

TITLE

A Community-Based Condom Social Marketing Initiative in Post-Conflict Liberia

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ABSTRACT

This study describes a condom promotion strategy to prevent HIV/STDs among vulnerable youth in a post-conflict, resource-constrained environment via the provision of both male and female condoms to non-traditional venues like music shops, ice cream parlors, money exchange centers, and beauty salons. Community members from four zones within designated catchment areas volunteered their services and the use of their small businesses to support this endeavor. We postulate that this approach may increase condom use among urban youth and community members in Monrovia, the capital city of Liberia. In this paper, we describe the condom promotion strategy and its implications within the context of a community-based participatory social marketing program to prevent risky sexual behaviors among highly vulnerable youth, as well as adults within the communities, in a post-conflict country.

INTRODUCTION

Risky sexual behaviors promote the transmission of sexual transmitted infections (STIs), including human immunodeficiency virus (HIV), while prevention research identifies appropriate strategies to effectively promote safer sexual behavioral change¹. The effective use of condoms has been regarded as one of the most effective public health strategies to prevent the transmission of HIV/STIs among sexually experienced individuals, especially for highly vulnerable populations^{2,3,4}.

A little more than one-tenth of the world's population live in sub-Saharan Africa which is the home to almost 64% of all people living with HIV; the HIV epidemic continues to rapidly expand, and heterosexual transmission remains the most common mode of HIV/STI infections^{5,6,7,8}. Correct and consistent condom use provides one of the most feasible methods to reduce the transmission of HIV/STDs and has been found to be more effective than the mere reduction of the number of sexual partners⁹. However, in most instances, condom use tends to vary based on the nature and duration of the sexual partnership of which condom use is lower among steady partnership than casual ones¹⁰.

While it is true that sub-Saharan Africa remains the worst affected region in the world, data on sexual behaviors among adolescents in Liberia, unlike many other sub-Saharan African countries of which we have a general understanding of transmission patterns among adults and youth, is scanty. Nearly two decades of civil war has devastated most of its health care infrastructure, including the infrastructure for transportation and communication, as well as the economy. Nevertheless, available data clearly document that Liberian adolescents engage in risky behaviors¹¹. For example, self-reported data collected in 1999-2000 documented that over 95% of 19 year-olds in Liberia have had sexual intercourse and about half (45%) have reportedly had multiple sexual partners and had not used condoms during their last sexual encounters¹¹. Also reported data indicates that about 40% of youth, aged 15-19 years and mainly those with more education, have knowledge of condom sources¹². Reports also shows that 18% of females and 9% of males have had sex by the time they are age 15, and condom use during first sexual intercourse is 6% among young people aged 15-24 years¹². Therefore, youth sexual activities, particularly their failure to engage in self-protective behaviors such as the consistent use of condoms and the delay in sexual activities, place them at significantly high risk for HIV/STIs and unintended pregnancy.

Availability and Accessibility of Condoms in Liberia

Condoms are widely available in Liberia through the Global Funds to fight AIDS, Tuberculosis and Malaria (GFATM) and the United Nations Population Fund (UNFPA). However, significant gap exists regarding its accessibility and availability within the urban communities of Monrovia and its environs, especially for sexually experienced, mobile and transient populations such as highly vulnerable urban youth, commercial sex workers (CSWs) and men who have sex with men (MSM). The primary outlets for condoms distributions are non-governmental organizations (NGOs), community-based and public health facilities. Generally, religious-based health facilities do not distribute condoms because their doctrines do not support the use of contraceptives and/or pre-marital sex.

At the community level, condom social marketing activities are nonexistent in Liberia. In addition, undocumented reports indicate that risky sexual behaviors have exponentially increased in urban communities, thereby increasing the risk for HIV/STI transmission among highly vulnerable populations. Although national data are limited, HIV seroprevalence is estimated to be 5.7% among pregnant women¹³ and 1.5% among the general population, with urban areas reported to be twice the rate of rural areas¹⁴. In addition, STIs are also rapidly increasing among young people in Liberia, especially females as a consequence of the prevailing post-conflict contexts, including socio-economic disparity, sexual violence, gender inequalities, social insecurities and substance use^{7-8, 13-14}. Yet, published data are unavailable to clearly describe and better understand the impact these social forces are having on HIV/STI transmission patterns.

We propose that a well designed participatory-based community-level condom distribution initiative would significantly bridge the gap between high risk populations who are in dire need of condoms and condom distribution programs. In addition, we assume that this proposed community-level condom distribution model has the potential to be replicated in other urban communities in Liberia, as well as other regions of sub-Saharan Africa. Although undocumented reports from the National AIDS/STI Control Program (NACP) of the Ministry of Health and Social Welfare (MOHSW) indicate that condom use is gradually increasing among the heterosexual population in Liberia, condom use remains relatively low¹³. In this report, we highlight efforts to maximize condom availability and accessibility via a community participatory process within the context of a randomized controlled trial (RCT) to prevent HIV/STIs among vulnerable urban youth in Monrovia, the capital city of Liberia.

METHODS AND PROCEDURES

Project Overview

A five year community-based intervention trial to adapt, administer and evaluate a proven behavioral-driven HIV/STI prevention program among urban youth, aged 15-17 years, is presently being implemented in Liberia by the UL-PIRE Africa Center. In view of the fact that this community-based HIV/STI prevention program promoted increased and sustained condom use among urban youth, we concluded that an easily accessible and culturally appropriate condom distribution program is critically important to achieving the primary aim of the increased use of condoms among urban youth in Liberia. With the existence of potential barriers (e.g., costs, availability, and accessibility) for condoms in community settings in Liberia, we hypothesized that an effectively designed condom social marketing initiative, integrated into an existing randomized trial based on a preventive intervention program would help promote, motivate, support and sustain condom use among vulnerable urban youth in post conflict Liberia.

Recruitment of Condom Distribution Sites

The condom social marketing initiative is being conducted in Monrovia, the capital city of Liberia, where the study methods and procedures were pre- and post-tested among key informants and members of the target population. Based on needs assessment conducted by the study team in consultation with community leaders and key informants (e.g. city planners, demographers from the University of Liberia, etc.), Monrovia was demarcated into four zones

based on the number of communities, distance between communities and census tract, respectively. In addition, convenient and geographically appropriate venues would prevent long commutes, embarrassment and/or intimidation, and enhance privacy protection and confidentiality.

In each zone, suitable venues were identified as potential condom distribution sites. The selection of condom distribution sites was based on variables such as for example, the proximity of the site to the surrounding neighborhoods, schools, markets, and/ recreational centers. Afterward, formal contacts were initiated with the owner/proprietor of each potential site to elicit his/her interest, participation, and commitment to the goals and objectives of the condom social marketing program. Mutually acceptable agreements were concluded and contact information obtained for future communication regarding follow-ups.

At the onset, we identified 106 potential condom distribution sites within the four zones, of which 88 (83%) consented and 18 (17%) declined to participate in the condom social marketing initiative. Reasons provided for the refusals by 17% (18) of potential sites included the lack of interest to participate in the distribution of condoms, pre-occupation with other business-related activities, and conflict with religious beliefs. The 88 sites included diverse businesses such as provision shops, CD/DVD/VCD rental shops, barber shops, ice cream parlors, beauty salons, money exchange centers, music recording centers, computer service centers, photo shops, entertainment centers, grocery shops and convenient stores.

Building Condom Knowledge and Skills of Community Distributors

A representative (business owner/shop keeper) from each of the 88 enrolled condom distribution sites was invited to one of three similar one-day training workshops regarding their roles and responsibilities. We conducted these three similarly structured training workshop sessions in August 2007 to accommodate all 88 business owners into our intensive skill building training program to get candid feedbacks from them. For the workshops, the following topics were covered: (1) Importance of Condoms; (2) Privacy and Confidentiality Regarding Community-Based Condom Distribution; (3) Condom Demonstration Skills; (4) Principles of Condom Social Marketing; (5) Beneficiaries of the Condoms; and (6) Condom Supply Chain Mechanism and Documentation. At the conclusion of each workshop session, each business owner was provided printed copies of all training program materials, including samples of the condom distribution and replenishment logs, as well as reimbursement of his/her transportation cost to and fro the workshop. No financial incentives were provided for participating in the workshop for the condom social marketing project.

Ninety (90) representatives from 88 condom sites completed the basic training programs for condom distributors. Each site was requested to send one representative; however, two sites sent an extra representative each totaling the workshop participants to 90. Of the workshop participants, 63 (70%) were males, while 27 (30%) were females. The attendance per training sessions revealed that 34 (38%) participants (21 males, 13 females) attended the first session; 32 (36%) participants (23 males, 9 females) in the second session, and 24 (27%) participants (19 males, 5 females) in the third session.

After the completion of the training sessions, a female representative from “Zone One” withdrew her participation due to concerns regarding the distribution of condom at her business center which conflicted with her perceived religious beliefs of allegedly promoting sexual promiscuity,

especially among unmarried youth. Accordingly, 87 business entities from the four zones, at the onset, accounted for the total number of condom distribution sites enrolled into the condom social marketing project (See Table 1), of which 61 (70%) of the owners were males (excluding the two extra representatives mentioned above, and 26 (30%) were females (excluding the female who withdrew the participation of her business entity).

Table 1

Condom Distribution Sites by Zones, Gender of Participants, and Types of Condoms Issued

Zones	Eligible Number of Consenting Condom Distribution Sites	Workshop Attendance by Number of Condom Distribution Sites & Gender of Site Representatives*			Number of Enrolled Condom Distribution Sites***			Types of Condoms Issued****	
		Sites	Males	Females	Sites	Males	Females	Male Condoms	Female Condoms
1	16	14	9	5	13	9	4	6,000	72
2	33	28	18	10	28	18	10	5,600	56
3	20	17	14	3	17	14	3	3,200	32
4	37	29	22**	9	29	20	9	5,600	156
Total	106	88	63	27	87	61	26	20,400	316

*The total number of male and female representatives from consenting condom distribution sites who attended the workshop was 90 participants.

**Two male participants, instead of one per site, represented two different sites from zone IV. Accordingly, there were 90 participants representing 88 sites.

***One site, with a female representative from zone 1, withdrew after the workshop due to religious concerns regarding condom distributions on her business premises. So, the total number of condom distribution sites enrolled into the study was 87 sites.

****Condoms Issued: Total number (or pieces) of male and female condoms distributed.

During the workshops, significant levels of enthusiasm were exhibited by participants. In addition, a wide range of questions and/or concerns were raised; some of which included: (1) the legal ramifications regarding the provision of condoms to youth under 18 years; (2) whether condom distributors with limited knowledge on safer sex-related issues were qualified to counsel and/or educate youth on HIV/STI prevention; (3) the need for the provision of incentives or enablers to condom distributors; (4) the issuance of condoms to individuals who reside outside the community where the condom distribution site is located; (5) the rationale for targeting young people rather than older adults; and (6) the perceived relationship between condom use and population growth. The workshop sessions provided a first opportunity for some of the participants to have seen and/heard about female condoms. All questions and concerns were fully addressed, and the interactive exchanges ended satisfactorily.

Community-Based Condom Distribution Initiative

Program staff visited each site and supplied fixed consignments of both male and female condoms to each representative of the 87 enrolled condom distribution sites (i.e. those who completed the training workshops). On average, we supplied about 225-250 and 3-5 pieces of male and female condoms, respectively, per distribution site. Appropriate forms were completed and signatures were obtained. During the supplies of condoms to distribution sites, the initiative was warmly embraced by community members of the four zones.

The business owners were provided standardized supply chain documentation forms containing information on such items such as the quantities and types of condoms (e.g., male or female condoms) issued, the date issued, the quantities and types of condoms requested, the types of individual requesting condoms (study participants, community members), the quantities and types of condoms replenished, and condoms replenishment and venues' follow-up dates. Youth enrolled into the randomized trial were issued non-name based photo identification cards with numerical-based identifiers to distinguish them from community members not enrolled into the program, for completing the supply chain logs. In order to prevent data collection error by business owners, different supply chain documentation forms were developed for randomized trial participants and community members. The purpose of the identification card was to track the randomized trial participants' request for condoms. In addition, condom-related data were obtained by zones and then analyzed based on demographic factors (i.e. genders, ages, communities, in-school, out-of –school, etc.), the frequencies and types of condoms requested, the quantities of condoms requested, and the types of condoms distribution sites commonly dispensed during the implementation of the project.

The total number of condoms initially issued to the four zones within the study catchment areas was 20,400 pieces of male condoms, and 316 pieces of female condoms. The quantities and types of condoms issued by zones were: 6,000 pieces of male condoms and 72 pieces of female condoms to zone one; 5,600 pieces of male condoms and 56 pieces of female condoms to zone two; 3,200 pieces of male condoms and 32 pieces of female condoms to zone three; and 5,600 pieces of male condoms and 156 pieces of female condoms to zone four (See Table 1). The disparity in the quantities of male and female condoms distributed to business sites can be contributed to a variety of reasons. They include: (1) the limited number of female condoms supplied to the project by donor; (2) a significant lack of knowledge and/or awareness of female condoms in Liberia; (3) The significantly low rate of usage of female condoms in Liberia; (4) unavailability of female condoms; and (5) cultural concerns regarding the perceived relationship between a female having to insert a condom and sexual promiscuity.

Community Involvement in Program Implementation

The strategy employed by this project, to make condoms more readily available and easily assessable at the community level, has been widely embraced by community leaders, key informants and stakeholders. Furthermore, the fact that community members had volunteered their business centers to distribute condoms to highly vulnerable youth and other community at no cost is indicative of the community's buy-in of the project, as well as the community's desire to proactively assist in the mitigation of HIV/STIs within their respective communities.

This is the first published report of a structured condom social marketing program in Liberia. Strikingly, this project has been overwhelmingly adopted by community members as a relevant

community-wide prevention strategy to promote, support, encourage and sustain condom use among highly vulnerable urban population in the country. Also, concerns initially raised by community-based key informants during the needs assessment site visits, such as privacy-related issues and the legality of condom provision to youth under 18 years, gradually subsided and the condom distribution sites became more visible and highly accessible to youths and community members.

Program Implementation Challenges in a Post-Conflict Environment

There are several potential challenges regarding the implementation of this condom social marketing initiative in a post-conflict country like Liberia: (1) A major challenge faced by the project is logistical concern regarding the continual supplies of condoms to the targeted communities within the contexts of a structured time frame as well as the continual lack of condom from our suppliers to meet the increasing demands of the communities. (2) Another challenge is the request by distributors for the provision of incentives to community volunteers who continually distribute condoms at no cost within the communities. (3) Business owners, who attended the workshop, delegated the responsibilities of dispensing condoms and filling in logs to business assistants who were not probably informed about the process.

Since condom social marketing is a new public health innovation in Liberia, motivating community volunteers to continually implement this program without financial incentives is gradually emerging as a significant community-level barrier for the continual operation of the project due to the deteriorating socio-economic situation in the country. Liberia is presently in a post-conflict transition, recovering from nearly two decades of political conflict, where the basic infrastructure for health, the socio-economic sector, and communication, have significantly collapsed^{8,9,11,13,15}. While these contexts are beyond the scope of this paper, it is documented that structural factors, including high rate of unemployment, fuel high risk sexual behaviors such as commercial sexual activities and substance use^{8, 9, 11, 13}.

We believe that the effective outcome of this condom social marketing initiative may likely influence community members in partnership with the project (UL-PIRE Africa Center), to develop a sustainability plan. Our expectation is that by disseminating our project-related experiences, including efficacy and lessons learned with major stakeholders such as the Government of Liberia's National AIDS/STI Control Program may provide the needed public and government support to this crucial public health initiative.

CONCLUSION

This program has been relatively successful in mobilizing community leaders, via a participatory mechanism, to take relevant public health actions regarding the need to prevent HIV/STIs within their respective communities. It has also increased the perceived intention of community members to begin to formulate preliminary social marketing plans, as a back-up prevention strategy, regarding future barriers that could be associated with donor reluctance to continually procure and/or supply condoms at the community level after the project has ended. Such a community generated sustainability plan has the potential to be effective in promoting safer sex behaviors and thus ensuring local buy-in of future condom promotion programs by adjacent communities. As we collect the relevant process and outcome data in the ongoing HIV/STI prevention project, we will, in future publications, document the potential short and long term-related program implementation challenges.

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