Rapid Needs Assessment Tool for Condom Programming

PROGRAM REPORT

Population Council

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CONTENTS

RNAT Main Report

Executive Summary 2

I. The Development of a Rapid Needs Assessment Tool for Condom Programming
- A. Background and Justification 3
- B. Aims and Outputs 4
- C. Initial Development of the Tool 4

II. The Rapid Needs Assessment of Condom Programming
- A. Objectives 5
- B. Activities 5
- C. Brief Summary of Field Tests
  1. Bangladesh 8
  2. Brazil 8
  3. Ghana 9
  4. Kenya 9

III. Lessons Learned
- A. Lessons About Condom Programming 10
- B. Lessons About Implementing the Rapid Needs Assessment 11

Appendices: Rapid Needs Assessment for Condom Programming Tools

1. Introduction and Instructions
   for Using the Rapid Needs Assessment Tool for Condom Programming 14

2. Basic Forms
   - Form A. Condom Programming Documents Checklist 17
   - Form B. Data Collection Guideline for Condom Programming 18
   - Form C. List of Agencies and Programs Involved in Condom Programming 21
   - Form D. Major Means of HIV Transmission, Condom Programming Policy, and Coordination Issues 22
   - Form E. Interview Guidelines for Program Managers, Policy Makers and Others Involved in Condom Programming 23

3. Rapid Needs Assessment Presentation PowerPoint Template (RapidNA.ppt) 27

4. Optional Forms:
   - Form F. Observation of Condom Counselling and Education 33
   - Form G. Observation of Social Marketing Sites 34
   - Form H. Special Issues for Condom Procurement And Distribution Agencies 35
   - Form I. Special Issues for Donor Organizations 36

EXECUTIVE SUMMARY

The Population Council has worked collaboratively with UNFPA to develop and test a rapid needs assessment and data-gathering tool to serve as a basis within a country for improving condom programming (including both distribution and promotion of condoms) to prevent HIV transmission. The project has three objectives:

1. Development of a rapid needs assessment tool for condom programming, which includes development of guidelines for utilizing the tool (see appendices).
2. Pre-testing of the initial assessment tool in four countries.
3. Dissemination of the revised tool with accompanying guidelines.

The rapid needs assessment tool has been developed through collaborative work with an expert group, and pre-tested in four countries—Bangladesh, Brazil, Ghana, and Kenya. The current report presents the results of these assessments along with issues for consideration in the possible improvement of the needs assessment tool and the recommended process for using the tool.

The four reports conclude that while condoms are widely available, and condom use is generally increasing, there is much that could be done to improve their distribution, their promotion, and their utilization, especially among key target groups that are at a high risk for HIV. In all four countries, a significant bifurcation of condom programming was found between the distribution of condoms through family planning services and the promotion and distribution of condoms by HIV/AIDS prevention programs. Little coordination or joint planning of condom programming was found.

Overall, the rapid needs assessment tool was found to be valuable and easily adjusted to local circumstances. However, the current forms and process of the assessment tool have incorporated suggestions from field implementers as well as UNFPA collaborators that will strengthen its future implementation. The process of consulting key condom programming managers and policy makers led to the identification of problems and the next steps for solving them (which was an important objective of the tool). In fact, the rapid needs assessment's bringing together all of the stake holders involved in condom issues for mutual discussion of problems and potential solutions proved effective in all four countries.

This process of engagement, discussion, argument, and ultimately, consensus, was probably the most valuable aspect of the exercise. Despite strong efforts to create a *rapid* needs assessment exercise, in none of the countries could it be implemented within the time frame of the 7-10 days that was desired. While data gathering activities did not necessarily take a long time, the process of scheduling meetings and interviews with high level government officials required a far greater time frame than anticipated – approximately two months — due to travel schedules, local administrative crises, and holidays.

All RNA Report Files including Templates, Forms,
and Tools in various formats may be found both on the attached CD
and on the web at ***http://www.unfpa.org/hiv/index.htm***

RAPID NEEDS ASSESSMENT OF CONDOM PROGRAMMING

I. The Development of a Condom Programming Rapid Needs Assessment Tool

A. Background and Justification

Condoms have been used for both disease protection and pregnancy prevention for centuries but have not generally been widely used in most developing countries. The development of non-coital methods of contraception (methods that do not require their use only during the sex act) in the 1960s and 1970s led to a decline in condom use as the service providers in expanding family planning programmes around the world generally favoured oral contraceptives and provider controlled methods—male and female sterilization, IUDs, and injectable contraceptives. These methods were believed to have higher rates of use effectiveness in preventing pregnancies. Further, in medium and high prevalence countries, HIV/AIDS has now spread from the original high-risk populations to married men and women, while use of condoms has been mostly limited to male use in extramarital relations.

Beginning in the 1980s, with the outbreak of the HIV/AIDS pandemic, interest in condoms for dual protection (i.e., prevention of both sexually transmitted infections, including HIV/AIDS, and pregnancies) among reproductive health programme managers increased substantially. Condoms remain the most effective method of preventing disease transmission during sexual intercourse. The female condom has been recently introduced as another method conferring dual protection. Advocates have argued that this provides an important option that may be used by women when men are unwilling to use male condoms. Additionally, use of the female condom may confer to women to a sense of *empowerment* that may be otherwise lacking in societies with traditional gender relations.

While use of both male and female condoms have been increasing, mainly through commercial distribution in areas of high HIV/AIDS prevalence such as Eastern and Southern Africa, for a variety of reasons, use of condoms in public sector family planning programmes has been dramatically under-emphasized, under-programmed, and under-utilized compared to the very high levels of need. For example, situation analysis studies have shown that in Eastern and Southern African countries with high HIV/AIDS prevalence, such as Botswana (1992), Tanzania (1997), and Zambia (1997), only about half of new family planning clients had even heard *any mention* of condoms during family planning counselling, and that in Zimbabwe (1997) —a country with one of the highest rates of HIV/AIDS prevalence—only about one-fifth of new family planning clients had heard any mention of condoms.[1] (In contrast, about 80 percent of new clients are told about oral contraceptives.) Of even greater concern, the proportion of clients told about the (non) ability of their contraceptive to protect against HIV/AIDS, and the proportion of clients who actually receive condoms, is usually well under 10 percent. Service providers in most countries seem reluctant to discuss, recommend, and provide family planning methods and HIV/AIDS prevention methods—such as condoms— that require explicit discussion of sexual intercourse, especially where there is doubt about their efficacy.

In the age of HIV/AIDS, promoting increased male and female condom use is a multi-level challenge. Condom programming must address: governmental policies on condom promotion, advertising and access, as well as importation/customs/production decisions, logistical supply and distribution systems, social customs and gender relations, and relevant knowledge, attitudes, and behaviour of individuals, special groups, and the general population. Other important issues include the potential effectiveness of various condom promotion interventions and the level of the intervention to be targeted— individuals, couples, social networks, community institutions, the commercial sector/mass media, and government policy and administration.

A number of programs have attempted to integrate HIV/STI prevention into family planning and other reproductive health (RH) services. One program design integrates HIV prevention with family planning services, emphasizing the dual protection value of condom use[2]**.** While this approach may increase condom use, it is limited to the mainly married female clientele of family planning clinics, and doesn't effectively reach youth, unmarried women, and men—those at highest risk of HIV infection. It also has to deal with the negative attitudes toward condoms held by many family planning providers. Other efforts have attempted to integrate the treatment of STIs into family planning and other RH services. However, the treatment of STIs in this manner has proven to have serious limitations.[3] Others have attempted to integrate HIV prevention with antenatal services and with voluntary HIV testing.[4] While the integration strategy is considered a valid approach, recent operations research studies have emphasized the difficulties that need to be overcome to achieve RH services integration. In addition, these services do not typically serve those at highest risk for HIV/AIDS. Thus, additional and more focused approaches to condom promotion and distribution are necessary.

The present project, a collaborative effort between UNFPA and the Population Council, contributes to RH by engaging programme and policy personnel in an exercise to broadly explore the challenges and opportunities involved in increasing use of male and female condoms and establishing priorities for action.

Clearly, planning programmes to increase condom use is a complex task requiring a broad assessment of challenges, opportunities, efficacy of interventions, and a large number of target groups at many different levels. Beginning an organized, structured, multi-level approach to condom programming requires a method of assessing these challenges, opportunities, and needs arising from of all these various factors. A rapid needs assessment tool and process for implementing it are critical to this process.

Various tools exist that assess particular components of condom programming needs, but there is no single tool that adequately and comprehensively covers all programming needs. This project is designed to create such a tool.

B. Aims and Outputs

This project aimed to prevent STIs/HIV through increasing access to and use of condoms. The Population Council worked collaboratively with UNFPA to develop and test a comprehensive needs assessment tool to serve as a basis within a country for condom programming to prevent HIV transmission. The project has three outputs:

1. Development of a rapid needs assessment tool for condom programming, which includes development of guidelines for utilizing the tool (see Appendices).
2. Pre-testing of the initial assessment tool in four countries.
3. Dissemination of the revised tool with accompanying guidelines.

The rapid needs assessment provides the foundation for assessing countries' perceptions regarding the importance and feasibility as well as the status of condom programming to guide its further development and improve condom use for HIV prevention.

C. Initial Development of the Tool

For the development of the needs assessment tool, a small consultative group of managers, policy makers, and researchers, including Population Council, UNFPA and others, were brought together on 22-23 August, 2002, to review a synthesis of the background factors, prioritise problems and barriers, and advise on potential programmatic interventions to strengthen condom use. (See Box 1 for members of this consultative group)

Based on this consultative process, an approach was selected to gather information about condoms, the extent of condom programming, barriers to condom use, quality assurance procedures, and improving condom programming. Initially the recommendations from the consultative group were substantial and comprehensive. But recognizing that there would be less chance of successful diffusion for a complex tool that required many months to implement, UNFPA suggested that the Population Council try to streamline the tool, and develop a process of use that would only take from seven to 10 days.

Following this guidance from UNFPA, a generic tool was developed that was adaptable to the HIV prevention and condom promotion programmes in each country through in-country group process mechanisms involving a variety of stakeholders—key programme and policy managers, service providers, procurement agents, and researchers. Guidelines explained:

1. How to adapt the tool to each country to address the particular condom programming conditions in the country. For example, procurement in one country might be conducted by a single source, whereas elsewhere there could be multiple procurement entities, and,

2. How to conduct the in-country consultative process.

The two fundamental considerations guiding the development of the tool and the process of using it were: the speed and cost-effectiveness of the needs assessment process, and the feasibility of efficient and cost-effective diffusion of the results of the tool.

(Footnotes)

[1] Miller, K., R. Miller, I. Askew, M. Horn, and L. Ndhlovu. Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies. Population Council, New York. 1998

[2] Adeokun, Laurence, J. Mantell, E. Weiss, G. Delano, T. Jagha, J. Olatoregun, D. Udo, S. Akinso, and E. Weiss, "Promoting Dual Protection in Family Planning Clinics in Ibadan, Nigeria". International Family Planning Perspectives. June, 2002.

[3] Askew, Ian, Goli Fassihian, and Ndugga Maggwa, 1998. "Integrating STI andHIV/AIDS Services at MCH/Family Planning Clinics," in Miller, Kate et al., op cit.

[4] Maggwa, Ndugga, Naomi Rutenberg, and Ian Askew, 1997. Integrating STI/HIV Management Strategies into Existing MCH/FP Programs: Lessons from Case Studies in East and Southern Africa. Africa Operations Research and Technical Assistance Project II, Population Council, Nairobi, Kenya

II. The Rapid Needs Assessment of Condom Programming

A. Objectives

The goal of the rapid needs assessment within each country is to identify the priority "next steps" to improve condom programming to prevent HIV transmission in the country of focus. The specific objectives of the rapid needs assessment are to:

1. Identify and engage key program managers and policy makers in improving condom programming.

2. Describe the current status of condom programming, including the level of policy support and the adequacy and sustainability of condom procurement and supply.

3. Identify the main sexual and other practices that influence HIV transmission.

4. Identify the conditions (knowledge, attitudes, geographic, economic and social) that facilitate and hinder condom use.

5. Identify the most pressing needs for improving condom programming.

B. Activities

The rapid needs assessment (RNA) is designed as an activity that takes approximately two weeks of full-time data gathering to accomplish, though the time period for the completed activity, including meetings and write-up, is likely to take approximately two months. The short implementation period is designed to encourage its utilization and implementation by government, NGOs and other organizations and agencies dedicated

Box 1

Consultative Development Group

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to HIV prevention through condom programming. The RNA concentrates on obtaining information within specific boundaries, i.e., only that required for the assessment's goal — identifying the next steps considered priorities for improving condom programming. (A comprehensive assessment of all factors that may inhibit or promote condom programming or HIV transmission is not the intention of this rapid needs assessment, though it might ultimately result from the initial RNA.)

1. The first task is to arrange for someone with expertise in demography, social sciences, or related fields, and experience in condom programming and/or HIV prevention to coordinate and direct the Rapid Needs Assessment for Condom Programming.

2. The RNA Coordinator should begin by collecting background information available from the internet and other sources. The **Condom Programming Documents Checklist** (See *Form A: Condom Programming Documents Checklist*) is to be a listing of all national surveys, specialized studies, program description and evaluation reports, and any other documents that will assist the assessment of condom programming in the country. This list can be completed at the meeting described below and at subsequent interviews.

3. The Coordinator should begin to summarize the information available in HIV and condom studies and program evaluations utilizing the **Data Collection Guideline For Condom Programming**. (See *Form B: Data Collection Guideline For Condom Programming.)* Further information will likely be obtained through the meetings and interviews described below.

4. The RNA Coordinator should also identify the persons responsible for condom programming activities in the country, and make a list (See *Form C: List of Agencies and Programs Involved in Condom Programming),* including contact information, of the 10 to 15 key program managers, policy makers and others most responsible for and knowledgeable of condom programming**.** Initial consultations with one or two knowledgeable persons may be necessary to gather these names. This **List of Agencies and Programs Involved in Condom Programming** will probably include individuals from:
   a. Official AIDS organizations/units
   b. Government (Ministry Of Health, outside of MOH)
   c. AIDS NGOs (including special condom programs for youth, sex workers, truck drivers, etc.)
   d. Family planning NGOs
   e. Social marketing organizations that distribute condoms
   f. Major commercial condom distributors
   g. University or other special condom programming/HIV prevention researchers

5. The Coordinator should then arrange for and hold a 2 to 4 hour initial meeting with the above individuals—to be known as the **Ad Hoc Expert Committee on Condom Programming** —to:
   a. Review the objectives and process of the rapid needs assessment (distributing this *Introduction and Instructions for Using the RNA).*
   b. Provide self-introductions, briefly describing involvement in condom programming and HIV prevention.
   c. Obtain feedback on the assessment process, and commitment for participation in the needs assessment.
   d. Review and add to the checklist of relevant documents/ studies/ evaluations (*Form A*: *Condom Programming Documents Checklist*)
   e. Distribute, review and complete the list of condom agencies and programs (*Form C*: *List of Agencies and Programs Involved in Condom Programming)*
   f. Identify a set of 7 to 10 agencies and persons to be visited in the next 2-4 weeks. Make appointments for a 1-2 hour visit with each to interview the key program managers and policy makers (including those invited who were unable to attend the meeting), to obtain reports about their condom programming efforts, and, if time permits, to observe their program activities.
   g. Engage in a focused discussion of the following three topics:
      i. What are the major means of HIV transmission in the country?
      ii. What are the current policies relevant to condom promotion and distribution?
      iii. Is there any coordination of condom promotion/distribution activities? If so, where, how?

      (See **Form D: Major Means of HIV Transmission, Condom Programming Policy, and Coordination Issues**)

h. Arrange for a follow-up meeting one-month later (or when the assessment is complete) with the same individuals (including those invited who were unable to attend the initial meeting) to discuss results of the assessment.

6. The RNA Coordinator should arrange to interview and visit the 7-10 agencies/persons previously selected utilizing **Form E: Interview Guidelines For Program Managers, Policy Makers And Others Involved In Condom Programming**. (If a representative of the agency was not at the initial assessment planning meeting, the respondent should also be asked the questions of *Form D: Major Means of HIV Transmission, Condom Programming Policy, and Coordination Issues.*) At these interviews and site visits, a number of **options** are available to the Coordinator for obtaining additional information depending upon the amount of time the consultant has available and the likely importance of the information to the overall assessment. These options include the following short forms (which are not pre-tested):

a. Observation of clinical, counselling, or educational activities
(See Form F: Observation of Condom Counselling and Education)

b. Observation of social marketing sites
(See Form G: Observation of Social Marketing Sites**)**

c. Documentation of the condom procurement and distribution process
(See Form H: Special Issues for Condom Procurement And Distribution Agencies**)**

d. Documentation of the donor support process
(See Form I: Special Issues for Donor Organizations**.)**

7. The Coordinator should hold a follow-up meeting of the Ad Hoc Expert Committee on Condom Programming:

a. As a foundation for the follow-up meeting discussion, the Coordinator could use the **PowerPoint Presentation Template** (see **RapidNA.ppt**) to summarize the available information collected from the internet sources, other documents, observations, and interviews. A critical note is to recognize that the power point template is meant only as a *guide*, and is expected to be and should be modified according to the information obtained and the country context.

b. Background and program information that has been gathered should be reviewed and discussed at the meeting, using either the RapidNA.ppt or another presentation format.

c. The group should then identify what it perceives are the country's priority needs or next steps for improving condom programming for HIV prevention. These next steps could include the dissemination of a report of the rapid needs assessment of condom programming, additional meetings of the Ad Hoc Expert Committee, or even a more comprehensive condom programming assessment.

d. If possible, the group should develop a Work Plan (specifying what needs to be done and who will do it) for accomplishing the recommended next steps.

An alternative approach was utilized in Brazil (see the **Brazil** final report on the attached CD and on http://www.unfpa.org/hiv/index.htm: **Rapid Needs Assessment Tool for Condom Programming**). The consultant prepared a substantial background document on condom programming in Brazil utilizing studies, program descriptions, evaluations, and internet and other sources. He then sent this report to15 to 20 key condom programming policy makers and program managers from throughout Brazil and invited them to come together for three days to discuss the report and make recommendations for improving condom programming. During the three days, he also met with each person individually to discuss the details of their program activities. While this methodology has limitations, it can result in a very useful needs assessment if the consultant is initially very well versed in the issues of condom programming and can prepare a well-researched background document

C. Brief Summary of Field Tests

Four countries were selected to test the tool: two in Africa, Ghana and Kenya, one in Asia, Bangladesh, and one in Latin America, Brazil. These countries cover different regions and offer a diversity of conditions for of condom programming. The field tests were implemented in a two-stage process, where an initial test was conducted in a single country, Bangladesh, after which researchers planned to modify the tool as necessary and test it in the remaining three countries.

A brief summary of each of the field tests is presented below. The full Country Reports along with PowerPoint Presentations (both prepared by local experts) are presented in the attached CD and on the website - *http://www.unfpa.org/hiv/index.htm*.

1. Bangladesh:

In Bangladesh, with minimum levels of HIV/AIDS, condoms were seen basically as part of the family planning services. There is still an overwhelming family planning focus to condom programming in Bangladesh and there is little program coordination between the family planning programs and HIV/AIDS prevention efforts. Condom use has been rising mainly due to a very effective social marketing condom program that reaches all corners of Bangladesh and provides 70% of all condoms distributed in the country. The social marketing program provides condoms at low cost in many thousands of outlets throughout the country. In addition, the government provides condoms at no cost through its clinics and other family planning programs. However, a large number of NGOs have begun AIDS awareness activities, especially with high-risk target groups, such as commercial sex workers.

While the national HIV prevalence is extremely low, it is rising in commercial sex workers of both sexes, and is a threat in border areas neighbouring countries and regions with much higher prevalence such as Burma and the hill states in India. Bangladesh has had condom stockouts/shortages in government programs due to inadequate policies, planning, and procurement and due to the total reliance on donors for condom supplies. In fact, donors prohibit the purchase of locally manufactured condoms.

The results of the rapid needs assessment were presented to a large and appreciative audience of government, NGO, and donor representatives through a PowerPoint presentation. A substantive discussion of the problems and needs of condom programming resulted in a major decision by the government to allow 10% of condom stocks to be committed to AIDS prevention condom use (condom stocks were previously universally allocated to family planning program use).

2. Brazil:

Brazil is a large diverse country with a moderate HIV prevalence that is being reduced by strong government and NGO programs, including the treatment of persons living with AIDS. In Brazil, condoms were also relatively neglected by the family planning program, though HIV prevalence has been decreasing and condom use rising through a social marketing program and efforts by a large number of government, NGO, industry, and community-based AIDS prevention programs. It has recently expanded the central financial support provided to HIV/AIDS programs throughout the country. Despite its being a Catholic country, there has been no significant Catholic opposition to AIDS prevention programs and the promotion of condoms. The main HIV problem is found in special populations of the poor, youth, men who have sex with men (MSM), prisoners, migrant workers, truck drivers, soldiers, and, especially, sex workers.

The assessment identified the need for increasing the specialized education and condom distribution programs to these target groups. However, there is still a major separation between family planning and AIDS programs which create problems of coordination and result in inadequate program planning (Brazil has a very widespread government family planning program). The needs assessment led to the identification of the need for training of health/family planning providers in condom education and promotion and the dual protection focus of condom use.

Brazil utilized a different approach to the assessment process. Because of its large size and the disbursement of relevant key informants throughout the country, a three-day meeting was organized in the capital at which the participants discussed a comprehensive background document that had been previously sent to them, suggested additions and revisions in it, and developed recommendations for improving condom programming. Participants were also interviewed individually during the three-day period.

3. Ghana:

Ghana has a substantial level of HIV prevalence, though it is much lower than that found in East and Southern Africa. Commercial sex workers and migrant workers are target high risk groups. Condom use has increased significantly over the last five years. Here, the main reasons seem to be a social marketing program and many AIDS prevention programs developed across a span of NGO, industry, and government agencies.

While many government and NGO agencies are involved, little coordination and joint planning takes place. Other than the family planning services, programs are relatively small scale and new, and dominated by a large number of donor/external agencies.

There has been little integration of family planning and AIDS prevention programming, and this requires further effort to develop more effective condom programming for HIV prevention. While there is a condom social marketing program, it needs to be expanded. The assessment report was presented to a key group of policy makers and program managers and generated substantial questions about condom programming which awaits further clarification. A further meeting is planned to focus on these questions.

4. Kenya:

While Kenya has a very high prevalence of HIV (though lower than the countries in Eastern and Southern Africa), the prevalence has begun to come down in the last three years and condom use has been increasing. Despite being relatively neglected by the family planning programs, condoms are still being made available throughout Kenya by family planning clinics, community-based distribution programs, local AIDS prevention agencies, and a widespread social marketing program.

An identified major problem is that most married couples do not know when one partner is HIV positive. This situation suggests the need for both AIDS prevention education activities along with widespread HIV voluntary counselling and testing. Youth are also a major target group, as sexual activity begins at a relatively young age. Other target groups were identified as young women, and sex workers.

A condom social marketing program exists, along with very many family planning clinic and CBD programs. A major problem is that a large number of people (estimated at 50% of the population) do not believe that the condom is effective in preventing AIDS. This is due, in large part, to very active religious opposition to condom programming by both Catholic and other leaders who spread this message. The Government has not supported active and frank condom promotion on a large scale. It has also had problems in procuring and distributing adequate supplies of condoms. New political leaders may offer hope for more openness.

The assessment exercise was concluded with a PowerPoint presentation that identified the problems in condom promotion and distribution. It was well received and is likely to lead to meaningful changes if planned dissemination plans are carried out.

III. Lessons Learned

A. Lessons About Condom Programming

The following are some of the major lessons learned about condom promotion and distribution from the pre-test of the Rapid Assessment of Condom Programming:

1. **Condom use is increasing and social marketing is a major factor:** All four countries investigated in the pre-test had substantial condom distribution and promotion activities, though each was different. In Bangladesh, with minimum levels of HIV/AIDS, condoms were seen basically as part of the family planning services. Though they were relatively neglected by these programs, at the same time, condom use has been rising mainly due to a very effective social marketing condom program that reaches all corners of Bangladesh and provides 70% of all condoms distributed in the country. In Brazil, condoms were also relatively neglected by the family planning program, though HIV prevalence has been decreasing and condom use rising through a social marketing program and efforts by a large number of government, NGO, industry, and community-based AIDS prevention programs. In Ghana, which has a low (for Africa) but rising prevalence of HIV, condom use has increased significantly over the last five years. Here, the main reasons seem to be a social marketing program and many AIDS prevention programs developed across a span of NGO, industry, and government agencies. Finally, in Kenya, with a fairly high prevalence of HIV, condom use has been rising as the level of HIV has begun to come down. Despite being neglected by the family planning programs, condoms are still being made available throughout Kenya by family planning clinics, community-based distribution programs, local AIDS prevention agencies, and a widespread social marketing program.

2. **Separating Condom Programming into HIV/AIDS Prevention and Family Planning:** The bifurcation of condom programming into family planning and HIV/AIDS prevention objectives was found in every country. This is seen very clearly in all of the assessments where AIDS prevention program managers know little of the family planning services role in condom promotion and FP program managers, likewise, know little of the practices of AIDS prevention programs. As a result, the agencies and individuals that play key roles in condom promotion and distribution do not typically collaborate either in planning or implementation. For example, in Bangladesh, the needs assessment process introduced the idea of comprehensive condom programming (incorporating both HIV/AIDS prevention and family planning) when it was previously entirely focused on family planning. Further, as the consultant who carried out the Ghana assessment indicated, the use of a condom for family planning, at the same time prevents HIV transmission:

   > *From the point of view of service provision, condom use should be seen more for its dual protection function than solely for HIV prevention. Moreover, in practice, condom programming for HIV prevention is not separated from that of FP. Therefore, the study title should not focus on HIV prevention but condom programming in general. (Ghana report)*

3. **Dual Protection:** In the four countries where the needs assessment was pre-tested, it was found that substantial condom education and distribution takes place within the framework of family planning services. However, it was found that condom promotion in family planning services requires strengthening before these services can fulfil their potential to become an effective participant in HIV/AIDS prevention efforts. It is not at all clear that family planning providers are even encouraging condom use; by emphasizing the most highly effective contraceptive methods, and ignoring the need for dual protection, providers may actually be discouraging condom use. As the consultant in Brazil found:

   > *Although the prevalence of the use of contraception in Brazil is fairly high, the concept of dual protection is not very well understood in the population, or by health service providers either. Moreover, the high prevalence of sterilization which reaches almost 40% among women in their reproductive years, may create a false illusion in a woman (and the couple) that they are adequately protected, forgetting the possibility of their contracting STIs and HIV. Service providers have received very little, or in some cases, no orientation to offer dual protection to all women and men who ask for a contraceptive method. (Brazil Report)*

4. **The Rapid Assessment was a first step in comprehensive condom programming:** A very important result of the Rapid Assessment was its getting all of the participants in condom programming together to discuss the problems they face. All four country assessments resulted in positive actions that will further condom promotion and distribution. In most cases, this broad perspective on condom programming previously had not been addressed within the countries and was strongly appreciated by the participants in the assessment.

B. Lessons About Implementing the Rapid Needs Assessment

1. **The amount of time required for a Rapid Needs Assessment:** UNFPA requested that the Population Council produce a tool that could be implemented in a 7-10 day exercise. Similarly, our request to the consultants in each of the four countries was for an assessment within this rapid time frame. However, our experience was that it took a relatively long time (up to one month) to schedule the initial meeting of key policy makers and program managers. It also took significant time (up to another month) to schedule interview meetings with all of the key participants, and finally, after the summarization of information, it took more time to schedule the final dissemination meeting. The delays were due to busy schedules, travel of the key informants, an administrative crisis that demanded the full attention of our key participants, as well as local holidays.

   Despite the fact that Population Council staff and consultants strived to develop a tool that could be used in a rapid time frame, clearly, our experience demonstrates that the tool and the procedures recommended took longer than UNFPA had requested in actual field conditions. Keeping in mind that the participation of and interaction among key participants was crucial to a substantive and meaningful outcome of the assessment, it is not clear how an effective assessment can be completed in the requested time frame. This discussion and interaction may have been the most valuable aspect of the assessment. Our experience suggests that it would be difficult to expect a completed assessment in less than two months, at the very best. As the Kenya consultant stated:

   > *To complete the rapid assessment in a country like Kenya in a couple of weeks proved to be difficult. The risk is that you will have over-representation of "vested interests" parties and not necessarily the institutions that need ownership of the process and output. Several respondents felt that this type of exercise should not be rushed. The task of interviewing the key players, often the program/country directors of large organizations, took longer than the two weeks. Not surprisingly, it proved particularly difficult to schedule meetings with the key players from the Ministry of Health and other government departments within a short space of time. More than three weeks is clearly needed for the Assessment. (Kenya Report)*

   Only in Brazil was the field component and interviewing of key informants completed within a week (three days of meetings). However, the writing of a background paper (review of the literature and of condom programming in Brazil) took over a month and the final report of the assessment also took over a month. The review of information is a component of the assessment that is essential to identification of priority needs; a final report of the pre-test was mandatory to evaluate the assessment tools, but is not required to fulfil the objective of the assessment (identification of priority needs and stimulation of actions to respond to those needs). Finally, we also have to consider the roles of the tool, the consultant, and the implementing agency in determining the length of time required for the assessment.

   a. **The length of the tool:** Is there something in the tool that contributed to the length of time required for the assessment? Clearly, the length of the tool and the number and difficulty of the questions therein are related to the overall length of time required for the assessment. However, we do not feel that the length of the instrument was the determining factor in the period of time required for the overall assessment. Overall, the tool was found to be appropriate and easily adjusted to local circumstances. Of course, some reductions in the amount of information requested may be appropriate. On the other hand, some additions may also be recommended. In the pre-tests, these adjustments were made as was felt appropriate.

   b. **Selection of local consultant:** The selection of an experienced local consultant is the key to an effective and comprehensive report. It is probably necessary to provide better guidelines for this in the tool itself. We previously emphasized that a doctoral degree in demography or

social science was necessary. We now see that the Rapid Needs Assessment is not only a data gathering activity but it is primarily an organizational and group process endeavour. In two of the pre-tests, the management of the assessment exercise was significantly facilitated by the consultant's exposure to and work experience in condom programming and HIV prevention.

c. The implementing agency: A factor influencing the length of time needed for the assessment may be the implementing person or agency. Options include an independent consultant, a UNFPA staff, or the staff of an outside organization — either an HIV/AIDS or RH agency. In three countries, the pre-tests were managed by requesting a Population Council expert in the Council's country office to appoint and supervise a local consultant to conduct the Rapid Needs Assessment. In Ghana, we contracted with the Health Research Unit of the MOH to select and supervise the consultant, though a Population Council staff member also played a facilitative role. Although we requested and received supportive letters from UNFPA NY to UNFPA country offices, it is possible that direct implementation by UNFPA – a major and influential donor agency – might have generated more responsiveness from the assessment participants and thereby reduced the time necessary for the entire exercise. It is also possible that implementation by a key HIV/AIDS donor or implementing agency also might have resulted in greater responsiveness from participants.

2. Possible adjustments and modifications to the tool and the process

The pre-test resulted in a number of suggestions offered by the consultants who implemented the rapid needs assessments in the four selected countries. The following are their main comments. These issues have been taken into account in a revision of the assessment process and in the revised forms that accompany this report.

a. Organizational issues: Several consultants felt that there was a need to place more emphasis on a series of organizational issues. These included which parts of the government are involved in any aspect of condom programming, what is the hierarchy of agencies and departments involved, the role of NGOs, and, especially, the role of donors and their supported external (to the country) and internal funding recipients. An assessment could also be made of the degree to which the organizational capability for effective condom programming exists within the country. Comments of one consultant were particularly relevant:

> More emphasis is needed to assess and identify the degree of coordination, duplication, and fragmentation of condom programs. For example, it would be useful to know how many different projects dealing with HIV are currently being funded by the donors as well as any that may be in the pipeline. For these latter projects, what are their objectives and how do they differ from what is currently ongoing? In addition, it would be worth knowing how much funds and resources are being channelled through NGOs versus how much is going to government agencies. Finally, it would be worth knowing government perceptions about the roles of donors and their projects with regards to coordination, duplication of effort, and the sustainability of projects. (Kenya Report)

b. Strategies for implementing the assessment: Improvements could be made in the selection of key informants used by the consultants for the investigation and interviewing. While it is appropriate to initially get an overview of the condom-programming situation, it would be worthwhile to then focus in on agencies that implement local programs to see the substance of condom programming. These can include family planning services, social marketing programs, and programs by NGOs aimed at high risk populations. In some of the assessments, it appeared that too little attention was directed at local service delivery, or, if local programs were examined, their documentation was not covered in the final reports.

c. Trying to separate HIV/AIDS from family planning condom programming was confusing: Our recommendation is that the questions in the tool should eliminate the phrase, "for HIV/AIDS prevention", after the words, "condom programming" because all condom use, whether for HIV prevention directly or for family planning purposes, contributes to HIV prevention. This led

to confusion on the part of some consultants who were not clear that the assignment included their investigating and assessing condom promotion and distribution by family planning agencies and services. Thus, while the purpose of the exercise is to further condom use to prevent HIV/STI transmission, the investigation in the field needs to look at all condom promotion and distribution, whether carried out by FP programs or AIDS prevention programs. Further, this distinction in programs, by itself, hinders more effective condom promotion, distribution and use.

d. Developing a Work Plan: None of the assessments included the development of a Work Plan for the accomplishment of activities to meet the identified priorities in condom programming. It appears the Work Plan was beyond the capability of the current field-testing of the assessment tool.

e. PowerPoint presentations: In some countries (Bangladesh and Kenya), a Power Point slide presentation summarizing the information obtained in the condom needs assessment was presented to the participants in the assessment. In the other two countries, the consultants were more comfortable in preparing a Microsoft Word written report of the assessment. Although we envisioned that the PowerPoint presentation would be more effective, other countries were able to move the process forward simply developing a Word document.

f. Epidemiological and other assessment topics: To reduce the scope of the required assessment, less emphasis might be placed on epidemiological information, such as the incidence rates of HIV and STI infection in different target groups and the numbers of persons involved. Other areas where the information requested could be limited include:

- Years of involvement in condom programming/HIV prevention: (Difficult to ascertain.)
- Geographic coverage areas: (Accurate and comprehensive mapping of coverage is beyond the scope of this rapid assessment.)
- Target Populations: (The answers given to questions about target populations did not provide particularly useful information on who is not covered by the current programs. Special studies are probably needed here.)

g. Overview of condom distribution and use: Not all of the assessments contained an adequate overview of condom use in the country. This should include, where the information is available, the number of condoms distributed or used and the proportion of different target groups (married men and women, single men and women or youth, sex workers, truck drivers or other mobile workers, etc.) that use condoms. All of the main sources of condom distribution and the role they play in overall condom use should also be documented. Other relevant questions include:

- How are condom procurement needs estimated and what are the assumptions?
- What procedures are followed in the procurement of the condoms and who are the key players?
- Who distributes the condoms? What is their procedure for getting supplies and what difficulties do they face in obtaining the required supplies?
- Do stock-outs occur? Is this a supply problem, an inadequate procurement problem, or simply inefficiency on the part of the organizations themselves?

h. How much background data is necessary? In the rapid assessment one question that became important is, "How much background data is necessary?" The challenge is clearly to provide sufficient information to give the "big picture" while not necessarily becoming overwhelmed with detail. A further challenge is to find some balance between the readily available data and the lack or absence of key data. Some consultants had difficulties obtaining all of the background material and studies that had been done and were relevant to a condom programming assessment. Some local consultants recommended that a more efficient methodology would be for someone at a central location to gather the references and background information that are relevant to each country and send this out to each country doing an assessment. The local consultant would then only have to add to this the research results and documents that are only locally available. An exception is in a country like Brazil where there is a lot of information easily accessible through the internet and publications. Even where substantial information exists, it may be relatively unavailable due to difficulties in internet communications and limited distribution of program reports.

APPENDIX 1

INTRODUCTION AND INSTRUCTIONS FOR USING THE RAPID NEEDS ASSESSMENT TOOL FOR CONDOM PROGRAMMING

Objectives

The goal of the rapid needs assessment (RNA) is to identify the priority "next steps" to improve condom programming to prevent HIV transmission in the country of focus. The specific objectives of the RNA are to:

1. Identify and engage key program managers and policy makers in improving condom programming.
2. Describe the current status of condom programming, including the level of policy support and the adequacy and sustainability of condom procurement and supply.
3. Identify the main sexual and other practices that influence HIV transmission.
4. Identify the conditions (knowledge, attitudes, geographic, economic and social) that facilitate and hinder condom use.
5. Identify the most pressing needs for improving condom programming.

The rapid needs assessment is designed as an activity that takes approximately two weeks of full-time data gathering to accomplish, though the time period for the completed activity, including meetings and write-up, is likely to take approximately two months. The short implementation period is designed to encourage its utilization and implementation by government, NGOs and other organizations and agencies dedicated to HIV prevention through condom programming. The RNA concentrates on obtaining information within specific boundaries, i.e., only that required for the assessment's goal — identifying the next steps considered priorities for improving condom programming. (A comprehensive assessment of all factors that may inhibit or promote condom programming or HIV transmission is not the intention of this rapid needs assessment, though it might ultimately result from the initial RNA.)

Activities

The rapid needs assessment is to be implemented by an **Ad Hoc Expert Committee on Condom Programming** that is to be coordinated by a person who will be responsible for carrying out the assessment.

1. The first task is to arrange for someone with expertise in demography, social sciences, or related fields, and experience in condom programming and/or HIV prevention to coordinate and direct the Rapid Needs Assessment for Condom Programming.
2. The RNA Coordinator should begin by collecting background information available from the internet and other sources. The **Condom Programming Documents Checklist** (See *Form A: Condom Programming Documents Checklist*) is to be a listing of all national surveys, specialized studies, program description and evaluation reports, and any other documents that will assist the assessment of condom programming in the country. This list can be completed at the meeting described below and at subsequent interviews.
3. The Coordinator should begin to summarize the information available in HIV and condom studies and program evaluations utilizing the **Data Collection Guideline For Condom Programming**. (See *Form B: Data Collection Guideline For Condom Programming.)* Further information will likely be obtained through the meetings and interviews described below.

4. The RNA Coordinator should also identify the persons responsible for condom programming activities in the country, and make a list (See *Form C: List of Agencies and Programs Involved in Condom Programming),* including contact information, of the 10 to 15 key program managers, policy makers and others most responsible for and knowledgeable of condom programming**.** Initial consultations with one or two knowledgeable persons may be necessary to gather these names. This **List of Agencies and Programs Involved in Condom Programming** will probably include individuals from:

    a. Official AIDS organizations/units

    b. Government (Ministry Of Health, outside of MOH)

    c. AIDS NGOs (including special condom programs for youth, sex workers, truck drivers, etc.)

    d. Family planning NGOs

    e. Social marketing organizations that distribute condoms

    f. Major commercial condom distributors

    g. University or other special condom programming/HIV prevention researchers

5. The Coordinator should then arrange for and hold a 2 to 4 hour initial meeting with the above individuals—to be known as the **Ad Hoc Expert Committee on Condom Programming** —to:

    a. Review the objectives and process of the rapid needs assessment (distributing this *Introduction and Instructions for Using the RNA).*

    b. Provide self-introductions, briefly describing involvement in condom programming and HIV prevention.

    c. Obtain feedback on the assessment process, and commitment for participation in the needs assessment.

    d. Review and add to the checklist of relevant documents/ studies/ evaluations (*Form A*: *Condom Programming Documents Checklist*)

    e. Distribute, review and complete the list of condom agencies and programs (*Form C*: *List of Agencies and Programs Involved in Condom Programming*

    f. Identify a set of 7 to 10 agencies and persons to be visited in the next 2-4 weeks. Make appointments for a 1-2 hour visit with each to interview the key program managers and policy makers (including those invited who were unable to attend the meeting), to obtain reports about their condom programming efforts, and, if time permits, to observe their program activities.

    g. Engage in a focused discussion of the following three topics:

        i. What are the major means of HIV transmission in the country?

        ii. What are the current policies relevant to condom promotion and distribution?

        iii. Is there any coordination of condom promotion/ distribution activities? If so, where, how?

        (See **Form D: Major Means of HIV Transmission, Condom Programming Policy, and Coordination Issues**)

    h. Arrange for a follow-up meeting one-month later (or when the assessment is complete) with the same individuals (including those invited who were unable to attend the initial meeting) to discuss results of the assessment.

6. The RNA Coordinator should arrange to interview and visit the 7-10 agencies/persons previously selected utilizing **Form E: Interview Guidelines For Program Managers, Policy Makers And Others Involved In Condom Programming**. (If a representative of the agency was not at the initial assessment planning meeting, the respondent should also be asked the questions of *Form D: Major Means of HIV Transmission, Condom Programming Policy, and Coordination Issues.*) At these interviews and site visits, a number of additional options are available to the Coordinator depending upon the

amount of time he has available and the likely importance of the information to the overall assessment. These options are suggested to obtain additional information if desirable, and include the following short forms (which are not pre-tested):

a. Observation of clinical, counselling, or educational activities (See Form F: Observation of Condom Counselling and Education)

b. Observation of social marketing sites (See Form G: Observation of Social Marketing Sites**)**

c. Observation of the condom procurement and distribution process (See Form H: Special Issues for Condom Procurement And Distribution Agencies**)**

d. Observation of the donor support process (See Form I: Special Issues for Donor Organizations**.)**

In the final report (of the pre-test) of the Rapid Needs Assessment Tool for Condom Programming, **lessons learned about condom programming and important tips for implementing the RNA are provided (pages 15-19) that can be of assistance for these interviews and site visits.**

7. The Coordinator should hold a follow-up meeting of the Ad Hoc Expert Committee on Condom Programming:

a. As a foundation for the follow-up meeting discussion, the Coordinator could use the **PowerPoint Presentation Template** (see **RapidNA.ppt**) to summarize the available information collected from the internet sources, other documents, observations, and interviews. A critical note is to recognize that the power point template is meant only as a *guide*, and is expected to be and should be modified according to the information obtained and the country context.

b. Background and program information that has been gathered should be reviewed and discussed at the meeting, using either the RapidNA.ppt Template or another presentation format.

c. The group should then identify what it perceives are the country's priority needs or next steps for improving condom programming for HIV prevention. These next steps could include the dissemination of a report of the rapid needs assessment of condom programming, additional meetings of the Ad Hoc Expert Committee, or even a more comprehensive condom programming assessment.

d. If possible, the group should develop a Work Plan (specifying what needs to be done and who will do it) for accomplishing the recommended next steps.

An alternative approach was utilized in Brazil (see the Brazil final report on the attached CD and http://www.unfpa.org/hiv/index.htm: **Rapid Needs Assessment Tool for Condom Programming**). A consultant prepared a substantial background document on condom programming in Brazil utilizing studies, program descriptions, evaluations, and internet and other sources. He then sent this report to15 to 20 key condom programming policy makers and program managers from throughout Brazil and invited them to come together for three days to discuss the report and make recommendations for improving condom programming. During the three days, he also met with each person individually to discuss the details of their program activities.

While this methodology has limitations, it can result in a very useful needs assessment if the consultant is initially very well versed in the issues of condom programming and can prepare a well-researched background document.

FORM A:

CONDOM PROGRAMMING DOCUMENTS CHECKLIST *Please Record The Most Recent Report's Year Of Publication For All Listed Evaluations And The Title And Report Year For Other Condom Programming And HIV Assessment Reports*	
Year	**Title of Report/Evaluation**
______	Demographic Health Survey (DHS)[1,2],
______	Situation Analysis (SA) Report [3]
______	Service Provider Assessment (SPA) Report [4]
	Behavioral Surveillance Surveys (BSS) Report [2]
______	Youth
______	MSM
______	CSW
______	IDU
______	Other (specify)______________________________
______	FHI/IMPACT Report[5] ____
______	Multiple Indicator Cluster Surveys[2]
______	Reproductive Health Surveys [2]
______	Sexual Behavior Surveys [2]
______	UNICEF evaluations ____
______	AIDS Programme Effort Index (API) [6]
______	MOH (FP/STI) statistics
______	UNFPA Donor Support for Contraceptives & Logistics Report
______	UNFPA Stock Survey, Global Estimates Of Condom Needs
______	WHO/GPA Protocol for Estimating Condom Availability at Central & Peripheral Levels (PI1,2) [7]
______	MEASURE Evaluation/WHO/PSI Compiled Condom Availability & Quality Protocol [7]
______	JHU "CD for Condoms"
______	JSI SPARKS TOOL
______	UNAIDS/WHO Guidelines for 2nd generation HIV surveillance
______	Sero-prevalence surveys, blood screening ___________________________
______	Special (market/pharmacy) surveys ______________________________
______	Annual/other reports ____
______	Other STI surveys ____
______	Special surveys, sentinel sites ___________________________________
______	Other [8] ____
______	Other ____

[1] http://www.measuredhs.com/pubs/start.cfm?CFID=167149&CFTOKEN=93979990 search & browse for country
[2] http://www.measuredhs.com/hivdata/surveys/start.cfm
[3] http://www.popcouncil.org search for situation analysis
[4] http://www.cpc.unc.edu/measure/guide/tools/spa/spa.html
[5] http://www.fhi.org/en/aids/impact/impact.html and search for country
[6] http://www.cpc.unc.edu/measure/guide/tools/api/api.html
[7] http://www.cpc.unc.edu/measure/guide/tools/whocondom/whocondom.html
[8] Check web site http://www.hptn.org/research_studies/hptn_countries.asp

FORM B:

DATA COLLECTION GUIDELINE FOR CONDOM PROGRAMMING *For use by the RNA Coordinator to summarize information gathered and to insert in the RapidNA.ppt Template PowerPoint guide*		
What is the prevalence of HIV?[1] *(Prevalence: Number existing cases/year)*		
Group		Prevalence
General Population		
Women at antenatal clinics		
Youth		
MSM		
CSW		
IDU		
Truck Drivers		
Other (specify): ___________		
What is the prevalence of other STIs? [9]		
Group	Type of STI	Level (Prevalence)
General Population		
Male		
Female		
Youth		
MSM		
CSW		
IVDU		
Truck Drivers		
Other (specify): ___________		
What is the level of knowledge and common attitudes toward condoms?[2, 3] (Summarize the main points related to awareness and use of condoms, their purpose, either for contraception or prevention of HIV/STIs, knowledge of where to obtain condoms, specific attitudes toward condoms by both males and females, reasons for condom disuse or discontinuation, attitudes toward male and female condom users, expressed willingness to use condoms)		

[1] http://www.who.int/emc-hiv/fact_sheets/
http://www.unaids.org/barcelona/presskit/barcelona%20report/table.pdf
http://www.mapnetwork.org/reports.shtml
http://www.unaids.org/epidemic_update/index.html

[2] http://www.measuredhs.com/pubs/start.cfm?CFID=167149&CFTOKEN=93979990 select most recent country report

[3] http://www.measuredhs.com/hivdata/reports/table_select.cfm and select country, view report

FORM B: *Page 2 of 3*	
Availability	
Effectiveness/Quality	
Affordability	
Comfort	
Willingness to use condoms	
Use with spouse	
Use in extramarital situations	
Inability to negotiate condom use	
Inability to use consistently	

What is the level of awareness and knowledge of HIV/AIDS and ways to avoid HIV/AIDS? [10, 11]
(Summarize main points related to awareness of HIV/AIDS, knowledge of AIDS signs and symptoms, knowledge of others who have AIDS, and perceived personal susceptibility to HIV/AIDS)

	Total	Urban	Rural	Men	Women	No Education	Primary Ed	Secondary+ Ed	Youth
Ever heard of HIV/AIDS									
Knows others with AIDS									
Knows how to prevent HIV/AIDS									
Knows how people get HIV/AIDS									
% Perceive they are susceptible to AIDS									

FORM B: *Page 3 of 3*		
Who uses condoms? [10, 11] (Summarize main points related to level of condom use, examining subgroups by educational level, urban/rural residence, married men and women within marital relationship and in extra-marital relations, youth/unmarried, commercial sex workers and other high risk groups, and any trends in condom use in last 10 years)		
	With Spouse	With Others
Urban		
Rural		
No education		
Primary education		
Secondary education		
Married men		
Married women		
Youth		
MSM		
CSW		
IDU		
Truck Drivers		

FORM C:

LIST OF AGENCIES AND PROGRAMMES INVOLVED IN CONDOM PROGRAMMING *For Discussion and Completion at Initial Meeting of the Ad Hoc Expert Committee on Condom Programming*		
What are the major condom promotion/distribution/coordination agencies and programmes? Prepare an organization chart showing all of the agencies and programmes.	*List name of director / contact person*	*Tick For visit?*
Official AIDS organizations/units		
________________________________	________	__
________________________________		
Government (Ministry of Health)		
________________________________	________	__
________________________________		
________________________________		
Government (outside of MOH)		
________________________________	________	__
________________________________		
________________________________		
AIDS NGOs (*including special condom programmes for youth, sex workers, truck drivers, etc.*)	________	__
________________________________		
________________________________		
________________________________		
NGO family planning organizations		
________________________________	________	__
________________________________		
________________________________		
Condom social marketing organizations		
________________________________	________	__
________________________________		
________________________________		
Major commercial condom distributors		
________________________________	________	__
________________________________		
________________________________		

FORM D:

MAJOR MEANS OF HIV TRANSMISSION, CONDOM PROGRAMMING POLICY, AND COORDINATION ISSUES *For Discussion and Completion at Initial Meeting of the Ad Hoc Expert Committee*
I. *What are local sexual and other practices that may influence HIV transmission?* (Consider: What is the level/nature of premarital, marital and extramarital sex, including monogamy and polygamy? What are the cultural attitudes regarding sexual practices? Are there special groups that pose particular risks for HIV transmission in the country, including youth, MSM, CSW, IDU, truck drivers, others?) ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________
II. *What are the current policies relevant to condom promotion and distribution?* (Consider: Government, MCH/FP policy on condom distribution, existence of an explicit dual protection policy, condom import/distribution policies/regulations, condom mass media policies/regulations on explicit promotion of condoms, policy on sex education/condom education in schools, major religious institutions' attitudes/support for condom programming) ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________
III. *Is there any coordination of condom promotion/distribution activities? If so, where, how?* ____________________ ____________________ ____________________ ____________________

FORM E:

INTERVIEW GUIDELINES FOR PROGRAM MANAGERS, POLICY MAKERS AND OTHERS INVOLVED IN CONDOM PROGRAMMING *This is a set of semi-structured questions. You should feel free to add or eliminate as appropriate depending on the respondent and the local context.*
Your organization's name: ____
Your name: ____
Your position/title: ____
Your responsibility in relation to condom programming or HIV prevention: ____ ____
How many years has your organization been in existence and how many years has it conducted/been involved with condom or HIV prevention programmes? Age (years) of organization ______ Years of organizational involvement in condom programming/HIV prevention ______
What is your organization's scale and level of funding for condom or HIV prevention programmes? No. of staff: Professional: Other: Overall annual budget: Budget devoted to HIV prevention or condom programming: Number of programme or service sites: _____________________________________
What are your organization's condom/HIV prevention programmes key objectives? (Consider: procurement, distribution, advocacy, key attitude change concepts/overcoming barriers to condom use, key informational/promotional messages including condom negotiation, etc.) ____ ____ ____ ____

FORM E:

Page 2 of 4

What are your organization's condom/HIV prevention programmes main activities?

(Consider: program components such as coordination, condom procurement, distribution, promotion, counselling, influencing attitudes, advocacy for political awareness, evaluation. Is the organization's main role financial support or implementation? Are the organization's efforts are stand-alone or integrated and, if so, how?)

____

____

____

____

____

____

What is your organization's experience with female condoms?

____

What are the barriers to increasing female condom use?

____

____

What is (are) your organization's condom/HIV prevention programme's geographic coverage area(s)?

____

____

____

____

What are your organization's condom/HIV prevention programme's target populations?

(Consider: general population, youth, MSM, CSW, etc.)

____

____

____

____

How does your organization's programmes reach these target populations?

(Consider: schools, peer promoters, employment-based/brothel-based activities, community-based distributors, clinics, pharmacies, mass media, outreach/educational/ counselling activities). Describe how they work.)

____

____

____

____

____

FORM E:

Page 3 of 4

What are the organization's main sources of male condoms (and female condoms, if any)? Are there any problems in keeping an adequate supply of condoms?

(Consider: sources and procurement practices)

____

_

____

_

____

_

What have been your organization's main condom/HIV prevention programme achievements?

(Consider: number and types of people reached with messages/services/condoms, change in knowledge, attitudes, behaviour, practice)

Number of condoms distributed in one year:

____

If the organization is a family planning agency, what is proportion of clients who receive condoms:

____

What have been your organization's main difficulties in achieving its condom/HIV prevention program objectives?

(Consider: distribution logistics, procurement practices, staff turnover, geographic, economic, religious, educational, occupational, and other factors including limited women's roles and autonomy/ability to negotiate condom use, and migration)

____

____

____

____

What do you consider to be the outstanding/pressing needs to improve condom program efforts for HIV prevention?

____

____

____

____

How do you think these outstanding/pressing needs can most pragmatically be met to improve condom/HIV prevention program efforts?

____

____

____

FORM E: *Page 4 of 4*
Has your organization conducted evaluations/assessments of condom programming (distribution, counselling, quality) and/or related KAPB? Yes _____ No_____
Please list (below) and provide/attach copies of your annual report/statistics and your organization's evaluations/assessments of condom programming and/or related KAPB Name of report:
Name of report:
Name of report:
Name of report:
Name of report:
Name of report:
Name of report:

APPENDIX 3 : Rapid Needs Assessment Powerpoint Presentattion

RAPID NEEDS ASSESSMENT
FOR CONDOM PROGRAMMING

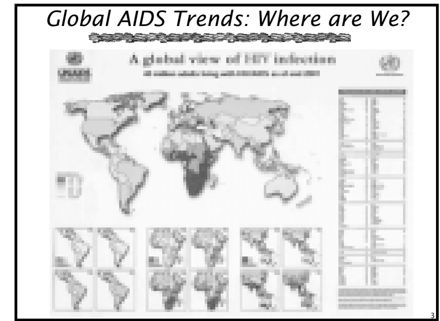
Insert Name of Country

1

I. AIDS SITUATION & CONDOM PROGRAMMING SETTING

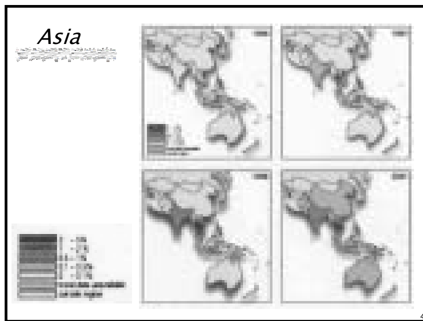
2

Global AIDS Trends: Where are We?



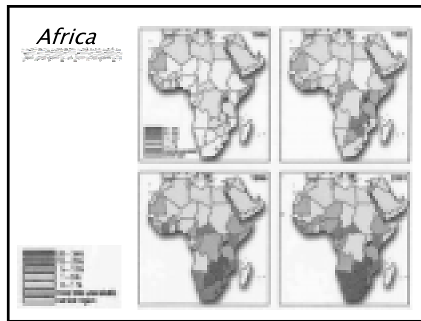
3

Asia



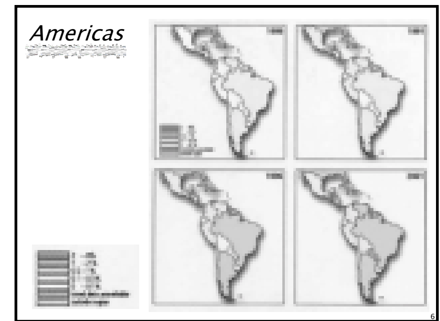
4

Africa



5

Americas



6

What is the HIV prevalence?

	Prevalence
General Population Men Women	
Youth	
MSM (men who have sex with men)	
CSW (commercial sex workers)	
IDU (injection drug users)	
Truck Drivers	
Others_______	

Prevalence: Number existing cases/year

7

What is the Level of Sexually Transmitted Infections (STIs)?

	Type of STI (Indicate type of STI)	Level (prevalence)
General population		
Men		
Women		
Youth		
MSM		
CSW		
IDU		
Truck Drivers		
Others________		

8

Who is most at risk?

Rank from 1 (top) to 10 (lowest) priority; estimate size of group

General population	
Married women	
Married men	
Female youth	
Male youth	
MSM	
CSW	
IDU	
Truck drivers	
Others	

9

What is the proportion of men and women who have higher risk (non-marital) sex?

	Total	Urban	Rural	Married Age 15–24	Age 25–49	No Education	Primary Education	Secondary+ Education	Unmarried Youth
% Men Higher Risk Sex									
% Women Higher Risk Sex									

What is their awareness & knowledge of HIV/AIDS & ways to avoid HIV/AIDS?

	Total	Urban	Rural	Men	Women	No Education	Primary Ed	Secondary+ Ed	Youth
% ever heard of AIDS									
% believe condoms can prevent AIDS									
% knows 2+ valid ways to avoid AIDS									
% spoke with spouse about preventing AIDS									
% perceive them-selves susceptible to AIDS									

What is the level of condom use?

(Either proportion currently using condoms or used condoms at last sex)

	With Spouse	With Others
Married men		
Married women		
Urban		
Rural		
Youth		
MSM		
CSW		
IDU		
Truck Drivers		

What are common attitudes and beliefs toward condoms?

Availability	
Quality/Effectiveness	
Affordability	
Comfort	
Willingness to use condoms with spouse	
Willingness to use condoms in extramarital situations	
Inability of women to negotiate condom use	
Inability to use consistently	

What are country policies relevant to condom promotion & distribution?

Importation	
Financial Support/ Subsidization	
Advertising/Promotion Restrictions General Public Youth/School	
Restrictions on Distribution	
Others	

II. CONDOM PROGRAMMING

What are the major condom coordination, promotion & distribution agencies and programmes?

(use an organization chart)

What are the programmes' key objectives?

What are the programmes' main activities?

What is the scale of the programme (number staff/activities/clients) and level of funding?

What are the programmes' main sources of condoms? Have supplies been adequate?

How many condoms have been sold or distributed over the last three years?

How do the programmes reach their target populations?

Pharmacies/other commercial outlets	
Health service facilities (type)	
School-based/youth programs	
Community-based outreach (type)	
Mass media (type)	
Others (type)	

Do the programmes adequately reach their target populations?

What is the extent of coverage?

General Population	
Urban	
Rural	
Youth	
MSM	
CSW	
IDU	
Truck Drivers	

What have been the major condom programming achievements?

What have been the major condom programming difficulties?

What are other barriers to increasing condom use ?

Is there coordination of condom distribution/promotion program activities?

Is condom programming integrated into other services and is the Dual Protection concept promoted?

What is the experience with female condoms?

28

What are the barriers to increasing female condom use ?

28

III. SUMMARY & RECOMMENDATIONS

29

What are the outstanding/pressing needs to improve condom programming efforts & use?

30

How can these outstanding/pressing needs be most pragmatically met?

Next steps

1. *What are the target groups/geographic areas most in need of improved condom programming?*
2. *What can be done to increase condom supply and distribution to those who most need it to prevent HIV?*
3. *What can be done at this time to more effectively promote increased demand and use of condoms?*
4. *What additional resources, training, technical assistance, and funds are needed for condom supply, distribution and promotion?*
5. *Are there critical knowledge gaps, and, if so, what are the priorities for further research and program evaluation?*

31

How can these outstanding/pressing needs be most pragmatically met?

Next steps

1. *What are the target groups/geographic areas most in need of improved condom programming?*

32

How can these outstanding/pressing needs be most pragmatically met?

Next steps

2. *What can be done at this time to increase condom supply and distribution to those who most need it to prevent HIV?*

33

How can these outstanding/pressing needs be most pragmatically met?

Next steps

3. *What can be done at this time to more effectively promote increased demand and use of condoms?*

34

How can these outstanding/pressing needs be most pragmatically met?
Next steps

4. *What additional resources, training, technical assistance and funds are needed for condom supply, distribution and promotion?*

35

How can these outstanding/pressing needs be most pragmatically met?
Next steps

5. *Are there critical knowledge gaps, and, if so, what are the priorities for further research and program evaluation?*

36

When should we next meet as a group to review our progress?

37

Thank you!

38

APPENDIX 4: OPTIONAL FORMS

A number of additional options (not pre-tested) are available to the RNA Coordinator depending upon the amount of time he has available and the importance of the information to the overall assessment of condom programming. These options include:

a. **Observation of clinical, counselling, or educational activities (*See*** Form F: Observation of Condom Counselling and Education**)**

b. Observation of social marketing sites (See **Form G: Observation of Social Marketing Sites**)

c. Observation of the condom procurement and distribution process (See **Form H: Special Issues for Condom Procurement And Distribution Agencies**)

d. Observation of the donor support process (See **Form I: Special Issues for Donor Organizations**).

FORM F:

OBSERVATION OF CONDOM COUNSELLING AND EDUCATION	
Name of organization or agency:________________________________	
Type of services observed: Family planning clinic Family planning outreach or CBD agent HIV/AIDS education or outreach Antenatal services Voluntary HIV testing and counselling School or youth group Other (specify)	*Check if Yes*
Site of observation________________________________	
Main content of condom counselling or education: ________________________________ ________________________________	
Was the concept of dual protection discussed?	*Yes* __ *No* __
Did the counselor or educator describe how to use a condom in detail and provide an example using a dildo?	*Yes* __ *No* __
Did the counselor or educator talk about how a woman can negotiate condom use with her partner?	*Yes* __ *No* __
Did the counselor talk about how to counter negative attitudes toward condoms?	*Yes* __ *No* __
Did the counselor talk about how to counter negative attitudes toward condoms?	*Yes* __ *No* __
Comments on the adequacy, effectiveness, appropriateness, and reaction to the condom counselling or education: ________________________________ ________________________________	
Description of IEC material provided about condoms or condom use: ________________________________ ________________________________	
Recommendations for improvements: ________________________________ ________________________________	

FORM G:

OBSERVATION OF SOCIAL MARKETING SITES	
Name of organization or agency: ______________________________	
Site of observation: ______________________________	
How many condoms are sold on an average day?	________
How many are sold in a typical week?	________
Who are the typical customers that buy condoms? ______________________________ ______________________________	
How much does a person pay to buy a condom? *Specify currency*: ______________	________
How much do they cost for the seller or agent? *Specify currency*: ______________	________
Does the agent have any suggestions for better promoting condoms? (What?) ______________________________ ______________________________	
Do customers have any complaints about the condoms? (What?) ______________________________ ______________________________	
Describe any point-of-sale advertising or media: ______________________________ ______________________________	
Ask the sales agent what he says to counter negative attitudes? ______________________________ ______________________________	
Does the agent have any problems in always having an adequate supply of condoms? ______________________________ ______________________________	

FORM H:

SPECIAL ISSUES FOR CONDOM PROCUREMENT AND DISTRIBUTION AGENCIES
The process by which condoms are procured and distributed by the national government or other major condom organizations needs to be documented. In addition, all of the main sources of distribution to condom users and the role these programmes or agencies play should also be documented. Relevant questions include:
How are condom procurement and distribution needs estimated and what are the assumptions? This is especially relevant at the national level. ____ ____ ____
What procedures are followed in the procurement of condoms and who are the key players? ____ ____ ____
What agencies distribute condoms? What is their procedure for getting supplies and what difficulties do they face in obtaining the required supplies? Family planning agencies AIDS prevention agencies Social marketing agencies Private commercial distributors
Do stock-outs occur? Is this a supply problem, an inadequate procurement problem, or simply inefficiency on the part of the organizations themselves? ____ ____ ____

FORM I:

SPECIAL ISSUES FOR DONOR ORGANIZATIONS	
Name of organization or agency: ______________________________	
Type of assistance provided: (describe in detail and indicate the level of financial support)	*Check if Yes*
Purchase of condoms:	____
Funds for programmes:	____
Technical assistance:	____
Other (specify):	____
Agencies or government departments receiving assistance: ______________________________ ______________________________ ______________________________	
Specific programmes or NGOs supported: ______________________________ ______________________________ ______________________________	
How are specific programmes or agencies selected for support? ______________________________ ______________________________ ______________________________	
What are your plans for future funding? ______________________________ ______________________________ ______________________________	
How do you coordinate your support with the support of other donors? ______________________________ ______________________________ ______________________________	