

The Female Condom in Uganda

A Situation Analysis



Ministry of Health
Kampala Uganda
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Acknowledgements

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Acronyms

AIC	AIDS Information Center
CDC	United States Centers for Disease Control and Prevention
CoCU	Condom Coordination Unit (Ministry of Health)
DfID	British Department for International Development
EU	European Union
IDP.	Internally Displaced Persons
IPPF	International Planned Parenthood Federation
MARPS	Most At Risk Populations
MOH	Ministry of Health
MoW	Ministry of Water
MSI	Marie Stopes International
PHLA	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
REACT	Rural Empowerment and Action for Communities Network
TASO	The AIDS Service Organization
UAC	Uganda AIDS Commission
UHMG	Uganda Health Management Group
UNFPA	United Nations Population Fund

Executive Summary

The female condom (FC) is the only female initiated method to prevent HIV/STIs whose efficacy and acceptability with specific groups has been well documented. It was first marketed in Uganda in 1998 by Marie Stopes International following a successful acceptability study, but registered little success. The Ministry of Health (MOH) now intends to develop a strategy to re-launch the FC in Uganda. This report presents the findings of a situational analysis to (1) review the previous FC program, (2) determine the extent and source of demand for the FC and how best to promote it, (3) evaluate capacity of each sector to deliver the FC to the target and (4) develop recommendations on way forward. The analysis was limited by the lack of documentation of the previous program and limited data to review. The review team had to depend on the memory of a few individuals and was unable to gain insights into FC user profiles.

Key Findings

The FC program adopted a strategic approach of using existing structures. However:

- It lacked an explicit implementation strategy and realistic provisions for funding to support training, community mobilization, demand generation and distribution.
- No promotion strategy was planned or executed, nor were target groups prioritized to optimize uptake through these existing channels.
- Service providers were not able to provide interpersonal outreach which has been shown to be a key factor for successful trial and subsequent uptake.
- The majority of people interviewed across the country had never seen the FC. It was difficult to find users who were not part of an FC study. Commercial Sex Workers (CSW) honed their negotiation skills and used it successfully with clients.
- Price was an important barrier to condom use for the FC users, all women of low income. Other factors that discouraged use were partner refusal, aesthetics and cultural practices.
- No operational systems were developed for M&E, quality assurance and management oversight.
- Stakeholders have sufficient capacity to deliver the FC to a variety of target groups through existing structures and programs. Capacity gaps relate to policy around allocations for FC programming, integrated planning, training of service providers, development of protocol and tools, coordination of the implementation effort and resource mobilization and allocation for sustained programming.

Recommendations

Comprehensive Condom Programming Framework (CCP)

Based on lessons learned in different countries the FC is likely to be successful and more cost effective when provided as part of an integrated package of STI/HIV and pregnancy prevention services and targeted to specific populations. UNFPA has developed the CCP Framework to

guide national planning and implementation of condoms. It promotes a multifaceted approach that:

- Includes condom promotion, behavior change communication, market research and coordinated supply management
- Makes optimal use of different entry points (i.e. Voluntary Counseling and Testing, Prevention of Mother to Child Transmission, Reproductive Health and other programs)
- Utilizes a complete market approach that involves the public and private sector and includes social marketing

Implementation of this framework requires simultaneous action at various levels:

- Policy direction on risk groups, settings and procedures for FC programming, linkages with related interventions such as VCT/STI/PMTCT/ART.
- Development and dissemination of national policies and guidelines, and strengthening relevant technical and management capacities at national level:
- Supporting program implementation by the public, private and NGO sectors at the District level
- Providing the user/potential user with quality services at the Operational/Site Level

Proposed Female Condom Program

Goal

To develop a comprehensive and integrated 5-year national female condom program

Program Objectives

1. Increase availability and access to female condoms for sexually active men and women in Uganda
2. Increase demand and utilization of female condoms for prevention of HIV/STI and unwanted pregnancies
3. Strengthen coordination, management and logistical support systems to ensure timely and consistent supply and distribution of female condoms

Target Groups

In order to maximize potential for program success in the initial phase, build capacity for implementation and generate support for expansion, the following target groups are proposed for the initial launch of the female condom program:

1. *People engaging in concurrent sexual partnerships* (transactional, multiple and extramarital relations):
 - Commercial Sex Workers and their clients
 - Women in institutions of higher learning
2. *Couples in stable relationships (married/cohabiting)*
 - Discordant couples
 - Concordant positives
3. *Sexually active women*
 - Single women

- Women seeking health related services (FP, ANC, VCT, STI treatment)

Scope of the Proposed Female Condom Program

The female condom will be piloted in 2-3 districts (to be determined based on funding available) for a period of up to one year, during which operational research will be undertaken to inform program improvement and scale up. Based on the results of the pilot the program could potentially be scaled up in phases as proposed below.

Proposed Phased Implementation of the Female Condom (2008/9-2013/14)

Year	Phase	Target Group	Public Sector Channel	Social Marketing & NGO Channel
1	0 Pilot Districts (a, b, c)	<ul style="list-style-type: none"> • Commercial Sex Workers • Young women in institutions of higher learning • Women in discordant relationships • Women living with HIV 	Public Health facilities Family Planning Clinics PMTCT Clinics VCT Centers	Peer Support Groups Mobile Outreach VCT Centers CBOs HIV+ Support Groups Post Test Groups
2-3	1 Scale up to (25%) Districts	All Target groups in pilot Men Uniformed Forces *High prevalence areas (transport corridors, conflict areas)	As above	As above Beauty shops Barber shops Bars, Night clubs Others to be determined
4-5	2 All Districts	All target groups All districts	As above	As above

The following pilot region/districts were proposed at the Female Condom Stakeholders workshop in order of priority:

1. Central region: Wakiso, Kampala
2. Eastern region: Mbale, Busia, Tororo
3. Northern region: Arua, Gulu, Kitgum, Lira

Strategies for Intervention

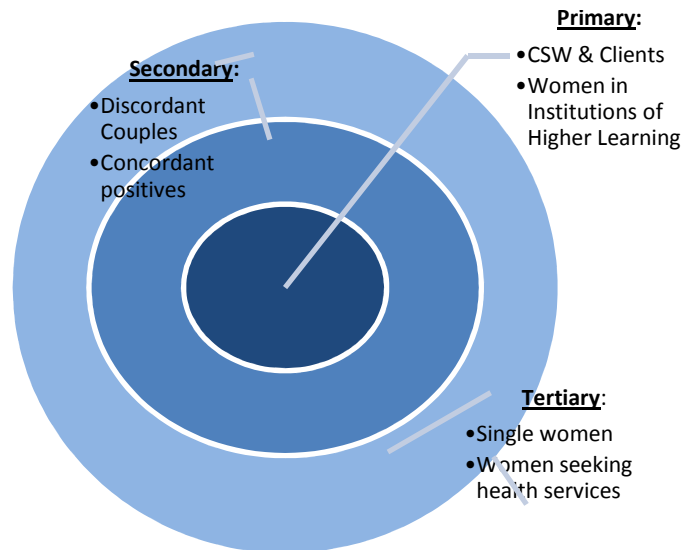
Positioning the Female Condom

The female condom should be positioned as a method for dual protection, i.e. as a contraceptive that can also be used to prevent HIV/STIs.

Targeting to Specific, Well Defined Groups

The female condom is most likely to prevent new infections in the primary and secondary target groups.

The Female Condom: Primary, Secondary and Tertiary Targets



Implementing Through Multiple Provider Channels

The female condom program should utilize a comprehensive approach that includes public sector facilities such as clinics, private sector (pharmacies and other retail outlets), social marketing and community involvement in both urban and rural areas.

Strengthening Integration of the Female Condom

As a starting point, the female condom should be made available in conjunction with the male condom. The female condom is most successful when integrated into HIV/STI Prevention and Sexual Reproductive Health services

Developing Innovative Promotion Strategies

Market research will be needed in order to guide the development of a culturally appealing and relevant marketing and communication strategy. Mass media approaches, peer support and male involvement have been shown to be effective in social marketing to create awareness, address stigma and influence attitudes at population level. This should be coupled with one-on-one interpersonal communication at distribution points for product demonstration, touching and feeling of product, training on correct use, discussion on condom negotiation techniques and opportunity to address personal questions.

Training Service Providers

It is important that target user's are fully aware of what to expect with their first trial of the female condom and are confident enough to experiment with insertion and use until they are comfortable. Social marketers have successfully used Condom Promoters a small, highly trained group of marketers who provide strategic support to develop and sustain client interest by promoting integration of the condom, brainstorming with providers on how best to position the condom for different client groups, training clients directly and assisting with securing adequate supplies.

Conducting Advocacy with Key Stakeholders

There are several categories of stakeholders who are critical to the successful planning, implementation and uptake of the female condom: AIDS Service Organizations, Community Based Organizations, Community Leaders, District Level Officials, Faith Based Leaders, Politicians, People Living with HIV, Service Providers, Women's Groups/Advocates, Government Ministries, Development Partners. Advocacy with stakeholders should begin early, during the strategy development process in order to build ownership of the female condom program.

Undertaking Operations Research Concurrently

In order to increase potential for successful replication of the female condom in other settings it is necessary to conduct operations research to understand the social, cultural, economical and structural factors that influence female condom use or non-use.

Mobilizing Sustained Financial and Technical Support

Sufficient resources need to be mobilized and allocated for introduction, marketing and implementation to ensure a successful trial, under the auspices of the Reproductive Health Commodities Securities Committee.

Next Steps

Pre-launch (June 2009-August 2009):

1. Conduct quality testing on the female condom
2. Integrate the proposed female condom program design into the consolidated Reproductive Health Commodity Strategy
3. Establish a multi-sectoral technical sub-committee to spearhead planning and management of the female condom program
4. Engage key stakeholders under the leadership of the Uganda AIDS Commission
5. Disseminate the proposed strategic plan to stakeholders for feedback
6. Finalize selection of pilot district(s)
7. Finalize detailed Project Implementation plan
 - a. Identify funding to implement plan
 - b. Conduct market research to inform the design of the marketing and communication strategy
 - c. Develop a public sector promotion plan for high risk groups
 - d. Develop training protocol and culturally appropriate training materials
 - e. Conduct TOT for service providers in each pilot district
8. Develop and disseminate program management protocols – logistics and supply management, operational procedures, monitoring and evaluation
9. Train designated focal points for stakeholder institutions in program management protocols.

Launch (September 2009)

10. Launch the female condom in District 1.
11. Launch the female condom in District 2.

Post Launch (September 2009-August 2010)

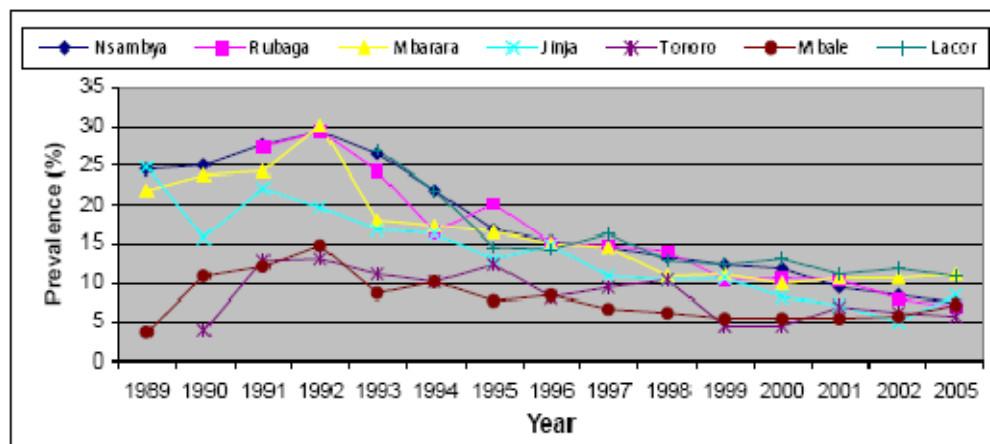
12. Conduct operational research
 - a. Collect data to answer research gaps
 - b. Monitor and evaluate
 - c. Adjust program in line with research findings
13. Review findings from operations research
14. Scale up the female condom program

Background

The Epidemic in Uganda

Uganda has a generalized HIV/AIDS epidemic and about 6.4% of adults are currently infected with HIV. The epidemic is quite heterogeneous with women, urban residents, central and mid-northern regions being among the most affected.

HIV Prevalence Among ANC Attendees in Sentinel Sites Located in Major Towns from 1989 to 2005



Source: *Accelerating HIV Prevention: The Road Map towards Universal Access to HIV Prevention in Uganda*, UAC 2007

Key trends in the epidemic

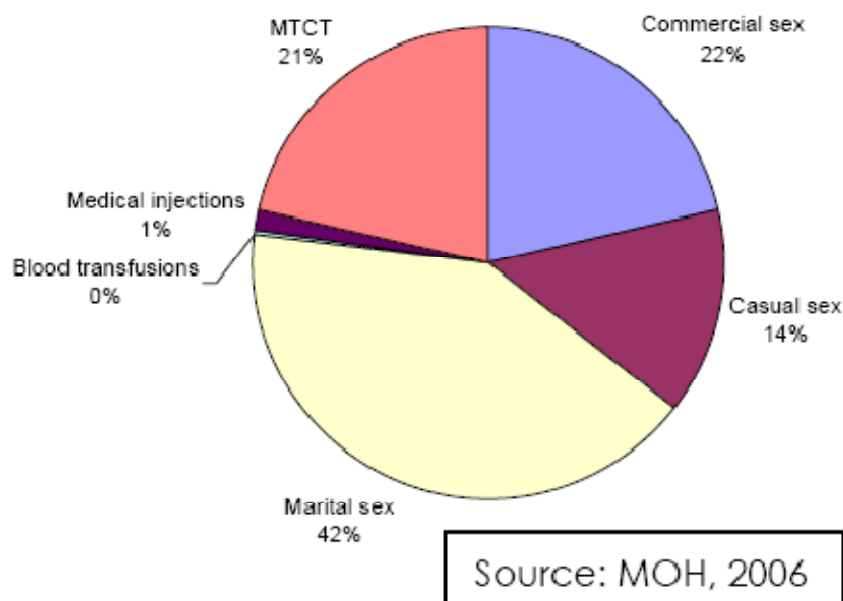
Over the past 25 years, the population most affected by the epidemic has shifted from young unmarried individuals to older and married or formerly married individuals. Recent surveys show several significant trends in the epidemic:

- A reversal of the prevention success achieved in the 1980's, with prevalence stagnating at between 6.4% and 6.7% in 2006.
- High risk sex behavior is on the rise, reflected in an increase in the number of sexually active adults reporting multiple partners.
- Shift from single/casual to long-term stable relationships. Uganda's 2005 sero-survey suggests that up to 65% of new HIV infections are occurring among married people; and discordant couples may comprise up to 50% of these transmissions.
- More women (60%) are infected compared to men (40%), and prevalence is also higher among women throughout the reproductive ages of 15-49.
- Urban areas are more affected than rural areas (10%:6%).

Major vulnerable and affected groups

Analysis of new infections by source reveals that sexual transmission accounts for 76% of the new infections. HIV transmission is highest during marital/cohabiting sex (42%), followed by commercial sex (22%), mother-to-child transmission (21%) and casual sex (14%), as highlighted in the chart below.

Distribution of New Infections by Source



Summary of Risk Factors Fuelling the HIV Epidemic in Uganda

Risk Factors for HIV Transmission	Drivers of the HIV/AIDS Epidemic
<ul style="list-style-type: none"> • Multiple concurrent partners • Discordance and non-disclosure • Lack of condom use • Transactional sex • Cross-generational sex • Presence of HSV-2 • Intact foreskin • Alcohol and drug use • Behavioural disinhibition due to ART 	<ul style="list-style-type: none"> • Socio-cultural factors • Wealth and Poverty • Low status of women and girls • Human rights, Stigma and discrimination • Inequity and access to prevention, care and treatment

Source: Uganda Modes of Transmission Country Synthesis Report - 2008

The risk factors for HIV transmission in Uganda are highly interrelated, implying significant overlap across behaviors:

- Sex with multiple, concurrent sexual partners is on the rise, with the proportion of respondents aged 15–49 years who reported having sex with 2 or more partners in the past year increasing from 2% to 4% in women and from 24% to 29% in men between 2001 and 2005. HIV prevalence among males increased proportionately as their number of partners increased (MoH and MACRO 2006).
- Extramarital sex increased slightly from 2% to 3% of women respondents but significantly for men from 11% to 18%, between 2001 and 2005.
- Non-spousal sex has increased, particularly among younger people (15-24 years). The proportion of men aged 15–49 years who reported having sex with a non-spousal partner increased from 28% to 37% between 2001 and 2005, whereas for women, it remained stable (14% in 2001, 15% in 2005).
- A high level of unprotected sex occurs among HIV-infected persons. In 2005 HIV discordance was 57% among couples in which 1 partner was HIV-infected.
- Lack of correct **and** consistent condom use, especially among men. Between 2001 and 2005, condom use (during the last non-spousal sex in the 12 months preceding the survey), increased in women aged 15-49 years from 39% to 48%, while it decreased among same-age men from 61% to 54%. The trend was the same among men and women aged 15-24 years. Reported consistent use (i.e. with all sexual partners) among 15-49 year olds increased among women from 7% to 9%, while it remained unchanged in men at 14%.

The epidemic is driven by a number of behavioural, social-cultural, economic and geographic factors. Women’s vulnerability to HIV infection is particularly compounded by socio-cultural factors, i.e. cultural values and traditional gender roles. Women have a generally lower status in society and are expected to submit to the men in their lives. The imbalanced gender relations promote lack of parity in decision making and control including around economic, health, sex and basic rights issues. As a consequence, women bear a disproportionate burden of the epidemic (through their own suffering and role as caretaker of sick partners, children and other relatives), and are more subject to HIV related stigma. This inequity extends to their ability to access prevention, care and treatment services and has implications for both access and uptake of the female condom.

The National Response to the HIV/AIDS Epidemic

The National Strategic Plan (NSP) 2007/8-2011/12, demonstrates Uganda’s commitment towards universal access for three priority service areas - prevention, care and treatment, and social support. The NSP aims to:

Reduce new HIV infection by 40%, scale up and reach 80% of those in need of care and treatment, and expand social support to 54% by the year 2012

Reducing the number of new infections is the cornerstone of the current National HIV/AIDS strategic plan for 2008-2012. This is in response to the changing epidemic, in which HIV incidence has increased among groups that constitute a large segment of the population and are not the focus of current prevention programs, such as married and cohabiting couples.

Prevention is therefore a key thematic area, with the goal of reducing incidence of HIV in Uganda by 40 percent by 2012. Priority areas associated with prevention include:

- Accelerating prevention of sexual transmission of HIV targeting vulnerable and most at risk populations;
- Promotion and scale-up of PMTCT;
- Ensuring blood transfusion safety, universal precautions and PEP;
- Controlling sexually transmitted infections;
- Developing appropriate policies and programmatic guidelines for implementation of new HIV preventive technologies that have been proven to be effective.

The NSP will achieve the target of substantially reducing the rate of new infections using a two-pronged approach:

- Targeting vulnerable and high risk groups:
 - CSW & Clients
 - Military (Uniformed Services)
 - Truckers
 - Fishermen
 - Discordant couples
 - People engaging in transactional, multiple, and extramarital sexual relations
 - People who use condoms inconsistently
- Strengthening priority prevention interventions
 - Voluntary Counselling and Testing
 - Prevention with Positives
 - Prevention of mother-to-child Transmission
 - Blood Transfusion Safety
 - Treatment of sexually transmitted infections
 - Male Circumcision

Increasing correct and consistent condom use with high risk partners and among most-at-risk groups is a high priority, with a targeted increase of 47% to 70% for females, and 53% to 79% for males.

Why the Female Condom?

The Female Condom is the only available and effective method to prevent HIV as well as STIs that is designed for female control and initiation. Its efficacy and acceptability with specific groups has been well documented:

- Correct and consistent use of the FC has been estimated to reduce the probability of HIV transmission by 97% per sex act.
- Studies have shown that introduction of the female condom can increase the total number of protected sex acts, increase consistency of condom use among female sex workers and decrease unprotected sex acts¹.

The benefits of the female condom extend beyond contraception and HIV/STI prevention. By providing women with the option to exercise control over one's own sexuality (i.e. protect oneself) the female condom acts as a powerful empowerment tool for women who are able to successfully negotiate its use. The female condom can also serve as a catalyst for communication around safer sexual practices at both individual/partner and societal level. As a public health intervention, successful implementation of the female condom can serve as a model for future promotion and distribution of female initiated prevention technologies, including microbicides.

Despite its high efficacy and the option to initiate protection that it provides women, programming of the female condom is not at a sufficient scale to impact HIV prevention even in the majority of countries where it is provided. Implementation has been affected by programmatic and socio-environmental related challenges:

- High cost of the female condom as compared to the male condom (US \$0.80 for the FC1², US \$0.57 for the FC2³ and US\$0.03 for the Male condom)
- Lack of sustained funding for female condom program commensurate with the programmatic needs
- Ensuring availability, affordability and access to users on a sustained basis
- Lack of social mobilization targeted to address the needs of specific population groups
- Insufficient focus on intensive interpersonal communication/education strategies for both men and women and skills building for negotiation and use
- Utilization of non-traditional distribution mechanisms to more effectively reach users where they are
- Developing the operational systems to maintain quality of service and sustain supply

Many lessons have been learned on how to successfully introduce, promote and distribute the female condom over the last decade. Expanded advocacy to make the female condom available to women as a basic right, has led to growing interest in funding and promotion of female condom programs at both global and local levels. In an epidemic in which women are highly vulnerable, disproportionately affected, and with limited options to take control of their own protection, it becomes increasingly challenging to make a case against incorporating the female condom into the prevention arsenal.

¹ **Smarter Programming of the Female Condom:** Increasing Its Impact on HIV Prevention in the Developing World October 2008 FSG Social Impact Advisors, Elliot Marseille and James G. Kahn

² FC1 is the original female condom made of polyurethane.

³ FC2 is the new and improved version of the female condom that is made of nitrile, which is less expensive.

Objectives of the Situation Analysis and Methodology

Objectives

The main goal of this situational analysis was to inform the development of a strategy to improve female condom promotion and distribution in Uganda.

Specific objectives were to:

1. Review the previous Female Condom program
2. Determine the extent and source of demand for FC and how best to promote it
3. Evaluate capacity of the public, private and NGO sectors to deliver the FC to the target
4. Develop recommendations for the way forward

Methodology

The assessment team utilized a variety of methods to collect and analyze information, which included the following:

Literature Review

The analysis commenced with the review of a broad range of published and gray literature relevant to the female condom in general, and the program in Uganda specifically. The assessment team found it useful to consult the literature and information gained through this review to inform the formulation of specific questions for key informant interviews and guide the interpretation of available qualitative and quantitative information gathered during the assessment.

Standardized Data Collection

Semi-structured questionnaires were used with each of the three key groups interviewed to ensure the collection of similar information from stakeholders in diverse settings: In-depth interview guides for policy makers and implementers at national and district level, and Focus Group Discussion Guide for relevant beneficiary groups and female condom users. Survey data was collected from December to January 2008. The data collection tools were designed to provide specific information related to the processes and context of access, uptake and use of the female condom, as outlined below:

- a. Determine the extent and source of demand for the FC – who and where is the target audience?
- b. Understand the existing demand for FC and how best to promote and distribute them.
- c. Conduct a stakeholder analysis to understand how best to implement the FC program as well as guidelines and regulations that will affect design and implementation.
- d. Evaluate the potential of the private, public and NGO sectors to deliver the FC to the target group and the specific capacity building needs related to each channel.
- e. Review the capacity of MOH and other stakeholders to implement the FC program and related policy, structural, functional and coordination issues.

Key Informant Interviews

In-depth interviews with key stakeholders and implementing partners - at national, regional and district level - were a major source of information for the assessment. The list of stakeholders was developed in consultation with the RHSC and is included at the end of this report.

Field/Site Visits

The research team visited representative districts in several regions of Uganda, namely:

- West Nile - Arua
- East - Mbale
- North - Lira
- West - Mbarara
- Central – Mpigi, Kampala

Focus Group discussions were held with District Health Officials, other stakeholders, and potential and/or actual users of the Female Condom in each district. An additional focus group discussion was held with commercial sex workers involved in a 2008 female condom use study. Translators were used during the focus group discussions to ensure that the questions were clear and unambiguous.

Stakeholders' Consultative Meeting

Stakeholders (including those interviewed) were invited to a workshop where preliminary findings were presented. This was followed by plenary discussions of the findings, recommendations and identification of priority issues for intervention. The outputs of this consultative session are included in this report.

Limitations of the Situation Analysis

Several challenges were encountered when this study commenced, the most significant being the ***lack of documentation of the previous female condom program and limited implementation data to review***. Subsequently the research team had to depend on a few key individuals for historical and anecdotal information on the female condom. The study was limited by the lack of data on several elements:

- Distribution and sales records to use as a base to project demand and/or utilization, or evaluate issues related to product pricing, placement and positioning.
- User demographic data to provide insights into user profile(s), i.e. who uses it, consistency of use, issues around negotiation and whether FC was presented more successfully as condom or FP tool, possible effect of income, marital status, education level and place of residence.
- Every effort was made to collect information from actual users of the female condom. However, available users were mostly limited to commercial sex workers in pilot studies.

While meeting with this group provided valuable information and a variety of experiences and opinions, it represented only one category of users.

It was clear from the interviews and anecdotal evidence that providers and potential users at both national and district level had very limited exposure to the female condom, and the majority of providers were not convinced or supportive of the use of the female condom as an intervention.

Review of the Previous Female Condom Program

History of the Female Condom in Uganda

Recognizing the increasing importance of the FC as a female initiated prevention tool, DfID funded an acceptability study that was conducted by Marie Stopes International (MSI) in 1997. The results indicated high levels of acceptability for the product, particularly amongst women in the urban areas, and in 1998 the World Bank (Sexual Transmitted Infections Project) provided funding for procurement of female condoms for Uganda.

A total of 1.2 million female condoms were procured; 1 million were to be distributed through social marketing MSI and SOMARK, (each was allocated 500,000 female condom) while 200,000 were to be used by the MoH for product demonstration and trials. However SOMARK withdrew their participation prior to launch, leaving the MoH with 700,000 female condoms to distribute through its network of health facilities at District and lower levels.

Despite the baseline study that indicated high levels of acceptability for the product, the program registered little success. The shortfalls of the program are attributable to a number of factors which cut across policy, strategic and programmatic practices, and social norms around condom use, and are discussed at length below.

Female Condom Launch 2000



National Leadership and Coordination of the Female Condom Program

The goal of a condom program 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 (UNFPA/PATH/WHO). A review of the previous female condom program in Uganda reflects a lack of comprehensive planning and limited allocation of resources. Strengths and weaknesses pertaining to the leadership and coordination of the female condom program are summarized below:

Strengths

- ✓ Condoms were promoted as part of the National HIV prevention ABC strategy
- ✓ There were designated Condom Focal Points at national, district and parish level
- ✓ There was a central mechanism for stakeholder coordination through the Condom TWG
- ✓ Strong support for the introduction of the female condom among women's groups and advocates

Weaknesses

- ✓ No comprehensive strategy and funding for promotion and distribution
- ✓ National policy of "Silent promotion" of both male and female condom
- ✓ Lack of condom distribution guidelines to inform program roll-out
- ✓ The relatively high initial investment necessary for successful introduction of the female condom was not made
- ✓ No budget was allocated for promotion of the female condom to potential users
- ✓ No resource commitments were made to ensure sustainability of program beyond the introduction

Key Issue(s):

- The effort lacked an explicit, national strategy to guide the implementation of the female condom.
- No realistic provisions were made for funding to support training of service providers, community mobilization to create awareness, demand generation, distribution and other operational elements which are critical to the successful achievement of this goal.

Generation of Demand and Promotion

The female condom was intended to reach users through three primary channels:

1. Organizational structures already in existence in their communities (i.e. Women’s Groups, NGO and Community based organizations and peer networks)
2. At the point of service within the health care system such as district hospitals, health centers, family planning and STI clinics
3. Commercial condom distribution points such as pharmacies, tuck shops, bars, lodges, etc.

The program approach of reaching potential targets through these existing structures was potentially cost-effective and strategic. However, when reviewed within the context of the lessons learned in programming the female condom, there were fundamental weaknesses, particularly related to generating demand and promoting uptake:

<u>Strengths</u>	<u>Weaknesses</u>
✓ Public Sector-MOH distributed free unbranded Female Condoms via District health facilities, FP and VCT sites	✓ No community wide IEC/BCC to create broad-based awareness and support for the female condom
✓ Social marketing-MSI distributed branded Female Condoms with attractive packaging via retail outlets (goods stores, clinics, drug stores, bars and lodges), peer networks & NGOs	✓ No clearly defined target group(s) of users or targeted promotion for the female condom.
✓ MSI’s promotion plan incorporated education, male involvement, branding and some targeted promotion	✓ Primarily urban based presence and activities
✓ MoH trained condom focal points from all the districts (which were 45 at the time) to support the female condom	✓ Relatively high cost compared to male condom
✓ MoH coordinated training for at least five women representatives from civil society in each district (225) to support the female condom among their constituents	✓ No follow-up of focal points/providers after training so the level and quality of support provided was unknown
✓ A network of distribution points was identified countrywide, including existing male condom outlets	✓ Since majority of health workers interfacing with women were not trained, there was inconsistent presence of the female condom within the communities
	✓ A significant proportion of the health workers were skeptical about the female condom and did not promote it or support its uptake
	✓ Limited funding was available for marketing and education so many condoms expired
	✓ No concerted advocacy and engagement with women’s groups to create awareness and mobilize for uptake at community level
	✓ One-time, short-term approach to product launch

Key Issue(s):

- There was inadequate attention to implementation arrangements: no broad based promotion strategy was planned or executed beyond the initial launch phase, nor were target groups prioritized to optimize uptake through these existing channels.
- Service providers were not able to provide one-on-one counseling or demonstrations to potential users at the point of purchase/service to increase their chances of negotiating condom use, and having a positive experience with the female condom.
- MSI had no funding for product marketing and support for the social marketing component so it was unable to generate sustained demand and promote uptake. Many condoms expired and were recalled.

Supply and Distribution

Once the program was launched and the initial round of training and supply completed, its success or failure on the ground depended on the initiative of civil society groups and MoH officials to solicit other sources for funds to support training, promotion and distribution of the female condom in their respective districts. The program was plagued with many weaknesses:

Strengths

- ✓ Collaboration between MoH and MSI at national and district level
- ✓ Standardized training program based on Female Health Company Guidelines

Weaknesses

- ✓ Lack of consistent access to condoms where needed; NGOs had no stock while MoH was overstocked
- ✓ Condoms were delivered to district focal points who had no resources to distribute them to lower levels
- ✓ “Push”/supply driven system used was not effective: shortages and stock-outs especially among NGOs vis-a-vis oversupply to retailers and risk of expiration in the public sector
- ✓ Trainees were each given 3 condoms after training with no follow-up
- ✓ No anatomical models or visual aids were provided for demonstrations
- ✓ Proposed cascade approach to provider training was not funded and did not occur: Trained district officials had no support for roll-out to lower cadres.
- ✓ Many health workers already overwhelmed before the additional responsibility of introducing and demonstrating female condom use
- ✓ Overall unsupportive attitudes among providers within the public sector
- ✓ Weak linkage with well established programs (VCT, RH, STI) because providers were not trained or provided with female condoms
- ✓ No monitoring and evaluation or quality assurance system

Key Issue(s):

- There was no clearly defined target group(s), and distribution was to all interested, sexually active individuals.
- The demand was not quantified and the supply system failed to close the gap between female condom supply and use.
- No operational systems were developed for effective monitoring, quality assurance and management oversight, which were critical for a new product rollout of this nature.

Perspectives from District Officials

There was limited institutional memory regarding the female condom project. The female condoms were sent to District Medical Stores, and then distributed to health facilities. Some facilities only received a one-time supply. However, supply or distribution records were available.

“They were just brought and put there, with no explanation given to health workers and from the district stores, they were also taken to health facilities and dumped there, hence they must have expired without being used.”

(District Health Officer)

Key Issue(s):

- The district condom focal persons were trained to serve as resource persons in each district, and then districts were supplied with female condoms. However due to funding and other resource constraints they were not able to implement the cascade training as anticipated, or distribute the female condom to lower levels. There was no follow-up or oversight from the central level.

The Extent and Source of Demand for the Female Condom

A major challenge encountered during this situation analysis was the lack of documentation on implementation of the previous female condom program. There was no historical demographic data to provide insights into user profile(s), i.e. who uses it, reasons for, frequency and consistency of use, issues around negotiation with partners, and whether the female condom was presented more successfully for protection from HIV and sexually transmitted infections or as a contraceptive. In addition, it was not possible to assess the effect of different variables that have been shown to influence uptake in other countries (such as income, marital status, education level and place of residence i.e. rural/urban).

Pattern of Demand and Distribution in the Female Condom Program

The 500,000 condoms marketed by MSI were branded and distributed countrywide through the same channels as the male condom. There was initial interest among users upon introduction which did not translate into repeated usage or sales. Sales stagnated after the initial spike and many condoms in the retail outlets eventually expired. However, there were pockets of repeated use among various groups of women in peer networks, primarily commercial sex workers, while supplies lasted. These groups had difficulty securing sustained supplies at the subsidized prices or from local health facilities which had also not received any stocks.

On the other hand most district health facilities had an oversupply of female condoms, but lacked resources to distribute them or to train other service providers. Since only the district condom focal points were trained the majority of health care workers who were in constant contact with patients were unaware that the female condom was available. Others were unsupportive and/or unfamiliar with the product and therefore did not motivate clients to use

it. In view of the above, the previous program does not provide an accurate pattern of demand due to the lack of an effective promotion and distribution strategy.

Feedback from Potential and Actual Users

The majority of people involved in the focus groups discussions (FGD) had not seen or used the female condom. It was difficult to find actual or “regular” users who were or had not been part of a research study. Commercial sex workers were the only women who reported regular use of the female condom while supplies lasted. They also requested supplies from the interviewers during the discussions. A profile of the focus group participants is provided in the table below.

Profile of Focus Group Participants

District	Type of People	No.	Ever Heard	Ever Seen	Ever Used
Arua	Wives of uniformed men	24	No	No	No
Lira	CSW School Girls Prof. Women	9	Yes	Some	NO
Mbale	Men	13	Yes	Some	No
Mbarara	Married Women	10	Yes	No	No
Mpigi	Clinic Staff	4	Yes	Yes	No
Kampala	CSW	12	Yes	Some	1
Moonlight Stars*	CSW	15	Yes	Yes	Yes

**These were participants in a 2008 Female Condom Use study by Reproductive Health Uganda in Kampala*

Despite the fact that the majority had not seen or used the female condom, many expressed concerns about its large size and myths such as how it interfered with a woman’s fertility, could disappear inside a woman’s body, etc.

“Other women say, when playing sex with rough men these female condoms may disappear or get squeezed inside.”

(Female focus group participant from Lira)

According to the FGD participants, the main barriers and facilitators to female condom use are:

<u>Barriers to Condom Use</u>	<u>Facilitators to Condom Use</u>
✓ Difficulty of insertion	✓ Inner ring pleasurable to men
✓ Painful inner ring	✓ Does not constrict like the male condom
✓ Partner refusal: hard to negotiate	✓ Partner does not need to withdraw after ejaculation
✓ Too noisy, smelly, unsightly	✓ Can use even if partner is drunk
✓ Needs to be held in place during intercourse, causing distraction	✓ Good if partner is cheating
✓ Condom not accessible/unavailable	✓ Prevents pregnancy
✓ Myths: e.g. inner ring getting lost inside	✓ Protects from STIs
✓ Negative perception of women who are using condoms (held by both men and women)	✓ Good for HIV+ couples
✓ Does not support different cultural styles of sex (especially western jazz and dry sex)	✓ Alternate to Engabu (perceived to be of lower quality)
✓ Cultural and religious opposition to condoms	
✓ Retail price is too high	

Key Issue(s):

- Focus group participants who had used the condom expressed frustration mostly about difficulty of insertion and discomfort/pain from the inner ring during initial trials. However, they were able to overcome this with practice and by strategizing with peers who were also using the female condom.
- Those who had used the female condom successfully had received training with demonstration and also had support from peers. They were all able to convince their male partners that it was more pleasurable for the men than the male condom. In contrast, non-users anticipated disapproval or refusal from their male partners.
- The users had received conflicting information regarding how the female condom is used, such as the need to hold it in place and remain in only one position during intercourse. This is not consistent with the premise that the female condom could be inserted several hours in advance.
- Non-users harbored myths and misperceptions that reflected a lack of knowledge on use and basic information on the female anatomy.
- Price was an important factor for the female condom users who participated in the focus groups, all women of relatively low income.

“It is easier for a woman to get on ARVs than it is to get the female condom.”
(Female stakeholder in Kampala.)

Issues for Consideration in Promoting the Female Condom

Target(s) of Promotion Efforts

When participants in the focus group discussions (most of whom had no direct experience with the female condom) were asked who they felt it was best suited for, responses were as follows in order of frequency:

- Married people
- People living with HIV
- HIV infected couples
- Those who need family planning
- Students in institutions of higher learning
- Sexually active women
- Sex workers

The above categories cover a broad spectrum of people, which implies that at this point there are low levels –if any– of stigma attached to the use of the female condom by any particular group. There is potential for acceptance of the female condom among the majority, rather than minority, with a mass media campaign, and uptake among specific groups with targeted promotion efforts. Many of the respondents felt that a significant level of infidelity occurs in marital situations, hence their view that this is an important target group⁴. The main ideas on how to promote/encourage use were to reduce the price/provide for free **and** involve the male partners:

“We are willing to involve our men for the female condoms use because they might refuse when you don’t tell him and as men are decision makers, they need to be talked to also.”

(Focus group participant from Arua, wife of a UPDF member)

The above perceptions on who would be best served by the female condom reinforce the need to:

- Actively target and involve men in efforts to increase awareness and support as partners of all the primary target(s), particularly couples in stable/steady relationships.
- Utilize multiple channels of distribution in order to ensure that different target groups can access the female condom and acquire the skills they need to ensure consistent uptake.

Pricing of the Female Condom

All stakeholders who were interviewed and focus group participants felt that the female condom should cost less than, or at most, the same as the male condom since most women who were considered the primary target are economically disadvantaged, and could simply not afford a steep price. The target users should not be forced to choose between meeting their basic needs and protecting themselves.

⁴ This is consistent with the findings from the 2004-05 Uganda HIV/AIDS Sero-Behavioural Survey.

“It will be ironical to have a product for women and yet women cannot afford it because of the high cost.”

(Technical Advisor at multi-lateral development organization in Kampala.)

The price of the Female Condom ranged from UG Shs. 700 to 7,000 per package of three condoms, about 3-5 times more than the male condom, depending on where it was purchased. (It was provided free of charge at government health facilities). The price was established based on the relative cost of male condoms and related contraceptive commodities. Male condoms range in price from UG Shs. 40 to 700 per pack.

The female condom should also be provided for free where the male condom is provided for free such as in the public sector, and sold at equivalent or lower price at retail points.

Lessons Learned by District Officials

The District level is pivotal in facilitating an effective roll-out. District officials proposed the following specific ideas based on lessons learned from the previous female condom program:

- Clarify the roles and responsibilities of the condom focal point to enable the districts to select persons with the appropriate set of skills to provide the required support
- Engage the District Health Officers in the planning process to ensure institutional ownership and buy-in
- Target the service providers and encourage them to experiment with the female condom in order to make them more effective condom promoters
- Model the supply system like that of the male condom so as to limit stock-outs
- Introduce the female condom as a product within existing programs, not on its own
- Promote the female condom as aggressively as the male condom
- Provide anatomical models for demonstrations
- Pilot the female condom before a full scale launch to minimize chances of failure

Any efforts to re-launch should start with stakeholders and promoters to remove doubt/skepticism, increase acceptance and begin the process of creating a supportive environment.

Public, Private and NGO Sector Assessment

Stakeholder Capacity to Deliver the Female Condom

A select group of stakeholders was identified for in-depth review based on their involvement in condom programming, potential and/or ability to reach vulnerable groups, existing infrastructure for service delivery, and ongoing projects in which the female condom can be effectively integrated.

The categories of stakeholders who availed themselves for in-depth interviews are highlighted below.



There are stakeholders across all sectors with existing structures and programs that they can leverage to promote and deliver the female condom to specific target groups among the communities that they currently serve.

Analysis of Providers/Channels

No single provider/channel is able to reach all high risk groups, expand coverage to multiple settings, or meet clients at their convenience or point of need, i.e. in the communities in which they live, work and engage in sex, during the day and/or night. In addition, some providers such as social marketing or community based organizations are better placed to provide the intensive interpersonal outreach that has been shown to be a key factor for successful trial and uptake of the female condom.

Providers/Channels – Strengths, Weaknesses and Capacity Gaps

Provider Involvement in FC	Strengths	Weaknesses	Capacity Gaps
<p>Public Health Facilities (Health Centers 5-1, MCH/STI/TB clinics, HIV Counseling and Testing centers, etc.)</p> <p>Moderate to high Involvement: Despite broad reach, visit is initiated by client and dependent on provider attitude, skills and time.</p>	<ul style="list-style-type: none"> -Extensive infrastructure nationwide -Large base of potential clients -Strong rural network -Strong linkages to HIV/STI prevention and reproductive health services 	<ul style="list-style-type: none"> -Providers have negative biases towards the female condom -Access confined to health system hours of service -Providers busy so limited time for FC promotion -Little privacy for clients -Community volunteers lack motivation 	<ul style="list-style-type: none"> -Resources for ongoing promotion & distribution Provider attitudes and skills: <ul style="list-style-type: none"> -Training on product -Interpersonal communication skills - Comm. Mobilization Tools: <ul style="list-style-type: none"> -Demo Model -Visual aids -Checklists -IEC materials -Procedural Guidelines -Monitoring systems
<p>Social Marketing (PSI, MSI, UHMG)</p> <p>High Involvement: Responsible for designing & implementing communications strategy, developing training, FC supply & distribution, and program oversight</p>	<ul style="list-style-type: none"> -Strong promotional and training support -High flexibility -Cost recovery possible -More privacy for clients -Can leverage existing programs at district and community level to integrate FC 	<ul style="list-style-type: none"> -High initial cost for development of branding, training and tools. -Need sustained, long term funding for ongoing promotion and distribution 	<ul style="list-style-type: none"> -Demo Model -Visual aids -Checklists -IEC materials -Procedural Guidelines -Monitoring systems
<p>NGO (TASO, AIC, RHU) CBOs, Women’s Groups</p> <p>High Involvement: Responsible for community mobilization, IPC, FC distribution and support</p>	<ul style="list-style-type: none"> -Target specific audience -Reach marginal clients through outreach -Provide ongoing client education and support -Highly supportive as FC is complementary to other services 	<ul style="list-style-type: none"> -Cover limited radius -Difficult to maintain motivation of community based providers 	
<p>Private/ Commercial (Pharmacies, Drug Shops, Private Health Facilities)</p> <p>Low Involvement: Limited to retail sales</p>	<ul style="list-style-type: none"> -Nationwide network: <ul style="list-style-type: none"> -extensive reach of distribution and outlets -Relatively low program costs 	<ul style="list-style-type: none"> -Motivated by profit so products /services more expensive -Difficult to provide client education and support -Limited time to attend to clients 	<p>Orientation and Information on product</p> <p>Tools: Visual aids, IEC materials</p>
<p>Development Partners (DfID, JSI-Deliver, OXFAM, UNFPA, UNAIDS, WHO, USAID)</p> <p>Moderate Involvement: Responsible for funding and technical assistance</p>	<ul style="list-style-type: none"> -Financial resources -Specialized technical assistance: <ul style="list-style-type: none"> Logistics Management Health Systems Operational Research Monitoring & Evaluation 	<ul style="list-style-type: none"> -Commitment to the female condom in Uganda not universal among development partners - 	<p>Mechanisms for:</p> <ul style="list-style-type: none"> -Role definition -Coordination -Integrated planning and management

Provider Involvement in FC	Strengths	Weaknesses	Capacity Gaps
Ministry of Health High Involvement: Responsible for Resource mobilization and allocation Coordination of Condom Technical Working Group to provide technical assistance for planning & implementation	Extensive Infrastructure: -RHCS Committee - HQ -Health Promotion Unit - HQ -Condom Coordination Unit	Limited training capacity Condom Policy disseminated	Funding: For sustained FC roll-out Policy: Disbursement schedule to facilitate bulk purchases of FC Sensitization: -To increase awareness & institutional support

In line with best practice, the recommended delivery strategy for female condom programming is a multi-channel approach. The level of involvement of each channel will vary as outlined in the table above. The urgent capacity building needs pertain to training of service providers and development of protocols and tools. Both activities should occur in the pre-launch phase⁵. PSI and MSI both have institutional experience with male and female condom programming in multiple countries, and MSI has experience promoting both the male and female condom in Uganda. PSI can lead the effort to develop training materials while MSI leads the effort to develop a communications campaign.

Capacity Issues/Gaps

Policy

The policy environment in Uganda is supportive of condom promotion in principle, and there are currently no regulations that would negatively affect design and implementation of the female condom program. Comprehensive Condom Distribution guidelines have been developed and are awaiting dissemination. However, no funding had been specifically allocated for implementation of the female condom program.

Integrated planning and management

Capacity gaps at national level relate to coordination required to facilitate resource mobilization, integrated planning and management of the female condom and related commodities. The development partners already supporting Uganda have a strong portfolio of funding and technical assistance relevant to all elements of female condom programming, that can leveraged to support the program. However, a Condom TWG needs to be established by the RHCS to facilitate ongoing collaboration.

⁵ Sequencing of specific activities will be detailed in the Female Condom Start-up Implementation Plan.

Coordination

A dedicated Condom Task Team consisting of policy makers and implementers is required to provide oversight from the pre-launch phase. There is need for high-level awareness and commitment to encourage institutional support for the female condom. However, in order to achieve lasting success it is important to ensure that the female condom is well integrated into existing systems and services and is not promoted as a vertical program.

Resource Mobilization and Allocation

The female condom requires significant funding particularly in the initial phases to support supplies, training, community mobilization, demand generation, distribution and monitoring. The interpersonal communication necessary for successful trial and uptake of the female condom requires intensive training of providers (across sectors and levels) to develop supportive attitudes and skills.

Training and Operational Protocols

Since consistent supply and access are critical success factors for the female condom, strengthening of the supply management systems at each level needs to be prioritized. Operational tools that need to be developed include training modules, procedural manuals, and marketing materials.

Conclusions

The female condom program reflects a lack of planning, limited allocation of resources and inadequate attention to promotion and implementation arrangements. The challenges faced by the program were underpinned by some of the core -financial, institutional, programmatic and human resource- deficiencies that have compromised many health programs in developing countries:

- Lack of **national coordination** to guide implementation and streamline efforts and resources.
- Lack of policies and mechanisms to ensure **integration** of female condom into HIV/STI prevention and reproductive health programs.
- No defined **promotion and distribution strategy** was executed beyond the initial launch. All interested sexually active individuals were targeted.
- Highly **limited training of service providers** to educate clients and promote uptake. Condom focal persons were trained, but were not able to implement the cascade training due to funding and other resource constraints.
- The focus on introduction via **interpersonal communication strategies** (including demonstration and practice) that has since been shown to increase uptake among initial female condom users was unknown at the time. It is now considered best practice.
- Lack of **anatomical models, visual aides and other tools** for product demonstration and instruction.

- **Procurement and supply management** to ensure that the right quantities of the female condom were available where needed. The demand was not quantified and the supply system failed to close the gap between female condom supply and use.
- No systems were developed for **monitoring, quality assurance and management oversight**, which were critical for a new product launch of this nature. Subsequently no implementation data was captured to inform future programming.

Support and commitment was not sustained beyond the initial activities. Demand dropped significantly after the initial excitement/curiosity and many condoms subsequently expired. The findings of this situation analysis reinforce the fact that strong political commitment and a comprehensive planning and implementation effort are critical to the success of any future female condom program.

Lessons that PSI has learned in its fourteen years of female condom programming experience:

- ✓ Lesson 1: Female condoms have an important place in global efforts to protect people engaging in unsafe acts that would otherwise go unprotected.
- ✓ Lesson 2: While female condoms are far more expensive than their male counterparts, there are ways to make the female condom more cost-effective, such as targeting it to most-at-risk populations, or reducing its marginal cost programs by sharing or spreading costs across other programs.
- ✓ Lesson 3: There is often strong demand for the female condom among women.
- ✓ Lesson 4: Market segmentation and targeted promotion is important to offset potential stigma that could occur if female condoms were only marketed to marginalized populations like sex workers.
- ✓ Lesson 5: A combination of innovative distribution methods and interpersonal outreach should be used to reach priority target groups.
- ✓ Lesson 6: Partner support for the female condom can increase the likelihood of sustained use.

Chastain Fitzgerald, PSI's Vice President for New Business and Advocacy.

Recommendations

It is recommended that a new female condom program be developed. It is further recommended that the program be launched as a pilot in 2-3 districts, and operations research conducted to inform future plans to scale up. Positive results from the pilot will also help to make the case for a scaled up, longer term program. Based on lessons learned from different countries (see insert), the female condom is likely to be successful and more cost effective when targeted to specific populations and provided as part of an integrated package of STI/HIV and pregnancy prevention services, rather than a stand-alone product.

A Framework for Condom Programming

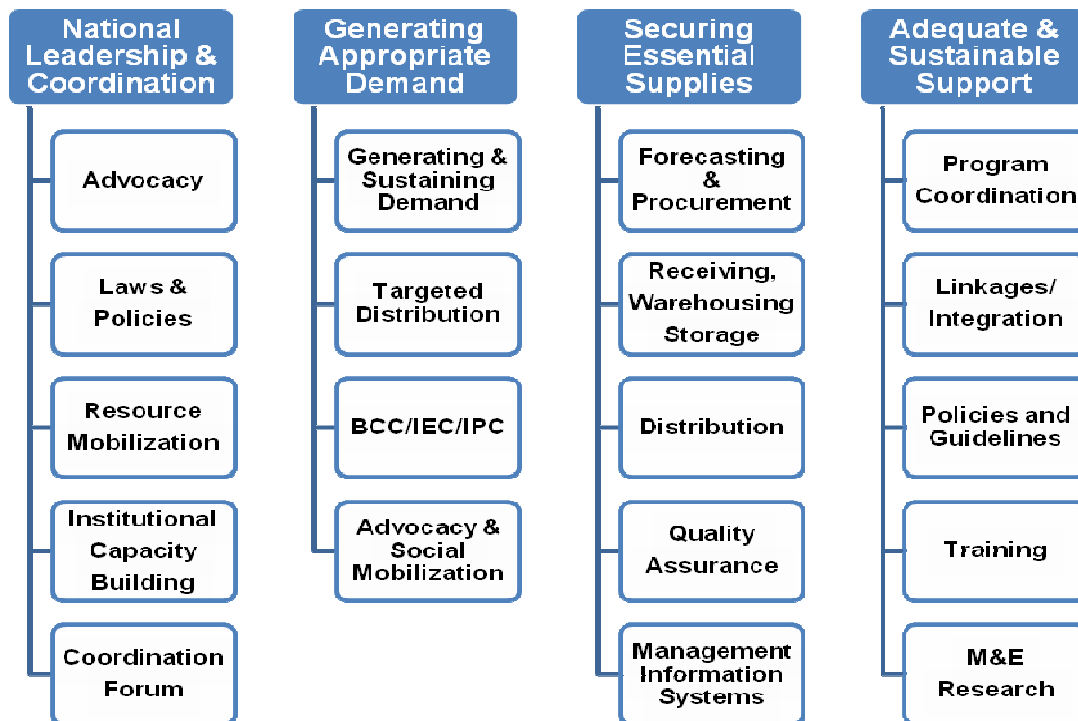
UNFPA has been instrumental in the development of a Comprehensive Condom Programming (CCP) Framework to guide national planning and implementation of (male and female) condom programs. CCP is a multifaceted approach to condom programming which:

- Includes condom promotion, behavior change communication, market research and coordinated supply management
- Makes optimal use of different entry points (i.e. Voluntary Counseling and Testing, Prevention of Mother to Child Transmission, Reproductive Health and other programs)
- Utilizes a complete market approach that involves the public and private sector and includes social marketing

The CCP framework presented below has been customized for the planning and introductory phase of the female condom program in Uganda, and is based on the findings of the situational analysis. It has four components, namely:

- **National Leadership and Coordination**
Providing leadership, establishing partnerships, defining roles and ensuring coordination
- **Generating Appropriate Demand**
Raising awareness and improving uptake of condoms using evidence based approaches
- **Securing Essential Supplies**
Ensuring adequate supply of female condoms on a sustained basis
- **Adequate and Sustainable Support**
Improving access, logistic and distribution capacity, building staff capacity and monitoring and evaluation to inform program adjustments

Uganda Comprehensive Condom Programming Framework



Adapted from UNFPA

In order to ensure success of the proposed female condom program, several items/actions are recommended within each component of the Uganda CCP framework, and summarized below.

<p style="text-align: center;"><u>National Leadership and Coordination</u></p> <ul style="list-style-type: none"> ✓ Coordination of government, UN Agencies, Donors, and NGOs efforts ✓ Establishment of a multi-sectoral condom sub-committee/team to guide planning and implementation ✓ Advocacy to political, religious, business and community leaders to create support ✓ Comprehensive policy to promote integration into “basic” package of services at appropriate entry points ✓ Resource mobilization to ensure sustainable programming of the female condom ✓ Leveraging part of current commitments for male condoms to support the female condom (currently not funded) 	<p style="text-align: center;"><u>Generating Appropriate Demand</u></p> <ul style="list-style-type: none"> ✓ Evidence based social marketing approaches appropriate for targeted users ✓ Evidence based behavior change communication strategy: Mass media and IPC ✓ Training to strengthen public and NGO sectors ✓ Establishment of linkages with HIV/STI prevention and reproductive health ✓ Expansion of distribution to community based sites ✓ Addressing issues of stigma and discrimination to avoid stereotyping/labeling of the Female condom through social mobilization
<p style="text-align: center;"><u>Securing Essential Supplies</u></p> <ul style="list-style-type: none"> ✓ Total market approach utilizing public and private sector with social marketing and community involvement ✓ Integration of female condom strategy into 5 year Commodity Security Plan (2009/10-13/14) ✓ Strengthening capacity for forecasting, procurement and distribution of female condoms ✓ Strengthening logistics management information system to facilitate timely data on distribution and stock levels 	<p style="text-align: center;"><u>Adequate and Sustainable Support</u></p> <ul style="list-style-type: none"> ✓ Developing policies and guidelines to standardize service provision ✓ Training service providers to adopt supportive attitudes, improve skills to motivate clients and manage supply ✓ Strengthening operational systems through training. Program can piggyback on ongoing (MoH) Condom Coordination Unit training ✓ Implementing an equitable pricing system to ensure access to women in particular ✓ Establishing a comprehensive M&E and Quality assurance system ✓ Mobilizing support from stakeholders most vested in female condom programming: <ul style="list-style-type: none"> ○ UNFPA- funding and technical leadership ○ USAID- Commodities, Health Systems Operations Research, BCC ○ DfID - Commodities, BCC ○ JSI-Deliver - Supply Chain Management

Supporting Implementation of the CCP

The female condom is a unique product that requires introduction through targeted interpersonal strategies, and is best promoted through both formal and non-traditional channels. A successful introduction of the female condom requires that several actions be undertaken at multiple levels as part of a highly coordinated effort.

Policy Level:

The MoH has been implementing a “quiet” condom promotion policy. A draft condom policy document has been developed by the MoH in Uganda. However, it has not been publicly launched, or disseminated widely due to a lack of consensus among key development partners. The condom policy should be finalized to include components that are specific to the female condom and to guide implementation. Additional policy actions are needed that:

- Identify the risk groups and vulnerable populations to be prioritized for female condom programming
- Define the national quality testing protocol and regulatory approval process
- Review the funding policy to allow for bulk female condom purchases that can facilitate price reductions and minimize gaps in supply
- Ensure longer term funding commitment to facilitate planning and secure buy-in from potential development and implementing partners

National Level Actions:

At this level the focus is on development and dissemination of national policies and guidelines, and strengthening relevant technical and management capacities:

- Addressing gaps in the national condom policy as discussed above
- Developing a national strategic framework and operational plans, data collection and monitoring tools
- Strengthening the logistics and management information system for the female condom.
- Developing training protocols to build capacity of different types/levels of service providers
- Conducting advocacy to build support among political, religious and community leaders and key constituents
- Designing a national communication campaign to build awareness and support for the female condom prior to its launch

It is important to create a multidisciplinary forum (i.e. a condom technical working group) to engage national and international partners in articulating the vision for the female condom, defining roles and responsibilities for planning and implementation and resource mobilization.

District Level Actions:

At the District level the focus is on supporting program implementation by the public, private and NGO sectors:

- Training service providers (e.g. counselors, promoters, community based agents)
- Supporting NGOs, religious, cultural and community based organizations to integrate the female condom into ongoing initiatives through approaches that are most appropriate to the target communities
- Developing mechanisms to ensure equity of access for vulnerable and disadvantaged groups
- Strengthening linkages with HIV/STI prevention, reproductive health and related interventions
- Conducting mobilization to encourage community leaders to embrace the female condom and build social support

Regular coordination meetings with District Health Department, partners and other stakeholders are needed to manage these district level actions.

Operational/Site Level Actions:

Actions at this level focus on providing the user/potential user with quality services:

- Conducting community awareness to create demand for the female condom
- Ensuring availability of well trained service providers to provide intensive IPC
- Locating supplies in close proximity to the target users
- Continuously monitoring the quality of care provided and client satisfaction

Each entity should incorporate the female condom into their existing operational and quality assurance systems.

Proposed Female Condom Program

Goal

To develop a comprehensive and integrated 5-year national female condom program

Program Objectives

4. Increase availability and access to female condoms for sexually active men and women in Uganda
5. Increase demand and utilization of female condoms for prevention of HIV/STI and unwanted pregnancies
6. Strengthen coordination, management and logistical support systems to ensure timely and consistent supply and distribution of female condoms

Target Groups

The choice of target groups was driven by three factors:

1. Condom use is most effective when targeted to persons at highest risk for sexual transmission:
 - Concurrent sexual partnerships
 - Discordant couples
 - Sex workers, uniformed personnel, mobile populations, youth
2. The NSP 2007/8-2011/12 prioritizes the same high risk groups above for prevention of new infections.
3. Studies show high condom use in transactional sex, and low use in stable relationships such as marriage and concurrent partnerships.

In order to maximize potential for program success in the initial phase, build capacity for implementation and generate support for expansion, the following target groups are proposed for the initial launch of the female condom program:

1. *People engaging in concurrent sexual partnerships* (transactional, multiple and extramarital relations):
 - Commercial Sex Workers and their clients
 - Women in institutions of higher learning
2. *Couples in stable relationships (married/cohabiting)*
 - Discordant couples
 - Concordant positives
3. *Sexually active women*
 - Single women
 - Women seeking health related services (FP, ANC, VCT, STI treatment)

Scope of the Proposed Female Condom Program

There are currently 98,000 female condoms in stock and ready for implementation once quality assurance tests have been completed by the National Drug Authority. There was a consensus among all stakeholders that they did not have sufficient information on, or experience with, the female condom in Uganda, or the technical capacities to implement a broad based launch at this point in time. Based on this reasoning and an estimation of the potential coverage that can be achieved with the current stock, it is proposed that the scope of the initial launch be limited to a pilot in selected geographical areas.

The female condom will be piloted in 2-3 districts (to be determined based on funding available) for a period of up to one year, during which operational research will be undertaken to inform program improvement and scale up. Based on the results of the pilot the program could potentially be scaled up in phases as proposed below.

Proposed Phased Implementation of the Female Condom (2008/9-2013/14)

Year	Phase	Target Group	Public Sector Channel	Social Marketing & NGO Channel
1	0 Pilot Districts (a, b, c)	<ul style="list-style-type: none"> • Commercial Sex Workers • Young women in institutions of higher learning • Women in discordant relationships • Women living with HIV 	Public Health facilities Family Planning Clinics PMTCT Clinics VCT Centers	Peer Support Groups Mobile Outreach VCT Centers CBOs HIV+ Support Groups Post Test Groups
2-3	1 Scale up to (25%) Districts	All Target groups in pilot Men Uniformed Forces *High prevalence areas (transport corridors, conflict areas)	As above	As above Beauty shops Barber shops Bars, Night clubs Others to be determined
4-5	2 All Districts	All target groups All districts	As above	As above

The following pilot region/districts were proposed at the Female Condom Stakeholders workshop in order of priority:

1. Central region: Wakiso, Kampala
2. Eastern region: Mbale, Busia, Tororo
3. Northern region: Arua, Gulu, Kitgum, Lira

The criteria for selection included areas with “moderate” sexual practices (e.g. no predominance of western jazz), significant economic activity, mix of rural and urban features, and strong NGO/CBO network.

Strategies for Intervention

Positioning the Female Condom

The female condom should be positioned as a method for dual protection, i.e. as a contraceptive that can also be used to prevent HIV/STIs. This is in order to create a broad appeal to men and women alike, since pregnancy prevention is easier to negotiate than disease prevention. It should be provided for free in the public sector and at the same price or lower than the male condom at retail and social marketing outlets.

Targeting to Specific, Well Defined Groups

Targeting involves identifying groups where the female condom is most likely to prevent new infections and where the male condom is not used consistently, such as commercial sex workers. The program should be designed to meet the specific needs of the group particularly in relation to positioning of the product, addressing specific barriers and ensuring easy access. Countries such as Zimbabwe have used research to define and target the “typical” female condom user:

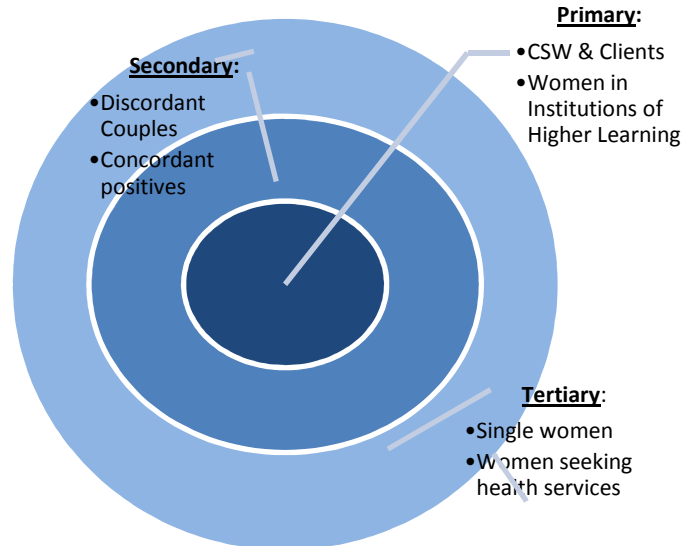
“A single woman, slightly older than 25 years, somewhat independent (i.e. does not entirely depend on men for support) and more likely to reside in the urban areas.”

The specific targets for the launch/pilot phase of the Uganda female condom program shown below are drawn from the following risk groups:

- People engaging in concurrent sexual partnerships
- Couples in stable relationships
- Sexually active women

Selection of targets was based on the epidemic profile in Uganda and research on groups in which the female condom is most effective.

The Female Condom: Primary, Secondary and Tertiary Targets



The female condom is most likely to prevent new infections in the primary and secondary target groups.

Implementing Through Multiple Provider Channels

Experience from different countries implies that the bulk of the female condom is likely to be distributed through non traditional outlets (Zimbabwe, Nigeria, Ghana, Malawi). These outlets, such as those based within communities (i.e. condom depots, community based distributors, peer educators) are in close proximity to clients and can provide condoms on an “as needed” basis unlike the traditional outlets that are not accessible, i.e. after hours and on weekends. Due to its extensive infrastructure, the health sector also plays an important role in reaching potential high risk clients when they come to seek health services. In view of this the female condom program should utilize a comprehensive approach that includes public sector facilities such as clinics, private sector (pharmacies and other retail outlets), social marketing and community involvement in both urban and rural areas.

Strengthening Integration of the Female Condom

As a starting point, the female condom should be made available in conjunction with the male condom. The female condom is most successful when integrated into HIV/STI Prevention and Sexual Reproductive Health services, namely:

- HIV counseling & testing
- STI services
- Positive prevention: PMTCT, ART, discordant couples
- Partner reduction programs
- Male circumcision when available
- Family Planning

Developing Innovative Promotion Strategies

Market research will be needed in order to guide the development of a culturally appealing and relevant marketing and communication strategy. A good starting point is branding the female condom and using attractive packaging such as the one developed by MSI in the previous program. Local research can be used to generate ideas on how to overcome a potential barrier, as described below:

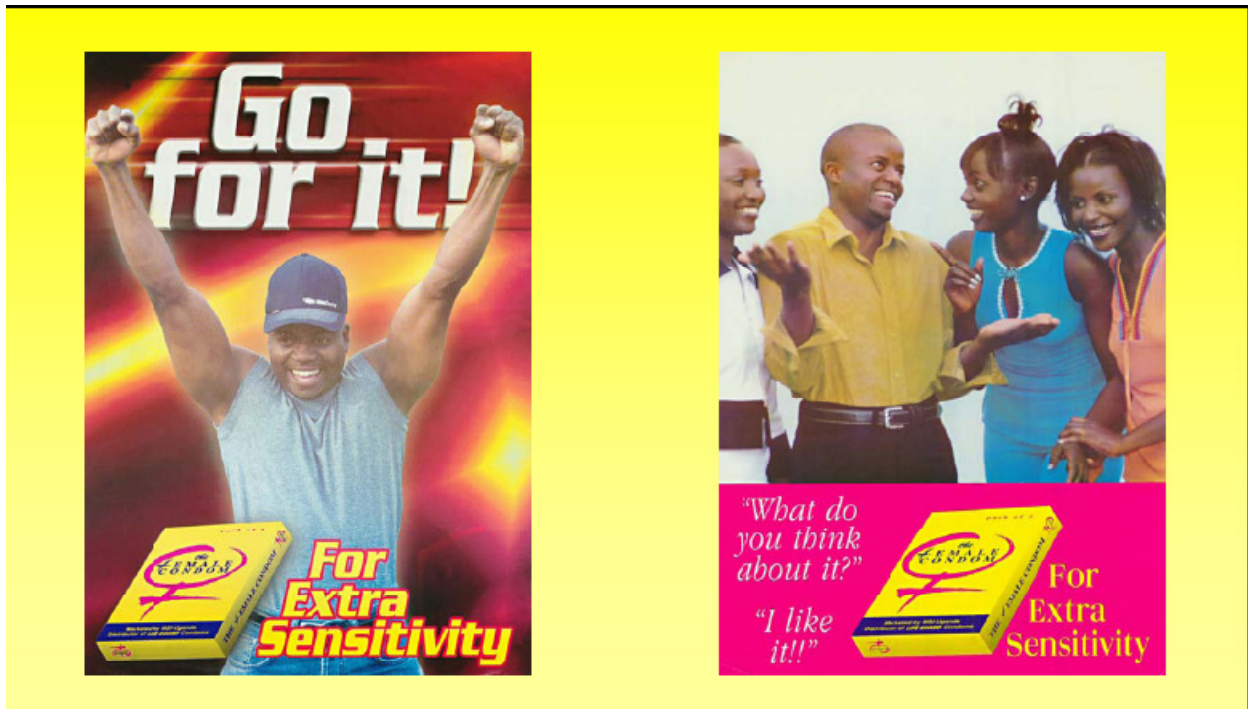
“In Senegal, the [female] condoms are sold with noisy bine bine beads, an erotic accessory that women wear around their hips. The rustle of the polyurethane during sex is now associated with the clicking of the beads—and so, a turn-on.”

— *The Sunday Independent*, 2005⁶

Mass media approaches (radio programs, peers, television advertisements, print media, community events and IEC materials) have been shown to be effective in social marketing and should be used to create awareness, address stigma and influence attitudes at population level. This should be coupled with one-on-one interpersonal communication at distribution points for product demonstration, touching and feeling of product, training on correct use, discussion on condom negotiation techniques and opportunity to address personal questions. Research has shown that women who were exposed to demonstrations are three times more likely to use the female condom. (PSI Zimbabwe).

Incorporating peer support through existing networks such as women’s groups, sex worker outreach programs and post-test clubs also provides opportunity to share ideas, testimonials and strategize on ways to overcome challenges in using the condom or negotiating with partners.

⁶ PATH, UNFPA. *Female Condom: A Powerful Tool for Protection*. Seattle: UNFPA, PATH; 2006.



Male involvement is a key success factor for all female condom programs and partner refusal is consistently cited as a major barrier to condom use. Promotion to males should identify benefits for men that resonate with the target audience, i.e. enhanced pleasure. Strategies to target and involve men will vary by sub-group and location, but include mass media campaigns (see above) and direct programming, i.e. through workplace peer programs, barber shops, bars, DVD dens, soccer clubs and other forums where men congregate.

Training Service Providers

It is important that target user’s are fully aware of what to expect with their first trial of the female condom and are confident enough to experiment with insertion and use until they are comfortable. This requires that they have:

- A. Skills to insert the condom properly
- B. Ability and confidence to negotiate use with partner(s)
- C. Adequate condom supplies/samples

Service providers have a direct and critical role to play in influencing A and B above. Users will access the female condom through these providers at different points: health facilities in the public sector, private clinics, retail stores, pharmacies in the private sector, multiple distribution points in the community such as condom depots, and community based distributors/volunteers (See below). Providers across all sectors should be trained to develop supportive attitudes and skills, using a Training of Trainers approach in order to develop a critical mass of skilled providers. A designated cadre of “master trainers” should provide follow-up support supervision to ensure consistency and quality of trainings.

Social marketers have successfully used Condom Promoters as a resource for service providers and clients alike. This is a small, highly trained group of marketers who provide strategic support to develop and sustain client interest by promoting integration of the condom, brainstorming with providers on how best to position the condom for different client groups, training clients directly and assisting with securing adequate supplies.

Potential Condom Outlets by Distribution Channel

User Group	Private and Social Marketing	NGO/Community-based Distribution (CBD)	Health Facilities
Women	Beauty salon, pharmacies	Women’s Organizations, Family Planning Distributors, PLHA support groups	Family Planning and Maternal Child Health clinics
Men	Barber shops, bars, pharmacies, soccer stadiums, street vendors, kiosks, petrol stations, hotels, restaurants	Workplace peer programs, condom vendors	STI and Primary Health Care clinics, factory clinics
Men away from Home	Bus terminals, roadside bars, army and police barracks, kiosks, hotels, nighttime vendors	CBD at hostels, bus terminals, workplace programs, condom vendors	Workplace clinics, military clinics,
Youth	Vending machines, kiosks, cinemas, festivals, drinking places, shopping centers,	Youth organizations, schools/colleges, peer educators	Youth friendly clinics, college clinics, nurses
Commercial Sex Workers	Brothels, bars, nightclubs, hotels	Sex workers trained in CBD/peer educators, condom vendors	Outreach clinics/services
Internally Displaced Persons		Refugees trained as health promoters, CBD agents	Clinics in refugee camps, mobile outreach, emergency relief packages

Adapted from UNFPA

Conducting Advocacy with Key Stakeholders

In general the condom is still subject to issues of stigma, lack of acceptance and support that are compounded in the case of the female condom, by cost, aesthetics and the inequity in sexual rights for women. There was a lot of skepticism among stakeholders at all levels (national, district and community) about user acceptance of the female condom and its viability as a public health intervention among women who are subject to significant socio-cultural and economic pressures. During in-depth interviews and at the Stakeholders Workshop there were lengthy discussions around cost, aesthetics, ease of use, acceptance and availability. Many of these stakeholders spoke passionately about the female condom in spite of the fact that the majority had not seen or touched one.

There are several categories of stakeholders who are critical to the successful planning, implementation and uptake of the female condom:

- AIDS Service Organizations
- Community Based Organizations
- Community Leaders
- District Level Officials
- Faith Based Leaders
- Politicians
- People Living With HIV
- Service Providers (at district and community level)
- Women's Groups/Advocates
- Government Ministries
- Development Partners

Advocacy with stakeholders should begin early, in this case representatives of the above group should be brought together during the strategy development process in order to build ownership of the female condom program. This female condom stakeholder's forum⁷ can be convened under the auspices of the Uganda AIDS Commission (UAC) and meet regularly to plan advocacy events and serve as a conduit to the different constituents they represent. (UAC already hosts a multi-sectoral partnership committee that includes donors). These groups would ideally participate in the national program launch and also organize their own individual female condom events and/or initiatives at the pilot district and community level.

Undertaking Operations Research

It is important to develop a monitoring and evaluation plan to track program outputs and outcomes and assess implementation progress. However, in order to increase potential for successful replication of the female condom in other settings it is necessary to conduct operations research to understand the social, cultural, economical and structural factors that influence female condom use or non-use. There is need for current data to identify what factors contribute to a successful female condom programs, as well as reasons for low uptake. The pilot will provide an opportunity to conduct comprehensive quantitative and qualitative research on the female condom in Uganda.

Research questions to address include the following:

- ✓ Who is a FC user?
- ✓ What are the levels of coverage, equity and access?
- ✓ What are the drivers of female condom use in Uganda?
- ✓ What are the best approaches to distribution of FC for specific targets?

⁷ This would be in addition to a Technical Working Group that would provide technical leadership and oversight.

- ✓ What type of service delivery model is suitable for highly vulnerable/special populations e.g. university/college students, mobile populations, uniformed forces, internally displaced persons?
- ✓ How do income, education, marital status, residence (rural/urban) and other variables affect uptake?
- ✓ What communication strategies can be adopted to overcome cultural barriers such as different sexual practices?
- ✓ What are innovative and culturally appropriate ways to involve men in female condom promotion?

Mobilizing Sustained Financial and Technical Support

Sufficient resources should be mobilized and allocated for introduction, marketing and implementation to ensure a successful trial. This can be done under the auspices of the Reproductive Health Commodities Securities Committee. Even more important is the urgent need to build support among current and potential stakeholders who are skeptical or unsure of the government's commitment to "go all the way" with the female condom, and to launch a program that will be sustained and scaled-up beyond the pilot phase.

Next Steps

Pre-launch (June 2009-August 2009):

15. Conduct quality testing on the female condom
16. Integrate the proposed female condom program design into the consolidated Reproductive Health Commodity Strategy
17. Establish a multi-sectoral technical sub-committee to spearhead planning and management of the female condom program
18. Engage key stakeholders under the leadership of the Uganda AIDS Commission
19. Disseminate the proposed strategic plan to stakeholders for feedback
20. Finalize selection of pilot district(s)
21. Finalize detailed Project Implementation plan
 - a. Identify funding to implement plan
 - b. Conduct market research to inform the design of the marketing and communication strategy
 - c. Develop a public sector promotion plan for high risk groups
 - d. Develop training protocol and culturally appropriate training materials
 - e. Conduct TOT for service providers in each pilot district
22. Develop and disseminate program management protocols – logistics and supply management, operational procedures, monitoring and evaluation
23. Train designated focal points for stakeholder institutions in program management protocols.

Launch (September 2009)

- 24. Launch the female condom in District 1.
- 25. Launch the female condom in District 2.

Post Launch (September 2009-August 2010)

- 26. Conduct operational research
 - a. Collect data to answer research questions
 - b. Monitor and evaluate
 - c. Adjust program in line with research findings
- 27. Review findings from operations research
- 28. Scale up the female condom program

Stakeholders Interviewed

- Reproductive Health Commodities Security Committee members
- Ministry of Health officials
- National Drug Authority
- Uganda AIDS Commission
- Family Planning Association of Uganda
- Bilateral and Multilateral Donors
 - UNFPA
 - WHO
 - World Bank
 - USAID
- International and National NGOs
 - PSI
 - MSI
 - UHMG
 - Deliver
- AIDS Service Organizations
 - AIC
 - TASO
- Advocacy Groups
 - Global Coalition of Women Against AIDS:
- Women's Groups
- Private Sector Providers
 - Uganda Private Midwives Association
- District Health Officials
 - West Nile - Arua
 - East - Mbale
 - North - Lira
 - West - Mbarara
 - Central – Mpigi, Kampala
- Uniformed Forces
 - Police
- Current and potential users of the Female Condom

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