-time user of condoms for one year, which is known as segment member-year protection. Programmes serving multiple client groups should calculate the need for each group and add them together to forecast total condom requirements.

Service statistics data. Reports at service-delivery sites commonly include data on new clients, revisits, and current users. These data can be used to forecast condom requirements for a particular period of time. The advantage of using service data is that it takes into account both system capacity and planned programme growth or other changes programme managers may implement. The principal disadvantage is that if unrealistic targets for programme growth have been set, then the condom forecast will be equally unrealistic.

Demographic data. When consumption data are scarce, forecasts based on demographic data are a viable alternative as these data are generally more available and accessible. The principal source for estimating condom consumption using demographic data is the Demographic and Health Surveys (DHS). Forecasts based on DHS results subtract the number of females in union using condoms from the number of males who report using condoms. The difference is the number of males using condoms with a partner other than their regular partner. The assumption is that men

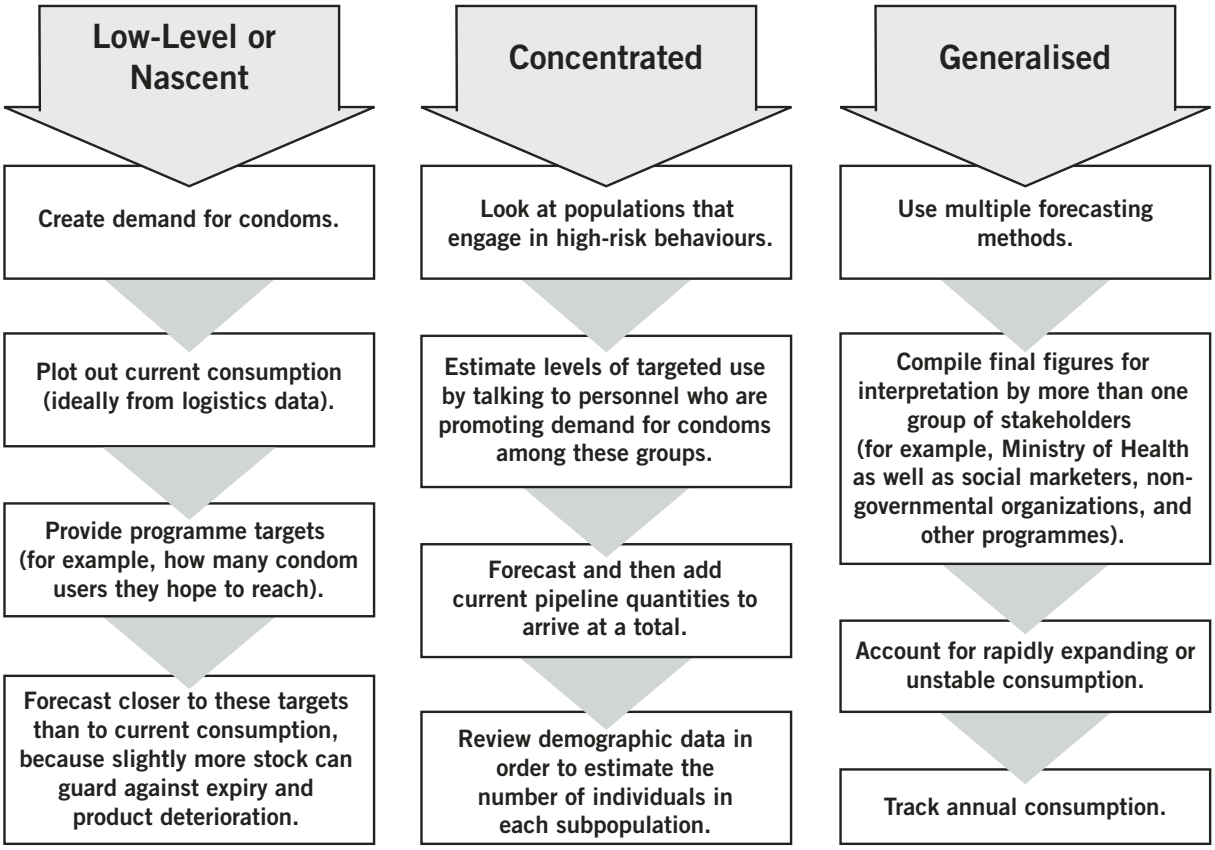


Figure 7. Forecasting for different stages of the epidemic.

are using these extra condoms for HIV/AIDS prevention. This group is generally considered to be the target population for HIV-prevention condom programmes.

ENSURING CONDOM QUALITY

The use of common standards, compliance testing, and careful selection of suppliers can help managers ensure the quality of the condoms they procure.

Standards. The International Organization for Standardization (ISO) has created standards to enhance production of products and quality of services. This system of quality management is known as Good Manufacturing Practice. The international basis for condom procurement is harmonised standard EN ISO 4074, which details optimal manufacturing standards for male latex condoms. HIV-prevention programmes and developing-country governments are also starting to develop standards for public health supplies such as condoms. Note that the quality of condoms must be established as the condoms enter the country.

Testing. Independent testing laboratories play an important role in ensuring that high-quality condoms are available to clients of HIV/AIDS condom programmes. Most such laboratories comply with the EN ISO 4074 for condoms, but programme managers must confirm that this is true before sending samples for prequalification, lot compliance, or quality monitoring of programme inventory holdings. Every lot of condoms made by a manufacturer for a procurement contract should be tested for compliance before the programme makes a final decision to accept it.

Selecting a supplier. Programme managers should not make procurement decisions based solely on price, but rather seek high-quality condoms at a competitive price. There are only a select number of condom suppliers who can reliably deliver high-quality condoms in the quantity necessary to fill the pipeline of most condom supply programmes. Therefore, the World Health Organization (WHO) and UNFPA recommend choosing suppliers by prequalification; limited (yet competitive) international tendering of a contract; and an integrated, ISO-certified laboratory, compliance-testing arrangement for each lot of condoms. Third-party lot-testing is only necessary until the supplier can ensure product quality statistically by other means such as reduced sampling or periodic audits. (Note that the procurement agent should have substantial experience and knowledge of sampling schemes and manufacturing process averages.)

Programmes that place large and frequent orders usually pre-qualify suppliers ahead of time—that is, they create a list of qualified manufacturers and invite them to bid for orders. Programmes can then feel confident that any bids received come from suppliers who will be able to meet the specifications of the procurement. When programmes order condoms less than once a year, they should combine the prequalification and tender process to minimise costly, complex, and lengthy procurement procedures.

PROCURE CONDOMS ACCORDING TO NATIONAL AND INTERNATIONAL STANDARDS AND SPECIFICATIONS

After the quantity of condoms needed has been estimated using one—or preferably a combination—of the commodity forecasting methods, the next step is to determine how many condoms must be procured or requested from donors. This is not the same as forecasting condom needs. Procurement quantities take into account how many condoms already exist within the distribution system and what adjustments are desired to stock levels throughout the distribution system.

WHO guidelines describe four commonly used procurement methods. Organisations should select one based on their own capabilities, the amount of condoms needed, time constraints, and donor requirements.

Buy Directly From a Manufacturer Through a Competitive Bidding Process

Although satisfactory for fairly large orders, this procurement method is complex and can take a long time. It allows good control of supply and quality assurance but requires reliable staff and experienced management with substantial technical capacity. The purchaser must develop the specification and procurement documents, implement the bidding process and prequalification of potential suppliers, select the manufacturer, and arrange for compliance testing and shipping.

If a programme does not have existing procurement capacity with competitive bidding experience, this method can be very challenging and can lead to significant delays. The approximate time required to complete an international competitive bidding process—from identification of requirements to delivery of product—can range from 12 to 18 months.

Buy Through a Procurement Agent

This is a good option for programmes that do not have the capacity to implement a competitive bidding process. The problem is that, although independent procurement agencies exist in most cities, few of them know the special requirements for buying condoms. It is very important to select a procurement agent with a track record of procuring quality condoms. For example, UNFPA, USAID Crown Agents, and Population Services International (PSI) can act as procurement agents. Do not use a nonspecialised commercial agent.

The procurement agency charges a fee for its services. The agent takes responsibility for procurement and quality checking. The purchaser has to develop the specifications and make a suitable contract, including an agreed-upon time frame, with the purchasing agent. The agent will be responsible for handling the prequalification of potential suppliers, selecting the supplier, and arranging compliance testing and shipping. Some procurement agents may have existing supply contracts with condom manufacturers and may be able to offer a purchaser a shorter delivery time. Small orders may be expensive. Arrangements can be made with an agent to purchase the quantity required as part of a larger bulk order, which can reduce procurement costs.

Buy From an International Agency

This is an option for organisations and national programmes that do not have the procurement capacity required to implement the more complex procurement methods. The international procurement agency charges a fee for its services but does offer very competitive prices. UNFPA and other international agencies, like the United States Agency for International Development (USAID), PSI, and International Planned Parenthood Federation (IPPF), buy condoms using WHO specifications, and undertake both the prequalification of manufacturers and lot-by-lot compliance testing. Some agencies, such as UNFPA, maintain a list of pre-qualified suppliers, thus reducing the lead time to respond to requests for supply. Packaging for these condoms is generally plain foil with no consumer packs, but unique programme requirements can be considered if the quantity ordered is significant and there is sufficient time for a manufacture to process the order. Depending on the quantity of condoms needed, this option can also offer a delivery time less than that required by a competitive bidding process.

Certain international organisations, for example UNFPA and PSI, maintain stocks of condoms to respond quickly to "stockouts" and other emergency situations. UNFPA will sell to programmes for distribution in-country (information available online at www.unfpa.org/procurement/faq_clients.htm).

Direct Clients to a Social Marketing Organisation

Social marketing organisations operate like commercial retail companies. They buy products and promote and sell them in the market at subsidised prices. Sometimes donors supply

condoms and the social marketing organisation adds consumer packaging before marketing them. For more on social marketing, see page 50.

GHANA SOCIAL MARKETING FOUNDATION

The Ghana Social Marketing Foundation (GSMF) sells contraceptives at low cost through private-sector retailers. It works with hundreds of private chemists, pharmacists, workplaces, and other outlets for contraceptive delivery. GSMF sells contraceptives at low cost to resellers, who sell them to these various outlets for a small profit. The outlets, in turn, sell the contraceptives to customers for a small profit. There is no fixed reordering system between the reseller and outlets. Chemists and others simply wait until they are low on stock, then call the reseller and ask for additional supplies. The outlets may not have a formal definition for *low*, but if the product is selling, they avoid a stockout by placing an order. Although the GSMF system is not a precise method, this is a good example of how the principles of continuous review can be applied.

Source: Family Planning Logistics Management/John Snow, Inc. *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs.* Arlington, Virginia: FPLM/JSI for USAID, 2000.

MANAGE INVENTORY, STORAGE, AND TRANSPORTATION SYSTEMS

With appropriate information about inventory levels, managers can determine how long current supplies will last, when to order more condoms, and how many to order (see Sample Form on following page).

SAMPLE ORDER AND REQUEST FORM

REPORT AND REQUEST FOR CONDOMS SERIAL NO.

PROVINCE DISTRICT LOCATION

FACILITY TYPE: DEPOT DISTRICT STORE CLINIC OR OTHER OUTLET OTHER

REPORT FOR PERIOD BEGINNING ENDING

DESCRIPTION (include lot number, manufacturing date, or shipment date)	BEGINNING BALANCE	RECEIVED THIS PERIOD	DISPENSED/ ISSUED	SAMPLED FOR TESTING	LOSSES	ENDING BALANCE	QUANTITY NEEDED
TOTAL							

EXPLANATION OF LOSSES:

SUBMITTED BY: DATE:

Every facility in a condom-supply programme—including distribution outlets, regional warehouses, and central warehouses—must maintain a safety or buffer stock, so that shortages, which could result in forced rationing and stock-outs, do not occur between the time an order is placed and the time the products arrive (known as "lead time"). However, facilities also must avoid excessive inventory, which increases holding costs and losses due to product expiry. Differences in the procurement process affect lead time—and hence stock levels and storage issues—for the central warehouses at the beginning of pipeline. Maximum-minimum (or "max-min") inventory control procedures are designed to avoid both shortages and excessive inventory while ensuring quality and availability.

Max-min levels are often set in terms of

number of months of stock on hand. For example, if there are 250 condoms in stock, and the average monthly consumption for the past six months has been 100, then the facility has 2.5 months of stock on hand. The rate can be determined from consumption data, or from quantities dispensed or shipped to the next lower level or customers. Because usage rates fluctuate from month to month, the rate should be calculated by analyzing facility data records from the most recent six months.

The minimum stock level is the point at which supplies should be reordered. To avoid excessive holdings, orders should not be placed unless condom stock levels fall at or below this point. The minimum stock level, therefore, consists of the quantity of condoms needed to meet demand during the lead time. The minimum stock level also includes a safety stock, kept to anticipate delays in delivery or other unexpected events.

ADAPTING TO LOCAL CONDITIONS

In Kenya and Bangladesh, continuous-review inventory-control systems are often used in condom programs for HIV/AIDS prevention. Condoms are placed in dispensers that are hung on the walls of clinics. Customers who need condoms yet want to remain anonymous simply take strips of condoms from the dispensers without giving their name or waiting in line.

When the dispensers need refilling, condoms are added from existing clinic stocks. This system does not use a max-min inventory control system because levels of condom stocks cannot be tracked due to the spontaneous nature of distribution. In this case, however, general principles have been adapted to local conditions to produce an effective system.

Source: Family Planning Logistics Management/John Snow, Inc. *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs.* Arlington, Virginia: FPLM/JSI for USAID, 2000.

Under typical conditions, inventory levels should never rise above the maximum stock level. This maximum must be set high enough above the minimum stock level to cover expected consumption until the next review period, when stock levels are reassessed. At the same time, the maximum should be kept low enough to avoid excessive stock levels or long storage periods.

A sample max-min level in a three-tier system may look like the following:

Level	Max	Min	Review Period
Central	9 months	6 months	Quarterly
Regional	6 months	3 months	Quarterly
Outlet	3 months	2 months	Monthly

The implication of these max-min levels is that it may take as long as 18 months—adding the central, regional, and outlet max levels—for condoms to move from the top of this system to the bottom. If storage conditions are not ideal, this lengthy product pipeline could lead to expired and deteriorated products. In this case, max-min levels would need to be lowered to store less stock for less time, and more frequent deliveries would be required. It is important for programme managers to periodically review max-min levels to ensure that condom stock balances are neither too high nor too low.

MAINTAIN GOOD STOREKEEPING PRACTICES FOR CONDOMS

Warehousing and storage are more than just shelving products. Managers must ensure they have quality products for distribution by maintaining environmental requirements for condom storage, employing routine inspection, and following other standard procedures.

Similarly, transportation links between different levels of the supply system need to be designed to maintain proper environmental conditions, minimise pipeline length, contain costs, create efficiencies, and integrate delivery schedules with

inventory control programmes.

Managers at each level of the condom supply programme should designate individuals responsible for orderly maintenance of the facility to ensure products are accessible when they are needed. Designated staff should be responsible for physical inventory, visual inspections, and for implementing management procedures through which inventory flow is regulated. When all levels of the system follow standard storage procedures (see Figure 8), clients can be assured that high-quality products will be available for use.

Physical inventory and the physical layout of all storage facilities should be the first considerations toward ensuring the security of the condom supplies.

Condoms are perishable items (see text box on following page). It is therefore important that they are appropriately dated. Most condoms shipped from the major manufacturers will arrive marked with the expiration date; some will carry only the manufacturing date. They should be stored according to the "first-expiry, first-out" (FEFO) rule. Harsh storage conditions may render condoms useless much earlier than the expiration. Products should therefore be stored away from direct sunlight, below 40°C, away from moist conditions such as leaks, and with the expiry date clearly visible to staff.

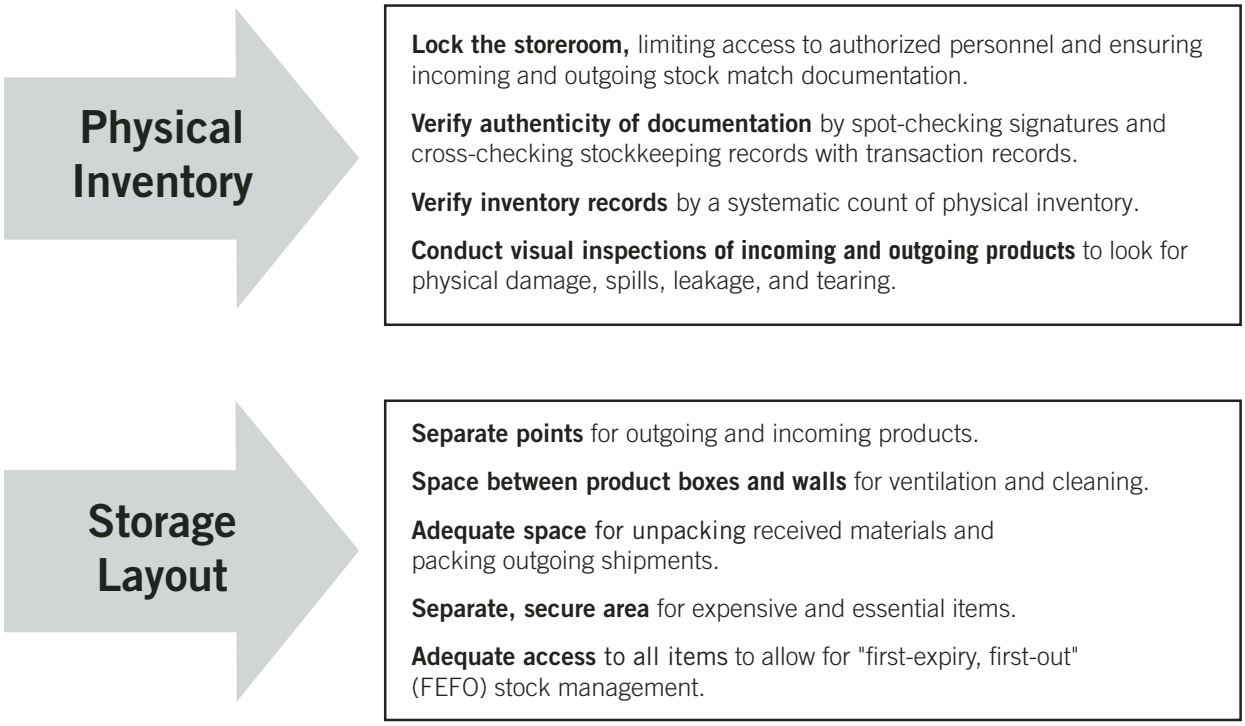


Figure 8. Inventory and storage procedures.

CONDOM SHELF LIFE

Male condoms

The shelf life, or time a male latex condom is useful and effective from manufacturing to use, varies considerably depending on storage conditions, temperature, humidity, moisture, and even ultraviolet light. Each of these factors can considerably reduce condoms' typical shelf life of three to five years.

As a general rule, male latex condoms should be kept away from extreme temperatures (above 40°C) and away from moisture and humidity. Even ozone, emitted from fluorescent (ultraviolet) lighting can destroy condoms within just a few hours. In many condom-supply programmes in sub-Saharan Africa and South Asia that experience constant heat and humidity, it has been necessary to cool central warehouses with air-conditioning units to maintain condom shelf life. Without such measures, many condoms have to be destroyed, given that the time from arrival in port to distribution to customer in many typical programmes is between one and two years.

Female condoms

The manufacturer of the female condom has determined the shelf life to be five years. Storing female condoms is easier than storing male latex condoms because female condoms are made out of polyurethane, a material that is unaffected by humidity and ozone levels. It requires no special storage conditions.

When an order for a lower-level facility or outlet is to be processed, the requested quantities should be verified against previous orders. Then, supplies should be drawn based on the FEFO rule and quality inspection rules. Finally, products should be marked as appropriate for transportation, and stockkeeping records should be updated to reflect the outgoing shipment.

TRANSPORTING CONDOMS

Managing the movement of supplies along the entire chain of storage facilities and transportation links, from manufacturer to the customer, is known as the pipeline. Transportation of condom supplies between the links in the product pipeline is therefore crucial if high-quality products are to reach customers.

The purpose of analyzing a supply pipeline is to ensure that products reach their final destination and to identify inefficiencies in the system. In many existing distribution systems, facilities are designed to mirror domestic political structures, with warehouses positioned at the district, provincial, and regional levels. Since each step adds holding costs and delays, such a design may be inappropriate. Many newer social marketing and NGO programmes have designed more flexible and efficient distribution systems.

Since the external portion of the pipeline is usually beyond the programme manager's control, it is important to keep the in-country pipeline as short as possible. Eliminating levels in the system and reducing the stock levels at each facility can accomplish this. In analyzing a pipeline, it is important to remember that inventories serve four functions: they hold condoms in-country between bulk shipments from manufacturers, they hold safety stocks in case resupply is delayed, they hold supplies for distribution points with limited storage space, and they hold condoms in case of future increases in demand.

Programme managers must estimate weight and volume, and then select the most appropriate method of commercial or programme-owned transportation. Typical methods include truck, boat, rail, or, at higher levels of the distribution system, air. Each method will have different capacity, speed, and costs. Programme managers should review each possible transportation mode to secure the best mix of availability, affordability, and quality.

MONITORING THE QUALITY OF STORED CONDOMS

There are two ways to monitor the quality of the condoms that the programme purchases. First, the manufacturer or supplier of the condoms should

comply with agreed-upon quality specifications. Second, programme managers should inspect, sample, and test the condoms in-country. Ensuring the quality of donated condoms is a responsibility of both donors and programmes (including host governments, NGOs, and social marketing programmes), who must carry out established recommendations and procedures.

The establishment and continued operation of a quality-assurance system also is critical to ensure a reliable supply of high-quality condoms that clients have confidence in. Because manufacturing or expiry dates cannot by themselves ensure the quality of condoms, programmes should monitor the quality of new condom shipments upon arrival in the central warehouse and then periodically monitor condom quality at central and regional warehouses.

When condoms have passed their expiry date or are otherwise unusable because of deterioration or damage, they must be disposed of properly and completely. Disposal should be carried out according to local laws or ordinances. Whatever the method of disposal (for example, incineration), it is crucial that the condoms be destroyed so that they cannot be recovered for use or resale. A record of the disposal should be kept, including the date, place, commodity, quantity, reason, and persons involved.

ESTABLISH RELIABLE SYSTEMS TO RESUPPLY DISTRIBUTION OUTLETS

Without reliable and adequate supplies of condoms, any distribution channel will quickly lose sales and credibility. Therefore, it is essential to set up reliable systems to resupply all distribution outlets on a timely basis. There are two possible approaches. In a "push" system, higher-level managers decide when and how many condoms to ship to outlets, based on information in reports they receive. In a "pull" system, personnel at distribution outlets are responsible for ordering more condoms as needed.

In either case, reordering is based on the max-min inventory system described earlier in this step, with minimum stock levels triggering orders. Some systems have a preset reorder schedule. Stock levels are reviewed at regular intervals, and, if they are at or below the minimum, as many condoms are ordered as needed to bring stock levels back up to the maximum level. Other systems continuously track stock levels. Whenever inventories reach the minimum level, a predetermined amount of condoms is ordered.

STEP 4.

EXPAND DISTRIBUTION SYSTEMS

KEY ACTIONS

- *Match distribution channels and outlets to clients' needs.*
- *Use multiple distribution channels and nontraditional outlets.*
- *Ensure easy access to condoms at health facilities.*

Increasing the number and types of outlets supplying condoms is an effective way to improve access, reach new client groups, and increase the visibility of condoms. Condom programmes are turning to nontraditional locations and distribution channels to reach couples at risk, for example, making condoms available from cigarette vendors, at factories, and in hotel rooms.

MATCH DISTRIBUTION CHANNELS AND OUTLETS TO CLIENTS' NEEDS

Condom programmes should select distribution channels and outlets in response to the circumstances and needs of specific client groups. The following four factors are especially important:

Convenient locations allow people to obtain condoms:

- Close to where they live or work, for example, at neighbourhood shops and kiosks or on the factory floor;
- Where unsafe sex is negotiated or conducted, for example, at bars, nightclubs, hotels, and brothels; or
- Where groups at high risk of HIV infection gather, for example, truck stops, military installations, and drug treatment clinics.

NICARAGUA: DISTRIBUTING CONDOMS AT MOTELS

An unusual research project in Managua took condoms and print materials on HIV prevention directly to motels where couples routinely rent rooms for brief sexual encounters. This randomised, controlled trial included 19 motels, which were visited by 6,463 couples in 24 days. To encourage condom use, glossy, decorated envelopes containing two condoms were either left on the motel bed or handed to the couple before they entered the room. Other couples, in contrast, received condoms only if they requested them. Half the couples also found a poster encouraging condom use ("when enjoying life—the condom is your best choice") on the wall of the room and an illustrated leaflet on condom use on the bed.

Leaving condoms in the room or handing them directly to couples increased the likelihood of their using condoms by about 30% for commercial sex and by 50% to 80% for casual, non-commercial sex. In contrast, displaying health education materials had no effect on condom use in non-commercial sex and may have even discouraged condom use in commercial sex.

Source: Egger M, Pauw J, Lopatatzidis A, Medrano D, Paccaud F, Smith GD, "Promotion of condom use in a high-risk setting in Nicaragua: a randomised controlled trial." *Lancet* 2000; 355:2101-2105.cit_af ref_bf(Egger, M. 2000 ref_num2770)ref_af

Extended and flexible hours ensure that condoms are available when it is convenient for clients. This may mean picking up condoms after work or buying them late at night just before a sexual encounter.

Privacy reduces potential embarrassment for clients. Retail sales, for example, offer relative anonymity, and vending machines eliminate face-to-face encounters altogether. In contrast, health facilities that keep patient records offer less privacy.

Cost affects whether clients can afford a steady supply of condoms. Public health systems and community-based distribution systems may offer condoms for free, social marketing programmes subsidise their cost, while commercial retailers charge full price.

Table 1 lists a variety of condom outlets that may meet the needs of common client groups. However, the possibilities vary widely between and within countries. Programme managers should survey the local area to identify traditional and nontraditional outlets that might meet the needs of targeted client groups, considering their lifestyles and social setting (see worksheet).

TABLE 1. APPROPRIATE CONDOM OUTLETS FOR VARIOUS CLIENT GROUPS.

	DISTRIBUTION CHANNEL		
CLIENT GROUP	COMMERCIAL AND SOCIAL MARKETING	COMMUNITY-BASED DISTRIBUTION (CBD)	HEALTH FACILITIES
Women	Hairdressers, groceries, pharmacies	Women's organisations, traditional healers, family planning distributors	Family planning clinics, maternal and child health clinics
Men	Barbers, gas stations, liquor stores, cigarette shops, sidewalk vendors, taxis, market stalls, kiosks, vending machines, pharmacies, gyms, stadiums	CBD agents in the workplace	STI and primary health care clinics, factory clinics
Youth	Vending machines, fast food outlets, kiosks, cinemas, youth festivals	Youth organisations, schools, peer educators,	Youth-friendly clinics, university clinics, school nurses
Men away from home	Truck stops, gas stations, roadside restaurants, army barracks, kiosks	CBD agents at hostels, truck stops, and workplaces	Employers' clinics, military clinics
Sex workers and their clients	Brothels, bars, nightclubs, hotels	Sex workers trained as CBD agents	Clinics in red light districts
Refugees and internally displaced people		Refugees trained as health promoters	Clinics in refugee camps, mobile clinics, emergency relief packages

WORKSHEET 9: LIST SPECIFIC CONDOM DISTRIBUTION CHANNELS AND OUTLETS THAT WOULD BE ACCESSIBLE, AFFORDABLE, APPROPRIATE, AND CONVENIENT FOR TARGETED CLIENT GROUPS.		
	FIRST CLIENT GROUP TARGETED:	SECOND CLIENT GROUP TARGETED:
Retail shops and kiosks		
Temporary stalls and travelling vendors		
Food and beverage outlets		
Workplaces		
Locations for condom vending machines		
Entertainment venues		
Special events		
Organisations that could sponsor CBD programmes		
Types of people who would make effective CBD agents or peer educators		
Health care facilities and providers		
Other:		
Other:		

USE MULTIPLE DISTRIBUTION CHANNELS AND NONTRADITIONAL OUTLETS

Condom programmers can dramatically increase access to male and female condoms by exploiting multiple distribution channels outside the public health care system, including commercial sales, social marketing, community-based distribution, and workplace promotion (see Table 2, page 51). Each has its own strengths and weaknesses and satisfies the needs of different client groups. Nontraditional outlets also have the potential to expand access to condoms.

COMMERCIAL SALES

Commercial retail outlets are already present in most communities and provide convenient sales points for condoms—at no cost to condom programmes. Compared with health facilities, retail shops also provide clients the relative anonymity of a commercial transaction. The drawback to commercial provision of condoms is high prices: many people cannot afford to pay full price for condoms. Limited profit margins also may discourage manufacturers from promoting condom sales, and sales clerks can provide little support or training to condom customers.

However, pharmacists can be trained to provide effective reproductive health care and counselling.

SOCIAL MARKETING

Social marketing programmes use commercial marketing techniques to sell brand-name products at low prices subsidised by donors or the government. Low prices make condoms more affordable, while ensuring that customers want and will probably use the condoms they receive, which is not always the case with free supplies. Charging for condoms also creates a profit for outlets selling the condoms and recovers some of the costs of distribution and promotional activities.

In addition to making condoms more affordable, social marketing programmes make them more accessible by distributing them through nontraditional outlets, including brothels, liquor stores, roadside stands, fast food restaurants, bakeries, tobacco shops, bookstores, barbers, and beauty shops. For example, socially marketing female condoms through hairdressers allows women to purchase them in a relaxed and friendly environment that conveys the message that female condoms are suitable for all women, not just sex workers. Social marketing programmes may employ sales agents to encourage these smaller, unconventional outlets to stock condoms and to inform retailers about the importance of condoms for HIV prevention.

ETHIOPIA: CONDOM SOCIAL MARKETING

In its first five years, the Ethiopia Social Marketing Project increased condom sales from about 300,000 to almost 20 million annually—despite the upheaval caused by an escalating civil war, limited familiarity with condoms, and the absence of a well-developed commercial marketing and distribution system. Key to the project's success was fielding a large, dedicated sales force to expand the number and type of outlets selling condoms and to keep these outlets resupplied. Due to their efforts, most sales took place at non-traditional outlets: kiosks accounted for 63 percent of sales, while hotels and bars contributed another 25 percent. Ensuring the smooth flow of commodities to these outlets was a continuing challenge, made easier by the use of private transport companies.

To educate the population about AIDS and promote condom use, the project advertised heavily on radio and also sponsored an array of seminars, workshops, lectures, and training programs for people who can influence condom use and for those at high risk of infection. Audiences included bar and hotel workers, sex workers, teachers, farmers, government employees, health workers, refugees, labourers, military, NGO workers, police, prisoners, vocational students, transport workers, and youth.

Sources: FHI, *Final Report for the AIDSCAP Program in Ethiopia January 1993 to December 1996*. Research Triangle Park, North Carolina: FHI, 1996; FHI, *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs*. Research Triangle Park, North Carolina: FHI, 2002.

Social marketing programmes typically promote condoms vigorously to boost sales and change social norms governing condom acceptability and use. Promotional campaigns, including mass media advertising and sponsorship of sports contests and other public events, can make discussion of HIV/AIDS and condoms socially acceptable, take the stigma out of condom use, and increase consumer confidence in condoms.

COMMUNITY-BASED DISTRIBUTION

Community-based distribution (CBD) programmes recruit local people and organisations to promote and distribute condoms to other community members. A wide variety of people have been trained as CBD agents by condom programmes, including traditional healers, sex workers, and members of women's organisations. By distributing condoms through existing community

structures, CBD programmes increase acceptability and access while reducing costs. CBD agents can carry condoms to people and places that are hard for other distribution channels to reach, and they can also serve as peer educators, counselling customers on HIV/STI risks, correct condom use, and condom negotiation skills.

WORKPLACE PROMOTION

Condom distribution programmes based in the workplace can give employees easy access to male and female condoms for free or at low cost. Successful approaches include placing condom vending machines in workplace bathrooms, recruiting peer educators to distribute condoms in factories, and making condoms and HIV/STI services available at company clinics and medical stations. Workplace promotion can play an especially important role for men away from home, such as miners, who may rely on their employers for a wide variety of services, including health care. Workplace programmes require the cooperation of employers, some of whom have subsidised condom education and distribution activities in order to protect the health of their workers.

TABLE 2. STRENGTHS AND WEAKNESSES OF CONDOM DISTRIBUTION CHANNELS.

CHANNEL	STRENGTHS	WEAKNESSES
Public health system	Uses existing structures Validates efficacy of product Has broad reach Provides client education Affordable	Provider bias against barrier methods and certain clients Does not reach people outside of health system Limited privacy for clients
Commercial provision	Uses existing distribution system and outlets Has broad reach Costs to programme are minimal	Products too expensive for some target audiences Difficult to provide client education and support
Social marketing	Strong media and promotional support Potential for cost recovery More privacy for customers	Expensive to start up Difficult to provide education and support
Community-based distribution	Targets specific audiences Provides client education and support Can reach marginal clients	May not cover large groups or areas Difficult to keep CBD agents motivated
Workplace promotion	Targets specific audience Can provide interpersonal support and promotion	Requires cooperation of employer Does not cover large group

ENSURE EASY ACCESS TO CONDOMS AT HEALTH FACILITIES

Many public health systems in developing countries distribute condoms for free. Health facilities also have the advantage of being able to counsel individual clients on HIV/STI risks, safer sex, the correct way to use condoms, and negotiating condom use with partners. For many potential clients, however, clinic locations, hours, or recurrent stockouts make them an inconvenient or unreliable source of supply. In addition, clients may feel embarrassed or uncomfortable asking staff members about condoms, especially if they are young or unmarried or if they must register as clinic patients. Some facilities also carry a stigma; for example, they may be known as a place for treating sexually transmitted infections or prostitutes.

By changing policies and service practices, however, health facilities can mitigate many of these obstacles to access and become condom-friendly (see Action Checklist).

Action Checklist for Easy Access to Condoms at Clinics

☐	Make male and female condoms available at all times.
☐	Offer different types of condoms, so that clients have a choice.
☐	Offer condoms to all clients, regardless of age or marital status.
☐	Expedite clients who only need to pick up a supply of condoms.
☐	Do not ask clients to fill out a form or sign in a register when they get condoms.
☐	Place condom dispensers in private yet easily accessible places, such as restrooms, so clients can obtain condoms without asking health personnel.
☐	Post signs indicating where and how condoms are available.
☐	Give clients enough condoms to meet their needs.
☐	Minimise any possible stigma associated with collecting condoms for STI prevention.

STEP 5.

PROMOTE CONDOMS AT DISTRIBUTION POINTS

KEY ACTIONS

- *Make confidential condom counselling available to clients.*
- *Train providers.*
- *Focus supervision on condom service delivery.*
- *Encourage partner communication and participation in counselling.*
- *Display and distribute educational materials.*

Whenever clients visit condom distribution points—whether health facilities, retail shops, or nontraditional outlets—they create an opportunity for condom promotion. To take advantage of this opportunity, programmes should encourage individual client counselling and, where this is not possible, display and distribute educational materials instead.

Effective programmes also promote condoms throughout the broader community, in order to ensure a favourable social, cultural, and political environment for condom use. For information on how to accomplish this, see Step 6 (page 61).

MAKE CONFIDENTIAL CONDOM COUNSELLING AVAILABLE TO CLIENTS

Individual counselling is one of the most effective ways to promote condom use, since providers can tailor their information and advice to the client's unique concerns and situation. Some types of condom distribution channels, such as health facilities and peer educators, routinely offer individual counselling to all clients. Managers can take steps to make sure that their clinics are indeed condom friendly (see Action Checklist).

Other condom distribution channels, such as retail sales outlets, provide little opportunity for personal counselling. When individual counselling is not possible, programmes should use educational materials, such as posters and leaflets, to give condom clients essential information on how to use condoms correctly. Educational materials also should refer clients with questions, concerns, or problems to local clinics and peer educators for individual counselling.

Action Checklist for Condom-Friendly Clinics

☐	Post signs that clearly indicate the availability of condoms and counselling.
☐	Set aside a meeting space for individual counselling that gives clients visual and auditory privacy.
☐	Train counsellors to reassure clients about the confidentiality of condom counselling.
☐	Train staff not to judge or lecture clients who request condoms.
☐	Create policies and procedures that guarantee the confidentiality of client records.
☐	Hold group talks that discuss condoms and HIV/STI prevention.
☐	Make individual and group counselling available in the community as well as at clinics.

Also see the "Action Checklist for Easy Access to Condoms at Clinics" on page 52.

TRAIN PROVIDERS

Everyone who offers information and advice to condom clients—whether based at health facilities or in the community—requires some kind of training or orientation (see Checklist). Even clinic receptionists and sales clerks, who do little more

than hand out condoms, need enough training to treat people nonjudgementally when they request condoms. Even with training, however, it may be a challenge to motivate poorly paid health workers or other staff to improve the way they treat condom clients and customers.

CHECKLIST: WHO REQUIRES CONDOM TRAINING?

At health facilities	*In the community*
❍ Nurses	❍ Peer educators
❍ Doctors	❍ CBD agents
❍ Social workers	❍ Pharmacists
❍ Receptionists	❍ Teachers
❍ Clerks	❍ Sales clerks
❍ Other:	❍ Local government staff
	❍ Women's groups
	❍ Other:

The amount and type of training varies, depending on who is being trained and what kinds of clients they serve. A training needs assessment can decide which providers need training, what the curriculum should cover, and how long training should last.

Generally, training should ensure that condom counsellors:

- Hold positive attitudes towards condoms and support their use;
- Feel comfortable counselling clients on sexual matters and relationship issues;
- Have good interpersonal communication and counselling skills;
- Are knowledgeable about technical issues and offer clients complete, accurate, and current information;
- Can demonstrate correct condom use; and
- Can teach clients how to negotiate condom use with sexual partners.

Training should help counsellors explore their own attitudes toward sexual and gender issues—which often reflect those of the larger community—and understand how their personal biases can undermine condom counselling. Training should promote tolerance and nonjudgemental attitudes, so that counsellors respect and are willing to serve clients of all kinds, no matter what their age, marital status, or sexual practices. It is also important to sensitise counsellors to gender issues, especially those affecting women's ability to communicate with their partners and negotiate safer sexual practices (see Appendix for "Gender and Condom Programming" fact sheet).

NIGERIA: TRAINING FAMILY PLANNING PROVIDERS TO PROMOTE DUAL PROTECTION

In 1998 the Association for Reproductive and Family Health (ARFH) introduced counselling on dual protection and the female condom at six family planning clinics in Ibadan. Family planning providers received intensive training to help them feel comfortable talking about sexual issues and to teach them how to assess sexual risk behaviours, educate clients on HIV/STIs, and give instructions on condom use and negotiation. A new counselling protocol made dual protection the standard of care and fully integrated HIV/STIs into routine family planning counselling. The protocol was reinforced by a dual protection flipchart for providers, posters and pamphlets for clients, continuing supervision, and changes in the data collected by the management information system.

The intervention succeeded in changing family planning providers' values and counselling practices. Providers embraced their role in responding to the AIDS epidemic and counselled most clients on dual protection. After training, they more often conducted STI assessments, discussed sexual behaviour, compared contraceptives' ability to protect against infection, and taught condom negotiation skills. Lingering negative attitudes towards male condoms, however, meant that clients using dual protection mostly relied on the female condom.

Source: Adeokun, L et al. "Promoting dual protection in family planning clinics in Ibadan, Nigeria." *International Family Planning Perspectives*. 2002; 28(2):87-95.

Current technical information on HIV, STIs, and condoms should be a core element of the curriculum, as should counselling skills (see text box below). Training on counselling skills should be tailored, if possible, to the needs of a specific client group. Peer educators based at a truck stop, for example, should consider the male perspective on condom use, especially the challenges of living away from home; sex education teachers have to learn about the special circumstances and concerns of adolescents.

KEY TOPICS FOR CONDOM TRAINING

Exploration of community norms and personal attitudes

- Gender roles and inequities
- Gender relations
- Impact of gender on sexual practices and HIV transmission
- Impact of social norms and peer pressure on sexual practices
- Sexual and reproductive rights
- Impact of providers' values and attitudes on quality of care

Technical information

- HIV/STI transmission routes and risk factors
- Effectiveness of male condoms at preventing HIV/STIs and pregnancy
- Effectiveness of female condoms at preventing HIV/STIs and pregnancy
- Correct way to store and use condoms
- Correct way to dispose of condoms after use
- Minimising breakage and slippage with male condoms
- Choosing and using lubricants with male and female condoms
- Practice of dry sex
- Sources of supply in community
- Access to emergency contraception

Counselling skills

- Ensuring confidentiality
- Interpersonal communication skills
- Client-centred counselling
- Discussing sexuality and sexual behaviour
- Assessing a client's HIV/STI risks
- Responding to common myths, perceptions, dislikes, and fears
- Identifying and resolving potential barriers to condom use
- Demonstrating correct condom use
- Teaching assertiveness and partner negotiation skills for condom use
- Making referrals for STIs, domestic violence, etc.

For more information about the technical content of training, see the fact sheets on female condoms, male condoms, and protecting against both HIV and pregnancy (in Appendix).

Interactive training methods, such as role-plays, can help counsellors practise and master key skills. Role-plays should be brief, with clear directions from the trainer about the communication skills being practised. Afterwards the trainer needs to give feedback on what was done well and what might have worked better, in a way that shows respect for participants and increases their confidence.

Training materials and methods should reflect the educational level and background of the participants. Peer educators and CBD agents, for example, may have little education and limited understanding of their job. Their training must emphasise practical and participatory training methods, allow sufficient time to practise skills, and clarify what their role will be. Some kind of written or oral exam is essential at the end of the training course to ensure that trainees understand the material presented and can competently perform key tasks.

After training ends, follow-up is needed to help providers apply their new knowledge and skills on the job. Trainers and supervisors can monitor providers' performance and provide further coaching during site visits. Onsite managers and coworkers can act as mentors and provide support

on a daily basis. Job aids can remind providers what to do and say.

Training is not a one-time activity. Continuing education is important to update information, refresh old skills, and to address weakness in performance identified by supervisors or staff. This may take place during on-the-job training conducted by supervisors or experienced colleagues or formal refresher courses.

Source: Adapted from Wotton K et al. "Training in STD management: in Dallabetta G, Laga M and Lamptey P eds. *Control of Sexually Trasmitted Diseases: A Handbook for the Design and Management of Programs*. Family Health International, 2001.

Figure 9. Steps in planning health worker training.

FOCUS SUPERVISION ON CONDOM SERVICE DELIVERY

Condom programming should be integrated into existing supervision systems to make sure that providers apply their training and perform well on the job. Conventionally, supervision has meant periodic site visits by external supervisors to check on condom storage conditions and supplies, observe providers' interactions with clients, and give feedback to providers. Alternative approaches include: supervisors meeting with groups of providers to resolve common problems, providers reviewing the performance of peers, and onsite managers providing continuing supervision to providers. Part-time and volunteer providers, such as peer educators and community-based distributors, may need especially close supervision to maintain their skills and their motivation.

Supervisors typically need additional training on condoms and related issues, such as gender relations, before they begin monitoring condom programming. Including supervisors in training courses for providers ensures that they receive the same technical updates, counselling instructions, and opportunity for self-examination; it may also improve the relationship between supervisor and provider. Equally important is developing simple tools, such as observation checklists, to guide supervisors and standardise the supervision process.

A supportive, or facilitative approach, to supervision can help providers identify and resolve problems and improve performance. Supportive supervisors act as a mentors, trainers, and coaches rather than as inspectors. They use praise and recognition to motivate providers, help them deal with discouraging situations, give constructive feedback, and provide on-the-job training to build providers' skills.

ENCOURAGE PARTNER COMMUNICATION AND PARTICIPATION IN COUNSELLING

Condom use requires the cooperation of both sexual partners, which is why partner negotiation skills are a central element of condom counselling. Experience shows, however, that condom promotion is even more effective when delivered to both partners (see Action Checklist).

Whether clients are counselled about condoms individually or as couples, it is important to address underlying gender relations and roles that shape the pattern of communication and balance of power between sexual partners. For example, counsellors advising women on how to negotiate condom use must investigate and acknowledge the possibility that male partners may react violently.

Action Checklist for Encouraging Couple Communication and Participation

- ☐ Invite both members of a couple to attend counselling
- ☐ Teach clients how to negotiate condom use with their partners.
- ☐ Encourage couples to discuss sexual and reproductive health.
- ☐ Create a broader dialogue between the sexes by holding community discussions among men and women on gender issues and safer sex practices.
- ☐ Build constructive partnerships between men and women in areas such as sexuality, reproductive intentions, new gender roles, fatherhood, and conflict resolution (an approach known as partnering).

DISPLAY AND DISTRIBUTE EDUCATIONAL MATERIALS

Small media, including leaflets, posters, videos, and audiocassettes, can effectively promote condoms to clients at all kinds of distribution outlets. Depending on the supply, materials can either be put on display or copies can be distributed to clients. Clients can look at these materials by themselves (for example, reading a poster in a barbershop or watching a video in a clinic waiting room), can view them together with the provider (reviewing a flipchart with a peer educator), or can take their own copies to read later (checking an instruction sheet on condom use at home). Print materials should be designed with the literacy levels of potential clients in mind.

Materials can also be developed to help providers counsel and communicate with clients more effectively. These resources, known as job aids, complement educational materials for clients. For example, questionnaires can guide providers making an HIV risk assessment, counselling checklists can remind providers what to discuss, and reference materials allow providers to look up the answers to difficult questions.

Printed materials and other media can reinforce providers' messages and enhance their credibility. In order to ensure that clients receive consistent and correct information, however, all of these materials must deliver the same message—and that message must be the same one that providers are delivering orally to clients.

Before developing new materials, condom programmes should inventory existing job aids and educational materials. It is possible that good materials are already present in clinics and other distribution points, but are hidden away in storage rather than on display or are not available in sufficient quantities. Other organisations in the region also may have developed good materials on condoms for similar audiences. Reproducing or adapting existing materials is much less expensive and more efficient than developing new materials from scratch, but it is important to make sure that they are appropriate, understandable, and effective and to ask permission to use them.

Whatever educational materials are developed, they must be distributed to all condom distribution points, put on display where clients can see them, and used on an everyday basis. Regular resupply also is needed for print materials that clients are given to take home.

STEP 6.

PROMOTE CONDOMS AT THE COMMUNITY, DISTRICT, AND NATIONAL LEVELS

KEY ACTIONS

- *Use behaviour change communication to promote condom use.*
- *Tailor condom programming to specific client groups.*
- *Link with other HIV-prevention and reproductive health programmes.*
- *Advocate for a supportive political and sociocultural environment.*

Having ready access to condoms and related services is not enough to ensure that condoms will be used. Programmes also must promote demand for condoms; that is, they must make women and men aware of the risks associated with their current sexual practices, teach them correct condom use and condom negotiation skills, and motivate them to try condoms. For this last step, a supportive environment is crucial. People are far more likely to use condoms if they perceive that the beliefs and behaviours of their partners, friends, peers, the immediate community, and broader society favour safer sex practices. Thus, condom programming should address the broader community and the political and sociocultural environment as well as individual clients.

USE BEHAVIOUR CHANGE COMMUNICATION TO PROMOTE CONDOM USE

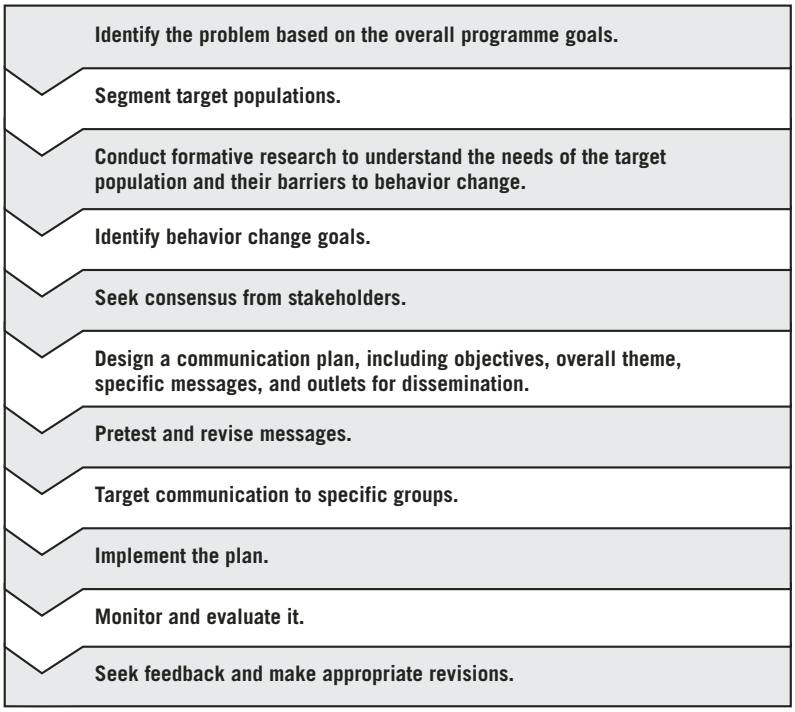
Carefully designed communication materials and activities—ranging from leaflets and group talks to mass media campaigns—can disseminate information, shape attitudes, and change behaviours. While potential clients are the primary audience for behaviour change communication, there is an important secondary audience of gatekeepers who influence access, service quality, attitudes, and social norms. They include health providers; educators; political, religious, and community leaders; and NGOs.

Behaviour change communication operates on many levels. If successful, it can:

- Increase knowledge by giving people the facts about safer sex and condoms in a language and medium that they can understand;
- Stimulate community dialogue to encourage people to reduce their personal risks and to eliminate any stigma associated with condom use;
- Promote advocacy so that policymakers and opinion leaders at every level address the issue of HIV prevention, particularly the need for condoms; and
- Reduce stigma and discrimination by disseminating messages based on positive views, instead of messages inspiring fear about HIV/AIDS.

To accomplish these objectives, condom programmes must develop a strategy that matches messages and communication channels with programme goals, desired actions, and the target audience (see Figure 10). Effective communication strategies use a mix of media and materials to disseminate and reinforce key messages, including

formats with special appeal for the target audience. Well-designed messages appeal to the emotions as well as the intellect, make sense in the social and cultural context, and direct clients to condom distribution points and counselling services so they can act on their decision to use condoms. Role models, whether real life testimonials or characters in social dramas, also are a powerful way to show potential condom clients why and how they should change their sexual practices.



Source: Adapted from Family Health International. Focus on Behavior Change Communications for HIV/AIDS. Fact Sheet. 2001.

Figure 10. Steps to develop a behaviour change communication strategy.

Peer education, community education, school-based education, and the mass media are some of the approaches that have proven most effective for promoting condoms. No matter what approach is used, NGOs are vital partners in promoting condoms. Of course, individual counselling by providers at health facilities, which was discussed in Step 5, is also a highly effective form of behaviour change communication.

Peer educators. Peer educators are recruited from a client group and trained to promote condom use among that group. Because they are peers and understand the realities of clients' lives, peer educators possess great credibility, are able to gain the confidence of potential clients, reduce suspicions and fears about a programme's intent, and present material in a culturally relevant way. Peer educators are especially effective at reaching high-risk groups, which are marginalised by mainstream health services, such as adolescents and sex workers.

Peer educators can serve in a variety of roles: educators or counsellors, popular opinion leaders, community-based distributors of condoms, referral agents to other HIV/AIDS services, and supporters of other HIV-prevention activities. They generally work one-on-one. This kind of interpersonal approach helps clients and potential clients personalise their risk of infection and develop condom negotiation skills. As a result, it can have greater impact on behaviour change. However, it reaches fewer people and is more expensive per contact than other approaches to behaviour change. Recruiting suitable candidates—who have the motivation, time, and communication skills to do a good job—also poses a challenge.

Community education. Anywhere local people gather, whether the setting is structured or unstructured, is a potential opportunity for community education about HIV/AIDS and condom use. Some settings, such as group talks at health facilities or skills-building workshops for young men, are formal. Many more are informal: for example, street theatre performances, story telling and puppet shows, and promotional items handed out at carnivals and sports events. Addressing groups of community

members, whether formal or informal, is an effective way to change the broader norms and values that govern the community and, in turn, individual behaviour.

School-based education. Schools are an efficient way to reach large numbers of vulnerable adolescents before they become sexually active. Successful HIV-prevention programmes in the schools have helped adolescents delay the initiation of sexual intercourse, reduce the number of sexual partners, and increase the use of condoms and other contraceptives. In many societies, however, discussing sexuality with young people is controversial. Therefore, programmers should involve policymakers, community members, and teachers in the planning and design of any sex education programme for adolescents.

The most effective sex education courses do not just instruct young people about HIV and how to avoid it. They also teach condom use and negotiation skills, encourage abstinence and delaying the onset of sexual activity, work to change harmful social norms, and try to reduce the stigma of condoms and HIV.

School-based programmes are less useful in countries where many children leave formal education after primary school. Reaching out-of-school youth before they become sexually active is challenging and demands different communication channels, such as radio, television, or counsellors based at popular gathering spots for adolescents.

Mass media. Popular communication channels, such as radio spots, television shows, newspapers, comic books, and popular songs, can reach large audiences at a relatively low cost per person. While the mass media cannot target specific client groups, they do reach a diverse mix of people, including those who rarely visit health facilities. Experience has shown that mass media promotional campaigns can increase knowledge of HIV, encourage people to discuss condoms with their partners, and foster a supportive environment for safer sex interventions. Social marketing and commercial sales organisations routinely use the mass media to advertise condoms. Uninformed journalists, however, may spread misconceptions about condoms through the mass media. Educating newspaper and television reporters about condom programming, through workshops and press releases, can prevent this problem.

ELEMENTS OF SUCCESSFUL SEX EDUCATION COURSES FOR ADOLESCENTS

- Reach youth before they become sexually active.
- Focus on changing risky behaviour.
- Base activities on behaviour change theory, with an emphasis on social and media influences.
- Include training and active learning, especially in communication and negotiation of abstinence and condom use.
- Acknowledge differences in sexual behaviours and risks between girls and boys.
- Include peer leaders.
- Educate teachers on the subject matter and help them handle controversial topics.
- Allow adequate time to cover all topics.

TAILOR CONDOM PROGRAMMING TO SPECIFIC CLIENT GROUPS

Condom programming, including behaviour change communication, is more effective when it is tailored to the needs and circumstances of a specific audience (see Table 3, p.64). The information collected about specific client groups in Step 1 can help condom programmers decide which services, messages, and communication channels are appropriate for a given client group. Even more effective is involving members of that client group—whether women, men, youth, sex workers, or refugees—in designing and implementing programme activities and behaviour change communication.

TABLE 3. TAILORING BEHAVIOUR CHANGE COMMUNICATION TO SPECIFIC AUDIENCES.

TARGET AUDIENCE	COMMUNICATION CHANNELS	MESSAGE TOPICS
Women	Family planning and maternal and child health programmes TV and radio (soap operas, radio novellas) Outdoor theatre, songs Posters Outdoor advertising Places where women gather for work or social occasions Materials in clinic waiting rooms	Gender issues awareness Promotion of female condoms Promotion of dual protection Empowerment Safer sex behaviours AIDS awareness Countering local myths, perceptions, dislikes, and fears Awareness of emergency contraception
Men	Workplace-based Male educators/role models STI programmes Sports events TV and radio (sports, radio novellas) Posters Packaging, point of distribution Music Bars Outdoor advertising Newspaper, magazines	Condoms for dual protection Gender issues awareness AIDS awareness Safer sex behaviours Positive images of men as responsible, caring partners
Youth	Sex education in schools Peer educators at youth organisations and universities TV and radio Sports events Outdoor advertising Packaging, point of distribution Comic books Games and toys Popular music Public events, carnivals	Physical abuse, coercion AIDS awareness Abstinence Safer sex Condoms for dual protection Awareness of emergency contraception Awareness of health issues such as STIs Condom negotiation skills
Sex workers	Peer educators Places where men and women gather to talk	Condom negotiation skills Female condoms Gender-based violence Awareness of emergency contraception Empowerment Basic health and reproductive health issues
Refugees	Refugee health programmes	Violence Condoms for dual protection Awareness of emergency contraception

Women and girls. Condom programming directed to women and girls must be sensitive to gender issues and address the gender-related factors that make women vulnerable to infection (see Appendix for "Gender and Condom Programming" fact sheet, p.95). Everyone involved in designing and implementing services and behaviour change communication for women should receive gender training. Programmes should promote female as well as male condoms to increase women's protective options, and they should stress the need for dual protection against infection as well as pregnancy. Communication also should take an empowerment approach, encouraging women to build a positive self-image and self-confidence, think critically, make independent decisions, and take action. Involving women's groups in all aspects of programme prevention, design, and implementation is a positive step in this direction.

Men. Men are more likely to respond to prevention messages if their male peers are also doing so. The use of trained male health educators and role models can substantially affect condom use. For example, male CBD agents are more effective at selling condoms—and hence promoting dual protection—than female CBD agents. They also are able to educate men on broader health issues, including HIV prevention. In fact, because social norms often value men's perspectives, men can help alter community beliefs and attitudes that stand in the way of using condoms. Religious leaders also can be strong influences.

Workplace interventions are an effective way to reach many men, but other strategies are required to reach some high-risk men. For instance, interventions directed at sex workers can reach their male clients as well, and advertisements featuring popular athletes have been successful at reaching younger men.

BRAZIL: USING SPORTS TO PROMOTE CONDOMS TO MEN IN BRAZIL

In Brazil, condom packets bearing the logos of famous Brazilian soccer teams are being widely sold as part of a safe-sex advertising campaign. The campaign also includes television ads featuring fans wearing condom-shaped caps with their teams' colours. The condom manufacturer has wholly financed the safe-sex advertisement campaign, which has been extraordinarily successful, especially among younger consumers. This is the first time a safe-sex television campaign has been financed by an agency other than the Brazilian government.

Source: Murray, I. "Brazil's passion for football condoms." BBC News website *(news.bbc.co.uk/1/hi/world/americas/1914998.stm),* April 7, 2002.

Youth. Communication directed to young people must be sensitive to the challenges facing youth, including the difficulty of asking for, obtaining, and using condoms properly and consistently. It must also acknowledge that for many young people, especially girls, sexual behaviour is the result of physical abuse, neglect, and coercion, rather than a voluntary decision.

Youth-centred interventions should focus on promoting condom use among sexually active youth. These interventions can also be used to help youth develop life skills and decision-making capabilities that enable them to avoid premature sexual relations, prepare for responsible parenthood, and learn the importance of respect and trust.

ELEMENTS OF YOUTH-ORIENTED INTERVENTIONS

- Sexuality education should begin before the onset of sexual activity.
- Directed preventive interventions focusing on high-risk youth are more effective than general educational programmes.
- Youth respond better to more personalised educational formats such as role-playing and small-group discussions, rather than lectures and classroom instruction.

Continued: Elements of Youth-Oriented Interventions

- Using trained peers and involving youth in all aspects of preventive interventions from programme design to implementation are recommended.
- Condom programmes should provide information and counselling services on condom use and safer sexual practices. They should also make condoms readily available.
- Messages to girls and to boys need to be tailored to address the different reasons for nonuse between the two groups.
- Interventions that promote abstinence only are less effective than more comprehensive ones.
- Interventions must guarantee ready availability of condoms.

Sex workers. The marginal, often illegal, status of sex workers shapes effective condom programming activities. An essential first step is advocacy to gain the support of sex worker communities and gatekeepers, such as brothel owners, who are naturally suspicious of outsiders. Involving sex workers in the design and implementation of an intervention can help overcome these suspicions as well as empower and motivate sex workers. Peer educators are especially valuable in working with this hard-to-reach group. Offering primary health care services, including a full range of reproductive health services, along with HIV-prevention activities can draw sex workers to clinics, while offering female condoms can help sex workers gain control over HIV prevention.

Refugees, displaced persons, migrants, and mobile workers. Peer educators are one of the best ways to reach these diverse populations. For refugees and displaced populations, HIV-prevention messages also can be integrated into adult literacy programmes as well as classes for adolescents. For mobile workers, recruiting stakeholders to advocate for condom use has proven effective. For example, condom programmes for truck drivers have sought the participation of transporters and brokers.

VIETNAM: REACHING TRUCK DRIVERS

To bring HIV-prevention activities to a highly mobile population of truck drivers, World Vision Vietnam collaborated with nine communities located along highway routes. The project trained two different types of peer educators, one to distribute condoms and educational materials to truck drivers and another to work with local women. The women's component also offered health care and community development activities. Feedback from truckers and women helped shape a wide array of promotional materials, including billboards, key chains, pocket-sized booklets on truckers' lives, and a cassette tape that combined pop music with brief dramas related to truckers' lives. Each community adapted the intervention to fit local circumstances so that, for example, peer educators in one village worked from a nearby motor vehicle inspection station, while elsewhere a commune health station offered gynaecological exams to all women.

The project increased its reach by enlisting large numbers of community members and by working with small businesses that had established relationships with truckers. Peer educators contacted about 70% of truck drivers in the area and raised local women's awareness of HIV risks. Peer educators distributed 2,000 to 3,000 condoms a month, but demand for condoms grew so much that pharmacy sales also increased.

Source: The Synergy Project and University of Washington Center for Health Education and Research, *Putting on the Brakes: Preventing HIV Transmission along Truck Routes.* Washington, D.C.: The Synergy Project and TvT Associates, 2000. *www.synergyaids.com/documents/Submoduletruckers.pdf.*

LINK WITH OTHER HIV-PREVENTION AND REPRODUCTIVE HEALTH PROGRAMMES

Condom promotion efforts can extend their reach by working with STI/HIV prevention, reproductive health, and refugee health programmes. No matter what type of programme, maintaining client confidentiality is essential because of the stigma attached to HIV, STIs, and often condoms themselves. For reproductive health programmes especially, adding condom promotion may raise sensitive personal issues that clients do not expect to be addressed.

There are two important questions to ask in deciding on collaboration with particular health programmes: How difficult will it be to integrate condom promotion into their current activities? And do they attract the client group(s) your programme has targeted?

Sexually transmitted infection programmes. Settings that offer STI services—including specialised clinics, primary health clinics, secondary and tertiary public-sector clinics, and pharmacies—offer an excellent opportunity to promote condoms. STI patients are sexually active and at high risk of further infection with HIV or another STI. In addition, infection with an STI (such as syphilis, chancroid, herpes, gonorrhoea, chlamydia, trichomoniasis, or bacterial vaginosis) increases an individual's risk for being infected with HIV as well as the likelihood that they will transmit HIV to a sexual partner. Because of their infection status and the increased risks it carries, STI patients—who are largely male—may be especially receptive to messages that encourage condom use.

Providers working in STI programmes are well prepared to promote condoms since they are already aware of the risks of infection, knowledgeable about the sexual transmission of disease, and comfortable discussing sexual matters with patients. In order to counsel patients on correct and consistent condom use, however, providers may need further training, as well as support materials (such as flip charts, posters, and pamphlets) on condom use and negotiation skills. Ensuring a steady and sufficient supply of condoms at STI clinics also is critical, so that providers can supply patients with condoms for their immediate use.

HIV-prevention programmes. Clinics where people are tested for HIV are an ideal setting for condom promotion since clients have recognised that they are at high risk of infection and shown they are willing to take action. During voluntary counselling and testing (VCT) sessions, providers can educate clients who prove to be HIV-negative on how to avoid future infections. They can educate clients who prove to be HIV-positive on how to avoid transmitting their infection to sexual partners. In either case, counselling on condom use is essential.

Both pre- and post-test counselling sessions are excellent opportunities to teach VCT clients about condom protection and use. Experience shows that VCT is more effective in changing behaviour when providers counsel both partners in a couple. Thus, HIV-prevention programmes should actively reach out to couples and invite clients' partners to accompany them to VCT sessions.

Providers in well-run HIV-prevention programs already possess the motivation and much of the technical knowledge needed to promote condoms. However, they will need training and support materials (such as flip charts, posters, and pamphlets) so that they can teach clients how to use condoms correctly and negotiate their use. They also will need a steady supply of condoms to distribute to clients as well as advice on where clients can continue to get affordable condoms in the future.

Reproductive health programmes. Both family planning (FP) and maternal and child health (MCH) programmes can be important entry points for HIV-prevention efforts. From a practical point of view, family planning and MCH services are well developed and readily accessible to most people in low-income countries. Their clientele also is a good fit. Family planning clients are

already concerned about the consequences of unprotected sex and may be open to using condoms for dual protection against both unwanted pregnancy and infection. The pregnant women attending MCH clinics can transmit HIV to their children if they become infected with the virus, so they are especially in need of the protection offered by condoms. In addition, promoting condoms to couples in stable relationships—who make up most family planning and MCH clients—also can help overcome the stigma associating condoms with commercial and casual sex.

Although the married women who make up family planning and MCH clients have traditionally been considered at low risk of infection, this is not the case where the prevalence of HIV is high. Men frequently bring HIV into a marriage, and, in some places, one-quarter or more of pregnant women have been found to carry HIV. Because of these risks, good standards of care already require family planning and MCH providers to consider women's infection status and risks before advising them on contraception, sexual practices, delivery options, and infant feeding.

Effectively promoting condom use through reproductive health programmes poses a difficult challenge, however, because it calls for a basic reorientation of services. Providers' attitudes, knowledge, and skills must change before they will be willing and able to discuss dual protection with family planning clients and warn pregnant women about the risks of infection for themselves and their unborn children (see Table 4). Maximising the impact of condom programming in reproductive health services also requires reaching out to different kinds of clients, including men, adolescents, and unmarried women.

TABLE 4. OBSTACLES TO INTEGRATING CONDOM PROGRAMMING INTO REPRODUCTIVE HEALTH SERVICES AND POSSIBLE SOLUTIONS.

OBSTACLE	SOLUTIONS
FP and MCH providers may not view HIV prevention as their job, they may regard condoms as a less effective contraceptive method, and they may feel uncomfortable discussing sexual matters.	Train providers to appreciate the importance of HIV prevention and condom use, help them reassess their core values, and desensitise them to discussing sexual issues. Reinforce with appropriate supervision.
FP and MCH providers may lack the knowledge and skills needed to counsel clients on HIV and related issues.	Draft guidelines and protocols, create refresher training courses, and refocus supervision to ensure that providers are knowledgeable about HIV/AIDS and condoms, can make sexual risk assessments, and can teach condom use and negotiation skills. Create job aids, such as standardised checklists, to guide providers through consultations that integrate condom promotion with FP and MCH services.
Given competing claims on providers' time, they may neglect condom promotion in favour of traditional FP and MCH messages.	Assess and modify providers' workloads so that they have time to discuss HIV and dual protection and offer condoms to all clients.
FP and MCH clients may have trouble understanding or remembering information on HIV and condoms, since it is not the primary purpose of their visit.	Create flip charts, posters, pamphlets, and other IEC materials on HIV, condoms, and dual protection for use in the clinic and/or distribution to clients.
Male and female condoms may not be readily and consistently available to FP and MCH clients.	Strengthen the logistics system to ensure a steady and sufficient supply of male and female condoms at FP and MCH clinics. Make condoms freely available in waiting rooms, examination rooms, and bathrooms.
FP and MCH programmes do not generally reach men, although men are more likely than women to bring HIV into a marriage, and men's cooperation is needed for women to use condoms.	Encourage men to accompany their partners during prenatal and FP visits. Encourage family planning CBDs to offer condoms and HIV counselling to men. Teach women how to discuss HIV and negotiate condom use with partners. Offer the option of female condoms, which some men may find more acceptable.
Adolescents, unmarried women, and sex workers are at higher risk for HIV infection, but they may not feel welcome at FP and MCH clinics.	Reorganise clinics and train providers to offer nonjudgemental, high quality care to clients, regardless of age, marital status, and sexual behaviour. Establish youth-friendly clinics. Use the mass media to encourage adolescents, unmarried women, and sex workers to visit FP and MCH clinics.

Emergency relief and refugee reproductive health programmes. International relief organisations and donor agencies include condoms as a standard part of the health package provided during an emergency response operation. Given the increased risks of HIV transmission in refugee settings due to high levels of violence and population mobility, health programmes serving refugees should launch condom promotion efforts as soon as possible after a crisis begins, and they should be directed to men, women, and young people. Even after the immediate crisis is over, condom promotion should remain an integral part of refugee health services. Guaranteeing refugees ready access to free condoms and instructions for their use, however, is complicated by problems intrinsic to emergency settings: a lack of trained staff, supplies, and infrastructure; fragmented and overlapping organisational responsibilities for providing health services; and the uncertain future of the refugees themselves.

ADVOCATE FOR A SUPPORTIVE POLITICAL AND SOCIOCULTURAL ENVIRONMENT

Fostering a supportive political and sociocultural environment is critical for condom programming to thrive—or to even have a chance to be implemented. Advocacy efforts (see Action Checklist, p.72) can raise awareness of HIV/AIDS; place prevention efforts, including condom programming, on the political agenda; and make condom promotion socially acceptable.

More specifically, condom advocacy activities may seek to:

- Overturn legal and regulatory barriers to condom access and use, for example, by lobbying to eliminate tariffs and other retail taxes that raise condom prices or to abolish laws that restrict condom advertising;
- Create policies, laws, and regulations that encourage wider condom use, for example, by advocating for regulatory approval of the female condom or lobbying for the inclusion of condom instruction in family life curricula;
- Mobilise resources to address HIV/AIDS, for example, by lobbying to increase government spending on the public health system;
- Gain the support of political, religious, community, and business leaders, for example, by presenting them with accurate information on the benefits of condom programming;
- Broaden participation in the policy process, for example, by encouraging the corporate sector, religious groups, the media, and trade unions to promote condoms; and
- Address the HIV-prevention needs of marginalised groups, such as refugees and sex workers.

UGANDA: WORKING WITH RELIGIOUS LEADERS

HIV-prevention projects in Uganda have addressed religious leaders because of their influence on the community, especially with regard to family values and sexual behaviour. While Christian religious leaders were enthusiastic about fighting HIV/AIDS, they were reluctant to promote condom use. The Family Planning Association of Uganda launched an advocacy campaign that included consultative meetings with government and religious leadership groups, workshops for 600 religious leaders from various Christian denominations, and an advocacy brochure. The workshops overcame the reservations of the religious leaders about condom use, and they began to fully participate in the nation's educational campaign about HIV/AIDS.

Also successful was a project designed by the Islamic Medical Association for Muslim religious leaders, or imams, in Uganda. More than 3,000 imams and volunteer assistants were trained in HIV prevention, safe sex, counselling, behaviour change principles, issues related to gender and adolescence, and the community's role in sustaining prevention activities. After training, these "family AIDS workers" educated their communities during home visits and at religious

gatherings. Two years later, condom use, other safe sex practices, and HIV knowledge all showed significant increases among urban men.

Sources: International Planned Parenthood Federation (IPPF), *Learning from the Field: Experience in HIV Prevention from Family Planning Associations Worldwide*. London: IPPF, 2002. Kagimu M, Marum E, Wabwire-Mangen F, Nakyanjo N, Walakira Y, Hogle J. "Evaluation of the effectiveness of AIDS health education interventions in the Muslim community in Uganda." *AIDS Educ Prev* 1998; 10:215-228.

Most successful HIV-prevention programs have benefited from the strong support of political, community, and religious leaders and other strategically placed public figures. In India, for example, the Chief Minister of Andhra Pradesh set an example by ordering the installation of condom vending machines in the state legislature as well as the display of a large picture of a condom. Advocacy activities for condom programming should consider targeting influential individuals at every level:

- The political will and commitment of top-level policymakers and political leaders helps determine resource allocations, law and policy, and societal acceptance of public discussion of safer sex.
- Influential people at the middle level—including provincial and community heads, religious leaders, media managers, and school principals—shape the environment and can facilitate (or block) specific activities, such as sex education in the schools or public advertising of condoms. Religious leaders are especially influential in many societies because of their traditional role in teaching family values and morals.
- At the grassroots levels, informal leaders drawn from the targeted client group(s) and interested parties (for example, youth leaders and parents, or sex workers and brothel owners) can play an active role in identifying and helping overcome obstacles to implementation.

Sustained advocacy campaigns can persuade influential people to take action by presenting them with accurate information on the benefits of condom programming, within the framework of a comprehensive HIV-prevention strategy. Effective advocacy campaigns deliver concise, easily understood messages in a compelling manner and at a time and place when recipients are most likely to be receptive. Possibilities include face-to-face meetings, policy forums, briefing packages, fact sheets, press releases, press conferences, media advertising, petitions, and public debates.

Like other elements of successful condom programming, advocacy efforts should be tailored to fit the setting and the needs of potential clients. For example, where religious leaders hold great influence over family values and behaviour is an obvious target for advocacy efforts. Alternatively, a condom programme focusing on migrant workers might lobby for specific policy changes to benefit this population. For example, allowing spouses and family to move with migrant labourers could help them avoid casual sexual encounters. Managers can use the information collected in Step 1 on political, religious, and community support for condom programming (Worksheet 3a, page 18) to decide where to direct advocacy efforts.

Although advocacy efforts can have a dramatic impact on condom use and, eventually, HIV incidence, such interventions are often harder to implement, take longer, and are more difficult to evaluate than interventions focused on individual behaviour change.

ZIMBABWE: ADVOCATING FOR FEMALE CONDOMS

The introduction of the female condom in Zimbabwe was due in large part to advocacy by the Women and AIDS Support Network (WASN), a women's organisation founded to address women's HIV-prevention and support needs. Women wanted a way to protect themselves when their partners refused to use male condoms. In response, two researchers, who were members of WASN, conducted an acceptability study of the female condom in Zimbabwe. Armed with the results of this study, WASN began lobbying the National AIDS Control Programme (NACP) and other government bodies to introduce the female condom. The organisation made conference and workshop presentations, conducted a press campaign, gathered 30,000 signatures in a petition drive, and encouraged women who had participated in the acceptability study to educate rural women about the female condom. To defuse potential opposition, the advocacy campaign stressed that the female condom was not for casual sex, but rather was needed to protect monogamous women placed at risk by their partners.

In response to concerted advocacy efforts, the Zimbabwe Medical Control Council approved the female condom for use nationwide in 1996. As a result, the female condom was offered through the public sector free of charge and is now being socially marketed to the general public.

Source: Population Council, *The female condom in Zimbabwe: The interplay of research, advocacy, and government action.* Horizons Research Summary. Washington, D.C.: Population Council, Horizons, 1999. *www.popcouncil.org/horizons/ressum/zimbabwe.html.*

Action Checklist for Advocacy

☐	Hold seminars and present evidence to convince decision makers about the need to take action to promote condom use.
☐	Arrange for decision makers to visit neighbouring countries where the promotion and use of condoms is accepted and widespread.
☐	Work to make condoms more affordable by lobbying the government to reduce taxes and import tariffs, seeking bulk purchasing benefits through a public-sector purchasing agency, and asking donors to provide supplies.
☐	Lobby government and businesses to lift restrictions on distribution in order to increase the range of outlets that can sell condoms.
☐	Lobby government to eliminate restrictions on who may obtain condoms.
☐	Persuade government that regulation of condom quality is essential.
☐	Work to eliminate government and media restrictions on condom advertising and promotion.
☐	Gain the support of the education sector for more widespread and more explicit health education in schools, universities, colleges, and workplaces.

Source: Adapted from UNAIDS, "The Male Latex Condom," Fact Sheet 2 *(www.unaids.org/publications)*

STEP 7.

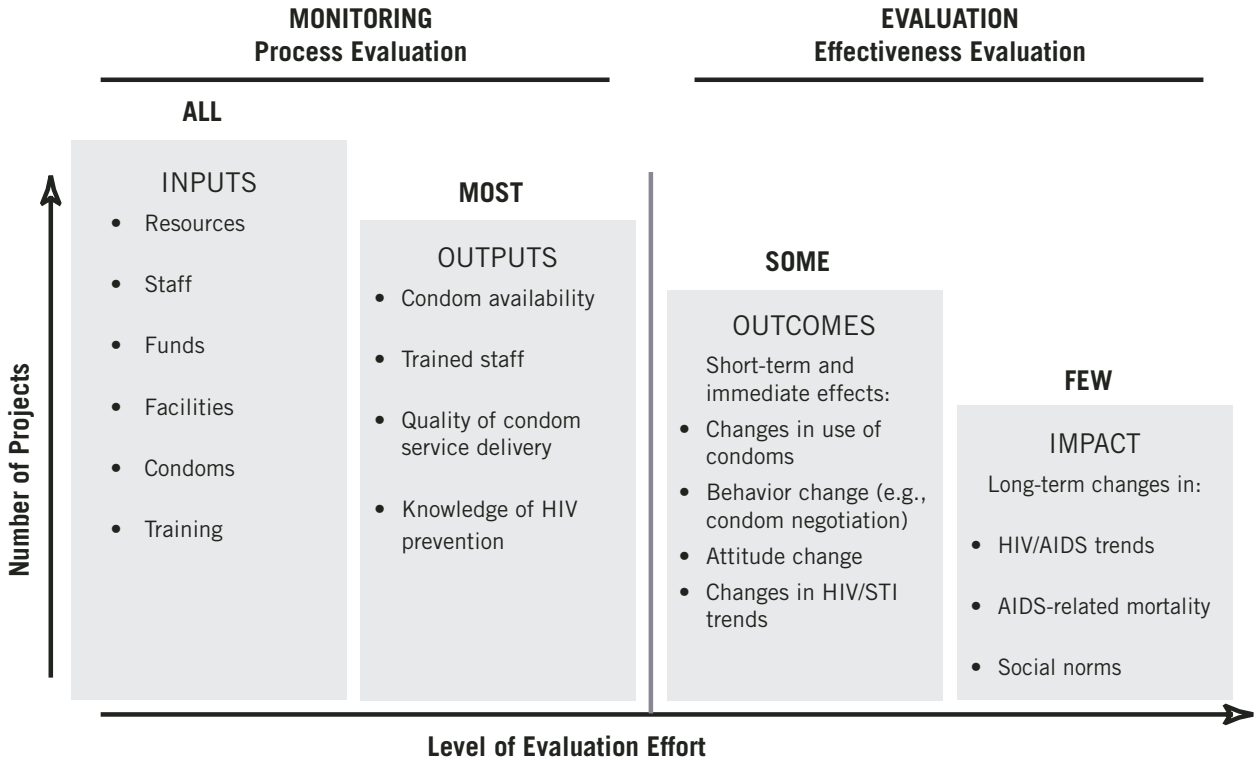
MONITOR PROGRAMME PROGRESS AND EVALUATE OUTCOMES

KEY ACTIONS

- *Measure programme performance and make improvements.*
- *Integrate condom indicators into the monitoring and evaluation system.*
- *Create an evaluation plan.*

MEASURE PROGRAMME PERFORMANCE AND MAKE IMPROVEMENTS

Monitoring and evaluation determine which of a condom programme's activities are efficient and effective (see Figure 11). Based on these findings, managers can detect and fix problems, decide which activities to expand, and decide which ones to stop. New condom programmes should build monitoring and evaluation into their management systems at the start. Established programmes should ensure that existing monitoring and evaluation systems include key condom indicators. Managers should consider the difficulty and expense of collecting different types of information, as well as their potential usefulness, when designing a monitoring and evaluation system.



Source: Adapted from Rehle, T and Hassig, S. "Role of Evaluation in HIV/AIDS Programming." In *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries.* Family Health International. 2002.

Figure 11. Level of effort for each type of evaluation.

Monitoring, which is sometimes called process evaluation, is an essential management tool. Managers use routine, daily monitoring to oversee ongoing programme activities and make adjustments to improve their efficiency. Monitoring systems can answer basic questions about:

- ***Inputs,*** that is, the people, training, and resources put into a project, and
- ***Outputs,*** that is, the quantity and quality of services delivered.

Important inputs for condom programming include the number of people trained in condom counselling and distribution, while key outputs are the availability and quality of condoms. As Figure 11 illustrates, all HIV/AIDS programmes have some type of monitoring system in place to ensure the quality of programme implementation.

ZIMBABWE: MONITORING A CONDOM DISTRIBUTION PROJECT

Over the course of a year-long project in Zimbabwe, farm health workers raised awareness of HIV risks among rural farm workers, distributed free condoms, and taught safe sex negotiation skills. To monitor project activities, researchers tracked the number of condoms distributed, the number of people attending discussion sessions, the number of STIs reported to farm health workers, and the number of STI cases treated at local clinics. Information collected during follow-up interviews and focus group discussions with farm owners and workers proved essential to interpreting these indicators.

The process evaluation found that condom demand fluctuated seasonally, based on the number of farm workers employed and the amount of money they earned from bonuses and paydays. The number of condoms distributed was inflated, however, because many condoms were taken for resale while people from other farm communities traveled to the intervention sites to get free condoms. Further examination of the data on STI cases also found that numbers declined during peak farming months, not because of a change in incidence but because workers were too busy to visit clinics. The mixed results of the process evaluation helped managers adjust the project's approach to better meet the needs of farm workers.

Source: Laver SM, Van de BB, Kok G, Woelk G. "Was the intervention implemented as intended? A process evaluation of an AIDS prevention intervention in rural Zimbabwe." *International Quarterly of Community Health Education* 1997; 16:25-46.cit_bf

Evaluation takes place episodically and uses information from population-based studies to answer basic questions about:

- ***Outcomes,*** that is, short-term changes in attitudes, behaviour, and skills, and
- ***Impacts,*** that is, long-term changes in health status.

The most important outcomes for condom programming are changes in condom use and sexual behaviour in the targeted client group or geographic area. Key impacts are changes in HIV and STI rates, usually measured over large geographic areas. Many programmes do not engage in evaluation. It is more complicated and requires greater resources than monitoring. It also may be less essential, since many condom programmes implement standard interventions that have already proven their worth. Finally, changes in impact indicators generally reflect the collective efforts of multiple projects, rather than changes wrought by a single organisation.

Although not strictly an outcome or impact, cost-effectiveness is another area that can be evaluated, to ensure that condom programming is using resources efficiently. By measuring the cost per number of condoms distributed, people counselled, or HIV infections averted, programmes can compare the efficiency of different condom promotion strategies and decide which approaches to expand or discontinue.

To get a full understanding of a condom programme's performance and progress, monitoring and evaluation systems must collect

TABLE 5. DATA SOURCES AND TIME FRAME FOR MONITORING AND EVALUATION SYSTEM.

	DATA ASSESSED	DATA SOURCES	EXPECTED TIME FRAME FOR PROGRESS
Inputs	Staff Training Supplies & equipment	Project records	6 months
Outputs	Availability of condoms Quality of condoms Quality of services	Project records Sales data Outlet surveys Client exit interviews Observation	1–2 years
Outcomes	Knowledge Attitudes Condom use Sexual behaviour Social support	Population-based surveys	2–3 years
Impacts	HIV incidence/ prevalence STI incidence/ prevalence	Surveillance systems Epidemiological studies	3–5 years in mature epidemics 7–10 years in nascent epidemics

Source: Adapted from UNAIDS, *National AIDS Councils Monitoring and Evaluation Operations Manual*. August 2002.

data on a regular basis from a wide variety of sources (see Table 5).

INTEGRATE CONDOM INDICATORS INTO THE MONITORING AND EVALUATION SYSTEM

UNAIDS has identified and field tested a standard set of core and additional indicators for HIV/AIDS programmes, including condom programming. Using standardised indicators like these makes it easier to collect, analyse, and summarise data. To understand their programmes fully, however, managers may need to collect additional data (note, though, that most programmes collect more data than they ever use). Monitoring and evaluation systems are more likely to succeed if they are kept simple.

INPUT INDICATORS

The UNAIDS indicators do not cover programme inputs, but managers should keep track of the personnel, training, equipment, supplies, and funds provided. Important indicators include:

- Number of paid and volunteer staff members providing condom services;
- Training on condom counselling and logistics management;
- Number of condoms purchased or received as donations; and
- Number of job aids and educational materials promoting condoms.

OUTPUT INDICATORS

The focus here is on the availability and quality of condoms (see Table 6, p78). Management information systems, service statistics, and sales data can provide information on the number of outlets distributing condoms relative to the size of the population and the number of condoms sold or distributed free. For a fuller and more realistic

understanding of availability, however, managers must conduct outlet checks and retail audits. During outlet checks, field workers visit a sample of condom distribution points to check whether condoms are in stock. During retail audits, field workers make repeat visits to outlets, monitor their condom inventories, and calculate sales. Both kinds of site visits give field workers the opportunity to check prices, the availability of promotional materials, and waiting times for purchases. They also can collect a sample of condoms for quality testing.

TABLE 6. OUTPUT INDICATORS FOR CONDOM PROGRAMMING.

INDICATOR	NUMERATOR	DENOMINATOR	DATA SOURCE	LIMITATIONS*
CONDOM AVAILABILITY				
Condoms available for distribution nationwide.	Number of condoms available for distribution nationwide during the preceding 12 months.	Total population aged 15-49.	Data collected from all condom manufacturers, commercial distributors, major donors, storage facilities, and government and NGO bodies involved in acquiring and distributing condoms.	Core indicator for all epidemics. Does not assess accessibility. Must gather data from all relevant organisations, including FP as well as HIV/STI programmes.
Retail outlets and services with condoms in stock.	Retail outlets and service-delivery points that have condoms in stock at time of survey.	All retail outlets and service-delivery points surveyed.	Survey of randomly selected retail outlets and service-delivery points. Can add question to broader retail surveys.	Core indicator for generalised epidemics and additional indicator for concentrated epidemics. May be difficult to identify and include informal distribution sites. Must repeat quarterly or annually to yield information about consistency of supply.
CONDOM QUALITY				
Condoms that meet quality control measures.	Condoms in central stock and retail outlets that meet WHO quality specifications.	All condoms in central stock and retail outlets.	Sample condoms are collected from retail outlets and central storage facilities and tested for quality.	Core indicator for all epidemics. Equipment and trained staff required to conduct testing. Will miss deterioration that takes place after clients acquire condoms.

Source: Adapted from UNAIDS, *National AIDS Programmes: A Guide to Monitoring and Evaluation*. 2000.
** Core indicators relate to important factors influencing the epidemic or tracking its course, and they are recommended for collection in all countries at a particular epidemic stage. Additional indicators are only recommended in countries where they have relevance to the local epidemic or national response.*

The quality of services—for example, whether clients are treated in a nonjudgemental manner, are told about dual protection, or receive sufficient condoms—is another important output for condom programming. Service statistics can determine the number and percentage of clients offered condoms. To assess the quality of the services they received, programmes can:

- Conduct exit interviews with people who buy condoms or seek condom counselling;
- Train people to pose as condom clients and report on services; or
- Train observers to rate services.

Managers can assess behaviour change communication and other condom promotion activities in a similar manner, looking first at their quantity and then at their quality. Programmes should track the quantity of materials and activities produced, for example, the number of peer educators recruited and trained, the number of poster and brochures distributed, or the number of radio and television spots broadcast. The more important measure of a programme's output, however, is how large an audience these promotional activities reached. Indicators include:

- Number of clients served by peer educators,
- Percentage of the target audience who saw posters or received brochures, and
- Percentage of the target audience who heard the radio and television programming.

To assess the quality of condom promotion activities, programmes can interview members of the targeted client group(s), for example, asking men and women how well they understood the messages disseminated in posters and radio spots. It is also possible to observe community activities, such as street dramas and sex education classes.

OUTCOME INDICATORS

Periodic behavioural surveillance surveys are the best way to assess changes in knowledge, attitudes, and behaviours regarding safer sex and condom use. Surveys can cover the general population or focus on a selected client group. They can reinterview the same panel of respondents or sample a new set of respondents each time. To save resources, programmes can add a few key questions on condoms to commercial, multipurpose surveys rather than conducting their own surveys.

UNAIDS indicators cover condom use at last intercourse, HIV knowledge, and sexual negotiation (see Table 7), but condom programming, especially behaviour change

TANZANIA: EVALUATING THE EFFECTIVENESS OF A RADIO SOAP OPERA

The radio soap opera *Twende na Wakati* ("Let's Go With the Times") was designed to change HIV-related knowledge, attitudes, and behaviours—including condom use—among the general population. To evaluate its effectiveness, staff collected data on outcome indicators by interviewing selected women aged 15 to 49 and men aged 15 to 60. The interviews were conducted once a year for five years, both in areas where the soap opera was broadcast and in areas where it was not.

Results showed that, from 1995 to 1997, condom use increased to 16 percent in the intervention area and to 13 percent in the comparison area, indicating that the soap opera did motivate people to use condoms. After a close analysis of other outcome indicators, the evaluation team attributed this increase to a change in listeners' perception of their risk of becoming infected with HIV/AIDS, their ability to prevent HIV/AIDS, their interpersonal communication skills about HIV/AIDS, and their identification with, and role modeling of, the primary characters in the soap opera.

Source: Vaughan PW, Rogers EM, Singhal A, Swalehe RM., "Entertainment-education and HIV/AIDS prevention: a field experiment in Tanzania." *Journal of Health Communication* 2000; 5 Suppl:81-100.

communication, typically has a far wider range of objectives. Surveys can investigate changes in individual attitudes and the sociocultural environment, mastery of essential skills, changes in sexual practices, and exposure to condom advertising and other programme activities.

Additional indicators might address condom use by type of partner (regular, casual, commercial); consistency of condom use; knowledge of correct condom use; partner communication; social pressures on condom use; and beliefs regarding the quality, effectiveness, and availability of condoms.

TABLE 7. OUTCOME INDICATORS FOR CONDOM PROGRAMMING.

INDICATOR	NUMERATOR	DENOMINATOR	DATA SOURCE	LIMITATIONS*
CONDOM USE				
Condom use at last higher-risk sex	Respondents who say they used a condom the last time they had sex with a nonmarital, noncohabiting partner	All those who have had sex with a nonmarital, noncohabiting partner in the last 12 months	Population survey	Core indicator for all epidemics. Good indicator of whether condom promotion campaign is having desired effect among principal target group. Does not measure consistency of use.
Condom use at last commercial sex, client report	Men reporting condom use the last time they had sex with a sex worker	All men who report they have had sex with a sex worker in the last 12 months	Population survey	Core indicator for concentrated epidemics. Additional indicator for generalised epidemics with defined population of sex workers. Can track success of programmes to promote condom use in commercial sex.
Condom use at last commercial sex, sex worker report	Sex workers who report using a condom with their most recent client	All sex workers who report having sex with any clients in the last 12 months	Survey of sex workers	Additional indicator for concentrated and low-level epidemics and for generalised epidemics with defined populations of sex workers. Does not measure consistency of use.
Condom use at last anal sex between men	Men who report using a condom at last anal sex with a male partner	All men who report they have had anal sex at least once with a male partner in the last 6 months	Survey of men who have sex with men	Core indicator for concentrated and low-level epidemics. Does not distinguish between regular and non-regular partners and whether information about sero-status is known.
CONDOM USE AMONG YOUTH				
Young people using a condom during premarital sex	Single people aged 15-24 who report using a condom the last time they had sex in the last 12 months	All single people aged 15-24 who were sexually active in the last 12 months	Population survey	Core indicator for generalised epidemics. Additional indicator for concentrated epidemics. Does not distinguish between partner types. Does not reflect overall frequency of premarital sex.

continued » Condom use among youth

INDICATOR	NUMERATOR	DENOMINATOR	DATA SOURCE	LIMITATIONS*
Young people using a condom at last higher-risk sex	People aged 15–24 who had sex in the last 12 months and used a condom at last sex with a non-marital, non-cohabiting partner	All people aged 15-24	Population survey	Core indicator for generalised epidemics. Additional indicator for concentrated epidemics. Captures both unmarried people having sex and married people having sex outside of marriage.
Condom use at first sex	People aged 15–24 who used a condom the first time they ever had sex	All people aged 15-24 who have ever had sex	Population survey	Additional indicator for all epidemics. May reflect short-term concern with preventing unwanted pregnancy rather than long-term commitment to preventing HIV/STI infection.
KNOWLEDGE				
Knowledge of HIV prevention	Respondents who, in response to prompted questions, say that a person can reduce their risk of contracting HIV by using condoms or having sex only with one faithful, uninfected partner	All sexually active adults	Population survey	Core indicator for all epidemics. Prompted answers may not reflect respondents' actual application of knowledge.
No incorrect beliefs about HIV	Respondents who correctly reject the two most common local misconceptions about AIDS transmission or prevention, and who know that a healthy-looking person can transmit AIDS	All respondents	Population survey. Requires preparatory work to determine most common misconceptions.	Core indicator for all epidemics. Gives good picture of level of false beliefs. Including misconceptions in questionnaire may increase their credibility.
SEXUAL NEGOTIATION AND ATTITUDES				
Women's ability to negotiate safe sex	Respondents who believe that, if her husband has an STI, a wife can either refuse to have sex with him or propose condom use	All respondents aged 15-49 who have heard of STIs	Population survey	Additional indicator for generalised epidemics. May be powerful data for advocacy, but not worth tracking unless action is being taken to change attitudes.

Source: Adapted from UNAIDS, *National AIDS Programmes: A Guide to Monitoring and Evaluation.* 2000.
** Core indicators relate to important factors influencing the epidemic or tracking its course, and they are recommended for collection in all countries at a particular epidemic stage. Additional indicators are only recommended in countries where they have relevance to the local epidemic or national response.*

IMPACT INDICATORS

If condom programming is successful in reducing the transmission of HIV/STIs, the incidence, or number of new cases, will decline. Because measuring incidence requires sophisticated data collection systems that operate continuously, condom programmes instead focus on changes in prevalence or on the number of existing cases (see Table 8). Sentinel surveillance systems (also called cross-sectional systems) collect data periodically on the prevalence of infection in a specific population and provide information about the spread of the infection. Second-generation surveillance systems monitor risk behaviours, such as unprotected sex with an infected partner, to help explain trends in prevalence.

The focus of the surveillance system depends on the nature of the epidemic. In low-level epidemics, surveillance systems try to identify high-risk behaviours that may lead to an outburst of infection among a particular group. In concentrated epidemics, they monitor subgroups with high levels of HIV infections (defined as an incidence over 5 percent) and the behavioural links between those groups and the general population. In generalised epidemics, they monitor HIV infection and risk behaviour in the general population.

TABLE 8. IMPACT INDICATORS FOR CONDOM PROGRAMMING.

INDICATOR	NUMERATOR	DENOMINATOR	DATA SOURCE	LIMITATIONS*
HEALTH AND SOCIAL IMPACT				
HIV prevalence among pregnant women	Blood samples that test positive for HIV	All blood samples taken from women aged 15–24 during routine sentinel surveillance at selected antenatal clinics	Anonymous testing for HIV of blood samples taken from women at sentinel antenatal clinics	Core indicator for all epidemics. Good indicator of trends in HIV infection where epidemic is heterosexually driven, but less reliable where HIV infection is confined to subgroups with especially high-risk behaviours.
Syphilis prevalence among pregnant women	Blood samples that test positive for syphilis	All blood samples taken from women aged 15–24 during routine sentinel surveillance at selected antenatal clinics	Anonymous testing for syphilis (by Rapid Plasma Reagin, or RPR) of blood samples taken from women at sentinel antenatal clinics	Core indicator for all epidemics. Reflects relatively recent infection since syphilis is curable.
HIV prevalence in subpopulations with high-risk behaviour	Members of at-risk subpopulation who test positive for HIV	Total number of members of at-risk population tested for HIV	HIV testing at sentinel sites providing health services to subpopulation. Or HIV testing of population-based sample.	Core indicator for concentrated epidemics and additional indicator for generalised epidemics. Difficulties with access to subpopulations may create biases in data.

Source: Adapted from UNAIDS, *National AIDS Programmes: A Guide to Monitoring and Evaluation.* 2000.
* Core indicators relate to important factors influencing the epidemic or tracking its course, and they are recommended for collection in all countries at a particular epidemic stage. Additional indicators are only recommended in countries where they have relevance to the local epidemic or national response.

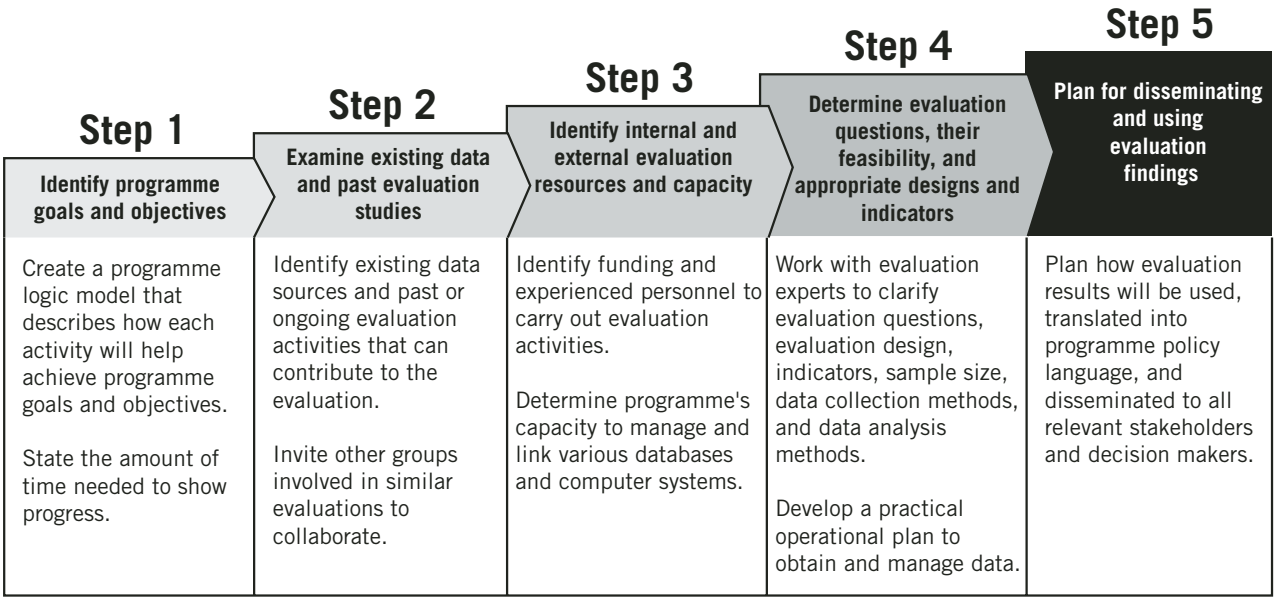
CREATE AN EVALUATION PLAN

Before launching a programme intervention, managers should create a plan to evaluate it that reflects programme goals and available resources. Comprehensive evaluation plans include:

- Purpose of the evaluation;
- Specific evaluation questions to be answered;
- Evaluation designs and methods to be used;
- What data are to be collected;
- How the data are to be collected;
- Resources that will be necessary;
- Who will implement the evaluation; and
- A timeline for completion.

Once the evaluation is completed, decision makers must have access to the results if they are to improve programme activities and policies. To encourage decision makers to take action, evaluation findings should be expressed clearly and concisely, in language familiar to programme managers and policymakers, with their practical implications explained. Although approaches will vary according to the nature of the programme and available resources, a typical evaluation approach proceeds as follows:

Collecting data is not always necessary. Sometimes existing data sources—such as national or regional demographic or epidemiological surveys—can provide needed information (see "Online Sources of Information" in Step 1, p. 15). Similarly, developing new monitoring and evaluation tools may not be necessary, since international organisations and NGOs have already developed a variety of such tools for HIV/AIDS programmes, many of which are available online at *www.cpc.unc.edu/measure/guide/tools/tools.html*.



Source: Adapted from Rugg D and Mills S. "Role of Evaluation in HIV/AIDS Programs." In Rehle T et al., eds. *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers.* Family Health International. 2002.

Figure 12. Steps in developing an evaluation plan.

RESOURCES

GENERAL

APDIME (Assessment, Planning, Design, Implementation Monitoring, and Evaluation) toolkit. 2003. *www.synergyaids.com/apdime/mod_1_assess/assess_index.htm*

FEMALE CONDOM

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AED Center for Community-Based Health Strategies. *Assessing the need for HIV-prevention services: a guide for community planning groups*. 1999. *www.healthstrategies.org/pubs/publications/needs_assessment_all.pdf*

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WHO, UNFPA, UNAIDS, FHI. *The Male Latex Condom: Specification and Guidelines for Condom Procurement*. Geneva: WHO, December 2003. *http://www.who.int/reproductive-health/publications/m_condom/who_specification_04.pdf*

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IPPF. *Programme Guidance on Counselling for STI/HIV Prevention in Sexual and Reproductive Health Settings*. 2002.
ippfnet.ippf.org/pub/Aids2002/CounsellingGuide.pdf

STEP 6

FHI. *Behavior Change Communication for HIV/AIDS: A Strategic Framework*. 2002.
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STEP 7

Policy Project. *HIV/AIDS Toolkit: Building Political Commitment for Effective HIV/AIDS Policies and Programs*. 2000.
www.policyproject.com/pubs/toolkit.cfm

Rehle, T. et al., eds. *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers*. FHI, 2002.
www.fhi.org/en/aids/impact/pubs/handbooks/evalchap/evalchapintro.html

UNAIDS. *National AIDS Programmes: A Guide to Monitoring and Evaluation*. 2000.
www.unaids.org/publications/documents/epidemiology/surveillance/JC427-Mon&Ev-Full-E.pdf
www.cpc.unc.edu/measure/guide/guide.html

APPENDIX

FACT SHEETS:

- *Female Condoms*
- *Male Condoms*
- *Protection Against Both HIV and Pregnancy*
- *Gender and Condom Programming*

FACT SHEET

FEMALE CONDOMS: SAFE, EFFECTIVE, AND ACCEPTABLE

The female condom is a polyurethane sheath, which is inserted into the vagina before sexual intercourse. Like the male condom, it provides dual protection against both HIV/STIs and pregnancy. Condom programmes have found that offering the female condom along with male condoms increases the proportion of protected sex acts.

Since 1992, when the female condom was first introduced into the market, more than 19 million female condoms have been supplied to more than 70 countries, and they have been mainstreamed into many national HIV-prevention programmes. Most men and women find female condoms acceptable—sometimes even more so than male condoms. While only one model of female condom is currently approved by the U.S. Food and Drug Administration, several other types of female condoms, including a latex version, are being developed.

EFFECTIVENESS

Female condoms offer couples dual protection against pregnancy and infection. The pregnancy rate for the female condom is about 5 percent during consistent and correct use and 21 percent in typical use. The female condom may provide better protection against STIs than the male condom because it covers the vagina, cervix, and vulva. Since it can be inserted before sex, the female condom also protects women from HIV/STIs potentially transmitted through pre-ejaculate fluid. The female condom has no known side effects or risks.

ADVANTAGES AND DISADVANTAGES

From the user's perspective, the female condom offers many benefits. Compared with the male condom, the female condom:

- Is more durable,
- Does not require special storage conditions because it is made of polyurethane,
- Can be used with either oil- or water-based lubricants,
- Offers women greater control over HIV and pregnancy prevention,
- Is less disruptive during sex since it can be inserted before intercourse,
- Allows users to take more time to withdraw after ejaculation, and
- Is more comfortable for men.

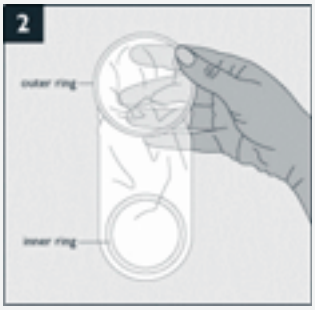
The method also has some disadvantages. Some women find the female condom difficult to insert, and it is less comfortable for women than the male condom. It is not appropriate for some sexual positions, and some users find it noisy and messy.

FEMALE EMPOWERMENT

Female condoms generally require the cooperation of the male partner for effective and sustained use. Women report that using the female condom encourages discussion of sexual topics with their partners and may enhance their bargaining power in sexual relationships. The method is especially valuable for sex workers, who can use female condoms to protect against HIV/STIs when their clients are reluctant to use male condoms. Some women have been able to use the female condom without their partner's knowledge or consent.

INSERTION INSTRUCTIONS FOR THE FEMALE CONDOM

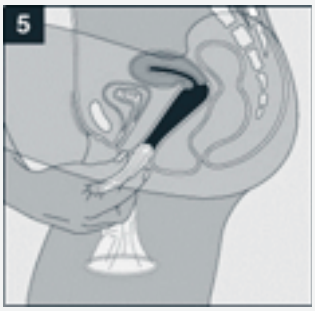
Open the Female condom package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open.



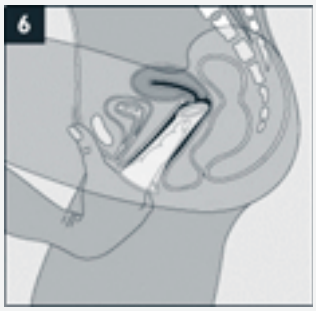
The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.

While holding the Female condom at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.

Choose a position that is comfortable for insertion – squat, raise one leg, sit or lie down.



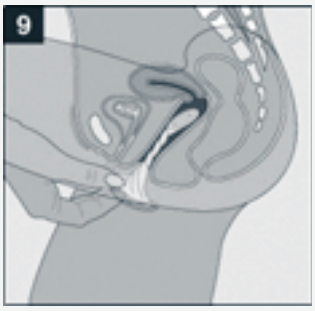
Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.



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.

The female condom is now in place and ready for use with your partner.

When you are ready, gently guide your partner's penis into the condom's opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall.



To remove the Female condom, twist the outer ring and gently pull the condom out.

Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.

Source: Illustrated instructions provided by the Female Health Company.

INTRODUCING THE FEMALE CONDOM

Introducing the female condom requires additional training for providers, since they usually know little about it and may believe the method is only suitable for single women and sex workers. Personal practice with the female condom encourages providers to appreciate its advantages and promote the device. Promotional campaigns, directed to both women and men, also are essential to raise awareness of the method and its advantages.

Women may need continuing counselling and support from providers to overcome initial difficulties in using the device and to sustain use with their partners. Key issues for instruction on female condom use are:

- How to insert the device and
- Avoiding penile misrouting, that is, penetration outside the device.

STORAGE AND SHELF LIFE

The manufacturer of the female condom has determined the shelf life to be five years. Storing female condoms is easier than storing male latex condoms because female condoms are made out of polyurethane, a material that is unaffected by humidity and ozone levels. It requires no special storage conditions.

COST-EFFECTIVENESS

The female condom is expensive, with a public-sector price of about 60 cents each compared with 3 cents for a male condom. Nonetheless, cost-effectiveness studies demonstrate that female condoms can save money in the public sector by reducing the need for HIV/AIDS, syphilis, and gonorrhoea treatment. Researchers are testing a draft protocol to disinfect and safely reuse female condoms up to five times, which would reduce costs. WHO currently recommends against reusing female condoms but has drafted a protocol for the safe handling and disinfection of female condoms when they are reused *(www.who.int/reproductive-health/rtis/reuse.en.html).*

FOR MORE INFORMATION ON FEMALE CONDOMS, SEE:

WHO and UNAIDS. *The Female Condom: A Guide for Planning and Programming.* 2000.

www.who.int/reproductive-health/publications/RHR_00_8/RHR_00_8_table_of_contents_en.html.

FACT SHEET

MALE CONDOMS: SAFE, EFFECTIVE, AND INEXPENSIVE

Some 6 to 9 billion male condoms are used every year. They have played a critical role in any place where HIV-prevention efforts have been successful in reducing HIV prevalence and infection rates. Experience has demonstrated that where male condoms are actively promoted and widely used, the spread of HIV has slowed. At a cost of less than three cents per condom, they provide affordable as well as effective protection.

EFFECTIVENESS

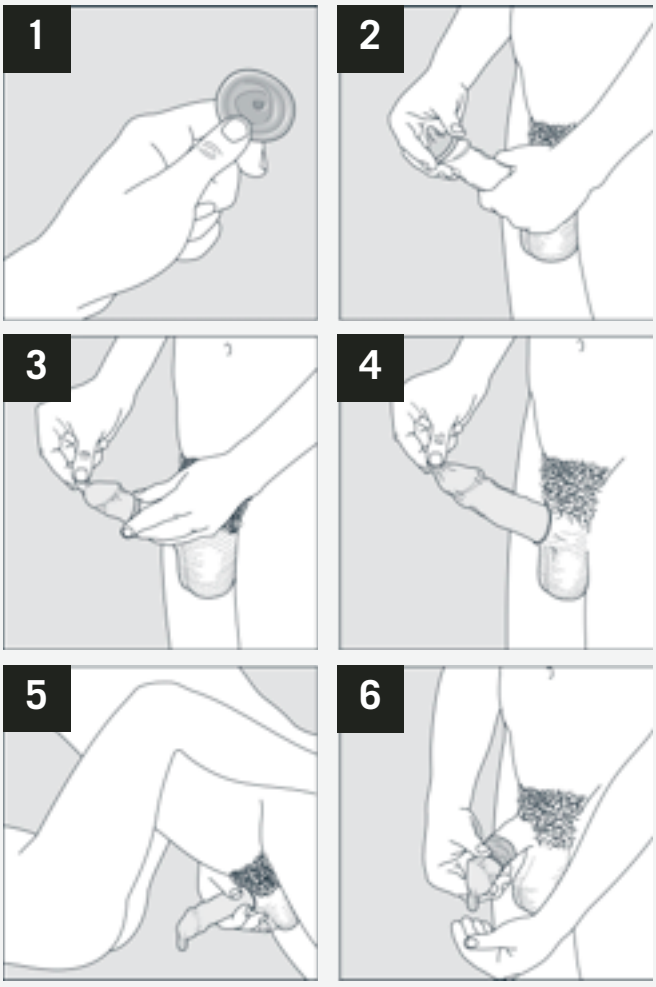
Male condoms offer couples dual protection against pregnancy and infection. The pregnancy rate for the male condom is 3 percent during consistent, correct use and 14 percent during typical use. Consistent condom use reduces the risk of heterosexual transmission of HIV by 80 percent and also protects against other STIs, such as gonorrhoea. However, male condoms may be less effective at protecting against STIs that can be transmitted by skin-to-skin contact in areas not covered by the condom; these include herpes and human papillomavirus (HPV).

COUNSELLING

Most male condom failures are not caused by a problem with the condom itself, but by incorrect or inconsistent use. Instructing men and women how to use male condoms correctly and consistently—using hands-on demonstrations with penis models—should be a key element of any condom programme. Users also need advice on which lubricants they can safely use, since latex deteriorates on contact with mineral or vegetable oils; on storing condoms away from heat; on opening packages carefully to avoid damage; and on checking the expiration date.

Several studies have found that condoms break or slip off in approximately 4 percent of coital acts. A minority of users, often young, inexperienced users, are involved in a disproportionate number of these incidents. Programmes should counsel condom users who report breakage and slippage and help them develop the skills to avoid these problems in the future.

INSTRUCTIONS FOR MALE CONDOM USE



BEFORE INTERCOURSE:

1. Carefully open the package so the condom does not tear. (Do not use teeth or a sharp object to open the package.) Do not unroll the condom before putting it on.

2. If you are not circumcised, pull back the foreskin. Put the condom on the end of the hard penis. **Note:** If the condom is initially placed on the penis backwards, do not turn it around. Throw it away and start with a new one.

3. Pinching the tip of the condom to squeeze out air, roll on the condom until it reaches the base of the penis.

4. Check to make sure there is space at the tip and that the condom is not broken. With the condom on, insert the penis for intercourse.

AFTER INTERCOURSE:

5. After ejaculation, hold onto the condom at the base of the penis. Keeping the condom on, pull the penis out before it gets soft.

6. Slide the condom off without spilling the liquid (semen) inside. Dispose of the used condom.

STORAGE AND SHELF LIFE

The shelf life, or time that a male latex condom remains useful and effective after its manufacture, varies considerably depending on storage conditions, temperature, humidity, moisture, and even ultraviolet light. Each of these factors can considerably reduce the shelf life of a condom from the typical manufacturer's expiry period of three to five years. As a general rule, male latex condoms should be kept away from extreme temperatures (above 40°C), moisture, and humidity. This may require air conditioning central warehouses in areas of high heat and humidity to maintain condom shelf life.

PRODUCT OPTIONS

Novel designs and materials may make male condoms more appealing to clients and more likely to be used. The "baggy" condom offers a roomier, more comfortable fit, while other condoms provide extra room at the tip to increase sensation and friction. Plastic condoms, initially developed for men with allergies to latex, offer increased sensation, a less restrictive fit, thinner feel, lack of odour, and the possibility of using oil-based lubricants. Male condoms made out of natural membranes, which protect against pregnancy but **not** against HIV/STIs, should be discouraged.

Stocking multiple sizes of male condoms can meet the needs of a wider array of potential users, although it creates logistical challenges. Standard size condoms may be too large for adolescents, which can lead to slippage, and too small for men with big penises, which may cause discomfort and breakage. Local needs should determine how many and what kinds of condoms a programme carries.

STOP PROMOTING CONDOMS WITH NONOXYNOL-9

Some male condoms are lubricated with the spermicide nonoxynol-9 (N-9), but data show that these condoms are no more effective than others in preventing pregnancy or HIV/STIs. Furthermore, using N-9 products with higher dosages or using them very frequently can cause vaginal inflammation and abrasions. Therefore, condom programmes should stop promoting condoms lubricated with N-9. If no other condoms are available, however, using N-9 lubricated condoms is better than using no condom at all to protect against HIV and STIs. The use of N-9 remains a contraceptive option for women at low risk of HIV infection, but it should not be used rectally.

FOR MORE INFORMATION ON MALE CONDOMS, SEE:

WHO and UNAIDS. The Male Latex Condom: 10 Condom Programming Fact Sheets. Geneva: WHO, 1998. *http://www.unaids.org*

FACT SHEET

PROTECTING AGAINST BOTH HIV AND PREGNANCY

DUAL PROTECTION

Sexually active couples need protection against pregnancy as well as HIV/STIs. Condoms are unique because they provide "dual protection," that is, they simultaneously prevent pregnancy and reduce the risk of infection. Dual protection is especially important to women, who face the risk of unwanted pregnancy as well as infection when they have unprotected sex.

With perfect use, the pregnancy rate for male and female condoms is just 3 to 5 percent. However, incorrect and inconsistent use pushes the pregnancy rate to 14 percent or more among typical couples—relatively high compared with hormonal contraceptives, intrauterine devices, and sterilisation. For this reason, couples relying on condoms for dual protection also need access to emergency contraceptive pills or safe and effective methods of pregnancy termination. Couples can use emergency contraceptive pills, which prevent pregnancy when taken within 72 hours of intercourse, if a condom breaks or they have unprotected intercourse.

Condom programmes have not adequately promoted condoms as a method of dual protection: HIV-prevention programmes focus exclusively on its ability to prevent infection, while family planning programmes focus on its contraceptive powers. Providers should mention dual protection to every client, and materials for information, education, and communication should broadly disseminate the dual protection message. Promoting dual protection has another benefit for condom programming: by focusing on the condom's family planning benefits, it can help dispel the idea that condoms are only for use with sex workers or casual partners.

DUAL METHOD USE

Clients who are concerned about pregnancy may be reluctant to rely on condoms alone. Another option is "dual method use," that is, using condoms along with another family planning method, such as injectable contraceptives.

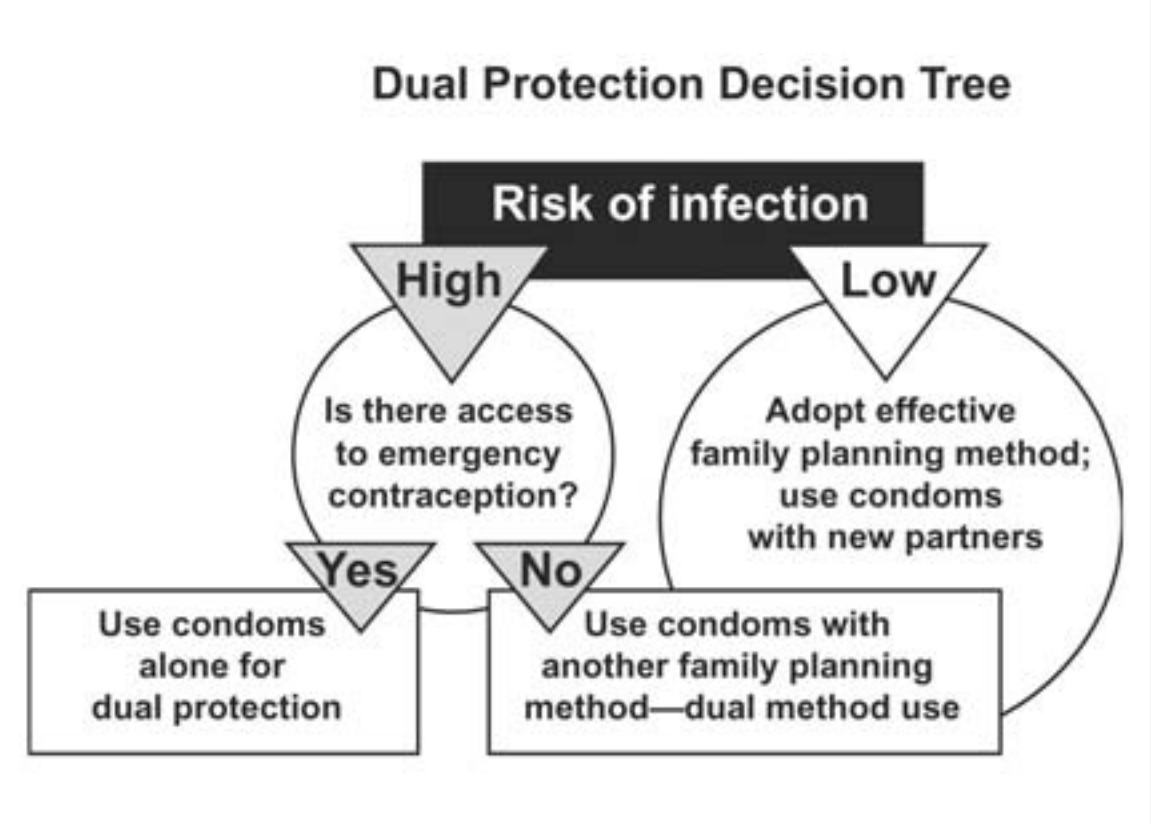
Dual method use presents greater challenges than dual protection: clients must be motivated enough to pay for and consistently and correctly use two methods instead of one. When women are already using a highly effective form of contraception, they may find it burdensome to use condoms as well. Adding condoms may actually weaken how effectively, consistently, and correctly women use their original method of contraception.

DECIDING ON DUAL PROTECTION OR DUAL METHOD USE

Before recommending dual protection or dual method use, providers should assess a client's risk of infection based upon community prevalence and individual risk behaviours (see decision tree). When the risk of infection is high, condoms are essential. However, condoms should be used alone for dual protection only where there is access to emergency contraception or

safe methods of pregnancy termination. Otherwise, condoms should be used in combination with another contraceptive method.

When the risk of infection is low, then clients' need for family planning outweighs their need for HIV prevention. In this situation, the clients should choose an effective family planning method appropriate to their personal circumstances. However, providers also should stress the importance of using condoms with any new partners, since they may carry an infection or engage in high-risk behaviours.



FACT SHEET

GENDER AND CONDOM PROGRAMMING

THE LINK BETWEEN GENDER AND HIV

In developing countries, gender-related social norms, roles, and inequities place women at higher risk of HIV infection than men:

- Women often lack the power to negotiate with men over safer sex, use of condoms, or sexual concerns.
- Women are more likely than men to live in or be vulnerable to poverty.
- Women are more likely to experience coerced sex or rape than their male counterparts.
- Women are more likely to have to sell sex to survive.
- Women who suggest condom use may be suspected of infidelity and subject to violence.

Yet social norms also put men at risk by reinforcing definitions of masculinity and its association with risky behaviours. Men are much more likely than women to engage in extramarital affairs, have multiple sex partners, and visit sex workers. They are even more likely to engage in these risky behaviours if they live or work in all-male settings, such as the military, or if poverty, unemployment, and the accompanying loss of status threatens their sense of masculinity. In many cultures, young boys may learn the attitudes and behaviours that eventually lead to risky behaviour by the time they are 12 years old.

TAKING ACTION

By understanding how gender affects men and women's vulnerability to HIV/AIDS—and how it creates obstacles to condom use—condom programmes can develop ways to overcome those obstacles, increase impact, and potentially improve gender relations.

DESIGN GENDER-SENSITIVE MESSAGES AND STRATEGIES. Counselling, education, and mass media campaigns should directly address underlying gender issues and social norms that make women and girls vulnerable to infection.

TRAIN PROVIDERS IN GENDER SKILLS. With appropriate training, health providers, peer educators, and other staff will be sensitive to gender issues when counselling clients.

SEEK OUT WOMEN'S PERSPECTIVES. Involving women's organisations in all aspects of programme design and implementation ensures that women's perspectives will be reflected throughout.

EMPOWER WOMEN. Programmes can incorporate an empowerment approach by including avenues for women to build positive self-images and self-confidence, develop the ability to think critically, build group support, and foster decision making and action.

REACH OUT TO MEN. Interventions that address the broader gender dynamics and discrimination that serve as obstacles to condom use and safer sex must address men

and boys. Positive messages about the importance of protecting themselves and their partners can promote male involvement.

FOSTER COUPLE COMMUNICATION. In addition to protecting men and their partners from HIV, condom programming that fosters open communication helps build relationships that are equal and safe and that strengthen the health of both partners.

CREATE COMMUNITY DIALOGUE BETWEEN MEN AND WOMEN. Guided group discussions can help women and men understand how gender roles and inequities heighten their vulnerability to infection and motivate them to take corrective action.

INCREASE WOMEN'S PROTECTIVE OPTIONS. Providing the female condom and educating clients about its use and promoting dual protection can help women protect themselves.

FIGHT STIGMA. Promoting condoms as a method of dual protection for couples in stable relationships can help overcome the stigma of condoms as a method to use with sex workers or casual partners only.

ASSESSING PROGRESS. Programme managers can assess how responsive their condom programming is to gender issues using tools developed by the International Planned Parenthood Federation (IPPF) (available online at *www.ippfwhr.org/publications/download/monographs/gender_continuum.pdf)* and by the Royal Tropical Institute (KIT) (available online at *www.kit.nl/information_services/assets/images/RPBook2.pdf*). Among the many areas considered are whether and how providers address gender-related vulnerabilities to HIV, decision making and negotiation skills on sexual relations, and partner communication.

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