PARTICIPANT 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.

CONTENTS

FIGURES AND TABLES

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 ConformitéEuropéen (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 means 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 refers to the linkage of HIV testing 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 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 is 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 timorously 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 is an approach that encourages and allows the healthcare provider to review the client comprehensively, 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 refers to 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 immune-deficiency virus in South Africa. These are carried out at health facilities, in communities and by individuals.

Human papilloma virus (HPV) is 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 refers to transient workers such as truckers or miners. These terms refer 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 within, 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. 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 sero-negative partners in sero-discordant 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 29years.

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**	The preparatory steps the facilitator should complete before the module is conducted.

1. RATIONALE FOR THE DEVELOPMENT OF THE TRAINING CURRICULUM

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 2012-2015UNAIDS Unified Budget, Results and Accountability Framework (UBRAF), sexual transmission accounts for more than 80 per cent of new HIV infections worldwide.

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.

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.

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. 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.

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

5. COURSE CONTENT AND MATERIALS

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

- Training Programme Agenda
- Introduction of facilitator and participants
- Learning objectives of each module
- Expected outcomes of the National Training Programme
- Templates and instructions for participants
- Pre-and post-course assessment
- Appendices
- References

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 consider that additional modules will be included in all trainings to familiarize participants on the importance consistent condom demonstration provision and use.

MODULE 1

1. OVERVIEW OF HIV EPIDEMIC

Learning objectives:

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

Duration: One Hour 30 Minutes

Section 1.1: Background

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, 36.7million 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

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. *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. *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:

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

Section 2.1: 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

TABLE2: 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 Drug treatment including opioid substitution therapy Male circumcision Biomedical prophylaxis – ARVs in PMTCT services, pre-andpost-exposure prophylaxis (PrEP and PEP), etc. Appropriate and accessible STI services, ART for prevention Blood safety, standard precautions in healthcare setting
Behavioural intervention strategies to promote individual risk reduction	HIV testing and risk reduction counselling. Behaviour change communication to promote partner reduction, condom use, uptake of HIV testing and counselling, etc. HIV education Interpersonal communication, including peer education and persuasion Social marketing of prevention commodities Cash incentives for individual risk avoidance etc.
Social and cultural intervention strategies	Community dialogue and mobilisation to demand services; Stigma reduction programmes Advocacy and coalition building for social justice Media and inter-personal communication to clarify values, change harmful social norms Education curriculum reform, expansion and quality control Support youth leadership etc.
Political, legal and economic strategies	Human rights programming Prevention diplomacy with leaders at all levels community micro finance/microcredit training/advocacy with police, judges, etc. Policies re: access to condoms (schools, prisons etc.) Review and revise workplace policies Stakeholder analysis and alliance building Strategic advocacy for legal reform Regulation/deregulation, taxes
Intervention strategies addressing physical environment:	Housing policy and standards Enhance farming, other modes of subsistence, for food security Infrastructure development – transportation, communications, etc.

What is combination prevention?

Discuss the key drivers of HIV in your local areas and develop local interventions for the identified key drivers of HIV

Section 2.2: 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:

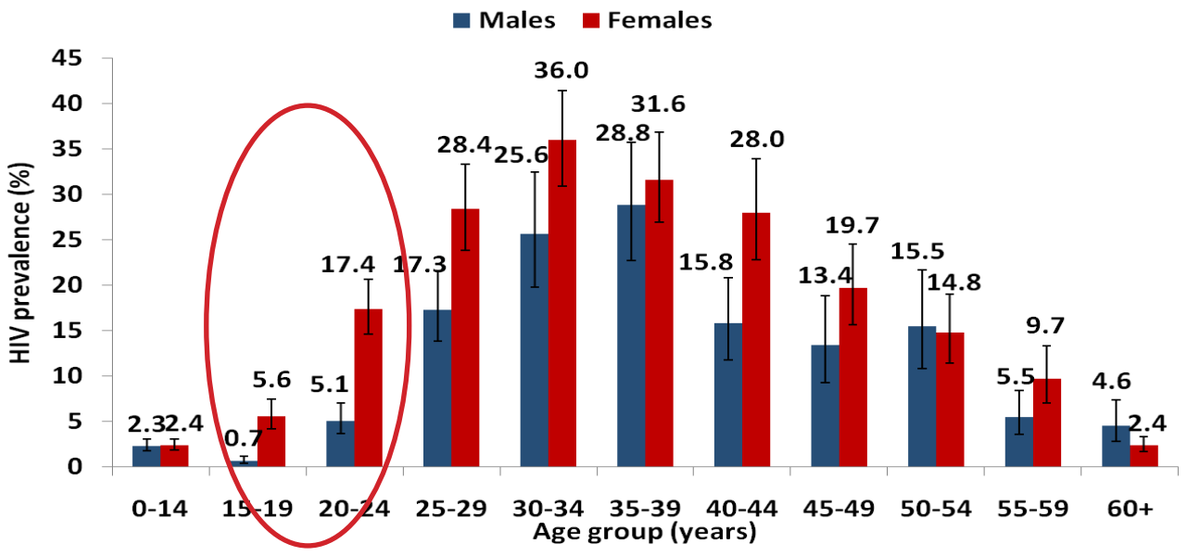


FIGURE 1. HIV PREVALENCE BY AGE, SEX. SOUTH AFRICA (2012)

The data above shows the hiv prevalence profile for females and males in different age groups. Hiv prevalence peaked amongst females ages between 15-19 years at 5,6% whilst for male counterparts the prevalence was only 0,7%, and again at 20-24 years amongst females disproportionately higher 17,4% with males at 5,1% for this cohort. Additionally, prevalence peaked for ages 25-29 years amongst females at 28,4% and again noticeably higher for females aged 30-34 years at 36%.

MODULE 3:

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

Section 3.1: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 3.2: Condoms and dual protection

Condoms are the only contraceptive method that can prevent HIV and other sexually transmitted infections (STIs) and unintended pregnancies, and can be used in conjunction with other contraceptive methods (e.g., oral contraceptive pills, injection, implants, etc.).

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.

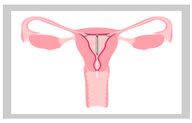
What are some key strategies for dual protection in a family planning setting?

- 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  **Female condom** 	Effective as contraceptive method when used consistently and correctly Overall effective in preventing STIs, including HIV Does not affect breastfeeding or interact with medications Must counsel regarding correct use Promote and provide access to emergency contraception 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 ofCOCs. As commonly used, 90-92% effective; ≥99% effective if breastfeeding Primarily thickens cervical mucus and so prevents sperm penetration (after two days of use). Also, inhibits ovulation in 60% of cycles.
Progestin-only injectables **(DMPA and NET-EN)**  **Implant** 	Injectables: 94% effective as commonly used; if return for re-injection on time 99.7% effective as contraceptive Concerns regarding bone mineral density in women < 18 years and > 45 years 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. 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. Implants: Almost 100% effective, remain in place for 3-5 years Not protective against STIs and HIV
Intrauterine contraception non-hormonal (Copper - CuIUD) 	Highly effective, long-acting and reversible method Approved for use up to 10 years (copper) 99.2-99.4% effective No age restrictions Does not affect breastfeeding, intercourse or have hormonal side effects Do not protect against STIs, including HIV and dual method with consistent condom use should be recommended

Method	Key factors
Emergency contraception  	Use at any time during menstrual cycle within fivedays (120 hours) following unprotected intercourse ECPs – POPs 58-95% effective, COCs 31-77% effective (effectiveness depends on how soon initiated following unprotected intercourse). *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').* Cu IUD – fails in only < 0.1% of cases. Insert under antibiotic cover (to prevent STIs) and remove during the next menstrual period *Risk of infection is higher than risk for pregnancy. Screen for STIs and consider post-exposure prophylaxis for HIV *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 	Breastfeeding as temporary method of contraception, 98-99% effective if amenorrhoeic and fully breastfeeding during first 6 months after childbirth.
Fertility Awareness-Based Methods 	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. 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.

Section3.3: 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 3.4: Male and female condoms

3.4.1 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.A *male condom* is a thin sheath that covers the penis during intercourse, protecting against unintended pregnancy and STIs.

FIGURE 2: CONDOMS AND DEMONSTRATION APPARATUS

3.4.2 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 is an option of barrier contraceptive method.

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

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 3.5: 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. Pushback 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.

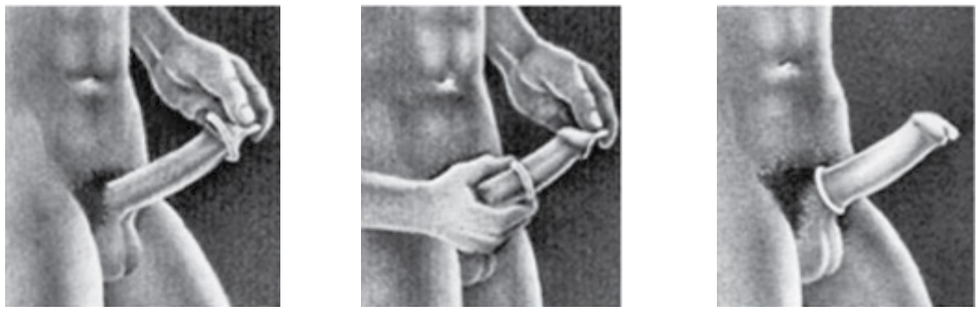


FIGURE 4: A STEP BY STEP APPLICATION OF A MALE CONDOM

Section 3.6: 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:

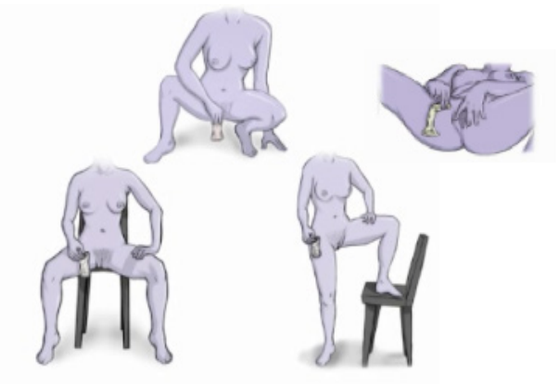
Cupid is made of a natural latex pouch that fits inside a woman's vagina. It has a soft ring on one end and a sponge on the other end. The outer ring stays on the outside of the vagina and partly covers the labia (lips). The sponge fits on the inside of the vagina, somewhat like a diaphragm, to hold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

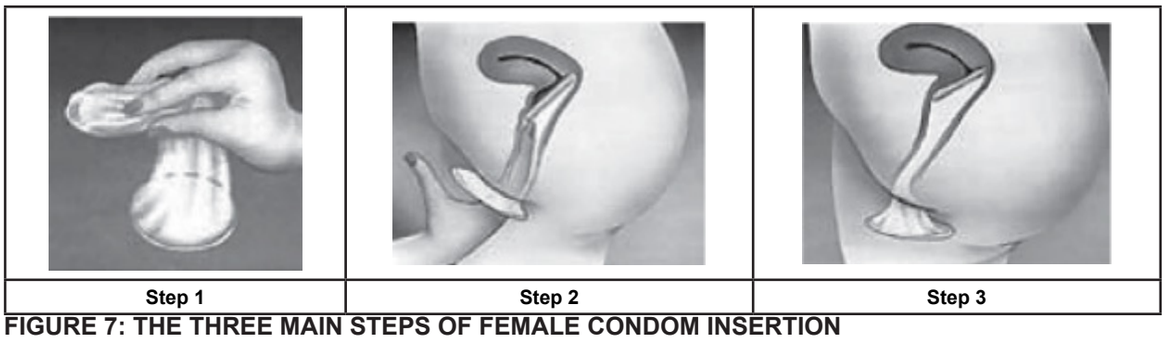
- Sitting
- One leg raised on a chair
- Squatting
- Lying on your back

Fig 6: The four main positions for female condom insertion

Steps for insertion:

1. Assess the integrity of the condom and the expiry date. If expired or damaged, do not use.
2. Squeeze the inner ring/sponge of the condom in the middle
3. 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.
4. Make sure that the outer ring stays outside the vagina.
5. Guide the penis into the condom.
6. After ejaculation, using a tissue twist the outer ring and then remove carefully to avoid spillage.
7. Using another tissue, wrap the used condom carefully (to avoid spilling the contents) in toilet paper, or ordinary paper, and dispose 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

WHAT ARE THE ADVANTAGES OF THE FEMALE CONDOM?

- IT IS A SAFE AND EFFECTIVE METHOD OF CONTRACEPTION
- IT CAN BE OBTAINED WITHOUT A PRESCRIPTION
- THE EXTERNAL RING MAY STIMULATE THE CLITORIS, MAKING SEX MORE PLEASURABLE.
- IT CAN BE USED IMMEDIATELY AFTER INSERTION. YOU DO NOT HAVE TO PUT IT ON 8 HOURS BEFORE HAVING SEX.
- THE FEMALE CONDOM PLACES THE CONTROL OF CONTRACEPTION AND PROTECTION FROM STIS, INCLUDING HIV, FIRMLY IN A WOMAN'S HANDS

Know your CONDOM DO's and DON'Ts	
DO's	**DON'Ts**
• Read all the information on the package and follow the instructions carefully. • Check the expiration date on the package. If it is expired, get a new package of condoms and throw away the old ones. • 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. • 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 • Condoms come in different colours and scents. • Assist your disabled partner to put on a condom.	• Do not use two condoms at the same time • Do not use the same condom on more than one partner • Do not use condoms made of animal skin, sometimes called "natural" condoms. • Avoid keeping condoms in your pockets for a long period of time as they may get damaged • 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 • 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. • Do not use male and female condoms together(at the same time) • Do not reuse condoms • 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 3.7: 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 NDoHcurrently distributes 5ml sachets of water-based lubricant.

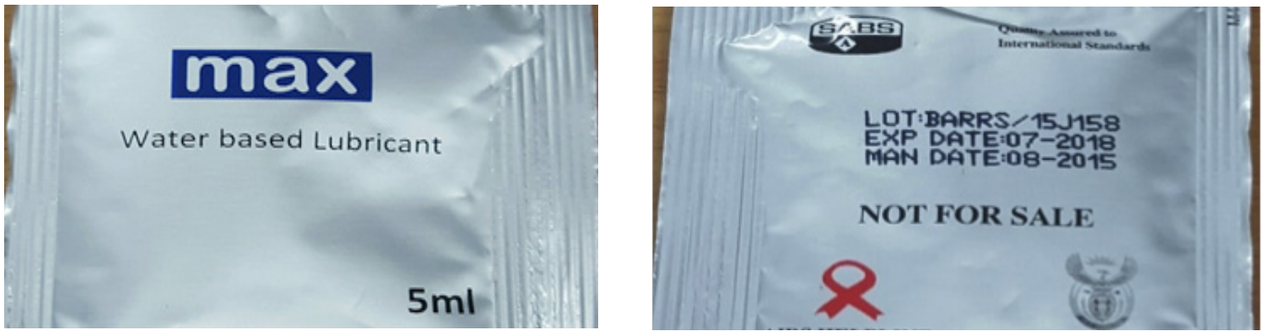


FIGURE 8: WATER-BASED LUBRICANT SACHETS

Section 3.8: 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 or HIV to another.

FIGURE 9: DENTAL DAMS

NB: Currently, the NDoH does not distribute dental dams

Dental dams are available in pharmacies and adultshops. A malecondom 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 barriersand improve provision of quality health services.

Duration: One Hour

Section 4.1: Values clarification session

4.1.1 Values Clarification

According to the WHO manual, Health Workers for Change, facilitators in public health are reminded to be aware of their feelings and prejudices and to try and avoid imposing their views on the client.

Values clarification process aims to reduce emotional distress and increase positive behaviours through reinforcement. It helps those in the process to identify and clarify the values that influence their decisions and behaviour and encourages them to build on their inner resources and strengths.

Values clarification is beneficial to everyone who receives public health services. Someone who has explored their personal values is often better able to identify what will enable them to effectively function in life and thus may be able to make more self-directed choices.

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.

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.

4.2.2 Key concepts in counselling for Risk Assessment

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. Examples of detailed risk assessment questions are listed 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?

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.

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

Sex and gender

These two terms, 'sex' and 'gender' are often confused, and often used interchangeably, when in fact they are quite different.

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. For example, male sexual characteristics (penis and testicles) or female sexual characteristics (vagina, uterus and ovaries and breasts development at puberty) characterize whether a person is of the male or female sex.

Not all people fall into the two categories. This may be due to their sex anatomy, reproductive organs or chromosomes.

Inter-sex: General term used for a variety of conditions in which a person was born with sexual organs or parts that does not fit the typical definitions of being either of the male or the female sex.

- Examples of Intersex: Variations may include sexual organs, sexual genes, and people who are intersex were previously known as hermaphrodites referring to the fact that they were born with both male and female sexual organs. In some case this is evident at birth but in other cases it becomes evident at puberty.
- The term "hermaphrodite" is now considered an offensive, outdated and medically incorrect term. Important to note, is that intersex people are never born with two complete sets of genitals.

Gender on the other hand refers to the roles that men and women play in society. Gender refers to the 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. This means that a person may be born male or female and then be taught behaviour, roles, attitudes, desires, expectations and activities through which he or she learns to be a boy or a girl or a man or a woman. (UNICEF2002). It important to again emphasise that sex is the biological difference between men and women, whereas gender refers to the difference in roles they are required to play in society

4.2.3 Gender categories

The examples of different types of gender are 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).

4.2.4 Gender inequalities

It is important to understand that a gender perspective is a perspective that promotes equality between men and women and focuses on the development of all human beings in all spheres in society. This means that given the imbalances between men and women's roles in society, women's empowerment is a key objective of any gender development programme. The advancement of women and girls in society, gender equality and the empowerment of women are all gender and human rights goals (UNICEF 2002).

Groups most affected by gender inequalities

- Women and girls living in poverty
- Unemployed and uneducated women
- Women using alcohol or whose partners use alcohol
- Women with a history of violence in their families
- Youth, young women and girls (AYWG)
- Additional 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 unintendedpregnancies*
- *Know your HIV status, get tested, to protect yourself and your partner*

Section 4.4: Gender and HIV

An issue of major concern is the gender disparity whereby females dominate both in terms of the proportions who undergo HCT and know their HIV status as well as subsequently accessing ARV treatment compared to their male counterparts. Men need to be encouraged to test for HIV and also access ARV treatment as much as their female counterparts do.

Several options have been considered to get more men to test, as listed below:

- The use of mobile services (van Rooyen, McGrath, Chirowodza*et al*. 2011).
- Providing non-traditional settings for HIV testing especially those that are most accessible to males such as the workplace
- Collaboration with traditional healers must be promoted.
- Developing male-friendly community centres where males can gather and interact with each other as well as discuss important social issues that affect them and also access some health services

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.

NSP 2017-2022 (Goal 3): State that "Nobody left behind "Reach all key and vulnerable populations with customised and targeted interventions. The scale-up interventions will aim to ensure that that by 2022 at least 90% of all key and vulnerable people have access to comprehensive, integrated services, including targeted social and behaviour change communication. Table 4 states key and vulnerable population for condom promotion and behaviour change strategies.

Table 4: Key and vulnerable populations

Key populations for HIV and STIs	Key populations for TB	Vulnerable populations for HIV and STIs
Sex Workers, Transgender people MSM, People who use drugs, Inmate.	People living with HIV, Household contacts of TB index patients, Health care workers, Inmates, Pregnant women, Children<5years old Diabetics, People living in informal settlements, Mine workers, and peri-mining communities.	Adolescent girls and young women, Children including Orphans and Vulnerable Children, People living in Informal Settlements, Mobile populations, Migrants and Undocumented foreigners, People with disabilities, Other lesbian, gay, bisexual,(LGBTI)populations.

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.

In South Africa, key STI and HIV prevention messages are promoted through national mass media, production media and social mobilisation by government and non-governmental organisations. In addition, numerous national HIV awareness and prevention programmes and interventions have been implemented in the last 10 years, many targeting youth aged 15–24 years.

These programmes and interventions have been successful in raising awareness of STIs and HIV and disseminating prevention messages. Some HIV interventions aimed at young people have included a component of condom behaviour change.

Section 4.6.1 Social Behaviour Change Communication and Health promotion

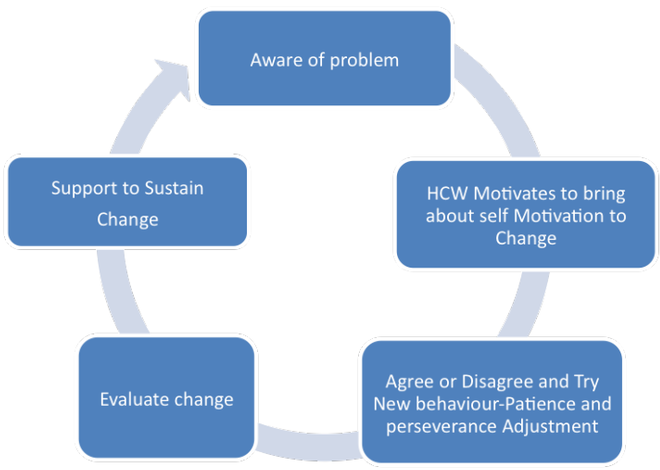
The definition of health behaviour as provided by Feuerstein, Labbe and Kuczmierczyk (1987, p.240) is “any activity undertaken by a person believing him- or herself to be healthy for the purpose of preventing disease or detecting it in an asymptomatic stage”. Schlebusch (1990) took this definition further with his concept of health protective behaviour (HPB), which he described as what people do in the belief that their behaviour facilitates or protects health.

Stages in Social Behaviour Change Communication (SBCC):

SBCC is the systematic application of interactive, theory based, and research-driven communication processes and strategies to address “tipping points” for change at the individual, community, and social levels.

The Stages of Behaviour Change Model suggests that 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. 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



Three Core Elements of SBCC

SBCC encompasses three core elements:

- **Communication** using channels and themes that fit a target audience's needs and preferences.
- **Behaviour Change** through efforts to make specific health actions easier, feasible, and closer to an ideal that will protect or improve health outcomes.
- **Social Change** to achieve shifts in the definition of an issue, people's participation and engagement, policies, and gender norms and relations.

Health communication is a broad term that describes a number of strategies to share information that can lead to better health outcomes. Health communication activities can vary widely, depending on the objectives, audience, and communication channels. For example, a health communication activity may be designed to advocate essential changes in health regulations to policymakers; or use interpersonal communication to promote actions that prevent childhood illness and malnutrition to mothers.

Health education can be defined as any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes. It involves providing health information and knowledge to individuals and communities and skills that enable individuals to adopt healthy behaviours voluntarily.

Health promotion: In 1945, Henry E. Sigerist, observed that *"the promotion of health obviously tends to prevent illness, yet effective prevention calls for special protective measures"*. According to WHO,health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment.

Information, Education and Communication (IEC) developed in the early 1970s, specifically focused on the communication aspect, when the use of mass media proved to be a useful tool in disseminating health information. IEC can range from didactic one-way communication to entertaining methods. It can utilize a wide range of media channels and materials.

Section 4.6.2 Social mobilisation and marketing strategy

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.

"Marketing" is the science and art of exploring, creating, and delivering value to satisfy needs of a targeted market.

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. More specifically, these terms were created to apply commercial marketing approaches to promoting products, services or behaviours that improve health.

Community engagement: involves working with community leaders, condom programme implementation partners and key stakeholders as a key point of entry. The lead on community engagement advocates for improved access by addressing stigma, discrimination, and personnel constraints within health service provision and within health care systems, with emphasis on application of applicable policy and where necessary review of policies in place.

Fig 11: Condom Social Advocacy & Activism

Section 4.6.3: Advocacy

Advocacy is defined as the act of pleading or arguing in favour of a cause, idea, policy, supporting a cause or proposal; enabling people to express their views and concerns; defend and promote their rights and responsibilities. To increase accessibility scheduled, planned, quarterly dialogues to be held with various high risk population groups - separate sessions to address unique needs of each group.

Section 4.6.4: Community dialogue

Community dialogue comprises purposeful engagement of communities with regards to health issues that require attention, planned interventions, with active targeted community participation to achieve agreed goals.

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.

Step 1: Develop a profile of the target population from formative BCC assessment.

Step 2: Identify desired behaviour change.

Step 3: Understand and take into account the varying situations that could affect action and decision-making.

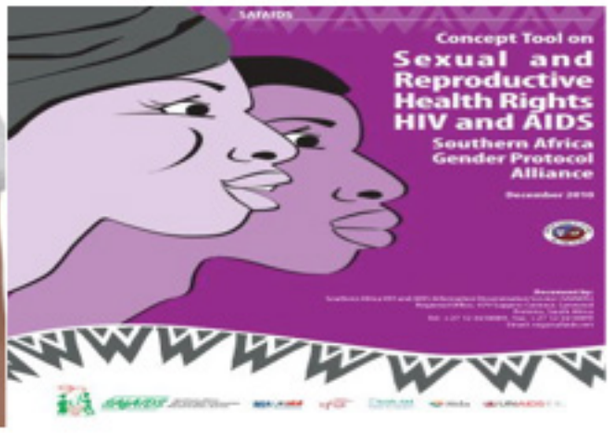
Step 4: Identify the information or data that you want understood by the target population.

Step 5: Develop key benefit statements that take the hopes and aspirations of the target population into account: “If I do X (use condoms and get information), I will benefit by Y” (being responsible, protecting my partner, etc.). Whatever the benefit, it will have to outweigh any disadvantages or “costs” the audiences might feel.

Step 6: Develop messages from key benefit statements. Messages should be simple, attractive and establish clearly benefits of promoted behaviour, through words or images.

Messages that promote condoms, must include information on where to access condoms and how to use them; correct usage must be emphasised. If a message promotes skill development or specific services, then the services that are being promoted must actually exist. The referrals must be appropriate and trustworthy, for example Youth Friendly Services.

MODULE 5: SEXUAL REPRODUCTIVE HEALTH (SRH) 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

The United Nations Population Fund (UNFPA) describe SRH services and rights as follows:

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.

To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby.

Source: http://www.unfpa.org/sexual-reproductive-health

Section 5.2: Specific rights relevant to sexual and reproductive health

Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights.

- **The right to sexual freedom.** Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation, and abuse at any time and situations in life.
- **The right to sexual autonomy, sexual integrity, and safety of the sexual body.** This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.
- **The right to sexual privacy.** This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.
- **The right to sexual equality.** This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.
- **The right to sexual pleasure.** Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual wellbeing.
- **The right to emotional sexual expression.** Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.
- **The right to sexually associate freely.** This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations
- **The right to make free and responsible reproductive choices.** This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.
- **The right to sexual information based upon scientific inquiry.** This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.
- **The right to comprehensive sexuality education.** This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.
- **The right to sexual health care.** Sexual health care should be available for prevention and treatment of all sexual concerns, problems, and disorders.

Source: World Association of Sexology (2002)

Class Discussion:
- What do you understand by the term sexual and reproductive health rights?
- List examples of sexual and reproductive health rights.
- Are the SRH rights you listed respected and upheld within your community?
- Discuss your response with the class and provide examples.

Some of the responses to the above discussion, may include the following:

- the right to be informed when a partner tests HIV positive
- the right of a partner to be protected from HIV infection
- the right to have access to all methods of protection from HIV
- the right to choose whether or not to have children
- the right to plan family size
- the right to choose a contraceptive method
- the right to choose one's sexual partner
- the right not to have children
- the right not to be coerced or forced into a sexual relationship
- the right not to be discriminated against in the workplace because of pregnancy or having children

Examples based upon: http://www.un.org/en/development/desa/population/theme/rights

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). There are a host 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:

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.

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 Quality controls
- SOP 008 Issues, Orders, Distributions & Payments of suppliers
- SOP 011 Contract management
- SOP 012 Supply chain management
- SOP 013 Condom promotion

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: Condom storage quality assurance and SOPs (10 minutes)

- Standards in the PDS condom warehouse have deteriorated and non-compliance has become almost impossible to measure due to the fact that no one has been assigned to conduct quality assurance checks and the official stock control register is missing, or never readily available.
- No one has ever read the SOPs and condoms are simply stacked as they come in. Recently, there was a report of a condom burst and a client was at risk, the first report of a burst in many years.
- The Provincial Chief Director HIV/AIDS and STIs prevention has tasked you with investigating whether quality assurance controls are in place to ensure similar incidences do not occur and forewarned you regarding quality assurance visit in three days-time.
- *What steps will you take to prepare for the* quality assurance *visit?* Develop a plan and identify procedures to be followed in order to comply with standards ahead of the visit by Chief Director.
- Suggested tools to assist you: SOPs (storage and distribution SOPs); quality assurance process; monitoring and evaluation and reporting; and quality improvement process.

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

MODULE 7:

1. **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.

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.

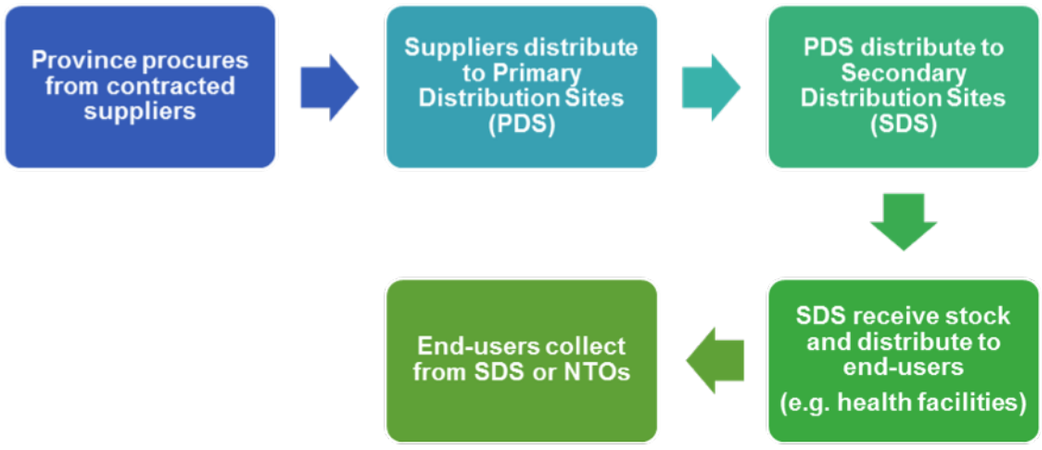


FIGURE 17:FLOW OF CONDOMS FROM CENTRAL PROCUREMENT

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

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.

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

ANNEXURES

A. TRAINING PROGRAMME AGENDA

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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 of the HIV Epidemic	
Morning tea [10:30 – 11:00]		
11:00 – 12:00	Module 2: Combination HIV Prevention	
12:00 – 13:00	Module 3: Correct and consistent use of condoms • Correct and consistent condom use • Condom demonstrations: male and female	
Lunch [13:00 – 14:00]		
Afternoon session:		
14:00 – 15:00	Module 4: Psychosexual Factors and Communication Section 4.1: Values clarification session Section 4.2: Counselling skills and risk assessment Section 4.3: Gender and sexuality: an introduction	
Afternoon mini-break [15:00 – 15:15] - Leg stretch		
15:15 – 16:15	Module 4: Psychosexual Factors and Communication (continued) • Section 4.4: Gender and HIV testing • Section 4.5: Key Populations (KPs) and Prevention of STIs • Section 4.6: Social Behaviour Change Communication (SBCC)	
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 5: Sexual Reproductive Health (SRH) and Rights	
9:45 – 10:45	Module 6: Condom Distribution: Procurement, Supply and Logistics	
Morning tea [10:45 – 11:15]		
11:15 – 12:15	Module 7: 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!

ANNEXURE B: PRE/ POST-TEST QUESTIONS SHEET

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. Dual protection 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) Using condom and contraceptives to prevent the risk of HIV infection and pregnancy
   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 sero-discordant 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 clients 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. Indicate which of the following activities indicate innovative approaches to influence positive change:
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

ANNEXURE C: PARTICIPANT HANDOUTS

a. Check list to assess step by step method for correct male condom use

No.	Activities required for step by step application of a male condom (tick whether the step was followed correctly)	✓ or X
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 and SABS mark 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 evenly distribute the lubricant.	
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 the penis is not circumcised.	
7.	Roll the condom over the penis fully 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 promptly before the penis loses erection. To avoid contact with fluids use one tissue for removal of the used condom and another tissue for disposal.	
10.	Wrap the used condom carefully (to avoid spilling the contents) in toilet paper, or ordinary paper, and dispose in the bin.	

b. Check list to assess step by step method for correct female condom use

No.	Activities required for step by step application of a female condom (tick whether the step was followed correctly)	✓ or X
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 and SABS mark on the individual condom packet. If it is expired, do not use the condom	
3.	If the package contains a lubricant, then smooth sealed package with the thumb, to distribute lubricant evenly	
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 destroy the condom itself	
5.	Squeeze the inner ring/sponge of the condom in the middle (participant lists comfortable positions for female condom insertion: standing with one leg raised, sitting, squatting or lying down)	
6.	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.	
7.	Make sure that the outer ring stays outside the vagina	
8.	Guide the penis into the condom. Make sure that the penis is entering into the condom and not entering on the side between the condom and vaginalwall.	
9.	After ejaculation, grasp the outer ring firmly before you twist it. This will keep the semen inside the pouch in the condom; twist the outer ring and then remove carefully to avoid spillage.	
10.	Wrap the used condom carefully (to avoid spilling the contents) in toilet paper, or ordinary paper, and dispose in the bin.	

c. Health Belief Model

The Health Belief Model, developed in the 1950s, holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model, a person must hold the following beliefs in order to be able to change behaviour:

(1) perceived susceptibility to a particular health problem ('am I at risk for HIV?')

(2) perceived seriousness of the condition ('how serious is AIDS; how hard would my life be if I got it?')

(3) belief in effectiveness of the new behaviour ('condoms are effective against HIV transmission')

(4) cues to action ("witnessing the death or illness of a close friend or relative due to AIDS")

(5) perceived benefits of preventive action ('if I start using condoms, I can avoid HIV infection')

(6) barriers to taking action ('I donot like using condoms').

In this model, promoting action to change behaviour includes changing individual personal beliefs, beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations. Theory for individual and social change or empowerment model. This theory asserts that social change happens through dialogue to build up a critical perception of the social, cultural, political and economic forces that structure reality and by taking action against forces that are oppressive (Parker, 1996).

In conclusion, community level theories, models or factors see human behaviour as a function not only of the individual or his or her immediate social relationships, but as depending on the community, organisation and the political and economic environment as well. They are multi-dimensional with an emphasis on linking the individual to the surrounding larger environmental systems. Interventions using this approach, thus, target organisations, communities and policy.

d. Principles of the condom procurement and tendering process

The principles that influence the condom contract management and tendering process are indicated in the table below:

PFMA pillars	• PFMA pillars described and outlined, including transparency, fairness, equity (BB-BEE) and following the contracting guidelines of PFMA. • RFQ process and request for price (to ascertain the competitive market cost of the goods and services requested) • Provide overview of procedure for reviewing proposals (Technical Evaluation Committee – TEC) and the rationale for awarding tenders to successful bidders.
Price	• Price: nominated market researchers (market intelligence) review the requirements of a bid and determine fair and acceptable price per unit for suppliers to ensure they maintain budget and costing within tender specifications.
Quality	• Quality: price and quality researchers seek to quality assure delivery within requirement specifications. It is required that samples of goods tendered be subjected to stringent quality testing of SABS. • Quality is stipulated by stipulated ***specifications***. • Customs recognise specific international bureau of standards to certify imported products. • Participating authorities are centrally designated and quality would be measured according to the specification of the tender bid. Requirements of the bid are SABS and quality approval from a registered and accredited quality assurance authority. • Delivery requirements and product specifications form part of bid specifications.
National Treasury database to be centralised	• It was announced at the SONA that from 1 April 2016 the tender process will now be centralised and all government suppliers must be registered on the central National Treasury database in order to do business with government and its intermediaries. • Master procurement registration provides suppliers with National Bid Number.
Communication with bidders and suppliers	• Strict guidelines are followed regarding communication to bidders, e.g. rules for participating authorities governing interaction with nominated parties • Bid specification meetings/briefing sessions: the guidelines and specification requirements are clearly explained; including standard conditions of contracts; and estimates • Communication back to parties and prospective supply source: the supply source is researched in line with the specifications and market related quotations, estimates and budgetary requirements to ensure fairness, realistic and acceptable prices are submitted. • Once drafted, the quality, delivery, price and specifications are communicated to bidders in a form of invitation. • This is done in accordance with e-procurement provisions of National Treasury, with information and guidance provided during bidding sessions (samples and presentations may be requested).
Closing the bid	• Due dates are communicated for closing of the bid. • Procurement SOP followed: only responsive bids considered.

BEC	• Responsive bids prepared for the Bid Evaluation Committee (BEC), submissions include samples, proposals and presentations, etc. • Matrix and calculations: table summarising all supplier submissions for evaluation. • BEC evaluate and recommend supplier to DDG and issue letter of acceptance once DDG has accepted and approved nominee.
Notification to successful bidder(s)	• Interaction with successful suppliers: letters of acceptance and signatures of all the parties. • Publish a contract circular with list of suppliers (who you may order and purchase from).
Electronic and manual ordering system	• National Treasury and departments are moving towards electronic system: checks and balances regarding price, quantity and other specifications (in-tender systems). • Currently partially manual systems which intends to be fully-electronic in future. • Electronic systems allow for ordering online from registered providers.
Compliance and non-compliance	• There are penalties issued to suppliers for non-compliance. • Monitoring mechanisms collect data and information on all registered suppliers to quality assure and maintain service levels. • Motivating suppliers to meet demands and requirements is an important task of procurement. • Orders can only be accepted in line with price indicated on tender document unless CPA (price increases) implemented according to Rand fluctuations and date of order placed must be after the annual price increase is applied, except under extenuating circumstances, as with extreme Rand fluctuations (only allowed every three months). • There is a national +/- 10% price adjustment schedule according to CPA procedures as the Rand worsens or improves.
Guidance to provinces	• Local level of procurement: provincial level requires at least the three-quote system • Local/provincial procurement team must communicate to National to request only the companies that comply with quality-approved procurement process.
Functional warehouse and depots	• The supply network includes functional warehouses and depots, as well as direct deliveries straight to end-users (sites)/facilities.
Circular 3 of 2016 from Treasury	• Refers to transferral contracts • Frowning upon decentralised procurement • Rules and regulations and laws of national expenditure • All supplies under pharmaceutical (including condoms) must comply with Circular 3 (2016)

APPENDIX D: PARTICIPANT EVALUATION FORM

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 interesting about the training? (please state your reason)_____				
2. What did you find least usefulabout the training?(please state your 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
7. How would you rate the activities and exercises applied in the training?				
1	2	3	4	5
8. What would you have changed regarding the presentation of the facilitator? _____				
SECTION B: TRAINING MATERIALS				
9. Please rate and comment on topics/ content covered (quality, scope, relevance, depth, etc.)				
1	2	3	4	5
Comments: _____				
10. Which aspects have, in your opinion, not been addressed in this course and should be included? _____ _____				
SECTION B: VENUE AND FACILITIES				
11. Pease rate and comment on the venue and the catering?				
1	2	3	4	5
Comments: _____				
SECTION C: WORKSHOP ADMINISTRATION				
12. Please rate the performance of the training coordinator(s) in terms of registration and workshop administration:				
1	2	3	4	5
13. Please rate the support you received from the training coordinator(s) during the workshop:				
1	2	3	4	5
14. General comments: _____ _____				

Thank you for taking the time and effort to complete this questionnaire!

Please hand in your evaluation to the facilitator/course coordinator.

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TRAINING MANUALS AND SLIDES CONSULTED

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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.
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6. HIV Rapid Testing Course No 2. NDoH Training Manual.

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