

SITUATIONAL ANALYSIS OF THE FEMALE CONDOM IN ZIMBABWE

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Executive Summary

Zimbabwe was the first country in Africa to advocate for and successfully bring Female Condom supplies to the population. In 1997 the Female Condom was launched in both the private and public sectors. The social marketing sector demonstrated a large initial novelty demand for the Female Condom with a subsequent dip in sales. Numbers of the Female Condom purchased have steadily increased since that initial dip and today more than 1 million FC are made available through the social marketing sector. The public sector has a less well documented and more problematic path. After great initial interest upon the 1997 launch of the condom, programme efforts have waxed and waned over time. In 2002, efforts were made to reinvigorate FC activities. For multiple reasons training for the Female Condom never reached the most cascaded and rural levels and Female Condom stocks have still been historically inadequate in the country.

This document attempts to take a snapshot of the current situation around the Female Condom in Zimbabwe. Social marketing activities have shifted but are still successfully distributing Female Condoms in significant numbers to targeted populations. Though no clear national policy exists for how the Female Condom should be distributed, programmes have developed in the public sector that attempt to reach the population at large. Because condom stocks have been inadequate, local decision makers often target FC stocks to those perceived to need female condom stocks the most in order to protect them from a perceived increased risk of HIV infection.

In current programme efforts, access to adequate supplies of Female Condom is the most outstanding impediment to successful distribution efforts. As training efforts fell short, small stocks and no training have left many geographic areas unaware of the Female Condom and without any programming. Many examples internationally have demonstrated that the Female Condom requires programmatic support of the product. Thus it is no surprise that stocks given to untrained providers do not move in most cases. The inability of women to successfully negotiate Female Condom use has also proved problematic. This is no surprise as programme efforts have failed to educate users to navigate the cultural and social barriers that women face. No tool exists in any country at this time which teaches both providers and end users to negotiate a female-initiated barrier method of protection.

This situational analysis is intended to guide the strategic planning process and be integrated into the national strategic plan for condoms in Zimbabwe and subsequently into the national strategic plan for prevention. This report recommends a phased scale up of Female Condom efforts over time. A couple of new promotion strategies have been suggested, namely, the pairing of the social marketing and public sector efforts to strategically position the Female Condom, the consideration of how to deal with the issue of re-use of the Female Condom and how the Triple Protection argument may be useful to Female Condom efforts. It is also strongly recommended that male and female condoms be paired together as protection strategies rather than methods and should be integrated into all levels of the HIV and AIDS response.

Acronyms

ACT	AIDS Counseling Trust
ART	Anti-Retroviral Therapy
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Service Organization
CBD	Community Based Distributor
CBO	Community Based Organization
CSW	Commercial Sex Worker
DAAC	District AIDS Action Committee
DFID	Department for International Development
DH	District Health
DTTU	Delivery Truck Top Up
HBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
FBO	Faith Based Organization
FC	Female Condom
IEC	Information, Education and Communication
JSI	John Snow International, Europe
MC	Male Condom
MCAZ	Medicines Control Authority of Zimbabwe
M&E	Monitoring and Evaluation
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non-Governmental Organization
PAC	Provincial AIDS Coordinator
PHE	Provincial Health Educator
PLC	Provincial Level Coordinator
PM	Provincial Manager
PMD	Provincial Medical Director
PPTCT	Prevention of Parent to Child Transmission
PSI	Population Services International
STI	Sexually Transmitted Infection
TOT	Training of Trainer
TSG	Technical Support Group on Condom Programming
UZ-UCSF	University of Zimbabwe – University of California, San Francisco
VAAC	Village AIDS Action Committee
VCT	Voluntary Counseling and Testing
WAAC	Ward AIDS Action Committee
WAG	Women’s Action Group
WASN	Women’s AIDS Support Network
WHO	World Health Organization
ZACH	Zimbabwe Association of Church Hospitals
ZAN	Zimbabwe AIDS Network
ZNFPC	Zimbabwe National Family Planning Council

1.0 Introduction

The Female Condom is a 17 cm polyurethane sheath. There are two rings - one internal, free-floating ring which anchors the end of the condom over the cervix and one external ring which covers the external genitalia during intercourse. It is intended for single use at this time, though a re-use protocol for up to 5 additional uses has been published by the WHO. This condom is intended for the dual protection purposes of preventing against HIV and other STIs, and for preventing unintended pregnancy. Zimbabwe was the first country in Africa to strategically introduce the FC in the public and private sectors and has established a history which informs the current discussion of how best to move forward in strategically planning for future FC efforts.

Besides being a dual protection barrier method, the FC offers several other opportunities. It is clear that the FC is not merely a product, but a programme. FC introduction requires accompanying education for use and negotiation. For many FC users, introduction to the FC has been the first opportunity that they have had to know their reproductive health anatomy. Perhaps more importantly, FC has proved to be a tool of empowerment for women. It is indeed the only dual protection method that is female-initiated.

The FC is the first new product to be introduced for protection against HIV transmission since the beginning of the epidemic. Since its introduction into the African market in 1994 for Zimbabwean acceptability studies, much data has been gathered about how programmes have introduced the FC. These studies will inform the HIV and AIDS community about how other new tools in the epidemic will best be introduced. With microbicides, yet another female-initiated HIV prevention tool, in the development pipeline, the lessons learned from the strategic long-term promotion of FC in Zimbabwe will certainly prove key in the creation of new strategies.

Despite the success of the female condom social marketing programme in Zimbabwe, the public sector FC programme has experienced wavering programmatic support and success. This situational analysis is part of a broader Female Condom assessment in Zimbabwe and is thus complemented by a research review of the pertinent documents published around the Female Condom in Zimbabwe. The intention of these documents is to inform the development of a new national strategic plan for female condom programming. This FC Strategic Plan will feed into the development of a national Condom Strategy and subsequently into the larger planning around HIV/AIDS prevention strategies at the national level. This analysis will take the findings of historical and present data to make recommendations to the Zimbabwe Technical Support Group¹ on Condom Programming.

Though this analysis is broad in scope and is able to take into consideration past successes (and failures) as well as current capacities, it bears noting that a thorough assessment of organizational capacity has not been undertaken. This exercise simply intends to take a verbal photograph of the current Female Condom in Zimbabwe. Simply

¹ Members of the Technical Support Group include MOHCW, ZNFPC, NAC, MCAZ, DFID, USAID, UNFPA, UNAIDS, UNICEF, JSI Europe, JSI Deliver, PSI and other key stakeholders as necessary.

through the exercise of speaking with stakeholders, the landscape has changed. The fact that this analysis has been proposed and executed implies that there is a renewed interest to reinvigorate the Female Condom programme. The act of asking stakeholders to focus on the Female Condom and consider how they might fit into the larger puzzle that must come together in order for the FC to reach those in most need of it, seems to have had an effect on the attention that is paid to the FC. In asking about potential arguments for the positioning of the FC, conversation and enthusiasm has been generated. This is by design, not hazard. It must be stated, then, that the photograph that was taken at the time of this analysis has changed in the meantime. The terrain upon which the future of the Female Condom will be drawn should be richer in enthusiasm and ideas as a result.

2.0 Methodology

This situational analysis is preceded by a research review which inspired questions asked during the activity as well as provided a base of knowledge for the consulting team to share with stakeholders.² The research review and terms of reference for the exercise gave structure for the development of an interview tool which was loosely used as a checklist to ensure that all subject areas were covered.

A list of all key stakeholders was developed between UNFPA and the internal and external consultants. As many of the stakeholders as were available were sent a letter by the UNFPA office and asked to participate. Meetings were scheduled in Harare by the UNFPA. Meetings conducted in Gweru and Bindura were coordinated on the spot in many cases because meeting coordination from Harare proved difficult.

In all, 51 interviews were conducted in Harare, Midlands and Mashonaland Central Provinces. Every attempt was made to reach all levels within complex structures. Table 1 shows which levels of pertinent structures were interviewed. Despite best efforts, time limitations and the inability to contact many partners left many structures unrepresented, especially in the private sector. The following types of organizations were visited:

² C Endsley (2005) "Review of Research on Zimbabwe's Experience with the Female Condom," JSI Europe and UNFPA

- Government Health Structures
- NAC Structures
- ZNFPC Structures
- Funding Partners
- UN Agencies
- NGOs
- ASOs
- FBOs
- Universities
- Users

For a complete listing of those contacted, included with their contact information, please see Annex 2.

Upon completion of the interviews, patterns in responses were analyzed, key issues identified and recommendations formulated. Recommendations reflect the international experience of the consultants and the data gathered during the interviews.

Table 1

Levels of Health Structures Visited by Female Condom Assessment Team
 Italicized structures were included in this assessment

National	Provincial	District	Rural
<i>ZNFPC</i>	<i>PM</i>	Group Leaders	<i>CBDs, Depot Holders</i>
<i>NAC</i>	<i>PAC</i>	<i>DAAC</i>	<i>WAAC/VAAC</i>
<i>MOHCW</i>	<i>PMD, PHE, Hospitals</i>	<i>DH Executive, Hospitals, Local Authority Facilities</i>	<i>Clinics, Village Health Workers</i>
ZACH	-	<i>Hospitals</i>	Hospitals
Private Sector	-	Hospitals, Clinics	Hospitals, Clinics (also urban) i.e. mining company clinics
<i>ZAN</i>	<i>PLC</i>	<i>ASOs</i>	CBOs

3.0 Findings

Female Condoms are made available via two different systems in Zimbabwe. PSI has distributed the Female Condom since 1997 via its social marketing system. Upon initial introduction of the FC, there was a larger than expected peak in FC demand which quickly dropped but then steadily increased over the years. Through the social marketing campaigns, PSI sells the Female condom for a price slightly more than twice that of the male condom. The second system is the public sector which distributes the Female Condom via government structures, ZNFPC clinics and some NGOs for free. This system also began distribution in 1997 and has experienced peaks and valleys in the numbers of FC distributed for many reasons over the years. The PSI FC is branded as the *care* contraceptive sheath while the public sector condom is the FC female condom. The condom in both the FC female condom package and the *care* package are exactly the same inside the packet, are made by the same manufacturer but are packaged with different wrappers.

These two systems both receive funding from outside sources for their programmatic efforts. The PSI effort has been distinctly targeted over time while the public sector condom aims to reach the population at large. PSI socially markets approximately 45 million male condoms in Zimbabwe and just over 1 million FC annually. The public sector uptake is more difficult to track and wavers based on funding availability. What is clear in both cases is that the FC is a programme and not just a product and requires significant support. The FC is demanded by those who know about it. The current systems are not able to adequately measure true demand for this product in either the social marketing or public sector as it is a supply driven product.

The efforts of the public and social marketing sectors must be complementary. Because the public sector distribution involves many more stakeholders than the social marketing sector and because it has been historically more problematic, the findings and recommendations presented pertain to the public sector condom unless otherwise specified.

The question of why the previous public sector distribution has waxed and waned is key to being able to create a more continuous and consistent programme presently. A bit of history is necessary. The ZNFPC has been the distribution focal point for stocks of public sector Female Condoms. The public sector FC had been launched by ZNFPC in 1997. In 2002, funding by DFID for procurement of 500,000 pieces was accompanied by technical assistance from JSI Europe to the ZNFPC to develop a strategic plan for FC distribution. From 2002-2003, there were introductory training activities in the public sector, including the monitoring and evaluation of programs and distribution logistics. The intention behind these first trainings was to cascade them to subsequent provincial and district levels. This, unfortunately, never was carried out to its intended extent. Monitoring and evaluation activities were particularly problematic. In 2002, an FC Symposium, hosted by JSI Europe, updated the stakeholder community as to the state of research and policy around FC in the country.

Distribution of all contraceptives was problematic, resulting in high stock outs at service delivery points. In 2003, the ZNFPC initiated the Delivery Truck Top Up (DTTU) system with support from JSI Europe and JSI /Deliver in order to ensure that service delivery points received family planning supplies (including Female Condoms) directly, and to strengthen the monitoring and evaluation of commodity distribution.

When the FC strategic plan was first adopted by ZNFPC in early programming years, there were sufficient stocks of female condom, but programming never blossomed. That training never cascaded to the most decentralized levels has impeded the ability of service providers to be effective in FC delivery. Fuel shortages in the country, shortage of foreign currency and lack of funds for programming have posed hurdles that still need to be leapt. More debilitating were changes in staff, including key leadership positions in ZNFPC, lack of clear priorities and FC expertise within the ZNFPC system and low levels of commitment.

Today, the Female Condom is distributed through PSI both geographically and programmatically. PSI gives an initial supply of FC to those attending New Start VCT centers when it is requested. It is also sold through the Hair Salon network which has been very successful in providing the motivation and training needed by end users. The Hair Salon program is only in some geographic areas. In sharp contrast, the public sector FC is distributed through government structures in an effort to provide generalized distribution. The major factors restraining successful distribution and uptake of the female condom in these areas are lack of access, inadequate training which lacks negotiation skill training for end-users, unintentional targeting and lack of awareness of the product. Other barriers are related to users themselves, social, cultural and economic situations in the country and programme discontinuity.

3.1 Availability

Availability was cited by providers, distributors and end-users alike as the most significant barrier to effective FC programming in Zimbabwe. The current distribution system is managed by ZNFPC with support from DTTU. ZNFPC receives central stock from donor purchases and then manages Female Condom stocks alongside other family planning method stocks. According to the DTTU, all contraceptives in the country except the Female Condom have stock outs of less than 5%. The logistics system in place is capable of anticipating shortages and ordering replacement supplies before stock outs occur in most places for these contraceptives. The Female Condom is a special case. Current distribution of the Female Condom in the public sector is based on previous use. Where stocks have been delivered and used, they are resupplied, but rarely with enough stock to satisfy demand in areas where the FC is moving through the system. Where stocks rest idle, which is what happens when trainers have inadequate training, the DTTU system does not resupply. Thus, DTTU is not able to deliver adequate supplies to those who do distribute Female Condoms and are in a few cases delivering FC to those who do not distribute. In these cases, FC is often collected and redistributed.

The inability of the system to deliver adequate stocks of the FC to trained providers negatively impacts the provider's willingness to raise awareness of the FC. Many health care providers say that they promote and explain the use of the FC while they are in stock, but indicate that there is no use in promoting or raising awareness of a product that they cannot deliver. We can surmise from this that if stocks were available in greater numbers and distributed to trained providers that promotion activities and awareness of the FC would increase even if no further training was provided.

Public service organizations (ASOs, FBOs, CBOs, NGOs) recognize the value of FC programming not only for the additional protection it offers, but also the contribution that the FC makes to supporting women in their efforts to protect themselves from HIV as a vulnerable population. ASOs which wish to do FC programming will make valiant efforts to secure FC stocks, but no stocks are specifically designated for their activities through the public sector. Furthermore, ASOs and NGOs lack the purchasing power to secure stocks directly from the manufacturer. Several ASOs reported buying stocks from the PSI projects in order to be able to integrate FC into their programmes. Despite the relatively low cost of the PSI condom, this is diverting funds from training efforts to commodity procurement. FC stocks are not consistent and PSI has not been able to always meet the demand for FC by ASOs. This siphoning of ASOs off PSI stocks negatively affects PSI's ability to demonstrate programmatic impact because the ASO stocks do not directly serve the target population of PSI programmes.

Most stakeholders believe that the FC is under marketed and overly expensive. This is particularly interesting as the FC is provided free of charge through the public sector. Misconceptions about the relative cost of the female condom seem to be based upon early comparisons between the cost of *care* and the male condom Protector Plus. This is seen as an equity and rights problem and most people we spoke with insist that all condoms be made available at the same cost. In the case of the public sector condom, this is already true. As ASOs are currently paying a subsidized price for the FC, the assessment that FC may be expensive could be accurate. This perception could also be linked to suggestions at the national level that FC is too expensive to bring to the scale that exists for male condoms.

In summary, the Female Condom is a supply-side driven commodity because of the limited numbers available. The DTTU system cannot accurately measure or meet demand for FC. What is clear is that demand far outweighs supplies as evidenced by significant national and local stock outs and the resulting artificially low average monthly consumption figures. The DTTU distribution system is a powerful tool in providing access to FC and with adequate stocks would be very successful in ensuring an uninterrupted pipeline. However, given inadequate stock, then strategic distribution must be done.

This being said, it is clear that the Female Condom is not a product in and of itself. It requires programmatic support and training for service providers and end users. The issues of availability and training are closely linked.

3.2 Training

Training efforts never cascaded during the 2002 training efforts for multiple reasons already described. As a result, there are few staff who are adequately trained to teach end users on the insertion and use of the female condom. Previous training efforts have given little information on how to motivate people to use the FC and have never provided information as to how to train users to negotiate condom use.

High staff turnover at the ZNFPC and in ASOs has meant that only about 25% of those originally trained are still in their positions. Some staff attrition is attributable to HIV/AIDS deaths. Those who are trained and have an adequate stock distribute the female condom until stocks are depleted.

When training has not been conducted, we see that providers are biased against distributing the female condom (see provider bias below) and stocks do not move but rather sit in storerooms until recuperated by the DTTU efforts. In one exemplary case, we found a clinic nurse who had never received any Female Condom training. He distributed his stock of female condoms within three days of having received the stock whenever he did receive some. He said that he simply normalized Female Condom among the women that visited his clinic by saying “Men carry their condoms, you must carry yours,” to his patients. In this case, lack of training did not lead to provider bias.

Where no stocks are present but providers are trained there is great frustration which is not necessarily bias. Providers with no stock to provide simply will not teach people to use a product which does not exist. (See Table 2)

Table 2
The Intersection of Provider Training on the FC and FC Stock Availability

	Training	No Training
Stock	FC gets distributed and stock outs occur in most cases	<ol style="list-style-type: none"> 1. Provider bias, stock doesn't move 2. Provider finds minimal training in order to move stock – no bias
No Stock	Frustrated service providers, not necessarily bias – they won't promote what they can't distribute	Low awareness of FC, no FC coverage

3.3 Awareness

Awareness of FC is low, especially in rural areas and those not targeted by PSI. There seems to be a correlation between low stocks, low training and low awareness, as one might expect. Where there is no training of providers and no stock of FC, awareness is low. This should not be misinterpreted as low demand. Latent demand seems to exist on some level. This conclusion is based upon discussions with those who do not use FC in areas where FC stocks are low.

It bears noting that the majority of FC stakeholders with whom we spoke have never tried FC themselves. When asked why they had not, most cited that they were married or used other contraceptive methods. Others stated that they did not see themselves to be at risk. Whether their perceived risk is accurate or not, those involved in the promotion of the FC should have at least tried the FC in order to know of what one speaks.

3.4 Targeting

Targeting strategies are very different between the public and social marketing sectors. The design of the PSI *care* programmes is clearly targeted. Those target groups have changed over time as lessons have been learned. In the public sector, there is no national policy on FC distribution. The design of the public sector distribution system is one of generalized distribution. In reality, targeting is happening at operational levels. Key decision makers (usually only one motivated person) are directing the majority of FC to target groups based on perceived need or risk in their geographic area. For example, in Gweru, the nurse at the City of Gweru Municipal Center assures that the Gweru Women's AIDS Prevention Association (GWAPA), a group of sex workers, receives an adequate supply of Female Condoms. Every other provider of Female Condoms in the Gweru area reports never having sufficient stocks.

When asked whether public sector female condoms should be targeted, stakeholders were divided. It is agreed that in an ideal situation anyone who desired to use a Female Condom to protect themselves should have access. Whether or not this was the best use of resources seemed to be the more key question. Targeted distribution of Female Condom is one solution to the problem of limited resources. Whether a stakeholder indicated that they prefer a targeted or generalized distribution of the FC in Zimbabwe, all agreed that clear strategic planning around FC distribution would be useful. Funding partners in particular felt that guidance from a group focused on how best to plan distribution in such a way that impact could be demonstrated would be useful.

The SWOT analysis below attempts to explore some of the advantages and risks involved with targeting versus generalized distribution.

Table3
Targeting SWOT Analysis

<p>Strengths:</p> <ul style="list-style-type: none"> • Can effectively reach high risk groups and strategically reduce HIV incidence. • Targeted groups often have adequate supplies. • Resources (i.e. training, fuel, models) are more directed and therefore less intense than in a generalized approach. Thus, cheaper. 	<p>Weaknesses:</p> <ul style="list-style-type: none"> • Misses the majority of the population, much of whom are at risk in a generalized epidemic. • Can lead to labeling or stigmatization of the product thus closing opportunities for future generalized distribution if not done deliberately. • Some target groups will be left out upon prioritization. • CYP are still the same, but concentrated in a few. • It is inherently an inequitable distribution of resources.
<p>Opportunities:</p> <ul style="list-style-type: none"> • Targeting strategically can avoid stigmatization • Previously underserved groups can be included • Provides the occasion for reflection and gearing up for generalized distribution while not stopping current services • Allows us to assess FC uptake in specific populations • Could stimulate latent demand in non-targeted populations 	<p>Threats:</p> <ul style="list-style-type: none"> • Could stimulate demand that could not be met in the future. • Could create a sense of competition among users and providers for scarce resources. • Could create a false sense of security among untargeted groups • Could be difficult to revert to a generalized distribution system

3.5 Distribution

The DTTU contraceptive delivery system is sophisticated and elegant. When it functions properly and with adequate stocks at the national level, DTTU allows for training or surveillance personnel to accompany distribution trucks. The delivery truck staff is well-trained in logistics management, contraceptive storage requirements and the like. At present, DTTU is funded by DFID and USAID and managed by JSI Europe, JSI Deliver and Crown Agents. Funding for the current DTTU ends in September 2006. However, in principle, the funding partners have indicated their interest in continued support.

The DTTU system is designed to distribute all contraceptives which are supplied in adequate quantities. The logistical management system does not deal with inadequate supplies well. Some efforts are made to remove stocks of FC where they are not being distributed and redistribute to those who are. The system is designed to do generalized distribution but could be adapted easily to reach target populations in geographic areas.

3.6 Barriers to FC use

3.6.1 User-related

The most frequently cited user barrier is the inability to negotiate female condom use. Mechanical barriers also impede users ability to effectively use the FC. Some users report that the FC is painful upon insertion, too noisy or too big. These perceived barriers have successfully been addressed by sympathetic and trained providers.

3.6.2 Service Provider Bias

At the national level, service provider bias is often cited as a barrier to effective FC programmes. The consultants explored this question in depth as provider bias could be a major blockage in effectively distributing FC which may require specialized intervention to overcome.

The consultants met no service provider who had received training that demonstrated any bias against the FC. To the contrary, most trained providers were enthusiastic distributors with inadequate stocks. Very few service providers had actually tried using a FC, however, even for experimental reasons. Despite enthusiasm, most providers did not see the FC as an appropriate prevention tool for themselves.

Every provider that the consultants met who seemed to have a bias, had never received training. Service provider bias does exist, but not to the extent thought at the central level. The key issues seem to be availability and training. When providers are trained and given adequate stocks to distribute, bias is not a problem. If after training, provider bias is a true issue, programmes should look to the history of how provider bias in IUD use has been successfully addressed.

3.6.3 Social, Cultural and Economic

There are several social, cultural and economic factors that make FC promotion more difficult:

- Dry sex is a significant sexual practice in Zimbabwe. It seems that some men are beginning to admit they do not like it, but the symbolic value of a dry vagina exists. It is believed that a dry vagina indicates that no other man has been inside it recently. A way the women can demonstrate their fidelity is by

having a dry vagina. The FC is lubricated and is thus incompatible with dry sex.

- Taboos exist around the discussion of sex and traditional roles make negotiation difficult for both sexes.
- Most relationships have men taking the lead in the when and how of sex. It is difficult for women to initiate sex or discussion of sexually related topics. Wearing a female condom in advance can easily be misinterpreted negatively as a woman stepping outside of her gender role.
- Self-esteem is related to cultural practices and beliefs, i.e. virginity testing, wife inheriting, payment of lobola, etc. Poor self-esteem whittles a woman's ability to insist on protected sex.
- Culturally, men think sex acts are not complete unless fluid is deposited into a woman, thus some men tear their condoms. This practice is more rife than previously thought.
- The FC is not yet stigmatized as a product for sex workers, nor is the public sector condom stigmatized as inferior to *care*. This is not true for the male condom. The generic blue package is thought to be of inferior quality to Protector Plus condoms.
- Fuel shortages make programmatic activities more expensive and sometimes impossible.
- Foreign currency (called Forex in Zimbabwe) shortages mean that costs of commodities are prohibitive and the economy is shifting toward a dollar based economy. FC procurement, programme delivery and staff turnover issues become problematic.
- Rapid inflation means programmes have to adjust budgets frequently thus increasing administrative burden.

While these factors create interesting challenges, they should be interpreted as programmatic considerations rather than arguments against the Female Condom. Programmes internationally have successfully addressed social, cultural and economic issues in the past. In fact, Female Condom has been used as a tool in some countries to raise awareness about some cultural practices that may not be beneficial to the health of couples.

3.7 Negotiation

After inadequate availability, lack of negotiation skills is one of the most significant barriers to using FC. No negotiation tools exist specifically for the FC in this country. As there is no tool or curriculum, negotiation was not included in initial trainings, thus even those who have been trained do not have this skill. Even male condom negotiation skills are rarely taught in Zimbabwe. Male condom negotiation is significantly different from FC negotiation, however. Gender dynamics, cultural practices and self-esteem can come in the way of good negotiation skills and are different between men and women. As a result, any tool that is developed for the purpose of teaching good negotiation skills must be specific to the FC and to the

Zimbabwean context. Any tools developed must address the needs of not only end users, but should also include a curriculum for teaching service providers how to help clients practice FC negotiation. Follow-up on FC use should address how attempts and negotiation went and provide ongoing support to end users wherever possible.

3.8 Social Marketing

PSI has been socially marketing the FC since the product came to the African continent. The *care* brand was initially marketed to “caring couples”. The results of initial campaigns are well documented. Subsequent programmes have scaled back media visibility of *care* without diminishing the numbers of Female Condoms made available through social marketing channels. Current distribution is done through a network of hair salons. Women in the PSI target audience spend a significant amount of time in these salons and have reported a willingness to discuss sexuality and learn from their hairdressers about Female Condoms. Home meetings have also been successful strategies for sharing information about Female Condoms from the comfort of women’s own homes.

PSI actively promotes Female Condoms through their franchise-model VCT centers. Trained staff make both male and female condoms available at no cost during counseling sessions.

What is most noteworthy about social marketing in Zimbabwe pertains to the male condom. Four male condoms are provided per capita per year in Zimbabwe via the Protector Plus campaign. No other country comes anywhere close to this sort of coverage. Protector Plus condoms are available in very remote areas and awareness is very high. PSI has enormous capacity to share their expertise in condom marketing.

3.9 Advocacy

Initial advocacy efforts in Zimbabwe were revolutionary and have never been repeated. WASN, with their partners, gathered 30,000 signatures on a petition demanding that Female Condom be made available. Groups like WASN are still raising awareness of the FC. WAG takes a wider approach and includes self-esteem and reproductive health rights. ZAN is prepared to take on advocacy of FC through thematic groups among ASOs. Unfortunately, however, national level advocacy efforts do not seem to include groups outside of the women’s movement. However, there is an opportunity to involve Padare, a national men’s association that addresses gender equity, as well as PLWHA organizations, in advocating for the FC.

Funding Partners indicate that FC promotion strategy must come from the grassroots to some extent. For example, shifting a focus to the infertility argument for barrier method use must come from constituents and receive support from donors and coordinating bodies. The role of the advocacy community around FC efforts must be reinvigorated and expanded if it is to truly guide grassroots FC promotion strategies.

3.10 Materials

The majority of IEC materials in Zimbabwe are related to the *care* campaign. Outside this campaign, few materials for FC promotion exist. No materials have been developed to address problems cited in 1994 research such as the need to add more lubrication when the FC is perceived to be too noisy or the perception that the FC is too big, among others (See the Research Review on the Female Condom in Zimbabwe, a companion to this document.).

Many providers and users cite the need for models or mannequins to demonstrate effective FC use. New Start VCT centers currently use the Ortho female pelvic model. All counseling rooms are equipped with these models. Soft models distributed by the HealthEdCo corporation were provided to the ZNFPC Provincial Offices and Headquarters during 2002 training efforts. Few providers are trained in how to use their hand to demonstrate FC use. As women's awareness of their bodies is low, many find models a necessary tool in FC demonstration and feel demonstration with the hand is inadequate.

3.11 Programme Implementation

Current findings support what research has said: Interpersonal Communication strategies are most effective for increasing FC use. This is why projects such as the PSI Hair Salon and GWAPA are so successful. After women have decided to use the FC, they simply need to have access to an adequate stock. In the case of PSI, hair salon users can either get their stocks from their salons or PSI has expressed a willingness to work with ZNFPC to link FC users to public sector condom supplies. PSI has also had success in addressing myths with fun social activities.

Research shows that 3-4 female condoms are necessary for a woman to try and see if she feels able to use them. Many programmes ration their stocks because of unavailability of sufficient numbers and give out fewer than 3 and thus may not be giving women adequate opportunity to see if the FC is an appropriate method.

3.12 Continuity of Programme

The Reproductive Health Commodity Security Steering Committee (made up of many members of the TSG) works to ensure an uninterrupted supply of contraceptives. They use contraceptive procurement tables and historical data to forecast the need for future condom purchases.

No parallel strategies are in place to ensure continued programming efforts.

3.13 Demand

The Female Condom is a supply-driven product because it has never been supplied in any country at a sufficient level where true demand could be measured. While we have no hard figures on demand on a grand scale, when ASOs and service providers who were currently distributing asked how many FC they would ideally have available all cited at least three times and as many as 15 times more condoms than they were currently receiving. A latent demand exists among those who have no awareness of the FC according to service providers and end users.

3.14 Integration cross-programmatically

FC is currently successfully being integrated to a limited extent into HBC, VCT, PMTCT, FP and general counseling programmes. At the ministerial level condoms are intended to be integrated into programs across the board. There is, however, more work to do to ensure the condoms are included in all pertinent Reproductive Health and HIV/AIDS programmes.

3.15 Public/Private Sector Collaboration

PSI has indicated that they are interested in collaborating with ZNFPC to assist in programme development. In particular, they can link their Hair Salon project with public sector distributors and can help identify how best to do marketing and destigmatization of the product. Partnerships are key in ensuring programme continuity, coverage and integration of condoms into other aspects of HIV/AIDS programming.

3.16 New Ideas

Triple Protection

The majority of stakeholders questioned about the added value of the fertility argument for condom use said that fertility defines adulthood in Zimbabwe. They believed that the Triple Protection argument held water and cited that especially in PMTCT, men were willing to wear condoms to protect their children, while they might not be willing to wear them for other reasons. Further research is necessary beyond the opinions of stakeholders to determine if the Triple Protection proposition could be useful in Zimbabwe.

Re-use of the Female Condom

Several stakeholders cited that they have heard of re-use happening in their Female Condom programmes. One even openly promoted re-use in view of the inaccessibility of FC. With the exception of this programme, the others who had heard of re-use occurring could not attribute this pattern to any cause.

Globally, when asked about their thoughts on re-use, stakeholder reactions varied, with the majority indicating that unless availability issues were addressed than discussion on re-use was inevitable. Those who were apprehensive cited the efficacy of the protocol as their primary concern; however, proponents saw re-use as a gender and equity issue.

There are no clear policies on re-use at the ministerial level. The WHO has created a protocol for the successful re-use of the female condom up to five re-uses. Despite this protocol, the WHO still recommends that a new condom be used for every sex act. Based on the extremely limited numbers of FC and evidence of FC re-use being performed without any training as to how to do so correctly, a clear policy at the national level on re-use would be helpful in either multiplying the protection offered by one female condom or in providing a more compelling argument for adequate FC stocks.

4.0 Recommendations

AVAILABILITY

Procurement of the FC must increase if it is to meet current demand and ensure an uninterrupted supply of FC. To not do so would be a slow painful death for this product and would incite a powerful negative response from the majority of stakeholders.

Distribution must become increasingly strategic over time (Phased planning).

The RH Commodity Security Steering Committee should be tasked to plan for an increase in FC procurement to accommodate the phased shift from a targeted to a generalized distribution.

ASOs should have access to a dedicated stock of Female Condoms. This stock must be managed and a protocol for access to this stock as well as a scheme for prioritizing target groups must be developed at the national level.

PHASING

The goal for distribution must be to eventually have enough FC supply and programme to ensure that every woman who would use the FC to protect herself from HIV transmission have access to a supply. The phasing plan suggested here advises strategically targeting initial supplies while preparing funding partners and the FC distribution network for an intensified FC effort which intends to reach generalised distribution levels. This phasing plan carries no timeline deliberately. Rather, phases should be completed and subsequent phases well planned in whatever time is necessary in order to ensure that stakeholders are well prepared for scaling up activities. It is entirely possible that generalized distribution will be many years in the future and that the plan on how to best get there will be dynamic.

The underlying assumption of this plan is that there will be a guiding body for movement through the phasing plan. Currently, the TSG on Condom Programming is the seat of this planning process. It would be ideal if the National Condom Coordinator position led this process and the hosting organization, wherever the position is seated, is held as the condom coordination authority in the country.

In the current phase (Phase 0) we see that in the public sector, there is intended generalized distribution but that key individuals are targeting the female condom to those perceived to be most in need of it. Without changing this strategy for the moment, strategic planning to shift away from this set up needs to occur and should be guided by the National Condom Coordinator and the TSG, particularly the ZNFPC, MOHCW, NAC and funding partners. During the strategic planning process decisions will need to be made on the recommendations of this document, a few of which suggest further plans of action.

In addition, the opportunity exists in Phase 0 to establish baseline data. DTTU data should be combined with PSI data to determine numbers of FC available. In addition to numbers of condoms, FC champions should be identified and geographic coverage of the FC should be examined. Any data on who is currently using the FC should be collected in order to determine if programme efforts shift in any way. Finally, HIV prevalence baseline data should be established. As this is a Demographic and Health Survey cycle year, there is a rich opportunity to look at characteristics of populations within the country. These data, when in the hands of appropriate monitoring and evaluation expertise, can help programmes demonstrate impact of FC programming on the epidemic when brought to scale.

During Phase I, the targeting of Female Condom distribution to currently active sites within the generalized distribution framework should remain active at the same or increased levels. A targeting scheme should be added to the existing system to ensure reaching those who have been targeted. It is essential that current users not be cut off from their supply in the process of targeting. Also during Phase I, advocacy efforts must be reinvigorated and issues other than availability should be placed on the advocacy radar. This recommendation is made in response to funding agencies' insistence that advocacy must be the source of any new initiative around the Female Condom. For any new strategy, such as re-use or triple protection, operations research should be conducted during this Phase in order to prepare for roll-out in the pilot programmes of Phase II. ASOs and NGOS should begin incorporating FC into their existing programmes and creating new programmes where appropriate during this phase in a second effort to reach target populations. At the end of Phase I evaluation should focus on the impact of the FC on target population, including HIV incidence.

In Phase II full scale generalized programming in two provinces should be added to the national distribution with target groups. Any new strategies should be fully incorporated into the training and programming activities in these two provinces. A consultant or organization with economics expertise should be involved in the planning of the Phase II roll-out in the target provinces so that the activity can attempt to measure

the actual demand for FC. Evaluation of the programme at the end of the phase will suggest if a national generalized distribution scheme is appropriate. Lessons learned from this phase should be the basis for programme development in the last phase of scale-up. This being said, it is essential that there be enough time after initial implementation of the generalized distribution in these provinces to ensure that demand measurements are not novelty demand.

Phase III is the last phase where a truly generalized distribution scheme will be put in place. Demand figures generated from Phase II will demonstrate what quantities of FC are needed to meet national demand. The target group in this phase becomes all sexually active men and women in Zimbabwe. At the end of a roll-out period where all the necessary providers are trained, a re-assessment of provider bias needs to be conducted to ensure that training addressed the needs of providers adequately.

Table 4
Schema of Phased Female Condom Scale Up Implementation

Phase 0	Phase I	Phase II	Phase III
Generalized w/ Strategic Targeting by key individuals	Generalized with Strategic Guided Targeting	Addition of Pilot Programme in 2 Provinces	Generalized National Distribution
Strategic Planning	Advocacy expanded beyond procurement, forum?	Concurrent roll-out of new strategies if necessary	Target becomes all sexually active men and women
Donor, MOHCW, NAC Buy-in	ASO/NGO programming w/ target groups		
Decisions made on other recs.	Operations research on any new strategy		
Establish baseline data for impact assessment	Careful evaluation of targeting impact	Evaluation of pilot programme	Re-assess provider bias

TARGETING

1. In Phases 0, I and II of the phasing plan, targeted distribution will still be in place. During this distribution, target groups should be established using the following criteria:

- a. The targeted group should have the ability to use the FC and prevent HIV transmission to themselves and to others.
- b. The targeted group should be likely to influence others to effectively use the FC to prevent HIV transmission.
- c. The targeted group should be able to negotiate the use of the FC with the appropriate training.

Once appropriate target groups meeting the above criteria have been established, they should be placed into groups which represent three different levels of stigmatization. For example, the following groups meet the above criteria and could be grouped as such:

Professional Groups	Potentially Stigmatising Groups	Demographic Groups at High Risk
Teachers	CSWs	Married Women
Health Workers	PLWHAs	University Students
Farm workers	Mistresses	Newlywed women
ASO workers	Women with Sugar Daddies	Women with partners that work away from home

2. Careful efforts should be made to avoid stigmatizing the FC in the process of targeting. PSI has some expertise in this, which should be shared with ZNFPC. Additionally, by choosing target groups from each of the categories suggested, the potential stigmatization of the FC as a result of careless targeting should be avoided.

3. At some level, men must be included in programming efforts, whether or not they are cited in target groups.

4. Targeting efforts should not duplicate those of PSI either geographically or substantively.

5. The DTTU system for distribution is not targeted by design and would thus require modification in order to make a targeted effort.

6. Consider providers as a target group for end-user training and distribution. They will be easy to access and protecting them against HIV infection helps preserve the integrity of the medical system. Additionally, those who are effective users are more likely to be effective teachers of the method.

7. Consider the ability and expertise of existing programmes in reaching the target populations. Also consider if the population is discrete and easy to reach. Perhaps by addressing a target group, there are other opportunities created. Explore these.

8. Once groups have been established and considerations made for the above factors, at least one group from each category should be chosen. One scenario, which would effectively address all the necessary considerations, is the following:

Health Workers

PLWHAs

University Students

In targeting these groups, which are recommended as a powerful set of potential target groups, each selection provides certain strength to the mix. Health Workers are easy to reach with health messages, have the necessary reproductive health anatomy to understand insertion and once good users, would be even better promoters and trainers in FC promotion activities. By targeting PLWHAs, programmes would also need to address issues around positive sexuality, integration of FC into VCT, HBC, ARV and PPTCT programs. Integrating FC into these programmes is also providing prevention tools to those who have already demonstrated an important first step of prevention by getting tested, knowing their status or wanting to protect their children. This tertiary, yet very important benefit of choosing PLWHAs makes it an ideal group. University students are often becoming sexual for the first time while there. They are easy to reach because of existing health structures and are in the age group that currently has the most rapid increase of HIV incidence rates. Most importantly, however, University students, once successful FC users, can influence others, are likely to have normalized FC use from the beginning and are establishing healthy protection strategies.

It is this confluence of opportunities that should be sought in developing a targeting scheme.

9. In addition to targeting strategies, every opportunity to expand existing FC programmes, to integrate FC into existing programmes and to institutionalize the FC as part of protection packages should be supported.

ADVOCACY

1. Create a role in the strategic planning process for continued advocacy efforts.

An advocacy forum may be one way of making sure that the needs of end users are kept on the radar of decision makers. As microbicides or other female condoms become available, this group should raise the key issues surrounding program implementation of new female-initiated technologies. Issues should go beyond availability and address substantive issues such as how male and female condoms can be paired together in programmatic efforts, if new promotion paradigms such as triple protection are pertinent and how re-use programs could be implemented to ensure equity and maximization of programmatic efforts.

2. WAG, WASN and ZAN via its thematic groups, are best placed to take up advocacy issues but advocacy around FC must not just be a women's group domain. Men's organisations should also be actively involved.

MARKETING/POSITIONING

1. Pair ZNFPC and PSI as strategic partners in image creation and "marketing" for the public sector condom, dispelling myths about the FC, avoiding stigmatization of the public sector condom and normalizing FC use.

2. IEC materials should support the visibility of the FC and need to be created.

TRAINING

1. Due to high staff turnover, training efforts must re-start from zero and incorporate continuous periodic retraining and follow-up efforts.

2. The ZNFPC requires institutional support to address the high staff turnover. If support is not provided to ZNFPC then high staff turnover rates must be figured in to the costs associated with introducing any new technology, including the Female Condom.

3. Training efforts must be cascaded to the most basic levels. Funding and logistic arrangements for fuel, trainers and the like must be planned for, budgeted and executed.

4. Consider cross referencing DTTU data with training data from ZNFPC to learn who the key advocates and successful distributors have been.

5. Use these "FC Champions" in their regions in training and advocacy efforts.

6. Create a negotiation tool to be used in training. Negotiation training should take socio-cultural issues into account and thus be specific to Zimbabwe. Self-esteem and power dynamics must be addressed in negotiation skills.

7. Interpersonal Communications Strategies and face-to-face efforts are the best methods of teaching all aspects of FC use. Creative methods of incorporating these strategies in trainings should be used.

8. Ensure stocks of FC are available to each trained individual distributor immediately after training to best harness the enthusiasm generated by the activity.

9. Adapt IEC materials to address FC problems and awareness. These should be made available to those who have received training at the training site immediately upon completion of FC training.

10. Consider which female pelvis model to purchase and budget model purchase time and money into training programmes. Involve MCAZ in this decision. From experience, allow at least three months for models to arrive if you do not anticipate paying expedition charges for the shipping. Also budget the customs expenses associated with getting the models out of holding. Legislation which exempts any product used to demonstrate an HIV/AIDS protection tool from import duty would be helpful. An advocacy forum, in conjunction with MCAZ may best be able to accomplish this.

INTEGRATION

1. Deliberate actions should be taken at the policy level (NAC) to integrate condoms into Reproductive Health programmes and all possible levels of the HIV/AIDS response (HBC, VCT, ART, PPTCT). There are current small scale efforts to include condoms into these programmes already. As male and female condoms are the only prevention tool that sexually active people have to protect themselves against HIV transmission, it is essential that they have access to this protection at every level of the HIV/AIDS response. In HBC, ACT is already including male and female condoms in their HBC Care Kits. In VCT the New Start centres are making the female condom available to those who chose to use it. In some mission hospitals PPTCT programmes are addressing the need of families to use condoms during the times when the fetus or newborn is most likely to become infected.

2. Male and Female Condoms should be paired as complementary strategies rather than separate methods at the policy and programmatic levels. Male and female condoms both require negotiation by the end user. Some findings suggest that normalization of the Female Condom as the prevention option for sexually active women, just as male condoms are the prevention option for sexually active men can be effective. This pairing means that any place where a male condom is made available, it should be considered as a potential site for Female Condom distribution. This holds true for PSI's social marketing sector delivery of condoms as well as the public sector. While it may not be feasible to make the Female Condom available in equal numbers as the male condom, if the venue for female condom is more closely linked to that of the male condom, the pairing of the condoms as a strategy becomes stronger.

DISTRIBUTION

The Female Condom is already unavailable because of small numbers at the disposal of national level distributors. **Once adequate supplies are available, DTTU should address how best to ensure distribution to trained service providers.**

NEW IDEAS

Triple Protection:

Stakeholders have demonstrated interest in the added value that a concept like triple protection could provide to the fertility-conscious Zimbabwean. Whether this interest is simply respondent bias is beyond the ability of this team to address, but the question of whether or not the triple protection argument merits further investigation is pertinent. If the strategic planning committee decides not to consider implementation of triple protection promotion strategies, then it must be ensured that the relationship between fertility and STIs be reinforced in STI curricula and that condoms are strongly advocated for in that arena. If the triple protection argument is considered, operations research on the topic would be useful. As this concept comes from the Population Council, there may be some interest there to facilitate or fund research. If the strategy is deemed useful, it should be included in the Phase II pilot roll-out in the two test provinces. Whether useful or not, results should be made widely available on the continent.

Re-use:

Again, the strategic planning committee must reflect on whether or not Female Condom re-use should even be considered for integration into FC programming on the national level. If the committee decides not to consider re-use of the Female Condom then they must work to ensure that adequate supplies are made available as soon as possible. Re-use will occur despite programmatic efforts to dissuade it until adequate stocks are made available. If re-use is considered by the committee, then advocacy efforts from the grassroots as well as national stakeholders must be the driving force that encourages the exploration of the topic. During Phase I operations research should be conducted in target groups in order to develop appropriate re-use programmes. As the original protocol is from the World Health Organization, they may be interested in participating in or funding re-use activities. In Phase II, re-use should be rolled out to the two province pilot sites and evaluated. Lessons from these activities should be shared on a global scale.

OVERSIGHT

- 1. Either the TSG or another group established for the purpose and seeking input from groups that are monitoring users perspectives should ensure the continuity and appropriateness of programming, especially follow-up of training in the early phases. This group should be the parallel programmatic system to the RH Commodity Security Steering Committee.** The Advocacy forum should be represented in this group as well as the ZNFPC. The National Condom Coordinator could head this group. The calibre of person currently serving on the TSG should be the target minimum level of decision-making power for this group.
- 2. The National Condom Coordinator should be invited to attend and inform the RH Commodity Security Steering Committee.**

5.0 Next Steps

1. Establish the commitment to funding for procurement and programming.
2. Hire and implement National Condom Coordinator position. The first task of this Coordinator should be to work with the TSG to finalize a strategic plan for the FC based on this document.
3. The TSG establishes who the Target Groups will be in Phase I implementation.
4. Share this report with stakeholders and ask them to engage in the effort. Begin meeting with potential partners and developing programmes in areas of expertise. All actions should be reported to the National Condom Coordinator who can track progress.
5. Ensure stock levels are adequate for roll-out.
6. Distribution, training, IEC strategies and Funding be planned for Phase 1 implementation.

ANNEX 1

WHO Re-use Protocol for the Female Condom

ANNEX 2

Contact Information for Participating Partners

ANNEX 3

Organizational Preparedness for Female Condom Programming

The following Annex identifies the potential areas of collaboration and the preparedness to engage in activities for NGO and ASO partners. Government structures (NAC, ZNFPC, MOHCW), UN Agencies and Multilaterals have been excluded from this analysis as they are large organizations with varying capacities at different levels which will be difficult (but not impossible) to address simply through FC programming.

ANNEX 4

Terms of Reference

Draft Terms of Reference for a Female Condom Situation Analysis in Zimbabwe

1. Background

In preparation for a national HIV prevention strategy, the Technical Support Group (TSG) on Condom Programming³ works toward the development of a national condom strategy. In order to develop a national condom strategy, a female condom strategic plan should be designed as a first priority. To facilitate the development of a female condom strategic plan, it has been recommended for an independent consultant to undertake a female condom situation analysis. This situation analysis will be complementary to a rapid review of existing research on female condom use in Zimbabwe.

2. Definition of the task

The overall objective of the situation analysis is to assess the policy, community and service environment for female condom programming and to provide the basis for the development of a female condom strategic plan. Key areas that need to be addressed in the analysis:

- Review the experience of public, NGO, and private sector social marketing institutions in the delivery and promotion of FCs to date
 - Identify main constraints in procurement, distribution and data collection
 - Explore cost recovery mechanisms, if any
 - Identify channels currently used (effectiveness of channels, trainings conducted till date, communication and advocacy efforts till date)
- Consult with key government stakeholders and donor partners regarding the current situation, existing and future plans and support
 - Assess government policy and regulatory climates
 - Explore knowledge and attitudes of public sector representatives and leading NGOs regarding FCs
 - Explore future areas of collaboration and coordination mechanisms to intensify FC programming
 - Identify donor interest in promoting FCs in Zimbabwe
- Identify the socio-cultural and political environment that shapes user beliefs and practices and thereby influences the level of demand for FCs
- Assess demand by reviewing user needs, potential target audiences, public awareness and attitudes, IEC needs and advocacy issues
- Determine the preparedness of selected institutions and the availability of trained manpower for interpersonal communication and delivery of FCs
- Estimate training and follow up support needs among a core group of interested institutions
- Review well-established distribution networks for male condoms, including current capacity and functionalities of logistics management, and suggest possible prioritisation of target audiences and distribution mechanisms for FCs using existing outlets

³ Members of the TSG include Ministry of Health, Zimbabwe National Family Planning Council, National AIDS Council, JSI/DELIVER, JSI/Europe, Population Services International, Zimbabwe AIDS Network, UNAIDS, UNFPA.

- Identify interest in establishing a coordinating team or focal person(s) to manage a reintroduction of FCs
- Coordination mechanisms that exist to ensure sharing responsibilities and activities among different partners
- Identify possible partners in reintroducing FCs in a culturally appropriate manner
- Estimate future FC supply needs for a five year period (to supply institutions likely to participate in a reintroduction of FCs)

3. Outputs/deliverables

Based upon the information obtained through the situation analysis, the consultant will deliver a coherent report that addresses all responsibilities outlined above.

The report will include recommendations for a female condom strategic plan to intensify FC programming. The recommendations should be discussed with the TSG at the end of the situation analysis.

The recommendations should be practical and time-bound. They should specify the agency/ies responsible for the various components of program implementation – including motivating demand and enabling environment – and specify coordination mechanisms. They should also specify how distribution will be organized, how logistics will be managed, how IEC needs will be addressed, how training will be organized and the costs for female condom programming.