

Condoms: An International Workshop Presentations



Contents

Overview of the issues	5
Workshop session 1: sexuality and condoms	8-15
Condom interventions and sperm management challenges (Jill Lewis) Explores how gender norms related to masculinity affect men's relationship with condom use, and argues that in order to successfully promote condom use we need to challenge dominant understandings of masculinity.	8
Can safer sex be good sex? Mixing pleasure and prevention... (Anne Philpott and Wendy Knerr) Argues that a focus on sexual pleasure is integral to successful safer sex communication and offers examples of programmes that achieve this.	10
Condoms, sex and sexuality (Juliet Richters) This presentation concludes that we can only tackle some of the problems people experience in using condoms by re-linking condoms with sex and sexuality and promoting sex-positive social acceptance of condoms.	12
Workshop session 2: condoms and young people	16-24
Working with young people in Zambia (Vincent Mwale) Describes the effects that the President's Emergency Plan for AIDS Relief (PEPFAR) policy is having on a sexual and reproductive health (SRH) and rights programme for HIV prevention with young people in Zambia.	16
The Mpondombili Project: preventing HIV and pregnancy among rural South African school-going adolescents (Abigail Harrison) Outlines evidence from a South African research project that studied young people's attitudes towards and use of condoms.	18
Young People We Care (YPWC), Zimbabwe: with adequate support, young people can make good choices about sex (Lovemore Magwere) Describes a project which links HIV prevention and HIV/AIDS care, and shows that young people can make informed decisions about sex and reduce unplanned pregnancy and sexually transmitted infection (STI) rates.	20
Argentina: promoting the use of condoms among young people (Maria Eugenia Miranda) Outlines campaigns organised and planned by the National Network of Adolescents to raise awareness of male and especially female condoms.	22
Workshop session 3: positive prevention	25-28
Prevention strategies for people living with HIV/AIDS (positive prevention): some basics, comments and the experience in Ecuador (Javier Hourcade Bellocq) Overview of positive prevention strategies and an example from the Frontiers Prevention Project in Ecuador.	25
Workshop session 4: key populations	29-39

Condom promotion for sex workers (Melissa Ditmore) Outlines some of the barriers to condom use by sex workers, including US policy and condom shortages.	29
100% Condom Use Programme for sex workers in Asia (Wiwat Rojanapithayakorn) Describes the 100% Condom Use Programme (100% CUP) pioneered in Thailand and other Asian countries and its effects in reducing HIV incidence.	31
Condoms and sex workers: Aviele, Oluku and Ugbague communities in Edo State, Nigeria (Christabel Ene Unobe) An overview of three interventions with sex workers in communities in Nigeria which focused on awareness raising and capacity building.	32
Promoting condoms to men who have sex with men in Brazil (Craig Darden) Outlines how social marketing of a brand of condom to men who have sex with men in Brazil was developed with the collaboration of the target market.	33
Promoting condom usage at the grassroots: Badagry, a border town experience (Femi Aina Fasinu) Outlines some of the strategies utilised for condom promotion in a Nigerian border town where tourism and migration were linked with unsafe sex.	35
Condom and safe sex promotion for drug users' communities (Catalina Iliuta) Explores the role of condoms and comprehensive information on sexual transmission in interventions for drug users in Romania.	37
Workshop session 5: dual protection, condoms and family planning services	40-44
Dual protection: more needed than practised or understood (Marge Berer) Explores the concepts of dual protection and the growing use of condoms and emergency contraception by young people, through an analysis of available research literature.	40
Trends in protective behaviour among young African women (John Cleland) Analyses data from 18 Demographic and Health Surveys from Africa that show a stable level of sexual activity and increasing condom use in young, single women, including for contraception.	42
Condoms in Paraguay: some strategies for their better promotion (Ariel Gonzalez Galeano) Provides an overview of how young people currently access condoms in Paraguay, explains some barriers to condom use and makes suggestions for future condom promotion	43
Workshop session 6: scaling up condom promotion and social marketing	45-48
Fiesta: development of youth condom in Indonesia (Christopher Purdy) Outlines DKT's programme of social marketing of condoms designed to appeal to young people in Indonesia.	45
100% Condom Use Programme combined with STI services for female sex workers in Cambodia (Vichea Ouk, François Crabbé) Describes the successes and challenges of Cambodia's adoption of the 100% CUP programme.	46
Social marketing and scaling up condom promotion (Shyama Prassana Bose) Describes a successful condom social marketing scheme in Ethiopia.	47

Workshop session 7: condom promotion at programme and community level	49-52
Empathy – the missing ingredient (Sunanda Ray) Explores the World Health Organization (WHO) consultation on the re-use of female condoms, making the point that policy strategies that are formulated without empathy are seldom effective.	49
AB?DE (Svenn Grant) Outlines the work of the YMCA and others during carnival in Jamaica to market condoms to young people using popular culture.	50
Condoms and sexual and reproductive health programmes: good bed partners? (Doortje Braeken) Looks at the ways in which the International Planned Parenthood Federation (IPPF) has approached condom programming with young people, highlighting the importance of youth involvement.	51
Workshop session 8: enabling policies and anti-condom policies	53-57
Enabling condom use (Sandra MacDonagh) This presentation outlines the strategy of the UK Department for International Development (DfID) to make condoms more available in developing countries.	53
Engaging with PEPFAR – abstinence, fidelity and young people (Gill Gordon) Addresses whether it is possible to use PEPFAR ABY funds well for HIV prevention with young people and how to limit negative impacts of this funding.	54
U.S. policy, ideology and the HIV epidemic: undermining effective prevention strategies (Jodi Jacobson) This presentation analyses the PEPFAR policy and the way in which it is implemented in practice.	56
Points for participants to consider in their future work	58
Annex 1: participant list	60
Annex 2: Useful Resources suggested by participants	63
Annex 3: Abbreviations	66

Overview of the issues

As the introductory presentation, from Joseph O'Reilly of the Alliance, made clear, condoms have a long history. The first evidence of condom use dates back to around 1000 BC when the ancient Egyptians used a linen sheath for protection against disease. In Europe the syphilis epidemic that spread across the continent gave rise to the first published account of the condom. Later in the 1500s, one of the first improvements to the condom was made, when the linen cloth sheaths were sometimes soaked in a chemical solution and then allowed to dry prior to use. These were the first condoms with spermicides. In the 1800s condom manufacturing was revolutionised by the discovery of rubber vulcanisation by Goodyear (founder of the tyre company) and Hancock. During the 1900s the quality of condoms improved with innovations in manufacturing technology. The female condom was made available in Europe in 1992 and it was approved in 1993 by the US Food and Drug Administration. In recent years, improved expertise in condom production has enabled the thickness of the condom to decrease, and allowed for variations in size, colour, shape and taste.

Why hold this meeting on condoms now?

The first reason to turn our attention to condoms now is the effect of the HIV/AIDS pandemic, which is currently the third leading killer worldwide. Although there are various routes of transmission, the vast majority of people contract the virus sexually. The condom remains the only technology available for protection from the sexual acquisition of HIV. Condoms save lives. Furthermore condoms help prevent other sexually transmitted infections which also cause ill health, including those that trigger cervical cancer, and can kill. Condoms also prevent unwanted pregnancies and the complications that arise from them.

Secondly, although demand for condoms is rising, we are still not making enough condoms available to meet this demand, let alone supplying enough condoms at reasonable cost for all those who need them. The United Nations Population Fund (UNFPA), Population Action International (PAI) and others have described this as the 'Condom Gap'. Of the 8 billion condoms needed in 2000, donors provided just 950 million. UNFPA estimates that these 8 billion condoms would have cost \$239 million. In 2000, donors spent only \$46 million which provided 950 million condoms. What is more, these figures represent only the cost of the condoms themselves; they don't include the cost of distribution, communication for behaviour change, or other services. Investments in these areas would have increased the cost to at least \$1.2 billion. Other obstacles to meeting demand include: the lack of coherent policy across contraceptive and HIV programming, erratic levels of funding, reporting difficulties, absence of a global mechanism for coordination among donors and with recipient country governments, and reliance on too few donors.

Thirdly, the condom is losing popularity among some international policy makers, financiers of the HIV/AIDS response, and sexual and reproductive health programmes. To some extent this is nothing new; support for condoms has always waxed and waned. There remain many influential states which have never favoured or funded condom provision. The US government is the single largest source of condoms for the developing world but in recent years changes in their HIV/AIDS related policy have meant that condoms are no longer afforded the prominence that they once were and strategies such as abstinence and mutual monogamy are being promoted in their place for some populations vulnerable to HIV/AIDS. There is an urgent need to diversify donor commitment as well as governmental, social marketing and commercial involvement in filling the condom gap, not just because we need more support for condom supply and programming, but also because the extent of US support gives its condom policy a great deal of influence on how other stakeholders, including recipient governments, work.

Support for condoms from some national governments is also decreasing, despite the fact that governments infringe the right to health when they limit people's access to contraceptives, or censor, withhold or intentionally misrepresent public health information. Government actions that limit effective access to condoms include:

- restrictive measures and legislation on the public distribution of condoms
- prohibition of information on condoms for young people and in schools
- prohibition of the free distribution of condoms anywhere
- taxes and tariffs on imported or even locally manufactured condoms or on the raw materials needed for their production
- procurement policies which prevent suppliers buying condoms at the cheapest available price
- stigmatisation, and at times criminalisation, of marginalised and at risk groups, which hinders condom promotion and use.

Finally, although we know condoms to be an effective method of preventing the sexual transmission of HIV, and an effective contraceptive, too few people use condoms correctly and consistently. Reasons for this include the fact that despite HIV/AIDS epidemics at crisis level, awareness and knowledge of the disease remains low. Whilst people perceive themselves at low risk of HIV infection, they will not use condoms. Other barriers to use include:

- norms of sexual behaviour and gender inequalities that make it difficult to negotiate condom use
- concerns, especially among non-users, that condoms will reduce sexual pleasure and affect sexual performance
- common misinformation about condom effectiveness .

Clearly a range of actions are needed to overcome some of these barriers to condom use. The aim of the workshop was to explore positive examples of condom promotion and the benefits of condom use from around the world.

Discussion following the introductory session:

Participants felt that it was important to make a distinction between demand and need, and to use the figures that we have accordingly. Given the crisis levels of HIV infection in many countries, we need to stimulate demand through better understanding of risk. Perhaps instead of talking about need, we should refer to 'latent demand'. Other participants stressed the role of the private sector in stimulating and meeting demand, as many of the figures commonly used tend to ignore the private sector and focus on donor responsibility. One of the barriers to demand is poverty, and participants pointed out the economic constraints to condom acquisition and use.

Another barrier to successful condom use identified by participants was the effect of culture and religion. For example in Zimbabwe, a largely Christian country, pastors are preaching abstinence for young people and the sinfulness of sex before marriage. This is a disincentive to providing education and commodities for safer sex.

An additional barrier to condom use is the way in which condom promotion projects are designed, which often leaves some at risk groups excluded. Examples of this are programmes which are developed in big urban cities, or that concentrate on schools and ignore out of school youth.

Workshop session 1: sexuality and condoms

Condom interventions and sperm management challenges

Jill Lewis, Hampshire College, USA

Condom use is often presented as a strategy or technique which you just have to understand and implement. The assumption is that when a person knows what condoms are, and has basic information about how to use them, condom use should fall into place. However, heterosexual men's relationship to condom use is influenced by gender roles.

Men have to organise their bodies, minds and emotions for male condom use to happen successfully. Most traditional gender systems have evolved with clear contrasts between the role and perception of men and women. These contrasts allocate power differently, and are value-laden and hierarchical. Boys and men feel they have to prove the legitimacy of masculine status by prioritising certain kinds of behaviour and attitudes over others.

The fear of losing status and risking humiliation are embedded within the sense of self that the boy acquires within the gender system of his culture. Certain learned and socially enforced behaviours surface cross-culturally. This can be seen in HIV prevention workshops in many different countries and cultures. When asked the question, "what expectations, pressures, vulnerabilities and difficulties must a boy baby here navigate to become a man?" very similar answers are given. Examples of these include:

- boys don't cry or show weak emotions
- boys must be tough, assertive, strong, play rough, and show bravado
- boys must be aggressive, play with guns and trucks, take risks, show leadership, and be in control
- boys must meet expectations, be self reliant, and have money
- boys must know about sex, be experienced, have relationships with girls, be fertile and have financial responsibility for women and children.

Showing a sense of inadequacy, loss of control or asking for help are to be avoided at all costs. If you do not avoid them you risk being demoted or marginalised. Being willing to be wrong or admit ignorance, being nervous, scared or embarrassed is risky.

In uncontested traditional gender systems, the prevailing forms of masculinity are not well-suited to condom use. If traditional gender norms are left unchallenged, condom use will be undermined and invalidated. If men are not able to question gender norms and behaviours, then the question of condom use can create

hesitation, anxiety, resentment, uncertainty and potential humiliation.

There are many things people do that may compromise the ultimate experience and could be seen as unnatural where behaviours are socially useful or agreed, for example wearing clothes or holding down a day job. However the naturalness of male sexuality is invoked to avoid discussion of sexual practices. Men in Latvia, Estonia, England, Norway, Sierra Leone, Liberia, many of whom have never used a condom, suggest that using a condom is like “smelling a rose through a gas mask”, “having a bath with your boots on”, or “eating candy through a wrapper”.

The strength of men’s sexual need is used to argue against condom use. In Kalemie, in Congo, the men I worked with believed that if men didn’t regularly inject sperm into women’s bodies they would go insane. In Monrovia, the men in the group maintained that for women to have pleasure, the man’s juices needed to blend with those of the woman. In Azerbaijan the group identified 36 reasons why people have sex, but argued that whatever the reason, a man has to do what a man has to do – and condoms risk puncturing his dignity, his control and his authority. In Norway medical students argued that the size of the ‘male gland’ required more action than the smaller organ of the woman. Some religions insist on non-condom sex in intractable terms of god and sacredness.

There are two strategies needed to establish and deepen safer sex through condom use within HIV prevention.

1. We must radically interrogate gender norms, using ways in which both men and women can engage. This will enable collaboration in shared understandings of shifted gender expectations and associations, and an understanding of the cost and damage of not setting this process in motion.
2. We need to start an informed discussion about cultural beliefs surrounding male sexuality, including performance and pleasure. This will ensure that men can engage in sexual activities without feeling the need to get it right and fearing losing face if things don’t happen in the way that is culturally proscribed. If we don’t, condom use will remain difficult and a potential source of anger and frustration for men.

Can safer sex be good sex? Mixing pleasure and prevention...

Anne Philpott and Wendy Knerr, The Pleasure Project/DfID, UK

Currently sex education is rarely sexy and erotica is rarely safe. There is a need to put the sexy back into safer sex, and doing so is a key way to promote condom use. The safer sex and HIV 'industry' avoid discussions about sexual desire and pleasure. Yet public health campaigns that focus on disease have had limited impact. There is evidence that promoting pleasure with safer sex messaging can have a positive impact and increase the uptake of safer sex. Conversely the pleasure industry avoids discussion of safer sex; few erotic films and resources feature condom use and non-penetrative pleasurable sex as a norm.

As a result, the Pleasure Project aims to promote sex education with the emphasis on 'sex', not 'education'. To this end it builds bridges between the pleasure/sex industry and the safer sex world by ensuring that erotic materials include discussions of safer sex, and that sexual health and training materials include pleasure as a key element. Pleasure and sexiness are often culturally specific, so we need to reflect reality in the techniques and tools that are used; messages and commodities need to be shaped to meet the needs of particular communities.

The Pleasure Project has conducted a global mapping exercise to increase understanding of the work that is already happening which includes sexual pleasure; the results of this can be found on their website. They found 27 programmes from Africa, Asia, Latin America and Europe that integrated the two concepts. Activities included sex-positive information, education and communication (IEC) materials, erotica for HIV positive people, safe erotic films and materials aimed at young people.

A Family Health International (FHI) study in Kenya discovered that male condoms were not used because they 'diminish pleasure'; emphasising disease reinforces this belief. In order to overcome this barrier, effective condom promotion must address masculine sexuality, pleasure and emotion. A number of the programmes concentrated on eroticising male condoms. Examples include:

- In Jamaica, randomised controlled trials found that the acceptability of male condoms improved when the choice offered included more "pleasure-focused condoms".
- The studded condom is marketed in Uganda, with annual sales of 12 million.

The joint packaging of condoms and lubricant has also been a successful strategy. In Cambodia there was a huge demand and need for water-based

lubricant among men who have sex with men. Similarly, sex workers reported that multiple and rapid sex acts, lack of stimulation and depression led to vaginal dryness. In a PSI study it was shown that condom use was avoided because of discomfort; they decided to package condoms and lubricant together using an established brand. These were marketed as making sex safer and more pleasurable by minimising condom breakage and reducing friction. Sales of the product exceeded expectations and are steadily increasing.

There have been various efforts to eroticise the female condom, for example in Senegal, the Society for Women Against AIDS in Africa (SWAA) marketed the female condom alongside Bine Bine beads (beads that are worn around the woman's waist and make an erotic sound during sex). The main selling point was that the sound of Bine Bine beads is similar to the sound that female condoms make during intercourse; noise was used as an arousal point. A similar noise-related strategy was used in India, with the message that 'it only makes noise when you give good strokes'. In this way use of the female condom was related to pleasure. In Madagascar women told FHI that use of the female condom was leading to 'strange water in their vaginas', evidence of the arousal thought to be caused by the outer ring of the condom touching the clitoris.

Female condoms have also been used as a signifier of femininity. The Sambhavana Trust, in India, reported that transsexual hijras were using female condoms (anally) as proof of their femininity as the receptive partner. Others have spoken of the joy of inserting the female condom for both partners. Sex workers reported charging more money for sex with a female condom where its appearance was described as "beautiful as a blooming Lotus flower", and there have been reports from India of women having an orgasm during self-insertion.

Men have also reported that the female condom can increase their sexual pleasure. In Zambia, Zimbabwe and Ghana the tapping of the ring on the penis has been said to be arousing, and in Ghana SWAA have heard of men using condom inner rings to masturbate in the absence of a partner. For some this has been a successful marketing strategy. In Mongolia the 'Lady Trust' brand was marketed to enhance male and female pleasure with explicit package inserts. They hit their first year sales projection in just 6 months.

Further research is needed in this area. A PubMed search on 'pleasure' and 'safer sex' only produced 19 articles in Jan 2006. To facilitate more work on safer sex and pleasure there is a need to know the social contexts in which the pleasure approach is successful, whether there are any adverse impacts, whether it could lead to more discrimination, the most effective forms of marketing and whether it is cost effective.

Condoms, sex and sexuality

Juliet Richters, National Centre in HIV Social Research, Australia

Part of the problem with condoms is that they are connected with sex. Before the age of HIV/AIDS and the pill they were men's business – historically they were sold by barbers and issued to servicemen to prevent STIs. As a result their early association was with illicit sex and they were considered smutty. In the clinical context, condoms have been desexualised and are not sexy. This is reflected in the way that they are depicted visually – they are generally not shown on the erect penis for fear of causing distress.

The health promotion model of condom promotion assumes the potential condom user is a rational actor avoiding risk. It assumes the person perceives risk and as a result has the desire to change risky behaviour. It presupposes that if a person has knowledge, a positive attitude and skills this will lead to the intention to change behaviour, and the capacity to do so. The end result is individual behaviour change.

There are many problems associated with this model. Sex is not necessarily rational, and it is not clear how much attitudes matter and the extent to which they can be changed. In addition context may be more important than individual intention. Fear of dying is not something that is necessarily a deterrent to having sex. The fear of rejection may be more important than concerns about long-term consequences, and sexual arousal may lead to irrational optimism.

Issues such as performance anxiety, fear of rejection, loss of arousal, insecurity about penis size and erection loss can prevent condom use. In-depth research has shown this is a serious issue for some men, and fear of loss of erection can lead to condom avoidance. Amongst young heterosexuals there is a perception that condoms are unromantic. There are also myths propagated about condom use, for example that dominant men take the decision to have sex without a condom, when the reality is that many women also want sex without a condom. Condom promotion implies penetrative sex, which makes it harder to promote non-penetrative sex. Because condoms are used during sex, their discussion is more difficult than discussion of antiretroviral drugs or vaccines. It may make authorities anxious, which can prevent open discussion or promotion in schools, prisons etc.

When we engage in condom promotion we need to talk about who needs to use condoms, and incorporate discussions about when it is ok to stop using condoms. Health promotion should retain human sympathy for sexual 'otherness'. Calm sex-positive public discourse about sexual health is a prerequisite for effective condom promotion, and governments should lead in

promoting 'sexual multi-culturalism', sexual tolerance and pluralism.

Discussion following the presentations:

Participants discussed ways of eroticising condom use and addressing barriers such as erection loss. Strategies suggested included:

- Incorporate condoms into love-making by getting your partner to put the condom on you (although this could create an opportunity for rejection).
- Practise condom use alone before being in a sexual situation

The contradiction between sexual pleasure and sexual anxiety was discussed. The marketing of sexual pleasure may limit spaces for discussion about the fact that people do not like sex and have sex for myriad reasons including survival, revenge, and because they are forced.

Anne Philpott responded that we should talk about the contexts of pleasure, to understand when a pleasure approach is appropriate and to appreciate that it may not be appropriate if people aren't happy with their sexual relations. Anne also pointed out that pleasure may be a way of negotiating safer sex, even if your primary reason for sex is not pleasure.

The social pressures attached to liking or not liking sex were raised. Many people experience un-pleasurable sex because they are not supposed to like it – this is something that we can change. We need to move beyond the protection of women from abuse to understanding that women desire sex and what this means for sexual rights policy. The evangelical right have used norms of masculinity to put women in their place regarding sex – we need to bear this in mind when we talk about masculinity.

It was pointed out that the women's rights discourse did not create a place where men could work collaboratively to change the gender system. As a result there is an entry point for evangelical approaches which should be addressed.

Participants suggested that we need to use a variety of approaches to condom promotion. For example, in Southern Africa female condoms were marketed as a form of protection and care which is very different from the way that they are positioned in Anne's presentation. This was a successful strategy and it emphasises the fact that marketing approaches should be context-driven. The caring, protection approach is not useful for young men, because they are pushed by other masculine norms to be risk takers.

Whether you are allowed to have pleasure may also be culturally mediated. Women in southern Africa are avoiding menopause through hormonal intervention, because the onset of menopause is associated with stopping sex

and the husband looking elsewhere for sexual partners.

One participant considered Jill Lewis's presentation overly pessimistic, suggesting that we do not need to have a gender revolution for people to use condoms. For example, in South Africa condom use is rising rapidly amongst young men and women yet gender norms are very strictly prescribed.

Jill countered that if we want to anchor condom use and bring men on board we have to challenge these norms. It allows for a discourse of diversity and the different strategies that you can use to promote condom use. Older men are not always more confident about their gender role and this may be a reason for their relationships with younger women.

One participant pointed out that most people will get their education about condoms through a 30 second TV advertisement. There is an urgent need to take all of these complex ideas and translate them into quick and clear messages. It was suggested that TV adverts should be supported using other channels.

An example from Cambodia was given where sex workers do not use condoms when having sex with their boyfriends as opposed to clients. Looked at from the outside this seems irrational; they are at risk and often their partner is not monogamous. However to them condom-less sex means trust and emotional commitment. Some participants were unsurprised by this and suggested that sex workers should be seen as part of the community not adjacent to it; when we do this it is obvious that the problems that they have in negotiating condom use with regular partners are the same as all other women. By making a distinction between sex workers and other people we buy into the split between good girls and whores; this is particularly pertinent in the US setting.

Other participants gave examples from the gay community of condom use with some but not all sexual partners. This strategy is called 'negotiated safety'. However to effectively negotiate safety you have to have a sophisticated understanding of risk, which allows you to make informed decisions. The idea of negotiated safety may not apply to the majority of men who have sex with men and gay men.

It was pointed out that people who are experienced with condoms may not like them. The literature around condoms doesn't tell you what you want to do if you want to change position or stop for a bit. The instructions aren't nuanced and this causes anxiety. Other participants felt that more detailed instructions can in themselves cause anxiety.

It was suggested that we should acknowledge the fact that people pay a lot of money throughout the world for sex. This suggests that people are interested in sexual pleasure, they just don't want to reduce pleasure through condom use. In

Thailand the quality of condoms is quite poor and they are badly lubricated which means that sex is painful; this leads to very high risk sex. By adding more lubricant sex was made more comfortable and breakage rate went down.

As a final point, one participant felt that we need to be mindful of the context in which we are promoting condoms and that many of the more racy images used in some of this promotion would not work in more conservative countries.

Workshop session 2: condoms and young people

Working with young people in Zambia

Vincent Mwale, Young Happy Healthy and Safe, Zambia

Eastern Province, Zambia

- There is a high HIV prevalence rate of 14%.
- Rates in urban areas are twice that of rural areas.
- Prevalence rates in young women are four times higher than young men of the same age.
- Highest prevalence is in women aged 25–34 (24–30%) and men aged 35–39 (23%).
- There is very low prevalence in the 5–14 year old age group.

Young Happy Healthy and Safe work with rural young people in Eastern Province, Zambia. Young people are vulnerable to HIV because they have strong sexual feelings and like sex; however, it is very difficult for them to access condoms. Traditional and cultural norms are changing and poverty is increasing. These norms lead to the marriage of young women to older men, and a need for income has led to increased rates of transactional sex. In addition young people are reaching puberty earlier and marrying later. Some young people are also subject to unwanted sex; they are pressured to be sexually active by elders and peers and they experience sexual abuse.

In order to address these vulnerabilities, the programme has mobilised the community to assess and address the causes of HIV infection; this has been done with the participation of young people. The programme has focused on:

- creating more enabling environments where condoms are freely distributed in urban and rural areas
- facilitating access to full and accurate SRH information and services, including counselling
- gender and youth equity and empowerment through facilitation of interactive sexuality education that includes values, demonstration and practising condom use, and assertiveness and negotiation skills
- working with decision makers within the community such as the Alangizi, the initiation advisors, who have changed their initiation curriculum to include condoms and advocacy work for young people's right to a happy, healthy and safe sexuality.

The programme has been funded by DfID and Comic Relief, and is currently funded by Nuffield and Danida. In addition to the activities outlined above, the current focus is on training teachers to provide SRH information, teaching young people to develop communication skills for negotiating safer sex and creating an enabling environment for young people to be safe from abuse.

Condom promotion and distribution has been a major challenge since PEPFAR programmes began operating in the Province. In the community, PEPFAR has trained a number of peer educators to preach abstinence and discourage condoms. This has been coupled with scholarships and livelihood skills for young people who decide to abstain. They are also influencing changes of policy at different levels. For example, through the Ministry of Youth (which deals with out-of-school young people) and the Ministry of Education, they have put in place a policy which prevents organisations from providing information about condoms in schools, and they have trained teachers not to talk about condoms and to use songs that say that condoms are bad. They have also provided abstinence and fidelity-only IEC materials.

The impact of this work has been increasing levels of stigma against young people who use or ask for condoms, and a reinforcement of local cultural and faith-based limits on prevention choices. There have also been condom shortages in the health system, and services are less likely to provide condoms to young people. As a result it is more difficult for young people to insist on condom use and to access condoms.

To overcome the effects of PEPFAR in Eastern Province, we need to train more peer educators to continue working with young people facilitating interactive education, promoting rights and empowering young people to advocate for implementation of good existing youth policies. We need to freely distribute condoms and teach self esteem and life skills so that young people are able to demand condoms assertively when they need them.

The Mpondombili Project: preventing HIV and pregnancy among rural South African school-going adolescents

Abigail Harrison, Brown University, USA

South Africa

- 10.1% of youth from 15–24 are infected.
- Amongst the 20–24 age group 24.5% of young women are living with HIV and 7.3% of men.
- There is no sign of a decline in HIV prevalence, although youth are reporting increased condom use.
- There has been no change in the reported age at first sex.

The research project worked in rural KwaZulu-Natal Province to study the adolescent lifecourse in the context of HIV/AIDS. The fact that infection rates rise so much in late teenage years shows that the teenage years are a key time for HIV interventions. By the end of the teenage years almost all young people are sexually active.

The project had a qualitative element that sought to capture young people's voices and a secondary emphasis on community and school surveys. The findings of the project fed into the development of intervention programmes. Peer group discussions and serial focus groups were used to capture the information. Groups were made up of both sexually active and abstinent youth, and they covered a series of eight topics related to sexuality and HIV prevention. The advantage of the serial focus groups was that they happen over time, which builds trust and rapport and allows researchers and subjects to create a relationship.

The research found myths and negative attitudes towards condoms but there were also positive responses, for example, "Using a condom is a sign of love and respect". The most encouraging finding was that young people are using condoms: 46.1% at last sex and 72% reported lifetime use.

The research showed that we need to know more about the gender dynamics of use and whether they are changing, and about the consistency of condom use and its dynamics.

Not only is condom use contested but sex itself is contested, and there is a conservative and restrictive environment surrounding sexuality. Young people expressed views like "I know what I am doing is wrong". Also, gender norms interact negatively with sexuality from an early age. Young girls were likely to have hidden relationships, whilst older people looked the other way if young men had sexual relationships and their relationships were positively encouraged by

their peers.

This has implications for HIV prevention. Clandestine relationships hinder prevention as it is difficult to access condoms or negotiate their use when girls are not even able to acknowledge they are having sex. They also create a permissive context for coercion and multiple partnering.

The research found that there were strong adult and community attitudes favouring abstinence, and that local values were intersecting with new global policy perspectives on abstinence. Younger adolescents internalise these attitudes and so abstinence is the preferred prevention strategy, even among sexually active girls. This led to a skewed perspective on prevention. Health workers would say “condoms don’t work” meaning that we need to devise new strategies for HIV prevention, but this would be interpreted as meaning that condoms are faulty. In South Africa the late age of marriage means that abstinence until marriage is unobtainable for many.

Based on their findings the research team designed a culturally appropriate intervention that responds to the needs of youth and their communities: the Mpondombili Project, an intervention for secondary school-based youth. They followed a 15-month participatory development process using youth peer educators and adult role models (teachers and nurses). The youth were in charge, and conducted initial review and feedback on modules. At the end of the process they had devised a 15-session classroom curriculum which aimed to prevent HIV and pregnancy and promote safer sex. It did this by challenging gender role norms and attitudes, teaching communication skills, and assertiveness, reducing stigma and fear around sexuality, and fostering positive norms.

The message focused on dual protection i.e. you should delay sex if you can and want to, and use condoms consistently if sexually active. They felt that delaying first sex is very different from abstinence only, and they have worked hard to counter perceptions that conflate the two. For example, everyone has access to the same information whether they are sexually active or not so that when they do decide to have sex they are properly informed. The programme was aimed at 14–17 year olds and gave them age-appropriate messages using complementary and reinforcing strategies.

Young People We Care (YPWC), Zimbabwe: with adequate support, young people can make good choices about sex

Lovemore Magwere, UNICEF/JSI Europe, Zimbabwe

Zimbabwe

- HIV prevalence is high but declining.
- The average age of sexual debut is 17 years.
- 50% of young people say that they have used condoms.
- There are high rates of orphans, about 1 million due to HIV/AIDS.
- Zimbabwe is a very politically polarised country.

The Young People We Care (YPWC) project links HIV prevention with HIV/AIDS care. 14–24 year olds work alongside home-based care providers; young people's energy is harnessed to aid people living with HIV and AIDS. They are training volunteers around HIV and AIDS throughout Zimbabwe and have been doing so for the past two and a half years with increasing numbers of YPWC clubs. The project is being implemented in towns, rural areas and farming communities and has allowed young people to express views about how they want to live their lives.

A Stepping Stones component will be added to the project from July 2006 to deepen young people's understanding of HIV/AIDS, particularly around gender and sexual abuse, and to empower youth. It is hoped this will complement the existing work of YPWC.

The project is based upon the following good practice:

- Volunteers are seen as role models.
- Staff and volunteers are well-trained in issues such as confidentiality and basic counselling.
- Each YPWC club is supported by a patron who acts as a link between the club and the community.
- The patron must be committed, supported and exemplary as they hold a key role in giving young people legitimacy within the community.
- Parents' (or guardians') trust and support is built, and they are engaged in the work.
- Getting support from the community and stakeholders is key.

YPWC volunteers feel that sex has been depicted as bad (even though they know it is not), and that young people are in need of love and want to be in mutually respectful relationships. They realise the need for a positive environment for this type of relationship in terms of education, employment and community services. In baseline studies marriage was identified third in their list

of goals, after employment and education. Volunteers feel that YPWC has strengthened their communication skills and increased their expectations of relationships.

Volunteers believe that young people need different methods of contraception at different times in their life. Condoms are one method of protecting against HIV and unplanned pregnancy. They provide dual protection against pregnancy, STIs and HIV. YPWC volunteers discuss how to store condoms safely and privately. However young people still worry that they may not be 100% effective and cite barriers to condom use. These include that sex is often spontaneous, it often takes place in inappropriate venues with limited time, they can't be seen to be preparing for sex (which would be the case if they carried condoms) and that because of crowded living arrangements with little privacy it is often difficult to store condoms.

On the basis of experiences gained during the project it is clear that with adequate support and choices, young people can make informed decisions about sex. This helps to reduce unplanned pregnancy (and consequently unsafe abortions), STIs and HIV.

Argentina: promoting the use of condoms among young people

Maria Eugenia Miranda, Youth Coalition

Argentina

- Population is 36 million.
- 27 % of the population (10 million) are young people aged 10 to 24.
- The official religion of Argentina is Catholicism and almost 90% of the population are practicing Catholics.
- In Buenos Aires, HIV/AIDS is the main cause of death among young women between 15 and 29, and 22.6 percent of people with HIV/AIDS are women.
- There are 2.8 men for every infected woman, but the proportion of HIV incidence among women compared to men is growing.
- Transmission from mother to child accounts for 6.7% of all infections; this is a high value compared with other countries in the region..
- 20% of adolescents become pregnant in the first sexual relationship.
- Unplanned pregnancy among young people is rising.
- 100,000 of the 700,000 births annually are to women who are less than 20 years old; about 30% of these are second or third babies.
- Abortion is illegal in Argentina and every year around 600,000 women face an abortion in unsafe and risky situations.

The National Network of Adolescents was created in 1999 and is funded by the Ford Foundation; it is composed of organisations representing the majority of the provinces of the country. They organise national activities coordinated to generate more impact on specific dates in the year, for example, May 28th (International Day of Action for Women's Health), November 25th (International Day of Non-Violence Against Women) and December 1st (World AIDS Day).

The Network has run a condom campaign to raise awareness of the use of male condoms. It was organised with the input of many organisations in the country and was implemented nationally. The campaign was very successful and helped to promote the use of condoms among young people, teach effective condom use, and promote condom use among civil society. Activities included public awareness raising, workshops and a poster competition.

The Network is now focusing on the female condom. The female condom is not well-known or well-distributed in Argentina, although it should be available everywhere according to legislation. Young women's groups are planning to launch a campaign for the promotion of the female condom, on the basis that it is safe and effective, and enables women to protect themselves without depending on the man to use a condom. The campaign will have three main targets: the Ministry of Health, health providers in hospitals and health centres, and young

women around the country.

Workshops on SRH in Argentina are usually conducted by doctors and other health professionals and do not have a gender or youth perspective. The gender perspective is important in addressing cultural norms. Young people are exposed to myths including “you can’t get pregnant during your first sexual relationship”, and they are pressurised into having sex to demonstrate love. There are also difficulties in terms of supply of condoms, which are mostly available through medical centres although distribution would work better if they were available in places that young people use, for example, bars.

Discussion following the presentations:

Vincent Mwale explained his project's distribution of free condoms, as young people in Eastern Province cannot afford to buy them as they spend their disposable income on necessities e.g. soap. Condom distribution is targeted. Vincent highlighted the Stepping Stones approach which is used by the project to support communication between young people and their parents.

In response to a question on payment of volunteers, Vincent said that the income-generation part of the programme had been very difficult, and that the strength of the PEPFAR programmes is that the peer educators are paid. Lovemore Magwere explained that in their project there is funding for volunteers, and that this tends to be used for sports equipment and other incentives like exchange visits. It is difficult to raise money for allowances. Some participants felt that volunteerism limits the potential for scaling-up and that there are inconsistencies between payment for work in international NGOs but not at national level.

Maria Eugenia Miranda talked about the impact of Catholicism on young people's sex lives. One of the effects of Catholicism is that young people may not practise penetration, but if they have oral sex they do not usually use condoms, which puts them at risk. Working in a Catholic context can mean a difficult mediation between personal values and the way in which discussion of condom use is expressed.

The meaning of abstinence was debated. Does the decision not to have sex need a different definition? One participant pointed out that it is important to think of delaying sexual debut as being a personal choice, rather than a matter of public policy. One young person felt that the term ‘abstinence’ discriminates: for the religious it is extreme and fundamental but for others it means that they will not engage in some risky activities. Abigail Harrison pointed out that the issue of abstinence versus delay is more than this – delay is more realistic as it recognises that people will become sexually active at some point. Others agreed that talking about abstinence makes people feel that they can never have sex

again and this seems impossible to them. The understanding of abstinence should be diversified, so that we can use the term without a moral anti-sex attitude. Young people should be asked for their own definitions of sex, abstinence and pleasure and then asked to reflect on the risk associated with each activity. Anne Philpott pointed out that in terms of the US policy on abstinence, sometimes we censor ourselves and don't allow for a flexible interpretation. Others felt that sometimes we over-emphasise US policy when the Vatican exerts such a strong influence in Latin America. It was also suggested that controversy about condoms can actually raise demand – it can have a positive effect.

Workshop session 3: positive prevention

Prevention strategies for people living with HIV/AIDS (known as positive prevention): some basics, comments and the experience in Ecuador

Javier Hourcade Bellocq, International HIV/AIDS Alliance, UK

People with HIV have always had an essential role to play in preventing new infections. However HIV/STI prevention strategies have failed to address the distinct prevention needs of people with HIV, and to acknowledge their significant efforts to avoid infecting others¹.

Positive prevention has only recently emerged as an area of interest, particularly in the USA with Centers for Disease Control and Prevention's (CDC) launch of the Sero-status Approach to Fighting the HIV Epidemic (SAFE). Strategies for positive prevention should aim to support people with HIV to protect their sexual health, to avoid acquiring new STIs, to delay HIV/AIDS disease progression and to avoid passing their infection on to others. Strategies for positive prevention are not stand alone, but work in combination with one another.

Currently most available studies are descriptive or use simple correlation for statistical analysis. A large proportion of the literature focuses on gay men in Europe, Australia and the USA. This limits the extent to which findings can be applied to other population groups and to cross-cultural contexts. Other relevant studies have been carried out in developing country contexts with heterosexual population groups. Many of these have been in high HIV-prevalence contexts and their effectiveness in other, lower prevalence contexts is not yet known.

Positive prevention is a priority because one positive person is involved in each case of HIV transmission. From an epidemiological and public health perspective, the most important group to address with HIV/STI prevention strategies are people already living with HIV. This is particularly the case in low prevalence settings where the epidemic is contained in certain key populations.

Positive prevention is also important because people living with HIV have the right to live well with HIV, which includes having a healthy sex life. From a human rights perspective, people with HIV have a right to know their HIV sero-status; they also have the right not to know.

Within positive prevention interventions, HIV prevention, treatment, care and support are inter-related. The prevention-treatment-care continuum reinforces the

rationale for supporting prevention interventions for people with HIV. For example, people living with HIV need access to medical care and psycho-social support services, and also support to build their skills for adopting and maintaining safe behaviour.

Constraints to behaviour change include the fact that most people do not know their HIV sero-status, and even if they are willing and able to find out their status, they may well not have the knowledge or the ability to reduce the risks of onward transmission. Disclosure of one's sero-status is difficult for many people with HIV, especially women, who may fear stigma, rejection or violence from their partners, and discrimination in the wider community or by health providers. Disclosure of HIV status is more difficult if you live in a developing country. The continuum of prevention, treatment and care and anti-stigma and anti-discrimination work should lead to an environment that enables disclosure.

Practising safer sex with all partners and always using clean needles are key prevention strategies. Many people with HIV, however, are not able to obtain condoms or clean needles. The target in positive prevention should be 100% access to and use of condoms (male and female) and lubricants for people living with HIV/AIDS.

Promoting access to voluntary counselling and testing (VCT) is vital. Good quality pre-test counselling and proper informed consent processes at VCT centres increases the return rate of people for results, particularly for confirmation tests. In addition there is a need for greater diversity of VCT centres, for example through community-based organisation (CBOs), NGOs, groups and organisations for key populations, sexual and reproductive health clinics, family planning clinics, the Red Cross etc. This needs to be coupled with good quality post-testing counselling and reliable local referral systems or networks.

Programming needs to be accompanied by national advocacy for legal reforms, proper national guidelines, reduction in workplace and recruitment discrimination, and proper budget allocation at the national and provincial level. Programmes should include tailored responses that contribute to addressing unequal gender relations, sexual violence and the dynamics related with poverty, power and marginalisation that make women and key populations vulnerable to HIV and poor sexual and reproductive health.

Focused prevention is prevention for key populations and may target gay men, transsexuals or sex workers. It uses messages that identify and amplify people's strengths instead of putting the emphasis on blaming and highlighting behaviour trends of certain groups. Within focused prevention it is important to ensure focused risk reduction counselling, and prevention case management for people living with HIV.

In Ecuador, the Alliance is supporting a project with key populations including sex workers and men who have sex with men, as part of the Frontiers Prevention Project (see box below for more information). Based on our experiences in this and other projects with key populations, the Alliance has published a report on positive prevention which outlines some of the strategies that need to be in place to conduct an effective positive prevention programme.

What we have learnt is that many complex factors influence human behaviour when it comes to prevention. To achieve behaviour change we need to enable the environment, build skills, act in a coordinated manner, ensure that commodities are accessible, and most importantly make our best effort to bring back sex and sexuality to HIV/AIDS.

Frontiers Prevention Project in Ecuador

The results of an initial baseline study showed that for sex workers the age of first sexual contact with intercourse was 15 years old, whilst the age of the first paid sexual contact was 22 years old. Condom use (with the last three clients) was 82%; 5% never used a condom, and 91% had been for HIV testing. Amongst men who have sex with men, condom use (with the last three partners) was at 26%. 24% of men had never used a condom, and 45% had been for an HIV test.

The project found that there was a continuum in terms of sexual behaviour, orientation and identity. People living with HIV/AIDS included sex workers and men who have sex with men, and these groups were linked by transvestites and men who have sex with women.

To respond to this situation, the Alliance supported interventions in Santo Domingo, Esmeraldas & Quevedo in which site committees made up of sexual and reproductive health clinics, sex worker CBOs, government STI centres, CBOs of people living with HIV and AIDS, gay and lesbian and transvestite CBOs, VCT centres and local government worked in partnership. These organisations received capacity building in order to work on community mobilisation, mutual support, distribution of condoms and lubricants, improving the quality of services, information and education communication, and influencing policy in order to strengthen individuals' ability to have safe sex.

Discussion following the presentation:

In his presentation Javier mentioned the problem of the 'feminisation' of HIV/AIDS and this prompted some debate. Although the phrase can highlight that women are vulnerable to HIV/AIDS, some participants felt the phrase was problematic because increased HIV prevalence amongst women in generalised

epidemics only demonstrates sexual networking patterns between younger women and older men and where men have more partners than women. Others felt that it could lead to the stigmatisation of women, and that it places the onus of responsibility upon them. Another view was that this may act to make men invisible. It was also suggested that it could divert money and energy from projects aimed at men who have sex with men to women's projects, when what is necessary is to work with men.

One participant commented that many people living with HIV aren't interested in condoms because they are stigmatised, and they are more interested in ARV treatment. Javier replied that although there is obviously diversity among people who are living with HIV and AIDS, positive prevention is an issue that the national and international networks, like the International Community of Women Living with HIV/AIDS (ICW) and the Global Network of People Living with HIV/AIDS (GNP+), are taking forward. In addition, when they are advocating around treatment they ensure that prevention is integrated. It is up to these networks to act, because if they wait for an external actor to come up with a strategy it could be stigmatising.

Another participant commented that treatment is a very effective prevention intervention, even if condoms are not being provided, and that we need to see the two things as a package. While it is vital to involve positive people in HIV prevention, the responsibility for safe sex should be one that is shared between them and their sexual partners whether positive or negative. Javier agreed but stressed that condom provision is an important intervention for positive people's health beyond preventing onward transmission, particularly with regard to reducing multi-resistant HIV, STIs and secondary infection.

A participant from the Latin America region commented that he felt prevention messages targeted at people living with HIV and AIDS in the region were very conservative, and an abstinence agenda is being pushed at them by religious organisations.

Workshop session 4: key populations

Condom promotion for sex workers

Melissa Ditmore, Network of Sex Work Projects, USA

Sex workers around the world are expected and want to use condoms in their work. Because of their occupation they require more condoms than other groups, so access issues have a particularly hard impact on them.

Obstacles to condom use by sex workers include:

- US funding restrictions
- availability and affordability
- resistance to condom use by clients
- not using condoms as a mark of love and trust with frequent or non-paying partners.

US funding restrictions are applied idiosyncratically depending on the organisation involved, and have been resisted in a variety of ways. Some organisations have rejected US funds, and smaller organisations may be able to recoup these funds elsewhere. But in general this approach is not sustainable, and organisations have been scapegoated for rejecting funds. Seeking clarification about what is in violation has been used as an attempt to force the US government to specify what is contrary to the policy. Others have signed the Anti-Prostitution Policy but have not altered their programmes. This is not a sustainable approach as it relies on US government ignorance of activities while the US government is focusing more attention on how programmes are being run. Some organisations have practiced pre-emptive capitulation – changing programmes in ways which go beyond the restrictions and not working with sex workers. This can only lead to higher rates of HIV and lower rates of condom use among sex workers. The policy has been used to deny medical care to sex workers at a clinic in Thailand and to fire outreach workers who reach out to sex workers in Cambodia.

Condom shortages have arisen because of abstinence promotion and pre-emptive capitulation, a need for production capacity and inadequate distribution. Because sex workers require more condoms for regular condom use than most people, these needs affect sex workers sooner and more urgently than others. Sex workers need to be included in the planning of programmes in order to ensure that they are relevant, useful, and well-implemented; sex workers are part of the solution. Programmes that impose fines or punishment for not using condoms violate the rights of sex workers. Health programmes should be implemented in line with the human rights of sex workers. Sex workers - of all genders - have the same difficulties using condoms with spouses and regular

partners as others.

The main elements of effective programmes with and for sex workers include:

- peer-based distribution
- subsidisation of condoms and lubricant to affordability (but not free distribution)
- adequate numbers of condoms
- condom buying cooperatives and selling schemes
- subsidised social marketing of lubricant
- eroticisation of condoms
- clandestine use of condoms.

100% Condom Use Programme for sex workers in Asia

Wiwat Rojanapithayakorn, WHO, China

The 100% Condom Use Programme (CUP) is a programme to prevent sexual transmission of HIV in the general population by ensuring a high level of condom use among sex workers and their clients. The programme was implemented because it is very effective in preventing sexual transmission of HIV, which is the main mode of transmission in most Asian countries, and because it targets sex work, which is associated with high transmission of HIV in Asia. In Thailand, general HIV/AIDS campaigns did not produce a significant impact on prevention. However the 100% CUP was incredibly effective and the decline in STIs it led to was linked to condom use, not the awareness-raising that may have encouraged people to stop using the services of sex work establishments.

The main principles of the 100% CUP are that it creates an enabling environment to empower sex workers in all sex establishments to refuse sex services if customers do not want to use condoms. This means that customers will no longer be in control of condom use in sex services. Local authorities and owners of sex businesses are responsible for promoting and maintaining this enabling environment.

In order to be effective, the programme must first gain the cooperation of government authorities and owners of all sex establishments so that they require condom use in all sexual encounters. There must be an understanding that if customers refuse to use condoms no sex services will be provided ('no condom – no sex'). This measure must be taken by all sex establishments so that customers will not be able to purchase sex services without using condoms elsewhere. Non-cooperative establishments are sanctioned. The programme is evaluated through the incidence and trends of STIs; the prevalence of HIV infection in different target populations; knowledge, attitudes, beliefs and practices (KABP) surveys on attitude and practice relating to condom use; the number of condoms supplied to sex establishments; and surveys to determine the level of condom use during commercial sex.

Condoms and sex workers: Aviele, Oluku and Ugbague communities in Edo State, Nigeria

Christabel Ene Unobe, Girls' Power Initiative, Youth Coalition, Nigeria

In Nigeria, Edo State, sex work is also a lucrative business. In order to capitalise on the role that sex workers could play in HIV prevention, a group of NGOs started a programme in 2002, Promoting Sexual and Reproductive Health and Combating HIV and AIDS. The programme is also known as 'Make We Talk' to raise awareness of the prevalence of the virus. It offers capacity building for female sex workers so that they are more able to negotiate safer sex with customers. The Aviele, Oluku and Ugbague communities were identified as intervention sites.

The Aviele community is a junction community and exists on a major route north. There are over 200 female sex workers in the community, both brothel and street-based. The Make We Talk team started its intervention by identifying different brothels in the area, and then working with the managers of these brothels to mobilise female sex workers and share HIV/AIDS education and negotiation skills for safer sex. To do this they facilitated the creation of the Aviele Community Action Committee, a group made up of women, young people, female sex workers, transport workers and others in the community who were responsible for coordinating the work.

The Oluku community is also situated on a route north, and is a site where commercial sex is prevalent. Here the project started an information centre to answer the questions of, and provide support for, female sex workers. Again, this was coordinated by an Action Committee.

In Ugbague community, which is in the centre of Benin, the capital city of Edo, studies revealed that female sex workers didn't have accurate information on modes of transmission of HIV. After the intervention most sex workers agreed that they were better informed on modes of transmission and spread of the virus, and on how to negotiate safer sex. In 8 of the brothels here they instituted a 'No condom, no sex' policy to support the sex workers' new skills in safe sex negotiation. Under this policy customers must pay for condoms for every sex act, and must provide a used condom to brothel staff as proof of use after every sex act. If they do not provide proof of use, they are fined. Since this policy was instituted the demand for condoms and lubricant has increased by over 60%. Finally, 6 sex workers from various brothels in Benin jointly formed a group called 'character changing ladies' to promote best practice and healthy behaviour in the area. This group holds regular meetings at the Society for Family Health (SFH) office in Benin; SFH are providing support through mentoring, finance and technical support until the group is strong enough to establish itself as an independent CBO.

Promoting condoms to men who have sex with men in Brazil

Craig Darden, DKT, Brazil

DKT launched the *Affair* brand of condoms 6 years ago as a way of subsidising a cheaper brand that they were also marketing, *Prudence*. It was marketed to young urban males using ads in Playboy. To their dismay sales started to decline soon after the product was launched. However although overall sales were down, reports from the field suggested that *Affair* was very well-liked by men who had sex with men.

DKT saw a marketing opportunity in this. There were no other brands in Brazil that were aimed at men who have sex with men (MSM). But from DKT's research they knew that MSM in Brazil had more partners and had sex more frequently than other groups. Although this demographic group used more condoms than others, many were still practising high risk behaviour.

They decided to take one more chance with the brand. They changed their advertising media to focus on gay and bisexual men. The new advertising emphasised the product's main feature (the ribbed texture), which was still a novelty in the Brazilian market. Because there is a relatively tolerant culture in Brazil they could use gay magazines and risqué TV programmes. As a result the sales slide stopped and began to improve.

In 2005, a new "baggy" style condom (with ribs) plus a companion condom-friendly lubricant were being prepared for introduction under the *Affair* brand name. A series of focus groups were conducted in the city of Curitiba with the help of the NGO Dignidade, a gay rights advocate in southern Brazil. Besides talking about condoms and condom promotion in general, they tested several storyboards, to support decisions on the ad campaign. Participants said that the ad campaign should focus on positive aspects like pleasure, respect, and a healthy lifestyle. It should be a campaign that features real people in real situations, not cartoons or caricatures, and certainly not stereotypes. The campaign should be sexy.

Based on the research, they developed advertising which was primarily focused on the target consumer rather than on the product. Promotional materials were developed for magazines, point-of-sale, consumer samplers, and outdoor billboards, as well as a 'hot-site', complete with podcast. The products were launched in early 2006.

Public response was overwhelmingly positive, but there were still some dissenting voices. Shortly after launch, the billboard campaign in São Paulo was removed by public officials, citing 'inappropriately excessive public sensuality'. Local newspapers, TV, radio, and the internet covered the story, with the public weighing in both 'for' and 'against' (by their count, mostly 'for'). DKT were surprised by the negative reaction to the ads in a city which supports the largest

gay pride parade in the world. But they welcomed the free publicity which was generated for the brand and for the debate on human rights. A positive reaction came in the form of product sales, which are increasing and forecast to climb to new heights.

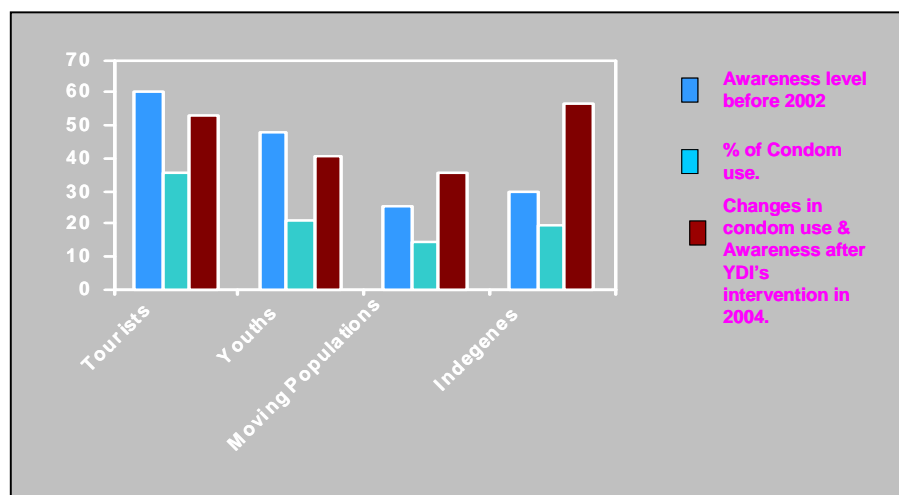
The lessons learned from this piece of marketing are: listen to your consumers, stay positive in your messages, sex sells and you can't please everybody!

Promoting condom usage at the grass roots: Badagry, a border town experience

Femi Aina Fasinu, Youth Dignity International, Youth Coalition, Nigeria

Badagry is the busiest land border in Nigeria, and also attracts a high number of tourists. In 1998, the Lagos State Action Committee on AIDS announced that Badagry had the highest HIV prevalence in the state. So in 1999, Youth Dignity International (YDI) was founded to respond to the AIDS epidemic in the community.

In 2002 they conducted a survey into condom use in the community. It measured the rate of awareness and use of condoms as a means of family planning and HIV prevention. The results of this survey and the effectiveness of the intervention can be seen below.



The challenges to condom promotion and use included:

- Poverty levels were so high that condoms were not a priority.
- Cultural and religious barriers to promoting condoms among young people existed.
- The area had little attention from government and civil society despite its vulnerability.
- There was only one known condom distribution organisation in the country.
- Myths and false information about the prevention of STIs existed.
- There was a high degree of gender inequality.
- Young girls and women had little negotiating power.

The project trained local tour guides to talk about condom use with tourists and local people, and also worked with traditional leaders. The project showed that

creating a positive image of condoms is the best way to increase the number of people using them. It was more effective when people bought condoms rather than getting them free as they were more likely to use them. Cheaper condoms are more accessible than expensive ones and price is more important than perception of quality. Effective messages targeted to different groups are important, especially in grassroots communities and areas where cultural and religious beliefs are strong.

Condom and safe sex promotion for drug users' communities

Catalina Iliuta, Romanian Association Against AIDS, Romania

In 2006, UNAIDS Update talked about the feminisation of the epidemic. There is anecdotal data to show that in Eastern Europe and Central Asia, where the leading cause of HIV/AIDS is injecting drug use, the feminisation of HIV is linked to sexual partners of drug users. Yet most of the time, sexual partners of drug users are not the target group for HIV programmes. Whilst this is an obvious gap in programming, using arguments around the feminisation of AIDS in a country like Romania is dangerous as it may be taken as an excuse to move money from projects with key populations to women's projects that wouldn't reflect the impact of the epidemic.

Condoms should be part of the minimum package of HIV prevention and treatment services for drug users, and most of the time they are. However, compared to safe injection messages, condom use and safe sex messages do not have the same prominence. Many services for drug users (and especially harm reduction services) are developed and implemented by civil society representatives, with international funds, and are not part of the medical system. Because of lack of funds, some programmes focus on risks associated with injection practices, and do not talk much about other risks related to drug use.

When discussing work with drug users we need to define who we are talking about and adapt interventions to meet their characteristics. There are many sub-groups in the drug user community who may have specific risks and vulnerabilities related to sex – for example, drug users who sell or trade sex, young people under 18 who use drugs, drug users in prison and drug users of substances that have an effect on sex life. Many service providers forget that drug users are not a homogenous group and therefore may need different messages and services.

In order to ensure the quality of programmes we need to:

- develop quality indicators for HIV services for drug users
- scale up programmes to deliver sustainable services for at risk groups
- fund programmes transparently
- fund programmes that are cost effective and respond to the local context
- offer comprehensive services and an integrated approach to programmes for drug users
- advocate for national and local funds for HIV/AIDS services for vulnerable groups
- advocate for an integrated approach to HIV/AIDS and drug use.

Countries recognise HIV prevention and services for drug users and other vulnerable groups as priorities in National AIDS Strategies, Reproductive Health

Strategies or other documents ratified at national and international level. However, most countries do not fund these services, or if they do, the services are not integrated and comprehensive. Many countries prefer to fund HIV services that are not linked with vulnerable groups for fear of supporting projects that are a 'bad thing' or that 'encourage promiscuity'. AIDS challenges us to deal with taboos and things that we are not comfortable talking about: sex, sexuality and drug use.

In Romania, a country with a low HIV/AIDS prevalence, progress has been made since 2001, when Romania ensured universal access to treatment. However, HIV prevention services for vulnerable groups are totally missing from the HIV/AIDS national funding agenda, which means that the progress that has been made is very fragile. Services that target drug users are very limited and condoms are only part of the service package in needle exchange programmes. National data and reports show increasing levels of synthetic drug use but no services are yet in place although these drugs are associated with unsafe sexual practices. Most condom promotion campaigns do not address drug users' needs, and none of the campaigns for condom use are targeted directly at drug users and their sexual partners.

Discussion following the presentations:

One participant asked if there were projects in which men were asked to take responsibility for condom use in commercial sex interactions with a female sex worker. Melissa Ditmore replied that some projects do fine clients for not using condoms. Another participant asked if the relative mobility of sex workers hindered the effectiveness of programmes with them and meant that resources were spent on training community members who would then move elsewhere. Melissa felt that mobility could be useful as it meant that sex workers went on to use their learnt skills in new locations.

In terms of the 100% CUP programme, participants questioned whether condoms were promoted for oral sex. Wiwat Rojanapithayakorn replied that the programme was focused on vaginal and anal sex services, and that enforced condom use had not created an upsurge in demand for unprotected oral sex as some had predicted. Others asked if the programme provided free condoms. Wiwat replied that condoms were marketed to sex workers and sex work establishments, and that the cost was passed on to clients.

Melissa pointed out that the first iteration of 100% CUP in Cambodia led to human rights abuses against sex workers by the police and army, who forced sex workers into sex. It was also characterised by unethical testing practices. Wiwat replied that in the Thai model the success was not judged by a reduction in STI rates, as they realised that condoms break and sex workers may have unprotected sex with their non-commercial partners. However other countries have used this marker of success and it could lead to coercive practices. One participant felt that a positive attribute of the programme was that it did not force

women to stop selling sex and that this is the type of approach needed for work with drug users.

Others pointed out that part of the success of 100% CUP in Thailand was the existence of a brothel-based and highly organised sex industry and that this is not necessarily the case in other countries. If the methodology was to be taken and used rigidly elsewhere, without taking account of the local situation it is unlikely to be as successful. Participants discussed other methodologies that have been used in settings where sex work is more illicit, such as the system in Mongolia where sex workers have a green card that allows them access to the national health programme and has lowered levels of harassment from police and other government officials. Finally participants discussed the fact that in some countries simply carrying condoms can be used as criminal evidence of intent to sell sex; strategies to overcome this have included producing condoms in smaller and less conspicuous packaging.

In response to Catalina Iliuta's presentation, participants asked who the drug users accessing existing harm reduction projects were. Catalina replied that drug users are a heterogeneous group, but that women do not access services as readily as men.

Others asked if there were any examples of successful condom promotion with drug users. Catalina explained that condom promotion is not usually the main focus of programmes for drug users but that condom promotion messages should have the same emphasis as those related to safe injecting practices. There is also a need to focus on the partners of drug users and employ peer educators to do this work. She emphasised that drug users in prison are a neglected group who are often sexually abused as they have no access to condoms and may be unable to negotiate safe sex due to imbalances in power. Participants found it difficult to think of projects that dealt with the sex lives of drug users although an example was given from Amsterdam of a project where outreach workers went to raves and tested the quality of drugs for party goers at the same time as distributing condoms. Other participants from the field of social marketing pointed out that drug users are definitely one group that need to be provided with free condoms, as often their disposable income is used to buy drugs; they also need to have condoms taken directly to them otherwise they are unlikely to access them.

Participants were interested in the fact that in the project described by Christabel Ene Unobe, a used condom had to be provided as proof of safe sex. Lovemore Magwere pointed out that in Zimbabwe a man would not want a woman to take his sperm because of the fear that that it would be used for witchcraft. Participants discussed other beliefs related to the link between sperm and the maintenance of male power.

Workshop session 5: dual protection, condoms and family planning services

Dual protection: more needed than practised or understood **Marge Berer, Reproductive Health Matters, UK**

While contraceptive use has become highly prevalent in the past 100 years in all world regions, unprotected sex in relation to STIs, including HIV, remains the norm. Dual protection is protection from both unwanted pregnancy and STIs/HIV, and condoms are the main form of dual protection. Condoms also afford protection against STI-related infertility and human papillomavirus, which can cause cervical cancer.

Sexual health/HIV clinicians are often not trained to promote contraception, and family planning providers often do not promote condoms because of the priority placed on contraceptive efficacy, and are often not trained in STI/HIV prevention. In addition the accepted definitions of dual protection are so narrow that it is believed few people will practise it or practise it consistently. However, the fact that people may not always use dual protection consistently and correctly is not a valid reason for not promoting it, and expanding the list of methods creates more options for those who need them.

Dual protection and dual method use are often confused, partly because of the belief that there is only one form of dual protection, i.e. condoms and the pill. In fact, dual protection can be achieved in a number of ways. Furthermore, dual method use may not achieve dual protection, e.g. taking the contraceptive pill and periodically using condoms to cover for missed pills. This is dual method use but only for contraceptive purposes. Methods of dual protection include:

- abstaining from sex altogether having sex but not penetrative sex
- mutual monogamy between partners with no pre-existing infection, with the use of an effective contraceptive method (or abortion) between partners with no pre-existing infection, the use of an effective contraceptive method, and with partners outside this relationship the use of dual protection the use of male or female condoms alone the use of male or female condoms plus a diaphragm or cervical cap the use of male or female condoms plus a non-barrier contraceptive, e.g. the pill, or male or female sterilisation (post-childbearing) male or female condoms with the back-up of emergency contraception
- male or female condoms with the back-up of induced abortion and post-exposure prophylaxis.
- breastfeeding on demand with condoms for the first months post-partum.

Other methods that reduce HIV and pregnancy risk but are not protective against STIs include:

- withdrawal alone
- withdrawal plus male or female condoms during the ovulation (unsafe) period
- withdrawal with the back-up of emergency contraception
- withdrawal with the back-up of induced abortion.

Microbicides will join this list if and when one or more comes onto the market. However, to focus efforts only on microbicide promotion, when a whole range of dual protection methods is already available, is highly problematic. Based on a literature review for 1998-2005, it appears that it is not uncommon for young people to be using condoms with the back-up of emergency contraception (where available). "Condoms were accessed by both sexes, but girls also requested emergency contraception". "Experience with emergency contraception [was] associated with an increased probability of condom use". A recent study in a family planning clinic in Italy found that 64% of 500 young women seeking emergency contraception who had used a contraceptive method had used condoms, and a further 15% had used oral pills and condoms.

Ways of capitalising on willingness to use this form of dual protection in clinics could be by promoting condoms along with advance provision of emergency contraception. Or they could be supplied through social marketing, where they could be packaged and sold together – a three-month supply of condoms together with three doses of emergency contraception.

Trends in protective behaviour among young African women **John Cleland, London School of Hygiene and Tropical Medicine, UK**

There has been intense condom promotion for HIV control over the past 10 years, but since the launch of PEPFAR the emphasis on abstinence has increased. Currently there is little contact, collaboration or synergy between HIV prevention and family planning.

Demographic and Health Survey (DHS) data were analysed for information on sexual history and current sexual and contraceptive practices. This allowed the tracking of trends and changes over the last ten years in Africa – although this must be done with caution, as there are huge differences in behaviour between countries as the continent is immensely diverse.

The evidence shows that there have been no significant changes regarding abstinence from the early 1990s to 2001, and that the abstinence message pushed by PEPFAR does not reflect natural trends in behaviour. There is a slight upward trend in secondary abstinence; about 40% of non-virgin women did not have sex in the last 3 months. This may not be all that significant as sex in single women is generally an infrequent occurrence. In terms of contraception there is a slight rise in use overall. Use of non barrier methods of contraception is low due to fears over fertility and lack of access. The use of condoms for family planning has risen from 5% to 19% which is a large increase in terms of change in contraception use. Among married women, levels of use are nowhere near that for single women, and are low compared with other regions. Among single women, condom use at last sex has gone up dramatically, from 19 to 28%.

The evidence shows that most condom use among women is, at least in part, motivated by a desire for contraception. Condoms are now the top family planning method for single women, so it might be more effective to promote condoms for family planning than for HIV control. Married couples should remain a concern for those wishing to promote condoms. In low contraceptive use countries, condoms could be promoted as dual protection (but not in high-use countries). Finally, 70% of condom users obtain supplies from private outlets, which shows that social marketing is a crucial factor in increasing access. To increase access more generally, donors need to compensate for the withdrawal of US funds for condom promotion to the general population.

Condoms in Paraguay: some strategies for their better promotion

Ariel Gonzalez Galeano, Youth Coalition

Paraguay

- Young people between the ages of 15 and 29 represent 28% of the total population.
- Almost 58% of young people have less than 10 years of formal schooling.
- Almost 50% of the total population live in poverty.
- The incidence of HIV/AIDS is 2.3%.
- There are high levels of adolescent pregnancy.

Access to condoms in Paraguay is met through social marketing programmes such as PSI Paraguay and the NGO PROMESA; since 2000 they have also been marketing female condoms. Condoms are distributed through the national health system and IPPF affiliates (who provide free condoms) but this is generally only in big cities. The private sector also plays a role in making condoms accessible and has a strong presence through mass media. Since 1997 PROMESA has run the 'Arte & Parte Project' which uses peer education, TV and radio programmes and street theatre to reach young people, and has developed IEC materials to this end.

Condom promotion suffers from the influence of conservative social forces, particularly the influence of the Catholic church which actively advocates against their use. In 2003 and 2004 training was provided through workshops to young people regarding the failure of condoms and the promotion of abstinence only. This is exacerbated by training sessions given by external 'professionals' from the USA, Argentina and Brazil who propagate information about the failure of condoms.

To overcome these negative influences it is vital that Paraguayan young people are provided with comprehensive sex education through school, NGO interventions and mass media. This must be conducted in local languages, not just Spanish. In particular condoms need to be marketed through family planning services using face-to-face promotion, which provides the opportunity to clarify any misunderstandings. In order to provide this information, health system staff need to be appropriately trained, and must gain the trust of young people by providing accurate information.

Discussion following the presentations:

Participants were interested in the DHS data from Uganda given the different approaches to HIV prevention that have been followed there. John Cleland

explained that the evidence pointed to the fact that delayed sexual debut had a role in lowering prevalence rates in the 1980s but not so much the 90s. In all of East Africa, Uganda has the highest rate of condom use at last sex and it appears that condom use amongst single women is a major factor.

One participant pointed out that breastfeeding and the use of condoms is actually triple protection, as it protects the baby from HIV through protecting the mother from becoming HIV positive in the post-partum period. Another pointed out that high rates of oral contraceptive use can be a barrier to dual protection, as family planners are reluctant to suggest an alternate barrier contraceptive method that could lead to migration from oral contraceptives. Emergency contraception is often marketed in African countries as a contraceptive method to be utilised if you are raped, which means that women are reluctant to access it on other occasions. Finally one participant pointed out that promoting condoms in order to protect fertility is another useful strategy.

Workshop session 6: scaling up condom promotion and social marketing

Fiesta: development of youth condom in Indonesia

Christopher Purdy, DKT, Indonesia

Indonesia

- The fourth largest country in the world with a concentrated HIV epidemic.
- Contains one in eight of all Muslims worldwide and is a country where the modern meets the traditional.
- The majority of young people first have sex between the ages of 16 and 18 years.

Surveys of sexual behaviour have found a discrepancy between young people's values about sex and their actual behaviour – most people think that sex before marriage is against their religion. They also found that the most frequent source of sex education cited by young people was their friends, followed by pornographic videos. Information from these sources is characterised by myths and inaccurate information about sex.

DKT tried to create a brand of condom that would respond to the needs of young people in its packaging and distribution. They distributed samples to young people and tried to offer choices. They also produced materials to be displayed at the point of sale so that young people didn't have to ask for condoms. They also worked to improve the attitudes of cashiers towards sexually active young people.

Advertising emphasised pregnancy prevention rather than STI or HIV prevention as this is the main concern expressed by young people in Indonesia. They also tried to make the advertising funky, sexy, and fun, and targeted TV advertising to address major issues. Print advertisements were run in various publications including Playboy. Other methods used included *Fiesta* text messaging, postcards displayed in cafes and bars, educational events in partnership with MTV, and pop concerts.

As a result *Fiesta* has been one of the main drivers of growth in the condom market in Indonesia. DKT market 3 brands there; one for family planning which sells at a higher price, *Fiesta* which is mid range and another much lower priced brand which is subsidised by the other two. Although young people have to pay for *Fiesta*, it is still sold at a lower price than many condoms on the market.

100% Condom Use Programme combined with STI services for female sex workers in Cambodia

Vichea Ouk, National Centre for HIV/AIDS, Dermatology and STI (NCHADS) of Ministry of Health, Cambodia

Cambodia

- First HIV infection was discovered in Cambodia in 1991.
- In 1998, 179,000 people were living with HIV/AIDS, 3.7% of the adult population.
- By 2003 this figure had dropped to 123,100 people living with HIV/AIDS, only 1.9% of adult population.
- There continue to be 8,000 new infections every year.
- Cambodia has one of the highest HIV prevalence rates in South East Asia.
- 1998 rates amongst direct sex workers were 42% and amongst indirect sex workers, 19%, in comparison to 2.4% of pregnant women.
- By 2003 rates amongst direct and indirect sex workers had dropped considerably to 21% and 12% respectively.
- In Cambodia men frequently visit sex work establishments – in 1998 57% of police, 56% of the military and 54% of moto-taxi drivers reported paying for sex in the last month.

The 100% CUP started in 1997 and was adapted from the Thai approach. The basic concepts of the project were a combination of mandatory condom use in all sex establishments monitored by local authorities and other stakeholders, outreach for sex workers and sex establishment managers, and STI care at special STI clinics for sex workers.

In the pilot programme although over 90% of direct sex workers were reached, only 25% of indirect sex workers accessed the interventions. Of those direct sex workers reached, 96% reported always using condoms with clients, and there were declining STI rates among direct sex workers.

On the basis of these results it was decided to scale up the programme, and a complete package of 100% CUP-related activities was implemented in 22 provinces. This included an official declaration by the Governor of 'no condom, no sex', strengthening of STI clinic services, condom promotion and distribution, outreach and peer education, mapping of establishments and setting up of monitoring systems.

The challenges of the programme were that the coverage of indirect sex workers was much lower than direct sex workers. Indirect sex workers reported lower rates of consistent condom use with clients. All sex workers reported low rates of condom use with their non-commercial partners. All sex workers reported high rates of violence, particularly in Phnom Penh.

Social marketing and scaling up condom promotion

Shyama Prassana Bose, DKT, Ethiopia

Social marketing aims to fill the gap between free distribution of condoms and those sold for profit. The social marketing of condoms in Ethiopia takes place under the auspices of the Federal Ministry of Health who are responsible for distribution, communication and networking. This is in keeping with the Health Sector Strategic Plan – 2006 to 2010, which aims to reduce the adult incidence of HIV from 0.68 to 0.65 and to maintain the prevalence of HIV at 4.4%. Social marketing of condoms in Ethiopia is subject to various guidelines.

Products and messaging have to be approved by the Drug Administration and Control Authority of Ethiopia as condoms are classed as medical devices. They are also responsible for in-country testing and approving packaging and messaging. There are no private sector brands in Ethiopia.

DKT market 3 brands of condoms in Ethiopia: *Hiwot Trust*, which are plain and highly subsidised; *Sensation*, which are ribbed and medium price; and *French Feelings* which are flavoured and more expensive. Cost recovery on *French Feelings* helps to subsidise the other brands. The products are advertised on television and radio, in newspapers, at point of purchase, on billboards, at events and in rural areas.

DKT works with a number of partners: Regional Health Bureaus, other government organisations, the Ministry of Defence and 350 NGOs. These partnerships are used for the delivery of condoms and also for advocacy campaigns. The impact of this work has been the distribution of 250 million condoms through social marketing and another 100 million through partners.

Discussion following the presentations:

In response to Vichea Ouk's presentation, participants asked if advocacy to decriminalise sex work was carried out alongside the 100% CUP. He responded that decriminalisation is politically unpopular and not socially acceptable, but better relations were fostered between the police and sex workers by the programme as it required them to work together to be successful. One participant pointed out that violence against sex workers in Cambodia is predominantly carried out by their clients, which includes members of the police force. Indeed one recent study showed that 97% of sex workers in Phnom Penh were raped within the last 12 months.

In response to presentations from DKT, a participant asked why they are marketing condoms with Nonoxynol-9 as some studies have shown that it increases the likelihood of HIV infection by damaging the cells of the vagina, anus and cervix. Other participants asked whether DKT market condoms of

varying sizes as many men report that condoms are too tight or small and this inhibits use; some young people report that condoms are too large for them. Craig responded that most governments have a range of standard sizes that you are allowed to market condoms in, but there is a new company in the US where you can buy condoms made to measure.

Workshop session 7: condom promotion at programme and community level

Empathy – the missing ingredient

Sunanda Ray, Brighton and Hove City Primary Care Trust, UK

Empathy affects the way in which we respond to users' needs for condoms. Empathy is the ability to recognise and understand the emotion of another. Empathy is often characterised as the ability to 'put oneself into another's shoes', or experiencing the outlook or emotions of another being within oneself – a sort of emotional resonance.

If you re-use the female condom five times it cuts the cost of a female condom by five. However in the WHO consultation on re-use of female condoms, 2000 women asking for advice on how to re-use female condoms were defeated at the international level by the recommendations of microbiologists for whom standards of hygiene were more important than the number of women who got infected with HIV in the meantime. What is needed is a 'good enough' solution not a perfect one. This separation of realities also exists in the dissonance between users and health workers, policy makers and programme implementers.

In national level discussions policy makers and medical professionals insist on the same standard of care for all women. So if women in the West are not asked to wash and re-use female condoms why should 'our' women have to. However they did not make sure that enough brand new condoms were provided for every person who wanted to use them. People in positions of power, either through politics or technology, who are charged with looking after the well-being of their constituents, make decisions for them based on their own values and assumptions. These can only be challenged by civil society groups who have confidence and knowledge, or have allies among professionals who can advise them.

The danger is that those with the loudest voice will have their rights respected, and those with the least power, the invisible, the fearful and the stigmatised, will not be heard, and will not know how to use the system. They will be the ones who continue to carry the heaviest burden of the impact of HIV and other disease epidemics.

AB?DE

Svenn Grant, YMCA of Trinidad and Tobago and the Youth Coalition, Trinidad and Tobago

The Caribbean has the second highest HIV prevalence rate in the world. Haiti and the Dominican Republic account for 85% of infections in the region. The Strategic Framework for the Caribbean stresses the need to distribute condoms to prevent the transmission of HIV among young people. Trinidad and Tobago's National Strategic Plan January 2003 – December 2007 includes specific strategies stressing the need for condom promotion, and increased condom use is highlighted as an indicator of success.

A group of party-going HIV and AIDS workers from the UN, the National AIDS Programme and the YMCA initiated condom social marketing during Carnival. The parties of the carnival season are marked with 'crews' of people branded with flags and other accessories that highlight their allegiance to certain groups. This group of volunteers started The Condom Krew, promoting the correct and consistent use of condoms, in 1998. It used a range of logos and catchphrases: Sexsafer; Rated S; Stimulating, Sensitive, Safe; Sexposition 'what is your position?'; and The S word 'yuh get d S?'. They also used the phrase AB?DE, a play on the more familiar ABC, which adds D for 'do get tested' and E for 'educate yourself'.

They carried out mass condom distribution with demonstrations; condoms came with an information card on use and safer sexual practices. They took free condoms and re-branded them in an appropriate way for young people. They did not consider some of the existing brands appropriate, for example, one brand *Slam*, gives the impression that women are objects to be 'slammed' and does not promote positive gender norms.

Most condoms were distributed in pouches leaving a number for future contact. They also produced T-shirts and posters with safer sex messaging and used pro-condom music and videos. The condoms were distributed to party-goers, carnival bandleaders, pubs, bars, and rum shops, masqueraders and men who have sex with men.

Condoms and sexual and reproductive health programmes: good bed partners?

Doortje Braeken, IPPF, UK

The sexual and reproductive health community has a central role to play in condom promotion and more generally making the linkages between reproductive health and HIV/AIDS. In IPPF's work, young people are involved in social marketing and in reaching the most marginalised young people. Examples of IPPF work are given below from the Baltic States, Kenya and Colombia.

Baltic States

In the Baltic States existing condom demand is generated almost exclusively by men, primarily 30–50 years of age. There is significant social stigma surrounding female purchasing of condoms, with prostitution cited as the primary reason why women carry condoms. Young people have limited access to condoms, as there are too few condom outlets. Furthermore they find the experience of purchasing condoms intimidating and stressful. The usual myths about how condoms interfere with sensitivity are prevalent and women are reluctant to insist on condom use. In the last ten years there has been a liberalisation of sexual norms and an escalating global youth culture driving increases in the incidence of STIs through unprotected sex.

In response to this, IPPF have supported young people in the development of a condom brand, *COOL*, with distinct youth appeal; it is trendy and has a feminine bias. It is marketed using messages and images relating to love, sensual experience and relationships rather than sex.

Young women and men are used as spokespersons and advocates of the programme and brand. Their market share reached 24% within six months of its launch in 1996. Sales currently stand at 2.1 million condoms a year in Latvia, with total use 6.3 million. Ongoing research analysis indicates that 50% of purchasers are female. *COOL* remains the best selling brand in the Baltic States.

Kenya

Youth centres can be an effective way of reaching young people if allied with outreach to involve the broader community. In Nairobi a VCT site in a youth centre was used as an entry point to recruit 20 young people to become peer educators. Ten of these young people were living with HIV/AIDS. They conducted outreach activities specifically targeted at vulnerable groups, including taxi drivers, young intravenous drug users, and young people (especially girls) living in informal settlements. Throughout the project, support meetings were held. These were used to discuss sexual and reproductive health topics, and boost the skills of the members in working on HIV prevention and care,

relationships and dating, drugs and other issues. During the same period, ongoing counselling was provided for members, as well as support and appropriate referrals for those living with HIV/AIDS. The involvement of young people living with HIV/AIDS led to an increase in the number of young people reached through peer education and outreach activities, and greater overall awareness about HIV and AIDS. Another positive result was that staff and peer educators had a more positive attitude when working with HIV positive people. People living with HIV were now participating in youth centre activities; a peer educator said “there is no differentiation/distinction between ‘us’ and ‘them’, we are all peer educators supporting one another”.

Colombia

In Bogota, IPPF affiliate Profamilia offered to get involved with local schools’ social service module. This is a module for older students who are coming to the end of education to get them involved in community work and orientate them for the world of work. Profamilia set up an SRH component to help educate the young people about SRH issues, and mutual respect and equality in relationships. The young people liked it as it gave them a space in which they could discuss things and ask questions that they felt they couldn’t do at home. They said it gave them confidence to discuss things with their partner, buy condoms and go for STI testing. In Colombia, girls are often reluctant to carry condoms because they feel it is stigmatising; these sessions gave girls the confidence to carry them and negotiate use, and also sensitised the boys so they accepted and supported their girlfriends in initiating condom use. The classes helped engender a mutual respect between the genders, taught them to be responsible, learn how to make decisions and have the confidence to carry them out.

In work with young people it is important to link condoms with a positive approach to sex and sexuality, to involve young people at all levels and to make condoms part of a comprehensive approach.

Discussion following the presentations:

In response to Doortje’s presentation a participant pointed out that a National AIDS Trust study in the UK found that young people critiqued condom marketing on the grounds that it failed to recognise love and relationships in its messaging and images. One of the youth participants felt that the use of models in condom marketing can be unappealing and that they would be more effective if they featured people who look like you.

Workshop session 8: enabling policies and anti-condom policies

Enabling condom use

Sandra MacDonagh, Department for International Development, UK

DfID provided funding for about a billion condoms last year. But the need far outstrips the funding provided by donors in this area. Globally there is one male condom per man of reproductive age; six if you are in Africa and one every two years if you are in Asia. There is only one female condom per 20 women of reproductive age in Africa and 259,000 for the 800 million women in Asia. Recent reports on contraceptive commodities show real blockages at country level, and that national capacity to forecast demand and to procure and manage supplies is very poor.

National governments are not helped by the way in which donors work. Often there are parallel sexual and reproductive health and HIV/AIDS procurement systems amongst donors. In response to this DfID is working to build national capacities and systems through sectoral and budget support. The aim of this is to encourage comprehensive programming, integrated service delivery, equity and cross sector links (for example, in the military or agricultural sectors not simply the health sector). To achieve this, what is needed is more and predictable money, used effectively and equitably. One problem is that condom supplies are often end of year spends, so there is too much short term investment rather than long-term, predictable interventions.

DfID are also working to try and create an enabling international environment for condom promotion. This is exemplified by their work at the recent AIDS United Nations General Assembly high level meeting in New York where the government spoke out strongly about the need to promote condoms in the response to HIV and AIDS.

Engaging with PEPFAR – abstinence, fidelity and young people

Gill Gordon

Good HIV prevention programming for young people mobilises communities and engages young people in all stages; reaches the most vulnerable; is public health and evidence-based; concentrates on risk reduction for many, not risk elimination for few; does not stigmatise and discriminate; and respects people's right to access comprehensive services and information.

The PEPFAR prevention guidelines promote abstinence only until monogamous marriage for life, mutual fidelity in marriage, and correct and consistent condom use for those most at risk of transmitting or becoming infected with HIV. This approach is coupled with guidance such as:

- One must always talk about the failure rates of condoms. One must not promote condoms in a way that implies that abstinence and condom use are equally viable choices, or that it is acceptable to engage in risky (i.e. condomised) sex. Condoms must be targeted to specific high risk individuals or groups, not the general population. Projects should adopt norms that denounce cross-generational sex and transactional sex.

Is it possible to do PEPFAR prevention programming for young people which corresponds with good practice?

In an ideal world PEPFAR-funded prevention programmes with young people would begin with a process of community mobilisation; all resources and activities in the community which reduce vulnerability would be mapped and a stakeholder analysis conducted. There would be transparency about ABY constraints and the programme would talk about the importance of condoms and ways to access them. Projects could also address the importance of delaying sexual debut and to ensure that the sex young people are having is wanted sex.

This would include comprehensive sexuality and life-skills education that covers caring relationships, gender norms, your right to decide not to have sex, self esteem, communication and assertiveness skills, information on non-penetrative sex and methods of seeking help. Alongside this group support and solidarity would be fostered along with strategies to stop sexual abuse and violence and to change harmful norms. You could encourage people to have fewer partners and to be faithful to their existing partner by equipping them with sexual and reproductive health and HIV awareness, and sexuality, relationship and communication skills. This would include information on condom use, contraception, VCT and prevention.

But there are considerable barriers to PEPFAR work that is in accordance with best practice. The abstinence earmark means that the US is not following its own

guidelines on ABC and ABY has become an entity in its own right. PEPFAR work is being carried out by more faith-based organisations (FBOs) who have low HIV capacity. United States Agency for International Development (USAID) tightly controls all stages of the project lifecycle, which creates anxiety about PEPFAR compliance and potential loss of funds and leads to conservative responses from programmers. Programmes are also saturated with sex-negative messages. The ABY message is reinforced by national/local conservative stakeholders. Demand for speed and coverage leads to lack of local contextualising, participation, monitoring, adequate capacity building, or sharing lessons learned. Finally PEPFAR gives out short, fixed grants that allow no time for behaviour change.

To overcome the negative aspects of PEPFAR it is necessary to contribute to the discourse on different models of prevention, to monitor and disseminate evidence on the impact of PEPFAR messages, and promote comprehensive prevention strategies and messages. Efforts must be made to lobby non-US government donors to strengthen their promotion and funding of comprehensive prevention programmes. The capacity of partners needs to be strengthened in order to develop comprehensive prevention strategies. In addition support should be given to beneficiaries and communities in their efforts to maintain positive attitudes and access to condoms.

Those working within PEPFAR-funded programmes should explore development of strategies which reduce the negative impacts and focus efforts on getting non-US government funding. They must engage with young people, who will usually say that they want to have condoms. Finally transparency is key so that communities can engage in open debate around the benefits and negatives associated with abstinence and behaviour change and can make their decisions around safe sex based on full and accurate information.

U.S. policy, ideology and the HIV epidemic: undermining effective prevention strategies

Jodi Jacobson, Center for Health and Gender Equity (CHANGE), USA

Our goal in tackling the HIV/AIDS pandemic is that people have safe, healthy, consensual sexual lives, that disease is prevented and risk reduced, and that the needs of all are met and their rights protected and promoted. One response to the pandemic is PEPFAR, a commitment of \$15 billion over five years to treat 2 million, provide care and support for 10 million and prevent 7 million new infections. PEPFAR is focused on 15 countries with 85 non-focus countries.

CHANGE has analysed PEPFAR at the central and country level. At the central level they have assessed the legislation and policy that makes up PEPFAR, how these are operationalised, and the interpretation of law and the way in which the policy has affected funding streams. They have looked at how funding is used in country, at any changes in country plans, the implementation of national law and policy and the actions of grant recipients and other government and civil society mechanisms.

PEPFAR policy contains certain conditions and conditionalities that have led to shifts in US policy. For example ABC conditionality and the 'Prostitution Loyalty Oath' have led to more money for FBOs and greater scrutiny of partners' work. These new restrictions accompany older policies such as the Global Gag Rule and restrictions on harm reduction work. The Prostitution Loyalty Oath denies funding to organisations that refuse to sign a pledge stating that they do not support the promotion or legalisation of prostitution. This vague policy stymies speech and action for vulnerable and marginalised populations and encourages a rescue and rehabilitation focus that may be counterproductive.

The ABC conditionality means that ABC-based programmes make up a high share of prevention funding. New USAID guidelines on bilateral AIDS programmes emphasise that youth should never be given condoms 'indiscriminately'. It also contains guidance on abstinence only which includes a ban on hugging and kissing and says that no other relationship is appropriate for sexual debut other than heterosexual marriage.

As a result of PEPFAR there have been shifts in condom procurement, distribution, and messaging. The overall budget for condoms under PEPFAR has not increased despite dramatically increased overall funding for HIV/AIDS. In 2004, the first year of PEPFAR, fewer condoms were distributed to the focus countries than in the previous year. Female condoms are not being talked about, supported, or scaled-up. U.S. policy on condoms is reducing their availability to the groups most in need, effectively restigmatising them, and aggravating condom gaps and shortages. In some countries, condom shortages have become chronic, even as HIV spreads rapidly.

Priorities of PEPFAR country programmes, and changes in these priorities, can be seen in their Congressional Budget Justifications. Kenya is the only country that mentions condoms in prevention in a comprehensive way and whilst Côte d'Ivoire, Uganda, and Rwanda mention comprehensive programming for youth, they are exceptions. Namibia, Nigeria, Rwanda, and Tanzania have modified, limited or eliminated aspects of prevention programmes. South Africa and Zambia completely eliminated condoms, comprehensive programmes, and/or risk reduction from prevention programmes between 2003 and 2004. All but one focus country includes a description of their abstinence prevention programme. Only five of the 15 countries mention prevention programming for 'high-risk' populations and most of these descriptions are vague. Only two focus countries substantively mention gender or women in reference to programming other than prevention of mother to child transmission (PMTCT); one of these references is to specifically targeting young women with virginity messages.

PEPFAR has led to institutionalised misinformation, stigma, and discrimination. This is mirrored by an increase in funding to organisations that provide misinformation, moralisation, and ideology. The consequence of PEPFAR is that prevention programming in generalised epidemics is undermined. Where prevalence rates are high there is little justification for limiting the definition of 'high-risk' as PEPFAR has done. PEPFAR ignores current sexual activity and the sexual and reproductive health needs of women and girls, men and boys. Finally, it denies access to HIV/AIDS related information and services.

Discussion following the presentations:

Participants noted that in addition to the problems raised above PEPFAR programmes are recruiting staff from existing health programmes which is causing knock on effects.

One pointed out that the relationship between donors and recipients is two way. Donors need to give their money away and NGOs need to take it. The US is using their money as an ideological weapon, and accepting their money makes that weapon effective. DfID global safe abortion fund is an example of how donors can support other types of initiative.

There was some discussion about whether other donors could fill the gap left now that the US has changed the emphasis of its HIV prevention policy, and how they could coordinate. There are parallels with when IPPF decided not to sign the Global Gag Rule. In this instance other donors did step in, including Norway, Sweden, Switzerland and an anonymous donor from the US.

In addition participants considered which other policy makers could counterbalance this policy. The African Union and NEPAD were mentioned as useful in challenging PEPFAR and Europe could also engage.

Points for participants to consider in their future work:

- Demand for condoms is increasing in many settings. How can we contribute to it?
- We need to unpack the figures associated with need and demand for condoms. How do you increase the demand? Once you have increased it how do you meet it?
- Do we want to use the term “abstinence” and if so how do we define it? If not, what should we replace it with?
- Demand for condoms is increasing in many settings. How can we contribute to it?
- When are free condoms, social marketed, donor- subsidised or government- distributed condoms appropriate? How do you choose when to charge for condoms, and how much? What is the role of the private sector in creating and meeting condom demand?
- How do we meet quality, procurement, storage and supply difficulties?
- How do we mainstreaming HIV prevention and treatment issues throughout gender, pleasure, and sexual and reproductive health and rights work?
- How do you get (heterosexual) men into discussions around gender and sexuality?
- Where is stigma in all of our discussions? Even sexually active people believe that abstinence is ‘better’.
- What about key population issues such as– violence and sexual violence against sex workers?
- Sexual pleasure is worth dying for and always has been. But issues of sexual pleasure and condom use may be a different matter for people who are indifferent to the experience or don’t desire sex. How do we respond to this?
- 30 second T.V. adverts versus labour intensive, interpersonal interventions (on gender, rights, sexuality etc), or both?
- The assumption when we say “condoms” is so-called male condoms. Female condoms are still greatly under-produced and promoted.
- How to can we describe the problems and difficulties into using condoms in condom promotion but still promote condom use?
- Lubricants – what kind and for whom? Should they be packaged with condoms?
- What is the role of the HIV prevention, treatment, care and support continuum as it relates to promotion of safer sex and condoms?
- How to address anti-condom messages, policies and programmes? How to reverse the effects that these programmes have? Counteracting the PEPFAR effects on policies, programmes and practice issues.
- How to alleviate the negative consequences of clandestine relationships?
- How to respond to the intersection of conservative and judgemental global policy, and traditional attitudes in many countries?

- How to achieve programmes need to happen at scale? What is the role of strategic assessments?

Recommendations:

- Eroticise condom packages, produce different shapes and sizes, give instructions for use, and adapt these for the local context; know your community.
- HIV prevalence rates continue to rise; condom promotion needs to be focused on reducing infection in those most at risk.
- Safe injecting drug use and condom promotion should be integrated.
- Listen to your consumers in the design, implementation and monitoring of condom promotion programmes; “Nothing about us without us”.
- Dual protection needs more promotion; address the different motivations for using condoms and the different people who need dual protection.
- Listen to young people’s voices and engage youth in condom policy, programme and service delivery development.
- Monogamy isn’t always mutual; young married women are also a high risk population in many countries. It’s time to talk about married men, and condom use in marriage too.
- Positive prevention means condoms for people living with HIV/AIDS too.
- Recognise the role of advocacy groups working in partnership with health workers in educating and promoting condoms.
- Comprehensive sexuality education is important.

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ANNEX 2: USEFUL RESOURCES SUGGESTED BY PARTICIPANTS

Organisational websites

Asia Pacific Network of Sex Workers

<http://www.apnsw.org>

Australian Federation of AIDS Organisations

<http://www.afao.org.au/>

Central and Eastern European Harm Reduction Network

<http://www.ceehrn.org/>

Centre for Health and Gender Equity

<http://www.genderhealth.org>

Department for International Development

<http://www.dfid.org>

DKT International

<http://www.dktinternational.org>

Family Health International

<http://www.fhi.org>

Female Health Company

<http://www.femalehealth.com/>

Global Network of People Living with HIV/AIDS

<http://www.gnpplus.net>

International Community of Women Living with HIV/AIDS

<http://www.icw.org>

International Harm Reduction Association

<http://www.ihra.net/>

International HIV/AIDS Alliance

<http://www.aidsalliance.org>

International Planned Parenthood Federation

<http://www.ippf.org>

National Centre in HIV Social Research, University of New South Wales

<http://nchsr.arts.unsw.edu.au>

Network of Sex Work Projects
<http://www.nswp.org>

North American PLWHA Network
<http://www.napwa.org>

Reproductive Health Matters
<http://www.rhmjournal.org.uk>
The Pleasure Project
<http://www.the-pleasure-project.org>

United Nations Children's Fund
<http://www.unicef.org>

Youth Coalition
<http://youthcoalition.org>

Publications and other resources

Positive Prevention

Positive prevention: prevention strategies for people with HIV/AIDS, 2003,
International HIV/AIDS Alliance, UK
<http://synkronweb.aidsalliance.org/sw9438.asp>

Temmerman, M. et al. (1995). 'The right not to know HIV test results' *The Lancet*
345: 969-970

Social Marketing

Website of the *Affair* brand www.umprazeramais.com.br

Female Condom

WHO (2002) Information update: considerations regarding re-use of the female
condom <http://www.who.int/reproductive-health/stis/reuse.en.html>

WHO (2002) The safety and feasibility of female condom re-use: report of a
WHO consultation (28–29 January 2002) http://www.who.int/reproductive-health/stis/docs/report_reuse.pdf

AVERT information page on the female condom
<http://www.avert.org/femcond.htm>

Website of 'Prevention Now!' a global campaign to increase access to female
condoms throughout the world www.preventionnow.net

Commercial sex

NSWP (1997) Making Sex Work Safe a Handbook for Programme Managers, Policy Makers and Field Workers www.nswp.org/safety/msws/index.html

The website of the WHO Western Pacific Regional Office contains a number of documents on the 100% CUP

<http://www.wpro.who.int/publications/publications.htm>

Celentano, D. D., Nelson, K. E., Lyles, C. M., Beyrer, C. Eiumtrakul, S., Go V. F., Kuntolbutra, S. and Khamboonruang C. (1998) 'Decreasing incidence of HIV and sexually transmitted diseases in young Thai men: evidence for success of the HIV/AIDS control and prevention program' *AIDS* 1998, 12:F29–F36

Pleasure

Passiononline, a sex toy and lingerie website and partner of The Pleasure Project www.passiononline.co.uk/

Modern Loving video the Pleasure Projects safe erotic guide

www.modernloving.com Resources on pleasure based programming with faith based organisations www.empowermentconcepts.com

The Pleasure Project (2004) Global mapping of pleasure <http://www.the-pleasure-project.org/GlobalMappingofPleasure.pdf>

Philpott, A. (forthcoming) 'Promoting protection and pleasure: maximising the effectiveness of barriers against sexually transmitted infection and pregnancy', *The Lancet*

Other

Website of the Demographic and Health Surveys programme www.measuredhs.com

Email address to subscribe to the Stepping Stones users group steppingstonesusers@yahoo.com

WHO, UNAIDS & UNFPA (2004) Position Statement on Condoms and HIV Prevention, Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment July 2004 http://data.unaids.org/una-docs/condom-policy_jul04_en.pdf

Saf aids website includes resources for the Southern Africa region <http://www.saf aids.org>

The Population Council's Horizons has many resources on HIV prevention <http://www.popcouncil.org/horizons>

ANNEX 3: ABBREVIATIONS

ABC	Abstain, be faithful, use condoms
ABY	Abstain, be faithful, work with youth
CBO	Community-based organisation
CDC	Centers for Disease Control and Prevention
CHANGE	Center for Health and Gender Equity
CUP	100% Condom Use Programme
DfID	UK Department for International Development
DHS	Demographic and Health Surveys
FBO	Faith-based organisation
FHI	Family Health International
GNP+	Global Network of People Living with HIV/AIDS
ICW	International Community of Women Living with HIV/AIDS
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
KABP	Knowledge, attitudes, beliefs and practices
MSI	Marie Stopes International
MSM	Men who have sex with men
NGO	Non-governmental organisation
OGAC	Office of the US Global AIDS Coordinator
PAI	Population Action International
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother to child transmission
RFA	Request for applications
RHM	Reproductive Health Matters
SAFE	Sero-status Approach to Fighting the HIV Epidemic
SFH	Society for Family Health, Nigeria
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWAA	Society for Women Against AIDS in Africa
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization
YDI	Youth Dignity International, Nigeria
YMCA	Young Men's Christian Association
YPWC	Young People We Care, Zimbabwe