FACILITATOR GUIDE

# NATIONAL DEPARTMENT OF HEALTH INTEGRATED NATIONAL CONDOM TRAINING CURRICULUM


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## OVERVIEW OF THE NDOH CONDOM TRAINING CURRICULUM

South Africa has a generalised HIV epidemic, thought to be influenced by a number of behavioural, historical and structural factors including patterns of sexual partnerships, heavy episodic alcohol use, gender inequality, violence and poverty. South Africa's prevalence is one of the highest in the world estimated at 19.2 per cent (%) in adults in 2015 (UNAIDS Gap report, 2016). Despite large scale HIV prevention efforts resulting in a decrease in new infections, high risk sexual behaviour with insufficient levels of condom use, continue to drive the HIV epidemic. Sexually transmitted infections (STIs), including HIV, are a major public health burden in South Africa.

Although the national antenatal prevalence has stabilised over the past four years at around 29%, there is a wide variation in HIV prevalence across age, race, gender, socio-economic status and geographical location. The burden of HIV is heightened amongst women, young people and some high risk population groups such as sex workers (SW) and men who have sex with men (MSM). Additionally, the prevalence of the sexually transmitted infection (STI), Genital Ulcer Syndrome (GUS), which is a co-factor in the acquisition of HIV, is still high in many sectors of the population.

The NDoH supports the fast-track planning, implementation and monitoring of progress towards meeting the 90-90-90 targets for HIV and TB by 2020 which are:

*90 per cent of people who are HIV positive should know their status, 90 per cent of HIV positive people should be put on treatment and 90 per cent of those on treatment should be virally suppressed.*

A continual need of innovative approaches in terms of Information, Education and Communication (IEC) materials and targeted community engagements with emphasis on high risk populations, will undoubtedly influence much needed changes to attitudes and sexual behaviour.

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## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | acquired immune deficiency syndrome |
| ANC | Antenatal care |
| APP | Annual Performance Plan |
| ARV | anti-retroviral |
| ART | ARV Treatment |
| CB | Capacity Building |
| CBO | Community Based Organisation |
| CCP | Comprehensive Condom Programming |
| CDC | Centre for Disease Control |
| CE | Mark Conformité Européen (European Conformity mark) |
| DHIS | District Health Information System |
| DCDIP | District Condom Distribution Implementation Plans |
| DIP | District Implementation Plan |
| FAQs | Frequently Asked Questions |
| FC1 | FC1 Female Condom (First generation) |
| FC2 | FC2 Female Condom (Second generation) |
| FHC | Female Health Company |
| FP | Family Planning |
| FSW | Female Sex Worker |
| GMS | Gender Mainstreaming |
| HSRC | Human Sciences Research Council |
| IPV | Intimate Partner Violence |
| HAST | HIV, AIDS and STI AND TB |
| HCT | HIV Counselling and Testing |
| HIV | human immunodeficiency virus |
| HSRC | Human Sciences Research Council |
| HTAs | High Transmission Areas |
| IEC | Information, Education and Communication |
| IUD | Intra-Uterine Device |
| LMIS | Logistics Management Information System |
| M&E | Monitoring and Evaluation |
| MSM | Men who have Sex with Men |
| MUS | Male Urethritis Syndrome |
| NDoH | National Department of Health |
| NGO | Non-governmental organisation |
| NTO | Non-Traditional Outlets |
| OVC | Orphans and Vulnerable Children |
| PDS | Primary Distribution Site |
| PEPFAR | The US President's Emergency Plan for AIDS Relief |
| PHC | primary healthcare |
| PMDS | Performance Management and Development System |
| PMTCT | Prevention of mother-to-child transmission (of HIV) |
| QA | Quality Assurance |
| QI | Quality Improvement |
| Q&A | Question and Answer |
| RH | Reproductive Health |
| SA | South Africa |
| SBCC | Social and Behaviour Change Communication |
| SBD | Sarah Baartman District |
| SDS | Secondary Distribution Site |
| SOP | Standard Operating Procedures |
| SOW | Scope of Work |
| SRH | Sexual and Reproductive Health |
| STIs | Sexually Transmitted Infections |
| USAID | United States Agency for International Development |
| UNFPA | United Nations Population Fund |
| USFDA | United States Food and Drug Administration |
| WHO | World Health Organization |

## GLOSSARY OF TERMS

The aim of the glossary is to standardise the interpretation of terms used by implementers of District Condom Implementation Plans (DCIPs) and facilitators of condom training in South Africa. The following terms are used in this manual, and should be understood by these definitions:

**Advocacy** is a process of supporting and enabling people to express their views and concerns; access information and services; and defend and promote their rights and responsibilities.

**Age-disparate** relationships refer to relationships where the age gap between sexual partners is five years or more. The terms "intergenerational relationships" and "cross-generation relationships" generally refer to a ten-year or greater age disparity between sexual partners.

**ARVs** are medications that treat HIV, and do not kill or cure the virus. However, when taken in combination they can prevent and slow down replication of HIV. Adherence to consistent lifelong ARV treatment reduces the disastrous effects of HIV and AIDS and can reduce the HIV viral load of an HIV+ person.

**Behaviour change communication (BCC)** refers to communication that promotes changes in behaviours and attitudes by providing tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership.

**Biomedical** refers to medical and biological interventions. These include medical male circumcision and prevention of mother-to-child transmission.

**Combination HIV prevention** is an approach that seeks to achieve maximum impact on preventing new HIV infections by combining biomedical, socio-behavioural and structural interventions that are human-rights based and evidence informed, in the context of a well-researched and understood local epidemic.

**Community dialogue** is a process of joint problem identification and analysis leading to modification and redirection of community and stakeholders' actions.

**Community engagement** refers to the process by which community benefit organisations and individuals build ongoing, permanent relationships for the purpose of applying a collective vision for the benefit of a community.

**Community systems strengthening** refer to initiatives that contribute to the development and/or strengthening of community-based organisations in order to increase knowledge of and access to improved health service delivery.

**Confidentiality:** the right to confidentiality means the right to keep information to yourself. People have a right to confidentiality about HIV and AIDS, and others have to respect a person's right to keep information private.

**Connection:** linkage of HIV testing services to services (clinics, mobiles, CHCs) that provide treatment which includes preventive, curative and rehabilitative care. These services should be supported by a national reference laboratory that uses advanced equipment and employs well trained staff who adhere to and comply with credible standards.

**Condom negotiation** refers to the relative ability or inability a person possesses in order to persuade their sexual partner(s) to allow and agree to condom use during sex.

**Contraceptive** (also known as personal "fertility control") is a method or device used to prevent pregnancy.

**Disclosure:** in law, disclosure means breaking confidentiality by giving private information to another person or to the general public. Disclosure is allowed in law in defined circumstances, for defined reasons.

**Discrimination** is when a person is treated differently and usually unfairly, because of a certain characteristic they have, e.g., a child is refused schooling because she is living with HIV.

**Dual protection:** condoms offer a comprehensive and sustainable approach to the prevention of HIV and other sexually transmitted infections (STIs) and are effective for preventing unintended pregnancies.

**Gender** refers to the roles that men and women play in society, including culturally and socially constructed relationships between men and women and the way we perceive roles to either be masculine or feminine. These roles are not determined by biology but rather by political, social, economic and cultural factors.

**Gender-based violence (GBV)** refers to violence that is directed against a person on the basis of gender. It constitutes a breach of the fundamental rights to life, liberty, security, dignity, equality between men and women, non-discrimination, and physical and mental integrity.

**Gender equality** means that both men and women are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services.

**Gender inequalities** refer to the unequal treatment or perceptions of individuals based on their gender. It arises from differences in socially constructed gender roles. Several programmes aim to address the socio-economic, behavioural and structural imbalances that exist between men and women's roles in society.

**Gender mainstreaming (GMS)** is the public policy concept of assessing the different implications for women and men of any planned policy action, including legislation and programmes, in all areas and levels. Mainstreaming essentially offers a pluralistic approach that values the diversity among both men and women.

**General population** refers to all residents of South Africa, irrespective of their gender, sexual orientation, geographical location or age.

**Healthcare provider** is any person providing health services in terms of any law, including the:

- Allied Health Professions Act, 1982 (Act No.63 of 1982)
- Health Professions Act, 1974 (Act No. 56 of 1974)
- Nursing Act, 2005 (Act No. 33 of 2005)
- Medicines and Related Substances Act, 1965 (Act 101 of 1965)
- Pharmacy Act, 1974 (Act No. 53 of 1974)

**Healthcare worker** is any person, excluding healthcare providers, involved in the provision of health services to a client. This includes lay counsellors and community caregivers and may also include a person who is trained to offer the same service to the deaf community.

**HIV counselling:** an intervention which gives the client an opportunity to be educated and supported in order to explore his or her HIV risk; to learn about his or her HIV status and manage the consequences; to learn about HIV prevention and HIV and AIDS treatment, to learn about care and support services; and to learn how to modify his or her behaviour to reduce the risk of HIV infection.

**HIV counsellor:** is a healthcare worker or a healthcare provider who has undergone training on HIV counselling.

**HIV testing services (HTS):** to identify people living with HIV timeously through the provision of quality testing services for all - including adults, children, couples and families - and effectively link them to appropriate prevention, care treatment and support services.

**Informed consent** is a process by which a client voluntarily confirms his or her willingness to provide written or verbal consent to be tested for HIV or to provide information about his or her HIV status to a healthcare provider, healthcare worker or researcher. This agreement is obtained after the client has received information about the HIV test and understands the purpose of the procedure, or after understanding the purpose of the exchange of information as being in the best interests of his or her own health or that of the partner or in the case of a pregnant woman, the foetus (baby in utero) or the infant being breastfed. Informed consent should be given voluntary and conducted according to the legal and ethical requirements as outlined in this document.

**Informed refusal** is a process whereby a client with or without clinical signs of opportunistic infections consults a healthcare worker, and is counselled and offered HIV testing which the client then refuses. Such refusal should be recorded in the client's file and signed by the client and healthcare worker.

**Integrated service delivery:** an approach that encourages and allows the healthcare provider to review the client as a whole, assessing needs beyond the primary reason for the visit. This provides the basis for offering additional services or referring the client to receive services from another provider or facility. Its aim is to increase the efficacy of service delivery and to reduce the stigma associated with HIV and AIDS.

**Health system:** a health system consists of all organisations and individuals whose actions are intended to promote, restore or maintain health. A health system involves a broad range of institutions and individuals; their actions help to ensure the efficient and effective delivery and use of products and information for the prevention, treatment, care, and support of people in need of these services.

**HIV prevention** refers to interventions and strategies designed to prevent the spread of the human immunodeficiency virus in South Africa. These are carried out at health facilities, in communities and by individuals.

**Human papilloma virus (HPV):** a virus that causes warts, including genital warts.

**Injecting drug users (IDU)** - illegal substances may be injected through subcutaneous, intramuscular, and intravenous routes.

**Key populations (KPs)** are populations that are at a higher risk of HIV exposure or onward transmission. These include men who have sex with men, transgender people, injecting drug users, people who abuse alcohol, sex workers and their clients, and detained populations. At-risk populations are among the most marginalised and most likely to be stigmatised. In addition, resources and national human immunodeficiency virus prevention campaigns are not necessarily geared to their specific prevention, treatment and care needs concerning the virus. The engagement of key populations is critical to a successful response to the virus. In all countries, key populations include people living with HIV.

**Men who have sex with men (MSM)** refers to males who have sex with males regardless of whether they have sex with women or have a personal or social gay or bisexual identity. This concept is inclusive of men who self-identify as heterosexual but have sex with other men.

**Migrant populations** refer to both internal (South African) and cross-border migrants. Migrants are people who move in search of better economic opportunities. In South Africa, internal migrants constitute the largest proportion of the migrants in the country.

**Mobile workers/population:** refer to transient workers such as truckers or miners. These terms refers to individuals who may cross borders or move within their own country on a frequent and short-term basis for a variety of work-related reasons, without changing place of habitual primary residence or home base. Mobile workers are usually in regular or constant transit, sometimes in (regular) circulatory patterns and often spanning two or more countries, away from their habitual or established place of residence for varying periods of time.

**Morbidity:** The state of being ill or having a disease.

**Mortality:** An individual's death or decease; loss of life.

**Opportunistic infections (OI)** refer to infections that take advantage of a weakened immune system. In people living with HIV, these are often tuberculosis, pneumonia, candidiasis, and the herpes simplex virus.

**Pre-exposure prophylaxis (PEP)** refers to antiretroviral medicines that are prescribed before exposure or possible exposure to HIV. Pre-exposure prophylaxis strategies under evaluation increasingly involve the addition of a post-exposure dosage.

**Post-exposure prophylaxis (PreP)** refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle-stick injury, or non-occupational, as in unprotected sex with a person living with the virus.

**Prevention of mother-to-child transmission (PMTCT)** refers to the four-pronged strategy to prevent new HIV infections in infants and keep mothers alive and families healthy. The four prongs are: halving HIV incidence in women; reducing the unmet need for family planning; providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding; and providing care, treatment, and support to mothers and their families. Some countries prefer to use the term 'vertical transmission' to acknowledge the role of the father/male sexual partner in transmitting HIV to the woman and infant. This may encourage male involvement in the prevention efforts.

**Priority populations** are groups of people who are susceptible to HIV infection because of their medical conditions. These include people with tuberculosis, pregnant women and people living with HIV.

**Serodiscordant couples** are couples where one partner is living with HIV while the other partner does not carry the virus. A couple refers to two people that have a sexual relationship.

**Sex work** refers to sex between consenting adults older than 18 years, either regularly or occasionally, formally or informally, for cash; a service where the person selling may or may not self-identify as selling sexual services.

**Sex worker** refers to consenting female, male and transgender adults, and young people older than 18 years who receive money or goods in exchange for sexual services, either regularly or occasionally.

**Sexual and reproductive health services (SRH services)** refer to services for family planning, infertility services, prevention of unsafe abortion and post-abortion care, diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynaecological morbidities, and the promotion of sexual health, including sexuality counselling.

**Sexually transmitted infection** refers to infections that are spread by the transfer of organisms from person to person during sexual contact. These include HIV, chlamydia trachomatis, and the human papillomavirus, which can cause cervical, penile, or anal cancer, genital herpes, cancroid, syphilis, and gonorrhoea.

**Stigma** is defined as a sign of disgrace or discredit, which sets a person apart from others.

**Stigmatisation:** comprises negative social labels that show prejudice against a person or group of people based on an individual's state of health or social status, e.g., children may be stigmatised because a parent is living with HIV.

**Sex** refers mainly to the sexual characteristics of a person, that is whether the person is male or female based on biological make-up. This means that your biological or physical characteristics at birth determine whether you are male or female.

**Sexual intercourse:** 1.) Heterosexual intercourse involving penetration of the vagina by the penis – "coitus". 2.) Intercourse (as anal or oral intercourse) that does not involve penetration of the vagina by the penis.

**Social marketing** is a process that uses marketing principles and techniques to influence target audience behaviours that will benefit society, as well as the individual.

**Social mobilisation** refers to mobilisation of civilian population; it allows people to think and understand their situation and to organise and initiate action; it is also a process that raises awareness and motivates people to demand change or a particular development.

**Syndromic approach** is based on the identification of consistent groups of symptoms and easily recognised signs or symptoms and the provision of treatment that deals with the most serious organisms responsible for producing such syndromes, and proves to be more cost-effective than a purely symptomatic approach to dealing with STIs. The client should not be coerced to undergo medical examination and consent is essential.

**Task shifting/task sharing** is a process of delegation whereby tasks are moved or shared, as appropriate, to less specialised health workers within a healthcare team. This is done by reorganising the workforce in this way; task shifting may facilitate a more effective use of human resources currently available. For example, when doctors are in short supply, a qualified nurse can initiate and manage antiretroviral treatment. Furthermore, trained community health workers including counsellors and community care givers can deliver a wide range of HIV services, thus freeing the time of other healthcare workers whose contribution may be crucial in delivering a more comprehensive service.

**Youth-friendly services** are services that offer an encouraging environment in which young people will access and use health services.

**Youth services** include youth-friendly services attached to health facilities that are promoted to youth through youth groups, school health services and community based health services. Their goal is to include young people in HIV testing services.

**Transgender** refers to a person with a gender identity that is different from his or her sex at birth; they may be male to female or female to male. They may also prefer not to conform to any gender binary, or to rather use gender-neutral references.

**Vulnerable populations** are groups of people that are particularly vulnerable to HIV infection under certain circumstances. These include young women and girls, orphaned and vulnerable children, people in prisons and detention centres, persons with disabilities, migrant and mobile workers, and seronegative partners in serodiscordant couples.

**Women who have sex with women (WSW):** It includes not only women who self-identify as lesbian or homosexual and have sex only with other women, but also bisexual women and those who self-identify as heterosexual but who have sex with other women.

**Young women** refer to girls between the ages of 15 and 19 years and young women between the ages of 20 and 29 years.

## RATIONALE FOR THE DEVELOPMENT OF THE TRAINING CURRICULUM

1. Evidence shows that the increase in condom use has played a key role in the decrease in new infections in South Africa. According to the 2012-2015 UNAIDS Unified Budget, Results and Accountability Framework (UBRAF), sexual transmission accounts for more than 80 per cent of new HIV infections worldwide.

2. Used consistently and correctly, condoms are a highly effective barrier method for preventing sexual transmission of HIV and other STI, and for reducing unintended pregnancies. In South Africa male and female condoms are widely available from Department of Health facilities, private hospitals and clinics, community venues, and for purchase in shops, places of entertainment, petrol stations, pharmacies and supermarkets.

3. The National Department of Health (NDoH) condom distribution has increased in the last three years (2014 – 2016) with a distribution of over 2.4 billion male condoms and over 70 million female condoms, however, despite these efforts studies have shown that condom use has decreased in the last few years, especially amongst young people. Based on these reports, the NDoH, in collaboration with Society for Family Health (SFH) with funding from UNFPA, embarked on a perception study on male condoms to identify barriers with regards to the use of condoms. The perception study reported that there were a few challenges that the young people cited with regards to the then nationally procured male condom brand, 'CHOICE'. These challenges included the latex smell of the condom and the fact that there were no variants such as scent and colour.

4. In response to the results of the perception study, the NDoH then revised the male condom specifications, procured and distributed coloured, scented and re-branded male condoms by the name of MAX, for maximum quality, pleasure and sensitivity. The re-branded condoms are available in four different varieties; red strawberry scent, yellow banana scent, purple grape scent and the original colour masked with a slight vanilla scent.

5. Female condoms distributed nationally are not branded and have the following trade names: FC2 and Cupid. The department is in the process of co-branding and scenting the female condoms. It is critical that a standardised national curriculum is developed in order to ensure correct use of the condoms, popularise and market the different types of male and female condoms procured nationally. In addition, NDoH currently procures condom compatible water-based lubricant sachets of 5ml for distribution with the condoms.

## 2. PURPOSE OF THE TRAINING CURRICULUM

### 2.1 Overall purpose

The overall purpose of the development of a National Training Programme is to build capacity and to standardise condom programme training in South Africa.

### 2.2 Specific objectives

The following objectives guide the expected outcomes that are to be achieved on the successful completion of this national training programme:

- To develop skills, knowledge, attitude, competency and values of programme managers, service providers, implementing partners, researchers, lay counsellors, community leaders, community health workers and care givers, to enable them to successfully integrate male and female condoms into HIV/STI prevention and Sexual Reproductive Health (SRH) and rights training programmes
- To provide a package of resources for use in training for condom programming, SRH and rights, HIV and STI prevention
- To develop knowledge, skills and attitudes on how to communicate, counsel and assess the risk of clients as well as to counsel on the correct use of male and female condoms.

### 2.3 Expected outcomes of the national training programme

- Availability of master trainers in all provinces and implementing partner organisations to ensure a comprehensive consistent standardised training of condom programme.
- Availability of condom 'champions' to lead the ongoing integration of condom training at district/sub-district level.
- Awareness, correct and increased consistent use of condoms by all.
- Reduced new infections in particular amongst key populations, young women and girls

## 3. COURSE DURATION

The duration of the course is one and a half days

**Day one:** covers mainly with the HIV Epidemic, the risks associated with sexual behaviour and the interventions available to address these risks and improve HIV testing services (HTS) as a point of departure for reducing the spread of HIV including demonstration of correct condom use.

**Day two:** covers the management, administration and reporting aspects of condom management incorporating quality improvement discussions.

## 4 TARGET AUDIENCE

The following target audience has been identified for the integrated national condom training programme: **NB: It is important to note that this manual has been created in a modular manner so that it can be adapted to different target audiences including those mentioned below:**

- Community care givers
- Health care professionals and health promoters
- District managers, provincial HAST managers/coordinators and condom logistics officers
- Civil society, NGO and CBO implementing partners involved in condom programming in districts and provinces
- Training coordinators and facilitators at Regional Training Centres (RTC)
- Researchers, private and other government departments
- Anyone with training needs in SRH and condom use

**NB: This manual was created in a modular manner so that it can be adapted over a series of shorter workshops depending on the target audience. Each integrated condom training workshop should be adapted to meet the specific needs of particular groups of participants. Workshop organisers should take into account that additional modules can also be included in the training to make it more relevant to the training needs of their organisations or their participants.**

## 5. COURSE CONTENT AND MATERIALS

The structure of the training manual comprises rationale for its development, a detailed curriculum divided into modules where each module covers distinct topics, and a series of annexures containing additional information. The contents include the following:

- Registration and administration forms
- Training programme Agenda
- Welcome and introduction of facilitator and participants
- Expected outcomes of the national training programme
- Learning objectives of each module
- Facilitator guide with notes to the facilitator
- Facilitator resources, templates and instructions for facilitation
- Pre and post course assessment
- Annexures
- References

The manual can also be used over a series of shorter workshops. Each integrated condom training workshop should be adapted to meet the specific needs of particular groups of participants. Workshop organisers should take into account that additional modules can also be included in the training to make it more relevant to the training needs of their organisations or their participants.

### 5.1. PARTICIPANT INDUCTION AND TRAINING MATERIALS

- Issue each participant with the participant training manual and ask him or her to put his or her names on it.
- Issue other accessories like a pencil, eraser, exam pad and timetable.
- Together with the participants, go through the timetable, adding the importance of punctuality after breaks.
- Explain the possibility of leaving later some days as some exercises may take longer than expected. Request their cooperation in this matter.
- If tea breaks are at different times on different days, explain this so that they do not make appointments without checking their timetables.
- Explain why pencils have been chosen for use in their exercises, for example, to allow them to erase and put correct answers after the exercise.
- Explain that exam pads are for additional notes that participants may wish to take down during the course.

## 6. TRAINING INVENTORY AND STATIONERY

- Participant manual, with required templates and handouts
- Name tags
- Name tents
- Whiteboard/flipchart/ newsprint /chalk board
- PowerPoint slides/OHTs (transparencies/ if projector is unavailable)
- Overhead projector
- Loudspeakers (for video clips)
- Koki pens/ whiteboard markers/ flipchart markers
- Bostik/ prestik (sticky putty)
- Post-It sticky note pads (three colours, or more)
- Coloured paper (three colours, or more)
- Ball of wool, or coloured string (clearly visible/ dark colour)
- Scissors

## 7. HOW TO USE THIS TRAINING MANUAL

The training manual is divided into eight modules. Within each module there are activities and exercises on a particular topic. Icons alert facilitators to specific types of information and the type of exercise or activity within each module.

## 8. LIST OF ICONS

Each module has activities and exercises on particular topics, and some require tools and templates. Please find below, icons for resources required and descriptions of activities:

| Icon | Name | Description |
|---|---|---|
|  | **Learning objectives** | Attitudes, skills and knowledge learners should acquire during the session. |
|  | **Duration** | Anticipated total time needed for the module/session. |
|  | **Exercise** | Exercise/discussion icon indicates a question and answer session which may be facilitated as an individual or group activity. |
|  | **Group work/ discussion** | Group work icon indicates an activity that will involve group discussions, and possibly a presentation to the main group. |
|  | **Class discussion** | This icon indicates facilitator-led class discussions in the larger group (plenary). |
|  | **Case study** | Questions are posed based on a case study provided following an individual or group exercise. |
|  | **Role play** | Role play icon indicates an activity where participants will be requested to perform a practical demonstration of a scenario. |
|  | **Tools/handouts** | Tools, handouts, templates, or worksheets required to complete the exercises and tasks in the session. |
|  | **Preparations/ equipment** | Preparatory steps the facilitator should complete before the module is conducted and inventory checklists. |

## 9. HOW TO USE THIS FACILITATOR GUIDE

In addition to facilitation methodology and techniques, this facilitator guide provides instructions to the facilitator on how to conduct the workshop with notes under each module. Please refer to the participant manual for further details on the information, content and core subject matter of the training programme.

## 10. WELCOME AND INTRODUCTIONS

### 10.1 Welcome and open remarks

- The main objective of the introductory session is to establish a supportive atmosphere for participatory learning
- Welcome all participants, introduce yourself and provide a brief overview of workshop programme, including purpose and overall learning objectives of the condom training programme.

### 10.2 Opening session:

The estimated timeframe for the opening session is as follows:

| Programme Item | Time |
|---|---|
| Registration and administration | 8:00am – 8:30am |
| Training commences | 8:30am |
| Welcome and opening remarks (inauguration of the training) | 5 minutes |
| Introductions/ ice breaker (get to know your neighbour: see below) | 5 minutes |
| Introductions/ ice breaker (present your neighbour to the plenary) | 20 minutes |
| Workshop norms and house rules | 5 minutes |
| Workshop expectations and goals discussion | 5 minutes |
| Pre-test quiz (10 minutes to complete and 10 minutes for answers) | 20 minutes |
| **Total time (from training commences):** | **1 hour** |

### 10.3 Introduction of participants (ice breaker/ warm up game):

Lead participants (in pairs/groups of two) on the warm-up game below:

Write down your answers to the following questions on a piece of paper:

- Name
- Place of work
- Responsibilities
- Positive comments about condoms
- Concerns about condoms
- Reason(s) for coming to the training workshop
- In two minutes, participants talk to their partner/neighbour, explaining answers very well because they will be introducing each other to the main group.
- Return to the main group and each person has 30 seconds to introduce their partner/neighbour, very quickly based on interview questions above.

### 10.4 Establish house rules and workshop norms

Introduction is normally followed by establishing and enforcing house rules. Tell the participants where bathrooms are and any other place they may need during the sessions. Tell them about what is acceptable and not acceptable in this workshop,

- Explain the purpose of having workshop rules and norms.
- Put up a flipchart sheet with the heading: House Rules for our Workshop.
- Participants propose norms; facilitator (or co-facilitator) records all agreed suggestions on the flipchart.
- Examples include: No cellular phones (silent mode and no vibration); Do not interrupt while other participants are speaking; non-judgemental attitude; respect each other; raise your hand to speak; participate and contribute your ideas; notify facilitator of any urgent calls expected; have fun
- Confirm that everyone agrees to the rules and norms.
- Remind participants that these norms will act as rules that everyone needs to follow in order to ensure a successful training programme.
- ***Make everyone commit to adhere to the Do's and Don'ts of the workshop***
- Post the completed flipchart on a wall (preferably at the front of the training room).

In terms of logistics, check if everybody has accommodation and transport to and from the workshop. Arrange to meet later with those who could be having problems with these, unless it is clear that arrangements are being privately or through individual offices.

### 10.5 Workshop expectations discussion

- Invite participants to share their expectations for the workshop
- Record the participant expectations on a flipchart
- If there are repeated expectations, then merge each duplicate submission with the existing ones already on the flipchart, and double-check with participants whether all points have been considered and recorded.
- Once participant expectations have been confirmed, tear-off that flipchart and stick it on the wall to the left or right of the room, at the front.

### 10.6 Workshop goals

- After expectations have been shared, work with participants to set workshop goals for the time you will be together in the training
- Add anything new to the list of expectations that has not been considered as yet.

### 10.7 Pre-test assessment

- Refer participants to the pre-test in annexure C. (10 minutes to complete the test)
- Spend five minutes going through the solutions and answers to the mini-test.

## MODULE 1

**Overview of the HIV epidemic**


**Learning objectives:**

- to promote understanding of HIV and AIDS
- to promote an appreciation of the HIV epidemic globally, in the Sub Saharan region and in South Africa
- to differentiate between prevalence and incidence
- to unpack different sources of HIV statistics and information

**Duration:** One hour 30 minutes

**Promote understanding of HIV and AIDS**

This section should set the scene and provide a brief background on HIV mortality and morbidity. The emphasis should be on HIV and STIs and why they are of public health concern.

**Differentiate between prevalence and incidence**

Prevalence and incidence are sometimes used interchangeably, often without understanding of their actual meaning. To recap PREVALENCE is the number of infections in the population at any given time; whilst INCIDENCE is the number of new infections within a specified figure in a population. The imperative is to ensure that the participants understand the difference, know when to use or apply either of them and understand and interpret the different values.

Whist in the earlier section you would have dealt with prevalence figures, in this section it is important to emphasise incidence – as it is the measure of new infections and prevention efforts are aimed at decreasing the number of new infections. Link these prevention activities to the UNAIDS three zeros – zero new infections, zero stigma, zero AIDS related deaths and make reference to the more recent 90:90:90 which similarly is a goal set by the UNAIDS towards the elimination of HIV (vision 2030).

### Section 1.1: Background

Provide an overview of the HIV/AIDS epidemic internationally, regionally (Sub-Saharan Africa) and the extent locally within South Africa.

✓ Refer to Participant Manual and the training slides.

**Global HIV epidemic**

Since the advent of HIV in the 1980's, the number of people infected and affected by the disease has grown exponentially with devastating social and economic consequences. In 2015, 36.7 million people were reported to be living with HIV globally (UNAIDS, 2016). Sub-Saharan Africa remains the region most affected by the pandemic, with 25.5 million people living with HIV. This accounts for 68 per cent of the global total number of people living with HIV.

**HIV in South Africa**

✓ STIs, including HIV, are a major public health burden in South Africa. With a generalised HIV epidemic, thought to be influenced by a number of behavioural, historical and structural factors including patterns of sexual partnerships, heavy episodic alcohol use, gender inequality, violence and poverty, South Africa's prevalence is one of the highest in the world. The HSRC (2014) reported an HIV prevalence of 18.8 per cent (HSRC, 2014) in the age group 15-49 years old and an incidence of 1.72 per cent amongst the 15-49 year olds.

## Section 1.2: HIV and STIs prevention

STIs remain a global health challenge with a need of urgent interventions as means to avert this challenge and are associated with increased acquisition of HIV. Control of STIs can be measured by reduced incidence.

In an effort to combat the burden of STIs, South Africa has adopted Syndromic management approach as the preferred method for the control and management of STIs since 1996. It is preferred in that it is simple, avoids expensive diagnostic tests that are unavailable in resource limited settings, and effective in treating symptomatic STIs (WHO, 2013). It is important to screen clients for symptoms of STI when they access health services. These include but are not limited to: vaginal, penile or rectal discharge, pain in the lower abdomen, genital ulcers, al partner/s in the last eight weeks.

The syndromic approach is based on the identification of consistent groups of symptoms and easily recognised signs or symptoms as well as the provision of treatment that deals with the most serious organisms responsible for producing such syndromes.

## Section 1.3: Measuring HIV infection

The facilitator explores how HIV infection is measured, and explains the difference between HIV prevalence and HIV incidence.

✓ Refer to Participant Manual and the training slides.

**What is the difference between HIV prevalence and HIV incidence?**

The two words are often mistakenly interchanged and yet they are different. Table 1 below describes the differences between the two terms:

**Table 1: Differences between HIV Prevalence and HIV incidence**

| HIV prevalence | HIV incidence |
|---|---|
| **HIV prevalence** describes the ***percentage of people who are infected with HIV***. It is often an estimate figure and there is no way of telling the exact number of people without all of them taking a test.<br><br>*Prevalence gives a figure for a factor at a single point in time. If you want to know how many males have HIV in South Africa at any given time – this is a measure called prevalence. It does not tell us when they were infected.* | **HIV incidence** on the other hand is the ***number of new infections of HIV*** in a given period. It is also an estimate of the number of people. It is important to track both prevalence and incidence data. Prevalence gives a measure of the extent and size of the epidemic.<br><br>*Incidence is the number of instances of illness commencing, or number of new infections during a specified period. For instance, if you wanted to measure the number of new people infected with HIV in 2012 – this measure is called incidence. It does not consider the already existing infections.* |

## MODULE 2

**Combination HIV prevention**



**Learning objectives:**

- to promote an understanding of the national strategic plan for HIV and AIDS
- to promote an understanding of the HIV prevention plan
- to explore drivers of HIV risk by age and gender
- to describe how the condom programme is integrated within broader HIV prevention efforts
- to develop an understanding of combination prevention and its application in different population risk groups

**Duration:** One hour

### Combination Prevention Interventions

In response to HIV, TB and STI infections, South Africa recommends combination prevention interventions. The Department of Health developed the Health Sector HIV prevention strategy in order to operationalise the national response.

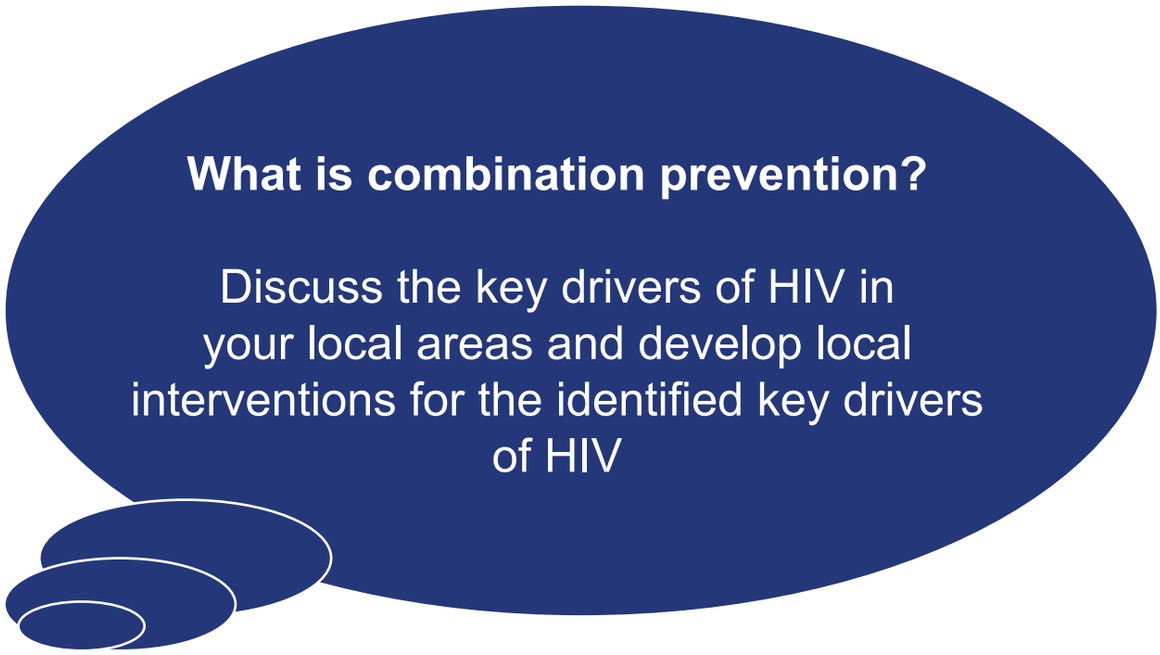
The *HIV Prevention Strategy* provides a framework for implementers for the planning and implementation of prevention interventions tailored to the needs and local context. The internationally accepted approach of 'combination prevention' is the cornerstone of this strategy. The approach offers the best prospects for addressing documented weaknesses in HIV prevention programming and for generating significant and sustained reductions in HIV incidence in diverse settings.

Combination prevention refers to the strategic simultaneous use of different classes of prevention interventions (i.e. biomedical, behavioural and structural) that operate on multiple levels (individual, couples, community and societal) to respond to the specific needs of particular audience and modes of HIV transmission, and to make efficient use of resources through prioritising partnership and engagement of affected communities.

**For more information, refer to the national Health Sector HIV Prevention Strategy, 2016**

**TABLE 2: EXAMPLES OF COMBINATION HIV PREVENTION APPROACHES**

| Approach | Examples of intervention |
|---|---|
| **Biomedical intervention strategies to reduce exposure, transmission and/or infection** | Male and female condom provision<br>Drug treatment including opioid substitution therapy<br>Male circumcision<br>Biomedical prophylaxis – ARVs in PMTCT services, pre-and post-exposure prophylaxis (PrEP and PEP), etc.<br>Appropriate and accessible STI services, ART for prevention<br>Blood safety, standard precautions in healthcare setting |
| **Behavioural intervention strategies to promote individual risk reduction** | HIV testing and risk reduction counselling.<br>Behaviour change communication to promote partner reduction, condom use, uptake of HIV testing and counselling, etc.<br>HIV education<br>Interpersonal communication, including peer education and persuasion<br>Social marketing of prevention commodities<br>Cash incentives for individual risk avoidance etc. |
| **Social and cultural intervention strategies** | Community dialogue and mobilisation to demand services;<br>Stigma reduction programmes<br>Advocacy and coalition building for social justice<br>Media and inter-personal communication to clarify values, change harmful social norms<br>Education curriculum reform, expansion and quality control<br>Support youth leadership etc. |
| **Political, legal and economic strategies** | Human rights programming<br>Prevention diplomacy with leaders at all levels community micro finance/microcredit training/advocacy with police, judges, etc.<br>Policies re: access to condoms (schools, prisons etc.)<br>Review and revise workplace policies<br>Stakeholder analysis and alliance building<br>Strategic advocacy for legal reform Regulation/deregulation, taxes |
| **Intervention strategies addressing physical environment:** | Housing policy and standards<br>Enhance farming, other modes of subsistence, for food security<br>Infrastructure development – transportation, communications, etc. |




**Group discussion exercise (45 mins): Combination interventions in your area**

1. Refer to the bubble cloud above
2. Break the class into 5 groups: each one will discuss, write up notes and present on one of the 5 areas within combination prevention (in the table above)
3. The groups will answer the following questions:

a. What are the key drivers of HIV in your local areas/ community?
b. Identify interventions under your category, to address each of the key drivers in a table format, list and number them.
c. Condoms: relate your interventions to the condom programme within your local area. Suggest ways that you would promote the correct and consistent use of condoms; address the objections to condom use and myths, and how would you address refusal to use condoms?
d. Each group will select a scribe and a presenter to share the group work with the class.
e. In the plenary, each group is given 5 mins to present.

**Important notes to consider when discussing this exercise (5 mins sum-up):**

- ✓ HIV/AIDS in South Africa has been described as a "feminised epidemic": certain cultural, sociological, economic and biological factors put women and girls at high risk of STI infection, in particular HIV.
- ✓ There are several determinants of HIV and STI transmission that put young women and girls, especially in the 15- 24 years age group.
- ✓ The facilitator discusses cultural, sociological, economic and biological factors that put women and girls at high risk of STI infection, in particular HIV.
- ✓ Look at the strategies from all the groups participating in the above exercise (according to the combination HIV prevention categories), then summarise inputs.

## HIV Risk Factors

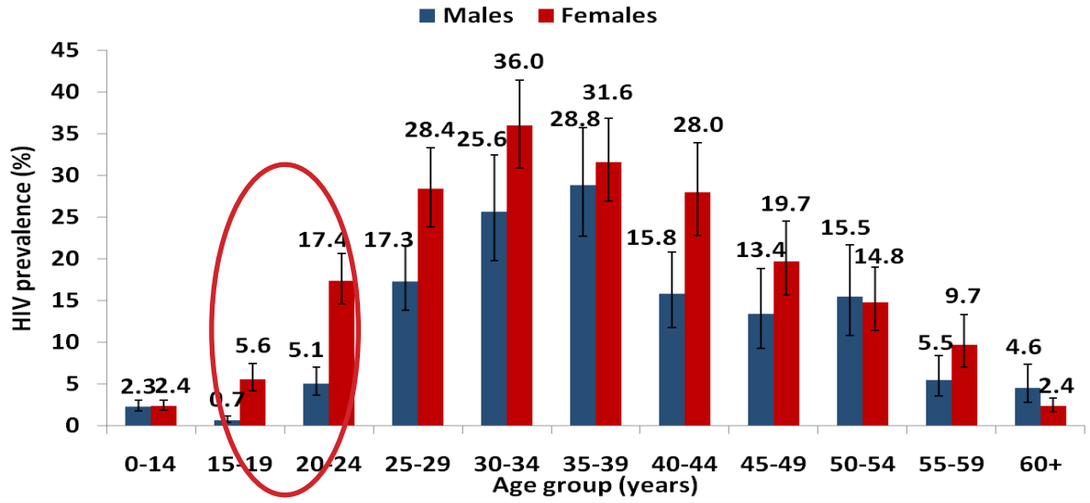
Certain sexual and social behaviours can increase your HIV risk. These are some of the most common HIV risk factors:

- Having unprotected vaginal, anal or oral sex with someone who is infected with HIV or whose HIV status you don't know.
- Having multiple sexual partners.
- Having sex with a sex worker or an IV drug user.
- Sharing needles, syringes or equipment used to prepare or inject drugs with someone who is HIV-positive.
- Using needles for piercing or tattooing that are not sterile.

**Other possible HIV risk factors**

Other factors may also increase your risk of HIV. For example, having sex under the influence of alcohol or drugs may lead to other risky behaviour such as having unprotected sex. Here are other potential HIV risk factors:

- Having another sexually transmitted infection (STI) such as herpes, chlamydia or gonorrhoea.
- Having sex after drinking alcohol or taking drugs.
- Intergenerational sex relationships
- Multiple sexual partners and other behavioural and structural factors.
- It was reported that young women and girls aged 15-24 are 8 times more likely to be infected with HIV than their male counterparts. This is shown in figure 1 below:



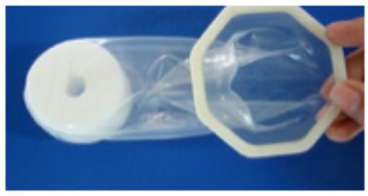

## Section 2.1: The national strategic plan for HIV, TB and STIs

Explore the NDoH recommended combination prevention interventions in response to HIV, TB and STI infections

- ✓ In this section, the facilitator provides overview and rationale for the Health Sector HIV prevention strategy.
- ✓ Combination prevention is defined in broad terms.
- ✓ Refer to participant manual and the training slides.

## MODULE 3

### CONDOMS: CORRECT AND CONSISTENT USE OF CONDOMS




**Learning objectives:**

- to outline the background of the condom programme in South Africa
- to highlight the importance of consistent and correct condom use
- to differentiate between male and female condoms
- to demonstrate the correct use of the male and female condom
- to understand the importance of using the correct lubricant
- to emphasise the importance of dual protection when providing sexual reproductive health (SRH) services

**Duration:** One hour 30 minutes

**Introduction and overview**

This module focuses on the benefits of correct use of male and female condoms. The facilitator needs to emphasise that:

- ✓ attention to detail, through adhering to a step by step methodology as demonstrated in the participant manual and selected training videos, is essential
- ✓ the videos and practical demonstration sessions support the mastery of the requisite skill in putting on a male and a female condom
- ✓ condoms, when used correctly and consistently are an effective means for preventing HIV infection, STIs infection and unplanned pregnancies
- ✓ risk persists when condoms are not used correctly and consistently

#### Background of the condom programme in South Africa

The NDoH condom distribution has increased in the last three years 2013 – 2016 with a distribution of over 1.8 billion male condoms and over 60 million female condoms. However, despite these efforts, studies have shown that condom use has decreased in the last few years, especially amongst young people. Based on these reports, the NDoH, in collaboration with Society for Family Health (SFH) with funding from UNFPA, embarked on a perception study on male condoms to identify barriers with regards to the use of condoms. The perception study reported that there were a few challenges that the young people cited with regards to the then nationally procured male condom brand, 'CHOICE'. These challenges included the latex smell of the condom and the fact that there were no variants such as scent and colour.

In response to the results of the perception study, the NDoH then revised the male condom specifications, procured and distributed coloured, scented and re-branded male condoms by the name of MAX, for maximum quality, pleasure and sensitivity. The re-branded condoms are available in four different varieties; red strawberry scent, yellow banana scent, purple grape scent and the original colour masked with a slight vanilla scent.

Female condoms distributed nationally are not branded and have the following trade names: FC2 and Cupid and the department is in the process of branding. It is critical that a standardised national curriculum is developed in order to ensure standardized procurement, storage, distribution, provision of males and female condoms and correct, consistent use.

It is important popularise and market the different types of male and female condoms procured nationally. All public-sector condoms are quality assured by an independent body. NDoH procures condom compatible water-based lubricants sachets of 5ml for distribution with the condoms.

## Section 3.1: Condoms and dual protection

The goal of dual method use is to prevent unintended pregnancy and to prevent sexually transmitted diseases through the use of more than one contraceptive method (e.g., oral contraceptive pills and condoms).

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

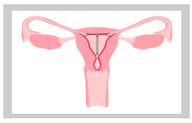
**What are some key strategies for dual protection in a family planning setting?**

- Working with clients on partner communication and condom negotiation skills.
- Involving men in counselling and education and addressing their concerns about condoms.
- Promoting the female condom as a viable method (where it is available).
- For every method of contraception, discuss the risk of STIs and HIV
- Remind all clients that only condoms protect against HIV and STIs and dual protection should be recommended with all other contraceptive methods

The various contraceptive methods available are depicted in the table below:

**TABLE 3: VARIOUS CONTRACEPTIVE METHODS AVAILABLE**

| Method | Key factors |
|---|---|
| **Male condom**<br>  <br>**Female condom**<br>  | Effective as contraceptive method when used consistently and correctly<br>Overall effective in preventing STIs, including HIV<br>Does not affect breastfeeding or interact with medications<br>Must counsel regarding correct use<br>Promote and provide access to emergency contraception<br>Condom use should always be encouraged as dual method use to maximise HIV and pregnancy protection |
| **Progestin-only pills** | POPs are appropriate for breastfeeding women and are a useful alternative for women who experience oestrogen-related side effects with COCs, or have health conditions that may preclude safe use of COCs.<br>As commonly used, 90-92% effective; ≥99% effective if breastfeeding<br>Primarily thickens cervical mucus and so prevents sperm penetration (after two days of use). Also, inhibits ovulation in 60% of cycles. |
| **Progestin-only injectables**<br>**(DMPA and NET-EN)**<br>  <br>**Implant**<br>  | Injectables: 94% effective as commonly used; if return for re-injection on time 99.7% effective as contraceptive<br>Concerns regarding bone mineral density in women < 18 years and > 45 years<br>Not protective against STIs, including HIV. Recent studies suggest they may increase the risk of HIV acquisition (specifically DMPA). While awaiting additional research, emphasise importance and proper condom use in conjunction with hormonal and non-hormonal contraceptives to prevent HIV.<br>Alternatives, such as lower dose hormonal contraceptives, and non-hormonal options, such as Cu IUDs, need to be explored with the client. Weigh risk of possible HIV against benefits in preventing pregnancy.<br>Implants: Almost 100% effective, remain in place for 3-5 years<br>Not protective against STIs and HIV |

| Method | Key factors |
|---|---|
| **Intrauterine contraception**<br><br>**non-hormonal**<br><br>(Copper - CuIUD)<br><br>  | Highly effective, long-acting and reversible method<br><br>Approved for use up to 10 years (copper)<br><br>99.2-99.4% effective<br><br>No age restrictions<br><br>Does not affect breastfeeding, intercourse or have hormonal side effects<br><br>Do not protect against STIs, including HIV and dual method with consistent condom use should be recommended |
| **Emergency contraception**<br><br>  <br><br>  | Use at any time during menstrual cycle within fivedays (120 hours) following unprotected intercourse<br><br>ECPs – POPs 58-95% effective, COCs 31-77% effective (effectiveness depends on how soon initiated following unprotected intercourse).<br><br>*The morning-after pill is a form of emergency contraception that prevents pregnancy after unprotected sex. It is safe and effective, though it shouldn't be considered a go-to form of contraception (hence the term 'emergency').*<br><br>Cu IUD – fails in only < 0.1% of cases. Insert under antibiotic cover (to prevent STIs) and remove during the next menstrual period<br><br>*Risk of infection is higher than risk for pregnancy. Screen for STIs and consider post-exposure prophylaxis for HIV<br><br>*The intrauterine device (IUD) is also known as the loop. The morning-after pill is short-acting, while the loop, once inserted, is active for up to 10 years.* |
| **Lactational Amenorrhoea Method**<br><br>  | Breastfeeding as temporary method of contraception, 98-99% effective if amenorrhoeic and fully breastfeeding during first 6 months after childbirth. |
| **Fertility Awareness-Based Methods**<br><br>  | Based on identification of natural signs and symptoms of fertile and infertile phases of menstrual cycle. Requires abstinence or condom use during the fertile phase of each cycle.<br><br>Depends on a woman's ability to identify her fertile window, as well as both partners' motivation and discipline to practise abstinence (or use condoms) when required. 95–97%effective during first year of consistent and correct use but only 75% effective as commonly used |

It is critical to note on family planning that women and men have the right to access all available family planning methods so that they can space or postpone pregnancy.

## Section 3.2: Encouraging consistent and correct condom use

When used correctly and consistently, condoms are an effective means to prevent HIV infection. Risk, however, persists when condoms are not used correctly and consistently. Condom use with primary partners – either spouses or steady partners – tends to be lower than condom use with non-regular partners as well as being lower among older persons. Promoting consistent use of both male and female condoms remains an important focal prevention opportunity.

An evidence-based, diversified and comprehensive response to the HIV and AIDS epidemic must include developing appropriate combination prevention packages to encourage fidelity and condom use. This could include reviving the basic 'abstinence, be faithful and condomise' (or simply ABC, and D, for Delay Sexual Debut) prevention interventions to equip the population with basic knowledge about HIV prevention.

Lower condom use rates among females compared to males and high multiple sexual partnership rates among males point to the structural issue of gender inequality in our country that continues to drive the HIV epidemic. This issue will also need to be addressed.

Male and female condoms are the only devices that reduce both the transmission of HIV and other STIs and prevent unintended pregnancy. Research among sero-discordant couples (where one partner is living with HIV and the other is not) shows that consistent condom use significantly reduces the risk of HIV transmission both from men to women and women to men. Consistent and correct use of condoms also reduces the risk of acquiring other STIs and associated conditions, including genital warts and cervical cancer. A recent global modelling analysis estimated that condoms have averted around 50 million new HIV infections since the onset of the HIV epidemic (UNAIDS, 2014). In 2015, 27 billion condoms estimated to have been available globally through the private and public sector provided up to an estimated 225 million couple years' protection from unintended pregnancies (UNAIDS, UNFPA and WHO, 2015)

## Section 3.3: Male and female condoms

### 3.3.1 The male condom

The national condom programme currently distributes over 800 million male condoms annually through a decentralised distribution system managed at provincial level. The National Contraceptive Policy lists condoms as a core dual contraceptive method that should always be available in public-sector facilities.


**FIGURE 2: CONDOMS AND DEMONSTRATION APPARATUS**

### 3.3.2 The female condom (FC)

FC distribution has been increasing yearly and currently South Africa is distributing over 25 million female condoms annually. Although FC distribution in South Africa is among of the highest in the world, it is not comparable to the current male condom distribution. The introduction of the synthetic latex FC2 and the natural latex Cupid female condom, which have replaced the polyurethane FC1 increased availability. The female condom provides options to using barrier methods.

**Figure 3: Female Condoms (Cupid and FC2) and female demonstration apparatus**

### 3.3.3 Correct condom use: Condom demonstration (practical)

**Practical exercise: Condom demonstrations**

Voluntary demonstration with models of reproductive organs

*Request for 2 volunteers. Each volunteer to:*

- ✓ *demonstrate the correct usage of a male condom*
- ✓ *demonstrate the correct usage of a female condom*

*All other attendees **by means of a checklist** critically evaluate this step by step demonstration and give constructive feedback thereafter.*

## Section 3.4: Ten step guide to using the male condom

Condoms can only achieve their effectiveness when they are used correctly and consistently. Before one uses a condom, these are important steps to take:

1. Assess the integrity of the condom packaging. If it is not intact, it is advisable not to use the condom
2. Check the date of expiry on the individual condom packet. If it is expired, do not use the condom
3. While the condom is still sealed, smooth your finger gently over the package to distribute the lubricant evenly, prior to opening the packaging. If preferred, you may apply a water based lubricant. Added lubrication can make sex feel more comfortable, but more importantly this helps prevent condoms from breaking.
4. carefully open the condom packaging on the serrated side without the use of a sharp object or teeth, to ensure that you do not damage the condom itself
5. Remove the condom from its packaging and hold it at its tip – where you will find an air sac. Pinch this air-sac to rid it of any air and apply the condom at the tip of an erect penis
6. Push back the foreskin before applying the condom if penis is not circumcised.
7. Roll the condom over the penis to the base of the shaft. Should you mistakenly find that the condom was the other way round, promptly discard and take another condom.
8. Check that the condom has a comfortable fit and covers the entire penis before penetration
9. After intercourse, it is important to withdraw the penis and remove the condom immediately before the penis loses erection. To avoid contact with fluids place a tissue at the base of the still erect penis and remove the used condom. Use another tissue to hold the penis in place while removing the used condom.
10. Wrap the used condom carefully (to avoid spilling the contents) in tissue, or ordinary paper, and dispose in the bin

**NB:** It is a risk to let the penis touch the vagina or anus before a condom is worn, or if it slips off during sex. Some people prefer to use a condom with added lubricant to make sex feel more comfortable, but more importantly this helps prevent condoms from breaking.

### Tips for using condoms

1. Plan ahead and make a decision to have sex, talk about safer sex with your partner, before you start to have sex.
2. Always keep a condom handy, do not rely on your partner to have condoms and store it in a cool dry place. Heat can cause the condom to deteriorate. Avoid putting a condom in your back pocket as you might damage the condom while sitting.
3. *Condoms should only be used provided as the cover is still intact and is still in its sealed packet.*
4. Use a new condom every time you have sex. Never use the same condom more than once.
5. Using lubricants can reduce the risk of condom breakage.
6. Only use water-based lubricants with condoms.
7. Do not use oil-based lubricants, such as Vaseline, baby oil or cooking oil as it can damage the integrity of the condom.
8. Never reuse a condom. Always change condoms each time you have sex, and if you are going to go from penetrating one orifice to another. You should, for example, never have vaginal intercourse after anal intercourse without changing condoms.

***Consistent and correct use of condoms is an effective way of preventing the spread of HIV, other STIs and unintended pregnancies.***

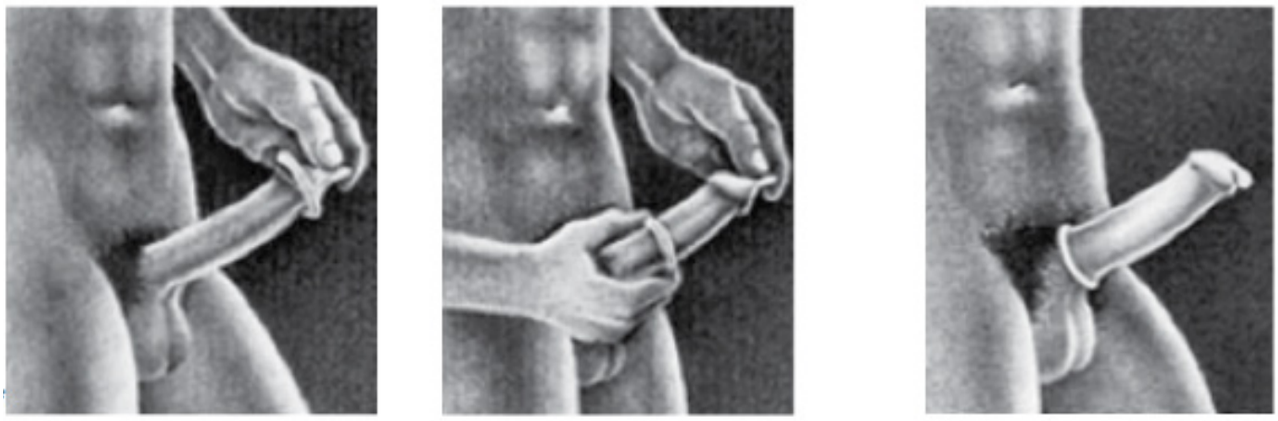


**FIGURE 4: A STEP BY STEP APPLICATION OF A MALE CONDOM**

## Section 3.5: The correct use of the female condom

The NDoH distributes two types of female condom: The FC2 and the Cupid.

**FC2:**

FC2 is made of a synthetic latex pouch that fits inside a woman's vagina. It has a soft ring on each end. The outer ring stays on the outside of the vagina and partly covers the labia (lips). The inner ring fits on the inside of the vagina, somewhat like a diaphragm, to hold the condom in place.

**Cupid:**

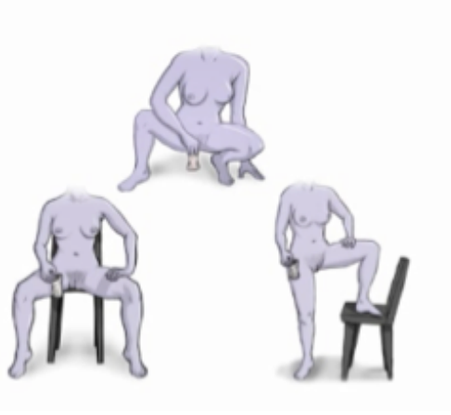
Cupid is made of a natural latex pouch that fits inside a woman's vagina. It has a soft ring on one end and a sponge on the other end. The outer ring stays on the outside of the vagina and partly covers the labia (lips). The sponge fits on the inside of the vagina, somewhat like a diaphragm, to hold the condom in place.

| Examples of female condoms (FC2 and Cupid) | |
|---|---|
| **FC2** | **Cupid** |
|  |  |

**Figure 5: Two types of female condoms: FC2 and Cupid**

***NB: The female condom may also be used with water-based lubrication***

***NB: The current female condoms (FC2 and Cupid) need not be inserted 8 hours before sex, they can be inserted and used immediately.***



Position for insertion of a female condom may include:

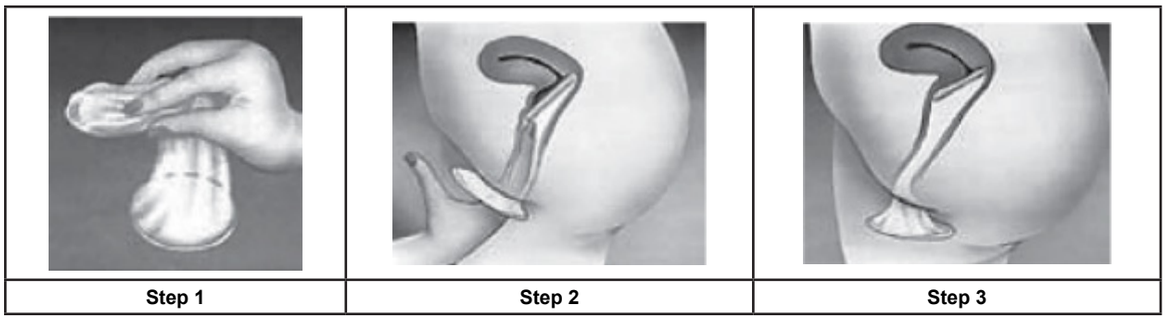
- Sitting
- One leg raised on a chair
- Squatting
- Lying on your back

**FIG 6: THE FOUR MAIN POSITIONS FOR FEMALE CONDON INSERTION**

**Steps for insertion:**

1. Squeeze the inner ring/sponge of the condom in the middle
2. Hold the outer ring in place and put the inner ring/sponge inside the vagina. With your finger, push the inner ring/sponge as far into the vagina as it will go.
3. Make sure that the outer ring stays outside the vagina.
4. Guide the penis into the condom. Be sure that the female condom is securely in place and penis is not entering on the side between the condom and vaginal wall.
5. After ejaculation, use a tissue to twist the outer ring and then remove carefully to avoid spillage.
6. Wrap the used condom carefully (to avoid spilling the contents) in a separate toilet paper, or ordinary paper, and dispose of in the bin.

***Insert the condom any time before the penis touches the vagina. Add lubricant to the inside of the condom if needed.***



| Step 1 | Step 2 | Step 3 |
|---|---|---|

**FIGURE 7: THE THREE MAIN STEPS OF FEMALE CONDOM INSERTION**

| Know your CONDOM DO's and DON'Ts | |
|---|---|
| **DO's** | **DON'Ts** |
| • Read all the information on the package and follow the instructions carefully.<br>• Check the expiration date on the package. If it is expired, get a new package of condoms and throw away the old ones.<br>• Use only condoms that are made of latex or polyurethane (plastic). Latex condoms and polyurethane condoms are the best types of condoms to use to help prevent pregnancy, STIs and HIV.<br>• Use a pre-lubricated condom to help prevent it from tearing. If you only have a non-lubricated condom, put a little bit of water-based lubricant ("lube") inside when applying the female condom, or outside when using the male condom<br>• Condoms come in different colours and scents.<br>• Assist your disabled partner to put on a condom. | • Do not use two condoms at the same time<br>• Do not use the same condom on more than one partner<br>• Do not use condoms made of animal skin, sometimes called "natural" condoms.<br>• Avoid keeping condoms in your pockets for a long period of time as they may get damaged<br>• Do not keep condoms in a place that can get very hot, like in a car. If you keep a condom in your wallet or purse, be sure you replace it with a new one regularly<br>• Do not use any kind of oil-based lubricants (like petroleum jellies, lotions, mineral oil, or vegetable oils). These can negatively affect the latex, making it more likely to rip or tear.<br>• Do not use male and female condoms together(at the same time)<br>• Do not reuse condoms<br>• Do not use condoms that are already opened, damaged or expired. |

**Myths about condoms and suggested responses**

- ***Condoms reduce sexual pleasure*** *(use a water-based lubricant)*
- ***Takes time to put on a condom, detracts from the moment – mood killer*** *(help your partner put it on, assist with insertion, it's fun!)*
- ***Government condoms are not of high quality*** *(actually SABS-approved)*
- ***Condoms are small for some men*** *(use consistently, adapt to condoms)*
- ***Two condoms used at the same time are better than one*** *(no, two condoms will rub against each other causing friction and will tear)*
- ***Guys are responsible for bringing condoms*** *(this stereotype is a myth)*
- ***Female condoms are noisy*** *(new FC is made from nitrile and is not noisy)*

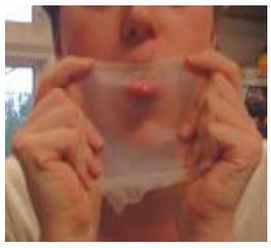
## Section 3.6: Provision of compatible lubricants

Adequate supplies of water based-lubricant also need to be provided to minimise condom usage failure, especially for vaginal dryness, anal sex and in the context of sex work. Approximately 50 percent of men and women who have used a lubricant stated that it was easier to reach an orgasm, according to a 2013 study from Indiana University's Centre for Sexual Health Promotion. The researchers found that men who used a lubricated condom became just as aroused as men with no rubber at all. Lubrication should be water-based. The NDoH currently distributes 5ml sachets of water-based lubricant.


**FIGURE 8: WATER-BASED LUBRICANT SACHETS**

## Section 3.7: Dental dams

There are several other forms of barriers that can be used to prevent transmission of STIs, e.g. the dental dam (as shown below). The dental dam can be used during oral sexual stimulation to protect one partner from passing an STI



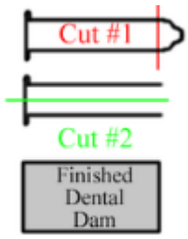



**FIGURE 9: DENTAL DAMS**

***NB: Currently, the NDoH does not distribute dental dams***

***Dental dams are available in pharmacies and adult shops. A male condom can be used to make a dental dam if one is not readily available, by cutting out a male condom as shown in the diagram above.***

**How to use dental dams:**

- Open the package carefully
- Carefully check for holes in the product
- Place the dental dam over the vulva or anus
- Using lubricant (only water based) may increase pleasure of the receiving party
- DO NOT flip the dental dam over to use the other side
- DO NOT switch the dental dam to other body part, e.g. from anus to vagina
- A condom could be used as a dental dam as shown in the figure above

## MODULE 4

**MODULE 4: PSYCHOSEXUAL FACTORS AND COMMUNICATION**

**Learning objectives:**

- to gain a deeper understanding of our own beliefs, values and attitudes through self-introspection and interaction with others
- to distinguish between personal and professional views in providing services to clients
- to apply the principles of safe counselling skills
- to identify and understand risk assessment
- to differentiate between gender, sex and sexuality
- to promote understanding of gender inequalities and understand how attitudes towards gender influence stereotypes, discrimination and stigma in relation to woman and girl's ability to negotiate safer sex
- to acquire an understanding of key populations, remove barriers and improve provision of quality health services.

**Duration:** One Hour

### Section 4.1: Values clarification session

#### 4.1.1 Values Clarification (defined)

Facilitator should discuss Values Clarification

- ✓ What is "Values Clarification"?
- ✓ Refer participants to the definition in the slides

#### 4.1.2 Self-Awareness

Self-awareness is important: we need to know how we can grow it and develop it. In human beings, we are able to see the behaviours and actions of individuals. However, there are many things about individuals that we do not see, like; thoughts, feelings, values, motivations; cultural influences and experience.

- ✓ Emphasise the importance of self awareness
- ✓ Refer participants to the slides on values clarification

**Exercise: conducting a values clarification exercise in a forum mode:**

A flip chart is needed

- ✓ Ask participants to answer values questions on flip chart
- ✓ To start discussions visual cues postcards or magazine clippings could be used as cues.
- ✓ Participants are asked to:
- ✓ *Select something that represents a value that is important to them*
- ✓ And substitute one of the questions being used to guide the exercise

Use the above exercise to demonstrate the dangers, risks and consequences of not using condoms correctly or consistently. Explain that values are like goals and dreams and demonstrate the pitfalls and disruptions that can prevent a client from achieving set goals and dreams (e.g. list on a flipchart).

**NB:** Emphasise the need to separate **personal** from **professional** values and beliefs when providing health care services or promoting condoms.

The health care worker/professional needs to educate and empower clients with information on HIV/AIDS and STIs, and the consequences of unintended pregnancy so that the client can decide whether to use condoms and practice a healthy lifestyle, or not. The exercises below assist participants to deepen understanding of values and beliefs further, and guide discussions on whether to change or continue behaviours.

**Exercise 4.1.1 Agree or Disagree**

*Refer to Condom Training slides for instructions of this participative exercise that will involve all participants*

**Exercise 4.1.2 Cross the line**

*Refer to Condom Training slides for instructions of this participative exercise that will involve all participants*

## Section 4.2: Counselling skills and risk assessment

### 4.2.1 Counselling Communication Skills

Counselling is a confidential dialogue between a client and a healthcare provider/worker, aimed at enabling the client to cope with stress and make personal decisions, e.g. coping and gaining knowledge and information related to HIV/AIDS and other STIs so as to know more about protection. The counselling setting allows health care providers to discuss risk and address risky sexual behaviours. Discuss the following with participants:

- ✓ How would you assist a client to deal with the trauma and stress associated with testing positive for HIV, or other STI?
- ✓ How would you promote condom use to a client newly diagnosed as HIV positive?
- ✓ If a client is negative, would you recommend condom use?
- ✓ How would you address the issue of sexual partners not present during the counselling session? Would you recommend couples counselling? How?

### 4.2.2 Key concepts in counselling for Risk Assessment

✓ In this section, the facilitator examines ways to discuss and reduce risk behaviours.

**Exercise 4.2.2.1 Interactive Exercise: "Bushfire"**

*Refer to Condom Training slides for instructions of this demonstrative exercise*

After the Bushfire exercise, the facilitator can lead a role-play, as described below:

✓ A table to guide counsellors on questions to ask that establish the level of risk is provided further below.

Discuss the risk assessment categories listed in the table below:

| | |
|---|---|
| Partners | •Number of recent sex partners |
| Substance | •Substance use including alcohol associated with sex |
| Gender | •Sex or gender of each partner |
| Risk behaviours | •Circumstances of risky sex behaviours e.g. with anonymous partners, in particular settings |
| HIV status | •HIV status of each partner |
| Activities | •Types of sexual activity engaged with each partner |
| Disclosure | •Has patient disclosed HIV status to partners or potential partners? |

Reassuring patients about confidentiality of their responses to questions about risk behaviours is key to establishing rapport and trust so that truthful responses may be obtained.

**Exercise 4.2.2.2 The "Hot Seat"**

*Refer to Condom Training slides for instructions*

- ✓ The Hot Seat exercise assists participants to apply skills of dealing with objections to condom use (I.e. dealing with negative attitudes, myths and misconceptions surrounding condoms)
- ✓ This role play exercise also assists participants and end-users to improve condom negotiation skills
- ✓ In this session, the facilitator needs to list and emphasise the risks associated with unprotected sex (not using condoms), understanding risk reduction, healthy sexual behaviour, and reinforce positive condom messaging.
- ✓ Address issues related to living a healthy lifestyle and encourage health-seeking behaviour in clients

## Section 4.3: Gender and sexuality: an introduction

This section deals with the following:

- Knowledge, attitudes, perceptions and beliefs towards gender-related issues and the manner in which gender influences access to quality health services.
- Sexual orientation, gender identity and expression.
- Being familiar with the appropriate terminology to provide inclusive services.

### 4.3.1 This section distinguishes between sex and gender and explores gender dynamics underlying the challenges faced by intimate partners. This in turn should be related to relative ability to negotiate consistent condom use. Sex and gender

**In this section, the facilitator will differentiate between gender, sex and sexuality:**

- ✓ Defining gender, sex and sexuality.
- ✓ Making the distinction between gender and sex.
- ✓ Discuss the importance of understanding this within a public health context.
- ✓ Name the different gender categories and describe them (instructions below).

***NB note:*** *these two terms, 'sex' and 'gender' are often confused, and often used interchangeably, when in fact they are quite different.*

- ✓ Refer to the slides: Define "Sex" and "Gender"?
- ✓ The Participant Manual (PM) and the training slides provide definitions for the following terminology:
  - Sex
  - Inter-sex
  - Gender
- ✓ Discuss how the 2 terms, "sex" and "gender" are often confused, and why?
- ✓ Sex: refers to the biological and physical characteristics of a person
- ✓ Gender: the socially-constructed and accepted norms regarding the roles of men and women, girls and boys. Often traditional beliefs, culture, socially learnt values and norms are taught to people as they are growing up. Gender is also seen as a person's sexual identity and can influence sexuality, and sexual orientation.

Now, invite the participants to reflect silently while you read all these questions:

- Are you a male? How do you know?
- Are you a female? How do you know?
- Is your gender other than male or female? Are you transgender, or gender neutral?
- How do you know?
- Allow a moment, then invite volunteers to respond

Gender tip: always use the correct words to describe someone's sexual orientation or gender identity. If you don't know the correct term, ask someone in a respectful way and be sure to comply with their response.

### 4.3.2 Gender categories

Read out and define the gender categories as listed below:

- Homosexual: a person who is emotionally and sexually attracted to someone of the same sex.
- Heterosexual: a person who is emotionally and sexually attracted to someone of the opposite sex.
- Bisexual: a person who is emotionally and sexually attracted to both sexes.
- Lesbian: a woman who is emotionally and sexually attracted to a woman.
- Gay: (often refers to) a man who is emotionally and sexually attracted to a man.
- "MSM": Men who have sex with men
- Transgender: denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex (to cross dress is by choice).

### 4.3.3 Gender inequalities

- ✓ Refer to the Participant Manual (PM) and training slides for the overview on this topic.
- ✓ Discuss with participants a few (2 or 3) of the following issues listed below, that happen in the community that influence the relative power of women and girls to negotiate condom use, and increase vulnerability to being infected with an STI, or having an unintended pregnancy.
- ✓ Discuss about the Termination of Pregnancy (TOP) rate in SA with over 80 000 TOPs conducted an average per year for the past 5 years, from 2012- 2017

**Groups most affected by gender inequalities**

- Women living in poverty
- Unemployed and uneducated women
- Youth: e.g. economic dependence and peer pressure amongst adolescent girls and young women, and young boys.
- Women using alcohol or whose partners use alcohol, and substance abuse
- Women with a history of violence in their familiesAdditional notes:
    - LGBTI community
    - Religious and traditional practices and beliefs

### 4.3.4 Safe Negotiation of Safer Sex

The process of negotiation involves at least two people with two different views on an issue, in this case, sexual behaviour

- Each person tries to persuade the other party to support his/her view, a 'win' situation, or at least to agree on a compromise or middle position, a 'win, win' situation
- The goal that each woman and man must have is to practice safer sex
- Safe sex depends on the ability to convince partners that it is in their mutual best interests to use a condom

However, negotiations for safe sex are not always easy

- Because it may be difficult to discuss the subject, practicing safe sex may be very limited or just not done

Factors that Enhance Negotiation for Safer Sex

- Persuasion
- Ability to assess the situation
- Good listening skills
- Knowledge to express one's self
- Appropriate timing
- Observation of non-verbal skills

**Tips for Communicating With Your Partner: Safe Sex**

- Choose a relaxing environment in a neutral location, preferably outside the bedroom, where neither of you feel pressured
- Do not wait until you or your partner are sexually aroused to discuss safer sex. In the heat of the moment, you and your partner may be unable to talk effectively
- Use "I" statements when talking. For example, "I would feel more comfortable if we used a condom**"**
- Ask questions to clarify what you believe you heard. For example, "I think you said you want us to use condoms. Is that right?"
- Avoid judging, labelling, blaming, threatening or bribing your partner. Don't let your partner judge, label, threaten, or bribe you

### 4.3.5 Sample Arguments and Counter-Arguments for Condom Negotiation:

"I don't like using condoms. It doesn't feel as good."
- You can say: "I'll feel more relaxed and if I'm more relaxed I can make it feel better for you."

"We have never used a condom before."
- You can say: "I don't want to take any more risks."

"Using condoms is not pleasant."
- You can say: "Unintended pregnancy is more unpleasant. Getting HIV is more unpleasant."

"Putting it on interrupts everything."
- You can say: "Not if I help put it on."

"Don't you trust me?"
- You can say: "I trust you are telling the truth. But with some STIs, there are no symptoms. Let's be safe and use condoms."

**Still not sure about whether to use a condom?**

- *Use a condom every time until you know the HIV status of your partner*
- *Condoms also protect you against other STI's and unintended pregnancies*
- *Know your HIV status, get tested, to protect yourself and your partner*

✓ Refer back to the hot seat exercise above (objections to condom use) and the training slides.
✓ Also consider: some people support condom use and other are against it.
✓ Look for the best answers in the class to support condom use and improve condom negotiation skills.
✓ Most importantly, there is no right or wrong answer: it is about developing our communication skills and understanding of the risks associated with not using condoms correctly and consistently.
✓ Ensure that participants respect the house rules and listen to each other's points of view carefully.
✓ Check back with participants that they are understood before continuing.

## Section 4.4: Gender and HIV

✓ Refer to the Participant Manual (PM) and training slides for the content on this topic.
✓ Discuss a few examples (1 or 2) of ways that gender issues impact upon risk of infection with HIV, or other STIs
✓ Discuss health-seeking behaviour: why do most men wait until they are very sick before seeking healthcare services? Why do most men not like to visit clinics?

## Section 4.5: Key Populations (KPs)

This section deals briefly with understanding the different categories of Key Populations (KPs) and creating awareness of appropriate interventions to support delivery of quality STI prevention and service delivery to KPs in addition to a regular supply of condoms.

✓ Refer to the NSP 2017-2022 (Goal 3) in the PM and training slides.
✓ Conduct discussion on key population
✓ Find out if the group is familiar with all the different key populations

Table 4 states key and vulnerable population for condom promotion and behaviour change strategies (refer to the participant manual for the KP categories).

## Section 4.6: Social Behaviour Change Communication (SBCC)

**Learning objectives:**

- to understand and apply an appropriate marketing for targeted key populations.
- to apply acquired knowledge to effective social mobilisation.
- to understand their responsibility in continuing development to empower them to fulfil an advocacy role for the various key population groups.

✓ Refer to the PM and training slides.
✓ Discuss programmes and interventions (advertising campaigns, slogans and health promotion events) that have been successful in raising awareness of STIs and HIV and disseminating prevention messages.
✓ What HIV interventions aimed at young people have included a component of condom behaviour change?
✓ Can we name a few interventions that appeal to young people?

### Section 4.6.1 Social Behaviour Change Communication and Health promotion

✓ Refer to the Participant Manual (PM) and training slides for the definition of "health behaviour".
✓ Discuss a few examples (1 or 2) of ways in which a person can practice Health Protective Behaviour (HPB).

**Stages in Social Behaviour Change Communication (SBCC):**

- ✓ Refer to the Participant Manual (PM) and training slides for the definition of SBCC.
- ✓ Emphasise that SBCC is a process.
- ✓ Not everyone will change at the same time, I.e. if a group of people hear the same message at the same time, a few will change immediately, some might change behaviour after the second time of hearing the message, and furthermore, others might only change when they hear different kinds of messages, on a variety of media, e.g. TV, radio, posters and print, social media, or in a public setting.
- ✓ Messages need to be crafted that appeal to the target audience population
- ✓ Present the: ***The Stages of Behaviour Change Model***
- ✓ Refer to the Participant Manual (PM) and training slides for the SBCC process cycle diagram and explain it to participants as follows:
    - Individuals go through a series of steps or "stages" before a particular behaviour change becomes ongoing or permanent.
    - The role of the health provider is to intervene in specific ways during each of the stages in an effort to help the client progress from stage to stage.
    - Explain each step briefly
    - It is considered to be a "forgiving" model, meaning that clients are expected to "recycle" back through the model ("relapse") at least once, if not several times, through the process.

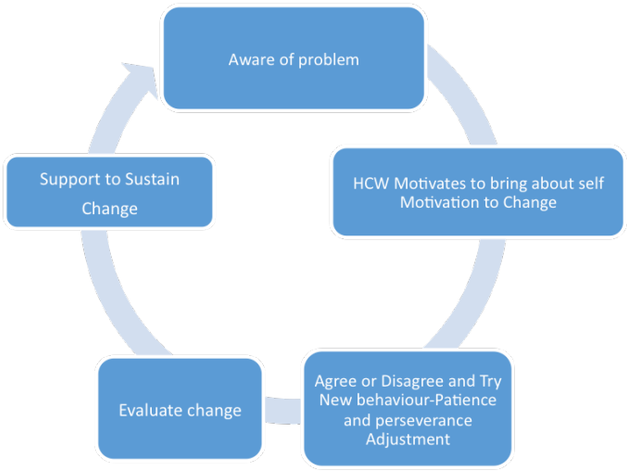



**Fig 10: STAGES OF BEHAVIOUR CHANGE: THE BEHAVIOUR CHANGE CYCLE**

- ✓ Refer to the Participant Manual (PM) and training slides for the 3 core elements of SBCC (table) and explain that these are components of the above process.
- ✓ Refer to the Participant Manual (PM) and training slides for definitions of the following terms and concepts in SBCC:

    •Health communication
    •Health education
    •Health promotion
    •Information, Education and Communication (IEC)

- ✓ Refer to the Participant Manual (PM) and training slides for the definition of IEC.

**Section 4.6.2 Social mobilisation and marketing strategy**

- ✓ Refer to the Participant Manual (PM) and training slides for the following definitions under the topic area:


**Fig 11: Condom Social Advocacy & Activism**

- ✓ Refer to the Participant Manual (PM) and training slides for the following definitions under the topic area:
    - Advocacy
    - Community Dialogue

**Proposed steps for a community dialogue**

There are several approaches to community dialogue, one in particular in use by FHI 360 uses standard methodology, working through a series of steps to develop the overall theme and key messages.

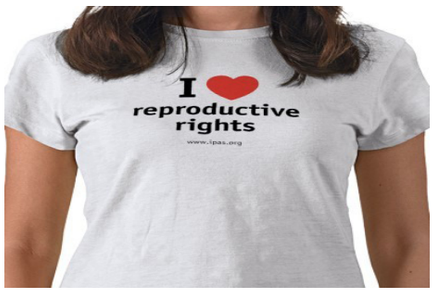
- ✓ **6 steps of the FHI 360 community dialogue process:** refer to the Participant Manual (PM) and training slides for the 6 steps of the FHI 360 community dialogue process
- ✓ Explain that both the SBCC process and the steps of community dialogue need to be understood well as both are complimentary: I.e. the HCW needs to continually encourage and promote behaviour change, at the same time working with the community to create messages that appeal to the target populations.
- ✓ It is important to collaborate with the community, motivate for change, monitor whether the desired change has occurred and provide support to all stakeholders throughout the community dialogue process.

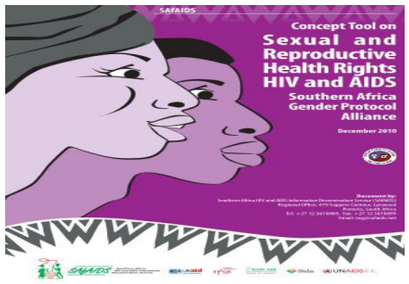
**Emphasise these points on community dialogue process:**

- ✓ Access: messages that promote condoms, must include information on where to access condoms and how to use them; and reinforce correct usage
- ✓ Service provision: If a message promotes skill development or specific services, then the services that are being promoted must actually exist.
- ✓ Quality health care and health services: the referrals must be appropriate and trustworthy, e.g. Youth Friendly Services, etc.

## MODULE 5

### 5.Sexual reproductive health, and rights




**Learning objectives:**

- to explain what is meant by SRH rights, state basic sexual and reproductive health rights, and identify when rights are violated.
- to argue the case for a woman's right to practice dual protection and provide responses for challenges to this right.
- to describe cultural, sociological, economic and biological factors that put women and girls at high risk of STI infection, in particular HIV.
- to explore the attempts of South African Government, Partners and Non-Governmental Organisations (NGO's) to address the "feminised epidemic" of HIV/AIDS through programming that focuses on women and girls.

### Section 5.1: Sexual Reproductive Health (SRH) and Rights of clients

Refer to the Participant Manual (PM) and training slides for further instructions on the following class discussion:

- 1. What or who do you love most in the world, more than anything?
- I.e. list of people you would do anything to protect, love and support?
- 2. List your top 5 loves from highest to lowest from 1- 5 (1 being the highest)
- The facilitator writes on the flipchart the top 5, and then adds more inputs.
- Revise the list, and then asks the participants, "Do You Love Yourself?"
- Some people do not put themselves at the top. Do we love our self?
- What about if something happens to you, who would you put at number 2?
- Some put their spouse, or fiancé? Some people put their children at the top?
- The message is first of all: love yourself, love your body, love your mind, love your heart, love your health, love your achievements, no matter what happens to you, and no matter what anyone thinks about you, love you! Love You!
- Love your family, your possessions you worked hard for, your close friends and other people who have changed your life for the better, don't forget to love you!

- ✓ Then, in the next session: briefly discuss the following with the class (10 mins):
- ✓ Briefly discuss the relationship between HIV and STIs
- ✓ Prevention of STIs and the dynamics for key populations (e.g. sex workers, MSM, LGBTI, etc.).
- ✓ HIV/AIDS in South Africa has been described as a "feminised epidemic". How can we improve access to SRH services and dual prevention so as to curb this?
- ✓ Ask the participants (5 mins) to discuss this in the class: in your local community, can any woman or young girl access quality SRH services? What barriers exist? What can public health professionals, facilities and health care professionals do to improve access to SRH services and SRH rights?
- ✓ This module explores the importance of understanding Sexual Reproductive Health and Rights (SRH & R) as it assists lay counsellors and condom plan implementers to engage with individuals and communities on dual protection of male and female condoms (both to prevent transmission of STIs and unwanted pregnancies).
- ✓ Male involvement in prevention of STIs, SRH and within condom programming is also highlighted as a means to create greater awareness and support in reducing risk sexual behaviour and promoting healthy sexual behaviours and practices.
- ✓ Refer to the Participant Manual (PM) and training slides for definitions and explanations regarding *The United Nations Population Fund (UNFPA) description of SRH services and rights.*

## Section 5.2: Specific rights relevant to sexual and reproductive health

**Notes to the facilitator**

**In the last section, you started to promote understanding of gender inequalities and how attitudes towards gender may influence stereotypes, discrimination and stigma in relation to women and girl's ability to negotiate safer sex practices:**

- ✓ In this section, relate gender issues and dynamics to the following topic areas:
    - explain how discrimination and prejudice based on gender or sex impacts on treatment and rights of individuals.
    - define stigma and its impacts on access to contraceptives, SRH and quality HTS.
    - the distinction is made between sex and gender, and the influence of gender dynamics should be discussed with reference to violence between intimate partners, and other forms of gender based violence, which in turn limit or constrain consistent condom use (e.g. reducing ability to negotiate condom use).
- ✓ Refer to the Participant Manual (PM) and training slides for definitions and explanations regarding the following concepts and terminology:
    - **"Sexual rights"**
    - *Source: World Association of Sexology (2002)*
- ✓ Refer to the Participant Manual (PM) and training slides for definitions and explanations regarding the following concepts and terminology:
    - **"Sexual And Reproductive Health Rights"**
    - *Source: UNFPA website*

**Class Discussion** (refer to the slide on SRH rights, from UNFPA):

The Facilitator can lead the following discussion with the class (write answers on flipchart):

- What do you understand by the term sexual and reproductive health rights?
- From the slide with the list of UNFPA sexual and reproductive health rights, answer the following
    - Share challenges with SRH rights in your local community with the class, give examples.
    - Explain your response and note down answers/rights not yet identified

Mention the following: several programmes of action have been implemented by partner organisations to remove barriers to sexual reproductive health (SRH) services for adolescents, young women and girls (AYWG). Appendix E comprises a list of programmes targeting AYWG to address barriers to SRH services, discrimination, risk, socio-economic limitations, and psychosexual factors that lead to vulnerability and increased chances of infection or unintended pregnancy.

## MODULE 6:

### 11. CONDOM DISTRIBUTION: PROCUREMENT, SUPPLY AND LOGISTICS



**Learning objectives:**

- To promote understanding and application of the condom distribution, supply, and storage SOPs.
- To unpack the condom procurement process from supplier to end-user, including different levels of orders to meet demand and achieve condom targets.
- To develop an understanding of quality assurance and correct condom disposal.
- To explore the condom distribution and supply chain process flow and identify ways to improve logistics management and ensure smooth condom supply

**Duration:** One hour 30 minutes

#### Section 6.1: Condom procurement and tendering process

Procurement of male and female condoms and lubricant in South Africa is through a 3 year national tender managed by national treasury (NT) as contract managers with the national department of health (NDOH) providing technical support. The tender is funded through national HIV and AIDS conditional grant. The funds are then allocated to provinces for procurement processes. Provinces place orders from the national tender and are expected to place the orders from only contracted suppliers. Agreed quantities and deliveries should be adhered to. The contracted suppliers are expected to deliver only quality compliant condoms as per specifications (SABS compliance).

All provinces must have a data base of their primary distribution sites (PDSes) that is updated regularly. Payments should be finalised within 30 days post-delivery according to the special conditions and should be based on delivered quantities as per registered PDSs. All PDSs should adhere to the standard operating procedures (SOPs) for storage. NDoH is committed to ensuring that high quality condoms are available to all people in South Africa who need them on continuous basis and condom procurement is one of the key components to provide a supply of quality condoms (male and female) and lubricant and service delivery is maintained.

✓ Refer to the training slides for the content and discussion exercises of this module.

#### Section 6.2: Condom SOPs

Most of the condom SOPs are related to ***distribution, supply*** and ***logistics***, as well as storage and quality.

The full list of existing national SOPs for condom management are as follows:

- SOP 001 Registration of new PDS
- SOP 002 Reporting and recording
- SOP 003 Receiving stock
- SOP 004 Managing donated stock
- SOP 005 Communications and complaints management
- SOP 006 Storage and quality control
- SOP 007 Condom Ware housing,procurement,quantification and transportation
- SOP 008 Issues, Distributions & Payments of suppliers
- SOP 009 Managing suppliers ,orders calculation,creating distribution and delivery list
- SOP 010 Managing supplier payment
- SOP 011 Monitoring supplier stock availability and compliance
- SOP 012 Recall and destruction procedure
- SOP 013 Research on condom issues
- SOP 014 Condom promotion campaigns

## Section 6.3: Condom quality assurance

**What is quality?**

An examination of internationally and academically- recognised dictionary definitions provided the following definition of "quality"

- The ability of a ***product or service to satisfy*** stated or implied ***needs*** of a specific ***customer***

**What is the objective of quality assurance?**

- Over time, quality should be **standardised, maintained**, and **improved** wherever possible by reducing error and seeking to eliminate defective or poor goods and services
- Quality assurance is an **ongoing process** which requires **monitoring** whether a good or service is produced according to **officially documented and established guidelines, SOPs and specifications**
- "Quality": is achieved by conforming to ***established requirements*** and ***standards***

  *Would you expect the same quality condom wherever you go, especially from the same service provider or organisation?*

  The answer should always be, "YES!" … and … the best quality every time!

### 6.3.1 Condom quality assurance

All condoms procured and distributed by the public sector go through quality assurance processes conducted by the SABS. The most critical of these quality checks include checking for pin holes, bursting pressure and package integrity. Other checks include designer compliance to length, width, amount of lubricant and designer packaging. The quality assurance certification is based on the following accredited bodies:

- WHO/UNFPA
- International Bureau of Standards
- SABS

**Other quality checks include:**

- Quality assurance mechanisms within supply chain management (handling condom stock)
- Making sure that all stakeholders involved in supply chain implement quality assurance processes


**FIGURE 12: SABS HEADQUARTERS IN PRETORIA**

***Discussion: Who is responsible for quality?***

- SABS?
- Condom Logistics Officer?
- District Information Officer?
- Warehouse Manager?
- Condom Logistics Manager?
- HAST Manager?
- Director: HIV/AIDS and STI Prevention

**Possible answers:**

- Some may say Information Officers are responsible for data quality
- Some may say HAST Managers are responsible for Quality Assurance in Distribution
- Some may say that SABS is responsible for overall male and female condom quality

***The correct answer is: Everyone is responsible for quality!!!***

*Condom quality assurance consists of shared roles and responsibilities*

**FIGURE 13: EVERY BATCH OF CONDOMS (MADE FROM THE SAME MIX OF LATEX) IS TESTED IN SEVERAL DIFFERENT WAYS**

### 6.3.2 Quality management

The benefits of quality management are as follows:

- Support monitoring and evaluation and reporting activities (monitoring all parts of systems and operations)
- Detect and reduce errors (e.g. inconsistent and incorrect condom use)
- Improve consistency between each level of the condom distribution supply chain, all the way from national NDoH to each individual distribution site (PDS, SDS, and sites, etc.)
- Help contain costs and improve operational efficiency

**FIGURE 14: CONDOMS INFLATED WITH AIR TO TEST THE STRENGTH OF THE LATEX – CONDOMS NORMALLY BREAK AT 34 LITRES OF AIR**

**FIGURE 15: EVERY CONDOM IS TESTED ELECTRONICALLY FOR PINHOLES AT THE FACTORY LEVEL. QUALITY IS EMPHASISED AT EVERY STAGE OF THE MANUFACTURING PROCESS**

**Condom storage and quality assurance**

This discussion exercise explores the challenges that affect the way condoms are being stored or handled by the warehouse and end-users.

**Discussion: purposeful reflection on risk and quality**

- What possible errors exist occur in the process of receiving and storage of condoms?
- What methods can be implemented to detect and correct problems in condom supply?
- How can you reduce costs, exceed targets and also improve health outcomes, within budget?

**Case Study exercise:** Condom storage quality assurance and SOPs (10 mins)

- ✓ Refer to the participant manual and slides for instructions on the case study
- ✓ Collect responses from participants after 5 minutes of discussion
- ✓ Write responses on the flipchart paper of problems underway
- ✓ Write down the solutions to the problems identified as a way forward.


**FIGURE 16: THE NEW MAX CONDOM IN FOUR SCENTED VARIANTS, STRAWBERRY, BANANA, GRAPE AND REGULAR (MASKED WITH VANILLA)**

## MODULE 7:

## MONITORING, EVALUATION AND REPORTING

**Learning objectives:**

- to understand the importance of monitoring and evaluation
- to understand key M&E processes in the condom programme
- to understand how indicators are formulated, the importance of quality improvement indicators with clear targets
- to understand data flow, management and reporting into the DHIS at SDS and PDS levels

**Duration:** One hour

The use of condoms depends on a consistent supply which ensures their availability to end users. In order to ensure an uninterrupted supply of condoms, there is need for a robust monitoring system that can pick up stock levels before they are depleted and proactively place orders without interrupted supply. This can be broad seen as monitoring and evaluation in the condom programme.

✓ Refer to the training slides for the content and discussion exercises of this module.

### Section 7.1: Monitoring and evaluation and reporting systems

A monitoring and evaluation system is designed to support different levels of management. It can be used to track the success of the program and help identify and solve problems at different levels. It enables managers to answer the following questions:

**1. Are we doing the right thing?**

Through an initial and continually updated analysis of the epidemic situation, we can determine the type of response that is the most appropriate and the package of services that is necessary for an effective condom programme. This analysis is important at national, provincial, district and site level and helps in determining the allocation of resources.

**2. Are we doing it right?**

For each site, what are we doing (i.e. what is the level of activity; does it follow standards)? Are we doing them to standard (i.e. are the outputs meeting our targets)? Are they making a difference (i.e. are there signs that the uptake of condoms is increasing and are we seeing the expected decline in new infections?

### Section 7.2: Tracking the flow of condoms

At district level a team dedicated to HIV management known as HAST managers and HIV prevention officers form the backbone of HIV prevention efforts. Currently condoms are procured by the provincial HIV prevention team through the approved suppliers - and delivered to primary distribution sites (PDS). There PDSs are managed by the prevention officers who are responsible for quality assurance, stock management, supply chain management, storage and distribution and the monitoring thereof. These PDSs service secondary distribution sites (SDSs) including non-traditional outlets.

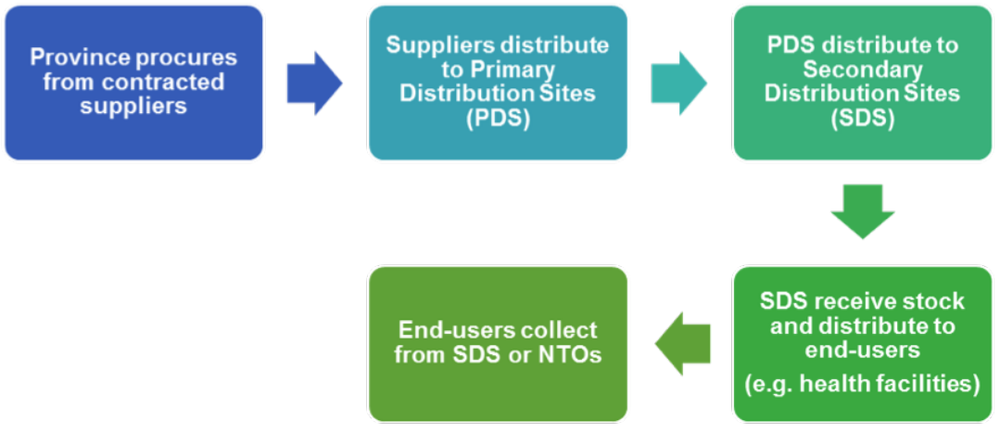



**FIGURE 17: FLOW OF CONDOMS FROM CENTRAL PROCUREMENT**

All public-sector facilities are expected to record total condom distribution for the district.

### 7.2.1 LMIS male condom bin cards

**LOGISTICS MANAGEMENT INFORMATION SYSTEM (LMIS)**
***MALE CONDOM BIN CARD***

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Max condoms are highly effective against STIs, HIV/AIDS and unwanted pregnancy

**National Department of Health**
**STI & HIV /AIDS Prevention Unit**

**Delivery site**…… **Card No** ……

| Date | No. of Condoms Received/Issued | Recipient Site/Organization /Person | Code | Balance | Signature |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Distribution Codes:*

A = Public Sector
A1 = DOH Hospitals/Clinics
A2 = District Regional Health Office
A3 = Government Department
A4 = Local Government

B = Private Sector
B1 = Priv. Hospitals / Clinics
B2 = Pharmacy
B3 = Private Doctors

C = Community Outreach/ Individuals
C1 = Community Outreach/ Taxi Ranks, Spaza shop/ Taverns
C2 = Individuals
C3 = NGO
D = Traditional Healers

[redacted]

**Distribution Codes:**

**A = Public Sector**
**A1 = DOH Hospitals/Clinics**
**A2 = District Regional Office**
**A3 = Government Dept.**
**A4 = Local Government, Municipality**
**A5 = Parastatal – Eskom, SAA,**

**B = Private Sector**
**B1 = Private Hospitals/Clinics**
**B2 = Private Enterprise**

**D = Traditional Healers**

**C =Community Outreach/Individuals**
**C1 =Community Outreach,**
**Taxi Ranks, taverns, Spaza shop,**
**C2 = Individuals**
**C3 = NGO**

## Section 7.3: Developing indicators for condoms M&E

The main condom programme indicator is the number of male and female condoms distributed at primary distribution site.

**NATIONAL DEPARTMENT OF HEALTH: Chief Directorate: HIV/AIDS & STI's**

**LOGISTICS MANAGEMENT INFORMATION SYSTEM** [LMIS]
Help Desk Tel. No 012 401 9682 / 012 401 9600 Fax: (012) 401 9666
Email: lmis@ndohlogistics.co.za

**MALE CONDOM**
**MONTHLY DISTRIBUTION AND STOCK RETURN**

1.DELIVERY SITE: _____
*2.*PHYSICAL ADDRESS: _____
*3.*PROVINCE: _____
4.PERSON REPORTING _____ TEL. NO _____
*5.*DESIGNATION: _____
6.REPORTING MONTH: _____ 7. YEAR: _____
8.BEGINNING BALANCE THIS MONTH -total number of Condoms pieces
9.QUANTITY RECEIVED: (total number of condoms received this month). 9b. DATE RECEIVED
*10.*DISTRIBUTED/ISSUED (total number of condoms distributed this month)
*11.*ADJUSTMENTS*
*12.*ENDING BALANCE / PHYSICAL COUNT**----------
*13.*DATE OF PHYSICAL COUNT ----------
*14.*COMMENTS *: _____
_____
Explain Stock adjustments in the comments space. **Physical Count on the last working day of the month.
***PLEASE SUBMIT THIS FORM BY FAX TO THE NDOH AT (012)-401 9666 OR BY EMAIL:***
***lmis@ndohlogistics.co.za*** ON THE FIRST WORKING DAY OF EVERY MONTH.

15.NAME ---------- 16.***DATE***---------- ***17.TEL. NO.***----------

**Current condom programme indicators:**

- total number of male condoms distributed
- total number of female condoms distributed

## Section 7.4: Target-setting for condoms M&E

Target-setting is fundamental as targets help define what a successful project should achieve. In condom programme M&E, targets are set based on target population in provinces. Implementers at PDS provide pipeline data to assist supply chain to determine amounts and quantities that are required over a certain period, normally every three months.

## Section 7.5: Managing condom stock at site level

The condom programme is managed through a manual logistics management information system (LMIS). Site level stock is managed through bin cards. Bin cards and stock cards are used to manage condom inventory at PDS and SDS sites. Consumption for condoms is reported from PDS while consumption at facility level is only reported through DHIS.

A common on site challenge is a discrepancy between what is recorded on the bin card and the actual stock levels. This suggests that not all deliveries or distribution is recorded on the bin card. To avoid this challenge, capacity building should be provided to those working with condom management and distribution.

## Section 7.6: Data management and reporting

Data management is a key aspect of condom distribution. Reporting to national is through the PDS level to the DHIS.

There are several challenges related to the handling of data. These include:

- The condom distribution indicator uses data obtained from the PDSs and SDSs.
- This data is a combination of condoms distributed to end users and those distributed at other outlets such as CBOs and other organisations involved in condom programming.
- There are some partners who are distributing their own condoms.
- Ideally, they should account for them at the nearest facility, but this does not happen all the time – resulting in an undercount.

*Addressing gaps in competencies and capacity building*

- High staff turnover necessitate conducting regular induction programmes mentoring and training on the implementation of the condom programme.

*Capacity building of condom programme staff at all levels:*

- needs analysis conducted to address identified needs of all levels of staff from HIV programme manager to WBOTs and administrative personnel
- annual training plan coordinated by Provincial HRD Chief Directorate to incorporate HIV training needs; RTCs to schedule delivery of training needs
- monitor implementation of training and where and as required competency based training verifying that proficiency in needed skills has indeed been acquired
- application of a total marketing approach that combines public sector distribution, social marketing and private sector sales
- increasing the number of outlets particularly at locations that have been underserved such as 'far to reach' and HTAs
- adequate targeting of high risk population groups to increase condom promotion and correct usage

**Group work exercise:**

| | | |
|---|---|---|
|  | **Tools/handouts** | None: refer participants to the training manual. |
|  | **Preparations/ equipment** | Flipchart paper, marker pens, training manual, pens and paper (to write notes). |

Working in groups, describe some challenges in the flow of condom distribution data and suggest how these can be improved.

## ANNEXURES

### A. TRAINING PROGRAMME AGENDA

# NATIONAL DEPARTMENT OF HEALTH INTEGRATED NATIONAL CONDOM TRAINING PROGRAMME

| Day one | | |
|---|---|---|
| **Time slot** | **Session** | **Facilitator** |
| **Morning Session:** | | |
| 8:00 – 8:30 | Registration and administration | |
| 8:30 – 9:00 | Welcome and introductions | |
| 9:00 – 9:30 | Pre-test (short quiz) and discussions | |
| 9:30-10:30 | Module 1: Overview on HIV/AIDS epidemic | |
| **Morning tea [10:30 – 11:00]** | | |
| 11:00 – 12:00 | Module 2: Combination prevention | |
| 12:00 – 13:00 | Module 3: Correct and consistent condom use<br>• Correct and consistent condom use<br>• Condom demonstrations: male and female | |
| **Lunch [13:00 – 14:00]** | | |
| **Afternoon session:** | | |
| 14:00 – 15:00 | Module 4: Sexual reproductive health and rights | |
| **Afternoon mini-break [15:00 – 15:15] - Leg Stretch** | | |
| 15:15 – 16:15 | Module 5: Counselling skills and risk assessment<br>• Risk assessment and counselling role plays | |
| 16:15 – 16:30 | Closing remarks: Day one summary | |
| **Day two** | | |
| **Time slot** | **Session** | **Facilitator** |
| **Morning session:** | | |
| 8:00 – 8:30 | Arrival and registration | |
| 8:30 – 8:45 | Recap day one | |
| 8:45 – 9:45 | Module 6: Social behaviour change communication (SBCC) | |
| 9:45 – 10:45 | Module 7: Condom distribution: Procurement, supply and logistics | |
| **Morning Tea [10:45 – 11:15]** | | |
| 11:15 – 12:15 | Module 8: Monitoring, evaluation and reporting | |
| 12:15 – 12:30 | Post-assessment test | |
| 12:30 – 12:45 | Closing remarks - end of workshop | |

*Thank you for attending the training workshop*

B. **PRE/ POST TEST QUESTIONS**

1. HIV incidence measures the percentage of people who are HIV infected in a population.
   a) True
   b) False
2. South Africa is in the top ten leading countries in HIV prevalence in the world.
   a) True
   b) False
3. In South Africa, young girls are more affected by HIV than their male counterparts.
   a) True
   b) False
4. Combination prevention refers to using a condom and contraception in order to prevent HIV infection.
   a) True
   b) False
5. When designing an HIV prevention programme the following are important aspects to address.
   a) Poverty
   b) Access to services
   c) Cultural norms
   d) Gender based violence
   e) Political affiliation
   f) Answers a, b, c, and d are all correct
6. Key Populations describes
   a) groups of people with a heightened risk of contracting HIV and other STI's
   b) activist groups involved in advocating for positive changes in HIV management
   c) key government officials involved in HIV prevention
   d) community health workers who are involved in promoting HIV prevention and management in high risk communities
   e) populations that use dual protection
7. **"Sex"** can be defined as follows (choose one correct answer):
   a) when someone is attracted to another person and they become lovers
   b) the sexual characteristics of a person, that is whether the person is male or female, based on biological make-up
   c) when an organism reproduces itself, also called reproduction
   d) when you get to know a stranger or "blesser" better
   e) none of the above
8. Which of the following is the correct definition for the term, **"Gender"**?
   a) Gender is the same as sex, the only difference is the name people use for someone who is male or female.
   b) Gender refers to a person's traditional heritage or culture.
   c) Gender refers to roles that men and women play in society, the culturally and socially constructed relationships between men and women, and the way we perceive roles to either be masculine or feminine.
   d) When a person has come of age and begins to show adult characteristics.
   e) All of the above
9. Choose an answer below that best describes **"dual protection"**:
   a) Two to three condoms should be worn at the same time, hence the term dual protection.
   b) Condoms prevent opportunistic infections and STIs.
   c) Condoms are a comprehensive and sustainable approach to the prevention of HIV and other sexually transmitted infections (STIs) and are effective for preventing unintended pregnancies.
   d) The main reasons people use condoms is to prevent TB and pregnancy.
   e) After having protected sex, a condom can be washed and used again (twice).
10. **Condom negotiation** refers to… (select the correct answer):
    a) Negotiation with suppliers and manufacturers on the best price to procure quality SABS-approved condoms.
    b) The relative ability or inability a person possesses in order to persuade their sexual partner(s) to allow and agree to condom use during sex.
    c) When people compare condoms and argue about which one works better.
    d) The path negotiated by a condom from supplier to end-user.
    e) When condom producers negotiate with global suppliers.
11. Select which one of the following statements is false:
    a) Male and female condoms are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy.
    b) Condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV.
    c) Research among serodiscordant couples (where one partner is living with HIV and the other is not) shows that inconsistent condom use significantly decreases the risk of HIV transmission both from men to women and women to men.

d) Consistent and correct use of condoms also reduces the risk of acquiring other STIs.
e) None of the above.

12. Oil-based lubricants, such as Vaseline, baby oil or cooking oil are the preferred lubricants as they do not damage the integrity of the latex condom.
    a) True
    b) False
13. Personal attributes of a counsellor are:
    a. to be able to discuss sexuality comfortably with younger clients; to be approachable and easy to talk to; to be accepting and patient
    b. To be unconcerned about his/her biases and moral judgments because it is his/her right to treat cli ents in a judgmental manner and make own opinions.
    c. both answer (a) and (b) are correct
    d. none of the above
    e. answer (a) only
14.
    a) Marketing and promotional activities to address the misconceptions of the public sector condom programme.
    b) Condom dispensing devices made available in NTOs such as all ablution facilities of hotels, shopping malls, soccer grounds especially at well attended tournaments, spaza shops, taxi ranks, train stations, taverns and night clubs.
    c) Providing adequate demonstration models to conduct ongoing training on correct condom use for both males and females.
    d) Targeting older men (often referred to as 'sugar daddys' or 'blessers') who have sex with younger girls.
    e) all of the above
15. Migrants have an increased risk to HIV as their vulnerability is exacerbated by inadequate access to HIV prevention, treatment and care services and their fear of being stigmatised for seeking HIV-related information or support.
    a) True
    b) False
16. Quality assurance is (choose the correct answer):
    a) Producing the same products and services as other countries.
    b) When you buy something of high quality and you are a satisfied customer.
    c) An ongoing process which requires monitoring whether a good or service is produced according to officially documented and established guidelines, SOPs and specifications.
    d) When a product or service is made so well that it can never fail.
    e) To solve problems customers have with your products or services and meet their expectations.
17. Prevention Officers at the PDS are responsible for quality assurance, stock management, supply chain management, storage and distribution and monitoring condoms.
    a) True
    b) False
18. It is important that officials, suppliers, and partners know about condom storage, disposal and quality assurance; apply quality assurance SOPs to all relevant aspects of condom management so as to ensure best practice in supply chain.
    a) True
    b) False

C. **PRE- POST TEST ANSWER SHEET**

1. (b) False
2. (a) True
3. (a) True
4. (b) False
5. (f) a, b, c, and d are correct
6. (a)
7. (b)
8. (c)
9. (c)
10. (b)
11. (c)
12. (b) False
13. (e) Answer (a) only
14. (e) All of the above
15. (a) True
16. (c)
17. (a) True
18. (a) True

D. **PARTICIPANT EVALUATION FORM**

| | | | | |
|---|---|---|---|---|
| E. health Department: Health REPUBLIC OF SOUTH AFRICA | | NATIONAL DEPARTMENT OF HEALTH INTEGRATED NATIONAL CONDOM TRAINING PROGRAMME | | |
| **TRAINING EVALUATION FORM** | | **DATE:** | | |
| 1 = Very poor | 2 = Poor | 3 = Satisfactory | 4 = Good | 5 = Excellent |
| **SECTION A: FACILITATION** | | | | |
| 1. What did you find most useful or about the training? (Please support your answer with a reason): | | | | |
| 2. What did you find least useful about the training? (Please support your answer with a reason): _____ | | | | |
| 3. How would you rate the facilitator's ability to encourage participation through questions, answers/ open discussion, etc.? | | | | |
| 1 | 2 | 3 | 4 | 5 |
| 4. How would you rate the facilitator's ability to answer your questions? | | | | |
| 1 | 2 | 3 | 4 | 5 |
| 5. How would you rate the quality of the slides and the presentations overall? | | | | |
| 1 | 2 | 3 | 4 | 5 |
| 6. How well did the facilitator relate the theory to the current workplace/ facility? | | | | |
| 1 | 2 | 3 | 4 | 5 |
| 6. How would you rate the activities and exercises applied in the training? | | | | |
| 1 | 2 | 3 | 4 | 5 |
| 7. What would you have changed regarding the presentation of the facilitator? | | | | |
| **SECTION B: TRAINING MATERIALS** | | | | |
| 8. Please rate and comment on topics/ content covered (quality, scope, relevance, depth, etc.) | | | | |
| 1 | 2 | 3 | 4 | 5 |
| Comments: _____ | | | | |
| 9. Which aspects have, in your opinion, not been addressed in this course and should be included? _____ _____ | | | | |
| **SECTION B: VENUE AND FACILITIES** | | | | |
| 10. Pease rate and comment on the venue and the facilities? | | | | |
| 1 | 2 | 3 | 4 | 5 |
| Comments: _____ | | | | |
| **SECTION C: WORKSHOP ADMINISTRATION** | | | | |
| Please rate the performance of the training coordinator(s) in terms of registration and workshop administration: | | | | |
| 1 | 2 | 3 | 4 | 5 |
| Please rate the support you received from the training coordinator(s) during the workshop: | | | | |
| 1 | 2 | 3 | 4 | 5 |
| General Comments: _____ | | | | |

*Thank you for taking the time and effort to complete this questionnaire!*
*Please hand in your evaluation to the facilitator/course coordinator.*

## E. PARTICIPANT HANDOUTS

***Refer to the participant manual for copies of the handouts.***

The list of handouts in the participant manual (as at 28 September 2016) is as follows:

a. Check list to assess step by step method for correct male condom use.
b. Checklist to assess step by step method for correct female condom use.
c. Health belief model.
d. Partners contributing to SBCC on the national women and girls campaign.

| **AT THE WORKSHOP** | | |
|---|---|---|
| Give a copy of the workshop agenda to each participant | | |
| Bring to workshop copies of relevant materials (e.g. resource materials, participant handouts, manuals, posters, etc.) | | |
| Confirm names of those attending workshop | | |
| **AFTER THE WORKSHOP** | | |
| Prepare report on outcomes (trainer/facilitator feedback report) | | |
| Send thank you letter and feedback to participants, as well as confirmed participant contact list | | |
| Send thank you letter to outside facilitators and guest speakers (if applicable) | | |
| Plan for follow-up, refresher training and evaluation of impact | | |

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**TRAINING MANUALS AND SLIDES CONSULTED**

1. HIV counselling and testing participant manual. NDoH.
2. Condom logistics management training manual: HIV/AIDS prevention. NDoH.
3. Couples HIV Counselling and Testing (CHCT) training manual. CDC/PEPFAR.
4. Female health company (Female Condom manufacturers) training programme and Participant manual for condom training. Training manual and slides.
5. HCT training slides, updated June 2015. NDoH training slides.
6. HIV rapid testing course No 2. NDoH Training Manual.
7. National HTS Training Manual curriculum (NDoH), 2017
8. HIV Training course (national RTC curriculum), 2018


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**Pretoria**
**0001**

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