

We may look back upon this time as a moment of opportunity, when concerted prevention efforts could have made—or did make—a huge difference.

Contracting HIV should not be a moral indictment. **Preventing the spread of HIV should be a moral imperative for all.**

Condoms are the only technology available to prevent the spread of HIV. Condoms Count establishes that, when combined with education and behavior change, condoms can be a powerful antidote to HIV.

Dr. Fred Sai, Advisor to the President of Ghana on Reproductive Health and HIV/AIDS

Condoms Count clearly highlights the enormous gap between condom supply and needs worldwide, and the alarming spread of HIV/AIDS in youth and high-risk groups and countries with elevated incidence of the disease. I feel that in view of the enormous suffering and costs that are caused by HIV/AIDS **the present support to condom use is deplorably tiny.** A lot more support should be given to implementing imaginative programs for the promotion and distribution of condoms.

Mechai Viravaidya, Chairman, Population and Community Development Association, Thailand

It is shocking that funding for condoms is decreasing as rates of HIV infection are increasing. Condoms Count quantifies the decline in both the supply and financial contributions for condoms as well as the growing need for education and prevention. **It should be required reading for anyone concerned about HIV prevention.**

And, as the report makes clear, that should be all of us.

The Honorable Timothy E. Wirth, President, UN Foundation

condoms COUNT

Meeting the Need
in the Era of HIV/AIDS

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with Michael Fox

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Summary

AIDS is now among the most devastating diseases in human history.

AIDS has already killed more than 20 million people worldwide. More than 40 million other people are today living with HIV infection, almost half of whom are women and a full third are young people aged 15-24. AIDS is the leading cause of death in sub-Saharan Africa, the fourth leading killer worldwide, and HIV, the cause of AIDS, continues to spread in every corner of the globe. No country is immune.

And yet infection by HIV can be avoided. All that is required is for all people everywhere to be given the information, education, skills and full access to the ways they need to protect themselves and others. **Male and female condoms are an essential component of such efforts and expanding and improving condom promotion and distribution are absolutely vital to success in the fight against the spread of AIDS.**

The fact that condoms can save

lives is indisputable. It is also a fact that a great many people in every country have no alternative to condom use for protecting themselves or their sexual partners, wives or husbands from infection. **Prevention efforts that do not include condoms are therefore incomplete and will ultimately be ineffective.**

Although the promotion and distribution of condoms have increased significantly since the onset of AIDS, the need for *both* promotion and distribution still far outstrips the resources committed. **It is estimated that a minimum of 8 billion condoms would have been needed in 2000** in order to achieve the kind of access required for significant reductions in the rate of infection and prevalence in the developing world and Eastern Europe. **Donors provided just 950 million condoms that year, less than one-eighth of the number needed.**

And while more developing coun-



try governments are allocating resources for prevention, national commitment remains inadequate.

With this report, *Condoms Count: Meeting the Need in the Era of HIV/AIDS*, Population Action International (PAI) continues its efforts to assess the world's progress towards achieving the reproductive health goals adopted by the international community. This report also complements the work by PAI and others to address the growing shortfalls of reproductive health supplies in many developing countries.

Supplies are, of course, only one part of the challenge in addressing poor reproductive health. This is particularly true with regard to the fight against HIV/AIDS, which requires significant changes not only in public policy, but also in individual attitudes, behaviors and in societal norms. Addressing poverty and the roots of gender inequities is key to such change.

To be effective, HIV/AIDS prevention programs must include a range and mix of interventions tailored to the specific needs of various groups and localities. **The range must include promotion of the "ABCs" of prevention: abstinence, being faithful to one's partner, and condom use by the**

sexually active. And the mix of interventions must always include condoms—a most basic reproductive health technology that provides dual protection from infection and pregnancy. **The international community, especially donor nations and institutions, must act quickly to mount large-scale comprehensive prevention efforts that strongly support promotion and distribution of condoms.**

Failure to act is already having tragic consequences, particularly in sub-Saharan Africa where last year 2.2 million people died of AIDS and 28 million currently live with HIV/AIDS and where, in high prevalence countries, at least a third of boys now aged 15 will die of AIDS.¹

These horrifying statistics for Africa presage the future for other regions and countries unless preventive action—including widespread condom promotion and distribution—is immediately intensified. Despite the hold that HIV currently has on sub-Saharan Africa and, increasingly, on the world, we may one day look back upon this time as a moment of opportunity, when concerted prevention efforts could have made—or did make—a huge difference.

Why Condoms?

Some 14 thousand people a day become infected with HIV and the vast majority of these infections are sexual. Yet sexual transmission of HIV can be avoided through the practice of safer sex. Despite this fact, HIV continues to spread mainly because not enough people are practicing safer sex. Abstaining from sex, mutual monogamy between uninfected sexual partners, and the correct and consistent use of male and female condoms are the only existing options for avoiding sexual infection. It is therefore essential that everyone have access to the information and tools that enable them to have safe and responsible sexual relations and to negotiate safer sex, including condom use.

The condom is the only technology available for protection from sexually transmitted HIV. It is scientifically undisputed that the transmission of HIV during sexual intercourse can be prevented when condoms are used correctly and consistently (see *Condom Effectiveness*). Nonetheless, condom use is still much too low, despite decades of promotion for use in the prevention of sexually transmitted infections (STIs)—including, since the early 1980s, HIV—and significant increases in distribution and availability. Insufficient use is due to many factors, among them generally low levels of awareness, poor availability and accessibility, especially for young people, misinformation, and the stigma attached to condoms.

Condom use is especially important for individuals at higher risk of infection, including men who have sex with men, sex workers and their clients, injecting drug users, migrant workers and others who are obliged to spend long periods away from their regular sexual partners. However, there are people everywhere who cannot adopt an alternative method to condom use for protecting themselves or others such as those whose sexual partners are

infected by HIV but also, and most obviously, the women and men forced by their circumstances into sex work. They must use condoms every time they have sex because they have little or no choice.

In those places where HIV prevention efforts have been successful in reducing prevalence and infection rates, condoms have played a key role. There are many documented cases illustrating the positive effects of condom promotion and increased use, including in Thailand among sex workers and their clients, and among young men in Brazil and India.

Condoms are a simple and affordable yet life-saving technology. They can be easy to use, do not require medical supervision, and can be distributed through schools, places of employment, bars, and other public venues, as well as health care facilities. Where they are available, both male and female condoms are increasingly affordable through free or subsidized distribution.

Prevention efforts that include condoms are highly cost-effective. It is obviously better to prevent HIV infection now than to bear the human, societal and financial costs of illness and its treatment and care later. According to a study by the University of California at Berkeley, interventions to control STIs among urban sex workers that include health education and condom distribution are the most cost-effective interventions and cost just US\$3.50 per life saved per year. Somewhat more costly, at US\$19.49 per life saved per year, were voluntary counseling and testing interventions (VCT) that included condom distribution to program participants. In comparison, treatment with the generic form of anti-retrovirals and monitoring the patient's therapy using a directly-observed therapy (DOT) regimen cost US\$1,033 per year.²

Whatever its initial entry point into a population, HIV eventually spreads through sexual transmission.

History of Condom Use

As early as 1000 BCE, the ancient Egyptians used a linen sheath for protection against disease, while the Chinese are known to have used oiled silk paper. However, the oldest condoms ever found date back to 1640 and were excavated near Birmingham, England. They were made of fish and animal intestine.

In 16th century Italy, Gabrielle Fallopius authored the first-known published description of prophylactic condom use. Fallopius conducted trials among 1,100 men using a sheath made of linen; none of the men became infected with syphilis. During this period, protection was also improved by soaking the cloth sheaths in a chemical solution and allowing them to dry prior to use—the first use of a spermicide on condoms. The condom's usefulness in preventing pregnancy was recognized in the 1700s.

Condoms made out of animal intestines became widely available in Europe, but were costly and often reused. In 19th century Japan, the Japanese had condoms made from two other materials: one made of thin leather and the other of thin tortoise shells or horns.

The mass-production of "rubbers" began after 1844 and the invention of vulcanization, a process that turns crude rubber into a strong elastic material. These were as thick as inner tubes, had a seam, and deteriorated rapidly. Latex manufacturing processes improved sufficiently in the 1930s to produce single-use condoms almost as thin and inexpensive as the ones used today.

The reservoir tip on the latex condom was introduced in the early 1950s, textured condoms in 1973. In 1994, Polyurethane emerged as an alternative to latex, leading to the development of both male condoms for latex-sensitive people and the female condom.

Sources:

Dooley, M.M. 1994. "History of the condom." *J Royal Soc Med* 87:58, January.
Himes, N. 1963. *Medical History of Contraception*. New York: Gamut Press, Inc.
Youssef, H. 1993. "The history of the condom." *J Royal Soc Med* 86:266-228, April.



Effectiveness of Condoms

Public health experts around the globe agree that condoms block contact with bodily fluids that can carry the HIV virus and have nearly 100 percent effectiveness when used correctly and consistently. According to multiple studies, male condoms reduce the risk of contracting HIV "as much as 10,000-fold."

Latex condoms available in international markets are of very high quality. A number of institutions, including the World Health Organization, set specifications and standards for manufacturing and procurement in order to assure the quality of condoms. As a result, poor quality is rarely a factor in condom failure. Breakage or slippage can happen occasionally because of improper use.

Condoms should not be reused, or used with oil-based lubricants that weaken latex; and packages should not be opened with teeth or sharp objects.

Condoms are also inexpensive, the average international price being just US\$0.03 (3 cents) per male condom, including the costs of sampling, testing and shipping.

Sources:

Carey, RF and others. 1992. "Effectiveness of Latex Condoms as a Barrier to Human Immunodeficiency Virus-Sized Particles under Conditions of Simulated Use." *Sexually Transmitted Diseases* 19(4): 230-234.

Cavallieri d'Oro, L and others. 1994. "Barrier Methods of Contraception, Spermicides, and Sexually Transmitted Diseases: A Review." *Genitourinary Medicine* 70(6): 410-417.

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National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services. 2001. "Workshop Summary: Scientific Evidence on Condom Effectiveness and Sexually Transmitted Disease Prevention" [Unpublished paper].

Steiner, MJ, W Cates, Jr. and L Warner. 1999. "The real problem with male condoms is nonuse" [Editorial]. *Sexually Transmitted Diseases* 26(8): 459-462.

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Although in its initial stages the epidemic may spread mainly through unsafe blood and injecting drug users, HIV inevitably spreads within the general population as a sexually transmitted infection. The most heavily affected countries are those in the later stages of the epidemic's development.

More than 80 percent of HIV transmission is now heterosexual in Africa, where the epidemic has been established the longest. The Caribbean is the second most affected region and the vast majority of infections in Central America and the Caribbean are the result of unsafe heterosexual sex and frequent partner exchange among young men and women. In parts of South America, which has a more diverse epidemic, men having sex with men account for as much as 70 percent of infections. In Asia and the Pacific, most HIV infections still result from unprotected sex between commercial sex workers and their clients and between men, in addition to injecting drug use, but this pattern will likely change if the epidemic develops further.

Where curable sexually transmitted infections exist, so does HIV. Worldwide, over 300 million new cases of curable STIs occur annually, with a regional distribution similar to that of HIV. Infection with an STI increases a person's risk of acquiring HIV, especially for a woman. If detected, many STIs can be successfully treated, but delays in seeking treatment, shortcomings of STI services, and the reality that many infections are asymptomatic, mean STIs too often go untreated. Correct and consistent condom use, and other behaviors to limit exposure to infection, can prevent sexually transmitted infections, especially HIV. The prevention and treatment of STIs can therefore be effective in reducing HIV incidence, particularly where HIV prevalence is low but that of STIs is high.³

While societies and their governments may view the promotion of condoms as a means to reduce rising rates of

HIV prevalence, the main reason for promoting condoms is to offer to individuals one of only three possible means of protection from sexual infection by a 99.9% fatal virus (only rabies is more deadly than HIV). **HIV/AIDS prevention efforts that do not include condoms as an option are incomplete and ultimately ineffective.**

Why Now?

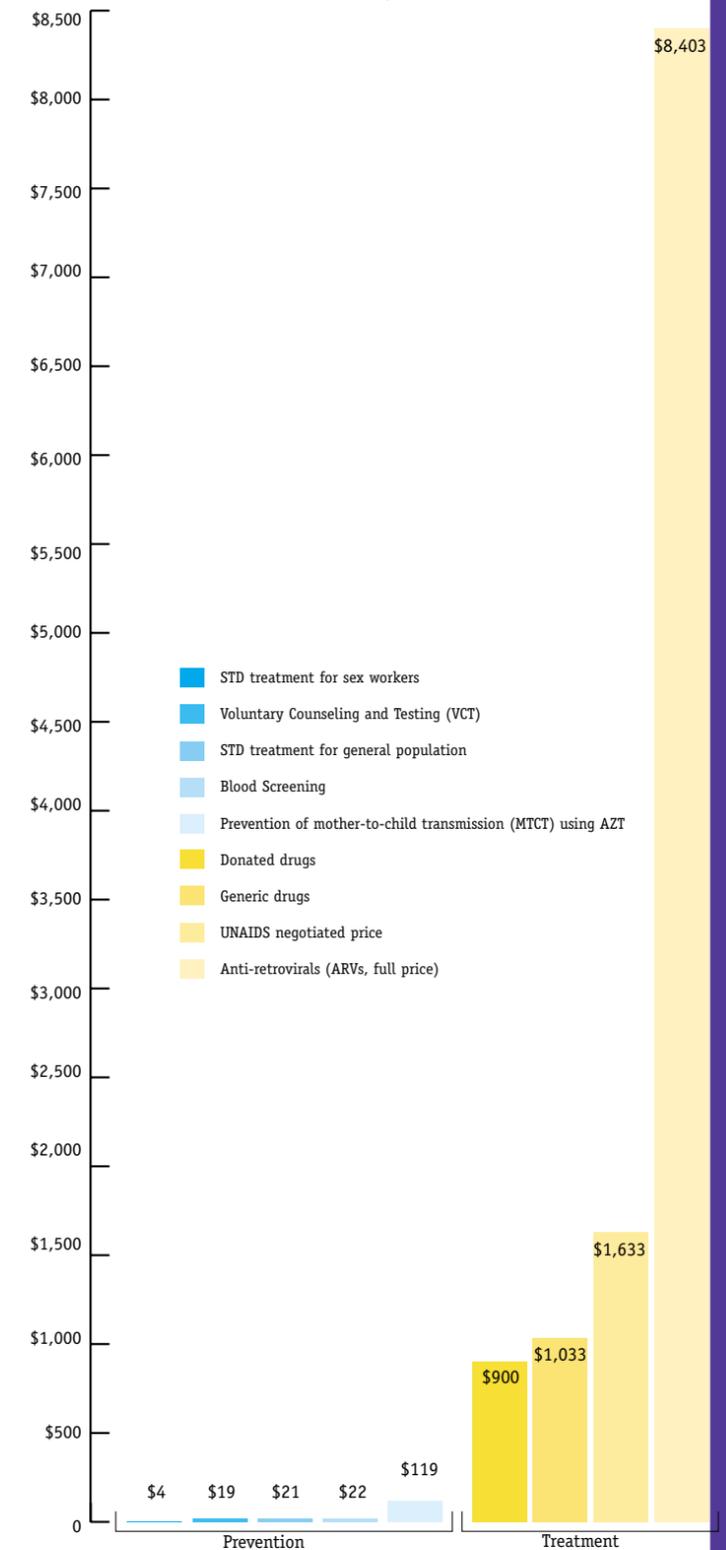
Few who watch television, listen to the radio, or read the news on paper or on-line can be unaware of the AIDS pandemic. Current statistics on the epidemic are staggering: a cumulative total of more than 60 million people infected, of whom 20 million have died. And while the disease is deadly to those individuals directly infected, its effects threaten economic and social development and stability. The present may appear bleak, but the future could be worse.

Almost half of all new HIV infections are occurring among people younger than 25. Most infected persons—who live in developing countries and of whom almost all are unable to access expensive, life-prolonging treatment and care—will die by the age of 35.⁴ The potential loss of generations of people in their most productive years impacts whole families, communities and nations.

Botswana, the country with the highest HIV prevalence, is projected to have fewer people aged 40-50 years, in 2020, than people aged 60-80 years, an unprecedented phenomenon for a developing country.⁵ Such a shrinking proportion of productive adults relative to the age-groups that are dependent on them, means fewer adults will be supporting more children and the elderly who, when both HIV-infected parents die from AIDS, are increasingly taking care of each other.

The combination of high or rising prevalence rates and growing numbers of people of reproductive age

Comparison of Cost Effectiveness of Various HIV Interventions (Cost per life year saved)



Source:

Masaki, E and others. 2001. "Cost effectiveness of HIV Prevention versus Treatment for Resource Scarce Countries: Setting Priorities for HIV/AIDS Management" [Unpublished paper]. Presented at the XIIIth International Conference on AIDS and STDs in Africa, Ouagadougou, Burkina Faso, 9-13 December 2001.

places a staggering number of people at risk of infection. Every country in the world has reported the presence of HIV in its population although infection rates vary. HIV prevalence rates are very high in many countries, especially in sub-Saharan Africa. In countries such as Botswana and Zimbabwe, between one-third and forty percent of adults are HIV-infected. Infection rates are low but rising rapidly in others, as is the case in Russia. With world population still growing, we now face the largest ever population of young people: 3 billion of the world's 6 billion people are under 25 years of age. More than a billion pre-teen youth stand at the threshold of sexual maturity and experimentation.

High proportions of young people in developing countries are sexually active. The majority of the world's youth aged 15-19—and many even younger—are sexually active and defining different rules for sexual conduct than their parents and grandparents.⁶ Their immature reproductive tracts make them more susceptible than adults to acquiring STIs. Their sexual activity is taking place within both socially approved and disapproved contexts, affording them varying degrees of access to protection from HIV.

In sub-Saharan Africa, one in three unmarried girls and approximately two in five boys aged 15-19 are sexually active. Among unmarried girls in Botswana, for example, close to two-thirds are sexually active, while in Senegal, only about 1 in 12 unmarried 15-to-19 year-old girls are sexually active.⁷ In six Latin American countries for which there are data, girls aged 15-19 report lower levels of sexual activity, ranging from 1 in 20 in Nicaragua to as high as one in five in Brazil.⁸ Among boys aged 15-19, 60 percent are reportedly sexually active in Brazil, as are 50 percent of boys in the other five countries.

As AIDS-related death rates rise, life expectancy is dropping. In highly affected countries in sub-Saharan Africa, average life expectancy is now only 47 years, rather



than the 62 years it would be in the absence of HIV/AIDS, largely because of the pandemic's toll on the lives of young adults. In four countries—Botswana, Malawi, Mozambique and Swaziland—life expectancy has dropped to less than 40 years. Average life expectancy in South Africa, which would have been 66 years, is 47 in the era of HIV/AIDS, and is expected to fall further to just 42 years by 2010.⁹ In Haiti, life expectancy is 53, rather than the 59 years it would have been without AIDS.

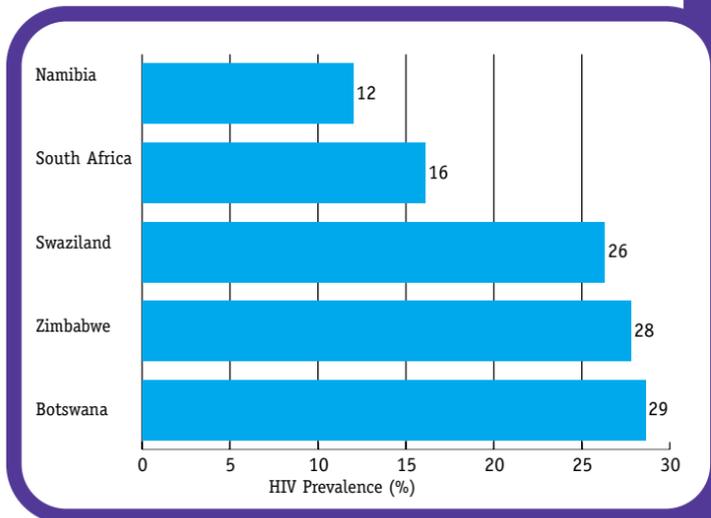
AIDS may have a tremendous impact in Russia, where the disease is spreading rapidly, despite current low HIV prevalence (0.9 percent in 2001). Cardiovascular diseases, injuries, and alcohol-related diseases have already dramatically lowered life expectancy in Russia.¹⁰ Life expectancy for Russian men in 2001 was 59 years, shorter than that of men in three-fourths of the world's countries.¹¹ This demographic trend, already predicted to

accelerate over the next two decades, may be further exacerbated as HIV steadily seeps into the general population.¹²

Life expectancy is also being pushed downward by increasing numbers of infants born HIV-positive, as well as by deaths among those children orphaned by AIDS. An estimated 70 percent of childhood deaths in Zimbabwe are now due to AIDS. More than 11 million children in sub-Saharan Africa have lost one or both parents to AIDS, a figure that is expected to double by 2010.¹³

The dissolution of families, loss of skilled workers, declines in productivity, and high public expenditures are endangering prospects for sustained economic

HIV Prevalence among Pregnant Girls Aged 15-19 Visiting Prenatal Clinics in Five Southern African Countries



In many parts of the world, where HIV is particularly epidemic among youth, teen girls are having sex with older men already infected with HIV. In Southern Africa, where HIV prevalence among youth is remarkably high, many teenage mothers are living with HIV/AIDS and passing along the disease to their children. In Swaziland, Zimbabwe and Botswana over a quarter of expectant young mothers attending a prenatal clinic were infected with HIV. HIV prevalence among 15-19 year old women is very high in these Southern African countries; clearly, safer sex is not practiced.

Source: UNAIDS



growth and social progress in the hardest-hit countries.

HIV/AIDS drives families into debt and certain penury when breadwinners become sick or die, as expenditures increase for medical care, drugs, and funeral expenses, and savings disappear. The epidemic is depleting already limited public resources in many countries of the developing world, where health budgets amount to much less than US\$50 per person per year. In some African countries, AIDS patients occupy between 30 and 75 percent of all hospital beds.

The impact of HIV/AIDS is being felt in both personal and national incomes. Per capita income (Gross Domestic Product per capita) is projected to drop by 8 percent by 2010 in some countries. By 2020, GDP in those countries most affected by HIV/AIDS could decline by 20 percent.¹⁴

Only Condoms?

Condoms are necessary for the success of HIV/AIDS prevention efforts, but they are by no means sufficient. Overall success is dependent on strong political leadership, appropriate funding, supportive policies, and well-planned and coordinated programs that work to influence attitudes and change behaviors and that provide the necessary services and supplies.

A supportive policy and social environment is key to the success of prevention strategies. Governments, in collaboration with a civil society that is well attuned to their communities' cultural nuances, need to provide such an environment. By addressing the policies, cultural practices and economic conditions that increase people's vulnerability to HIV infection, governments and societies can encourage individuals' behavior change.

Changing attitudes and behavior is at the heart of HIV prevention. A successful strategy establishes the con-

ditions and environment that allows people to protect themselves against infection, educates about sexual health and HIV transmission, and emphasizes abstinence and delaying the onset of sexual activity for those who are not sexually active. It encourages having fewer sexual partners, provides the skills to negotiate safer sex, and promotes condom use for those who are sexually active. A good prevention strategy also treats STIs, provides HIV counseling and testing for those who want to know their HIV status, prevents mother-to-child transmission by protecting the mother from infection, and treats infected mothers. It should also address traditional practices, such as female genital cutting, that increase the risk of HIV infection. Strategies should also be in place to ensure the safety of blood supplies and to address injecting drug use.

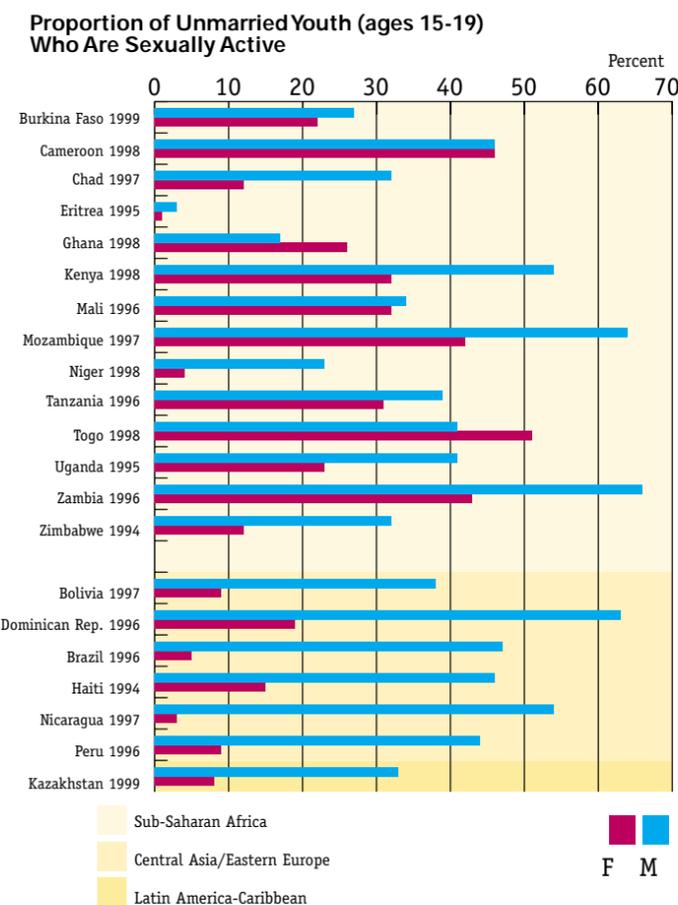
Prevention from infection will remain for the foreseeable future the mainstay of the battle against AIDS and the inclusion of condoms in prevention efforts is essential. The ever-changing nature of the virus that causes AIDS makes finding a cure and vaccine among the most urgent challenges of our time, but development and testing is still expected to take years, with even more precious time required to distribute widely.

The Condom Challenge: Too little use, too little access, inadequate availability

The stigma, secrecy and discrimination surrounding HIV/AIDS remain major obstacles to addressing the disease in general and sexual behavior in particular. Condom use is further complicated by a host of other factors, among them generally low levels of awareness,

availability and accessibility—especially for young people—as well as widespread misinformation.

Individual knowledge, attitude, awareness and personalization of HIV risk, as well as the communication and power-sharing dynamics in relationships, all influence condom use. The attitudes of parents, peers, religious figures, political leaders and role models are also very influential. The availability of and access to male and female condoms may be complicated by inadequate government or donor financial support, as well as by the lack of coordination among programs, and the absence of any comprehensive HIV/AIDS strategy. And ultimately, these obstacles to access reflect the strength—or weakness—of political support for



Source: Demographic and Health Surveys

HIV/AIDS prevention efforts at both the national and international level.

Individual and societal obstacles to use

HIV/AIDS is at crisis levels, but awareness and knowledge of the disease remain low. Forty million people are living with HIV or AIDS worldwide, yet only 5 to 10 percent of those infected know their status. Millions of people have still never heard of AIDS, or have few or inaccurate ideas about how it is transmitted. UNICEF reports that more than half of young people aged 15-24 in more than a dozen countries—representing all the developing regions—are in this situation.¹⁵ Such a lack of knowledge is particularly disturbing given the increasing toll the disease is taking on young people.

Low perceived risk of HIV infection contributes to low condom use. Condom use is lowest among married partners and youth, who often believe they are “safe” from or invulnerable to infection. An eight-country study in sub-Saharan Africa found that low perception of personal risk is the most important reason that people avoid using condoms: men and women tend to trust their marital or regular partners.¹⁶ Other studies have shown that relationships with higher levels of love and commitment are associated with lower levels of condom use.¹⁷ Even female commercial sex workers are more likely to acquire STIs from their lovers, with whom they have unprotected sex, than from their clients. And many men do use condoms with casual partners because of a higher perceived risk of contracting HIV.

Sexually active youth in particular may not feel they are at risk. Young people tend to consider themselves invulnerable to risk, even in countries where HIV is widespread, and the unplanned or secretive nature of many of their



sexual encounters makes it difficult for them to protect themselves even when they are aware. In Zambia, for example, youth who have only seen older people die of AIDS believe that HIV infection only occurs among older people. Youth feel more confident about having sex with partners who do not suggest condom use, because they think them less likely to have STIs, including HIV.¹⁸

Norms of sexual behavior in many societies make it difficult for the sexually active to negotiate condom use. In many societies, people associate condoms with infidelity and commercial sex; adolescents often consider the discussion of condom use with a partner a signal of distrust.¹⁹ Married women may hesitate to initiate condom use for fear that they will be accused of infidelity.

Many feel powerless to propose condom use with the conjugal partners on whom they depend for financial and emotional support.²⁰ Such obstacles thwart both public dialogue about the importance of condoms and the negotiation of condom use in caring relationships.

Gender roles and inequalities jeopardize sexual and reproductive health for both women and men. Concepts of masculinity lead men in many settings to take sexual risks, including seeking out multiple partners, engaging in unprotected sex, and avoiding clinical settings as sources of information and services. Notions of femininity make it difficult for women to discuss sex and reproduction with their partners, and may also inhibit their mobility, restrict their access to health services and the resources to pay for them, and subject them to violence or coercive sex.

Condom use is further affected by dislike for the way condoms feel. Condom users have indicated that they reduce sensation and compromise the spontaneity of sexual encounters. These were frequently cited reasons for non-use of condoms by women and men, in response to the same

Low perception of personal risk is the most important reason that people avoid using condoms.

eight-country survey referenced above.²¹ Resistance to use is also sometimes as much about beliefs or fears, as it is about reality. Men may not want to use condoms because they believe that condoms reduce the pleasure of sex or reduce their virility. Such concerns, including worries by either partner about loss of erection, can add to the difficulty of negotiating condom use.

Misinformation about condoms is common. Incomplete information on condoms can result in people having misconceptions about condom effectiveness or, worse, in their using condoms incorrectly. Opponents of condom use have also spread misinformation and false claims about condoms.

Programmatic and policy barriers to access

Many governments still hinder condom-related activities in their countries, despite the obvious need to guarantee unimpeded access to all forms of protection from life-threatening dangers such as HIV, and the international community's stated commitment to such access—reaffirmed most recently at the UN Special Session on HIV/AIDS in 2001 (see *The United Nations and HIV/AIDS*). Policy-level obstacles to condoms vary among countries, and may be applicable at national, district or community levels, but can include: restrictive measures and legislation on distribution of and public communication regarding condoms; prohibition of information on condoms for young people and in schools; prohibitions against 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; and policies that require condom procurement from local manufacturers at prices much higher than available from other countries.

Many prevention programs are obliged to respect these

limitations and are therefore less effective in combating AIDS and the spread of HIV. Over the years since the appearance of HIV/AIDS, these restrictions, which were once almost universal, have gradually been loosened but are still strongly applied in too many countries in both the North and South.

Too many programs fail to adequately promote condoms and to impart the skills and knowledge required to use them effectively. A study among youth in Rwanda showed that fewer than 20 percent knew how to use condoms correctly.²² In Pakistan, as in India, where condoms have been promoted for family planning for decades, many individuals at high risk of acquiring HIV do not know that condoms can protect them against HIV transmission.²³

Adult bias blocks young people's access to condoms and information about them. In spite of evidence to the contrary, a common and dangerous misconception is that condom promotion results in increased sexual activity and promiscuity, especially among young people. Fearing that



it will promote sexual activity out-of-wedlock, many service providers and pharmacists do not make condoms easily accessible to youth. Adolescents may hesitate to obtain condoms available at clinics because service providers act judgmentally towards them.²⁴ Young women may be especially timid because it is considered inappropriate for them to seek condoms.

Abstinence-only programs reflect adult discomfort with comprehensive sexuality education. The promotion of condoms as part of comprehensive HIV prevention programming, including sexuality and sexual health education, is not fully accepted. Drawing on the U.S. experience, there is no evidence that abstinence-only programs delay onset of sexual activity or other sexual behavior.²⁵

Limited distribution systems complicate access, especially in rural areas. Government outlets may be relatively few and widely dispersed, or private-sector sources may favor wealthier urban areas, resulting in uneven availability within a country.



The Crisis in Reproductive Health Supplies

The last few years have seen an enormous increase in the use of reproductive health services around the world—reflecting not only a growing population, but also increased interest in family planning and concern about STIs, especially HIV/AIDS. Large supplies of products essential to reproductive health programs will be needed to meet the growing demand. And yet, just as funding for condoms has seen a declining trend in the past five years, so has support for other supplies essential to good reproductive health care including, in particular, contraceptives. Without an adequate supply of contraceptives and condoms, no amount of reproductive health service improvement or education will succeed. AIDS is the leading cause of death among reproductive health-related problems, and condoms are absolutely critical to efforts to halt its spread.

Estimates by several organizations, including Population Action International, indicate that for each additional one million couples worldwide given access to modern methods of contraception, including condoms, there will be:

- 370,000 fewer unintended pregnancies;
- 130,000 fewer unintended births;
- 190,000 fewer abortions; and
- 40,000 fewer miscarriages.

In response to the growing crisis in reproductive health supplies, leaders of United Nations agencies, developing country delegations, representatives of non-governmental organizations, private and public funders, and technical agencies met in May 2001 as partners on equal footing to address this critical issue.

The conference entitled "Meeting the Reproductive Health Challenge: Securing Contraceptives, and Condoms for HIV/AIDS Prevention," held in Istanbul, Turkey, was organized by the Interim Working Group (IWG), a collaboration of Population Action International, John Snow, Inc., Program for Appropriate Technology in Health (PATH) and the Wallace Global Fund. The meeting served to raise awareness, engage critical stakeholders and to define key areas and mechanisms for implementing an action agenda to ensure the provision of reproductive health supplies to all who desire them.

A new alliance of nine member organizations, the International Initiative on Reproductive Health Supplies (IIRHS) grew out of the IWG and is actively working to make the action agenda a reality.

Sources:

Interim Working Group on Reproductive Health Commodity Security (IWG). 2001. *Meeting the Challenge: Securing Contraceptive Supplies*. Washington, DC: Population Action International for the IWG.
Population Action International. 2000. "Potential Impact of increased family planning funding on the lives of women & their families overseas" (Unpublished paper). Washington, DC: PAI.

Lack of donor support, coordination, are obstacles to availability

In 2000, donors provided less than one billion of the estimated eight billion condoms required in developing countries and Eastern Europe to greatly expand access for those in need. Many developing country governments are providing and promoting condoms as part of their HIV prevention strategies, but for the poorest countries, assistance from the wealthier developed countries remains the main source of condoms. In other countries, sustainable prevention efforts that include promotion and provision of condoms are hurt by inadequate government commitment.

Condom supply and distribution systems are not coordinated or streamlined. Condoms move through multiple supply systems—donor, developing country government and private sector—each with its own exacting demands regarding storage, logistics, and purchasing practices. Many of these supply and distribution systems are not coordinated or streamlined. For instance, international donors currently have inconsistent policies and practices regarding the procurement of condoms for countries in need. Developing country governments often have weak communication lines and many lack a national strategy for managing reproductive health supplies. Conditions such as these can and do result in supply system breakdowns and wasted resources.

Meeting the Challenge: Promoting use, expanding access, ensuring availability

Achieving the needed increases in condom access and use will require changes in attitude and behavior at all levels of society and governance: by individuals, service providers,



Dhal Bahadur (Condom Man) leads a rally on Condom Day in Nepal



Social Marketing

Social marketing adapts the commercial marketing approach to achieve social goals. It recognizes the synergies created by addressing supply and demand using commercial infrastructure, research, packaging, promotion, and sales techniques to make and distribute condoms, and to promote behavior change among target populations. To complement traditional outlets and better reach some specific groups or geographical areas, individuals from specific communities may be recruited and trained to act as sales agents.

Social marketing programs have helped make condoms more accessible and affordable to various segments of the society, including low-income and high-risk groups in many developing countries. In 2000, 1.2 billion condoms were sold at below market prices through social marketing programs in 59 countries. An effective mechanism for condom distribution, social marketing produced dramatic increases in sales by promoting condoms as an HIV prevention strategy. When an effective

microbicide is available on the market, experience from condom social marketing will help make it accessible in the developing world.

Social marketing programs do not seek to make profits. They use sales and other revenue (e.g. government or donor subsidies) for reinvestment and to defray distribution and promotion costs. For instance, the Social Marketing Company of Bangladesh partially financed the purchase of a new building through sales revenue, reducing the long-term operational costs of the project.

Social marketing programs tailor their subsidies to their markets' income levels. In middle-income countries social marketing programs strive to keep prices low enough for the lowest income earners, while maintaining enough net income to fund new inventory, advertising campaigns and general operating expenses. In lower-income countries, such as Ethiopia and Bangladesh, prices have to be more heavily subsidized.

Social marketing programs can act as a bridge between the public and private sectors. Programs are developed in collaboration with

governments to complement existing services and distribution systems. For example, by providing low-cost condoms outside of the health clinics, they serve consumers who shun systems they perceive as lacking privacy or who are unable to frequent clinics. Social marketing can also increase the overall demand, segmenting markets and paving the way for greater commercial participation. Dependence on government-supplied free condoms can be lessened through cost-recovery from those who can afford to pay. DKT-Brazil is a case in point: it sells condoms at full price to some and uses some of the profits to subsidize condom sales to the poor. Aggressive marketing by DKT-Brazil in the early 1990s served to boost demand and sales when the condom market was small, making the Brazilian market more attractive to the private sector.

Sources:
DKT International. 2002. *2000 Contraceptive Social Marketing Statistics*. Washington, DC: DKT International.
DKT International. 2002. *2001-2002 Progress Report, Weaving the Social Fabric*. Washington, DC: DKT.
PSI, UNAIDS. 1997. *Social Marketing: An Effective Tool in the Global Response to HIV/AIDS*. Geneva, Switzerland: UNAIDS.
UNAIDS. 2000. *Condom Social Marketing: Selected Case Studies*. Geneva, Switzerland: UNAIDS.

and by influential individuals and policymakers in the local, national and international arenas. For individuals, the biggest change needed may be with regard to perceived risk of infection and attitudes toward condoms. Programs and service providers must give condoms the priority they deserve, and teach proper use and the communications skills needed to negotiate that use. Those active or influential in the policy arena must take the lead in breaking the silence around HIV/AIDS and how it can be prevented. And those with the necessary financial and technical resources must make those resources available where needed. Only with good programs, sound policies, and strong political commitment can there be sustained, successful prevention of HIV/AIDS.

Promoting use

Individuals need to understand and accept their risk of infection. Those providing information about HIV need to recognize that information alone does not necessarily translate into behavior change. To be effective, communications efforts must not only inform people about the risk of unsafe sexual behavior and the “ABCs of prevention”—abstinence, being faithful to one’s partner, and condom use—but also make the risks of unsafe sex look real to people. This “personalization” of risk motivates behavior change.

Programs must promote a range of safer sex behaviors in order to succeed.²⁶ Uganda offers a clear example: with an emphasis on interpersonal communication among family members and friends, knowledge about HIV is diffused in a socially sanctioned setting that not only presents a personalized view of HIV risk but also lends credibility to behavior change recommendations. In concert with very public support by the country’s political leadership, this approach yielded increases in condom use, a significant decrease in the number of non-regular partners (especial-

ly among those never married), and a reduction in the proportion of sexually active males among those aged 15-19. These behavioral changes limited personal exposure to the risk of infection and reduced the total number of new infections. HIV prevalence in Uganda dropped significantly between 1994 and 1998—from 21 to 10 percent among 15-49 year olds, and from 21 to 5 percent among 15-19 year olds.²⁷

Local, culturally sensitive communications networks can help slow the HIV epidemic. Such networks can quickly disseminate accurate and timely information about risk and prevention. Senegal, with a tradition of active community involvement in health and development issues, had such networks in place when AIDS surfaced. In this predominantly Muslim country, religious leaders delivered sermons about HIV, making a major contribution to the success



of the national program. In Thailand, health service providers traveled to villages to educate community members about HIV, with the involvement of Buddhist monks and traditional healers.

Promotion strategies need to reinforce the idea that condom use is responsible, not promiscuous, behavior. Mass media support for condoms can be important in overcoming cultural resistance and changing societal norms. Governments can take the lead in breaking the public silence on condoms through use of mass media, as has happened in some countries, but increasingly social marketing programs, which apply advertising principles to health communication, are taking on this challenge (often with direct or passive support from governments). For example, an evaluation of a social marketing intervention in



Microbicides

The bringing to market of microbicides would add to the narrow range of methods available for protection from HIV/AIDS. Condom use, mutual monogamy and abstinence are not options for many women, particularly in the developing world. For people who lack the ability to negotiate condom use, microbicides will provide a welcome—and potentially lifesaving—alternative to condoms. Some could give women the option to protect themselves from infections even when they decide to get pregnant.

A microbicide is any substance that can substantially reduce transmission of sexually transmitted infections (STIs) when applied topically either in the vagina or rectum. A microbicide could be produced in many forms, including gels, creams, suppositories, films, lubricants, or in the form of a sponge or a vaginal ring that slowly releases the active ingredient over time.

Microbicides work in four ways. They may kill or immobilize pathogens, create a barrier between the microbe and the vulnerable tissues or target cells, boost the vagina’s own defense system, or prevent an infection from taking hold after it has entered the body by preventing viral replication. Some microbicides could potentially combine mechanisms for extra effectiveness. The ideal microbicide would be odorless, non-staining, easy to apply, and virtually unnoticeable by a person’s sexual partner.

An estimated investment of \$500 million is needed to bring Carraguard, the most promising candidate, to the market. Estimates of the potential market for such products range from US\$900 million in 2011 to US\$5 billion annually. A study by The Alan Guttmacher Institute (AGI) estimated that 21.3 million women in the United States alone would be interested in using the product when it is available.

Almost 60 microbicidal products or compounds are under development. One enters phase III effectiveness trials in 2002; two are in phase II trials and will be entering phase III in the near future; another nine are in Phase I trials to establish human safety, (see *Understanding Clinical Trials*). Virtually all microbicide research is being conducted by non-profit and academic institutions or small biotechnology companies dependent on government or donor funding. Private donors, including the Bill & Melinda Gates Foundation, have recently increased their investment in microbicides. Big pharmaceutical companies’ investment in microbicides have been minimal because of perceived low profits from such an enterprise.

The Global Campaign for Microbicides believes that with sufficient investment now, a product could be available for use as early as 2007. It has been estimated that 2.5 million HIV infections could be averted over three years if a microbicide that was only 60 percent efficacious was used in 73 lower income countries.

Sources:

Darroch, JE and JJ Frost. 1999. “Women’s Interest in Vaginal Microbicides.” *Family Planning Perspectives* 31(1): 16-23, January/February.
The Microbicide Initiative. 2002. *Mobilization for Microbicides: The Decisive Decade*. New York: The Rockefeller Foundation.

Paraguay, designed to increase the positive perception of condoms, showed increases in the proportion of girls who believe that it is responsible for them to suggest condom use to their partners.²⁸

Young people require special attention, both in and out of school. Statistics from Ghana and Kenya show disproportionately high infection rates among girls aged 15-19 compared with boys the same age, suggesting the need to start HIV prevention education at earlier ages.²⁹ Such early education may be critical both because of the demonstrated success of school-based HIV prevention programs in changing behavior and because so many young people drop out before they reach secondary school. In addition to information about sexual health and HIV transmission, such programs should emphasize abstinence and delaying the onset of sexual activity for those who are not sexually active, as well as having fewer sexual partners, while providing the skills to negotiate safer sex, including use of condoms, for those who are sexually active.

Simply by virtue of being in school, students can be reached systematically. And, because changes in attitudes and behaviors at a younger age can last a lifetime, school-based programs are cost-effective long-term interventions. Critical to their success, however, is the involvement and support of parents, as well as government.

Expanding access

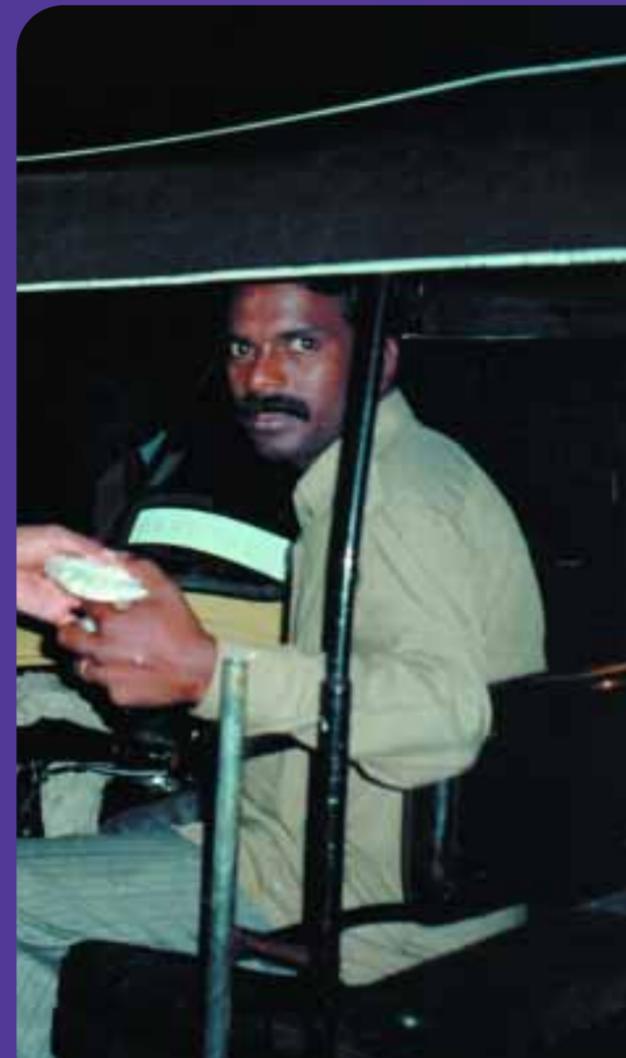
Increasing access to male and female condoms requires not only breaking down the taboos against use, but also ensuring that condoms are in places where people can obtain them at a price they can afford—including, if necessary, free of charge. Understanding the socio-economic structure of a particular society is as important as updated training for service providers to reduce bias against certain population groups—whether men having sex with men, the young, or others.



A volunteer distributes condoms to truck drivers in India, a population at high risk for HIV/AIDS.

Changing unhelpful national policies, encouraging the involvement of civil society organizations, correcting the misallocation of resources, and strengthening infrastructure are all key to program success. Donors need to support governments in setting and reaching their goals, while the involvement of civil society is crucial to the development of effective local and national plans. Governments and local authorities must implement their commitments to expanding condom availability and access to their populations, including young people. Strong coordination among all actors—donors, governments, and community stakeholders—can help maximize the use of available resources and the impact of activities.

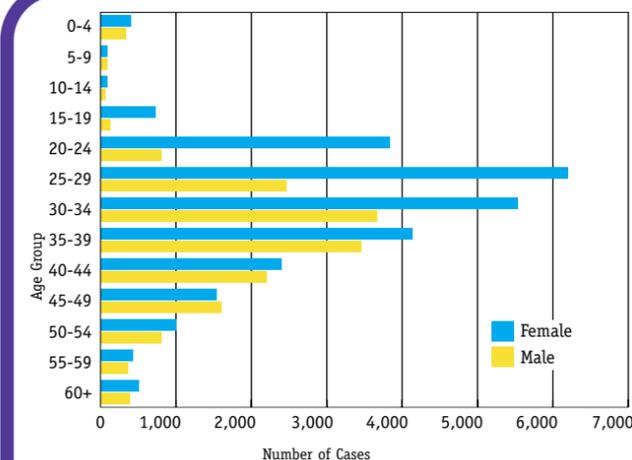
Market research can help determine the most appropriate condom promotion and distribution strategies for populations with varying needs. This involves an



assessment of the socio-economic and demographic characteristics of target populations and an understanding of their cultural context, values, attitudes, beliefs, and motivations. It also involves research on patterns of condom use and sexual practices, as well as honest evaluations of existing promotion and distribution strategies, including product pricing, brand identities, packaging, instructions, and the quality of the condoms themselves.

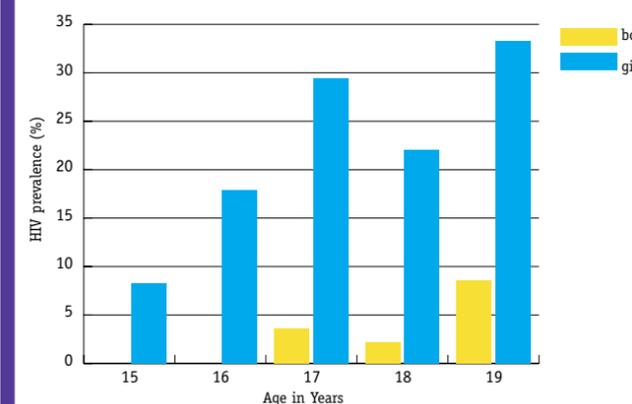
Public sector and social marketing programs can channel free and subsidized condoms to the poor, while the private sector accommodates people who can afford to pay more for condoms. By limiting subsidies to those in need, market segmentation maximizes government and donor investments, freeing up funds for other strategies like programming to prevent commodity shortages. For example, a study completed by USAID's Commercial Market

Age-Sex Distribution of Reported AIDS Cases in Ghana, 1986-2000



Source: Ghana Ministry of Health National AIDS/STD Control Program, 2000. HIV/AIDS in Ghana.

HIV Prevalence Rates Among Teenagers Aged 15-19 in Kisumu, Kenya



Source: UNAIDS, 2000. Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS.

Strategies (CMS) project reports that targeting the poor and needy could reduce government and donor costs by US\$8 million for condoms and by \$34 million for oral contraceptives yearly by 2015.³⁰ The money saved could be invested in other aspects of the programs like strengthening logistics, training of service providers, or implementing educational campaigns.

Expanded use of social marketing can help with hard-to-reach and low-income groups. Social marketing applies

Worldwide, 40 million people are living with HIV or AIDS, almost half of whom are women and a full third are young people aged 15-24.

And yet infection by HIV can be avoided. All that is required is for all people everywhere to be given the information, education, skills and full access to the ways they need to protect themselves and others. Male and female condoms are an essential component of such efforts and expanding and improving condom promotion and distribution are absolutely vital to success in the fight against the spread of AIDS. While condoms are necessary for the success of HIV/AIDS prevention efforts, they are by no means sufficient. Overall success is dependent on strong political leadership, appropriate funding, supportive policies, and well-planned and coordinated programs that

work to influence attitudes and change behaviors and that provide the necessary services and supplies. And in every arena, the active participation of civil society actors, including non-governmental organizations.

To be effective, HIV/AIDS prevention programs must include a range and mix of interventions tailored to the specific needs of various localities and groups, especially those at higher risk of infection. The range must include promotion of the "ABCs" of prevention: abstinence, being faithful to one's partner, and condom use by the sexually active. And the mix of interventions must always include condoms.

The fight against HIV/AIDS requires significant changes not only in public policy, but also in individual attitudes, behaviors and in societal norms.

- Individuals need to understand and accept their risk of infection.
- Programs must promote a range of safer sex behaviors in order to succeed
- Young people require special attention, both in and out of school.
- Public sector and social marketing programs can channel free and subsidized condoms to the poor, while the private sector accommodates people who can afford to pay more for condoms.
- Diversifying points of distribution, including use of non-traditional outlets, can maximize the reach of prevention programs.
- Expansion of prevention programs, including condom distribution, to rural areas is vital, as HIV has almost everywhere spread into even the most remote regions.
- Strong logistical systems are a prerequisite to the timely delivery, constant flow, and appropriate storage and shipping of high quality condoms.
- The donor community must provide the necessary financial and technical resources to support the availability, accessibility, and quality of condoms.

A B S T I N E N C E

C O N D O M S

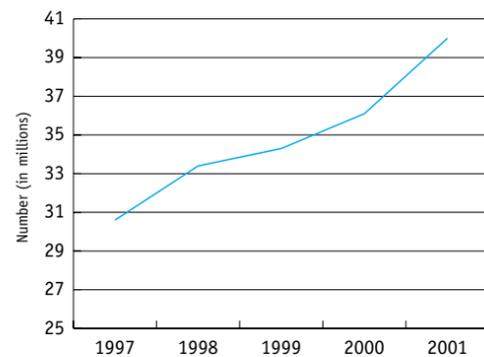


B E I N G F A I T H F U L

Condoms have played a key role in those places where HIV prevention efforts have been successful in reducing prevalence and infection rates.

In concert with very public support by the country's political leadership, Uganda's emphasis on interpersonal communication among family members and friends yielded increases in condom use, a significant decrease in the number of non-regular partners (especially among those never married), and a reduction in the proportion of sexually active males among those aged 15-19. Senegal, with a tradition of active community involvement in health and development issues, had networks in place when AIDS surfaced. Religious leaders delivered sermons about HIV, making a major contribution to the success of the national program. In Thailand, health service providers traveled to villages to educate community members about HIV, with the involvement of Buddhist monks and traditional healers. Both Thailand and Brazil illustrate the positive effects of condom promotion and increased use.

People Living with HIV or AIDS, 1997-2001 (Worldwide, in Millions)

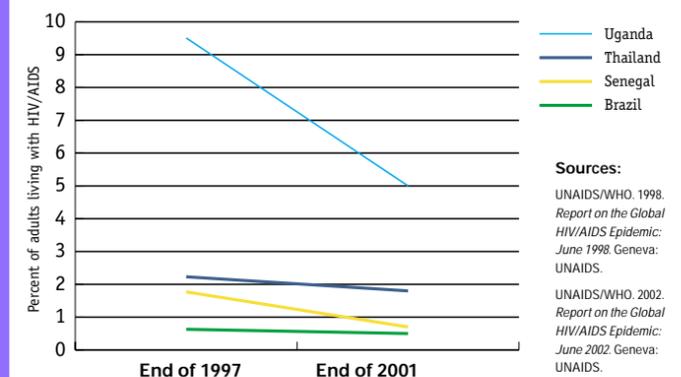


Sources:
UNAIDS. Various years. *AIDS Epidemic Update and Report on the Global HIV/AIDS Epidemic*. Geneva: UNAIDS.

Key Recommendations

- **Male and female condoms should be available to everyone who needs them when and wherever they want them. If cigarettes can get to the remotest corners of the Earth, so can condoms. AIDS is everywhere and the means for protection from HIV infection must also be there.**
- **More money, effectively used, is key to making AIDS prevention programs — including condom promotion and distribution — work.**
- **Unwavering commitment to preventing HIV, at the highest levels of government and society, has been key in countries such as Thailand, Uganda, Brazil and Senegal that have had success against the spread of HIV/AIDS.**

Stabilizing HIV/AIDS Prevalence in Brazil, Senegal, Thailand and Uganda, 1997-2001



Sources:
UNAIDS/WHO. 1998. *Report on the Global HIV/AIDS Epidemic: June 1998*. Geneva: UNAIDS.
UNAIDS/WHO. 2002. *Report on the Global HIV/AIDS Epidemic: June 2002*. Geneva: UNAIDS.

business principles and techniques to improving public health and bringing about individual change to healthier, less risky behavior. It usually complements government activities, particularly in areas where government is at a disadvantage or has difficulties in accessing specific groups such as sex workers, migrant laborers, long distance haulers, and young people. It has been widely and successfully applied for decades to many health issues, including condom promotion. In 2000, social marketing programs for condoms existed in more than 50 developing countries and distributed over 1.2 billion condoms at subsidized, easily affordable prices to low-income groups.

Diversifying points of distribution, including use of non-traditional outlets, can maximize the reach of prevention programs. A variety of distribution outlets can serve population groups with different needs and levels of income. Diversification also helps to reduce costs of service delivery and promotion by maximizing the contribution of existing pharmacies, public health clinics and social marketing programs. Pharmacies and supermarkets are typical commercial outlets, along with restrooms and bars. At the other end of the spectrum, primary health care clinics, family planning clinics and mobile units distribute free condoms to those who cannot afford them. Social marketing and community-based distribution utilize alternative outlets such as bars, hotels, peer educators, and taxi drivers. Making condoms available through such non-traditional outlets is likely to encourage use, especially by young people who may feel uncomfortable getting them elsewhere.

Expansion of prevention programs, including condom distribution, to rural areas is vital, as HIV has almost everywhere spread into even the most remote regions. Despite industrialization and migration to urban areas, many developing countries still have predominantly rural populations. But due to limited resources and politi-



A coffee kiosk in the capital of Burkina Faso with a condom promotion painted on the side. The dialogue in the illustration takes place between a sex worker and her customer or employer. He asks her, "Already at work?" and she responds, "Yes, but only with a condom!"

Beyond Condoms: Strong Programs Key to Success

Condoms are necessary for the success of HIV/AIDS prevention efforts, but they are by no means sufficient. They need to be supported with strong political leadership, appropriate funding, sound policies, and well-coordinated programs.

A supportive policy and social environment is key to the success of prevention strategies. Governments, in collaboration with a civil society that is well attuned to their communities' cultural nuances, need to provide such an environment. By addressing the policies, cultural practices and economic conditions that increase people's vulnerability to HIV infection, governments and societies can encourage individuals' behavior change.

Changing attitudes and behavior is at the heart of HIV prevention. A successful strategy establishes the conditions and environment that allows people to protect themselves against infection, educates about sexual health and HIV transmission, and emphasizes abstinence and delaying the onset of sexual activity for those who are not sexually active. It encourages having fewer sexual partners, provides the skills to negotiate safer sex, and promotes condom use for those who are sexually active. A good prevention strategy also treats STIs, provides HIV counseling and testing for those who want to know their HIV status, prevents mother-to-child transmission by protecting the

mother from infection, and treats infected mothers. It should also address traditional practices, such as female genital cutting, that increase the risk of HIV infection. Strategies should also be in place to ensure the safety of blood supplies and to address injecting drug use.

Following are three elements key to the success of HIV/AIDS prevention programs.

Act Early, Act Now

Investing now in prevention activities and expanding awareness of and access to condoms, by all possible means, can minimize the need for huge financial investments later in care and treatment of persons living with HIV/AIDS. Early action also lessens the social and economic disruption caused by higher mortality rates among adults in their most productive years.

Among developing countries, there are few examples of intervention early enough to reduce risk from the full onset of AIDS. Where early action was taken, however, prevention has been more successful and the effects of the epidemic were reduced from what they could have been. Senegal, Thailand, and Brazil are notable examples. In Cambodia, for example, serious prevention efforts got underway in the mid 1990s. With a focus on reducing high-risk behavior among men and increasing condom use,

the Cambodian program is seeing evidence of success. The HIV infection rate fell from 3.9 percent in 1997 to 2.8 percent in 2000, while HIV prevalence among pregnant women declined from 3.2 percent to 2.3 percent over the same period.

Target Prevention Interventions

Finding ways to prioritize prevention interventions is strategically important for long-term public health, especially where resources are limited. Priorities are determined by the stage and pattern of the epidemic in population subgroups and on the country's financial resources and capacity for implementation. At the beginning of an epidemic, it is important to target high-risk groups and individuals to prevent a localized epidemic from spreading into the general population. As the epidemic develops, other strategies should address appropriate issues and groups.

Scale Up Successful Efforts

Small-scale, successful HIV prevention activities abound, but national level coordination has been achieved in only a few countries. Expanding the coverage, impact, quality and sustainability of existing operations entails building on the experience of successful small-scale programs, and adapting

them to the demands of a wider community. Leadership and sound administrative systems are needed for effective scaling up of programs.

Though such efforts remain largely undocumented, Uganda is a good example of a successful, large-scale multi-sectoral response, in which condoms were a key component. Uganda has cut infection rates in half, in recent years, with education, testing, counseling, and condom promotion. Government action involved multiple ministries, while other groups in society—including religious leaders and community development organizations—assisted in ways that made best use of their particular skills. Uganda focused on promotion of safer sex behaviors through condom marketing and distribution, radio and TV advertising, peer education, and use of people living with AIDS (PLWA) as educators. This broad-based approach made it easier to reach individuals at the grassroots level and contributed to a reduction in HIV infections among young pregnant women and adolescent girls. The significant increase in condom use probably contributed to declines in teenage pregnancies as well.

Sources:

UNAIDS. 2001. *AIDS Epidemic Update: December 2001*. Geneva: UNAIDS.
International HIV/AIDS Alliance. 2001. *Expanding Community Action on HIV/AIDS: NGO/CBO Strategies for Scaling-up*. Report of the third year of the "Community Lessons, Global Learning" collaboration between the International HIV/AIDS Alliance and Positive Action. GlaxoSmithKline. London: International HIV/AIDS Alliance.

cal priorities, public health facilities tend to be concentrated in urban areas. Among the reasons for ensuring the availability of condoms in rural areas is to encourage their use by those men and women who travel frequently between their urban workplaces and rural homes.

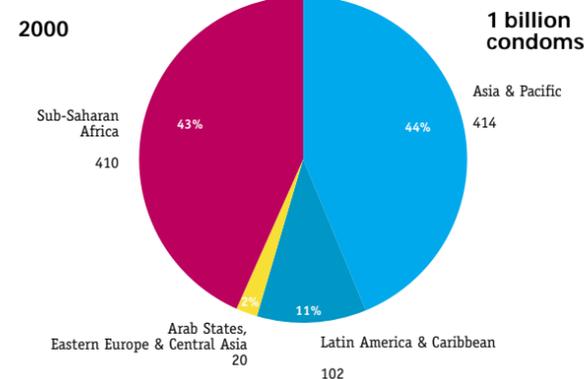
Ensuring availability

Whether a country can make condoms available to its people also depends on a myriad of factors, in particular the availability of adequate financial resources and sufficient technical capacity in the areas of procurement and logistics.

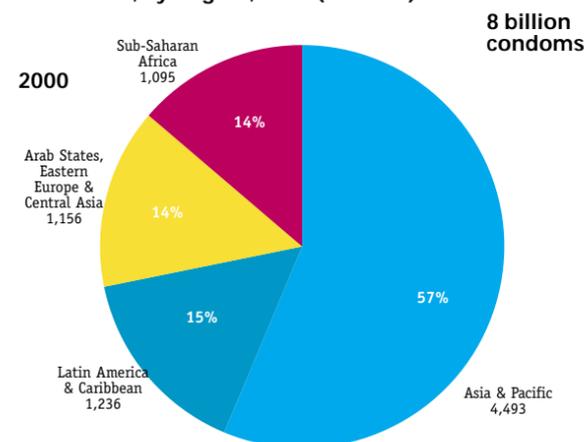
Strong logistical systems are a prerequisite to the timely delivery, constant flow, and appropriate storage and shipping of high quality condoms. Each step in the complex process of financing, procuring, shipping, storage, and distribution of condoms holds challenges. Even with the funds in hand, it typically takes at least twelve months from the placement of an order to the actual delivery of condoms. This means that the work of forecasting condom requirements must happen well in advance of when the condoms will actually be used. Condoms are also somewhat fragile; exposure to heat and humidity contribute to more rapid deterioration of latex and reduce the shelf life of condoms.³¹

International standards are applied to ensure high quality condoms. Latex is a natural product with impurities that make condom production technically complex. As manufacturing may vary around the world, the standards of international agencies like the International Organization for Standardization (ISO), the Comité Européen de Normalisation (CEN), or the American Society for Testing and Materials (ASTM) are used for quality control. To ensure the procurement and distribution of high quality condoms, WHO/UNAIDS establishes and regularly updates guidelines and specifications for condom procurement that include

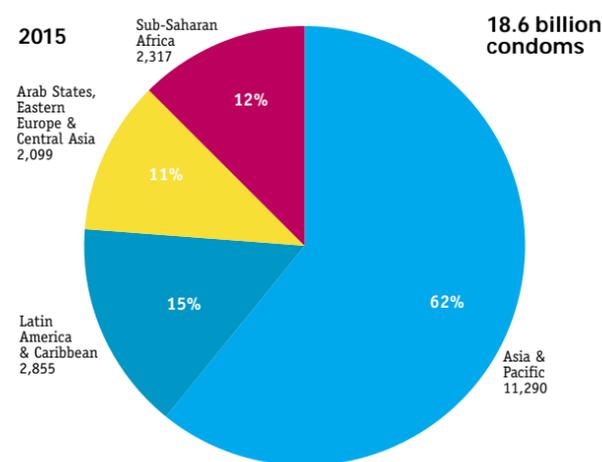
Donor Support for Condoms by Region, 2000 (millions)



Number of Condoms Needed for HIV/STI Prevention, by Region, 2000 (millions)



Number of Condoms Needed for HIV/STI Prevention, by Region, 2015 (millions)



Sources:
UNFPA. 2002. Database on Donor Support for Contraceptives and Logistics Management. New York: UNFPA.
UNFPA. 2002. Global Estimates of Contraceptive Commodities and Condoms for STI/HIV Prevention, 2000-2015. New York: UNFPA.

these standards. The UN Population Fund (UNFPA), for example, requires all its suppliers to conform to WHO/UNAIDS standards of technical expertise and factory conditions. Each batch of condoms is sampled and tested for quality assurance.

The donor community must provide the necessary financial and technical resources to support the availability, accessibility, and quality of condoms. While some countries have the resources to successfully manage and implement HIV/AIDS prevention programs, the poorest countries will require greater, sustained support. Donors also have a responsibility to better coordinate their efforts, both with each other and with aid-receiving countries.

Counting Condoms: How Many Are Needed for HIV Prevention Efforts?

Estimates of the number of condoms needed are complicated by the lack of data on condom use for HIV/STI prevention. Estimates of need are most often based on data on the number of condoms *supplied*. One rough estimate of the numbers of condoms actually used worldwide spans a range of six to nine billion condoms annually (1999 data), which translates into exceedingly low levels of use in the developing world, given what survey data reveal about the frequency of sexual intercourse among married and unmarried men.³²

At least 8 billion condoms would have been needed to expand access and availability in the developing world and Eastern Europe in the year 2000. An accurate estimate of need is difficult to calculate, however. The number of condoms required depends not only on the nature of other prevention activities being implemented, but also on the assumptions used and countries included in the calculations. Indeed, there are various estimates of need, but

each one uses different assumptions, methodologies, and is for a different set of countries.

Whatever the precise number of condoms needed, however, the fact is that current use is too low to have an impact on the rate of increase of infection. Condom availability and access must be greatly expanded everywhere.

UNFPA estimates that 8 billion condoms were needed in 2000 for STI/HIV prevention in Africa, Asia, Latin



America and Eastern Europe, but the actual need is greater.³³ UNFPA's is among the few estimates of need that cover all countries except for the wealthy donor countries of Northern America, Europe, Eastern Asia and Oceania.³⁴ It is regarded as a minimum figure because it excludes condoms intended for family planning purposes (most of which are used by married couples), and assumes that condoms will not be used consistently.

Most of the condoms are needed in Asia (excluding Central Asia), due to the large population size (4.5 billion

Understanding Clinical Trials

A candidate product—a microbicide, for example—first passes through pre-clinical trials demonstrating that it is stable and non-toxic in laboratory tests and animal studies. Three phases of human clinical trials then follow. In Phase I, a product is tested among 50 or fewer healthy, low-risk women to investigate whether it is non-irritating and safe. Phase II trials enroll 50-500 volunteers, including women at higher risk, and men, to establish the product's efficacy for women and their partners. Only products that successfully pass through Phase I and II trials proceed to Phase III, a large-scale trial of longer-term use among thousands of volunteers, to determine if a product actually works to prevent HIV or other STIs and to assess side effects. Clinical trials are followed by Phase IV post-distribution assessment and market testing, including reporting of unusual events and clinical education. The average time required for testing and product registration is 10.5 years.

Source: www.microbicide.org, accessed 14 February 2002

condoms in 2000), according to UNFPA's estimate. Latin America and the Caribbean follow with an estimated need for 1.2 billion condoms, while another 1.2 billion were needed in the Arab States, Central Asia and Eastern Europe combined. The need for sub-Saharan Africa stood at 1.1 billion condoms. By 2015, at least 18.6 billion condoms will be needed, according to UNFPA.

It would have cost US\$239 million to purchase the minimum 8 billion condoms needed in 2000, based on the average international price of US\$0.03 (3 cents) per condom, and more than \$557 million will be required in 2015. These dollar figures, however, represent only the costs of the condoms themselves (plus sampling and testing). They do not include any of the costs of distribution systems, communication for behavior change, or the other

services required to get condoms into the hands of those who need them, which would have increased the cost to *at least* \$1.2 billion for 2000 and likely higher. For 2015, total costs would be *at least* \$2.8 billion.

A similarly conservative estimate of the costs associated with condom-related prevention activities projects that US\$736 million will be needed in 2005.³⁵ The costs of overall HIV/AIDS prevention efforts are projected at \$4.8 billion, with another \$4.4 billion for care and treatment of persons living with HIV/AIDS. In 2001, only about \$1.8 billion (from all sources) was reportedly spent on all aspects of HIV/AIDS programs in developing countries and Eastern Europe, a far cry from the \$9.2 billion total projected for prevention, care and treatment.³⁶

Who Pays for Condoms? The Roles of the Various Sectors in Condom Supply and Promotion

Significantly and rapidly expanding condom promotion and distribution in developing countries will require coordinated, concerted effort from governments, donors, international agencies and other organizations. What needs to be done—and how—is clear. What is lacking is firm, unambiguous acceptance of the indispensable role of condom promotion in prevention, commitment to action—principally on the part of governments and some key donors—and the resources for implementation.

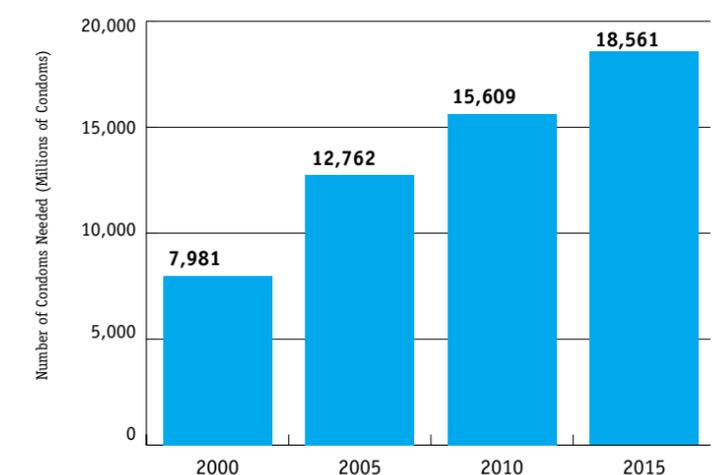
Of the estimated 8 billion condoms needed in 2000, donors provided just 950 million—less than one-eighth of the number needed—valued at US\$46 million. While this figure takes into account only grant support, loans from the World Bank, for example, are also sometimes used to obtain condoms and other reproductive health supplies.

Donor support for condoms is channeled similarly to overall support for HIV/AIDS programs. Grants and loans for HIV/AIDS

UNFPA estimates that 8 billion condoms were needed in 2000 for STI/HIV prevention in Africa, Asia, Latin America and Eastern Europe, but the actual need is greater.



Projected Number of Condoms Needed for HIV/STI Prevention in the Developing World and Eastern Europe, 2000-2015



Source: UNFPA. 2002. Global Estimates of Contraceptive Commodities and Condoms for STI/HIV Prevention, 2000-2015. New York: UNFPA.

programs are channeled bilaterally, that is, directly from one government to another; multilaterally, through international organizations such as the United Nations including the World Bank; and through the new Global Fund to Fight AIDS, Tuberculosis and Malaria.

The past decade has seen little increase in the overall donor provision of condoms in response to the HIV/AIDS epidemic. Indeed, the response of donor countries has been both erratic and inadequate. Annual donor support for condoms averaged slightly over one billion condoms over the past decade (1990-2000), peaking in 1995 and 1996 at slightly more than 1.5 billion condoms. In financial terms, the US\$46 million contributed in 2000 was only slightly more than the US\$42 million contributed by donors in 1990, and less when adjusted for inflation.

The absence of significant increases in donor support for condom supplies belies the entry of additional donors into the field. The U.S. Agency for International Development (USAID) and UN Population Fund (UNFPA) remain the two largest sources of condoms for developing countries. In 1990 and 1991, USAID, UNFPA, the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF) were the only donors funding condoms. Then, USAID provided over 80 percent of the 970 million condoms supplied by donors annually; UNFPA, WHO and IPPF, accounted for 10 percent, 6 percent and 2 percent, respectively. By 1993, several other donors stepped in, raising the average number of donors to around ten. These donors are the German Kreditanstalt für Wiederaufbau (KfW, or German development bank) the British Department for International Development (DFID), the European Union (EU), Marie Stopes International (MSI), Pathfinder International, and the governments of the Netherlands and Japan.

In 2000, donor support for 950 million condoms totaled US\$46 million.³⁷ This figure included only the

costs of the condoms themselves and their sampling and testing for quality. The costs of getting condoms into the hands of users—which involves improving access, logistics and distribution capacity, raising awareness and promoting use—is many times that of the supplies themselves. For contraceptive supplies generally, these costs are estimated at four times the costs of the supplies.³⁸ Some believe these costs are even higher for condoms.

International donors

USAID and UNFPA remain the two largest sources of condoms for the developing world



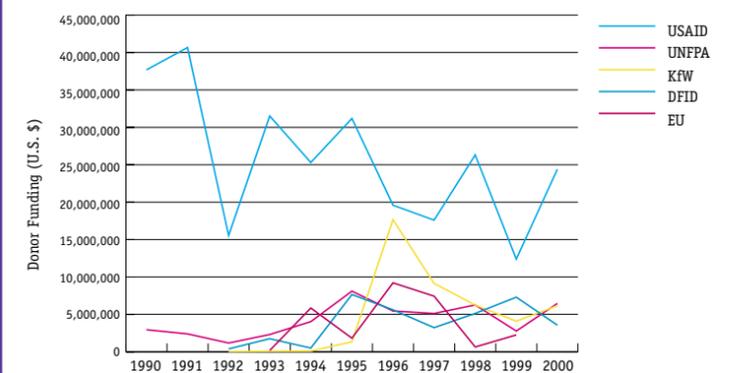
This Marie Stopes International (MSI) clinic in Kenya closed due in part to U.S. policy restrictions

(see Appendices 2 and 3). However, at this writing, both are facing restrictions imposed by the Bush Administration. UNFPA's current-year contribution has been withheld. "Buy-America" policies force USAID to pay much more for condoms than other donors and, therefore, to supply fewer condoms. And the U.S.-imposed Global Gag Rule, which denies U.S. family planning funds to foreign organizations that use other funds to counsel, refer or advocate on abortion, has resulted in a number of local organizations losing access to U.S.-supplied contraceptives, including condoms.

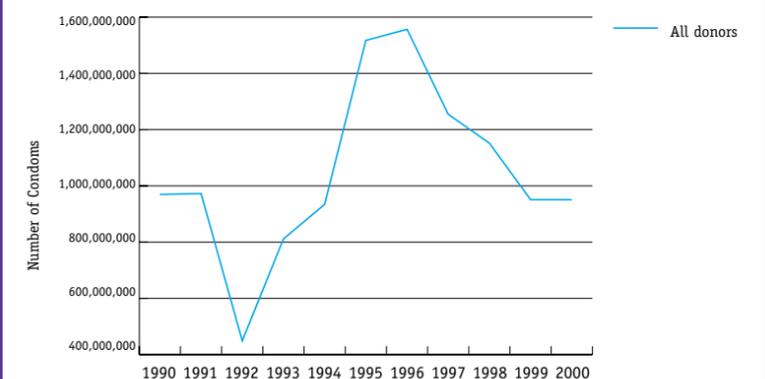
USAID's annual support for condoms averaged 475 million condoms in the 1990s; that figure was just 360 million condoms in 2000. Except in 1996 and 1997, when Germany's KfW

For sub-Saharan Africa alone, at least 1.1 billion condoms were needed in 2000.

Donor Funding for Condoms, 1990-2000 (Leading Donors)



Donor Support for Condoms, 1990-2000



Source: UNFPA. 2002. Database on Donor Support for Contraceptives and Logistics Management, 2000-2015. New York: UNFPA.

USAID and UNFPA remain the two largest sources of condoms for the developing world; both are facing restrictions imposed by the Bush administration.

upped its support, and 1999, when Britain's DFID donated more condoms than any other donor, USAID has always been the major donor of condoms. However, USAID's support was highest in 1990 and 1991, at around 800 million condoms. The remainder of the decade was characterized by an overall downward trend, although with yearly fluctuations typical of the condom supply cycle.

UNFPA, the second largest donor of condoms, supplied 144 million condoms in 2000. Annual support averaged 140 million condoms annually (1990-2000), peaking in 1995 at 290 million condoms. Since 1999, UNFPA has been responsible for procuring condoms for all UN agencies including WHO, previously the source of an average of 40 million condoms annually (1990-1999). As the lead agency within the United Nations for HIV/AIDS prevention activities, UNFPA is responsible for all condom promotion and distribution for HIV/AIDS as well as family planning. (UNAIDS does not run programs on the ground.)

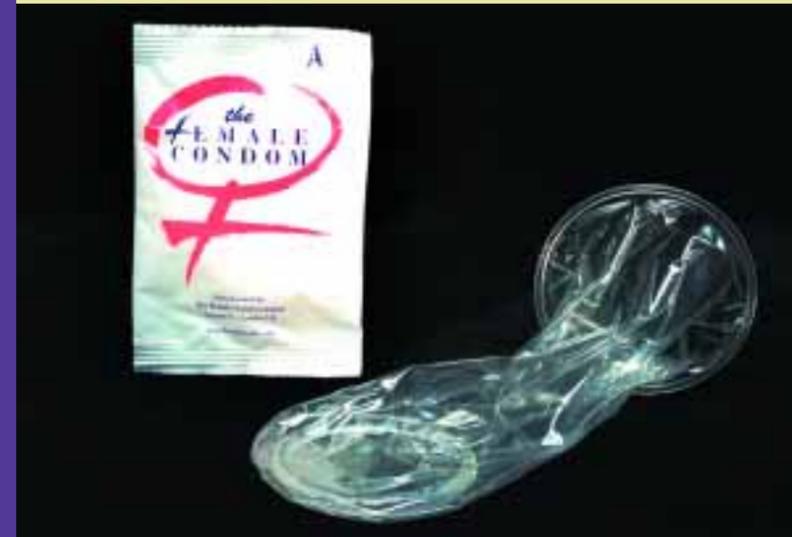
KfW and DFID have also become major sources of condoms, beginning in 1992. In 1996 and 1997—peak years for donor support overall—KfW provided almost a third of all donor-supplied condoms. DFID's support peaked at 280 million condoms in 1995. In 1999, DFID was the largest donor of condoms, providing more than one-fifth of the 950 million condoms donated that year. In 2000, KfW and DFID contributed roughly 205 million and 73 million condoms, respectively.

The European Union (EU) made significant contributions between 1993 and 1999, with a peak donation in 1996 of over 260 million condoms, or close to one-fifth of all condoms distributed by donors that year. IPPF consistently gives about 20 million condoms every year to its developing country affiliates.

Over the five-year period 1996-2000, the above donors distributed a yearly average of fewer than 600 million con-

The Female Condom

The female condom expands the very limited range of options available for protection from infection from HIV and other STIs. It is a relatively new barrier method that helps women protect them-



selves against pregnancy and STIs, including HIV. The female condom gives women who are unable to insist that their partners use a male condom, a barrier method with which they can initiate use themselves. And by adding to the range of methods available, overall use of barrier methods is likely to increase.¹

While some women do report using the female condom without their male partner's notice or objection, many find that negotiation and some cooperation are required.² Some men fear that the female condom may decrease sexual pleasure, decrease their power within the relationship, or encourage their partner's infidelity—the same reasons given for opposing male condoms. Targeting men—particularly clients of sex workers—for promotional and educational efforts is essential to increasing acceptability of the female condom.

Around the world, women of diverse backgrounds and experience have inte-

grated the female condom into their own method mix. Programmatic and marketing decisions heavily influence who uses the female condom. Some projects have focused on people with multiple partners, promoting the female condom specifically for disease prevention. Others are aimed at women in stable, monogamous relationships, emphasizing contraception.

The female condom is now being promoted around the world. It has been approved by the United States Food and Drug Administration (FDA) and by similar regulatory authorities in other countries.³ More than 19 million female condoms have been supplied to ministries of health and non-governmental organizations in over 70 countries. Major national programs of note include those in Brazil, Ghana, Namibia, South Africa, Zambia and Zimbabwe.

The current global market for the female condom is about 10 million units. Through an innovative public-private partnership, it has been available to public sector agencies since 1996 at a reduced cost of about US\$ 0.56, and about 70 percent of the condoms sold go to public sector programs in developing countries.⁴ The low global volume is a factor in the product's relatively high cost, which is more than ten times that of a male condom. An investment of \$10 million in female condoms would protect no fewer than 20 million sex acts, reduce the unit cost by more than 25 percent, and support dozens of country, regional, and community programs.

¹ Laska, Mary. 2001. "Female-Initiated Barrier Methods for the Prevention of STI/HIV: Where Are We Now? Where Should We Go?" *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 78(4), December 2001.

² Young, A. 1997. *The Female Condom: A Review*. Geneva: World Health Organization.

³ Other countries include Australia, Brazil, Canada, Japan, South Africa, and Zimbabwe.

⁴ Between UNAIDS and The Female Health Company (FHC), the sole manufacturer of the female condom. The fixed price is £0.38, converted to US currency on May 3, 2002.

doms in Asia and the Pacific, around 450 million condoms in sub-Saharan Africa, over 110 million in Latin America and the Caribbean, and 40 million in the Arab States, Eastern Europe and Central Asia. For sub-Saharan Africa alone, at least 1.1 billion condoms were needed in 2000.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), established in 2001, is a public-private partnership for combating these three diseases. It is a funding mechanism—not an implementing body—intended to function in addition to and independent of existing bilateral and multilateral donor funding. The Global Fund represents another valuable resource available to countries, which are required to form Country Coordinating Committees with government, private sector and NGO representation in order to submit proposals.

In April 2002, the Global Fund approved grants totaling US\$616 million over 2 years for 58 programs. GFATM has raised slightly more than US\$2 billion from developed and developing country governments, private sector, foundations, and individuals, although many of the contributions are multi-year pledges.

Making male and female condoms available and affordable is one of the components of the World Bank's strategy for HIV/AIDS prevention. The World Bank is a major source of funding for HIV/AIDS programs and has a comprehensive strategy against HIV/AIDS that combines prevention, care and treatment. As part of this effort, the World Bank encourages countries with adequate procurement capacity (such as Brazil) to use Bank loan funds to procure condoms directly from manufacturers. For countries with less capacity, UNFPA does the procurement.

Developing country governments

Developing country governments that have the resources and political commitment are promoting condom use.



For example, the governments of South Africa and Botswana, two of the wealthiest and hardest-hit countries in sub-Saharan Africa, provide the vast majority of condoms for distribution in their countries through the public sector and social marketing, and in 2000 they purchased 290 million and 12 million condoms, respectively. In comparison, all donors combined provided 400 million condoms to all of sub-Saharan Africa in that year.

The Indian government, like several other Asian nations, has long promoted condom use for family planning. More recently, there has been a push to increase condom availability in response to the growing HIV problem in southern India and elsewhere. In 2000, 450 millions con-



doms were sold through a variety of government social marketing programs that subsidize both condoms and their promotion. In the private commercial sector, close to 300 million were sold. India is currently regarded as self-sufficient with respect to condoms and the government is a major manufacturer and exporter of male condoms.

The level of public sector support for condom promotion and distribution varies enormously from one country to another. Many governments, even those with sufficient resources and political will, have difficulty addressing sexual behavior and promoting condoms in the face of social and political resistance and a lack of programmatic expertise.

The United Nations and HIV/AIDS

The HIV/AIDS pandemic received significant attention at the 1994 International Conference on Population and Development in Cairo. The ICPD Programme of Action called for both promotion and expanded distribution of condoms in the context of HIV/AIDS prevention efforts. Five years later, as the United Nations concluded its review and assessment of progress since the ICPD, more explicit goals were set and then further reinforced at the UN Special Session on HIV/AIDS in 2001. The following goals were agreed upon with respect to condoms:

- Governments should strive to ensure that by 2015 all primary health-care and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; ... and barrier methods (such as male and female condoms and microbicides if available) to prevent infection.... (Key actions, Para. 53.)
- Governments, with assistance from UNAIDS and donors, should, by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.... [including] access to preventive methods such as female and male condoms ... with the goal of ensuring that by ... 2010 prevalence in this age group is reduced globally by 25 per cent. (Key actions, Para. 70.)
- By 2005, ensure: that a wide range of prevention programmes ... is available in all countries, ... aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections; (Declaration of Commitment, Para. 52)

Sources:

United Nations. 1994. "Programme of the Action of the International Conference on Population and Development." New York: United Nations.
United Nations. 1999. "Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development." New York: United Nations.
United Nations. 2001. "Declaration of Commitment on AIDS—Global Crisis, Global Action." New York: United Nations.

The private commercial sector

Because the commercial sector is profit-driven, it does not usually venture where it sees little potential for profit. The for-profit sector has its strongest presence, therefore, among developing countries in Asia and Latin America—in particular, in Brazil, the Philippines, Indonesia, Thailand, South Korea, and Malaysia. In Brazil, for example, 350 million male condoms were sold through the commercial sector in 2000, three times the number distributed by the government.³⁹ In contrast, the commercial sector plays only a minimal role in condom provision in sub-Saharan Africa.

There is potential for greater commercial sector involvement in condom provision, given the gap between the need for condoms, and the lagging support forthcoming from donors and developing country governments. Barriers to commercial private sector participation—ranging from tariffs and regulations to the lack of communication and coordination among sectors—can be addressed.



Key Recommendations

The international community has set forth and agreed to a basic framework for addressing the AIDS pandemic, most recently at the UN General Assembly Special Session on HIV/AIDS. Repeatedly, the overwhelming majority of nations have agreed on financial and programmatic goals for reduction of HIV prevalence. Yet HIV/AIDS is still gaining ground.

The ingredients for success in the fight against HIV/AIDS are well known: they include comprehensive national-level plans for action; an enabling social and political environment; adequate financial resources; a focus on behavior change activities; improved access to education and to health information and services, especially for women and youth; and in every arena, the active participation of civil society actors, including non-governmental organizations.

Population Action International hopes that this report will serve as a tool for governments, donors and civil society—and in particular, advocates—in making the argument for action, now.

Condoms for all

Male and female condoms should be available to everyone who needs them when and wherever they want them. If cigarettes can get to the remotest corners of the Earth, so can condoms. AIDS is everywhere and the means for protection from HIV infection must also be there.

- Reproductive health and HIV/AIDS programs must promote the complete “ABCs” of prevention and not just parts: abstinence, being faithful to one’s partner (or limiting the number of one’s partners), and condom use by the sexually active at risk of infection.
- Countries must have the capacity to finance, procure and deliver condoms to those who use them, which

means having the necessary logistics and supply systems in place—or access to such systems.

Money matters

More money, effectively used, is key to making AIDS prevention programs—including condom promotion and distribution—work.

- Better coordination—among donor nations, foundations, developing country governments, and the private sector—is needed to ensure that countries and communities in need do not fall through the cracks, and that donor efforts complement, rather than contradict, the efforts of others.
- Financial resources must be targeted to groups in greatest need, which implies a need for honesty in identifying and targeting high-risk populations, without regard to cultural taboos and stigmas.
- South-to-South transfer of information and technical expertise is crucial to making condoms affordable, accessible, and *attractive* to potential users.
- AIDS prevention should be integrated into existing health services, especially family planning, just as it should be integrated into other sectors.
- Partnerships between the private commercial sector and non-profit organizations (NGOs) should be encouraged, along with market segmentation. Wealthier people can afford to pay more for health services, including condoms—and will have to in order for poor and marginalized communities to be served.
- Continued and increasing support for research on both a cure for AIDS and other means to prevent its spread—a vaccine and microbicides—should be priorities.

Political commitment counts

Unwavering commitment to preventing HIV, at the highest levels of government and society, has been key in countries such as Thailand, Uganda, Brazil and Senegal that have had success against the spread of HIV/AIDS.

- The commitment to lead must come from all sectors of society including political, religious, business, special interest, community, academic leaders and, especially young people.
- Leaders at all levels of society must be willing to challenge cultural barriers, stigmas, and other societal norms that discourage condom use.
- Advocates have a special responsibility to give political and other leaders the support and tools they need to speak out and lead on the issue, and must hold them accountable for their success or failure.

It is well past time to set aside the stigmas, taboos, and religious precepts that would deny condoms to anyone living under the threat of HIV/AIDS—regardless of age, gender, or where they live. Otherwise, humanity faces the loss of a significant proportion of its most productive generation—a loss it cannot afford.

Notes

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- ² Masaki, E and others. 2001. "Cost-Effectiveness of HIV Prevention versus Treatment for Resource Scarce Countries: Setting Priorities for HIV/AIDS Management" [Unpublished paper]. Presented at the XIIth International Conference on AIDS and STDs in Africa, Ouagadougou, Burkina Faso, 9-13 December.
- ³ Lamptey, PR. 2002. "Reducing Heterosexual Transmission of HIV in Poor Countries." *British Medical Journal* 324(7331): 207-211, 26 January.
- ⁴ Chaya, N and others. 2001. *The PAI Report Card 2001, A World of Difference: Sexual and Reproductive Health & Risks*. Washington, DC: Population Action International (PAI).
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- ⁷ Demographic and Health Surveys (DHS). 1990-1999. Calverton, MD, USA: Macro International Inc.
- ⁸ Demographic and Health Surveys (DHS). Dominican Republic, DHS 1996; Nicaragua, DHS 1997; Haiti, DHS 1994; and Brazil, DHS 1996. Calverton, MD, USA: Macro International Inc.
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- ¹⁰ Notzon, FC and others. 1998. Causes of Declining Life Expectancy in Russia. *Journal of the American Medical Association* 279:10, March 11.
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- ¹³ UNAIDS. 2001. *AIDS Epidemic Update*.
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- ¹⁶ Agha, S and others. 2002. "Reasons for Non-use of Condoms in Eight Countries in Sub-Saharan Africa." *PSI Research Division Working Papers (49)*. Washington, DC: Population Services International (PSI).
- ¹⁷ Civic, D. 1999. "The Association between Characteristics of Dating Relationships and Condom Use among Heterosexual Young Adults." *AIDS Education and Prevention* 11(4): 343-352.
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- ²⁰ Ulin, P. 1992. "African Women and AIDS: Negotiating Behavioral Change." *Social Science and Medicine* 34(1): 63-73.
- ²¹ Agha, S and others. 2002. "Reasons for Non-use of Condoms in Eight Countries in sub-Saharan Africa." *PSI Research Division Working Paper (49)*. Washington, DC: PSI.
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- ²³ Agha, S. "Sexual Behavior Among Truck Drivers in Pakistan." *Culture, Health and Sexuality* 4(3), forthcoming.

²⁴ For one example from Botswana, see Meekers, D, G Ahmed and T Molatlegi. 1997. "Understanding Constraints to Adolescent Condom Procurement: The Case of Urban Botswana." *PSI Research Division Working Papers (12)*. Washington, DC: PSI.

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²⁹ Observations based on graph from Alice Lamptey, Ghana National Coordinator, Society for Women and AIDS in Africa (SWAA), Accra, Ghana.

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³¹ Five years usually constitutes a condom's life span. WHO stipulates a minimum of 3 years.

³² Between 8 and 10 billion condoms are produced each year (data from 1999), of which an estimated 10 to 20 percent are never used. The remaining 6 to 9 billion condoms are assumed to be used around the world annually. This amounts to between 3 and 5 condoms per man aged 15-59 annually—a very low level of use, as the average number of sexual acts per year is estimated to be around 100 within marriage.

³³ United Nations Population Fund (UNFPA). 2001. *Donor Support for Contraceptives and Logistics: 2000*. New York: UNFPA.

³⁴ For additional estimates of need, see Shelton, JD and B Johnston. 2001. "The Condom Gap in Africa." *British Medical Journal* 323 (139). The Futures Group International; Ross, J and R Bulatao. 2002. "Contraceptive Projections and the Donor Gap," *In Meeting the Challenge: Securing Contraceptive Supplies*. Washington, DC: Population Action International for the Interim Working Group on Reproductive Health Commodity Security; Gardner, R, RD Blackburn, and UD Uphaday. 1999. "Closing the Condom Gap." *Population Reports Series H*, No. 9. Baltimore, MD, USA: Population Information Program, Johns Hopkins University School of Public Health.

³⁵ Schwartlander, B and others. 2001. "Resource Needs for HIV/AIDS." *Scienceexpress Policy Forum*. Available from www.scienceexpress.org/21 June 2001/Page 1/10.1126/science.10628786; Internet; accessed 1 May 2002.

³⁶ Forsythe, S and W McGreevey. 2001. "Current (2001) spending on HIV/AIDS prevention and care activities" [Unpublished working paper]. Washington, DC: The Futures Group International

³⁷ For more information about data on donor support for condoms, see UNFPA database on Donor Support for Contraceptives and Logistics Management. UNFPA collects donor-reported country-specific information on quantity and cost of various contraceptive commodities provided by donors to developing countries. This database contains the best available information on donor support for contraceptive commodities, including condoms, and is useful in analyzing trends of donor support over the past decade.

³⁸ UNFPA. 2002. "Global Estimates of Contraceptives Commodities and Condoms for STI/HIV Prevention, 2000-2015 [Draft]". New York: UNFPA.

³⁹ Ahrens, H, Brazil National AIDS Program. 2002. Interview by author, Washington, DC, 11 April.

Appendix 1

Why Condoms Count: Selected Indicators of Vulnerability to HIV/AIDS

| | Total Population (in thousands, year 2000) | Couples Using Condoms for Family Planning | GDP per Capita (PPP US\$, 1999) | Life Expectancy at Birth | Illiteracy Rate Adults Aged 15 Years & Above (%, 2000) | Health Expenditures per Capita (PPP US\$, 1998) |
|---------------------------|--|---|---------------------------------------|-----------------------------|---|--|
| Eastern Africa | | | | | | |
| Burundi | 6,356 | 0.1 | 578 | 40.6 | 52 | 21 |
| Comoros | 706 | 1.0 | 1,429 | 58.8 | 44 | No Data |
| Eritrea | 3,659 | 0.3 | 880 | 51.5 | No Data | No Data |
| Ethiopia | 62,908 | 0.3 | 628 | 44.5 | 61 | 25 |
| Kenya | 30,669 | 1.3 | 1,022 | 52.2 | 18 | 79 |
| Madagascar | 15,970 | 0.7 | 799 | 51.6 | No Data | 16 |
| Malawi | 11,308 | 1.6 | 586 | 40.7 | 40 | 36 |
| Mauritius | 1,161 | No Data | 9,107 | 70.7 | 16 | 302 |
| Mozambique | 18,292 | 0.3 | 861 | 40.6 | 56 | 28 |
| Rwanda | 7,609 | 0.4 | 885 | 39.4 | 33 | 34 |
| Tanzania | 35,119 | 0.8 | 501 | 51.1 | 25 | 15 |
| Uganda | 23,300 | 1.9 | 1,167 | 41.9 | 33 | 65 |
| Zambia | 10,421 | 3.5 | 756 | 40.5 | 22 | 52 |
| Zimbabwe | 12,627 | 2.3 | 2,876 | 42.9 | 7 | No Data |
| Middle Africa | | | | | | |
| Cameroon | 14,876 | 2.1 | 1,573 | 50.0 | 25 | No Data |
| Central African Republic | 3,717 | 1.0 | 1,166 | 44.3 | 54 | 33 |
| Chad | 7,885 | 0.2 | 850 | 45.2 | 46 | 25 |
| Congo | 3,018 | No Data | 727 | 50.9 | 19 | 46 |
| Equatorial Guinea | 457 | No Data | 4,676 | 50.0 | 17 | No Data |
| Northern Africa | | | | | | |
| Algeria | 30,291 | No Data | 5,063 | 68.9 | 37 | No Data |
| Egypt | 67,884 | No Data | 3,420 | 66.3 | 45 | No Data |
| Libya | 5,290 | No Data | 7,570 | 70.0 | 20 | No Data |
| Morocco | 29,878 | 1.4 | 3,419 | 66.6 | 51 | No Data |
| Sudan | 31,095 | 0.1 | 664 | 55.0 | 43 | No Data |
| Tunisia | 9,459 | No Data | 5,957 | 69.5 | 29 | 287 |
| Western Africa | | | | | | |
| Benin | 6,272 | 0.7 | 933 | 53.5 | 63 | 29 |
| Burkina Faso | 11,535 | 1.2 | 965 | 45.3 | 77 | 36 |
| Côte d'Ivoire | 16,013 | 0.7 | 1,654 | 47.7 | 53 | 62 |
| Gambia | 1,303 | No Data | 1,580 | 45.4 | 64 | 56 |
| Ghana | 19,306 | 2.7 | 1,881 | 56.3 | 30 | 85 |
| Guinea | 8,154 | 0.6 | 1,934 | 46.5 | 59 | 68 |
| Guinea-Bissau | 1,199 | No Data | 678 | 44.1 | 63 | No Data |
| Mali | 11,351 | 0.4 | 753 | 50.9 | 60 | 30 |
| Mauritania | 2,665 | 0.8 | 1,609 | 50.5 | 60 | 74 |
| Niger | 10,832 | 0.0 | 753 | 44.2 | 84 | 20 |
| Nigeria | 113,862 | 1.2 | 853 | 51.3 | 36 | 23 |
| Senegal | 9,421 | 0.6 | 1,419 | 52.3 | 63 | 61 |
| Sierra Leone | 4,405 | No Data | 448 | 37.3 | 64 | 27 |
| Togo | 4,527 | 1.5 | 1,410 | 51.3 | 43 | 36 |
| Southern Africa | | | | | | |
| Botswana | 1,541 | 1.3 | 6,872 | 44.4 | 23 | 267 |
| Lesotho | 2,035 | No Data | 1,854 | 51.2 | 16 | No Data |
| Namibia | 1,757 | 0.3 | 5,468 | 45.1 | 18 | 417 |
| South Africa | 43,309 | No Data | 8,908 | 56.7 | 15 | 623 |
| Swaziland | 925 | No Data | 3,987 | 50.8 | 20 | 148 |
| East Asia | | | | | | |
| China | 1,275,133 | No Data | 3,617 | 69.8 | 15 | No Data |
| Mongolia | 2,533 | No Data | 1,711 | 61.9 | 1 | No Data |
| South Korea | 46,740 | No Data | 15,712 | 74.3 | 2 | 720 |
| South Central Asia | | | | | | |
| Bangladesh | 137,439 | 3.9 | 1,483 | 58.1 | 59 | 51 |
| Bhutan | 2,085 | No Data | 1,341 | 60.7 | 53 | 87 |
| India | 1,008,937 | 3.1 | 2,248 | 62.3 | 44 | No Data |
| Iran | 70,330 | No Data | 5,531 | 68.0 | 23 | 229 |
| Kazakhstan | 16,172 | 4.5 | 4,951 | 64.1 | No Data | 273 |
| Kyrgyzstan | 4,921 | 5.7 | 2,573 | 66.9 | No Data | 109 |
| Maldives | 291 | No Data | 4,423 | 65.4 | 4 | 472 |
| Nepal | 23,043 | 2.9 | 1,237 | 57.3 | 59 | 66 |
| Pakistan | 141,256 | 2.7 | 1,834 | 59.0 | 57 | 71 |
| Sri Lanka | 18,924 | 1.9 | 3,279 | 71.6 | 8 | 95 |
| Tajikistan | 6,087 | No Data | 1,031 | 67.2 | 1 | 63 |
| Turkmenistan | 4,737 | 2.0 | 3,347 | 65.4 | No Data | 146 |
| Uzbekistan | 24,881 | 1.7 | 2,251 | 68.3 | No Data | 87 |
| South East Asia | | | | | | |
| Cambodia | 13,104 | No Data | 1,361 | 56.5 | No Data | 90 |
| Indonesia | 212,092 | 0.7 | 2,857 | 65.1 | 13 | 44 |
| Laos | 5,279 | No Data | 1,471 | 52.5 | 38 | 35 |
| Malaysia | 22,218 | No Data | 8,209 | 71.9 | 13 | 189 |
| Philippines | 75,653 | 1.6 | 3,805 | 68.6 | 5 | 136 |

| Adults 15-49 Living with HIV/AIDS (%, End of 2001) | Adults 15-49 Living with HIV/AIDS (Number, End of 2001) | Annual Average Donor Support for Male Condoms (Number of Condoms, 1996-2000) | Annual Average Donor Support for Female Condoms (Number of Condoms, 1996-2000) | Average Number of Male & Female Condoms Donated Annually Per Male Aged 15-59 (1996-2000) |
|--|---|--|--|--|
| 8.3 | 330,000 | 808,568 | 2,800 | 0.6 |
| 0.1 | 400 | 202,936 | 200 | 1.1 |
| 2.8 | 49,000 | 2,850,927 | 9,200 | 3.1 |
| 6.4 | 1,900,000 | 65,231,711 | 13,200 | 4.2 |
| 15.0 | 2,300,000 | 22,016,836 | 102,000 | 2.8 |
| 0.3 | 21,000 | 4,442,790 | 5,200 | 1.1 |
| 15.0 | 780,000 | 12,972,806 | 1,200 | 4.7 |
| 0.1 | 700 | 190,111 | 200 | 0.5 |
| 13.0 | 1,000,000 | 16,891,836 | 2,528 | 3.7 |
| 8.9 | 430,000 | 22,687,578 | 3,600 | 11.7 |
| 7.8 | 1,300,000 | 25,183,154 | 55,700 | 2.9 |
| 5.0 | 510,000 | 34,968,706 | 242,000 | 6.4 |
| 21.5 | 1,000,000 | 13,164,961 | 101,200 | 5.2 |
| 33.7 | 2,000,000 | 48,146,428 | 378,200 | 15.3 |
| 11.8 | 860,000 | 13,651,584 | 1,600 | 3.6 |
| 12.9 | 220,000 | 630,129 | 3,240 | 0.7 |
| 3.6 | 130,000 | 2,601,801 | 8,000 | 1.4 |
| 7.2 | 99,000 | 4,583,956 | No Support | 6.4 |
| 3.4 | 5,500 | 25,920 | 4,000 | 0.3 |
| 0.1 | 13,000 | 1,447,520 | No Support | 0.2 |
| <0.1 | 8,000 | 5,131,000 | No Support | 0.3 |
| 0.2 | 7,000 | No Support | No Support | No Support |
| 0.1 | 13,000 | 5,652,284 | No Support | 0.6 |
| 2.6 | 410,000 | 284,062 | 200 | 0.0 |
| 0.1 | 2,200 | 1,121,242 | No Support | 0.4 |
| 3.6 | 110,000 | 7,276,100 | 2,400 | 4.8 |
| 6.5 | 380,000 | 11,437,959 | No Support | 4.5 |
| 9.7 | 690,000 | 28,080,540 | 24,300 | 6.4 |
| 1.6 | 7,900 | 928,057 | No Support | 2.7 |
| 3.0 | 330,000 | 10,370,100 | 302,600 | 2.1 |
| 1.5 | 52,000 | 3,817,776 | No Support | 1.8 |
| 2.8 | 16,000 | 101,340 | No Support | 0.3 |
| 1.7 | 100,000 | 5,660,580 | 3,200 | 2.1 |
| 0.5 | 6,300 | 278,984 | 200 | 0.4 |
| 1.4 | 61,000 | 1,101,866 | 1,200 | 0.4 |
| 5.8 | 3,200,000 | 43,837,946 | 34,000 | 1.5 |
| 0.5 | 24,000 | 7,447,540 | 8,200 | 3.1 |
| 7.0 | 150,000 | 2,180,430 | 2,000 | 2.0 |
| 6.0 | 130,000 | 6,418,908 | 20,974 | 5.6 |
| 38.8 | 300,000 | 360,440 | 2,400 | 0.9 |
| 31.0 | 330,000 | 766,608 | 16,400 | 1.4 |
| 22.5 | 200,000 | 2,069,067 | 54,684 | 4.9 |
| 20.1 | 4,700,000 | 15,364,800 | 984,600 | 1.3 |
| 33.4 | 150,000 | 2,089,988 | 2,600 | 8.7 |
| 0.1 | 850,000 | 16,874,896 | 1,000 | 0.0 |
| <0.1 | <100 | 4,083,138 | 1,900 | 4.4 |
| <0.1 | 4,000 | No Support | 400 | 0.0 |
| <0.1 | 13,000 | 178,241,842 | 6,200 | 4.4 |
| <0.1 | <100 | 1,922,930 | 200 | 3.6 |
| 0.8 | 3,800,000 | 121,390,608 | 18,100 | 0.4 |
| <0.1 | 20,000 | No Support | No Support | No Support |
| 0.1 | 6,000 | 1,546,520 | No Support | 0.3 |
| <0.1 | 500 | 1,646,960 | No Support | 1.2 |
| 0.1 | <100 | 403,230 | No Support | 5.3 |
| 0.5 | 56,000 | 28,472,356 | No Support | 4.6 |
| 0.1 | 76,000 | 62,721,103 | No Support | 1.6 |
| <0.1 | 4,700 | 10,677,838 | 400 | 1.7 |
| <0.1 | 200 | 297,293 | 1000 | 0.2 |
| <0.1 | <100 | 432,600 | No Support | 0.3 |
| <0.1 | 740 | 556,400 | No Support | 0.1 |
| 2.7 | 160,000 | 43,707,928 | 10,000 | 13.4 |
| 0.1 | 120,000 | 33,277,278 | 3,000 | 0.5 |
| <0.1 | 1,300 | 712,982 | No Support | 0.5 |
| 0.4 | 41,000 | 4,377,013 | No Support | 0.7 |
| <0.1 | 9,400 | 36,949,736 | No Support | 1.7 |

| | Total Population (in thousands, year 2000) | Couples Using Condoms for Family Planning (%) | GDP per Capita (PPP US\$, 1999) | Life Expectancy at Birth | Illiteracy Rate Adults Aged 15 Years & Above (%, 2000) | Health Expenditures per Capita (PPP US\$, 1998) |
|------------------------|--|--|---------------------------------------|-----------------------------|---|--|
| Singapore | 4,018 | No Data | 20,767 | 77.1 | 8 | 777 |
| Thailand | 62,806 | 1.1 | 6,132 | 69.6 | 4 | 349 |
| Viet Nam | 78,137 | 5.9 | 1,860 | 67.2 | 7 | 81 |
| Western Asia | | | | | | |
| Bahrain | 640 | No Data | 13,688 | 72.9 | 12 | 585 |
| Georgia | 5,262 | 6.3 | 2,431 | 72.7 | No Data | 73 |
| Iraq | 22,946 | 1.0 | 3,205 | 58.7 | No Data | No Data |
| Jordan | 4,913 | 2.4 | 3,955 | 69.7 | 10 | No Data |
| Kuwait | 1,914 | No Data | 17,289 | 75.9 | 18 | No Data |
| Lebanon | 3,496 | 5.6 | 4,705 | 72.6 | 14 | No Data |
| Oman | 2,538 | No Data | 13,356 | 70.5 | 28 | No Data |
| Qatar | 565 | No Data | 18,789 | 68.9 | 19 | No Data |
| Saudi Arabia | 20,346 | No Data | 10,815 | 70.9 | 23 | No Data |
| Syria | 16,189 | 0.3 | 4,454 | 70.5 | 26 | 90 |
| Turkey | 66,668 | 8.2 | 6,380 | 69.0 | 15 | No Data |
| United Arab Emirates | 2,606 | No Data | 18,162 | 74.6 | 24 | 1,495 |
| Yemen | 18,349 | 0.3 | 806 | 59.4 | 54 | No Data |
| Caribbean | | | | | | |
| Bahamas | 304 | No Data | 15,258 | 69.1 | 4 | 658 |
| Barbados | 267 | No Data | 14,353 | 76.4 | No Data | 938 |
| Dominican Republic | 8,373 | 1.4 | 5,507 | 67.3 | 16 | 246 |
| Haiti | 8,142 | 2.9 | 1,464 | 52.0 | 51 | 61 |
| Jamaica | 2,576 | 17.0 | 3,561 | 74.8 | 13 | 202 |
| Trinidad and Tobago | 1,294 | 11.8 | 8,176 | 73.8 | 2 | 323 |
| Central America | | | | | | |
| Belize | 226 | 1.9 | 4,959 | 73.6 | No Data | 132 |
| Costa Rica | 4,024 | 15.7 | 8,860 | 76.0 | 4 | 509 |
| El Salvador | 6,278 | 3.0 | 4,344 | 69.1 | 21 | 298 |
| Guatemala | 11,385 | 2.3 | 3,674 | 64.0 | 31 | 155 |
| Honduras | 6,417 | 3.0 | 2,340 | 65.6 | 28 | 210 |
| Mexico | 98,872 | 1.9 | 8,297 | 72.2 | 9 | No Data |
| Nicaragua | 5,071 | 2.6 | 2,279 | 67.7 | 36 | 266 |
| Panama | 2,856 | No Data | 5,875 | 73.6 | 8 | 410 |
| South America | | | | | | |
| Argentina | 37,032 | No Data | 12,277 | 72.9 | 3 | 1,291 |
| Bolivia | 8,329 | 2.6 | 2,355 | 61.4 | 14 | 150 |
| Brazil | 170,406 | 4.4 | 7,037 | 67.2 | 15 | 453 |
| Chile | 15,211 | No Data | 8,652 | 74.9 | 4 | 511 |
| Colombia | 42,105 | 4.3 | 5,749 | 70.4 | 8 | 553 |
| Ecuador | 12,646 | 3.0 | 2,994 | 69.5 | 8 | 115 |
| Guyana | 761 | No Data | 3,640 | 63.7 | 2 | 186 |
| Paraguay | 5,496 | 7.0 | 4,384 | 69.6 | 7 | 233 |
| Peru | 25,662 | 4.4 | 4,622 | 68.0 | 10 | 278 |
| Suriname | 417 | No Data | 4,178 | 70.1 | 6 | No Data |
| Uruguay | 3,337 | No Data | 8,879 | 73.9 | 2 | 823 |
| Venezuela | 24,170 | No Data | 5,495 | 72.4 | 7 | 248 |
| Melanesia | | | | | | |
| Fiji | 814 | No Data | 4,799 | 68.4 | 7 | 196 |
| Papua New Guinea | 4,809 | No Data | 2,367 | 55.6 | 24 | 75 |
| Eastern Europe | | | | | | |
| Belarus | 10,187 | No Data | 6,876 | 68.5 | 1 | 387 |
| Bulgaria | 7,949 | No Data | 5,071 | 70.8 | 2 | 230 |
| Czech Republic | 10,272 | 16.7 | 13,018 | 74.3 | No Data | 928 |
| Hungary | 9,968 | 7.8 | 11,430 | 70.7 | 1 | No Data |
| Poland | 38,605 | 9.1 | 8,450 | 72.8 | 0 | 510 |
| Moldova | 4,295 | 5.9 | 2,037 | 66.6 | 1 | 177 |
| Romania | 22,438 | 8.5 | 6,041 | 69.8 | 2 | No Data |
| Russian Federation | 145,491 | No Data | 7,473 | 66.1 | 1 | No Data |
| Slovakia | 5,399 | No Data | 10,591 | 72.8 | No Data | 728 |
| Ukraine | 49,568 | 14.0 | 3,458 | 68.1 | No Data | 169 |
| Southern Europe | | | | | | |
| Croatia | 4,654 | No Data | 7,387 | 73.3 | 2 | No Data |
| Malta | 390 | No Data | 15,189 | 77.6 | 8 | No Data |
| Slovenia | 1,988 | No Data | 15,977 | 75.0 | 0 | 1,126 |
| Macedonia | 2,034 | No Data | 4,651 | 72.7 | No Data | 288 |
| Northern Europe | | | | | | |
| Estonia | 1,393 | 12.1 | 8,355 | 70.0 | No Data | No Data |
| Latvia | 2,421 | 9.6 | 6,264 | 69.6 | 0 | 410 |
| Lithuania | 3,696 | 13.1 | 6,656 | 71.4 | 1 | 429 |

This tables includes countries in Africa, Asia (except Japan and Israel), Latin America and the Caribbean, Oceania (except Australia and New Zealand), and European countries in economic transition for which data is available for eight or more indicators.

Data on adults living with HIV/AIDS and support for condoms are for the end of 2001, except for 11 countries—Comoros, Guinea, Kuwait, Lebanon, Mauritania, Niger, Paraguay, Saudi Arabia, Syria, Tunisia and the United Arab Emirates—for which data are for the end of 1999.

Sources: Demographic and Health Surveys (DHS). Calverton, MD: Macro International; Gulf Family Health Surveys (GFHS). Council of Ministers of GCC States; U.S. Centers for Disease Control and Prevention. Atlanta, GA; and Council of Europe.

UN Development Program. 2001. *Human Development Report 2001*. Oxford: Oxford University Press.

UN Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.

| Adults 15-49 Living with HIV/AIDS (%, End of 2001) | Adults 15-49 Living with HIV/AIDS (Number, End of 2001) | Annual Average Donor Support for Male Condoms (Number of Condoms, 1996-2000) | Annual Average Donor Support for Female Condoms (Number of Condoms, 1996-2000) | Average Number of Male & Female Condoms Donated Annually Per Male Aged 15-59 (1996-2000) |
|--|---|--|--|--|
| 0.2 | 3,400 | No Support | No Support | No Support |
| 1.8 | 650,000 | 42,120 | No Support | 0.0 |
| 0.3 | 130,000 | 47,384,929 | 6,000 | 2.1 |
| 0.3 | <1,000 | No Support | No Support | No Support |
| <0.1 | 900 | 954,080 | 800 | 0.6 |
| <0.1 | <1,000 | 695,160 | No Support | 0.1 |
| <0.1 | <1,000 | 1,552,320 | No Support | 1.1 |
| 0.1 | 1,300 | No Support | No Support | No Support |
| <0.1 | 1,500 | 275,906 | No Support | 0.3 |
| 0.1 | 1,300 | 127,814 | No Support | 0.2 |
| 0.1 | 1,300 | No Support | No Support | No Support |
| 0.1 | 1,100 | No Support | No Support | No Support |
| 0.1 | 800 | 1,360,213 | 200 | 0.3 |
| <0.1 | 3,700 | 8,612,842 | No Support | 0.4 |
| 0.2 | 2,300 | No Support | No Support | No Support |
| 0.1 | 9,900 | 471,965 | 1,100 | 0.1 |
| 3.5 | 6,100 | 77,658 | No Support | 0.8 |
| 1.2 | 2,000 | 25,531 | No Support | 0.3 |
| 2.5 | 120,000 | 2,704,208 | No Support | 1.1 |
| 6.1 | 240,000 | 24,816,521 | 26,200 | 11.8 |
| 1.2 | 18,000 | 171,020 | 560 | 0.2 |
| 2.5 | 17,000 | 319,205 | No Support | 0.8 |
| 2.0 | 2,200 | 165,444 | No Support | 2.6 |
| 0.6 | 11,000 | 732,720 | 3,000 | 0.6 |
| 0.6 | 23,000 | 3,530,940 | No Support | 2.0 |
| 1.0 | 63,000 | 7,530,500 | 3,456 | 2.6 |
| 1.6 | 54,000 | 5,882,992 | No Support | 3.4 |
| 0.3 | 150,000 | 7,466,055 | 6,520 | 0.3 |
| 0.2 | 5,600 | 4,754,101 | No Support | 3.6 |
| 1.5 | 25,000 | 364,257 | No Support | 0.4 |
| 0.7 | 130,000 | 63,360 | No Support | 0.0 |
| 0.1 | 4,500 | 4,063,593 | 28,400 | 1.8 |
| 0.7 | 600,000 | 29,667,180 | 1,246,248 | 0.6 |
| 0.3 | 20,000 | 167,808 | 400 | 0.0 |
| 0.4 | 140,000 | 358,382 | No Support | 0.0 |
| 0.3 | 19,000 | 3,031,929 | No Support | 0.8 |
| 2.7 | 17,000 | 626,957 | No Support | 2.7 |
| 0.1 | 2,900 | 1,640,800 | 3,928 | 1.1 |
| 0.4 | 51,000 | 12,631,346 | No Support | 1.7 |
| 1.2 | 3,600 | 69,162 | No Support | 0.5 |
| 0.3 | 6,200 | 102,850 | 1,000 | 0.1 |
| 0.5 | 62,000 | 105,921 | 13,536 | 0.0 |
| 0.1 | 300 | 312,394 | No Support | 1.2 |
| 0.7 | 16,000 | 134,691 | 6,000 | 0.1 |
| 0.3 | 15,000 | 7,200 | No Support | 0.0 |
| <0.1 | 400 | 1,667,202 | 100 | 0.7 |
| <0.1 | 500 | 65,760 | No Support | 0.0 |
| 0.1 | 2,800 | 20,980 | No Support | 0.0 |
| 0.1 | 14,000 | 267,800 | No Support | 0.0 |
| 0.2 | 5,500 | 432,000 | No Support | 0.3 |
| <0.1 | 2,500 | 892,952 | No Support | 0.1 |
| 0.9 | 700,000 | 1,113,640 | No Support | 0.0 |
| <0.1 | <100 | No Support | No Support | No Support |
| 1.0 | 250,000 | 742,267 | 200 | 0.1 |
| <0.1 | 200 | No Support | No Support | No Support |
| 0.1 | 240 | No Support | No Support | No Support |
| <0.1 | 280 | No Support | No Support | No Support |
| <0.1 | <100 | 1,042,314 | No Support | 1.6 |
| 1.0 | 7,700 | No Support | No Support | No Support |
| 0.4 | 5,000 | 8,640 | No Support | 0.0 |
| 0.1 | 1,300 | No Support | No Support | No Support |

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Acknowledgments

The authors are grateful to Sohail Agha, Senior Scientist with Abt Associates and Deputy Director of Research, Commercial Market Strategies; John Ross, Senior Fellow, and John Stover, Vice President, The Futures Group International for reviewing an early draft of this report.

They thank Jagdish Upadhyay, Senior Technical Officer, Commodity Management Unit, Inter-Country Programmes and Field Support Branch, Technical Support Division, UNFPA; and Mitchell Warren, Director, International Affairs, The Female Health Company for their invaluable contributions to the report; Megan Goetemueller, Global Campaign for Microbicides and Prevention Options for Women and Program Officer, Program for Appropriate Technology in Health; Polly Harrison, Director, Alliance for Microbicide Development; and Mary Collett Partlow, Senior Analyst for International Development, Global Health Council for their comments; and Carol Ashkinaze for her editorial support.

The authors also wish to express their appreciation to UNFPA and UNAIDS for sharing data with PAI.

The PAI Report Card 2002 Condoms Count: Meeting the Need in the Era of HIV/AIDS

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ISSN: 1537-0631
ISBN: 1-889735-35-3

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Publications Team:

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Design:

AURAS Design, Inc., Silver Spring, Maryland

Printing:

Stephenson Printing, Alexandria, Virginia

Printed on recycled paper.

Photos & Images:

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CORBIS (pp. 4, 10, 14, 36)

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Donor Support for Condoms, 1990-2000

(Number of Condoms)

| | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | Cumulative Total 1990-2000 |
|------------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------------|----------------------|----------------------|----------------------|--------------------|--------------------|-------------------------------|
| USAID | 794,502,000 | 820,002,000 | 267,822,000 | 548,838,000 | 484,218,000 | 613,391,270 | 346,444,354 | 308,274,000 | 484,487,566 | 190,298,000 | 363,756,661 | 5,222,033,851 |
| UNFPA | 98,343,360 | 79,834,176 | 34,519,392 | 72,253,728 | 185,601,056 | 291,513,168 | 159,093,152 | 150,344,317 | 209,224,750 | 102,663,228 | 144,210,974 | 1,527,601,301 |
| KFW | ... | ... | 1,000,000 | 2,465,000 | 2,980,000 | 39,200,000 | 427,230,600 | 407,503,096 | 204,144,384 | 120,588,106 | 204,605,298 | 1,409,716,484 |
| DFID | ... | ... | 3,283,200 | 78,596,752 | 15,014,000 | 280,192,280 | 117,295,460 | 61,659,435 | 98,192,194 | 205,706,712 | 73,408,635 | 933,348,668 |
| EU | ... | ... | ... | 6,000,000 | 167,000,000 | 46,800,000 | 263,300,000 | 148,700,000 | 22,900,000 | 79,786,000 | ... | 734,486,000 |
| DKT | 61,751,952 | 54,167,328 | 32,378,400 | 31,471,200 | 30,331,648 | 47,488,032 | 54,977,174 | 69,753,740 | 2,738,410 | 42,232,470 | ... | 427,290,354 |
| WHO | ... | ... | 19,871,424 | ... | ... | 3,480,000 | ... | ... | 103,474,094 | 127,906,000 | 134,040,065 | 388,771,583 |
| Pop. Services Int'l (PSI) | ... | ... | ... | ... | ... | 146,047,450 | 141,389,000 | 46,987,118 | 660,000 | 9,504,000 | 17,862,048 | 362,449,616 |
| IPPF | 14,955,840 | 18,480,816 | 33,787,880 | 19,401,752 | 28,164,168 | 33,924,800 | 18,805,904 | 16,037,320 | 17,869,494 | 14,060,304 | 9,801,912 | 225,290,190 |
| MSI | ... | ... | 7,801,953 | 31,111,270 | 16,716,816 | ... | ... | 32,187,770 | 782,144 | ... | ... | 88,599,953 |
| Netherlands Pathfinder Int'l | ... | ... | ... | ... | ... | 3,400,000 | ... | ... | 7,327,440 | 51,687,820 | ... | 62,415,260 |
| Japan | ... | ... | 21,828,000 | 21,162,110 | 3,843,660 | 10,686,000 | 25,000,000 | ... | ... | ... | ... | 57,519,770 |
| SIDA | ... | ... | 26,928,000 | ... | 288,000 | 100,000 | 3,219,757 | 13,145,566 | 7,670 | 6,000,000 | 3,146,242 | 26,650,592 |
| UNAIDS | ... | ... | ... | ... | ... | 1,031,357 | ... | ... | ... | 492,500 | ... | 492,500 |
| ALL DONORS | 969,553,152 | 972,484,320 | 449,220,249 | 811,299,812 | 934,257,348 | 1,517,154,357 | 1,556,755,401 | 1,254,592,362 | 1,151,808,146 | 950,925,140 | 950,831,835 | 11,518,882,122 |

Source: UNFPA, 2002. Database on Donor Support for Contraceptives and Logistics Management. New York: UNFPA.

... indicates no donor support

Donor Funding for Condoms, 1990-2000

(Current US\$)

| | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | Cumulative Total 1990-2000 |
|------------------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------------------|
| USAID | 37,683,204 | 40,661,473 | 15,540,096 | 31,510,682 | 25,301,868 | 31,188,886 | 19,594,884 | 17,596,580 | 26,309,673 | 12,387,859 | 24,403,949 | 282,179,154 |
| UNFPA | 2,950,301 | 2,395,025 | 1,173,659 | 2,312,119 | 4,032,251 | 8,107,115 | 5,449,954 | 5,121,658 | 6,258,163 | 2,775,552 | 6,461,375 | 47,037,173 |
| KFW | ... | ... | 34,000 | 78,880 | 95,360 | 1,340,390 | 17,650,310 | 9,136,816 | 6,246,779 | 4,092,053 | 6,165,480 | 44,840,068 |
| DFID | ... | ... | 387,627 | 1,753,460 | 501,846 | 7,653,361 | 5,611,004 | 3,227,504 | 5,127,141 | 7,298,980 | 3,554,281 | 35,115,204 |
| EU | ... | ... | ... | 180,000 | 5,845,000 | 1,820,000 | 9,215,500 | 7,435,000 | 643,575 | 2,258,493 | ... | 27,397,568 |
| Pop. Services Int'l (PSI) | ... | ... | ... | ... | ... | 7,340,991 | 7,069,450 | 3,859,800 | 199,800 | 264,420 | 455,972 | 19,190,433 |
| IPPF | 448,675 | 554,424 | 1,013,636 | 554,304 | 863,448 | 963,556 | 793,643 | 861,949 | 642,983 | 394,638 | 356,131 | 7,447,388 |
| DKT | ... | ... | 418,388 | ... | ... | 177,480 | ... | ... | 3,104,223 | 4,695,200 | 4,318,000 | 12,713,291 |
| WHO | 957,155 | 975,012 | 628,141 | 482,580 | 615,498 | 1,276,138 | 1,815,817 | 2,261,846 | 104,740 | 733,667 | ... | 9,850,594 |
| Netherlands Pathfinder Int'l | ... | ... | ... | ... | ... | 102,000 | ... | ... | 2,700,000 | 2,584,391 | ... | 5,386,391 |
| MSI | ... | ... | 1,091,400 | 1,058,106 | 249,971 | 629,460 | ... | 1,015,632 | 39,007 | ... | ... | 3,028,937 |
| SIDA | ... | ... | 395,656 | 1,105,087 | 285,026 | ... | 750,000 | ... | ... | ... | ... | 2,840,408 |
| Japan | ... | ... | 573,107 | ... | 6,100 | ... | 127,507 | 394,367 | 6,880 | 159,000 | 265,637 | 1,329,207 |
| UNAIDS | ... | ... | ... | ... | 27,542 | 44,956 | ... | ... | ... | ... | ... | 1,025,889 |
| ALL DONORS | 42,039,335 | 44,585,935 | 21,255,711 | 39,035,217 | 37,823,911 | 60,644,333 | 68,078,069 | 50,911,152 | 51,382,964 | 37,862,328 | 45,980,826 | \$499,599,780 |

Source: UNFPA, 2002. Database on Donor Support for Contraceptives and Logistics Management. New York: UNFPA.

... indicates no donor funding