

Models of Female Condom Introduction and Distribution: Associated Uptake and Sustained Use

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Distribution/Introduction Models

Social marketing

- General population
- Usually cross-sectional surveys, w/ or w/o qualitative

Targeted distribution –

- Often uses CBOs, peer education
- Cross-sectional surveys or longitudinal, w/or w/o qualitative

Intensive clinic- or community-based interventions

- Usually longitudinal, may include qualitative

Clinic-based programs

- Rarely evaluated

Questions to be addressed

- What do successful models of each distribution/introduction type teach us about FC uptake and sustained use?
- How can we capitalize on the strengths and compensate for weaknesses of each model?
- Where do provider and community training belong in the schema?
- What research priorities remain?

Distribution Systems: Advantages

Focussed Distribution

- targets hi-risk group
- diffuses peer counseling
- boosts community capacity

Mass/Social Marketing

- expands access
- normalizes use
- allows rapid feedback

Clinic or Community-Based Interventions

- in-depth/personalized participant training
- strongest research designs
- defines best practices
- pioneers innovative approaches
- may boost community capacity

Clinic-Based Programs

- improves access
- allows possibility for quality training of subjects and providers
- continuity of care
- allows possibility for integration of services

Distribution Systems: Disadvantages

Focussed Distribution

- limited access for general pop'n
- often x-sect eval'n only

Mass/social Marketing

- limited client training
- limited trainer training
- x-sect eval'n
- no comm'ty capacity-bldg

Clinic or Community-Based interventions

- limited access and user education
- requires accompanying structural changes for maximal impact

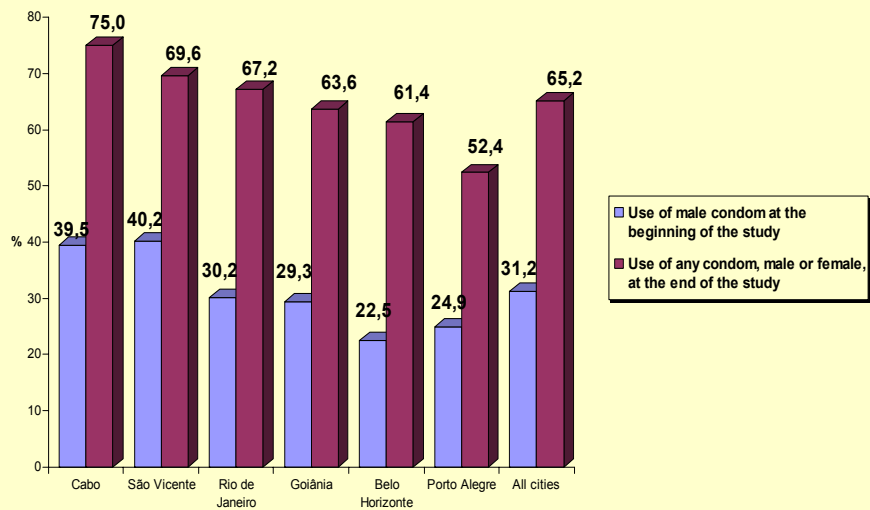
Clinic-based Programs

- support for LT change in provider "culture" often not provided
- quality of counseling for client often not ideal
- rarely evaluated
- resistance to integrat'n

Brazil – Social marketing

- Launched with support from National AIDS Program (1998, 276 K →2000, 2 M FCs)
- Longitudinal trial launched one year later
- Pilot study of 2382 women followed for 3 mo. in 20 different health units, 1998-99, recruited in FP/other clinics (Barbosa et al., 2000)
- 238 "awareness groups" held: focus on concept of women's autonomy and need for double protection, effectiveness and use information
- 69% available at 3 mo. follow-up (31% LFU)

Proportion of safer sex in the last sexual intercourse at the beginning and at the end of the study (Barbosa et al.)

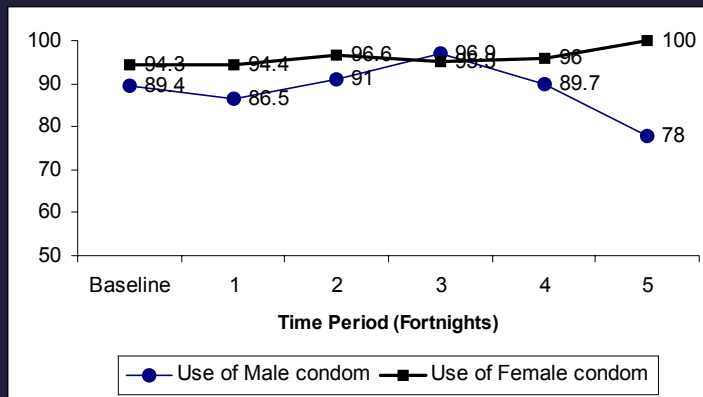


India - Targeted distribution

- Free samples provided for over 10 weeks in 3 high HIV-prevalence states
- NGO and State AIDS Control Societies collaboration
- Substantial community/outreach worker training
- Longitudinal study with 717 subjects included 372 FSW, 144 MSM and 201 women in stable married couples
- Overall retention rate 94% over the 10 weeks (HLFPPT & FHC, 2004).

India - Targeted distribution

TABLE 6.1 Use of male and female condoms



India - Targeted distribution

■ Among entire sample (N=675):

- Over 80% consulted field workers in the first several weeks of use
- By 8 weeks of use, problems related to FC insertion dropped from 36% of users to zero.

Zimbabwe – Social marketing

- Requested by National AIDS Program (result of lobbying, WASN) mainly in pharmacies and clinics, for FP use. Price heavily subsidized.
- Cross-sectional study undertaken one year later
- PSI and Horizons conducted intercept survey from those exiting urban sales outlets.
- Sample included 493 FC users, 633 MC users and 624 non-users of either method.
- Qualitative evaluation techniques also used for users.

Zimbabwe – Social marketing

- FC users: mid-late 20s, higher levels education and access to household resources as compared to MC or non-users.
- Majority of men and women received their prior information on FC from the package brochure

Zimbabwe – Social marketing

- 15% men and women FC users reported use for all sex acts with all partners
- 68% women and 54% men indicated intention to use FC in future
- 13% women used FC without partner's knowledge
- 27% married women who used FC had no prior MC use

South Africa – Social marketing, clinic distribution, and ToT

- Jan-April 1996 training of nearly 300 health care providers in broader protection program:
 - ▶ 3-day workshop consisting of 13 modules
 - ▶ Content: integrated FC in with overall reproductive health focus and hierarchical counseling (other female barrier methods)
 - ▶ Emphasis on women's right to make decisions about protection
- No formal evaluation was conducted; qualitative assessments suggested success in increasing knowledge, skills, positive attitudes (Mantell et al.2000)

South Africa – Social marketing with training-of-trainers (ToT)

- 1998 joint FC Program launched in 8 of 9 provinces, diverse sites, populations (Depts of Health, RHRU, FHI)
- FC program involved primary care sites, CSW community sites and social marketing program
- Included further large-scale training of providers, quality assurance and supervision

Togo – Targeted distribution

- Social marketing of FC in Togo via PSI since 1999, supported by Togolese government
- “Sister-to-Sister” project developed in 2000 with financial aid from DFID, and partner NGO as a complement to USAID project targeting FSWs
- Aim: to reduce HIV/AIDS transmission by empowering CSWs to practice safer sex by increasing access to the FC along major transport routes in Togo

Togo – Targeted distribution

- Peer education took place in brothels, at roadside or at social venues
- During its 2nd year, 50 peer educators and 15 supervisors had 29,650 contacts with CSWs, their clients and members of the surrounding communities.
- Activities planned for Year 3 included 2500 group discussions and 11,000 counselling sessions with CSWs as well as 5 community demonstrations

Togo: Targeted distribution

- Qualitative study of 95 FSWs conducted in 2001
- All had heard of the FC female condom but 62% of them had never seen it.
- All except one thought that the FC female condom was their “ami fidele” – faithful friend – in the fight against HIV/AIDS.
- Of 25 who had used it, all said they were “very satisfied” with the device.
- 11/25 did not inform client: 6 withdrew during act for explanation, 5/6 continued with act

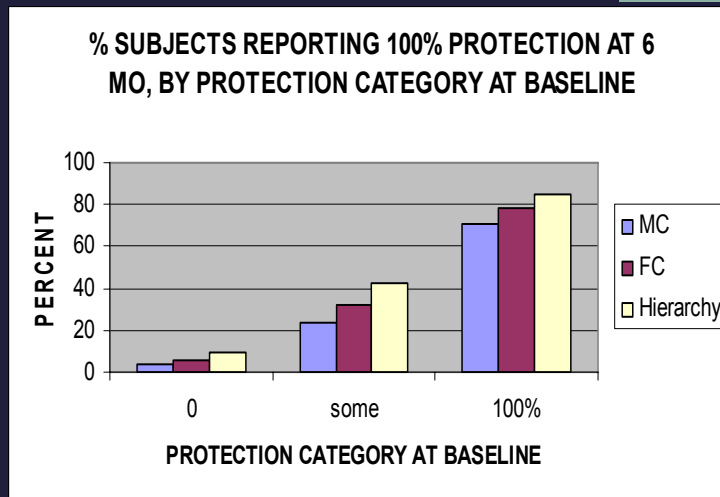
Philadelphia – Clinic-based program & clinic/community studies

- City of Philadelphia provided strong support and subsidy for FCs in early 90s
- Two clinic based studies instituted 1994 (CDC, FHC funding)
- CBO funding of street outreach for gay men, other hi-risk groups
- STD clinic integrated a weekly FP drop-in center for dual services ~ 1997

Philadelphia – Clinic-based intervention

- Brief (30 min) intervention delivered by trained counselors to 292 STD clinic patients (“Sister Studies”, Gollub et al. 2001, French et al 2003, Latka et al.2001)
- One-day training of STD clinic staff including FC, hierarchical counseling, etc.
- One-day clinical training for cervical cap/diaphragm fitting
- Longitudinal trial : 6 month follow-up comparing hierarchy versus single method, and MC vs. FC

Philadelphia - Clinic-based intervention

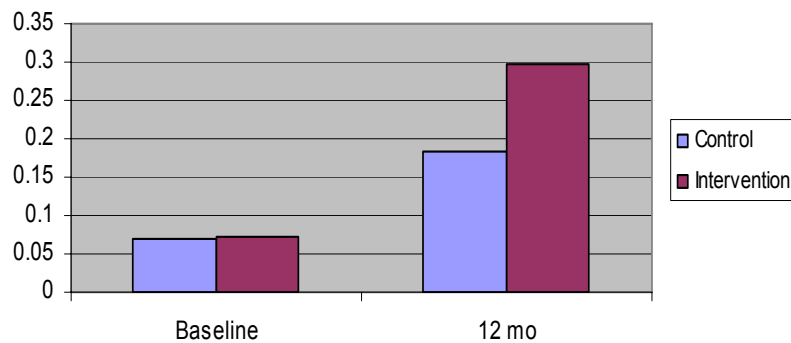


Philadelphia – Community-based intervention

- Intensive, 5-session, “body-empowerment” community-based intervention for out-of-treatment, drug-using women (N=198), “BestBET” study (Gollub et al.,2004)
- Week-long training of 4-5 near-peers and 3 CBO counselors
- Collaborative agreements with major family planning organization for cap/diaphragm fitting; CBO collaboration and capacity-building.
- FC use greater in hierarchy, multi-session than HIV C&T arm

Philadelphia – Community-based intervention

Proportion protected vaginal/anal sex with primary partner



Critical Role of Providers and Peer Educators

Health care providers can play a key role:

- A post-marketing survey in Zimbabwe found that more than half of women using the FC had heard about the method from a clinic, hospital, or doctor's office (*Kerrigan et al., 2000*)
- In a Tanzanian study, communication by a peer educator or provider had a direct impact on FC uptake (*Agha & Van Rossem, 2002*)
- India targeted distribution: 80% consulted field worker in first weeks of use

Critical Role of Providers and Peer Educators

There is growing evidence that providers may undermine promotional efforts and marginalize the FC

- **Studies of health care providers in several different national settings demonstrate that they often have negative views of the method and have little information on how to promote it** (Mantell, 2002; 2003; Morrissey, 2002)

Critical Role of Providers and Peer Educators

Moderator: Had any of you heard about using the female condom before this intervention?

P3: Yeah, I would just get them and throw them in the closet because – no one explained to me how to use it. They just gave it to me. So I thought it had a hole on both ends and I was, like, “Well, what good is this going to do? You know?”.

But, coming here, when we got it for homework and we went – I went home and I done my [vulval self exam] homework with my little mirror....I found out that [the female condom] didn't have a hole at the other end. And it does work if you put it in. You know what I mean? So it was like – it was a lot of eye opening for me.

(Gollub&Mason,unpub)

Critical Role of Providers and Peer Educators

Kenyan trial of FC+MC vs. MC alone...(Welsh, 2001)

- A gap existed between clinicians' reported condom promotion activities and their observed behaviors.
- 58% participants reported never using FC
- In 42 observed family planning visits, only once did a provider suggest a condom as a supplemental method to OCs for STI protection.
- Many clinicians viewed the FC as a feasible method only for single women and sex workers, not for women in stable unions.
- Only one of 10 intervention site clinics distributed FCs all 12 months of the trial as called for by the protocol.

Conclusions

- Strengths can be multiplied, and weaknesses offset, by using multiple distribution systems simultaneously, and by building in a large-scale and sustained training component from the start, with the aim of establishing a trained cadre of easily-accessible field workers/ peer counselors and integrated FC training in STI/FP service provision. This approach will result in a greater chance of sustained use, and of easier uptake of other and future women's protection methods (microbicides, diaphragms, etc).

Recommendations – (1)

1. Models need to be used to complement each other (eg. Social marketing + widespread peer/CBO training +targeted distribution). Results in greater number of users, greater diversity in populations reached, and faster diffusion.
2. Global resource-sharing, clearinghouse approaches must to be instituted. Successful country packages should be easily available for dissemination, adaptation from a centralized source. Collaboration among women’s methods “camps” (FC, microbicides, etc.) is crucial.

Recommendations – (2)

3. Behavioral interventions and training programs should be described in greater detail in published and unpublished literature....
 - ▶ Better understanding of “exposure”
 - ▶ Aid in considering replicability, adaptability for other populations
 - ▶ Speeds collaboration and progress
4. Training as essential part of package, with added value of ToT programs and user counseling better demonstrated and quantified. Monitoring and program evaluations of training and client counseling should be routine.

Recommendations – (3)

6. We must continue to insist that concepts be reframed and language changed to fit a women-centered paradigm. Move beyond traditional outcome measures – in informal discussions, published reports, strategic planning, etc. – to better reflect women's diverse needs and the reality of their experience with the method.

Examples of questions that need reframing

- Does it just replace male condom use?
- To whom should we grant access to female condoms?