Guidelines for scaling-up the 100% condom use programme: Experience from Cambodia

World Health Organization
Regional Office for the Western Pacific
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2003
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The WHO Western Pacific Regional Office would like to thank Dr Hor Bunleng and Dr Wiwat Rojanapithayakorn for their contributions to this brochure.
The Joint United Nations Programme on AIDS (UNAIDS) and WHO have estimated that by the end of 2002, the total number of people living with HIV/AIDS will have reached almost 42 million, comprising 38.6 million adults (with almost equal numbers of men and women) and 3.2 million children under the age of 15.

The epidemic in the Western Pacific Region began late, but HIV/AIDS prevalence has risen dramatically since 1997. The number of people living with HIV/AIDS in the Region has increased more than four-fold, from an estimated 363,573 in 1997 to an estimated 1,681,479 by the end of 2002.

The main modes of HIV transmission in the Western Pacific Region are through sexual transmission from sex workers, and sharing of needles among drug users in selected areas.

As a prevention strategy for sexual transmission from sex work, the 100% condom use programme (CUP) among establishment-based sex workers has shown to be successful in Thailand (initiated in 1989) and in Cambodia (initiated in 1998). HIV surveillance data in Thailand indicates that HIV prevalence peaked in female sex workers and their clients around the mid-1990s and has been slowly decreasing since then. Recently, Cambodia has reported stabilizing levels of infection since HIV prevalence rates among pregnant women in major urban areas fell from 3.2% in 1996 to 2.8% in 2002.

Experiences so far indicates that the 100% CUP is an effective HIV prevention strategy. It should be actively promoted in countries where sex work is a major determinant of HIV transmission. Furthermore, the strategy should be implemented on a nation-wide basis in order to achieve high impact.

This brochure is a guide on how the 100% CUP can be expanded nation-wide once it has been piloted in one or more demonstration sites in a country. The example taken is from Cambodia.
In early 1998, the Ministry of Health of Cambodia and WHO’s Regional Office for the Western Pacific conducted a preliminary assessment on the HIV/AIDS situation in Cambodia and the possibility of implementing the 100% CUP. The conclusion was that it would be difficult to implement the programme nation-wide unless it was first demonstrated that it would be feasible to implement this approach in the country. Thus a demonstration project was developed, and Sihanouk Ville province was selected based on the following criteria:

- strong willingness, commitment and support from the local authorities at all levels (provincial and district governor, police, military police, commune council and village chief, establishment owners and sex workers);
- high prevalence of HIV and sexually transmitted infection (STI) based on the HIV sentinel surveillance (HSS) and STI prevalence studies;
- low consistent condom use rate among sex workers based on behavioural surveillance survey (BSS) and other studies;
- high number of establishment based sex workers (both direct and indirect); and
- available STI services.

After a year of implementation, the pilot project was evaluated and it was documented that the approach was socially acceptable as shown by the support provided by community and decision makers. Data analysis showed a significant decline in STI and an increase in self-reported condom use among the establishment-based sex workers. These results were used as an advocacy tool to request for higher political support and expansion of the strategy to other provinces.
There are five steps to successful scaling-up:

1. Advocacy on the acceptability, effectiveness and feasibility of the strategy;

2. Development of policy and national guidelines, including the production of an implementation handbook;

3. Development of a scaling-up plan;

4. Support for implementation, including study visits to the demonstration site, training and capacity building, and field support; and

5. Ensure the availability and accessibility of condoms.

1. Advocacy on the acceptability, effectiveness and feasibility of the strategy

   The first step on advocacy is to decide which group of people to reach. In Cambodia advocacy was carried out with the Ministry of Health, National AIDS Authority and international agencies such as the European Union, Family Health International, Population Services International, UNAIDS, and WHO through a dissemination workshop on the results of the pilot project.

   Other advocacy opportunity includes the introduction of the Sihanouk Ville project to authorities and personnel in other provinces during the First National AIDS Conference in March 1999.

   The study visits by heads of various ministries in late July 1999 further contributed to the advocacy activities. This important event led to more acceptance and willingness of national authorities to promote and support the expansion of
the programme and the consensus to get a policy direction from the Prime Minister of Cambodia.

Working with the media is another strategy for further advocacy but it is extremely important to carefully plan how to communicate information to the media. Messages presented should be simple, catchy, new, targeted to the audience and with visuals when possible. In Cambodia, the Ministry of Health and the National AIDS Authority (NAA) work with the media to advocate for policy support for the 100% CUP.

2. Development of policy and national guidelines, including the production of an implementation handbook

There is a need to have a policy, resolution or directive from the central level to facilitate scaling-up the 100% CUP in any country.

On 14 October 1999, the Prime Minister of Cambodia adopted and declared the nationwide expansion of the 100% CUP in the country. The issuance of the Prime Minister’s Order in Cambodia was the most powerful tool for scaling-up the programme. It should be noted that the approval of the national leader is the best policy and political device for scaling-up a programme strategy in any country in the world.
The NAA in Cambodia translated and disseminated the national policy for the 100% CUP to all levels of authority throughout the country. These include members of the policy board, members of the technical board of NAA, the Provincial AIDS Committee and Provincial AIDS Secretariat for their consideration and preparation for action.

(For detailed information on the Cambodian National Policy on 100% condom use, please refer to Annex 3 of the document Controlling STI and HIV in Cambodia – The Success of Condom Promotion).

Following the lessons learned from the 100% CUP pilot project in Sihanouk Ville, and the issuance of the national policy of the 100% CUP, the National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Disease (NCHADS) of the Ministry of Health was given the responsibility to implement the 100% CUP nationwide. A national guideline for the 100% CUP was developed for training those who were given the responsibility to implement the 100% CUP within their provinces or towns. This guideline describes comprehensively the steps for implementing the 100% CUP in a province or town and includes:
(1) Situation assessment and mapping
(2) Preparation of the advocacy tool
(3) Sensitization/advocacy meeting
(4) Local study tour
(5) Establishment of the coordinating committee and multi-sectoral working groups
(6) Linking to STI clinics
(7) Training of staff
(8) Annual plan development
(9) Implementation of the 100% CUP
(10) Monitoring and evaluation.

(For detail information, please refer to Annex 1 and the document on Controlling STI and HIV in Cambodia – The Success of Condom Promotion).

3. Development of scaling-up plan

A plan has to be developed for scaling-up the 100% CUP in a country. Using the experience from the pilot project in Sihanouk Ville, NCHADS developed a national plan for scaling-up the 100% CUP, including a timetable for phasing in additional provinces/towns and the budget for each site. Once this plan was developed, NCHADS played a very important role in resource mobilization to ensure that the necessary resources were available for each phase of the scaling-up process.

Because of limited financial support, the 100% CUP in Cambodia was scaled-up as a nationwide programme in two steps. The provinces and towns that met the criteria applied
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to the selection of the pilot project were scaled-up during the first phase. There were nine provinces that met the criteria and were selected to initiate the 100% CUP during the first phase of the scaling-up plan which took place from mid 2000 to early 2001. Those provinces were major urban centres, located primarily along the Thai-Cambodian border. During the second phase, the programme was expanded to the rest of the provinces with the exception of three provinces where establishment-based sex workers were not available.

4. Implementation support, including study visit to the demonstration site, training and capacity building, and field support

In order to scale-up the 100% CUP to other provinces, there is a need to operationalize the work-plan. Appointment or assignment of a responsible person or team within the health ministry is an important initial step. This person or team will work with provinces to implement the scaling-up plan, which includes resource mobilization, provision of technical advice to provincial authorities, training of provincial staff, and jointly conducting initial activities with the province to introduce the strategy at each site.

One major activity is for the new sites to learn from the experience of the pilot project. In Cambodia, since Sihanouk Ville was the pilot site implementing the 100% CUP, it was selected as the site for study tours for new provinces planning to implement the 100% CUP. During these visits, it is crucial to analyse the strengths and weaknesses of the 100% CUP to identify those that could be useful for initiating the programme in the new provinces and towns.
Capacity building at the new sites in the area of advocacy with the local authority, police, owners of establishments and sex workers should be included. This training should include topics on the formation of the various committees to follow-up and monitor condom use. Linkage and referral to STI clinics and the necessary reporting forms should be established.

A schedule and checklist should be developed for monitoring the sites by the central level and a regular reporting system should be set-up.

5. Ensure availability and accessibility of condoms

Condom availability is crucial to the 100% CUP. All three common sources of condom supplies should be strengthened in the country: government condom supply, social marketing of condoms, and private condom sale.

To ensure availability and accessibility of condoms in Cambodia, NCHADS work with Population Services International, a nongovernmental organization working in Cambodia under the mandate to support the government to fill the gap on condoms through social marketing. In this regard NCHADS worked closely with Population Services International to ensure that the condom distribution network was in place in the provinces and towns where scaling-up was going to be initiated.
Steps on how to implement the 100% CUP in a province:

(1) Situation assessment and mapping

Before the programme can be implemented, it is important to analyse the local situation. Data on the following topics should be collected systematically:

- the existing regulations in place to deal with sex work;
- existing information, education, and communication (IEC) activities;
- a list of known sex work sites and sex-related entertainment establishments throughout the province/town;
- the relationship between the local authority, establishment owners and sex workers;
- the HIV/STI data among sex workers;
- information about condom use, availability, condom price, types of condom, condom outlets and condom distribution network;
- an assessment of current STI services, types of clients, and capacity; and
- mapping the location of STI services and entertainment establishments.

(2) Preparation of the advocacy tool

An advocacy tool appropriate to the local situation should be developed in each province. The analysis from the situation assessment and mapping should be used for this development. The tool should include the following:
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- a description of the HIV/AIDS/STI epidemic within the province, the country, the region and the world. All these data could be available through the national HIV Sentinel Surveillance (HSS) report, the national STI prevalence study report and the UNAIDS/WHO report;

- factors contributing to the spread of HIV/STI in the province/town. These data could be found in the National Behavioural Surveillance Survey (BSS) report, as well as reports from different research projects and studies conducted by governmental or nongovernmental organizations;

- national and provincial policy, strategy and guidelines related to HIV prevention and care, including the 100% CUP;

- lessons learned or success stories related to the 100% CUP that have been published nationally and internationally;

- proposed plan for 100% CUP implementation in the province/town; and

- if possible, experts, consultants, and people living with HIV/AIDS should be invited to participate in the development of the tool.

The advocacy tool should be prepared and ready for presentation either as overhead transparencies or power point, with enough copies for each attendee at the sensitization meeting.

(3) Sensitization/advocacy meeting

The Provincial AIDS Secretariat and health department plays an important role in organizing the sensitization/advocacy meeting. The first meeting is for the provincial
governor, local authority and public security. Topics should include the roles of the different sectors in supporting this strategy. The second meeting is with owners of entertainment establishments and sex workers to inform them about the 100% condom use policy. The meeting includes presentations, questions and clarifications and dialogue to gain consensus on the proposed plan for the 100% CUP implementation.

(4) Local study tour

Since Sihanouk Ville was the pilot site implementing the 100% CUP, it was selected as the site for study tour for new provinces planning to implement the 100% CUP. It is very important that the study tour be used as an opportunity to show the strength and weaknesses of the 100% CUP so that others can learn what should be applied or avoided when initiating in the new provinces and towns. The study tour, which should last from two to three days, should be coordinated by NCHADS with support from the provincial level authorities. Each study tour should have a combination of two to three delegates including the potential authority that is expected to be a member of the coordinating committee or multi-sectoral working group. The agenda of the study tour should include the following:

- briefing on the overall process of the 100% CUP implementation to the tour members by the key implementers of 100% in the initial pilot project;
- meeting with chair or deputy chair of the coordinating committee;
- meeting with chief and members of the multi-sectoral working group;
- meeting with provincial AIDS programme manager and the chief of the STI clinic;
• visit to establishments and a meeting with owners and sex workers;
• visit to STI clinics; and
• final meeting with the whole group of implementers for questions, clarifications, recommendations and advice.

(5) Establishment of the coordinating committee and multi-sectoral working groups

In Cambodia, the creation of the coordinating committee was under the chairmanship of the provincial governor. Typically, a multi-sectoral working group consisted of four members but the total number of multi-sectoral working groups depended on the location as well as the number of establishments and sex workers. The provincial authority authorized the official nomination of the committees, which has to be established before moving ahead to other components.

The main function of the coordinating committee is programme planning, resource mobilization, and monitoring and evaluation and to ensure that the 100% CUP is implemented effectively. In addition, this committee is responsible for issuing administrative paper or local regulations to support the 100% CUP.

The main function of the multi-sectoral working group is to support fieldwork. It registers and updates the list of entertainment establishments, sex workers, condom usage, and referrals from STI clinics and intervenes if any abuse or violation happens in the establishments.
(6) Linking to STI clinics

STI clinics are used for monitoring condom use and treatment. This could be done through regular screening of establishment workers to link STI data with the establishment. Another way is by linking male STI patients with the entertainment establishment they visited. A referral system should be set-up.

(7) Training of staff

Training should be conducted on the implementation of the 100% CUP for the coordinating committee, the multi-sectoral working groups and STI clinic staff. Training on the development of the work-plan should also be included. The training workshop usually lasts for three days and may be organized locally at the provincial or the national level. It can be at the same or at a different time as the study tour once the provinces have officially nominated the coordinating committees and the multi-sectoral working groups.

(8) Annual plan development

After training, the coordinating committee and the multi-sectoral groups in each province should develop an annual work plan for the 100% CUP implementation. This plan should contain a work plan for implementation and an estimate of the costs for the first year of the programme. Costs of the programme should cover the following:

Resources needed to initiate the 100% CUP in a province:

- assessment and mapping;
- sensitization/advocacy meetings;
- public launching (if applicable); and
- strengthening of STI clinics to support the programme.
Resources needed for running costs:

- meetings of coordinating committees and multi-sectoral working groups;
- monitoring and supervision of entertainment establishments by multi-sectoral working groups;
- monitoring and evaluation of the programme (if applicable to the country):
  - number of male STI patients
  - number of condoms distributed to outlets
  - proportion of male clients of STI clinics who contracted STI from sex workers
  - proportion of sex workers reporting condom use at last sex with clients
  - proportion of sex workers with STI infection
  - proportion of sex workers with HIV infection

(9) Implementation of the 100% CUP

After all components of the 100% CUP are in place, the NCHADS, the coordinating committee and the multi-sectoral working groups will run the programme following their respective tasks.

(10) Monitoring and evaluation

NCHADS, the coordinating committee, the multi-sectoral working group and the STI clinic all play an important role in monitoring the implementation of the 100% CUP, each with a different task:
• NCHADS:
  • develop a check-list for monitoring the 100% CUP
  • receive quarterly report from the coordinating committee
  • perform regular supervision at least monthly in each province
  • produce and disseminate a national quarterly report for concerned institution such as the NAA, the Ministry of Health, United Nations agencies, etc.

• Coordinating committee:
  • ensure that the check-list is used
  • receive monthly report from the multi sectoral working group
  • organize a monthly meeting
  • produce a quarterly report and send to NCHADS
  • organize mystery client programme – in Cambodia, the mystery client programme was organized every six months. The mystery client is randomly selected from different professions (motor-taxi-driver, police, military, civil servant) under set criteria (completion of primary school and having experienced a brothel visit). After selection, the mystery client is trained on how to perform the task and how to develop the report.

• Multi-sectoral working group:
  • organize a monthly meeting
  • complete the check-list
• produce a monthly report and send to coordinating committee
• participate regularly in coordinating committee meeting
• coordinate with STI clinics to gather STI data

♦ STI clinics
• conduct a weekly meeting
• produce a monthly report and send to coordinating committee and NCHADS
• coordinate with multi-sectoral working group for the collection of STI data

There are two ways of conducting an evaluation. In Cambodia, an internal evaluation is completed annually through the joint effort of NCHADS, the provincial health department, the provincial AIDS office, the coordinating committee, the multi-sectoral working group, establishment owners and sex workers. The external evaluation could be scheduled every two to three years by an outside consultant in collaboration with NCHADS. Indicators should include both process and impact indicators.