



# Barriers to Condom Access: setting an advocacy agenda



## ICASO Advocacy Briefing



Peer educator condom demonstration, South Africa  
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It is the right of people living with HIV and those most at risk and vulnerable to HIV infection to access comprehensive services and commodities. This includes proven prevention approaches such as the promotion and use of condoms. However, the failure to remove barriers that determines whether a person can access and use a condom is one of the biggest impediments to preventing millions more HIV infections.

'Frontline' community research supported by ICASO in fourteen countries has provided analysis of some of these barriers to condom access. In particular, it is clear that governments and donors around the world need to commit new resources and enact and reform legislation, policy and programming that will ensure condom access and availability. A mobilized community sector that can forcefully advocate for condom access is needed now more than ever.

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# Methodology

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Peer educators during a World AIDS Day event, Sierra Leone  
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This *Advocacy Briefing* provides an analysis of some of the barriers to condom access based on the findings from ‘front-line’ community research supported by ICASO. This information was sourced from a community-led monitoring project undertaken in 2005 and 2006 assessing the implementation of the United Nations General Assembly Special Session on

HIV/AIDS (UNGASS) Declaration of Commitment on HIV/AIDS<sup>1</sup>.

Community groups from 14 countries<sup>2</sup> collected and analyzed data and information on the broad response to HIV and AIDS, preparing country reports of the findings and the critical issues for communities in their country. In relation to condom access, most of the analysis focused on male condoms, with some community researchers including issues around female condoms.

Given that this document relies mainly on this community analysis, it does not purport nor aim to be a comprehensive analysis of all the barriers to condom access. However, where necessary, the analysis has been complemented with current best practices from the HIV prevention literature and additional input from consultations with community sector advocates.

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## HIV prevention and condoms

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AIDS is the third largest killer in the world, but it is preventable. Yet every day 14,000 people become infected with HIV, the majority through sex<sup>3</sup>. Many of these cases could have been avoided<sup>4</sup> if it were not for restrictions and barriers on proven and effective prevention strategies, such

as condoms. It has been estimated that as many as two-thirds of the new infections expected to occur in the next 10 years could be averted by the implementation of a comprehensive range of evidence-based prevention measures.<sup>5</sup>

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<sup>1</sup> United Nations General Assembly Special Session on HIV/AIDS. *Declaration of Commitment on HIV/AIDS*, adopted June 27, 2001

<sup>2</sup> Cameroon, Canada, El Salvador, Honduras, Indonesia, Ireland, Jamaica, Morocco, Nepal, Nigeria, Peru, Romania, Serbia and Montenegro, and South Africa

<sup>3</sup> UNAIDS, *2006 Report on the global AIDS Epidemic* (May 2006)

<sup>4</sup> Human Rights Watch, *Access to Condoms and HIV/AIDS Information: A global health and human rights concern* (December 2004)

<sup>5</sup> UNAIDS, *2006 Report on the global AIDS Epidemic* (May 2006)

Male and female condoms<sup>6</sup>, if used correctly and consistently, can reduce the risk of sexual transmission by 80-90<sup>7</sup> percent. In fact, condoms are the only product that can effectively protect against HIV and other sexually transmitted infections (STIs)<sup>8</sup>. Condoms are also essential to prevention efforts for people living with HIV (PLHIV), providing protection from STIs and re-infection, as well as protecting their sexual partners.

However there is a serious gap in the availability of condoms and relevant information on how to effectively use them.<sup>9</sup> In the last few years, less than half of all people at risk of sexual transmission of HIV had access to condoms and less than one quarter had access to basic HIV/AIDS education.<sup>10</sup> Researchers project supply gaps of billions of male condoms in sub-Saharan Africa alone.<sup>11</sup> The United Nations Population Fund (UNFPA) estimates that developing countries need around 10 billion condoms per year, and may need more than 18 billion by 2015.<sup>12</sup>

Condom shortages stem not only from resource constraints, but also from government policies that restrict condom

manufacture, procurement, distribution, and information on their use. Such policies violate basic human rights, such as the right to health, because states are required to refrain “from limiting access to contraceptives [...] and from censoring, withholding or intentionally misrepresenting public health information.”<sup>13</sup>

As this suggests, constraints on supply is only one aspect of the ‘condom problem’. Health development literature shows us that the determinants of health include a broad range of interrelated factors, including biological, behavioral, cultural, political, legal and socio-economic<sup>14</sup>. These factors will determine the levels of individual risk and vulnerability to HIV infection, including determining whether a person uses a condom correctly and consistently.

The ‘frontline’ community research supported by ICASO has provided evidence of the influence of these determinants and how they act as barriers to condom use in the countries reviewed. For the purposes of this paper, these barriers to condom access have been grouped into four categories.



Condom dress by Adriana Bertini, AIDS 2004  
© ICASO

<sup>6</sup> The male condom is placed over the glans and shaft of the penis, and is available in latex, lambskin, and polyurethane. The female condom is a strong, soft, transparent sheath inserted into the vagina prior to sexual intercourse with a flexible ring at each end, available in polyurethane and nitrile.

<sup>7</sup> UNAIDS, *2006 Report on the global AIDS Epidemic* (May 2006)

<sup>8</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>9</sup> GTZ, *HIV/AIDS Prevention through Social Marketing of Condoms* (undated)

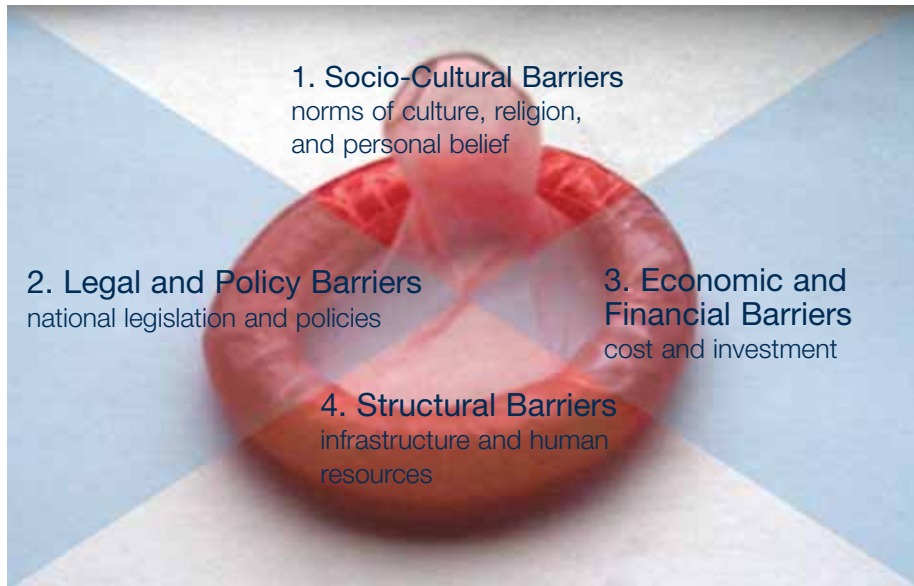
<sup>10</sup> Human Rights Watch, *Access to Condoms and HIV/AIDS Information: A global health and human rights concern* (December 2004)

<sup>11</sup> Estimates range from 1.9 to 13 billion. Shelton JD, et al., *Condom gap in Africa: evidence from donor agencies and key informants*. (2006); See also The Supply Initiative, *Access to Condoms and Contraceptives – Vital for the Prevention of HIV* (2005).

<sup>12</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>13</sup> Committee on Economic, Social and Cultural Rights (CESCR), *The Right to the Highest Attainable Standard of Health: CESCR General Comment 14* (22nd Sess., 2000) 04/07/200 E/C 12/2000/4

<sup>14</sup> Canadian HIV/AIDS Legal Network, *Healthy Public Policy. Assessing the impact of law and policy on human rights and HIV prevention and care* (2002).



This document aims to provide an analysis of these barriers to condom use and access that were identified by community research, and where possible provides recommendations for community sector advocacy.

## Condom Access Barriers



### Socio-Cultural Barriers

While sex is a deeply personal experience, condom use during intercourse is often tied to religious and cultural norms as well as personal beliefs. Such norms help people define their own concepts of sexual morality or to internalize acceptable behaviors. This section explores barriers to condom use that stem primarily from personal beliefs and knowledge, culture, social relations and religion.

#### Barrier 1.1:

**Lack of women’s empowerment and gender equality**

The promotion of equality between men and women is essential to successful HIV

prevention, addressing both barriers to empowerment and sexual pleasure and performance. Inside a heterosexual relation, gender power relations are directly tied to a woman’s ability to negotiate safer sex with her partner. In many cultures, women lack the power to insist on condom use, both inside and outside marriage.

Violence against women inside and outside marriage, including rape and sexual assault, takes away women’s control over when, with whom, and how they have sex, and over whether or not they can negotiate condom use during sexual intercourse. Furthermore, many women do not feel comfortable talking about sex with their partners or may stop using condoms when involved in a long term relationship as a sign of trust and faithfulness.

Whether or not protection is used—and what kind—is often decided by the man. Sometimes even the suggestion of using a condom will be seen as an accusation of the partner’s infidelity, or an admission of adultery on the part of the woman herself. Such implications could provoke violence and silence a woman from speaking up, even if her partner’s faithfulness is suspect. In South Africa, for example, fear of violence is reported as a major barrier to condom use.<sup>15</sup> In Morocco, the appearance of fidelity is so important that women can rarely insist on condom use even when her partner is HIV positive and she is not.<sup>16</sup>

Women also refuse to use condoms as many relate condoms only with contraception (and not with protection against STIs) and given that in many cultures becoming pregnant is an indicator of intimacy and commitment, women fear negative repercussions from their partners. Married couples are among the least likely groups to use condoms<sup>17</sup>, and marriage itself has become a prime risk factor for women. In Morocco, as elsewhere, the majority of HIV positive women have been infected by their husbands (65 percent).<sup>18</sup> In some cultures where adultery or polygamy is common<sup>19</sup> unprotected sex within marriage is inherently risky. Early marriage (sometimes forced) and desire or social pressure to have children are other factors complicating condom use.

Gender norms around masculinity dictate that men should be sexual risk takers and should be aggressive within sexual activity. This of course affects the power dynamics in the relationship, be this a heterosexual or homosexual relation. Men who have sex with men (MSM), feminized

men and transgender people also experience difficulties with condom negotiation and experience high levels of sexual violence.<sup>20</sup> Stigmatization and social exclusion further disempowers these populations, increasing their vulnerability to HIV infection. For many, the sexual and gender roles they perform within male sexual practices lead to significant levels of ‘dominant’ sexual partners, sexual abuse, violence, rape, and harassment, often from an early age.<sup>21</sup> And of course, such forced sex is usually unsafe, and often resulting in internal injuries, further increasing their vulnerability to HIV infection.

Despite the effects of gender inequality on condom use, very few of the country reports supported by ICASO identified HIV/AIDS programs specifically addressing women’s and sexual minorities’ rights and gender equality.<sup>22</sup> This is despite government commitments, including those made in the Declaration of Commitment on HIV/AIDS in 2001.

“By 2005, ensure development and accelerated implementation of national strategies for women’s empowerment, promotion and protection of women’s full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls[...].”

- (paragraph 61)

<sup>15</sup> Mellors, S. *Monitoring the Implementation of the UNGASS Declaration of Commitment: South Africa Country Report (2005)* [hereinafter South Africa UNGASS Report]

<sup>16</sup> Association de lutte contre le SIDA (ALCS), *Monitoring the Implementation of the UNGASS Declaration of Commitment: Morocco Country Report (2005)* [hereinafter Morocco UNGASS Report]

<sup>17</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card (2002)*

<sup>18</sup> Morocco UNGASS Report

<sup>19</sup> Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), *Monitoring the Implementation of the UNGASS Declaration of Commitment: Nigeria Country Report (2005)* [hereinafter Nigeria UNGASS Report]

<sup>20</sup> NAZ Foundation International, *The impact of social, legal and judicial impediments to sexual health promotion, and HIV and AIDS related care and support for males who have sex with males in Bangladesh and India (2005)*

<sup>21</sup> Ibid.

<sup>22</sup> Out of ICASO’s 14 case studies, countries specifically reporting HIV/AIDS programs addressing gender are South Africa, El Salvador, Jamaica, and Nigeria

Sexual negotiation skills, taught as part of comprehensive programs exploring understanding of HIV, gender roles and promoting men’s involvement in sexual and reproductive health, can have significant effects on condom use. Both women and men can be trained to improve their communication, listening and relationship skills and to respect each others needs and desires for condoms. In El Salvador, for example, workshops have been held on gender and women’s empowerment, emphasizing women’s right to negotiate safe sex and men’s and women’s shared responsibility in sexual decision making.<sup>23</sup> In Jamaica, women’s NGOs worked closely with the Ministry of Health in the development of

the National Strategic Plan and National HIV/AIDS Policy.<sup>24</sup> Strategies adopted in the policy include increased provision and use of female condoms and strengthening condom negotiation skills.

In Morocco, programs designed for female sex workers focus on building their confidence, as a pre-requisite to successful negotiation with clients for condom use. In addition to distributing condoms and lubricants, and informing sex workers about prevention methods, their self-esteem is improved through work with social workers. Developing a positive image of themselves is a prerequisite to engaging in safer sexual patterns.<sup>25</sup>

## Recommendations for community sector advocacy

- Advocate for governments and donors to scale up, cost, and budget policy and programmatic actions promoting gender equality in their national responses to HIV/AIDS. This includes measures to support the empowerment of women and sexual minorities and to increase their ability to negotiate condom use.
- Advocate for governments to adopt legislation and/or establish effective enforcement mechanisms that support gender equality (e.g. inheritance rights).
- Advocate for governments to abolish laws and policies that criminalize behaviours of sexual minorities, such as MSM and transgender.

### Barrier 1.2:

#### Religion and morality

An overly rigid, or moralistic, view of sexual activity – and the belief that condom promotion encourages sex — is a strong deterrent to condom use. Cultural and religious notions of “morality” equating condoms with promiscuity limits both the

availability of condoms and personal ease of comfort in using them. Although official Roman Catholic teaching is silent on the use of condoms to protect against HIV infection,<sup>26</sup> it opposes the use of condoms for birth control, and many within the hierarchy of the Church have interpreted this as ban on condom use for any purpose.

<sup>23</sup> Asociación Atlacatl Vivo Positivo, *Monitoring the Implementation of the UNGASS Declaration of Commitment: El Salvador Country Report (2006)* [hereinafter El Salvador UNGASS Report]

<sup>24</sup> Jamaican AIDS Support (JAS) *Monitoring the Implementation of the UNGASS Declaration of Commitment: Jamaica Country Report (2005)* [hereinafter Jamaica UNGASS Report]

<sup>25</sup> Morocco UNGASS Report

<sup>26</sup> Human Rights Watch, *Access to condoms and HIV/AIDS information: A Global health and human rights concern (2004)*



Workshop on HIV prevention and condom use, Yukpa indigenous community, Venezuela  
© AMA VIDA 2007

Many faith-based organisations, and governments influenced by religious ideology, have adopted the 'ABC' approach to prevention: Abstinence, Be faithful; and use Condoms.<sup>27</sup> Often their emphasis is only on abstinence and be faithful, positioning condom use for those unable to meet 'moral standards'. This ABC approach fails to deal with the need for a more comprehensive approach to prevention including, for example, empowerment, sexuality and life skills education. This particular approach is most problematic because it increases the stigma and discrimination of those using condoms.<sup>28</sup>

In Nigeria, many people are reluctant to buy condoms for fear of seeming sexually "loose".<sup>29</sup> In El Salvador, pharmacists have refused to sell condoms due to religious beliefs, which also influenced health care workers' willingness to

promote condom use.<sup>30</sup> In some countries, condoms are primarily associated with marginalized groups such as sex workers: until recently in Morocco, the possession of condoms was seen as "proof" of soliciting sex.<sup>31</sup>

In Indonesia, prevention efforts are heavily criticized by some religious organizations claiming that such messages – including condom promotion – encourages sex.<sup>32</sup> Not only do some religious ideologies make it difficult to advocate for safer sex, but some religious leaders have sent inaccurate messages about condom effectiveness.<sup>33</sup> The high status of religious leaders in many societies puts them in position of influence that needs to be harnessed for HIV prevention and condom promotion.

<sup>27</sup> UNAIDS, *Practical Guidelines for Intensifying HIV prevention* (2006)

<sup>28</sup> International HIV/AIDS Alliance and Reproductive Health Matters, *Emerging Issues: Condom policy and programming*, (2006)

<sup>29</sup> Nigeria UNGASS Report

<sup>30</sup> El Salvador UNGASS Report

<sup>31</sup> Morocco UNGASS Report

<sup>32</sup> PITA Foundation, *Monitoring the Implementation of the UNGASS Declaration of Commitment: Indonesia Country Report* (2006) [hereinafter Indonesia UNGASS Report]

<sup>33</sup> Human Rights Watch, *Access to Condoms and HIV/AIDS Information: A global health and human rights concern* (December 2004)

Fellow South Africans, I am Archbishop Desmond Tutu. Our great nation faces a terrible challenge with HIV and AIDS spreading so fast. We in the church believe that sex should only take place within marriage. However, for those of you who do practice sex outside of marriage, I encourage you to take the right precautions and practice safer sex. Please use condoms.<sup>34</sup>

- The Most Revd Dr. Desmond Tutu

Primate of the Church of the Province of Southern Africa

In Morocco, a project with the Ministry of Islamic Affairs aims to transform Imams into major actors in the fight against AIDS.<sup>35</sup> This includes a training/mobilizing plan for 30,000 Moroccan Imams. This initiative came out of the Regional Cairo Colloquium for Religious Leaders in Response to HIV/AIDS, which involved 80 top Muslim and Christian Arab religious leaders. These leaders produced a progressive – and somewhat revolutionary – declaration.<sup>36</sup>

In Nigeria, a new curriculum for comprehensive sex education has been introduced, developed in consultation with religious and community leaders.<sup>37</sup> While

the previous nationally-approved curriculum for HIV prevention included condom information as part of comprehensive education strategies, this curriculum was rarely taught. In fact, local government – bowing to religious pressure – blocked its implementation.<sup>38</sup>

In Mozambique, a project involving local Catholic priests and nuns promoted safer sex among married couples. Couple counseling focused on pleasure facilitated better communication between married couples and encouraged them to talk more openly about their likes and dislikes about sex.<sup>39</sup>

## Recommendations for community sector advocacy

- Advocate for religious leaders to promote a more comprehensive prevention approach that includes the right of people to access complete, accurate, evidence-based information about HIV prevention, including sexuality and life skills education and condom use.

<sup>34</sup> UNAIDS and PSI, *Social marketing: Expanding access to essential products and services to prevent HIV/AIDS and to limit the impact of the epidemic* (2000).

<sup>35</sup> Morocco UNGASS Report

<sup>36</sup> Network of Arab Religious Leaders Responding to AIDS (CHAHAMA) *The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic* (2004).

<sup>37</sup> Nigeria UNGASS Report

<sup>38</sup> Human Rights Watch, *Access to condoms and HIV/AIDS information: A Global health and human rights concern* (2004).

<sup>39</sup> Anne Philpott, et al., *Pleasure and Prevention: When Good Sex Is Safer sex*, *Reproductive Health Matters*, Vol 14, No.28 (Nov 2006).



### Barrier 1.3:

#### Personal beliefs and pleasure

Lack of understanding about HIV—including misperceptions of risk—impedes condom promotion efforts. Research has shown that condom use is lowest amongst married partners, who tend to trust their regular partner, and young people who may feel invincible from disease.<sup>40</sup> The rates of condom use are even lower among women and men in the general population who have not been exposed to condom promotion. This data also shows that men are generally less willing to use condoms with their long-term partners than they are with casual partners or paid sex partners.<sup>41</sup>

In most cultures, a ‘real man’ is defined by his sexual conquests. Some men consider sex to be their right, and pleasure an obvious by-product of sexual relations. Across the world, however, concern exists—primarily among men—about whether condoms reduce the sensation and enjoyment of sex, and affect sexual performance. Men in multiple contexts compare wearing a condom to “taking a bath with your boots on” or “smelling a rose through a gas mask”.<sup>42</sup> Social pressures on men to enjoy sex or prove their masculinity may impede condom use, even in high-risk situations. In Nigeria, for

example, low levels of condom use among sex workers stems from a lack of acceptance by male clients,<sup>43</sup> based on their personal beliefs.

Pursuit of pleasure is an important reason that people have sex. Growing evidence exists that associating pleasure with male and female condoms increases their use.<sup>44</sup> Conversely, emphasis on disease and the negative potential outcomes of sex may limit the effectiveness of prevention and condom promotion.<sup>45</sup> Focusing on positive approaches and eroticizing condom use is therefore a means for overcoming concerns of pleasure and performance.

Social marketing efforts can capitalize on these opportunities. Packaging condoms along with lubricant to diminish friction and discomfort, and promoting condoms along with other kinds of erotic accessories are only a few of the means that have been used to boost condom sales. In Mongolia, for example, the Lady Trust brand of female condoms, explicitly marketed to increase male and female pleasure, experienced high sales growth.<sup>46</sup>

Another strategy used to promote condom use is using entertainment while educating. Examples include radio and TV shows, street and music festivals,<sup>47</sup> art and performance.<sup>48</sup> Most of these are targeted to youth and have messages on HIV prevention, particularly condom use.

<sup>40</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>41</sup> Global Campaign for Microbicides, *Addressing Questions and Common Misperceptions about Microbicide Clinical Trials* (Fact Sheet #18) (undated)

<sup>42</sup> International HIV/AIDS Alliance, Reproductive Health Matters, *Emerging Issues: Condom Policy and Programming* (2006)

<sup>43</sup> Nigeria UNGASS Report

<sup>44</sup> Anne Philpott, *Promoting protection and pleasure: amplifying the effectiveness of barriers against sexually transmitted infections and pregnancy*, 368 *The Lancet*

<sup>45</sup> *Ibid*

<sup>46</sup> *Ibid*

<sup>47</sup> For example, 48 Fest, an initiative of the Staying Alive Foundation (<http://eu.staying-alive.org/48fest/index.html>).

<sup>48</sup> The Condom Project [www.thecondomproject.org](http://www.thecondomproject.org)

## Recommendations for community sector advocacy

- Advocate for governments and other stakeholders to implement programs to educate people on condom use in a friendly, non-threatening way. These programs should focus on positive incentives to condom use, particularly on how condoms can enhance the sexual experience and increase pleasure.
- Advocate for governments to develop and implement AIDS plans that strengthen social marketing and the community level provision of condoms and condom counseling, including support for peer education.



## 2 Legal and Policy Barriers

“Countries and donors should remove laws and conditionalities that restrict or criminalize the use or promotion of HIV commodities and services including [...] male and female condoms [...]”<sup>49</sup>

– Community sector advocates, 2006

Culture, religion and personal beliefs about condom use are inextricably linked to country level policies. Such policies reflect traditions and norms, as well as influence them. This section explores barriers to condom use that stem from national policies and laws. These include policies and legislation that ban or restrict condom distribution, that discriminate against those most vulnerable to HIV infection, and that criminalize certain behaviors.

### Barrier 2.1:

#### Legislation and policy on condom availability

In some countries, restrictive measures on condoms are institutionalized as official government policy. In the Philippines, for example, the government refused to supply

condoms to the public sector with national funds, condoms were prohibited from public health clinics, and police actively interfered with condom promotion.<sup>50</sup>

In other countries, government is divided on AIDS policies with one sector undermining the work of the other. In Morocco, for example, staff and beneficiaries working under programs created and supported by the Ministry of Health have been arrested for condom promotion.<sup>51</sup> Even social workers working with at-risk populations have been arrested and accused of “incitement to vice.”<sup>52</sup> In Nepal, MSM and sex workers – the highest risk groups – have been arrested for carrying condoms.<sup>53</sup> In Jamaica, the Ministry of Health has developed specific prevention messages for young people, and women, yet nothing targeting MSM or sex workers.<sup>54</sup>

<sup>49</sup> ICASO, *A Call for Political Leadership: Community Sector recommendations for the UN Political Declaration on HIV/AIDS* (2006)

<sup>50</sup> Human Rights Watch, *Unprotected: sex, condoms and the human right to health* (2004)

<sup>51</sup> Morocco UNGASS Report

<sup>52</sup> Morocco UNGASS Report

<sup>53</sup> Blue Diamond Society, *Monitoring the Implementation of the UNGASS Declaration of Commitment: Nepal Country Report* (2006) [hereinafter Nepal UNGASS Report]

<sup>54</sup> Jamaica UNGASS Report

Even in Canada, a country with universal health care, high standards of living, and an awareness of human rights, some of the most vulnerable populations – youth, Aborigines, small rural communities, refugees, and trafficked women – have limited access to male and female condoms.<sup>55</sup> In Romania, while the government has carried out campaigns for urban youth, out of school youngsters and rural youth are virtually excluded from condom promotion activities.<sup>56</sup> Despite high levels of adolescent sexual activity in Jamaica, health workers cannot freely offer prevention options to youth. Instead, they must balance the best interests of the child with the parent's right of consent.<sup>57</sup>

Prisoners remain another excluded group, often without regular access to condoms. Reports from Honduras to Romania commented on the lack of condom distribution within prisons, and the need for better prevention efforts within jails.<sup>58</sup> In Canada, condoms and lubricant are not available in some provincial prisons, and in many provincial prisons they are not easily or discreetly available.<sup>59</sup> In Morocco, prisoners can only get condoms covertly through their family or wardens, and it is common to hide condoms in basket meals brought by visiting families.<sup>60</sup>

## Recommendations for community sector advocacy

- Advocate for governments to remove laws and conditionalities that restrict and/or criminalize the promotion or use of condoms, including for those most vulnerable to or at risk of HIV infection and in certain settings.



'Khote'/transgender sex workers at a trucking depot  
© The Condom Project

<sup>55</sup> AIDS Calgary Awareness Association, *Monitoring the Implementation of the UNGASS Declaration of Commitment: Canada Country Report (2005)* [hereinafter Canada UNGASS Report]

<sup>56</sup> ARAS, *Monitoring the Implementation of the UNGASS Declaration of Commitment: Romania Country Report (2005)* [hereinafter Romania UNGASS Report]

<sup>57</sup> Jamaica UNGASS Report

<sup>58</sup> ICASO, *Community Monitoring and evaluation of the implementation of the UNGASS Declaration of Commitment on HIV/AIDS (2006)*

<sup>59</sup> Canada UNGASS Report

<sup>60</sup> Morocco UNGASS Report

**Barrier 2.2:**

Marginalization, discrimination and criminalization of vulnerable populations

In 2001, through the Declaration of Commitment on HIV/AIDS<sup>61</sup>, governments pledged to implement measures to eliminate all forms of discrimination against PLHIV and members of groups most vulnerable to HIV. Other international treaties, resolutions, and declarations, and many national legal systems are set up to protect – in theory – the fundamental right to be free from discrimination.



Rodrigo and Carlos, gay rights and HIV activists, LGBTT Pride March, Mexico (2005) © Ave de México

“By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to [...], health care, social and health services, prevention, [...] information and legal protections [...] and develop strategies to combat stigma and social exclusion connected with the epidemic”

– The Declaration of Commitment on HIV/AIDS, 2001 (paragraph 58)

However, there remains a huge gap between what exists on paper on anti-discrimination policy and law and what happens in reality. Reports abound of discrimination in service provision, especially against the most marginalized, including sex workers, men who have sex with men, and injecting drug users (IDU)

who have a higher risk and vulnerability to HIV infection, as well as against people living with HIV.<sup>62</sup> Lack of protections against discrimination by some health and HIV prevention workers poses one of the biggest barriers to the provision and access to services and commodities (including condoms) for these populations.

<sup>61</sup> United Nations General Assembly Special Session on HIV/AIDS, *Declaration of Commitment on HIV/AIDS*, adopted June 27, 2001

<sup>62</sup> UNAIDS, *2006 Report on the global AIDS Epidemic* (May 2006)

Making things worse is the fact that morality and social norms dictate that certain behaviors or professions need to be criminalized, such as drug use, sex work and same sex sexual relations, particularly between men. For example, while health and social welfare ministers include in their programs to work with marginalized and vulnerable groups, other ministries and levels of government (such as judicial and internal affairs) promote laws that criminalize these behaviors.

In countries where sex work is illegal – sex work remains illegal in most of the 14 countries that were analyzed in the ICASO

study<sup>63</sup> – sex workers have difficulty accessing health services, obtaining a sufficient number of condoms from clinics, or insisting on condom use. Street-based sex workers in particular have little time to negotiate condom use with clients before driving off with them because they fear arrest.<sup>64</sup> In many countries arrest can result in violence and rape. In these environments, police or military personnel should not be given any form of control over sex workers, or other vulnerable groups in prevention and condom promotion programmes [see 100% condom use programs box].

### 100% Condom Use Programs – violations of human rights

One HIV prevention approach that is highly criticized by sex workers for its human rights violations is the 100% Condom Use Program (100% CUP). It is designed as a collaborative program between local authorities and the sex entertainment establishments that aims to reduce sexual transmission of HIV by assuring condom use among sex workers and their clients.<sup>65</sup> However, the 100% CUP was developed without consultation with sex workers and their advocates.<sup>66</sup>

The 100% CUP implemented in Thailand and Cambodia include mechanisms of control over sex workers by armed personnel, including the police and military. Sex workers around the world regularly cite these groups as the most frequent violators of their rights, including forced sex that usually takes place without a condom. While reductions in HIV infection are being identified in the short term, there are concerns by sex worker networks that this approach continues to have negative repercussions for sex workers, increasing their risk to violence and abuse, and therefore to HIV infection.<sup>67</sup>

This program assumes that sex workers have the ability, or even the power, to negotiate condom use, although there have been documented cases of sex workers being beaten because of their position of “no condom – no sex”.<sup>68</sup> This program fails to address likely human rights violations stemming from the role of the police and the military in enforcing the program. It fails to address and protect sex workers who are dismissed from the “establishments” (either because they have an STI, including HIV, or because they did not comply with the 100% CUP). These sex workers often end up in more vulnerable work situations and at higher risk of HIV infection.<sup>69</sup>

<sup>63</sup> ICASO, *Community Monitoring and evaluation of the implementation of the UNGASS Declaration of Commitment on HIV/AIDS* (2006)

<sup>64</sup> Business Day, Johannesburg. *Old Law a Curse on South Africa's Sex workers*, March 3, 2006

<sup>65</sup> Wiwat R., *The 100% condom use programme in Asia*, Reproductive Health Matters, Vol 14, No.28 (Nov 2006).

<sup>66</sup> Lof, B., Over C., and Longo, P., *Can health programmes lead to mistreatment of sex workers?* 361 *The Lancet* 1982 (2003)

<sup>67</sup> Ibid

<sup>68</sup> Business Day, Johannesburg. *Old Law a Curse on South Africa's Sex workers*, March 3, 2006

<sup>69</sup> Ibid

More efforts are needed to empower sex workers – and other marginalized groups – to negotiate condom use and perform safer sex. This includes training to simulate risky acts, to promote non-penetrative alternatives, and to eroticize condoms. Other methods of condom promotion

without violating human rights or decreasing the earnings of sex workers (and thereby forcing sex workers to pursue more clients) are recommended for everyone, including clients of sex workers, managers and go-betweens, as well as sex workers themselves.<sup>70</sup>

## Recommendations

for community sector advocacy

- Advocate for governments to review, implement, and adopt additional legislation and policies and establish effective enforcement mechanisms to support gender equality and non-discrimination of those most at risk and vulnerable. This includes people living with HIV, women, youth, men who have sex with men, sex workers, injection drug users, transgender, prisoners and migrants<sup>71</sup>.
- Advocate for governments to “know their epidemic” to ensure that they design programs that will be most effective,<sup>72</sup> including providing condoms and information about their use to those most at risk of HIV infection.
- Advocate for governments to remove laws that criminalize certain behaviors or work, such as same sex relations, drug use and sex work.
- Advocate for governments to ensure that legal and policy protections are extended to outreach workers and advocates, to prevent them from being detained and/or harassed for distributing condoms or providing prevention information.
- Advocate for governments and donors to provide financial support to encourage the involvement of those most at risk and vulnerable in the design of prevention strategies, outreach programs and condom and lubricant promotion and distribution.



### Economic and Financial Barriers

Condom use is one of the least expensive, most cost-effective methods for preventing HIV. In addition, HIV infections averted now save millions of dollars spent later on treatment, lost productivity, and lives. Yet cost continues to be a major barrier to

accessing condoms. Many governments have consistently failed to keep condom prices affordable through the imposition of taxes and a lack of investment in social marketing. This lack of support has also been affected by the financial influence of some international donors imposing ideologically motivated restrictions on condom promotion.

<sup>70</sup> Deanna Kerrigan, et al., *Environmental-Structural Interventions to Reduce HIV/STI Risk Among Female Sex Workers in the Dominican Republic*, 96 *American Journal of Public Health* (2006)

<sup>71</sup> ICASO, *A Call for Political Leadership: Community Sector Recommendations for the UN Political Declaration on HIV/AIDS* (2006)

<sup>72</sup> UNAIDS, *Practical Guidelines for Intensifying HIV prevention*, (2006)



Condom dress by Adriana Bertini, AIDS 2004  
© ICASO

### Barrier 3.1:

#### Taxes, economic restrictions, and cost

Taxes and tariffs on imported or even locally manufactured condoms or on the raw materials needed for their production cause the price of condoms to rise in some countries. In Ireland, despite current high rates of sexually transmitted infections, condoms are designated as a luxury good, rather than an essential item. They are therefore subject to a 21 percent value-added tax, one of the highest in Europe, that increases their price, and that then constitutes an impediment to their use, particularly among low-income populations.<sup>73</sup>

In Brazil in the early 1990's, high import tariffs on latex (the raw material used for condoms) and multiple taxes at every retail level made condoms extremely

expensive, resulting in low per capita condom use. In recognizing this barrier, a partnership developed between international organisations, manufacturers, importers, the private sector, trade unions, the media, and the public sector on a campaign to eliminate condom taxes and make them more affordable. Their advocacy resulted in the Brazilian government eliminating import tax on imported brands and significantly lowering the price of those locally produced. Condom sales rose from 53 million in 1995 to 300 million in 1998.<sup>74</sup>

Of critical importance is the need to invest in scaling up the social marketing of condoms, making them available and affordable to low-income people.<sup>75</sup> This is particularly true for female condoms, where limited awareness and demand is keeping costs high.

[see the female condom box]

<sup>73</sup> Gay HIV Strategies - Gay and Lesbian Equality Network (GLEN) and Health and Development Networks, *Monitoring the Implementation of the UNGASS Declaration of Commitment: Ireland Country Report* (2006) [hereinafter Ireland UNGASS Report]

<sup>74</sup> FHI, *Involving the Private Sector in HIV Prevention in Brazil* (undated)

<sup>75</sup> UNAIDS and PSI, *Social marketing: Expanding access to essential products and services to prevent HIV/AIDS and to limit the impact of the epidemic* (2000).

## The Female Condom – high cost and limited marketing

Cost still remains the principle barrier to female condom use and access in most countries.<sup>76</sup> Even when available in limited quantities, as in Peru and parts of Indonesia, the price of the female condom is often so high as to make it inaccessible to most of the population.<sup>77</sup> Female condoms universally cost more than male condoms, often significantly more than the average person can afford. In Peru, for example, the female condom costs around US\$ 8.50, whereas more than half of the Peruvian population live on less than US\$ 2.00 per day.<sup>78</sup>

However, the high price is in part due to limited demand and limited global markets. In 2004, for example, 346 million male condoms were available in South Africa, compared to 2.6 million female condoms.<sup>79</sup> If female condoms were heavily marketed and seen both as a prevention method as well as sexual aids, their desirability and consequently affordability could dramatically increase worldwide.



Peer educator condom demonstration, South Africa  
© Students Partnership Worldwide

Innovative approaches are needed to ensure that the cost of condoms is not a barrier to their use. Market segmentation is one approach, where subsidies can be limited to those in need, using social marketing programs to reach the poor, and the commercial sector catering to

those who can pay more.<sup>80</sup> In Romania, for example, commercial condom brands reach significant market shares while the private sector and NGOs distribute free unbranded condoms in rural and urban areas.<sup>81</sup>

<sup>76</sup> ICASO, *Community Monitoring and evaluation of the implementation of the UNGASS Declaration of Commitment on HIV/AIDS* (2006).

<sup>77</sup> Asociación Vía Libre, *Monitoring the Implementation of the UNGASS Declaration of Commitment: Peru Country Report* (2006) [hereinafter Peru UNGASS Report]. See also Indonesia UNGASS Report.

<sup>78</sup> Peru UNGASS Report

<sup>79</sup> South Africa UNGASS Report

<sup>80</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>81</sup> Romania UNGASS Report



## Recommendations for community sector advocacy

- Advocate for governments to eliminate tariffs and taxes on male and female condoms and other prevention commodities that may increase cost and decrease access to condoms.
- Advocate for manufacturers to reduce the price of female condoms, and for governments and donors to increase funding for the marketing and distribution of female condoms.
- Advocate for increased investment in the development of prevention methods that women can control, including microbicides<sup>82</sup>.

### Barrier 3.2:

#### Influence of donors on condom access

Governments from developing countries have consistently failed to adequately prioritize condom purchase in their budgets.<sup>83</sup> Consequently, in much of the developing world condom availability has been overly dependent upon a small group of bilateral and multilateral donors such as the United States, Germany, the United Kingdom and UNFPA, as well as international organizations such as PSI [see the annual average number of condoms chart].

In 2004 donor governments provided fewer than four male condoms per man per year in the developing world.<sup>84</sup>

This has resulted in a significant under-supply problem. In the year 2000, donors provided support for fewer than one billion condoms to the developing world, only one-eighth of what was needed.<sup>85</sup> In 2002 that figure rose to 3.6 billion, or one-third of estimated condom need. However this increase was only due to one-time contributions from Canada, the Netherlands and the United Kingdom.<sup>86</sup> If donor governments give the same percentage in 2015 as they did in 2002, there will still be a 12.6 billion condom gap.<sup>87</sup>

<sup>82</sup> Microbicides are vaginal products being developed to reduce the transmission of HIV during sexual intercourse. Microbicides could take the form of a gel, cream, film, suppository or sponge, or be contained in a vaginal ring that releases the active ingredient gradually. See the International Partnership for Microbicides: [www.ipm-microbicides.org](http://www.ipm-microbicides.org).

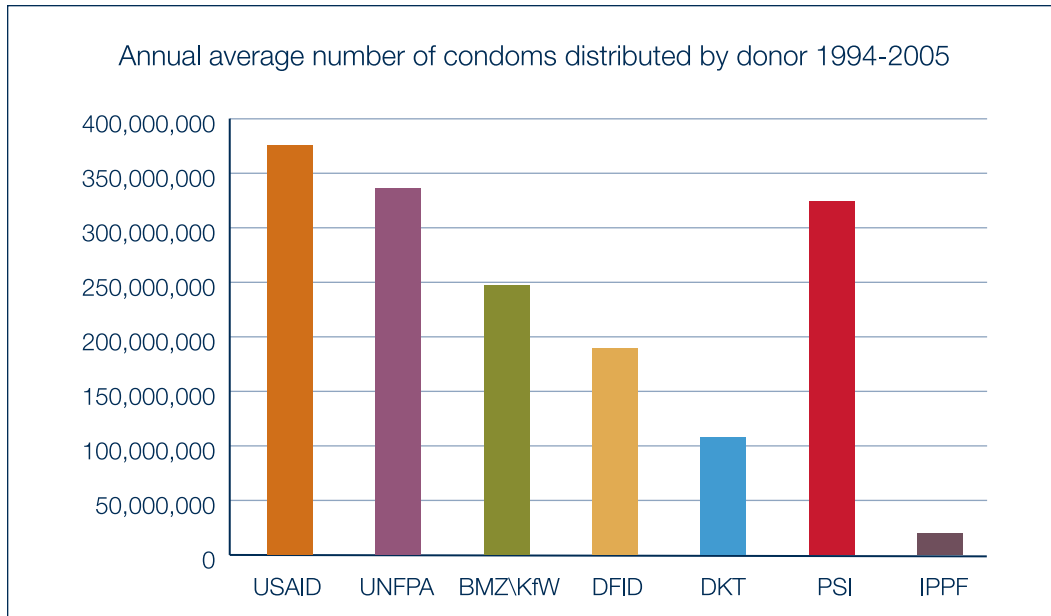
<sup>83</sup> Interact Worldwide, *Condom shortage: counting the cost in lives* (2006).

<sup>84</sup> Ibid

<sup>85</sup> The Supply Initiative, *Access to Condoms and Contraceptives – Vital For the Prevention of HIV* (2005).

<sup>86</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>87</sup> The Supply Initiative, *Access to Condoms and Contraceptives – Vital For the Prevention of HIV* (2005).



(Source: PAI, Condom count 2006 Data Update)

Added to this lack of funding, the reliance on a few donors leaves condom access and availability open to influence by individual donor policies and agendas. This includes the imposition of ideologically-motivated restrictions on condom promotion over evidence-based prevention approaches, violating recognized human rights.<sup>88</sup> For example, while the United States has been the single largest source of condoms for the developing world, recent changes in policies, through the President’s Emergency Program for AIDS Relief (PEPFAR), has seen budget allocations emphasize abstinence and fidelity over condom use.

PEPFAR stipulates that one-third of prevention funding must be spent on abstinence before marriage interventions. It advocates condom promotion only for so called high risk groups such as sex workers, truck drivers and HIV-discordant couples.<sup>89</sup> This approach does not suffi-

ciently recognize marriage as a risk factor or include married couples as a special focus of its programming interventions. By designating certain groups as ‘high risk’, it not only promotes stigma of condom use, but implies that other groups are somehow immune to HIV and do not need access to condoms. Furthermore, its focus on HIV-discordant couples is futile in countries where the majority of people are unaware of their HIV status.

As the largest global health grant ever announced by any donor government, the US\$15 billion HIV/AIDS program provides a huge influx of new resources to countries with significant epidemics, primarily those in sub-Saharan Africa. However, with the current reliance on international funding of condoms, PEPFAR is strongly affecting policies and programming priorities around condom-based prevention.

<sup>88</sup> Committee on Economic, Social and Cultural Rights (CESCR), The Right to the Highest Attainable Standard of Health: CESCR General Comment 14 (22nd Sess., 2000) 04/07/200 E/C 12/2000/4

<sup>89</sup> Center for Health and Gender Equity (CHANGE), *New Analysis Shows U.S. Global AIDS Policy Further Undermining HIV Prevention in Sub-Saharan Africa* (2005).

Some civil society actors and governments have responded to these budget restrictions by changing the direction of their work to abstinence and faithfulness over condom promotion or more comprehensive prevention approaches. In Nigeria, for example, it is evident that

there has been an increasing shift within the prevention budget of the projects supported by PEPFAR to favor abstinence and faithfulness approaches (a shift from 40 percent of the allocation of the 2004 budget to 70 percent in 2005).<sup>90</sup>

## Recommendations

for community sector advocacy

- Advocate for governments to allocate specific lines in national budgets for the purchase of condoms and other health supplies, establishing tracking mechanisms to monitor spending in order to predict and avoid condom shortfalls.
- Advocate for donors to increase their financing of condom purchases, and call on alternative donors to provide funding where existing donors impose ideologically-based restrictions on condom promotion and comprehensive HIV prevention programming.
- Advocate for all donors to remove conditionalities that restrict the use or promotion of condoms and related services.



## 4 Structural Barriers

HIV/AIDS infrastructure can be defined as everything it takes to get prevention, treatment, care and support to the people who need it, including human resources; commodities and supplies; and health, education, and other systems necessary to ensure quality and consistent services.

In relation to condom access, there are some systemic infrastructural barriers that have been identified by community groups. These include lack of quality sex education, complicated condom supply, procurement, and distribution systems, and limited integration between sexual and reproductive health and HIV/AIDS services.

### Barrier 4.1:

#### Availability and quality of sexuality education

Taught properly, sex, health, and life skills education can empower boys and girls to make healthy choices about sexual behaviors, including protecting themselves from HIV. Young people, in particular, may be ignorant about how HIV is transmitted or underestimate the consequences of acquiring it. In Serbia, 29 percent of young people aged 18-28 think HIV can be transmitted by kissing an HIV positive person, while 28 percent think they can be infected through mosquito bites.<sup>91</sup> In Canada, approximately 50 percent of students aged 14-15 do not know that there is no cure for AIDS.<sup>92</sup>

<sup>90</sup> Center for Health and Gender Equity (CHANGE), *Risk and Reality: U.S. Funding of HIV Prevention Programs in Nigeria* (2006).

<sup>91</sup> Yugoslav Youth Information center (YYIC), *Monitoring the Implementation of the UNGASS Declaration of Commitment: Serbia and Montenegro Country Report* (2005) [hereinafter Serbia and Montenegro UNGASS Report]

<sup>92</sup> Council of Ministers of Education, Canada, *Canadian Youth, Sexual Health and HIV/AIDS Study: Factors influencing knowledge, attitudes and behaviors* (2002).

In Morocco, while most young people are aware of the existence of HIV/AIDS, their prevention knowledge is extremely limited, even in urban areas. Studies among college students show that less than two-thirds of men and only one-third of women could identify condoms as a means of protection. Knowledge levels amongst uneducated and less-educated young people in Morocco are dramatically lower.<sup>93</sup> A recent international review<sup>94</sup> found that girls who had completed secondary education had a lower risk of HIV infection and practiced safer sex than girls who had only finished primary education.



Condom outreach work with youth, Ethiopia  
© The Condom Project

“By 2005, ensure that at least 90% and by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection [...]”

– The Declaration of Commitment on HIV/AIDS, 2001.

Schools have become the main venue for providing sex education, either integrated into existing curricula or as a stand-alone subject. School-based education on condoms and HIV prevention is especially important because of the changing roles of family and community in providing guidance about sex. For example, whereas the provision of information about sex in Africa used to be formalized as part of “initiation” into adulthood, this information is often now obtained from the media, school, or friends.<sup>95</sup>

However, in a recent study the Policy Project estimated that the percentage of secondary students receiving HIV/AIDS education in 69 countries (middle and low income) was less than 50 percent, even though almost 90 percent of the countries had included HIV/AIDS as part of secondary school curriculum.<sup>96</sup>

In some countries, there is no sex education at all, leaving children without the benefit of information or vulnerable to misinformation about HIV. In other countries

<sup>93</sup> Morocco UNGASS Report

<sup>94</sup> Hargreaves J., et al. (Action Aid International), *Girl power: The impact of girls’ education on HIV and sexual behaviour.* (2005)

<sup>95</sup> Rivers, K, Aggelton, P. *Adolescent Sexuality, Gender and the HIV Epidemic* (undated)

<sup>96</sup> Policy Project, et al., *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003* (2004)

such as Jamaica, information about condoms may be left out of health education programs, in response to complaints from parents or teachers afraid that teaching about condoms itself promotes sex.<sup>97</sup> In India, for example, even in schools where HIV/AIDS information is offered, details of transmission and condom use may be omitted. Frequently, students are not taught that they can get HIV through sexual contact, or how to protect themselves. Rather, the focus of such programs is on parenting, disease, and abstinence.<sup>98</sup>

Condom promotion in Nigerian schools is limited. While the national curriculum for HIV prevention education includes comprehensive education and condom promotion messages, few state governments have adopted and implemented it in their schools.<sup>99</sup> In contrast, Senegal, with its active HIV prevention education campaigns, including in-school sexuality education, maintained one of the lowest HIV prevalence rates in Africa.<sup>100</sup>

## Recommendations for community sector advocacy

- Advocate for governments to review the content of HIV-related curricula in schools and to implement comprehensive, accurate, evidence-based sexuality and reproductive health education, including information about condom use.
- Advocate for governments to scale up efforts to reach those who are not part of the school system, such as street kids or young adults who have finished their education.



"I use, and you?" Campaign to promote condom use among young gay men, Cuernavaca, Mexico © Edgar Marquez Ortega (2006)

<sup>97</sup> Jamaica UNGASS Report

<sup>98</sup> Human Rights Watch, *Access to condoms and HIV/AIDS information: A Global Health and human rights concern* (2004)

<sup>99</sup> *Ibid*

<sup>100</sup> CHANGE, *Barrier Methods For HIV Prevention: Science, Evidence, and Politics in Global AIDS Prevention* (undated)

**Barrier 4.2:**

**Supply and distribution systems**

Condoms move through multiple supply systems before they get to their final point of sale or distribution. From manufacturers to quality control, and from donors to governments and the private sector, condoms are subject to particular standards of storage, logistics, and purchasing. Procurement policies of both donors and developing country governments are often inconsistent and uncoordinated, resulting in wasted resources and inadequate supplies.<sup>101</sup>

Limited distribution systems, particularly in rural areas, constrain their availability and complicate access. In Ireland, for example, prevention information and commodities are primarily available in the urban areas and on the East Coast, while rural areas are poorly served.<sup>102</sup> In Romania, wide differences in condom availability exist by

residence, type of outlet and region of the country. Condoms are widely available in pharmacies and supermarkets (over 80 percent) and service stations (over 60 percent), but are only available in about 40 percent of hotels and only 25 percent of all retail outlets sell them in rural areas.<sup>103</sup>

Diversifying points of distribution can help address issues around condom supply and access, for example, providing free condoms to clients at HIV-treatment and voluntary counseling and testing centers. In addition to providing condoms in health settings and making them available in supermarkets and pharmacies, condoms should be distributed to non-traditional outlets such as hotels, clubs, taxi stands, and by peer educators.<sup>104</sup> In South Africa, community groups recommended supplying condoms in “spaza shops”, informal businesses in township and poorer areas.<sup>105</sup>

**Recommendations**  
for community sector advocacy

- Advocate for governments to improve and streamline condom procurement, purchasing and distribution systems, for both family planning and HIV prevention services.
- Advocate for programmes to make condoms and information about them available in more diverse places where those most at risk and vulnerable to HIV infection meet.

<sup>101</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>102</sup> Ireland UNGASS Report

<sup>103</sup> Romania UNGASS Report

<sup>104</sup> Population Action International, *Condoms count. Meeting the need in the era of HIV/AIDS. The PAI report card* (2002)

<sup>105</sup> South Africa UNGASS Report

### Barrier 4.3:

#### Integration of sexual and reproductive health and HIV/AIDS services

Commitments have been made by the international community to intensify linkages between sexual and reproductive health (SRH) and HIV/AIDS at the policy and program level.<sup>106</sup> Stronger linkages should lead to important public health benefits, such as improved access and uptake of services, particularly for PLHIV, with SRH services specially tailored to their needs, and better support for the use of condoms as dual protection against unwanted pregnancy and sexually transmitted infections, including HIV.

Most HIV infections worldwide are sexually transmitted or are associated with pregnancy, childbirth or breastfeeding.<sup>107</sup> Furthermore, the presence of sexually transmitted infections increases the probability of contracting HIV. Many of the same responses used to address sexual and reproductive health, including condom use, can also be used to address HIV and AIDS.

Better integration of SRH and HIV/AIDS services can help cut costs, increase effectiveness, and better serve client needs. Weak linkages between agencies procuring condoms for HIV prevention and those for family planning increase the inefficiency of procurement systems.

On an operational level, better integration can include coordination to involve SRH services such as family planning or STI diagnosis as part of VCT services, and to ensure male and female condoms are available at all points of service. Pre- and post-test counseling sessions available as part of VCT can support effective condom use, and may reach people who might not use traditional family planning services, such as men and adolescents. VCT services can also make greater use of condom social marketing and free condom distribution as a way to promote demand for their services. Working together and pooling human resources may also be a way to address the shortage of trained counselors promoting condom use.

#### Recommendations for community sector advocacy

- Advocate for AIDS service providers to offer sexual and reproductive health services, such as testing and treatment for STI and counseling about safe pregnancy for PLHIV.
- Advocate for sexual and reproductive health service providers to offer AIDS-related services to their clients, including voluntary HIV counseling and testing, referrals, and condom counseling and supplies.

<sup>106</sup> Examples of these include the *UNAIDS policy position paper on Intensifying HIV Prevention (2006)* and the *Glion Call to Action on Family Planning and HIV/AIDS in women and children (2004)*.

<sup>107</sup> International Planned Parenthood Federation (IPPF), et al., *Sexual and Reproductive Health and HIV/AIDS: A framework for Priority Linkages*, (2005)

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## Next Steps

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Many of the community advocacy recommendations within this Advocacy Briefing are based on existing calls to national governments and the international community from community representatives. As such this document forms part of a broader community mobilisation to ensure that governments, donors and other stakeholders address the fundamental barriers to condom access.

Working together, the community sector needs to ensure that those most at risk and vulnerable to HIV are able to protect themselves, and that governments deliver on their existing commitments to preventing HIV.

ICASO works with community organisations around the world to ensure that these and other community calls for action are delivered upon. If you wish to work with ICASO on condom access advocacy or have suggestions for other recommendations and action, please contact us directly.



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