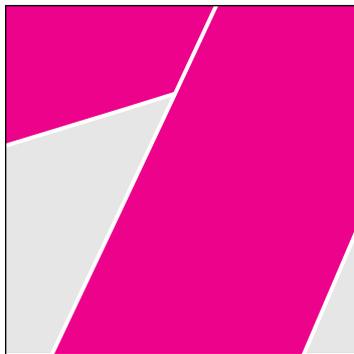
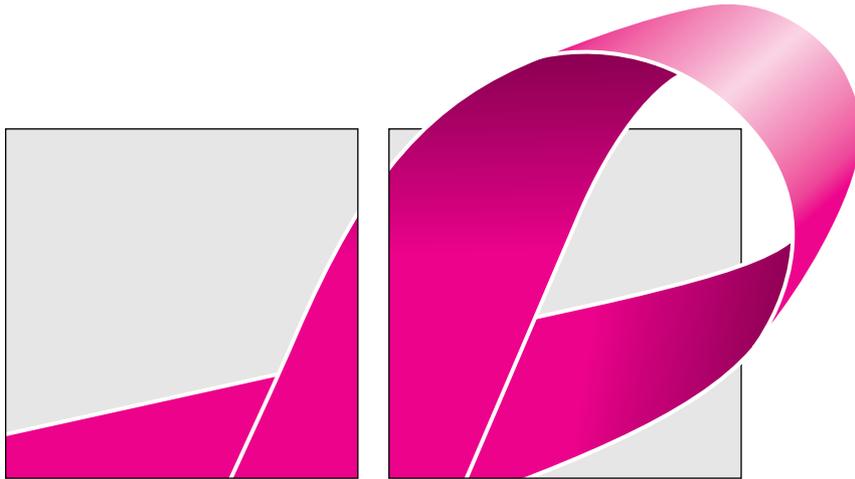


Condom Social Marketing: *Selected Case Studies*



Joint United Nations Programme on HIV/AIDS
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UNAIDS - 20 avenue Appia - 1211 Geneva 27 - Switzerland
Telephone: (+41 22) 791 46 51 - Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org - Internet: <http://www.unaids.org>

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Geneva, Switzerland
November 2000

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Acronyms

AIDS	Acquired immunodeficiency syndrome
CA	Community agent
CBD	Community-based distributor
CBO	Community-based organization
CBSM	Community-based social marketing
CSM	Condom social marketing
DHMT	District health management team
DKT	DKT International
FGE	The Futures Group Europe
FP	Family planning
FPAK	Family Planning Association of Kenya
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IFH	International Family Health
IICH	Indian Institute of Community Health
IPPF	International Planned Parenthood Federation
KAP	Knowledge, attitude and practice
MCH	Maternal and child health
NACP	National AIDS Control Programme
NGO	Nongovernmental organization
PMSC	Programme de Marketing Social au Cameroun
PROFAMILIA	Asociación Colombiana Pro-bienestar de la Familia
PSI	Population Services International
SM	Social Marketing
STD	Sexually transmitted disease
TFGI	The Futures Group International
UK /DFID	United Kingdom /Department for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

Since its establishment in 1996, UNAIDS has promoted and supported social marketing, and especially the social marketing of condoms, as a key strategy in the fight against the spread of HIV/AIDS and STDs. Social marketing projects and programmes exist in dozens of developing countries but, at the same time, there are still many more countries with the potential to adopt or expand similar activities.

This document is the fourth in a series on social marketing produced by UNAIDS to provide basic information on this activity and how its concepts and techniques may be applied in response to the spread of HIV/AIDS, particularly in developing countries. Previous documents were “Social Marketing: An Effective Tool in the Global Response to HIV/AIDS”, as an introduction to social marketing which describes its main concepts and techniques; “Social Marketing: Expanding Access to Essential Products and Services”, which highlights lessons learned from three examples of social marketing applied to male and female condom promotion in developing countries; and “A Global Directory of Condom Social Marketing Projects and Programmes”, as a compendium of existing condom social marketing projects in 1999.

“Condom Social Marketing: Selected Case Studies” presents six applications of different social marketing techniques drawn from among on-going projects in developing countries in the field of reproductive health and prevention of HIV/AIDS and STDs. Individually they illustrate different, real-life approaches to condom promotion through social marketing in response to particular challenges and needs. All describe activities from which significant lessons may be learned. In addition, they demonstrate the flexibility of social marketing and how the technique can be adapted to deal with differing situations and constraints.

The booklet is intended mainly for distribution to individuals and organizations, from both the public and private sectors, who are interested in learning more about social marketing, and how its concepts and techniques can be applied in response to the spread of HIV/AIDS and STDs, particularly in developing countries. It is also intended to provide basic information, as an aid to training, programme planning and related activities.

2. What is social marketing?

“Social marketing” may be defined as the adaptation of commercial marketing and sales concepts and techniques to the attainment of social goals. It seeks to make health-related information, products and services easily available and affordable to low-income populations and those at risk while at the same time promoting the adoption of healthier behaviour. In fact, it may be said that the ultimate goal of social marketing is to effect healthy and sustainable behaviour change.

Making quality products and services affordable and available is just one part of the social marketing equation. Encouraging their use represents the other. Market research and a strong communications component are essential to the success of a social marketing programme.

Social marketing has become increasingly popular among governments and donors as an efficient and effective means of addressing serious health issues in developing countries. It has its roots in family planning but the concept is now applied across many fields in public life and health, in both developed and developing countries, including such areas as protection of the environment, campaigns against smoking and alcohol abuse, and the prevention and care of malaria, leprosy and tuberculosis. However, the use of social marketing in response to the challenge of improving the sexual and reproductive health of women and men in developing countries has attracted particular attention.

Social marketing complements, and does not replace (or even seek to replace), free access to health services and products. It therefore does not compete with the public health system and in fact supports existing systems. By making low-cost products available outside the health system, social marketing programmes alleviate the pressure on existing services and thus allow the health system to use limited resources more efficiently.

In addition, and particularly in the case of condoms, social marketing can be an alternative source of products and information for people who may be unable or unwilling to access locations where privacy is too often impaired. For instance, through social marketing condoms are widely available in places where people routinely go, as opposed to reproductive health clinics, which tend to be much less frequented by men and young people. The possibility of anonymity in a commercial transaction then becomes attractive, particularly to women and sexually active young people.

Government support, then, is key to the success of social marketing programmes and these are often developed in close collaboration with host country governments in line with national priorities and needs. Many governments recognize the significant contributions of social marketing to improving the sexual and reproductive health of their low-income populations and extend important financial and political support to the activity. In many countries, for example, socially marketed products, frequently condoms, are allowed tax exemptions or may be directly subsidized by local or national government in order to reduce costs and prices; other examples include the use of IEC materials developed by social marketing in public schools and clinics, or the relaxation of restrictions on

the use of mass media for educational communications on sexual and reproductive health issues. Condoms are a case in point, where only a few years ago it was very rare to find a country where advertising this product was permitted in the mass media channels, something that has now become quite common.

Condom social marketing

In the mid-1980s, condom social marketing (CSM) emerged as an effective tool in combating the spread of HIV/AIDS. Through social marketing programmes and projects in many countries affected by the epidemic condoms have become more easily available, affordable and acceptable to sexually active men, women and young people in general as well as to those in high-risk groups. Although the programmes have generally focused on the product, concomitant communications and IEC activities have significantly contributed to raised awareness of the risks of infection and the means of prevention, reaching people, governments and institutions in all sectors of public and private life.

Condom social marketing programmes have made condoms more accessible, affordable and acceptable in many of the world's poorest countries. In 1997 these distributed about 900 million male and female condoms. By 1999, at least 71 different social marketing programmes for male and female condoms were active in 59 developing countries.

It has been said that in the case of condoms social marketing has acted as a "normalizer" of the product, reducing the stigmas popularly attached to it. Until recently in many developing countries, public access to condoms was difficult as the product was often available only in pharmacies and health clinics and generally thought to be more appropriate for use by and with commercial sex workers. Now, thanks to years of persistent social marketing activities, condoms in many countries are widely available from a variety of outlets, openly discussed in public and in the media, and are seen by many, including many of those at high risk of HIV infection, to be common household items.

The "destigmatization" of condoms in many countries illustrates how social marketing can help populations to overcome social and cultural resistance to practising effective prevention of STDs and HIV/AIDS.

The role of UNAIDS in social marketing

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities, and alleviating the impact of the epidemic. Since its establishment in 1996, UNAIDS has promoted and supported social marketing, and particularly the social marketing of condoms, as a key strategy in the fight against the spread of HIV and AIDS.

As a cosponsored programme, UNAIDS plays a unique and important role in garnering support for social marketing programmes. At the national level, UNAIDS encourages governments and NGOs to support, develop and implement HIV/AIDS prevention social marketing initiatives within their countries. This may include advocating for the inclusion of social marketing in national plans, the allocation of resources to social marketing programmes from multilateral and bilateral donors, and the facilitation of a positive legislative environment for social marketing. The exchange of experiences between organizations and countries is also encouraged.

In countries where social marketing programmes are being launched, UNAIDS takes an active role as fundraiser and, more recently, as a potential provider of technical assistance in collaboration with leading social marketing organizations, such as Population Services International (PSI) and suppliers of products, such as with The Female Health Company, sole manufacturer of female condoms. In addition, through its regional and country network of programme advisers, Theme Groups and cosponsors, UNAIDS offers an excellent means of disseminating information, experiences, best practices and lessons learned in social marketing.

UNAIDS stimulates social marketing in the field:

- Myanmar, the Russian Federation, Haiti, Cuba and Ghana
- Female condoms
- Application of social marketing to other HIV/AIDS-related products and services

UNAIDS promotes expanded interest in social marketing:

- UNAIDS website
- Social marketing assessments in Bulgaria, Cuba, Guyana, Liberia, the former Yugoslav Republic of Macedonia, and Turkey
- Regional Marketing Training Exchange with projects in Albania and Romania
- Forum 2000 on Social Marketing (in development)

UNAIDS provides key resources such as best practice materials and case studies, including:

- "Social Marketing: An Effective Tool in the Global Response to HIV/AIDS"
- "Three Key Lessons Learned in Condom Social Marketing"
- "A Global Directory of Condom Social Marketing Projects and Programmes"

3. Different approaches to social marketing

Social marketing programmes generally use the existing commercial infrastructures in countries to develop and distribute specifically branded products such as condoms. This “traditional” approach, also known as the “own brand model”, is the most common amongst social marketing programmes in developing countries and is closely associated with Population Services International (PSI) and DKT International, organizations that pioneered international social marketing in the 1970s and 1980s. It applies standard commercial marketing and sales techniques for promotion and distribution through wholesale and retail sales points to the mass market. The social marketing organization may receive unbranded products from international or national donors, or may directly procure quality products from manufacturers, and develops its own brands and packaging for distribution. This entails the establishment of a professional in-country sales force and management structure, frequently involving a local partner organization.

However, the ability to operate as effectively as possible in a wide variety of contexts is a key element in any social marketing programme. In most developing countries low-income populations form the great majority and within it there is a frequent need to target specific, often difficult to access, population groups with particular needs. In addition to working through traditional sales networks involving wholesalers and existing retail outlets for consumer goods, social marketing programmes must frequently seek to develop non-traditional outlets and informal distribution systems to meet the needs of specific groups, and even communities, within the population.

The potential use of alternative distribution systems is an essential aspect of social marketing. Today, in many developing countries, socially marketed condoms are to be found in both traditional retail outlets such as pharmacies and drugstores and non-traditional points such as bars, coffee shops, brothels, beauty parlours, workplaces, gas stations, and bus and truck terminals.

Therefore, other ways of social marketing of products have been developed and are also common. These approaches are not mutually exclusive although one or more may be applied exclusively by a programme or project, or also as parts of a project for strengthening and improvement of an existing “traditional” approach.

These models, or possible approaches to social marketing, include:

- Community-based systems of product promotion and distribution (“community-based distribution” /CBD) where non-professional sales agents are recruited from among particular groups within the general population. The individuals receive basic training in IEC and sales and are usually rewarded financially from small margins on their sales. This approach is increasingly chosen as a means of reaching geographical areas and socio-cultural groups that are difficult to access. Many

programmes incorporate the method to complement more traditional, retail outlet sales; some programmes, usually run by local NGOs, are based entirely on the system.

- An innovative and promising variant of the CBD approach has recently been developed and piloted over two years in Chennai, India, by International Family Health (IFH) and its local partner NGO, the Indian Institute of Community Health (IICH). In this model (“community-based social marketing” /CBSM) sales agents are recruited from among the general public as well as from within specific groups. In addition to benefiting from basic training in reproductive health and from commissions on their sales, the agents also benefit financially from recruiting others to act as educational and sales agents. CBSM is derived from commercial “network” and “multi-level” marketing techniques successfully applied in developed countries, and has shown potential in rapidly attaining community penetration and involvement in reproductive health issues and HIV prevention.
- The “manufacturer’s model”, where support is provided for the promotion and distribution of brands developed and owned by a manufacturer (foreign or local) or local manufacturer’s agent, frequently an importer of the product. The support usually takes the form of grants directly to the manufacturers and/or their distribution agents so as to reduce their commercial marketing costs and therefore allow greater investment in key activities, such as promotion and advertising. A retail price significantly below the usual market price is the expected end result. In contrast to the “traditional /own brand model” the “manufacturer’s model” is the least common. The approach has been almost exclusively associated with The Futures Group International (TFGI) and its international, USAID-supported SOMARC project.
- The “targeted service delivery” approach involves planning appropriate social marketing activities, through which the project strives to reach and distribute products to specific target groups, usually high-risk or other priority segments of the general public. These groups are often inadequately served by other service delivery mechanisms, including standard social marketing activities. Their identification usually results from market segmentation studies carried out once the basic distribution structure to the mass market is established, so targeted service delivery is often a component of programmes mainly structured around the “traditional” or wider commercial approach. However, many local organizations, usually NGOs, adopt this approach either from necessity (restricted resources) or from particular interest.

There are many ways of applying social marketing concepts, approaches and techniques at the national, local or community levels. Flexibility in planning and implementation are key to successfully meeting the needs for information and products such as condoms in the fight against the spread of HIV and AIDS.

Planning and implementing social marketing programmes is by no means restricted to large, well-funded international organizations. Local initiatives in social marketing by organizations within the national “private sector”, including NGOs, exist in many countries. These can range widely in size and purpose from small, localized projects restricted, for instance, to training and employing ex-commercial sex workers in a particular location as sales and IEC agents only for condoms, to comprehensive, full-scale reproductive health programmes active at the national level.

Of particular interest to local initiatives is the fact that well-managed and adequately supported social marketing projects are among the most cost-effective of health interventions. The projects can recover a large proportion of costs and revenues from sales which can be invested in other activities, such as capacity-building or strengthening the programme itself if the organization works exclusively in social marketing (the Social Marketing Company of Bangladesh, for example). If the organization has other activities, as does PROFAMILIA in Colombia, then these revenues can also be used to subsidize these activities within a policy of cross-subsidization.

The following concrete examples of social marketing applied to the prevention of HIV/AIDS and STDs in different countries and contexts are offered to illustrate the various approaches described above. The cases described below are examples of the uses of these approaches to social marketing that have been adopted in some countries by different organizations; all the cases focus on ways of condom distribution and promotion that were designed and implemented in response to different situations.

4. Case studies

Community-based distribution in Haiti and Mozambique

The use of individuals drawn from the community and trained in IEC and condom promotion and sales is key to the performance of the condom social marketing programmes in several countries, among them Haiti and Mozambique. However, the principal reasons for adopting this strategy, either on its own or complementing other forms of condom distribution, may vary as also the forms it takes may vary. The examples of Haiti and Mozambique serve not only to illustrate the potential effectiveness of CBD systems in condom social marketing, but also to demonstrate different reasons for the choices and different ways of working by CSM programmes.

In both countries the social marketing programmes must deal with the difficulties involved in making condoms easily accessible to dispersed and largely rural populations and communities. In Haiti the mountainous terrain, pocketed with valleys inhabited by semi-isolated communities and served by a precarious transportation infrastructure, was a key factor in the decision to recruit sales agents from the communities through existing local NGOs. The agents work to strengthen a system that includes traditional commercial distribution based on an existing commercial network for other consumer goods. Significant volumes of condom sales are achieved through the community-based distributors (CBDs), but traditional distribution accounts for most of the volume.

On the other hand, in Mozambique the existence of large communities, isolated by the geographical terrain, was much less problematic than the fact that many years of civil war had devastated the national infrastructure for transportation and communications as well as the economy and an incipient commercial sector. Standard distribution of products was therefore extremely difficult, even in urban areas, and there was no commercial distribution “up-country”. It was decided to focus initially on establishing a distribution system based on a network of locally recruited and trained sales and motivation teams. One team was established per province; the role of the motivation agent was focused on creating demand for condoms (particularly amongst high-risk groups through interpersonal communications activities), whilst the equally important role of the sales agent was to meet the demand by supplying the retailer. This was necessary due to the fact that condoms in Mozambique were still a relatively new and unknown product.

A more formal, traditional means of distribution through a wholesaler-retailer chain could be expected to build up over time. In 1999, 49% of sales were to community agents, 34% to commercial distributors and 16% to workplaces and NGOs. The proportion of sales to community agents in the year 2000 is expected to be 45% and further reductions are expected as the commercial sector grows.



Relevant facts about Haiti

Haiti has a total land area, which is very mountainous, of 27 600 square kilometres, and a total estimated population of 8.1 million of whom almost 70% live in rural areas (in contrast with the average for Latin America and the Caribbean which is 74% urban); 55% of the population is below the age of 20. The capital, Port-au-Prince, has an estimated population of 1.5 million. Ethnically, 95% of the population is Afro-Caribbean. French and Creole are the official languages and male/female literacy rates are estimated at 48/42 %. The principal religions are Christianity (Roman Catholic) and Vodun.

Haiti is the poorest of the Latin American and Caribbean countries. Its GNP per capita in 1995 was estimated by the World Bank to be US\$ 250 and the vast majority of the population live on subsistence incomes, mainly from agriculture. Haiti ranks 156 on UNDP's Human Development Index and life expectancy at birth is estimated at 54 years, much lower than the regional average of 70 years.

The prevalence of HIV infection amongst Haitians aged 15-49 years is estimated at 5.17% by the end of 1999, perhaps the highest in the region, with an estimated 210 000 people living with HIV/AIDS and 23 000 deaths due to AIDS in 1999. Already by the late 1980s HIV prevalence among sex workers tested in major urban areas ranged from 42% to 53%. The prevalence of STD is known to be high, and a 1992 study of male STD clinic patients found that 25 % of patients tested were HIV-positive.

Programme: "Haiti Social Marketing for AIDS prevention"

Population Services International (PSI) has been active in social marketing for reproductive health and reduction in high-risk sexual behaviour in Haiti since 1989, focusing its efforts principally on providing accessible and affordable condoms to the

low-income segments of the population for HIV/STD prevention. By the end of 1996, two branded condoms (one male, one female) had been successfully launched on to the market and in that year other contraceptive products (pills and injectables) were added to the range of products.

However, geographical, economic and political conditions in Haiti make it extremely difficult to implement a social marketing programme of regular product distribution through the commercial wholesaler-to-retailer structure adopted in most countries. In Haiti the majority of the population lives in rural areas that are not easily accessed due to the mountainous terrain and a precarious infrastructure of roads and transportation. The vast majority of the population has little or no regular income, and, additionally, political instability and unrest is a constant aspect of daily life.

Thus it was decided in 1990 to implement a supplementary programme for creating a system based on the sale of products, mainly male condoms, together with related IEC activities. This was effected through trained individuals, locally recruited from the communities and population groups targeted by the overall programme, i.e. a system of community-based distributors, and motivated by a reasonable financial incentive usually with a commission on sales.

Some other key advantages found in Haiti by PSI of promoting and distributing condoms, and other products, through CBDs are:

- *Credibility, as relatives, friends and neighbours tend to be more favourably received than salespeople from outside;
- *Availability, as CBDs are usually much more easily accessed at any time of the day or night;
- *Privacy and discretion, where condoms can be obtained on a one-to-one, personal basis;
- *Effective counselling, dealing with individual needs and, especially in the case of condoms, ensuring correct and consistent use.

In order to achieve this, PSI/Haiti formed an initial partnership with four local NGOs, later expanding this number to nine with wide access to rural communities, and created and registered its own NGO, "Programme de Santé et Information" (PSI/Haiti). Initially, PSI trained 175 members of the NGOs to act as wholesale distributors selling to retail outlets and as retail sales agents to consumers. The training sessions included such topics as STDs and HIV/AIDS prevention, social marketing goals and strategies, interpersonal communication and direct sales techniques, condom use demonstrations and basic money management.

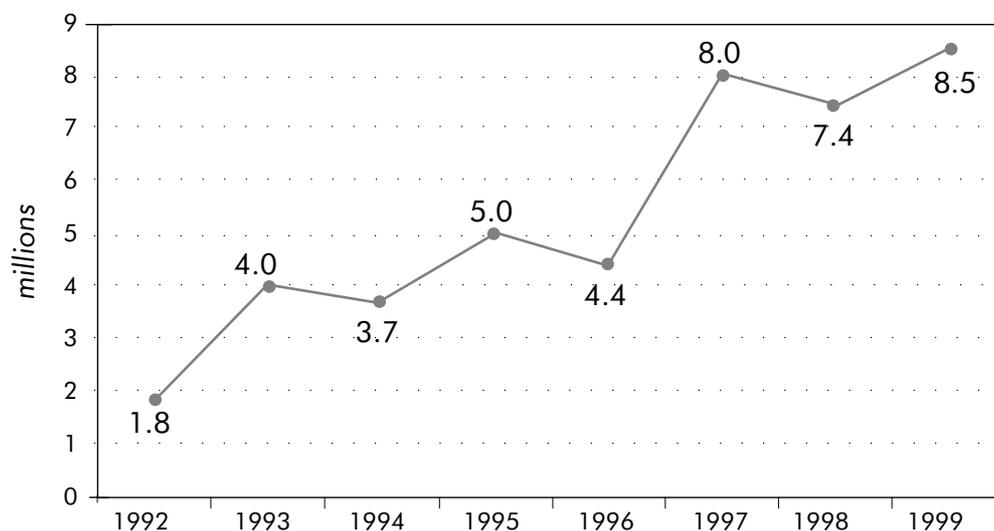
Following training, each CBD was provided with a free stock of condoms, up to 10 retail dispensers each containing 144 condoms, in order to begin selling and, with the resulting revenues, repurchase more supplies after retaining an agreed margin. PSI/Haiti in fact provided the CBDs with the means (capital) to become "micro-entrepreneurs".

There was an initial concern that some CBDs might prefer to sell their condoms to higher-income groups rather than their targeted populations and, also, that the IEC obligations of the CBD role might be neglected in favour of sales. PSI/Haiti therefore monitored the activities of many CBDs and discovered that, whilst in fact some were selling condoms to more affluent people, they were not neglecting their target groups who reported that condoms were available whenever needed. Whether the educational obligations were being neglected was admittedly more difficult to evaluate, but the dramatic

increase in sales recorded showed that individuals were being convinced to purchase and use condoms, indicating that the IEC function was being carried out.

The project was very successful. In all, more than 3000 points of sale for male condoms were created throughout Haiti, ensuring availability for hundreds of thousands of customers and included, besides traditional markets and commercial sales outlets, bars, hotels and even beauty salons in both urban and remote rural areas. Over the first four years, monthly sales of PSI/Haiti's male condoms ("Panté") increased from 3 000 to over 400 000 pieces and continues to increase. It is estimated that at least 33% of total sales through all channels employed in Haiti were due to CBDs, and a large share of regular sales outlets were opened by these individuals.

Sales graph with total socially marketed condom sales volumes 1992-1998



Further indicators of success include the observations that, by the end of 1996, between 70 and 95% of sexually active adults, including 85% of adolescent males, 70% of adolescent females and 95% of commercial sex workers, knew about "Panté" and recognized that condoms protect against AIDS. In 1998 nearly one in five women reported having used condoms specifically for STD/HIV protection. At the same time, however, survey results show that both awareness and use are still lower than could be expected in rural areas and that efforts must be maintained or even increased.

According to reports from PSI/Haiti, the main constraints and obstacles encountered included:

- Rapport between NGOs and social marketing in promoting HIV prevention is not automatic, and there were occasional conflicts between an NGO's mission and that of the project.
- It was easier for NGO salespeople to sell to more affluent customers in the cities than to the rural outreach targets, and to confine their activities to selling instead

of meeting their educational obligations. However, this conflict was recognized early and successfully countered through monitoring and training.

- The period of the project coincided with the aftermath of the military coup in 1991, when daily life was particularly difficult in Haiti. The international economic embargo cut off imported fuel and raw materials, factories and businesses closed, and hundreds of thousands of workers were forced into abject poverty. In this uncertain environment, highly motivated CBDs provided stability to the project, finding ways to continue their work despite the problems and dangers, and continuing to open up new sales outlets and share information on AIDS and its prevention.

Key lessons learned from the experience were:

- Overall, CBDs can make very significant contributions to both condom availability and accessibility, although individual performance can be expected to vary considerably.
- CBDs are able to open new sales regions and outlets that will be regularly serviced later by the professional sales force.
- The direct costs to the organization of adding CBDs to its sales force, as opposed to professional salespersons, is small compared to the benefits. However, more supervision and management time is required, particularly in the first months of operations.
- Even small margins on sales can be attractive and motivating to CBDs. The personal income generated by CBDs also appears to counteract "volunteer burn-out" and many CBDs worked continuously for years. However, the income should be personal and not remitted to an organization to which the CBD might belong.
- NGOs and community-based organizations (CBOs) should not count on this activity as a source of income. Nevertheless, NGOs are much better able to reach non-traditional outlets than commercial distributors.
- Condom brand promotion is most effective when accompanied not only by mass media IEC but also by interpersonal, community-based condom promotion campaigns.
- To function effectively in Haiti with maximum cooperation from government and international agencies, PSI needed to operate through NGOs as well as through commercial distributors.

Haiti: Additional information

Project duration: Original project from 1991 to 1996, but continued funding has permitted activities through 1999.

Implementing agencies:

a) At the national level: Programme de Santé et Information (PSI/Haiti) managed the project, with the direct involvement of four national NGOs, and in partnership with the Ministry of Public Health and Population.

b) At international level: Population Services International (PSI) and USAID (AIDSCAP).

Funding sources: USAID; additionally, the Government of the Netherlands, PSI Partnership Fund, World Bank, UNFPA, UNAIDS, the Bergstrom Foundation and the Summit Foundation.

Project objectives: The goal of the project was to reduce high-risk sexual behaviour and thus the transmission of HIV/AIDS. The main objectives were to:

*Target low income populations by making affordable condoms accessible;

*Create consumer demand based on high awareness of correct and consistent condom use;

*Reduce the incidence of other STDs (e.g. gonorrhoea, syphilis, and chlamydial infection), which significantly facilitate the transmission of HIV/AIDS.

Target areas: The whole country, with emphasis on the rural areas where 70% of the population live, and where access to condoms and other products is very limited. More than 3000 points of sale, created directly through CBDs, and through them to non-traditional retail outlets such as night clubs, bars and beauty salons.

Target audience: General and high-risk populations, especially young people (age group 15 to 24 years), including female commercial sex workers, migrants and transport workers.

Other CSM projects in Haiti: None

For additional information on this programme:

PSI/Haiti
Rue Theodule #1
Bourdon Port-au-Prince
Haiti

Examples of condom pack and posters

The PSI-branded male condom, “Kapòt Panté” (“Panther”), was launched in Haiti in 1990 and is now available nationwide at a low price of US\$ 0.07 for a packet of three. This is an affordable price for a population with an estimated per capita annual income of US\$ 400 and is roughly 10 times lower than the commercial brands.

Targeted consumers were high-risk populations, with emphasis on young people aged 15 to 24 years, and — since 1994 — on women. Intensive mass advertising depicted the “Panté” as denoting strength and masculinity.

National media were heavily involved in promoting condoms for the prevention of AIDS and in addition, education of the client was an integral part of the work of each CBD. The Carnival period (January to April) is the highest risk period for sexual transmission of disease and PSI/Haiti ended the millennium with a highly visible campaign to make “Carnaval 2000” the safest since HIV and AIDS came to Haiti.



Mozambique



Relevant facts about Mozambique

Mozambique has a total land area of 801 600 square kilometres and a total estimated population of 19.3 million of whom 66% live in rural areas; 56% of the population is below the age of 20. The capital, Maputo, is on the coast and has an estimated population of 2.2 million. Ethnically, the population is made up of varied groups with several major languages but Portuguese is widely spoken and is the official language; male/female literacy rates are estimated at 58/23%. The principal religions are indigenous beliefs (60%) and Christianity (30%).

Mozambique is one of the poorest countries in the world. Its GNP per capita in 1995 was estimated by the World Bank to be US\$ 80 and the country ranks 166 on UNDP's Human Development Index; half of the national income is derived from agriculture. Life expectancy at birth is estimated at 47 years, below the average for Africa of 51 years.

The prevalence of HIV infection amongst adults in Mozambique was estimated at 13.2% by the end of 1999, among the highest in Africa, with 1 200 000 people living with HIV/AIDS and 98 000 deaths due to AIDS in 1999. By 1996 HIV prevalence among antenatal women tested in different locations across the country was found to be between 18% and 23%; in addition, the prevalence of STD is known to be high and by 1995, depending on the location, studies of male STD clinic patients found that between 23% and 40% of those tested were HIV-positive.

Programme: “Communications and Condom Marketing for AIDS Prevention: the promotion of safer sex among high-risk individuals in Mozambique”

As a result of the end of its civil war in 1992, HIV transmission rates in Mozambique rose dramatically with the return of refugees from neighbouring countries where HIV prevalence had been higher than in Mozambique. The government had a programme of free distribution of condoms but this had been severely affected by the years of civil war and prospects for improvement were thin. In 1994 the government’s National AIDS Control Programme (NACP) invited PSI International to design and implement an AIDS prevention social marketing project to promote safer sexual behaviour and the use of condoms as a component of the NACP’s own programme.

The overall goal for PSI was to improve the health of sexually active men and women and their children, by reducing transmission of HIV/AIDS and other STDs.

The project that was implemented in early 1995 had two specific objectives:

*Increase the use of condoms, particularly by persons vulnerable to HIV transmission, through the introduction, promotion and sale of a condom specifically developed for social marketing in Mozambique (“JeitO”, the condom brand name, meaning in Portuguese “style” or “flair”, which lends itself to popular slogans such as Living with Style);

*Increase the demand for condoms through the implementation of an integrated behaviour change communications strategy which would promote safe sex, especially targeting high-risk groups such as commercial sex workers, long-distance truck drivers, STD clinic attendees, night club patrons, military and police, people with non-regular sex partners, youth (in and out of school) and women.

Having begun as a pilot project in limited urban and periurban areas in four provinces in 1995, the project was expanded to the national level by 1996 with sales and motivation teams established in all ten provinces. Together with the National AIDS Control Programme, from the total of 140 districts in Mozambique, 71 priority districts for AIDS prevention were then identified based on the following criteria:

- *High incidence of STDs
- *Common borders with high HIV prevalence countries
- *High volume of trucking
- *High urban population density
- *High incidence of returning refugees and migrant labourers.

The project then recruited and trained 65 Community Agents (CAs) from these districts. The CAs were trained in interpersonal communications (for example, each CA conducts monthly 15 small group discussions with project target groups) and in sales techniques for “JeitO” condoms, focusing on ensuring access to these by high-risk groups through non-traditional outlets. The CAs receive a monthly stipend for their work in communications and, additionally, a margin from their sales of condoms. Supervision of the CAs is provided by the PSI Provincial Sales /Motivation agent. They are also regularly evaluated and provided with refresher training when necessary. New CAs are recruited and trained as vacancies are filled whilst maintaining the total of 65.

The CAs have an important role in the overall project strategy to promote behaviour change, i.e. correct and consistent use of condoms, reduction in the number of sexual partners, treatment of STDs and, particularly for young people, sexual abstinence until marriage. The project developed a framework based on six factors deemed necessary for behaviour change to occur:

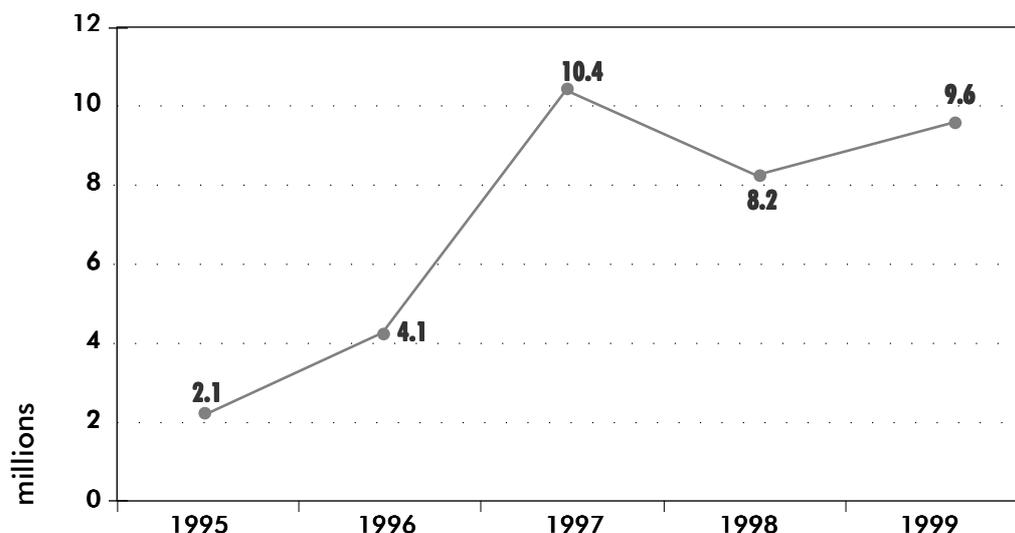
- *Personal perception of being at risk
- *Education on condoms
- *Existence of an enabling, supportive environment
- *Ready access to condoms
- *Self-efficacy, or having the intent and skills to take preventive action
- *Appropriate condom brand positioning: the “JeitO” brand concept.

In applying this framework, the project developed activities designed to affect each of the factors based on information gathered from the different target groups. The activities are designed around a mutually reinforcing media mix, emphasizing interpersonal communications (drama, theatre and small group discussions) along with mass media (radio and TV spots, music videos and cassettes) and promotional materials. The project has eight theatre groups trained to conduct five different targeted plays in every province of Mozambique, and on any given day it can be expected that five plays are performed somewhere in the country.

The results have been impressive. To date, an estimated total of 50 000 peer education AIDS/STD sessions have been held, reaching about 1 million members of the target population. In addition, 150 traditional healers and some traditional birth attendants have been trained in promoting the use of condoms with their clients. A KAP survey conducted in 1997 in urban and periurban areas revealed that 87% of respondents were aware that condoms exist, 31% had used condoms at least once and 78% cited condoms as a means of preventing HIV infection (as compared to 38% in a similar survey in Malawi).

More than 3000 condom sales outlets have been established nationwide, including non-traditional outlets for condoms in Mozambique such as bars and clubs, kiosks and tobacconists, gas stations, market stalls, NGOs, supermarkets, street vendors, “traditional healer” outlets and within workplaces. Demand for and sales of socially marketed condoms then rose dramatically, although sales were affected by a shortage of subsidized product in 1998.

Sales graph: "JeitO" condoms



According to reports from PSI/Mozambique, the main constraints and obstacles encountered included:

- ❑ The "JeitO" package of four condoms is sold to consumers for the equivalent of US\$ 0.08 and condoms are still donor-supported; in 1998 there was a shortage of subsidized condoms due to donor shortfall.
- ❑ PSI in Mozambique is seen as an international organization in spite of the fact that the management of the project is 98% Mozambican and it has a close relationship with the national government. One solution might be to entrust the capacity in social marketing to a local NGO.

Key lessons learned from the experience include:

- ❑ Government can be an active partner in social marketing and even include it in its own programmes, as in this case with the NACP in Mozambique where the condom social marketing project is a component of the national HIV prevention strategy. The government recognizes the need for coordinating free condom distribution through the national health system with the social marketing project, bringing condoms to the entire population regardless of the individual client's purchasing power. This is an objective of the current NACP strategic plan.
- ❑ The principal factor in the success of the project has been the emphasis given to involving the community in sales and promotion, right down to individual input through peer education and direct promotion at points of sale.
- ❑ The success of the project has been in large part due to its intensive promotional activities — not only through the media and theatre performances, but also by the individual community-based promotion by sales outlets, CAs, peer educators and traditional practitioners.

Mozambique: Additional information

Project duration:

Pilot project in 4 provinces, 2 years from 1995 to 1996. Phase I, extended to national scale, 3 years 1997 to 1999. Phase II, planned for a further 3 years.

Implementing agencies:

a) at national level: National AIDS Control Programme, Ministry of Health, PSI/Mozambique, national media.

b) at international level: PSI/Washington, USAID.

Funding sources:

For the pilot study and Phases I and II, USAID and the Government of the Netherlands, with the addition of UK/DFID from 2000.

Target areas:

Pilot project in 4 provinces (Maputo, Sofala, Manica and Tete). Phase I, extension to national level. By December 1996, the project was operating in all 10 provinces, and by December 1998, the national structure was fully consolidated.

Other CSM projects in Mozambique: None

For additional information on this programme:

PSI/Mozambique,

Av. Patrice Lumumba 204,

C.P. 4059,

Maputo, Mozambique

Community-based social marketing in India



Relevant facts about India

The Indian sub-continent has a total land area of 3.3 million square kilometres and a total estimated population of 998 million of whom 73% live in rural areas; 49% of the population is below the age of 20. The capital, New Delhi, has an estimated population of 6 million. Ethnically, 72% of the population is Indo-Aryan, 25% is Dravidian and others account for 3%. There are more than 14 official languages, including Hindi and English, and male/female literacy rates are estimated at 66/38%. The principal religions are Hindu (83%) and Islam (11%).

India's GNP per capita in 1997 was estimated by the World Bank to be US\$ 370 and the vast majority of the population live on subsistence incomes, mainly from agriculture. India ranks 132 on UNDP's Human Development Index and life expectancy at birth is estimated at 63 years, as compared to a regional average of 67 years.

The prevalence of HIV infection amongst Indians aged 15-49 years is estimated at 0.70% by the end of 1999, with an estimated 3 700 000 people, including children, currently living with HIV/AIDS. This is more than any other country in the world except South Africa. India's epidemic, however, is diverse. While some states currently show almost no HIV infection others have reached adult HIV prevalence rates of over 2%.

The southern state of Tamil Nadu has an estimated population of 60 million, of which some 4 million live in the capital, Chennai. The first case of AIDS in India was reported in Madras (now Chennai) in 1986. Local surveillance systems have shown that HIV infection has risen significantly; for example, rates among pregnant women tripled between 1995 and 1997 to 1.25%. Bold safe-sex campaigns, including intensive condom promotion, in Tamil Nadu have resulted in dramatic increases in condom use in risky sexual encounters.

An innovative approach to both social marketing and the CBD system has recently been pilot-tested over three years in Chennai (Madras), India, by International Family Health (IFH) and its local partner NGO, the Indian Institute of Community Health (IICH). Called "Community-based social marketing" (CBSM), the model is derived from commercial "network" and "multi-level" marketing techniques successfully applied in developed countries in direct, person-to-person product promotion and sales. As such, it was felt to have potential for rapidly attaining community penetration and involvement in condom promotion and distribution and STD/HIV prevention in general. In the Chennai pilot test, the first of its kind, the products developed and marketed in this way were condoms and sanitary napkins.

An additional attraction of the model is that CBSM offers not only an efficient means to effective promotion of reproductive health awareness and practices but also the opportunity for significantly increased income to many individuals and households. It would therefore contribute directly to improved quality of life in the community.

The CBSM experience also illustrates how some international donors are willing to support new, even experimental concepts and techniques in social marketing.

Programme: "aXess", a community-based social marketing pilot project

Among the various possible ways of effecting "community-based distribution" of products, including condoms, within social marketing is that of recruiting and training sales agents from among members of the general public, exclusively or in addition to members of particular risk groups. In addition to benefiting from commissions on their sales of condoms, these agents would also benefit financially from their successful recruitment of others in the community to act as additional sales agents and educators. The number of sales and IEC agents increases progressively through the establishment of sales and communications networks and is expected to result in a higher demand for information and products as the community becomes increasingly involved.

The sales agents, or “partners”, are people from all walks of life who correctly use quality health products and know why these products should be used. The partners sell the products to others and receive a margin on the sales. In addition, they involve others who will also use, sell and in their turn involve others. When one recruits new partners in this way, he/she is financially rewarded based on the volume of the product that was used by the people recruited.

The system differs significantly from “standard” social marketing in that health-related information and products are disseminated solely by individuals rather than through mass advertising and the wholesale distribution of products to selected commercial retailers. As information and products are spread in this way through the community, new networks are continuously created, resulting in increasingly widespread and correct knowledge about family planning, the prevention of STDs and AIDS, and the use of health-promoting products.

In order to test this concept for delivering health products and information to the less privileged and more vulnerable segments of the population in developing countries, IFH developed the following principal activities:

- *Development of a sophisticated PC-based software package to register and track “partners”, individual sales, referrals, payments and commissions due;
- *Development of a “family” brand (“aXess”) for condoms and sanitary napkins. Other products such as iodized salt and soap were later added to the project;
- *Development of a training package for network marketing and health IEC;
- *Establishment of a specific NGO as a centre for administration, product depot and training to run the project independently under the brand name. Other local NGOs were later added;
- *Recruitment and training of community-based “partners” in lower-income areas of Chennai as sales and IEC agents;
- *Qualitative, diagnostic research to monitor performance, partner activities and identify constraints;
- *Formal evaluation after two years’ activities.

The project was designed by IFH in 1994 and 1995. Following implementation in Chennai in 1996, the CBSM activities as such began in early 1997 and evaluation, as planned, was conducted after two years in late 1999. The pilot test was therefore successfully completed.



It is clear that basic information on sexual and reproductive health, including on HIV/AIDS, can be effectively disseminated through this “one-to-one” approach, i.e. public health education by word of mouth within the community. In the two years of implementation, 8000 “partners” were enrolled and it can be assumed that each partner passed on the message about sexual and reproductive health, condoms and sanitary napkins to several others, although overall sales figures were less than anticipated.

In conducting the pilot test, the main constraints and obstacles encountered were:

- *High initial investment in time and funds in implementation, especially in information technology and training in network sales. Nevertheless, backing from interested international donors was obtained;
- *Strong cultural barriers inhibited recruitment within a general population very reluctant to discuss sexual matters and sell related products;
- *Training the average person in sales concepts and techniques proved more difficult than expected;
- *Viable condom prices proved too low for the project to attain sustainability without heavy cross-subsidization from other products, particularly sanitary napkins;
- *Price competition from the commercial sector as demand for products increased with awareness, especially for sanitary napkins, reduced the project’s expected margins on sales.

The key lessons already learned from the experience are:

- *With the right product mix, i.e. including condoms within a range that includes other less controversial products, it is possible to achieve community participation in the process of public health education;
- *The introduction of innovative marketing or sales procedures and techniques, particularly within a sexual and reproductive health context, requires prior detailed research and planning in the local context;
- *Intensive training and persistent, continuous support to community agents can overcome initial reluctance caused by cultural inhibitions;
- *Some incentive is required by people who are expected to replicate their training (“cascade training”);
- *Women are prepared to sell condoms as well as sanitary napkins to their peers;
- *The financial incentives offered to the community “partners” must be clear, transparent and easily calculable from the beginning;
- *To manage a social project with a commercial brief, the non-profit implementing agency must be prepared to deal with the dichotomy between its social and financial objectives, and project a clearly defined image to its participants and the public in general;
- *Some international donors who are especially interested in social marketing may be convinced to provide significant support for pilot, experimental activities in social marketing;
- *There is potential for further development of this approach to social marketing.

CBSM: Additional information

Pilot test objectives:

*To test whether the promotion, distribution and dissemination of reproductive and sexual health products and information can be effectively achieved through the application of network /multi-level sales and marketing techniques within a social marketing programme;

*To test whether CBSM translates in reality into an effective reproductive and sexual health strategic alternative for low-income groups.

Main focus of project:

Reduction in high-risk sexual behaviour with emphasis on HIV/STD prevention and family planning; additionally, personal and community income generation.

Funding sources: UK/DFID, USAID/Profit, IFH, Packard Foundation

Key collaborators:

Local manufacturers of products (condoms and sanitary napkins), government at federal and state levels, local advertising and other marketing services agencies, PSI India and YRG (Care), a Chennai-based HIV education and care nongovernmental organization.

For additional information on this programme:

International Family Health,

Cityside House,

40 Adler Street,

London E1 1EE, United Kingdom

Social marketing based on targeted service delivery in Cameroon



From May 1996 to September 1997, the Cameroon Social Marketing Programme (Programme de Marketing Social au Cameroun /PMSC), PSI's local affiliate, implemented a Young Adult Reproductive Health Project in the city of Edéa. The project integrated a youth-targeted intervention within the nationwide PSI social marketing programme. It was designed as an operations research study with the objective of assessing the effectiveness of social marketing techniques for promoting sexual and reproductive health among adolescents and young adults aged between 12 and 24 years.

The Young Adult Reproductive Health Project ("Horizons Jeunes") made use of a "targeted service delivery" approach or model. In this approach, a social marketing project strives to reach and distribute products to specific target groups, or priority segments, of the general public who are often inadequately served by other product/service delivery mechanisms including standard social marketing activities.

"Targeted service delivery" is often a strategy adopted within programmes structured around wider, commercially-based distribution. Targeting specific groups can result from surveys and market segmentation studies carried out once the basic distribution structure to the mass market is established and opportunities for improvement are identified.

Relevant facts about Cameroon

Cameroon has a total land area, including a coastal plain and highlands, of 475 400 square kilometres and a total estimated population of 14.7 million, of whom 55% live in rural areas; 55% of the population is below the age of 20. The capital, Yaoundé, is in the highlands and has an estimated population of 1.1 million whilst the larger city of Douala, on the coast, has a population of 1.3 million. Ethnically, the population is made up of some 200 groups with 24 major languages, but both English and French are widely spoken and are the official languages; male/female literacy rates are estimated at 75/52%. The principal religions are Christianity (53%), indigenous beliefs (25%) and Islam (22%).

Cameroon's GNP per capita in 1995 was estimated by the World Bank to be US\$ 650 and the country ranks 133 on UNDP's Human Development Index. Some 40% of the national income is derived from agriculture whilst industries account for about 22%. Life expectancy at birth is estimated at 55 years, slightly higher than the average of 51 for Africa.

The prevalence of HIV infection amongst adults in Cameroon was estimated at 7.7% by the end of 1999, with 540 000 people living with HIV/AIDS and 340 000 deaths due to AIDS since the beginning of the epidemic. In 1993, HIV prevalence among sex workers tested was found to be nearly 30% and, by 1996, 5% of antenatal women tested in Douala were HIV-positive; prevalence among antenatal women tested in rural areas in 1996 was found to be 8%.

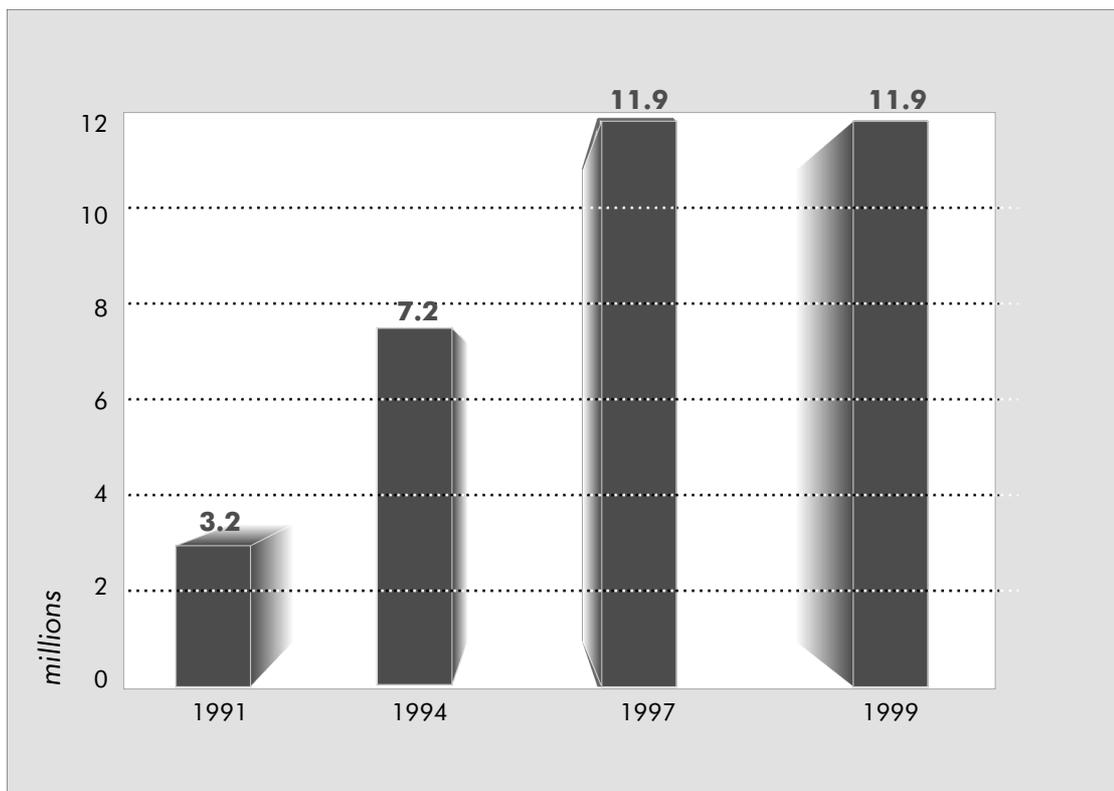
Programme: "Horizon Jeunes"

PSI's Cameroon Social Marketing Programme is focused on HIV/STD prevention, family planning, safe sex, improved awareness and preventive behaviour, and reduction in unwanted pregnancies and related abortions (in 1996, 42% of declared pregnancies were terminated by abortion). Activities also include linkages with child survival, use of mass media, peer education, and extension of the adolescent reproductive health component to other cities in the country.

PMSC's system of distribution of its products, including condoms, is nationwide and effected through a traditional, commercial structure involving wholesalers, retailers and a sales force. Its principal product is the male condom, "Prudence Plus", sold in packets of four at the low, affordable price of US\$ 0.18 per packet (private condoms in the market are sold at between 4 and 5 times this price). The packets have a distinctive logo of a panther, denoting strength and masculinity, "For the man who is sure of himself". The brand mainly targets low-income, high-risk population groups of both sexes.

"Prudence Plus" was developed and launched in late 1989 and is sold nationwide. In 1998 sales attained 6 713 053. In 1992 a second condom was launched, "Promesse", at a higher price (approximately US\$ 0.27 /unit) and targeting higher income groups. It therefore sells considerably less than "Prudence". To date total sales of both brands have attained almost 60 million.

Socially marketed condoms in Cameroon



“Horizons Jeunes” was a key component within PMSC’s social marketing strategy. Designed as an operations research study, the project’s overall objective was to assess the effectiveness of social marketing techniques for promoting sexual and reproductive health among young people aged 12 to 24 years, of both sexes, in Edéa, a coastal city of 86 000 inhabitants located about 60 kilometres from Douala, the second largest city in Cameroon. Changes in behaviour of young people were compared with those in a control city. The concept was based on similar successful PSI projects in Botswana and South Africa with young people.

Specific objectives included:

- *Target behaviour change in youth through communication and promotion;
- *Effect distribution of condoms and, to a lesser extent, of “Novelle” oral contraceptives targeted at youth;
- *Determine the effectiveness of targeted social marketing in addressing the key reproductive health problems of young people.

During the design phase of the project, PMSC trained staff to increase their understanding of the concerns of young people, and held discussions with community leaders and government officials to ensure their support for the project. PMSC also hired a local research agency to learn more about the target group and help guide the project design.

Three main approaches to execution were used:

*Community-based activities, with active participation and contribution of young people in all project activities (e.g. development and production of campaign messages, radio talk-shows, brochures).

*The extensive use of mass media and IEC campaigns, in support of the on-going peer education, with radio talk-shows and distribution of IEC materials on reproductive health, video broadcasts, theatrical sketches, and round-table discussions, many of which targeted also parents, teachers and community leaders.

*PMSC developed a campaign brand name, "Horizon Jeunes" (Youth Horizons) and logo to tie all project activities and materials together. Later in the project, peer educators developed slogans, "Pensez Avant d'Agir" (Think Before Acting) and "Choisissons la Vie" (Let's Choose Life). The brand name and slogans appeared on promotional materials as well as in radio spots and programmes.

*Peer education: PMSC recruited and trained 28 peer educators, including 17 out-of-school youth and 11 students, in communication techniques and reproductive health topics. The peer educators carried fanny-packs (printed with the brand name) packed with condoms to sell to youth, acted in effect as mobile sales points, and held educational sessions on weekends at popular youth hangouts in Edéa.

Peer educators also created and maintained "Clubs Horizon Jeunes" at six junior high schools in the project area with club promotional logos, T-shirts and caps. Each club had about 50 members and was led by two or three peer educators. Club members organized activities such as debates, conferences, and theatre performances tied to reproductive health issues. The clubs greatly enhanced the project's ability to reach in-school youth.

In addition, several "Edutainment Events" were organized in order to make extensive use of entertainment as a way to communicate with youth, as described below:

- During a football match, peer educators rode into a stadium on motorcycles and used a portable microphone to give a lively AIDS-prevention presentation and distribute brochures focused on youth;
- Peer educators led a round-table ("town meeting") discussion among 800 community members, including youth and their parents;
- At popular video clubs, the project showed reproductive health-related films for 50 CFA (approximately US\$ 0.08), much less than the price of a movie theatre ticket. After the films, peer educators led a discussion and answered questions from viewers;
- The project conducted AIDS-awareness sessions at popular dance clubs by preparing tapes of popular music interspersed with short health messages. Disk jockeys in the participating clubs agreed to play the tapes and allowed peer educators to conduct question-and-answer contests, giving out campaign T-shirts, hats, and condoms as prizes;
- The project made heavy use of the media by working with a popular radio station, FM105, based in Douala. Two well-known DJs hosted the *Horizon Jeunes* bi-weekly radio programme, which covered a reproductive health topic and encouraged young people to call in with questions and comments.

The results of the project were evaluated by the effect on condom sales in Edéa and, in addition, by operations research conducted in Edéa and a control city. There was a considerable increase in the numbers of condoms sold in Edéa, and a significant improvement in understanding by both male and female adolescents of ways of avoiding unwanted pregnancies and HIV/STD infection.

Project staff created new condom outlets in areas frequented by youth and promoted these outlets as “youth-friendly”. Monthly sales at 23 sales points in Edéa rose from about 6000 to over 17 000 condoms between December 1996 and August 1997. There was also significant spin-off to parents, teachers and community leaders. However, it was felt that the project duration had been too short to allow this knowledge impact to develop into common practice. For this reason, PMSC is seeking funds to extend the project, as well as to apply the successful method to other cities in Cameroon.

At the same time, however, some difficulties and obstacles were reported by PMSC, summarized as follows:

- *A high percentage of young men have tried condoms but do not use them consistently.
- *There is a belief that condoms are not necessary in trustworthy or steady relationships.
- *There is a strong stigma attached to female adolescents obtaining or carrying condoms.
- *Different motivations to condom use must be addressed: basically, young women mainly use condoms to prevent pregnancies and young men to avoid STDs.

Key lessons learned from the project include:

- Young people’s exposure to project activities was high. After the intervention, surveys showed that 91% of young people in Edéa had heard about *Horizon Jeunes*, compared with only 5% in the control city of Bafia. Twenty-eight per cent of youth in Edéa were actively involved in *Horizon Jeunes*; 60% had talked to a club member; and 47% had attended at least one club meeting. Moreover, since the local radio station had a wide reach, a large segment of the young had been exposed to the radio talk show.
- In a relatively short period, the project had a positive impact on several areas of young people’s health beliefs and behaviour. Among young women, there was greater self-efficacy (the belief that they can take action to protect themselves) and more contraceptive use. Fewer young women reported having their first sexual experience by age 15 and more reported using abstinence for pregnancy prevention. Among men, there was an increase in contraceptive use (methods other than condoms) and an increase in abstinence.
- The project experience confirms that involving the target audience is one of the best ways to ensure the effectiveness of an intervention directed at young people. PMSC staff found that their efforts to involve youth in the design and implementation of the project were welcomed. By tapping into young people’s energy, creativity, and desire to belong, the project helped them find their voices and eased their way to becoming young adults.



Cameroon: Additional information

Project duration: May 1996 to September 1997

Implementing agency:

a) At national level: overall project management by PMSC. The adolescent programme, "Horizon Jeunes", has been integrated into the nationwide social marketing programme; partnership with the Ministry of Public Health, the National AIDS Committee and local NGOs.

b) At international level: PSI (Europe); limited contact with WHO and UNICEF.

Funding sources:

USAID for "Horizon Jeunes"; other donors to PMSC include Japan, France, GTZ and WHO.

For additional information on this programme:

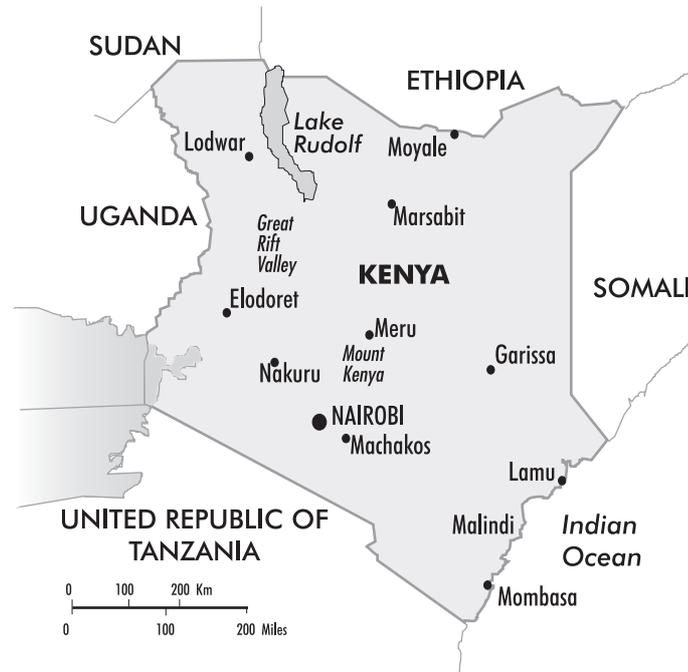
PSI-PMSC,

B.P. 14025,

Yaoundé, Cameroun

Social marketing with existing commercial brands in Kenya

The Kenya Midwives project of the Futures Group Europe (FGE) is an example of how the private commercial sector can collaborate with social marketing projects. In some cases of the “manufacturer’s model” approach to social marketing, support is provided for the promotion and distribution of products developed and owned by a manufacturer (foreign or local) or local manufacturer’s agent, frequently an importer of the product. The support can take the form of grants directly to the manufacturers or to their distribution agents. In others, such as the project described below, the social marketing organization negotiates for the procurement of product and subsidizes their distribution. In either event, the expected end result is that costs and prices to the targeted population are significantly below the usual market price.



Relevant facts about Kenya

Kenya has a total land area, including a coastal plain and highlands, of 580 400 square kilometres and a total estimated population of 29.5 million of whom 72% live in rural areas; 62% of the population is below the age of 20. The capital, Nairobi, is in the highlands and has an estimated population of 2.1 million whilst the next largest city, Mombasa, on the coast, has a population of almost 500 thousand. Ethnically, the population is made up of varied groups with several major languages, but both English and Swahili are widely spoken and are the official languages; male/female literacy rates are estimated at 86/70%. The principal religions are Christianity (70%) and indigenous beliefs (10%).

Kenya’s GNP per capita in 1995 was estimated by the World Bank to be US\$ 280 and the country ranks 134 on UNDP’s Human Development

Index. Half of the national income is derived from agriculture whilst industries and construction account for about 41%. Life expectancy at birth is estimated at 54 years, slightly higher than the average of 51 years for Africa.

The prevalence of HIV infection amongst adults in Kenya was estimated at 13.95% by the end of 1999, with 210 000 people living with HIV/AIDS and 660 000 cases of AIDS having occurred since the beginning of the epidemic. By 1995, HIV prevalence among antenatal women tested in Nairobi was found to be 25%, and 55% of sex workers tested in Mombasa were HIV-positive. The prevalence of STD is known to be high, and a 1996 study of male STD clinic patients in Nairobi found that 14% of those tested were HIV-positive.

Programme: "Expanding Family Planning Service Delivery through Market Day Midwives in Kenya"

Kenya is a country in which social marketing, including that of condoms, has been extensively employed in the social and health sectors. In addition to the Futures Group Europe project under consideration, at least two other social marketing projects are already well established: PSI/Kenya and the FGE/Kenya HIV/AIDS Prevention and Care Project. There was thus already considerable national experience in social marketing when the Market Day Midwives project began in 1996.

The main issue addressed by the project was the improvement of access to affordable reproductive health products and services by population segments that were very difficult to reach by traditional means — in this case people in remote rural areas. The strategy chosen was to be present at locations more easily accessed by the programme but regularly frequented by these people. Thus it was decided to establish reproductive health "kiosks" in markets in 12 districts in Nyanza Province and the Greater Nairobi Area, each staffed by a specially trained midwife.

The target audience was middle and low-income visitors to markets coming from remote and inaccessible areas. Initial emphasis was placed on reaching women but, in response to the interest and demand that resulted, this was gradually expanded to include children, adolescents of both sexes and adult men.

A total of 38 nurse/midwives were selected, trained and set up to operate in specially built wooden kiosks in the different markets, extending services and products to these previously unreached populations. The initial emphasis was on family planning and mother and child health, but this was expanded to include perinatal care and prevention of STD/HIV/AIDS. All the kiosks were supplied with contraceptives and male condoms, medical supplies and vaccines, family planning promotion kits and STD Syndromic Management kits. The commodities were procured at negotiated prices from pharmaceutical and condom manufacturers. Thus, the midwife kiosks progressively became informal mini-clinics, catering for the reproductive and sexual health needs of this hard-to-reach population.

Success was admittedly difficult to measure. A main achievement was the wide-spread acceptance of the kiosks by the population and the local authorities. The number of clients at the 38 kiosks increased by 600% after 2 years of operation, from 164 600 to 989 000 per annum.

According to FGE/Kenya, the main constraints encountered involved religious (Christian) resistance to what was originally advertised as a family planning project. There was also resistance by the local authorities to the new idea of health care by midwife-manned market kiosks. Both issues were overcome and the project was accepted because of the enormous diversity of services offered, of which family planning was only a part. The local authorities were involved in the publicity drives, through billboards, puppets, the media, and the participation of leading secular and religious personalities. This, combined with the enthusiastic response of the population in these remote areas, finally persuaded the district authorities to give their full cooperation. The willing participation of the District Health Management Teams (DHMTs) has also been an important factor.

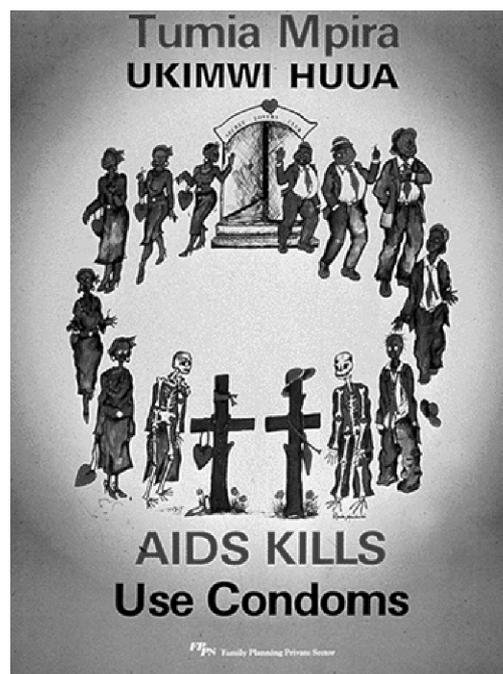
The principal lesson learned from the project is that offering low-cost, high-quality health care access, including reproductive health, HIV/STD, MCH and primary care, on market days in remote, under-served areas, through the mechanism used (kiosks, intensive promotion, client assessment, efficient supply system, social mobilization), meets with enthusiastic public support.

A strong motivational element is that midwives are very poorly paid in Kenya. This project provides them with salary supplements, which provide a real incentive for their active participation and support.

Possible initial objections by local and religious authorities can be overcome once the usefulness of the project to the public is clearly visible.

The method lends itself to extension within Kenya and to other countries. UK/DFID has used the project as an example of an effective grass-roots programme with high reach at a low cost.

Kenyan Condom Promotion posters



Kenya: Additional information

Project duration: 3 years, 1996-1999

Implementing agency:

The Futures Group Europe (Kenya), which acts as project manager and evaluator.

Other involved parties include:

a) At national level: Private Midwives Practitioners (PMP) Society, Ministry of Health and local government, ACOBOS, FPAK, district authorities

b) At international level: The Futures Group Europe

Funding source: UK/DFID

Target audience:

Middle and low-income visitors to markets in 12 districts in Nyanza province and the Greater Nairobi Area; a total of 38 markets

Specific project objectives:

*Improve and expand the accessibility of quality FP methods and services;

*Strengthen and improve the quality and range of services offered by midwives at kiosks in the markets;

*Establish safer sexual behaviours among hard-to-reach populations;

*Increase income flows for the midwives and the PMP Society;

*Expand market base of contraceptive products and FP services.

*Increase the numbers of beneficiaries of the project, especially women of childbearing age, adolescents, and those at particular risk of HIV/AIDS.

For additional information on this programme:

Futures Group Europe (Kenya),

PO Box 75367,

Nairobi, Kenya

A local private sector initiative in social marketing in Colombia

Planning and implementing social marketing programmes, from small-scale projects targeted at specific groups to large and comprehensive nationwide programmes, is possible for local organizations in developing countries. Many such projects exist around the world. The successful example of the Asociación Colombiana Pro-bienestar de la Familia (PROFAMILIA) in Colombia substantiates this possibility. It also illustrates how social marketing can significantly contribute towards the recovery of running costs in middle-income countries, or even the attainment of financial self-sufficiency, by a national, independent NGO working in reproductive health through a strategy of cross-subsidization.



Relevant facts about Colombia

Colombia has a total land area, including a coastal plain, high Andean mountains and valleys, of 1 139 000 square kilometres and a total estimated population of 41.6 million of whom 73% live in urban areas; 48% of the population is below the age of 20. The capital, Santafé de Bogotá, is in the central highlands and has an estimated population of 5.6 million. Ethnically, the population is mainly of racially mixed descent but includes whites, Afro-Americans and native Americans. Spanish is spoken throughout the country; male/female literacy rates are both estimated at 91%. The principal religion is Christian (Roman Catholic).

Colombia's GNP per capita in 1995 was estimated by the World Bank to be US\$ 1910 and the country ranks 51 on UNDP's Human Development Index. Half of the national income is derived from agriculture whilst industries account for about 31%. Life expectancy at birth is estimated at 71 years, typical for South America.

The prevalence of HIV infection amongst adults in Colombia was 0.31% by the end of 1999, close to that of other South American countries, with an estimated 71 000 people living with HIV/AIDS and 1 700 deaths due to AIDS in 1999. In 1994, HIV prevalence among antenatal women tested was found to be 0.5%.

Programme: "Condoms, Towards a Definitive Segmentation of the Market"

PROFAMILIA is a private, independent and non-profit organization that has provided education and comprehensive public services in family planning and reproductive health in Colombia since 1965, and has been affiliated with the IPPF since 1967. HIV/AIDS prevention was included in its activities as of 1987.

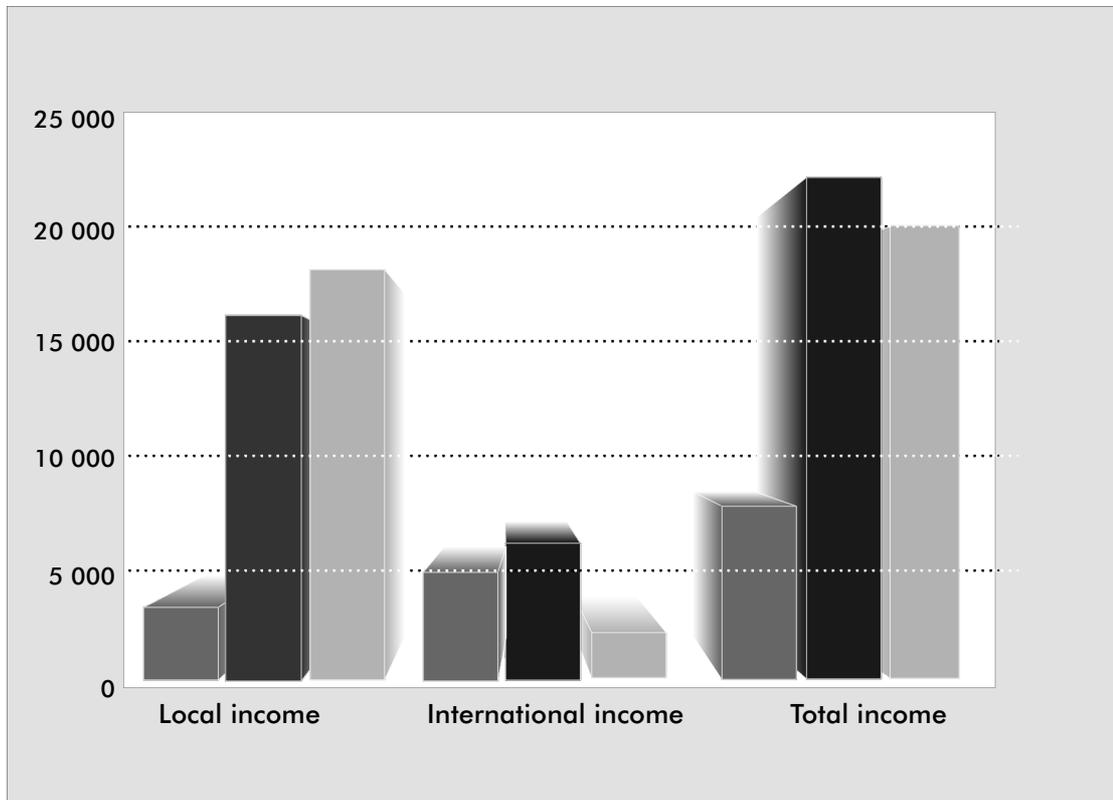
PROFAMILIA's mission is to serve the needs of Colombia's lower-income groups, which account for almost 80% of the population. The organization has grown steadily over the years since its founding to the point where it now accounts for over 50% of family planning and reproductive health services in the country. It is currently the largest national, private organization of its kind in the world

Although initially heavily dependent on foreign donors for funding its activities, PROFAMILIA soon adopted a successful strategy of diversification of its services with the goal of eventually achieving sustainability and financial self-sufficiency. The social marketing of contraceptive products, including condoms, was a key element of that strategy and this activity was begun in the early 1970s.

By commercially distributing quality assured-condoms and other relevant products at costs affordable to lower-income groups, and at the same time providing comprehensive clinical services related to reproductive health, PROFAMILIA has been able both to subsidize its core family planning activities from the modest profits that resulted from diversification, and at the same time come close to virtual financial self-sufficiency.

The effects of this strategy may be seen in the following chart:

PROFAMILIA Sources of income (US \$s)



1987

1995

1997

Today PROFAMILIA is 90% self-sufficient, with some 65% of its income derived from its diversified services and 18% from its social marketing (SM) activities.

Key reasons for PROFAMILIA's success with SM:

- *Top management commitment to adopting and investing in commercial marketing and sales techniques, staffing and motivational training of field and clinic staff in the concepts and aims of social marketing;
- *Management emphasis on creativity and willingness to try new ideas;
- *Addition of clinics and community-based health workers in the sales structure;
- *Regular strategic planning and reviews including cost-benefit analyses of alternatives and options, frequent consumer and operations research

studies on effectiveness, satisfaction, trends, needs, market segmentation, and product development, particularly for pack designs, pricing and communications;

*Initial, start-up support from international donors, particularly with subsidized, quality-assured products;

*Cultivation of national and local government support, especially amongst policy-makers and particularly regarding import duties, pricing and distribution permits.

PROFAMILIA's social marketing programme distributes a range of contraceptive products, including condoms, through a national network of almost 4 000 retailers and 140 wholesalers. The country is divided into four regions, each with a sales team and each member of which has a sales district or, in some cases, a specific population group to serve. Each team is attached to one of PROFAMILIA's 35 clinics around Colombia and in addition all the clinics have depots and sales counters for individual clients, general consumers and wholesalers. Large volumes for some wholesalers are dispatched from a central warehouse in the capital city, Bogotá, which also distributes to PROFAMILIA's regional depots. In rural and marginal urban areas, community-based health workers complement the sales network as distributors.

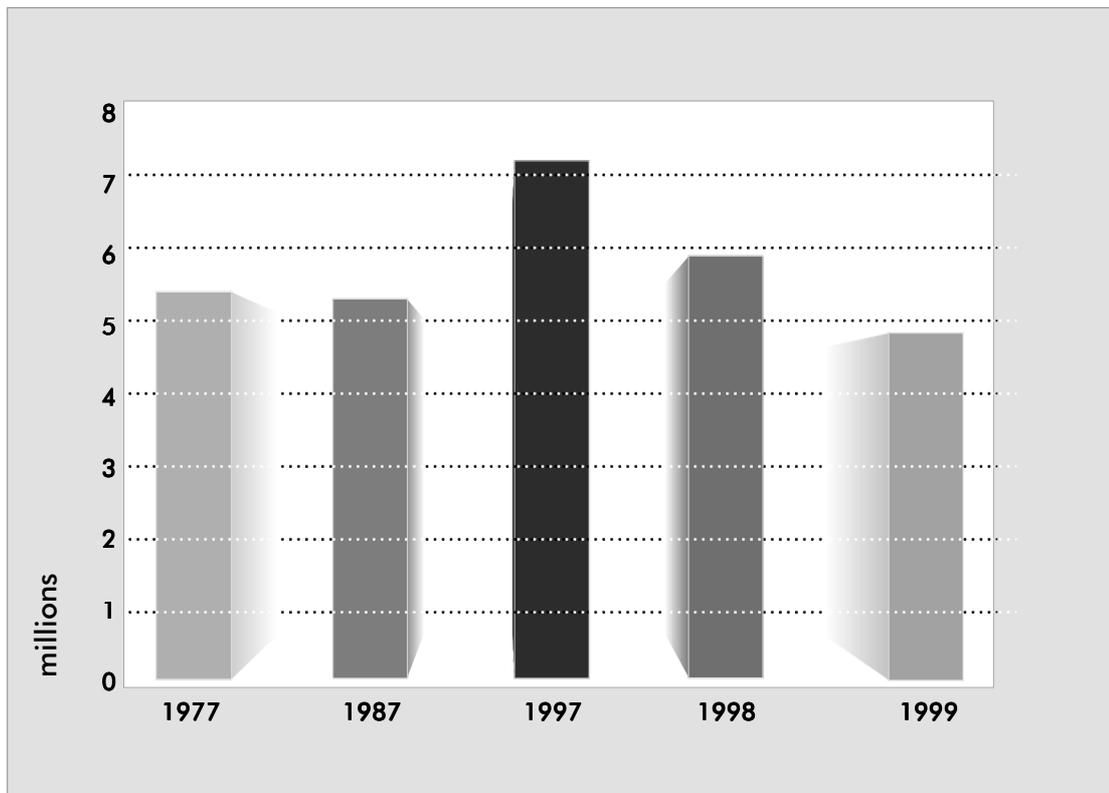
All staff and volunteers involved in distribution and sales are trained in AIDS and STD prevention as well as family planning, and provided with specific IEC materials for their clients; communications materials for condoms focus on "double protection".

Condoms were first introduced into Colombia by PROFAMILIA with the development and distribution of its social marketing brand "Tahiti" in 1976. Two additional brands have since been introduced by PROFAMILIA, "Confiamor" in 1993 and "Piel" in late 1999. The acceptance of condoms by Colombians has resulted in the appearance over the years of a number of competitive organizations and brands seeking to follow the trail blazed by PROFAMILIA.

Competition increases yearly. If in 1997 PROFAMILIA still led the market in total sales, today it ranks fourth, although "Tahiti" remains the most popular brand. Considerably more significant than PROFAMILIA's performance and market position in commercial terms is the fact that — due to this organization's efforts — the availability and accessibility in Colombia of quality-assured, affordable protection from both unwanted pregnancies and infection by STDs and HIV has been enormously increased.

From virtually nothing in the early 1970s, when PROFAMILIA introduced the first brand, total condom sales today in Colombia average an estimated 40 million units a year. By the end of 1998, PROFAMILIA alone had sold 133.5 million condoms since the launch of "Tahiti" in 1976. It is worth noting that of these 133.5 million, 45 million were donated by international development agencies, mainly USAID, so that affordable prices to lower-income groups could be assured. However, these donations progressively declined in time, and PROFAMILIA has increasingly procured its condoms on the international market (there are no manufacturers of latex condoms in Colombia), mainly from the United States, Germany and, more recently, China and Thailand.

Sales graph: bar chart, PROFAMILIA total condom sales



By 1995, and within an overall contraceptive prevalence rate of 72%, condoms were the fourth preferred method regularly used among married women of reproductive age in general (4%) and had been tried by 20%. However, they were also the second method most used amongst unmarried but sexually active women (38%). In addition, trial and use is known to have increased significantly as awareness about AIDS increases, particularly among young men. Condom awareness amongst youth is high: by 1994, 76% of young people knew of condoms and 72% knew where to obtain them.

Although the target consumers or clients of PROFAMILIA's condom social marketing activities are primarily sexually active adult males, the increasing importance and participation of women in condom usage and purchase is recognized and taken into account.

The success of condom social marketing programmes should be evaluated not only in terms of sales and distribution figures but also through their impact within the wider social and reproductive health context. PROFAMILIA invests heavily in market, consumer, and demographic health surveys in order to monitor and evaluate its performance, identify trends and opportunities, and plan effectively.

The individual condom brands were developed entirely within PROFAMILIA. Outside suppliers for packaging designs and communications were contracted as needed,

such as advertising agencies, printers, and a central media agency. With key decisions based on research, the brands, although generally aiming at adult males, are positioned in the market for specific target groups within the population that include women and sexually active young people.

Currently, there are no other condom social marketing projects in Colombia.

Condom brands socially marketed by PROFAMILIA are:



TAHITI: With a recommended retail price equivalent to US\$ 0.16 per condom, the brand is positioned in the lowest price segment and therefore targeted at the highest number of people. It is the lowest price within PROFAMILIA's line of condoms and one of the lowest in the market. Its primary target group is made up of young adults and adults aged 25 to 46 within low to middle-income groups.

CONFIAMOR: Positioned in the mid-price segments, at US\$ 0.25/unit, for young adults and adults aged 25 to 45 within middle to high-income groups.

PIEL: At the equivalent of US\$ 0.35/condom, it is positioned as a premium-priced brand primarily for sexually active young people and adults within middle to highest-income groups. The brand was launched in late 1999 in response to a need for a brand at this high-income level but also with the aim of increasing PROFAMILIA's financial returns for its cross-subsidization plans for 2000 onwards.

The main constraints and obstacles encountered by PROFAMILIA in its social marketing of condoms were reported as follows:

Constraints	Action taken
Restrictions exist on the times that condom information is allowed in electronic media, especially TV	Respecting the allowed times
Smuggled /black market cheap condoms in the market	PROFAMILIA sales staff emphasize the need for buyers to demand quality; Quality awareness campaigns which explain about expiry dates, seals of approval etc.; Sales promotions: adding extra condoms to the pack but maintaining the original price; Use of the PROFAMILIA name as a value-added feature on the packaging
Making sure pack designs do not get out of date and are always attractive and appealing	Update, even redesign packs, based on information and feedback from the sales force and consumers
Maintaining market share is demanding of resources	Develop specific brands, increase the line of brands targeted at specific market and consumer segments
Limited resources for use of electronic media in promotion	Consumer research, including market segmentation and consumer behaviour studies; Media planning to identify the most appropriate media channels for different market segments

The key lessons learned by PROFAMILIA from its social marketing programme are:

- ❑ If cross-subsidization is adopted within an organization in order to fund other activities, the planning should consider maximizing margins on sales, i.e. condom social marketing is not an end in itself but a means to aid in achieving the organization's wider objectives.
- ❑ In a situation where funds and resources are always limited there is a premium on creativity and initiative, particularly for promotional and communication activities.
- ❑ Building team spirit is key, motivated by the wider social objectives of the organization.

For additional information on this programme:

PROFAMILIA,
Depto. de Mercadeo Social,
Calle 34 No. 14-52,
Santafé de Bogotá DC,
Colombia

5. Key Lessons

This booklet is offered as a key material within the UNAIDS Best Practice Collection which seeks to disseminate, as widely as possible, working practices around the world that have been tried or adopted in response to the spread of HIV/AIDS and STDs. The aim of the Collection is not necessarily to promote the activities or practices *per se* as “best” solutions to the problems for which they were originally adopted, but, more importantly, to provide a source of lessons learned that may save others in the field considerable effort, resources and time.

Each of the social marketing country programmes described provides valuable lessons that may be applied in other countries and circumstances, whether in planning new projects or in working towards expanding or improving existing programmes. These lessons are included in the sections on each project. However, some general issues are relevant as key points to be considered.

1. **Social marketing for HIV/AIDS and STDs is at present largely focused on condoms. This will not always be so.**

UNAIDS advocates social marketing, and particularly the social marketing of condoms, as a key strategy in the fight against the global HIV/AIDS pandemic. The case studies described here have much to offer both new and other on-going condom promotion projects. However, although male and female condoms are currently the only manufactured products that provide protection against infection from HIV and many STDs, other products, such as microbicides and vaccines, are in development and will one day become available. They will be more quickly and easily accessed by those who can afford their commercial price. However, in developing countries, the vast majority of the population will find it difficult, frequently impossible, to avail themselves of the new products and increased protection. The lessons to be learned from the past experience and experiments in condom social marketing can help significantly in making new products and services more widely available and accessible as quickly as possible.

2. **Marketing, and consequently social marketing, is a very flexible and adaptable technique.**

The concepts and principles of marketing can be applied to almost any products and services and on virtually any scale, whether for commercial or social ends. Nor is there a single model of marketing that is necessarily any better than any other; the practical application of the technique's guiding principles may take many forms, depending on circumstances and aims. The few examples of applied social marketing described in this booklet illustrate the range and flexibility of the discipline, and how it may be adapted to deal with widely differing situations, constraints and opportunities.

Social marketing projects and programmes can be large and nationwide or, as appropriate, small and targeted at specific locations or groups within the population. A programme may stand alone or be a component of a larger, more comprehensive project; similarly, a social marketing programme may contain within itself different tactics and strategic approaches, such as when “traditional” product distribution through commercial wholesalers to shops is complemented with community-based distribution to individuals. Nor, as has been seen, does a social marketing programme necessarily require the exclusive use of experienced marketing professionals. People drawn from the general public or from specific, targeted groups can be effectively involved in a project's design and implementation.

3. Research is fundamental to effective social marketing and achieving behaviour change.

In designing and implementing a social marketing project, detailed knowledge of the target group's situation and context is essential: assessing the availability of and degrees of accessibility to needed products and services, and discovering the group's values, attitudes, habits, needs and wants in relation to the project's goals, are necessary for the identification of opportunities and means for action. In other words, the planning process and subsequent reviews, as well as the monitoring and evaluation of performance and progress following implementation, must be guided by relevant, reliable, up-to-date information and data.

Social marketing therefore requires comprehensive "market" and "consumer" research, and several of the cases described above have illustrated its importance. The depth and scale of the research conducted will of course depend on the amount and quality of available resources, but even where resources are limited, whether for lack of funds or technical "know-how" or both, it is possible to collect and analyse reliable information.

Where technical resources for research are limited, obtaining and acting upon knowledge about targeted groups is often made easier, or even fully achieved, through the partnerships that are increasingly being forged between social marketing projects and local, often community-based, organizations. Many of these joint projects are set up in order to improve the reach of social marketing to specific groups or population segments but individuals can be trained also in collecting information from their peers, through individual interviews and focus group discussions, as well as in sales and distribution.

4. The measure of success of a social marketing programme is much more than the volume of product sales achieved.

The success of social marketing should be evaluated not only in terms of sales and distribution figures but also through their impact within the wider social and reproductive health context. Techniques and indicators that can document the impact of programmes above and beyond sales figures exist, such as measures of awareness, recognition and acceptance of risk, behaviour and social change, and programme reach, and others are being developed.

5. There is a need for increased and expanded implementation of social marketing in the fight against HIV and STDs.

Social marketing has been applied towards the improvement of sexual and reproductive health since the 1970s. Its contributions in this field have been significant, especially in expanding access to reproductive health services and products in developing countries. Within the area of HIV/AIDS and STDs, the social marketing of male and female condoms to low-income and high-risk groups is becoming increasingly widespread and has resulted in many countries in greatly improved access to condoms. For example, in 1991 social marketing programmes operated in 37 developing countries and sold about 575 million condoms; by the end of 1999, programmes existed in almost 60 developing countries and sold over 900 million male and female condoms.

Nevertheless, there is still room for expansion and further growth. Many more countries can adopt social marketing as a key strategy within their HIV and STD prevention programmes and many of those with existing programmes would benefit from assessing their needs for improvement. It is hoped that the experiences and lessons learned from the programmes described here may contribute to this.

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.



Joint United Nations Programme on HIV/AIDS

UNAIDS

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Joint United Nations Programme on HIV/AIDS (UNAIDS)
UNAIDS - 20 avenue Appia - 1211 Geneva 27 - Switzerland
Telephone: (+41 22) 791 46 51 - Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org - Internet: <http://www.unaids.org>