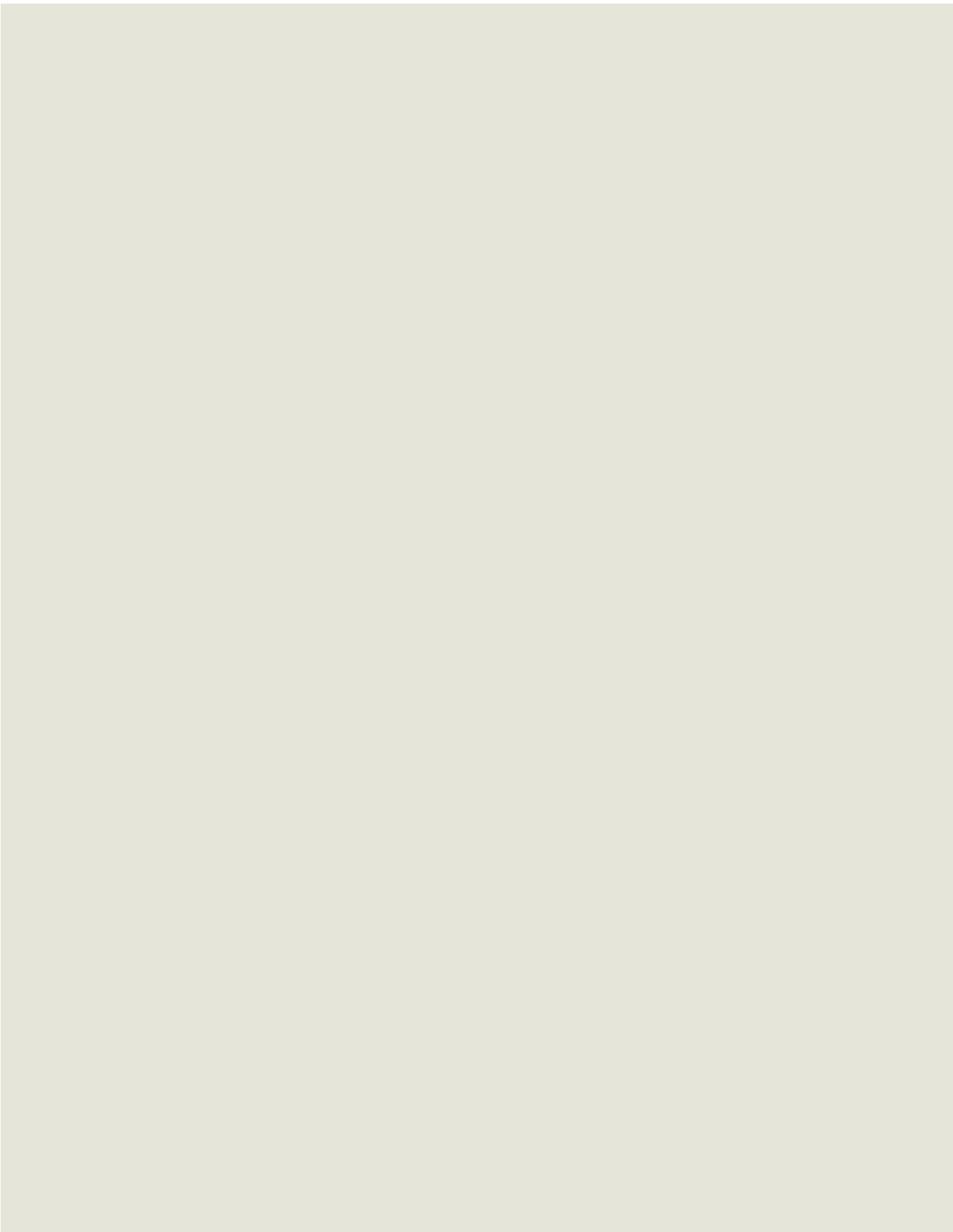


Comprehensive Condom Programming

A guide for resource mobilization
and country programming





Rationale

In most parts of the world, HIV is spread primarily through unprotected sexual intercourse. Changing behaviour to promote safer sexual practices, including condom use, is therefore fundamental to controlling the epidemic.

Male and female condoms are key because they are currently the only barrier methods that protect against sexually transmitted infections (STIs), including HIV. Correct and consistent condom use is one of the most effective means of preventing sexual transmission of HIV, and it belongs at the heart of any HIV prevention strategy. Moreover, experience has shown that actions to increase uptake and use of effective barrier methods are more successful and sustainable when they are part of a strategic, coordinated and comprehensive condom programming effort. Despite this knowledge, condom programming has not been scaled up at the urgent pace the epidemic demands. In many countries, condom programming is hampered by weak political leadership and inadequate resources. But this can change.

Condoms are effective

Strong evidence from laboratory and clinical studies shows that condoms effectively reduce the risk of HIV transmission. For specific populations, increased levels of condom use are also associated with decreased rates of reported STIs. Male and female condoms play a central role in halting the rising rates of STIs, including HIV. For people who are not practising monogamous sex with an uninfected partner, condoms remain the best tool for reducing the risk of acquiring STIs (if uninfected) or transmitting these infections (if infected).

Condoms are cost-effective

There are no published studies on the cost-effectiveness of promoting male condoms as a stand-alone intervention. However, recent national population-based surveys in seven sub-Saharan African countries have shown that an increase in condom use – in conjunction with delayed sexual debut and a reduction in sexual partners – is an important factor in the decline of HIV prevalence, contributing to substantial savings in terms of lives and costs.

Introducing female condoms into programmes already promoting male condoms has been shown to increase the number of protected sex acts and to provide an option to women who are less likely to use other dual-protection methods (i.e., methods that protect against both STIs and unintended pregnancy). Female condom programmes are especially likely to be cost-effective in areas of high STI/HIV prevalence, even among women with moderate rates of partner change.

Female condoms and male condoms are roughly equivalent in terms of their effectiveness in reducing the risk of HIV transmission. However, female condoms are far more costly. Cost-effectiveness results are therefore sensitive to assumptions made about the rate of substitution between the two types of condoms (that is, the portion of sex acts covered by female condoms that would have been covered by male condoms had the female condoms not been available). In reality, the female condom has its own niche – specifically, among women and girls who are unable to insist that their male partners use condoms. Their partners may be reluctant to use male condoms, even when available, and women often lack the power to negotiate their use.

The UNFPA Programme

Guided by international development principles, UNFPA pledges to:

- Ensure that all condom programming efforts are nationally owned and country-led
- Assist national HIV-prevention programmes to develop condom programming strategies through which every sexually active person at risk of HIV/STIs – regardless of age, culture, economic situation, gender, marital status, religion or sexual orientation – has access to good quality condoms when and where s/he needs them, is motivated to use male or female condoms as appropriate, and has the information and knowledge to use them consistently and correctly.

UNFPA has facilitated the design and implementation of culturally appropriate and effective efforts towards comprehensive condom programming (CCP). For example, in many countries, UNFPA has helped coordinate the security of national reproductive health commodities and develop condom support teams. In some countries, existing bodies or institutions already manage condom planning and coordination, so additional assistance is not necessary. These working groups include representatives from government, the private sector, civil society and donor agencies working on HIV prevention and reproductive health programmes.

In supporting this effort, UNFPA employs a 10-Step Strategic Approach (outlined on the following pages) to scale up CCP that encourages the participation of donors and international agencies while placing ultimate responsibility for decision-making and implementation in the hands of national partners. This 10-step approach is being implemented in selected countries in most regions.

The design of a condom programme may vary from country to country depending on many factors, ranging from the local epidemiology of STIs/HIV and the condition of a country's health infrastructure to the cultural context of targeted areas and budgetary issues. However, the process of designing and implementing a SMART (specific, measurable, achievable, realistic and time-governed) strategy has many common features, which are described in this document.

The 10-Step Strategic Approach

DEVELOPMENT PHASE

STEP 1

Establish a national condom support team

Assemble a team from an existing reproductive health commodity security working group and/or HIV prevention committee. The team should include representatives from:

- Line ministries (such as health, finance, gender, education and tourism)
- Institutions working in family planning and sexual and reproductive health
- National AIDS council
- Local condom 'champions'
- Regulatory authorities responsible for local standards and quality assurance
- Donor community
- Civil society (including people living with HIV, young people, faith-based and non-governmental organizations)
- Social marketing organizations
- Private sector and business coalitions.

The purpose of the team is to provide guidance and support to government in developing and monitoring the national CCP strategy and operational plan. The team should have clearly designated roles and responsibilities.

STEP 2

Undertake a situation analysis

Undertake a desk review of documents, reports and research pertaining to HIV and sexual and reproductive health to gain background information on the various components of the CCP framework (leadership and coordination; demand, access and utilization; supply and commodity security; and support).

Where information from the desk review is insufficient, collect data from the field (see the **CCP Rapid Needs Assessment and Strategic Planning Tool**).

Convene a stakeholders meeting to share findings from the situation analysis, build consensus and support, and agree on a concrete roadmap for scaling up condom programming efforts.



STEP 3

Develop a comprehensive and integrated national strategy for male and female condoms

Identify responsible agencies and/or stakeholders to implement and oversee coordinated activities in each of the following areas and, if possible, link them programmatically. The national strategy should reflect the components of the CCP framework:

Leadership and coordination

- Coordination of partnerships
- Advocacy
- Policies and regulations
- Resource mobilization

Demand, access and utilization

- Market research
- Total market approach
- Targeted distribution
- IEC and behaviour change communication strategies
- Social mobilization

Supply and commodity security

- Forecasting
- Procurement
- Quality assurance
- Warehousing and storage
- Distribution to supply chains
- Logistics management information system

Support

- Advocacy
- Social, behavioural and operations research
- Capacity and institutional strengthening
- Monitoring and evaluation
- Documentation and dissemination.

STEP 4

Develop a multi-year operational plan and budget

For each component of the national condom strategy, including integration with other programmes and the steps outlined below, ensure that the operational plan specifies:

- Activities
- Division of labour for each partner
- Time frame
- Cost
- Process indicators.

Most importantly, ensure the buy-in of key stakeholders, including 'gate-keepers', by including them in important programme decisions.



IMPLEMENTATION PHASE

STEP 5

Link the multi-year operational plan with the national commodity security plan

Link the operational plan, where possible, to the existing logistics system for essential drugs and reproductive health and HIV-related commodities, including systems for forecasting, procurement, distribution and warehousing.

If there is no reproductive health commodity security committee, the national condom support team should advocate for the establishment of one.

STEP 6

Mobilize financial resources

Based on the operational plan:

Identify available, committed and potential resources at the local, national, regional and global levels in the areas of HIV prevention, treatment, care and support, and sexual and reproductive health, to scale up CCP.

Determine funding gaps in the operational plan.

Advocate and secure funds for implementation of the operational plan.

Develop a reporting system to provide routine feedback about programme implementation to donors.

STEP 7

Strengthen human resources and institutional capacity

Identify human resource capacity strengths and gaps and determine how these can be utilized or filled.

Identify institutional capacity strengths and gaps and determine how these can be utilized or filled.

Develop, obtain or adapt existing training materials (such as manuals, guidelines and demonstration models).

Train trainers, drawing from the public and private sectors, civil society and social marketers. Ensure standards are met and support is maintained.

Cascade training to service providers at different levels (for example, at the provincial, district and community level) and ensure quality of training.

STEP 8

Create and sustain demand for condoms

Conduct formative research, including market research, on preferences, target audience segmentation and values and perceptions that influence the use of male and female condoms.

Develop a communication strategy that includes key messages, target audiences, and channels for stimulating and sustaining demand.

Employ creative and nontraditional outlets for promoting and distributing condoms (such as condom dispensers, hair salons and youth centres).

Stimulate social mobilization of communities to ensure a supportive environment for male and female condoms.

STEP 9

Strengthen advocacy and engage the media

Initiate policy and regulatory analysis and dialogue.

- From the situation analysis, identify policy issues that require advocacy for change.
- Hold a stakeholders meeting to review policy issues and start the dialogue process.

Identify and strengthen condom 'champions'.

- Champions may be found in government, civil society, and among those providing reproductive health/family planning or HIV services or implementing related programmes.
- Strengthen technical and advocacy skills of condom champions through training.

Build coalitions and partnerships (through networking and engagement with civil society and other segments of society).

- Identify a wide range of stakeholders interested in working to improve the policy environment.
- Establish a common goal, mission statement, roles and responsibilities, and communication process.
- Develop and implement the advocacy plan.

Coordinate media outreach and capacity-building.

Develop a communication strategy to engage the media.

Provide sensitization and skills-building for journalists and members of the mass media.

STEP 10

Monitor programme implementation routinely, conduct research and evaluate outcomes

Incorporate the CCP monitoring & evaluation framework into the national M & E framework.

Review and update operational plan indicators.

Identify research areas and conduct research to support programme implementation.

Establish baselines.

- Identify milestones and intended targets.
- Update baseline data indicators and undertake a baseline study, as necessary.

Monitor programme implementation.

- Collect and analyse routine data on programme delivery among target populations (risk groups) and the various public-health interventions in which condom programming has been integrated.
- Hold regular review and planning meetings with the national condom support team.
- Share feedback from the review with implementing partners.
- Ensure that feedback is used by implementing partners to adapt, readjust and improve programme implementation.

Evaluation

- Conduct annual, mid-term and end-of-term evaluations.
- Provide feedback from evaluations to implementing partners.
- Evaluate overall impact of the national strategy.

Establishing a National Programme

Identifying programme goals, activities and deliverables

Condom programmes will have different objectives, based on the circumstances of a particular locality. Examples of possible programme objectives, activities and deliverables follow:

PROGRAMME OBJECTIVES

Increase the number of sex acts that are protected against STIs, including HIV, and unintended pregnancy.

Expand access and use of male and female condoms for dual protection in low- and middle-income countries.

Make male and female condom programming an essential component of national policy guidelines and programmes for HIV/AIDS and reproductive health.

PROGRAMME ACTIVITIES

Hire service providers, as needed, and train and equip them to educate, counsel and follow up with people who use male and female condoms.

Educate women and men (including adolescents) about HIV and other STIs; explain how barrier methods such as male and female condoms can help protect them from STIs.

Improve women's skills to negotiate safer sex when their partner(s) is reluctant to use male condoms.

Increase overall uptake and sustained use of male and female condoms.

Promote correct and consistent use of male and female condoms for prevention against HIV and/or unintended pregnancy.

Ensure that adequate numbers and a continuous supply of male and female condoms are provided in target countries.

Advocate, as necessary, for the inclusion of male and female condoms in national essential drug lists.

Promote male and female condoms as a dual-protection method and integrate condoms into a wide range of reproductive health services and non-health services.

Support inclusion of male and female condom programming into national HIV/AIDS strategies.

Create or augment gender-sensitive prevention programmes that focus on women; ensure that these programmes incorporate information on female condoms and encourage male participation.

Work with and monitor all relevant donors, foundations and international agencies to ensure that efforts in condom programming are strategic, coordinated and sustainable.

Develop specific programmes that are gender sensitive and that reach out to men and boys as partners in sexual and reproductive health.

KEY DELIVERABLES

Key deliverables will include:

Strategy documents: national condom strategy, multi-year strategic plan, strategy on demand-creation, and a condom security plan.

Tools: monitoring and evaluation framework, instruments for a baseline survey and programme evaluation.

Capacity development workshops: on monitoring and evaluation, creating demand, behaviour change communication, reaching the mass media, and disseminating lessons learned.

Reports: biannual progress reports and end-of-programme report.

Selecting countries for assistance

The identification of countries to receive assistance should be undertaken in conjunction with an analysis of the problem. In epidemiological terms, there are three AIDS epidemics (see box).* The Joint UN Programme on HIV/AIDS (UNAIDS) and the World Health Organization have characterized these epidemics as low-level, concentrated and generalized. Given the dynamic nature of the epidemic, countries can move across these categories. Within a given country, there is often a series of multiple, changing and overlapping micro-epidemics, each with its own nature (the population most affected), dynamics (patterns of change over time) and characteristics (severity of impact).

An understanding of the nature, dynamics and characteristics of local epidemics is needed to ensure that HIV prevention strategies are adapted to fit local conditions (Step 2 of the 10-Step Strategic Approach to CCP).

The three categories of AIDS epidemics

LOW-LEVEL

Principle: Although HIV infection may have existed for many years, it has not spread to a significant level in any subpopulation.

Recorded infection is largely confined to individuals with high-risk behaviour such as sex workers, injecting drug users, and men having sex with men. The epidemic state suggests that networks of risk are rather diffuse or that the virus has been introduced only very recently.

Numerical proxy: HIV prevalence has not consistently exceeded 5 per cent in any defined subpopulation.

CONCENTRATED

Principle: HIV has spread rapidly in a defined subpopulation, but is not well established in the general population. The epidemic state suggests an active network of risk within the subpopulation. The future course of the epidemic is determined by the frequency and nature of links between highly infected subpopulations and the general population.

Numerical proxy: HIV prevalence is consistently over 5 per cent in at least one defined subpopulation; HIV prevalence is below 1 per cent in pregnant women in urban areas.

GENERALIZED

Principle: HIV is firmly established in the general population. Though subpopulations at higher risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independently of subpopulations at higher risk of infection.

Numerical proxy: HIV prevalence is consistently over 1 per cent in pregnant women.

* In 2008, UNAIDS added a fourth category of epidemics. In these 'hyperepidemic scenarios', found only in a few Southern African countries to date, HIV prevalence exceeds 15 per cent in the adult population. The epidemic is driven in particular by multiple, concurrent partnerships among heterosexual couples as well as low and inconsistent condom use. Source: UNAIDS. 2008. Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS: Geneva.

Targeting populations

- 1. In low-level and concentrated HIV-prevalence settings** where the epidemic is nascent, the primary focus is on those at highest risk who have been identified by epidemiological and social mapping. These highest-risk groups include marginalized and vulnerable populations.

Marginalized populations

Marginalized populations include sex workers, injecting drugs users, men who have sex with men and those living with HIV. Certain factors increase their vulnerability to HIV infection, including stigma and discrimination, gender inequality, poverty, lack of HIV awareness, and limited access to education, health and other services. The negative attitudes others might have towards these marginalized groups are compounded by stigma related to HIV. To make matters worse, countries frequently have laws that criminalize their behaviour and make it difficult for marginalized groups to exercise their human rights, including accessing health services.

Vulnerable populations

Young people are at particular risk of contracting HIV. Because of their biology and physiology, girls and young women are at least twice as susceptible to HIV infection as boys and young men. They are also more socially, culturally and economically vulnerable. Poverty, gender inequality, sexual violence, lack of economic independence and poor educational opportunities can limit their ability to choose when, how and with whom to have sex.

Approximately half of all people living with HIV are women, of whom the vast majority were infected through heterosexual transmission. In sub-Saharan Africa, almost 60 per cent of adults living with HIV are women. The majority of new HIV infections in women occur in marriage or in long-term relationships with primary partners, according to UNAIDS. Vulnerable populations therefore include:

- Women, including pregnant women and women who are married or in a long-term relationship with a primary partner
 - Young people, especially young women and girls.
- 2. In generalized HIV epidemics**, specific strategies for reaching marginalized and vulnerable populations are needed, combined with broader strategies to reach all segments of society at a sufficient scale.

Monitoring and evaluation

The success of a condom programme is determined by monitoring implementation and measuring increases in awareness, access to and use of male and female condoms for STI/HIV prevention. These increases will be measured by the expansion of activities that result from the programme, by the uptake of condoms, by the rate of continued condom use over time and by reductions in STIs, including HIV, in subpopulations.

The lessons learned and case study documents will identify strengths and weaknesses of the overall programme and of individual implementation strategies. These documents will also help to refine and adapt the programme on an ongoing basis. An annual review and needs assessment should be produced by the partners to review progress and to plan the subsequent year's work plan.

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Produced by HIV/AIDS Branch/CCP
UNFPA Technical Division

May 2010



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ISBN 978-0-89714-928-0