

Condom Services in Two Ugandan HIV Prevention and Treatment Programs

Condoms remain a key component of evidence-based, high-impact HIV prevention programs. Thus, the quality of condom counseling remains a corollary concern. To add to the limited evidence on condom counseling in the context of biomedical interventions, the Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project conducted a case study that closely examined approaches for providing condom services, and the quality of services, in two Ugandan programs that offer antiretroviral therapy (ART) and combination HIV prevention services.

AIDSFree conducted in-depth interviews with nine service providers and seven supervisors and observed individual and group counseling sessions. Counseling services were provided by nurses and certified counselors (at Kabarole Hospital) and trained ART clients (at Iganga and Bugiri hospitals). Overall, male condom services were good in both programs, though inconsistencies in the quality of counseling were observed. Gender roles and relations and condom negotiation skills were very often omitted. In Kabarole Hospital, female condom programming was weak, mainly due to lack of organizational support and low uptake by women. In Iganga and Bugiri, overall male and female condom programming was good, but low auditory and visual privacy affected the quality of counseling provided by service providers. Supply and access to free male condoms was excellent, though limited to one brand, while condom dispensers and educational talks and materials helped reduce stigma and increase demand.

This study highlights the need to routinely monitor the quality of condom services, specifically the level of organizational support and training or refreshers for condom counselors, within the context of increasing condom uptake and combination prevention.



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A community health worker counsels a client on condoms.

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Background

In recent years, the HIV prevention landscape has evolved to feature promising biomedical interventions, including voluntary medical male circumcision (VMMC) (Auvert et al. 2005; Bailey et al. 2007), pre- and post-exposure prophylaxis (PrEP and PEP) (Krakover et al. 2015), microbicides, and treatment as prevention (TasP) (Cohen et al. 2011; the Kesho Bora study group 2011).

However, none of these interventions alone provide full protection against HIV, and new HIV infections are still occurring among sexually active populations. In 2013, 2.1 million people were newly infected with HIV, and 500 million acquired other sexually transmitted infections (STIs) including chlamydia, gonorrhea, syphilis, and trichomonas (UNAIDS 2014).

These data suggest opportunities to increase the effectiveness of combination and biomedical preventions by adding a component promoting the use of condoms. Male and female condoms are the only devices that provide “triple protection”: they prevent unintended pregnancy (Kost et al. 2008; Cleland et al. 2006); reduce transmission of HIV (Holmes et al. 2004; Weller et al. 2002; Smith et al. 2015); and prevent other sexually transmitted infections (STIs). Thus, condom promotion remains a key component of high-impact HIV prevention programs (UNAIDS 2015).

Condom programming is a strategic approach to ensure that sexually active populations at risk of HIV and other STIs are motivated to use condoms, have access to quality condoms, and use them consistently and correctly. Effective condom programs must address both supply of and demand for high-quality condoms and the environment which is the critical operating framework through which access and use of condoms is ensured (UNFPA n.d.)

Although substantial work has been done on factors associated with condom use (Allen et al. 2010, Nostlinger et al. 2010; Salaudeen et al. 2014; Widman et al. 2014; Yaba et al. 2013; Chandran et al. 2012; Ayiga et al. 2011; Haddad et al. 2015; Nakaie et al. 2014) there is currently limited information on the quality of condom counseling at HIV testing services (HTS) or clinics providing other prevention or treatment interventions.

To address this gap, AIDSFree conducted a case study examining the approach for and quality of condom services at three hospitals covered by two projects in Uganda that provide combination HIV prevention and antiretroviral therapy (ART) services. Both projects appear to offer comprehensive condom services, operate in high-HIV prevalence areas, and target similar populations of sexually active men and women with risk factors including multiple sexual partners, unprotected sex, gender-based violence, and alcohol abuse (UAC 2014). While the settings are similar, the programs take different approaches to providing clients with condom services. This case study is aimed at providing an analysis of condom services and their approaches, and identifying useful program information for managers and service providers involved in condom programming.

Kabarole Hospital

Kabarole Hospital is part of the network of facilities covered by the National Expansion of Sustainable HIV Services (NESH) Project. NESH is funded by the U.S. Centers for Disease Control (CDC)/Uganda and implemented by the Uganda Protestant Medical Bureau across 10 districts in Uganda. The project supports 13 health facilities to deliver quality HIV prevention, care, treatment, and support services, and to strengthen district health systems to provide sustainable, integrated, high-quality HIV services.

Kabarole Hospital, the site selected for the case study, is located in the Western region of Uganda, in Fort Portal, an urban district of approximately 500,000 inhabitants. HIV prevalence within the region is 8.2 percent (national HIV prevalence of 7.3%) (Uganda AIDS Indicator Survey 2011). Kabarole's clients comprise sexually active men and women including youth (age 15–24 years), and some specific groups, such as mobile populations (e.g., truck drivers) and migrant workers. NESH supports HTS, condom distribution, VMMC, prevention of mother-to-child transmission (PMTCT), diagnosis and treatment of STIs, and integration of family planning with ART services.

Iganga and Bugiri Hospitals

Iganga and Bugiri hospitals are covered by the Strengthening TB and HIV/AIDS Responses in East-Central Uganda (STAR-EC) Project (2009–2016), implemented by JSI Research and Training Institute, Inc. with support from the U.S. Agency for International Development (USAID). STAR-EC focuses on increasing access to HIV and tuberculosis (TB) prevention and treatment services within districts and communities of Uganda's East Central region, inhabited by 3.1 million people, and with an HIV prevalence estimated at 5.85 percent (UNAIDS 2014). The project supports biomedical and combination prevention activities in nine districts, including the two sites selected for the case study, Iganga (506,388 inhabitants) and Bugiri (390,076 inhabitants).

STAR-EC provides biomedical and combination prevention activities to general and key populations (fisher folks, sex workers, PMTCT and VMMC clients, and truck drivers). STAR-EC supports HTS, condom, VMMC, PMTCT and ART services. It also scales up the use of task shifting of routine activities like TB screening, health education, and condom services.

Implementation

AIDSFree researchers conducted in-depth interviews, followed by observation of client-provider interactions, with a total of seven condom program supervisors and nine service providers, using a structured questionnaire and checklist based on United Nations Population Fund (UNFPA) manuals for managers and providers of condom services (UNFPA n.d.).

Interviews of both condom supervisors and service providers covered their work environment and practices in detail, including a description of the project setting and type of facility; information about condom clients (clients' major HIV risk factors, barriers to condom use); existing condom programs in the same locality, town or district; condom supply and distribution; access to condoms; and promotion and public support for condom use. Additional questions covered providers' attitudes, knowledge, and skills about condoms; organizational support for condom services; and quality of services. Providers and supervisors also filled out a checklist to assess clients' access to condoms.

Nine client-provider interactions were observed following the interviews to assess the quality of condom counseling services, with consent from both the provider and the client.

The interviews and observations took place in June 2015. An Interchurch Medical Assistance (IMA) researcher conducted the interviews with the help of a translator whenever needed. All in-depth interview sessions were digitally recorded for data quality check.

Data were analyzed by compiling and describing answers and observations under each of the selected components of condom programming. Findings were compared between the two projects to describe similarities and/or differences in condom services and practices.

Interviewees

Selection of participants was designed to include both men and women and ensure a good representation of HIV services. At Kabarole Hospital, three condom program supervisors and five female service providers were interviewed:

Kabarole supervisors

- NESH program coordinator (MD)
- Supervisor managing ART clinic condom and drug supplies
- Supervisor managing VMMC and client services.

Kabarole providers

- Nurse providing counseling on ART adherence and HIV counseling and testing
- Two nurses providing counseling, health education, condoms for PMTCT clients, and other services
- Two certified counselors in the ART clinic.

At STAR-EC's Iganga and Bugiri hospitals, two condom program supervisors (nurses) and two service providers in each facility participated in the study. Because of high workloads in these facilities, supervisors used task-shifting to cover condom provision along with other responsibilities.

Iganga and Bugiri

- Two supervisors in the ART clinic
- Two supervisors of supply stores
- Four condom service providers: "expert clients" (people living with HIV, attached as volunteers and clients to the ART clinic) providing health education, condom services, community outreach, and adherence counseling; and directing clients to different units or departments within the hospital. (The NESH program also has expert clients, but they are mainly tasked with community outreach activities.)

Findings

This section describes interviews with condom supervisors; interviews with providers (findings for both in terms of availability and access by facilities and clients over the past 12 months; providers' attitudes and knowledge; and quality of services); and observations of client-provider interactions.

Interviews with condom program supervisors

Availability and affordability of condoms: In Kabarole Hospital, male and female condoms are provided free and are furnished by the Uganda Ministry of Health and by local and international nongovernmental organizations such as Uganda's Program for Accessible Health, Communication and Education (PACE) and Marie Stopes International. Condoms can also be purchased from pharmacies or drug shops, private clinics, and supermarkets at a cost of US\$0.15 to \$1.50, depending on the brand.

In Iganga and Bugiri, male and female condoms are provided free of charge by the STAR-EC project. Condoms also can be obtained free from other nongovernmental organizations, or can be purchased from bars or pharmacies at a price similar to that around Kabarole.

All condom program supervisors mentioned using a condom dispensing protocol along with different registers for condom requisition, supply, and distribution.

Several nonprofit organizations conduct condom promotion in both projects' catchment areas. These include the Program for Accessible Health Communication and Education (PACE), Marie Stopes, FHI 360 through its "How's Your Love Life?" campaign, and University Research Co., LLC through the Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) project.

Program supervisors from both sites described an increase in condom uptake over the last 12 months following promotional activities through mass media and health talks in hospital facilities and catchment areas. Supervisors were satisfied with the stock management by condom service providers in their respective program. They also conducted monthly monitoring visits, which most of them judged as adequate for achieving their supervisory role.

Condom supply: In Kabarole, supervisors reported frequent problems with supplies of female condoms over the past 12 months, including shortages and stockouts. Overall, there was a limited availability of female condoms, and many women do not know where to get them even if they could afford them. Supervisors from both projects reported no problems with supplies of male condoms, storage facilities, and availability of free condoms. Locations or hours at condom distribution points, privacy and confidentiality during transaction were not an area of concern.

Clients' access to condoms: Condom supervisors from both projects stated that accessibility to condoms by clients was good and acknowledged that only male condoms, and only one brand, were available at all times. Female condoms were virtually unavailable at Kabarole Hospital.

At Iganga and Bugiri, there was no report of shortage or stockout of male or female condoms over the last 12 months, but both facilities have experienced an oversupply of female condoms. At Iganga Hospital, condoms are only available at the family planning and ART clinics, so that the locations of supplies and hours of condom availability are not very convenient for clients.

Supervisors did not feel that distance, language, social stigma, and population mobility posed significant barriers to condom use and services. Supervisors said that clients within the catchment areas of both projects have ready access to affordable male and female condoms and are easy to reach with HIV prevention activities.

Restrictions to condom access: Neither project reported licensing or prescription requirements that limit the sale of condom to certain types of outlets. Supervisors said that no legal restrictions or social norms prevent adolescents and unmarried women from buying condoms; and that community leaders and public views posed no barrier to the number or types of settings in which condoms were sold. Condom vending machines and displays of condoms for self-service purchase are apparently allowed, but condom program supervisors in Kabarole had not seen any in place.

Promotion and public support: Condom program supervisors said that public discussions on safer sex and condoms were socially acceptable. Political and religious speakers have spoken out publicly about the need for HIV prevention and the importance of condoms. However, some religious groups (Catholic and Islamic institutions) have spoken against condoms and were more supportive of abstinence and faithfulness among married couples.

Understanding of government policy: Condom supervisors in the two projects had different understandings of government policy on sex education in schools; supervisors at Kabarole were not aware that the Ugandan government supports sex education in schools.

Providers' attitudes, knowledge and skills: In both sites, supervisors stated that overall, service providers hold favorable attitudes towards condoms, and have nonjudgmental, respectful attitudes towards all clients regardless of age, marital status, and sexual practices. They said that providers feel comfortable discussing sexuality, have accurate knowledge of HIV, and can respond to myths, perception, and concerns.

However, supervisors at Kabarole Hospital described providers' attitudes, knowledge, and skills as inconsistent or weak with regard to female condoms. They said that providers are insufficiently experienced in handling female condoms, do not favor these condoms, and do not know how to demonstrate their use. One supervisor described providers' teaching skills for condom negotiation as inconsistent.

In Iganga and Bugiri, supervisors said that most providers in general know how to provide counseling on and demonstrate the use of male and female condoms, despite some inconsistencies.

Quality of services: Based on their overall observations of client-provider interactions or interviews with clients, supervisors at Kabarole Hospital stated that the quality of service to female clients was poor, specifically for female condom education and access. They also described inconsistent auditory and visual privacy for clients in the ART clinic.

At Bugiri and Iganga, supervisors rated the quality of services as good, but noted some challenges or inconsistencies in providing auditory and visual privacy during counseling. Waiting times can be long, especially in ART clinics, where the workload is very often high.

Interviews with condom service providers

All service providers reported an increase in uptake of male condoms because of greater awareness through health talks, information, education, and communication (IEC) campaigns, and condom accessibility. Various units in the hospitals have provided private, accessible locations for obtaining condoms, as well as health talks on condom use. These have reduced the stigma associated with collecting condoms for STI prevention.

Availability of condoms: Service providers in both the NESH and STAR-EC projects said that one brand of male condom is available at all times to all clients. Condoms are free to clients in both projects. Clients can access the number of condoms they need directly from private dispensers or from service providers without making appointments, filling out forms, or registering. Those who visit facilities to pick up a supply of condoms are given preference (expedited service) compared to clients who need a counseling session or clinical services. Signs and information indicate where and how to get condoms. When clients seek condoms from providers, the providers record the number obtained.

At Kabarole Hospital, condom dispensers are placed in several locations (in toilets, corners within the hospital, and counseling rooms) and can be accessed by clients without the help of health personnel. However, in the PMTCT unit, the service provider offering condom counseling is different from the health care worker managing condom distribution to clients. At Iganga and Bugiri hospitals, providers said that condoms are only available during clinic hours or at the ART clinics, and privacy and confidentiality during transaction were sometimes lacking.

Each day, Kabarole providers offer individual condom counseling to five clients on average and distribute approximately 200 condoms. During health talk days, more people are reached (70 to 100 clients) with condom counseling services. Counselors provide a monthly report on the number of condoms distributed to their supervisors or program supervisors.

Expert clients at Iganga and Bugiri hospitals reported counseling between 5 and 10 clients (up to 30 during group sessions), and distributing between 432 and 2,160 condoms daily (3 to 15 boxes of 144 condoms each). The number of condoms distributed is reported monthly, but a daily report is required in some cases.

Providers in both projects reported wide availability of condoms in hospital catchment areas. Providers in Karabole said that besides hospital-based health talks, IEC materials, television shows, and local radio programs promote condoms locally. In the Iganga and Bugiri catchment areas, several organizations, including the STAR-EC grantee, Uganda Development and Health Associates, and the Family Life Education Program, conduct entertainment or campaign outreach to promote condoms.

Condom supplies: Providers at Kabarole reported no problems with shortages or stockouts of male condoms over the last 12 months, or with storage of condoms—though oversupply or waste did occur in some units. The major problem raised by all service providers at Kabarole Hospital was the weakness of the female condom programming. Promotion, supplies, and uptake of female condoms are all limited; and providers are not trained, and have no job aids or IEC materials, to promote or demonstrate female condoms.

Service quality: Providers at Kabarole said that the locations and hours at condom distribution points, and

privacy during service provision, were acceptable. At Iganga and Bugiri hospitals, providers said that privacy and confidentiality were sometimes lacking during client-provider interactions; for some sessions, they had to use the medical records room.

Organizational support: Providers expressed mixed views about organizational support.

- **IEC materials:** At Kabarole Hospital, IEC materials were posted in areas where clients could see them (waiting areas, triage, and consulting rooms). Condom counselors had essential job aids, except for female condom demonstration materials. Expert clients at Iganga and Bugiri hospitals had condom posters, brochures and IEC materials, and essential job aids, including both penis and vagina models, though shortages of materials did occur.
- **Training:** Only one service provider at Kabarole Hospital reported receiving formal training on condom counseling and a refresher course over the last 12 months. At Iganga and Bugiri, all expert clients but one had received formal training on condom counseling; none had had a refresher course over the previous 12 months.

All providers expressed a need for training or refresher courses on condom counseling.

Supervision: Most providers at Kabarole reported that their supervisors visited them weekly to oversee the quality of their condom services. At Iganga and Bugiri, monitoring visits could occur monthly or quarterly, but regularly; and condom supplies were checked daily. All service providers reported that their supervisors had the knowledge, skills, and job aids needed to provide feedback on their services.

Observations of client-provider interactions

Observations of client-provider interactions took place at the end of each provider's interview. In general, these observations corroborated some of the views expressed during interviews with supervisors and providers.

The nurses, counselors, and expert clients who participated in this study were experienced, with an average of nine years' experience offering condom services. Overall, counselors at all three hospitals treated clients respectfully and tailored their condom messages to client needs. Counselors were mindful of the potential for risk compensation due to other HIV intervention activities, and encouraged clients to adopt safer sex practices (including dual protection) even if they also received ART or accepted VMMC. Interactions and observers' findings were as follows:

- **Kabarole:** Condom clients comprised two ART patients, a sex worker, a group of 60 students aged 12 to 17 years, and a couple in the PMTCT unit. All clients had a scheduled appointment for other PMTCT- and ART-related services and their waiting time for services was brief.

Auditory and visual privacy during counseling sessions was average but not ideal. Service providers had to lower their voices during discussions with clients because the counseling room was close to the waiting area, and counseling sessions were frequently disturbed by the comings and goings of other health care workers collecting registers or other materials. Overall, all clients were treated in a respectful, nonjudgmental manner.

Counselors provided accurate information and answered clients' questions, but none of them discussed the

option of female condoms. Some general information covered during health talks was not revisited during individual sessions, though counselors did discuss sexual practices and the client's personal risk factors for HIV and other STIs after an initial risk assessment.

Counseling sessions were tailored to each client's needs and circumstances. With the couple, counseling included family planning methods (including dual protection), HIV and STI risks, and the HIV status of their children. The service provider involved both partners when discussing risk factors and solutions. With the self-identified female sex worker, the counselor discussed the HIV risk factors ensuing from her work, and provided the number of condoms she requested.

Overall, providers were sensitive to gender issues (gender relations, roles and inequities, and the impact of gender, social norms, and peer pressure on sexual practices). However, the topic was not covered consistently. Providers discussed dual protection and dual method use (using condoms along with another contraceptive method) with all clients except the female sex workers.

Handouts or IEC materials and male condoms were provided to all clients. No handout or information on female condoms was available.

Hands-on demonstration of condom use was inconsistent. Female condoms were not available and there was no vagina model for demonstration. Service providers did advise clients to discuss condom use with their partners, but they did not inquire about or teach condom negotiation skills.

- **Iganga:** At Iganga Hospital, the day of the interviews coincided with condom counseling for two groups of adolescent girls and boys. Sessions had been scheduled previously, and the waiting time was brief. The facility had provided good auditory and visual privacy during counseling sessions.

The expert clients offered accurate, complete information about condoms, including use of dual protection for pregnancy and STIs, safety and effectiveness of condoms, and the need to check their condition and expiration date before use. They also covered gender issues, and engaged both male and female clients in discussion of sexual practices and HIV/STI risk factors.

The expert clients gave hands-on demonstrations of proper condom use using both male and female models. All clients were given condoms. However, providers did not discuss condom negotiation skills and did not offer handouts or IEC materials.

- **Bugiri:** Two client-provider interactions were observed. Clients were female, and their counseling sessions were held in a corner along a corridor, since there were few private rooms for counseling. There was no auditory or visual privacy during counseling.

Counselors discussed their clients' sexual practices and assessed their risk factors for HIV and STIs. One provider offered a home visit to engage the client and her partner together in condom counseling. The second referred her client to a clinician after inquiring about her needs.

Both providers at Bugiri discussed male condoms and showed sensitivity to gender roles and relations. Dual protection and dual method use were discussed with the women of childbearing age. One provider demonstrated both male and female condom use, but the other demonstrated male condoms only, because he lacked the knowledge to demonstrate use of the female condom. Only one service provider addressed con-

dom negotiation skills; in this instance, the client requested her support to help convince her partner. Flyers and male and female condoms were provided to both clients.

Providers' attitudes, knowledge and skills on condom counseling: Overall, condom service providers had adequate attitudes, knowledge, and skills related to their work. Only one provider reported feeling insufficiently trained on STIs and uncomfortable with discussing sexual relations. The rest reported no difficulty or discomfort in handling condoms and demonstrating their use; describing signs of STIs and reproductive tract infections; discussing risky sexual behaviors (including risk compensation); or talking about sexuality with a client whose opinions differed from theirs. Almost all providers said that they were comfortable talking about condoms with all clients regardless of age (including young people aged 15 and older), gender, marital status, sexual practices, and types of sexual relations. Some providers at Kabarole Hospital said that they were cautious when counseling clients from certain religious denominations (e.g., Muslims, Catholics).

Lessons Learned

AIDSFree's study highlighted two different approaches to providing condom services within similar hospital-based combination HIV prevention packages. In the NESH Project, nurses and certified counselors provide condom counseling services, while the STAR-EC program uses expert clients for these services. Specific findings include:

- **Training for providers:** At Kabarole Hospital, only one service provider reported receiving training on condom counseling. By contrast, at Iganga and Bugiri hospitals, all but one provider had received training. This difference may be due to expert clients' limited, but specific, scopes of work, which would warrant content-specific training. The nurses and certified counselors who provided condom services at Kabarole Hospital might have received more comprehensive counseling training, but not training that specifically focused on condom counseling skills.
- **Condom availability:** Both projects operate in catchments where condoms are widely available. The hospitals make condoms available free of charge and providers offer the number of condoms that clients request. Male condoms are available at all times (with some variations in terms of convenience for clients).
- **Female condoms:** Uptake of female condoms was limited in all sites, and programming for female condoms was almost nonexistent in Kabarole Hospital. The low supply and uptake of female condoms could be explained by numerous counselors' reports on women's lack of interest on female condom, pain or discomfort attributed to the inner ring of female condom, and myths about their use, such as the risk of cervical cancer. However, providers reported limited knowledge of and training on female condoms.
- **Clients' need for counseling:** Both condom supervisors and providers described their clients as very knowledgeable about HIV and male and female condoms. However, the last Demographic Health Survey in both study areas indicated a low percentage of people with comprehensive knowledge about HIV, and low condom use during last sexual intercourse among men who had two or more partners in the past 12 months (UBOS 2012). This underscores the importance of optimizing the quality of condom counseling to improve health outcomes in these areas.
- **Quality of condom services:** In both projects, supervisors conducted regular visits to monitor condom services. However, observations of client-provider interactions showed inconsistencies in the quality

of condom counseling services provided to condom clients. Providers performed well on many elements of condom counseling services, such as tailoring advice to needs revealed during discussions with clients. However, overall they failed to discuss condom negotiation skills and gender roles and relations. This may be due to inconsistent training on these topics; yet these findings indicate a need to monitor these services more closely.

- **Privacy:** Auditory and visual privacy during counseling ranged from average to poor due to disturbance or lack of private rooms. All clients had scheduled appointments and waiting time for services was brief. However, providers in ART clinics where the workload is usually heavier mentioned that waiting time could be sometimes longer.



A condom counseling class.

Recommendations

Provide training: All service providers suggested the need for more organizational support to improve the quality of their work, including training or refresher courses, more male and female models, job aids, and IEC materials, especially in local dialects. Supervisors or supply managers should also receive support to prevent oversupply or shortages of female condoms. In Kabarole Hospital, both supervisors and service providers should receive training and refresher courses on female condoms, and promotional activities should increase emphasis on female condoms, as newer, better-quality brands are being developed (Wanyenze et al. 2014; Beksinka et al. 2012; Beksinka et al. 2013; Peters et al. 2014; Mantell et al. 2015).

Develop job aids: In both projects, a checklist or flipchart outlining all major important topics on condom counseling could help to improve service quality and prevent omissions during counseling sessions.

Address supplies, availability, and uptake of female condoms: This could be done with better monitoring of female condom uptake and supply management following promotional activities regarding female condoms.

Schedule sessions to ensure privacy: Facilities in both projects should seek ways of ensuring auditory and visual privacy, prevent interruptions during condom counseling sessions, and avoid long waits for clients seeking condoms. Ideally, a private place or room should be reserved for counseling services only. Other alternatives include scheduling appointments in a way that minimizes interruptions, or integrating condom distribution within PMCT or other services. If acceptable, tents, portable cabins, or refurbished containers could be used to mitigate the lack of consulting or private rooms.

Increase ease of self-service condom access: To increase access to condoms, dispensers need to be placed in other locations within Iganga and Bugiri hospitals, such as the outpatient department, or near clinic entrances.

Consider broad orientation on HIV interventions: HIV programming is becoming more complex with the scale-up of such evidence-informed interventions as treatment as prevention, pre-exposure prophylaxis, and VMMC, among others. Counselors will need a broad understanding of their facility's approaches to HIV prevention, treatment, and care. Nurses are better placed than expert clients to absorb this information. However, the scale-up of new approaches in both facilities and communities will increase the pressure on health facilities, which are usually short-staffed. This pressure could result in increased involvement of lay counselors and expert clients in HIV interventions, including condom counseling. Training, refresher courses, and supervision activities will greatly improve the quality of condom services regardless of the type of health workers providing them.

Conclusion

The quality of condom services is critical, since male and female condoms are the only devices that can reliably prevent HIV transmission, STIs, and unintended pregnancies. As programs to address HIV through biomedical and other means expand, managers will need to ensure that allied program elements—such as condom programming—reach or maintain uniformly high quality. This case study illustrates two approaches to condom programming. In one, nurses and certified counselors from HIV clinics provided condom counseling services. In the other, supervisors used task-shifting to manage condom programming, and the counseling was provided by expert clients.

Findings showed that both of these approaches resulted in good condom services overall. However, the study also revealed significant weaknesses in female condom programming, including supplies and counselors' knowledge and service quality. It also suggests the importance of regular training or refreshers for any condom counselors, whether professional or paraprofessional. These findings highlight the need for regular monitoring of condom services—specifically, the level of organizational support, and the quality of condom counseling—and development of specific actions to address problems once they are identified. Given the context of increasing condom uptake and more complex HIV programming, it is essential to ensure that all components for a successful condom program operate effectively and efficiently.

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