5 PILLARS FOR HIV PREVENTION

Issue Brief 3

The Missing Piece of the Puzzle

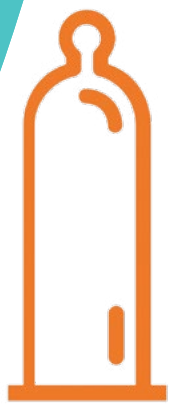
RIGHTS+EQUITY+JUSTICE for HIV PREVENTION

Strengthened national condom and related behavioural change programmes

Condoms have prevented about 50 million infections since the beginning of the HIV epidemic. Condoms, both male and female, are highly cost-effective. They are also the only method to offer triple protection – against HIV, STIs and unintended pregnancy.

Currently, condoms and lubricants are sub-optimally programmed in East and Southern Africa.

There are major gaps in condom use and availability. As part of the 2016 UN Political Declaration on Ending AIDS, countries committed to a target of ensuring:



distribution of

20 billion

condoms per year between 2016 and 2020.

This includes approximately **7 billion** condoms for sub-Saharan Africa annually and 30–50 condoms per male, per year in high-prevalence countries.

per male

per year in high-prevalence countries

For that target to be achieved, however, several of the structural barriers to optimal condom programming need to be addressed. The time has come for a new generation of comprehensive, data-driven and people-centred condom programmes.

ARASA AIDS & Rights Alliance for Southern Africa

The HIV epidemic in East and Southern Africa: where are we now?

The 2020 targets

In June 2016, at the United Nations High-Level Meeting (HLM) on Ending AIDS, countries pledged to leave no one behind and: **end the AIDS epidemic** as a public health threat by **2030** and **reach ambitious milestones** by **2020.**

- reduce AIDS-related deaths
- reduce new infections

} to less than 500 000[i]

The HLM, for the first time, set specific programme targets for HIV prevention, supported by 5 pillars:

For condoms, the global target set by UNAIDS is to make:

20

billion condoms

available annually in low- and middle-income countries, in order to stem new HIV infections.

While reductions in global AIDS-related deaths continue at a pace that puts the 2020 target within reach, the rate of new HIV infections is not falling fast enough to reach the 2020 target of under half a million new infections per year.

Out of all regions of the world, East and Southern Africa is in fact faring the best, with new HIV infections declining by 30% between 2010 and 2017.

Pillar		Target
adolescent girls and young women (AGYW)	1	reduce new HIV infections among young women and girls to under 100 000
key populations	2	ensure that 90% of people at risk of HIV can access prevention services
condom programming	3	make 20 billion condoms available annually in low and middle-income countries
voluntary medical male circumcision (VMMC)	4	provide 25 million more men with VMMC
pre-exposure prophylaxis (PrEP)[iii]	5	provide PrEP to 3 million people at risk of HIV

In order to reach the global targets, SADC has committed to reduce the amount of new infections by 230 000 per year. This is a 75% reduction from the levels in the SADC region in 2010.

PROGRESS TOWARDS 2020 HIV PREVENTION TARGETS IN SADC

Progress is still too slow, and if the region continues at the current trajectory, it will fail to meet the 2020 targets.[iv]

[New HIV Infections per year]

1990 — 669 856

1995 — 1 276 730

2010 — 903 576

30% decline in new infections between 2010 and 2017

2017 — 532 946 — 590 590

2019 — 328 242 — 501 174

2020 — 225 890 — 456 466

[Political Declaration Target] [Projection on currrent trends]

Treatment as Prevention is not enough

The goal of getting people onto antiretroviral treatment has surpassed everyone's expectations. Treatment has been shown to be an effective means of HIV prevention.

Estimates shows that achieving UN treatment goals alone can only reduce 60% of new infections[iv]. We therefore need a renewed focus on primary prevention[1].

Principles of programme interventions for all 5 pillars

Effective and efficient prevention programmes have the following elements:[v]

- They are comprehensive and integrated
- They are smart: they ask, "What works?", "With which populations?" and "In which settings?"
- They respect and protect human rights
- They are gender-sensitive and/or gender-transformative[2]
- Services are delivered at community level
- They make use of local programme data to for continuous improvement.
- They can be scaled up.

The 5 HIV prevention pillars are components of an integrated response.

Why condoms?

Condoms are also a highly cost-effective way of preventing HIV. For example, they are a fraction of the cost of antiretroviral medication (used as either Treatment as Prevention (TasP)[3] or Pre-exposure prophylaxis (PrEP).[4]

Condoms are a critical component in a comprehensive and sustainable approach to the prevention of HIV and other sexually transmitted infections (STIs) and are effective for preventing unintended pregnancies (thus offering 'triple protection').

Did you know?

Condoms have prevented around 50 million new HIV infections since the onset of the HIV epidemic.

Combination prevention programmes are rights-based, evidence-informed, and community-owned. They combine biomedical, behavioural, and structural interventions. These are prioritised to meet the needs of particular individuals and communities in order to have the greatest impact.

Zimbabwe and **South Africa** are two high-prevalence countries where strategic condom programming has led to increased condom use, which in turn has contributed to reductions in HIV incidence.[5]

New generation, data-driven condom programming prioritises groups who have high rates of sex with people other than their regular partners.

For key populations - sex workers, men who have sex with men, transgender people and people who inject drugs - the distribution of condoms, as part of a combination prevention approach, is a core intervention with proven success.

For example, in Burkino Faso,[vivii] condoms were an integral part of an intervention package for sex workers, consisting of peer-led education sessions, psychological support, STI screening and treatment and HIV care, general routine health care and reproductive health services.

During the study there was zero incidence of HIV, which was related to an increase in consistent condom use with casual and regular clients. Complete prevention of new infections was related to very high levels of reported consistent condom use.

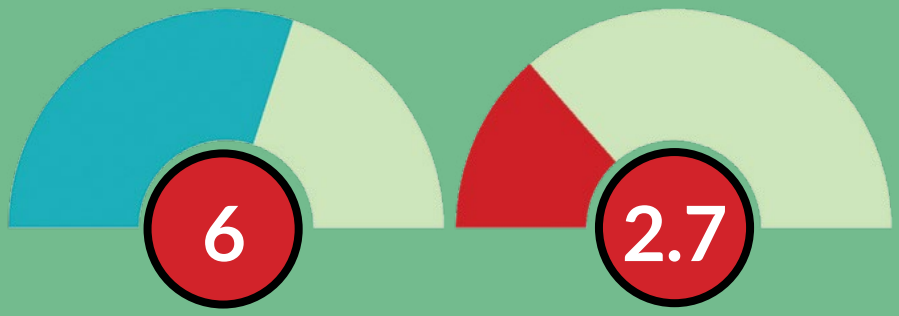
From region to region, and from country to country, such groups may vary, and planning should be informed by both research data and multi-stakeholder consultation. For example, a multi-stakeholder consultation on HIV prevention in East Africa in 2018 decided that men in certain occupational groups, such armed forces, truck drivers, taxi drivers, plantation workers, herdsmen and fisherfolk as being some of the priority groups.[viii]

Other priority groups for condom programming include men in mobile and migrant occupations, who generally have higher rates of casual and concurrent sexual partners compared to the general population.

Other groups that should be factored in when setting targets for condom programming include those using condoms for family planning, as well as HIV-affected couples.[ix]

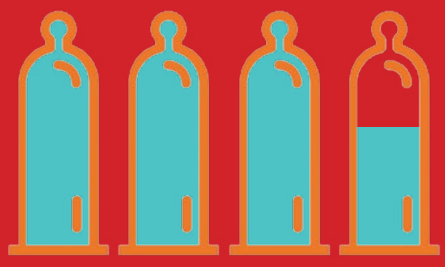
What are the barriers to condom programming?

Not enough condoms are being distributed to meet the need, and to make the impact on HIV prevention which they could make.



The estimated condom need in 47 countries in sub-Saharan Africa in 2015 was 6 billion male condoms.

Only 2.7 billion condoms were distributed that year.



a shortfall of 3.3 billion!

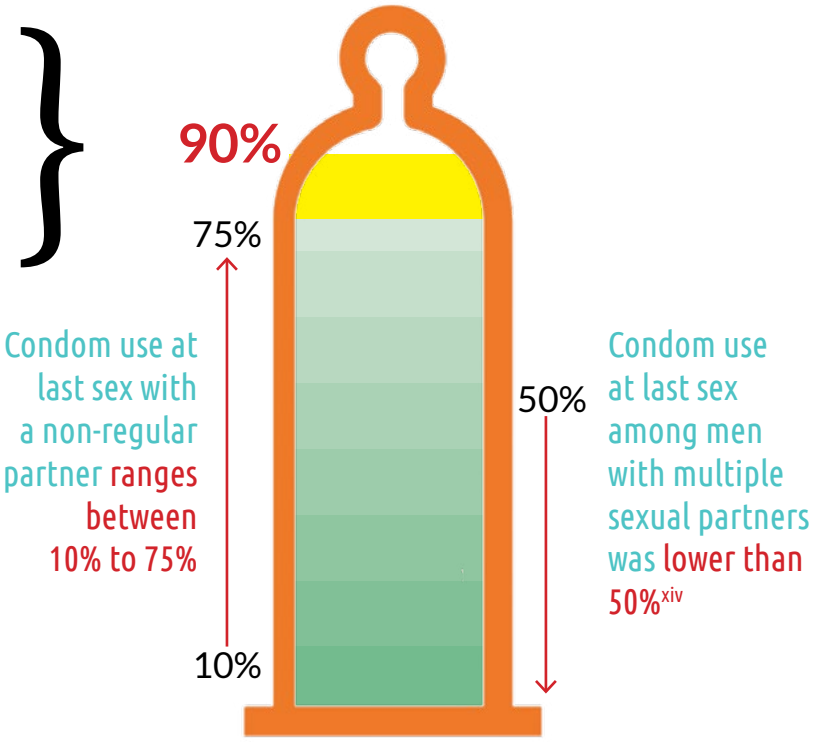
1. Condom availability challenges

More than half of sub-Saharan Africa's condom need was not met.[x] Why is this? There are several reasons:

- Lack of funding: International funding for condom procurement in sub-Saharan Africa has actually decreased in recent years, and domestic funding has not sufficiently increased,. In several countries condom programming, in particular condom promotion and demand creation, has stalled due to a lack of funding and decreased investment.[xi]
- Female condoms and lubricant distribution very low: The number of female condoms and lubricants being distributed remained very low, despite their proven benefits. In 2015, The number of female condoms distributed was only 1.6% of the total condom distribution.[xii]
- Procurement and supply chain management: In many countries in East and Southern Africa (ESA) procurement and supply chain management systems are weak.
- Lack of African manufacturers: Most of Africa's condoms are manufactured outside the continent. Currently, condom manufacturing occurs in five places in Africa. Together, these five manufacturers produce less than 10 per cent of the condom requirement for the entire continent. Moreover, none of these manufacturing units meet the pre-qualification standards set by the World Health Organization (WHO) and the United Nations Population fund (UNFPA).[xiii]

2. Condom use challenges

- The condom gap: Condom use at last sex with a non-regular partner in sub-Saharan Africa ranges between 10% to 75%, but nowhere is yet at the required target of 90%. In 23 of 25 countries in sub-Saharan Africa with available data, condom use at last sex among men with multiple sexual partners was lower than 50%.



3. Policy and Programme challenges

- Data challenges: In many countries, estimations of the number of condoms needed are inadequate. In addition, many countries in the region experiencing challenges in aggregating the numbers of condoms distributed through different channels, through public and private sectors, and via social marketing.

- Demand creation: Demand creation activities may be inadequate or else poorly conceived. There is a need to boost the appeal of condoms by making them 'cool' and 'sexy'.

- Barriers affecting young people: There are a range of barriers which prohibit young people from accessing sexual and reproductive health and rights (SRHR) services, often underpinned by punitive social and gender norms around adolescent sexuality. For example, in many countries there is resistance to distributing condoms in schools and colleges.

- Key populations: Stigma and discrimination towards key populations interfere with optimal condom programming. In countries where sex work is criminalised, sex workers have reported that police use condom possession as evidence of sex work or confiscate or destroy condoms . In most countries laws, regulations or policies are obstacles for the distribution of condoms to people in prisons and other closed settings.

- Need to dig deeper: Within countries, there is large variation in condom use, between genders, between rural and urban, across age groups, and across different levels of education.[xv]

- Young people: Condom use by young people in particular at last sex with non-regular partners is still not high enough. For many women, especially young women, and those with low control in relationships, it is challenging to negotiate condom use with their male partners.

- Norms and values: Social, cultural and religious norms and values regarding gender and sexuality are often barriers to condom use.

For example, in the Democratic Republic of Congo (DRC), some popular musicians sing songs about condoms.

out of 100 countries in 2017 reported that their national plan or strategy related to condoms, included condom promotion in secondary schools

In most countries in sub-Saharan Africa, condom use amongst young men and women who have casual and concurrent sexual partners is under 60%.

Entry points for advocacy

- Human rights as the foundation: Condom programming needs to built on a strong foundation of sexual and reproductive health and rights and gender equality. It must integrate—and be integrated into—comprehensive sexuality education (CSE) and efforts to promote respect for the right to the enjoyment of sex and to the expression of sexual identity.

- Available and affordable: Quality-assured condoms must be readily available universally, either free or at low cost. HIV prevention programmes need to ensure that a sufficient number and variety of quality assured condoms are accessible to people who need them, when they need them.

The challenge ahead is to invest in, and scale up, a new generation of data-driven and people-centred comprehensive condom programmes. Comprehensive condom programmes should include these essential components:

- demand creation,
- community mobilisation,
- supply chain management,
- planning,
- programme management and
- monitoring and evaluation.

- Multi-stakeholder consultation and coordination: There is a need for effective multi-stakeholder condom programming coordination and oversight platforms and ensure the full involvement of beneficiaries and communities in planning, service delivery and monitoring.

- Informed by data: Condom promotion and distribution strategies and approaches need to be informed by data, tailored to the context and needs of different communities.

- Addressing stigma and harmful gender norms: Programmes promoting condoms must address stigma and gender-based and socio-cultural factors that hinder effective access and use of condoms.

- Key populations: Programmes which improve the human rights status of key populations will create a more enabling environment in which key populations have improved access to HIV prevention, treatment and care, and also have greater agency to negotiate condom use.

- Prisons: Condoms should also be made available in prisons and closed settings, and in humanitarian crises situations.

- Mobilise financing: Collective actions at all levels are needed to support the efforts of countries that depend on external assistance for condom procurement, promotion, and distribution and to increase domestic funding and private sector investment.

- Total market approach: National condom distribution and sales can be strengthened by applying a total market approach that combines public sector distribution, social marketing and private sector sales.

- Integration at community level: In high-HIV prevalence locations condom promotion and distribution should become systematically integrated in community outreach and service delivery, and in broader health service provision.

References

[i]Dehne, K., Dallabetta, G., Wilson, D., Garnett, G., Laga, M., Benomar, E. et al. (2016). HIV Prevention 2020: a framework for delivery and a call for action. The Lancet, v3 (7), pe323-e332.
[ii]Dehne et al. ibid
[iii]SADC (2018). Meeting Report: Stock-Taking on the Progress in Fast-Tracking HIV Prevention by SADC Member States. Gaborone: SADC
[iv]Wilton Park (2017. Building a stronger HIV prevention movement in sub-Saharan Africa. Available at https://www.wiltonpark.org.uk/event/wp1518/
[v]SADC (2017). Framework for target-setting for HIV prevention in the SADC region
[vi]Traore I. et al. (2015) HIV prevention and care services for female sex workers: efficacy of a targeted community-based intervention in Burkina Faso, Journal of the International AIDS Society.
[vii]EAC (2018). East African Community regional meeting to accelerate HIV prevention. 30 April-2 May, Entebbe, Uganda
[viii]Van Renterghem et al. (2016) Estimating condom needs and gaps for fast-tracking people- centred condom programming in sub—Saharan Africa. International AIDS Conference, July 2016. Session D73 Condom and lubricant availability, accessibility, distribution and social marketing
[ix]UNAIDS prevention gap report 2016
[x]UNAIDS prevention gap report 2016
[xi]UNAIDS prevention gap report 2016
[xii]https://southafrica.unfpa.org/en/news/manufacturing-condoms-africa-urgent-health-and-economic-priority
[xiii]Demographic and Health Survey data, 2000–2015, from statcompiler.com
[xiv]Van Renterghem, H. (2017) Targets for fast-tracking condom programming. SADC Target setting meeting, October 2-3 2017, Johannesburg. UNAIDS.
[xv]Open Society Foundations (2012). Criminalizing condoms: How Policing Practices Put Sex Workers and HIV Services at Risk in Kenya, Namibia, Russia, South Africa, the United States, and Zimbabwe. Available at https://www.opensocietyfoundations.org/reports/criminalizing-condoms
[xvi]UNFPA, WHO and UNAIDS: Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy. Available at: http://www.unaids.org/en/resources/presscentre/featurestories/2015/july/20150702_condoms_prevention

End Notes

[1]Primary prevention means activities which aim to prevent a person becoming infected with HIV. In contrast, secondary prevention is aimed at people who are already infected with HIV, to stop them from transmitting the virus to those who are HIV-negative.

[2]Gender-sensitive programmes recognise and respond to the different needs and constraints of individuals based on their gender and sexuality. These activities significantly improve women's and girls' and/or men's and boys' access to protection, treatment or care; however, in themselves, they do little to change the larger contextual issues that lie at the root of gender inequities.

Gender-transformative programmes, on the other hand, actively seek to transform gender roles and create relations that are more gender-equitable.

[3]Treatment as prevention (TasP) refers to HIV prevention methods and programmes that use antiretroviral treatment (ART) for HIV-positive people to decrease the risk of HIV transmission.

[4]Pre-exposure prophylaxis (PrEP) is the taking of a prescription drug as a means of preventing HIV infection in an HIV-negative person.

[5]The terms 'incidence' and 'prevalence' are sometimes confused, but the difference between them is quite simple. Incidence means the number or rate of people who are newly diagnosed with a disease, in this case HIV. Prevalence means the overall number or rate of people who are living with that disease in the population.

Resources

1. UNFPA, WHO and UNAIDS: Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy[xvii]

2. UNAIDS: Condoms: The prevention of HIV, other sexually transmitted infections and unintended pregnancies Available at: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/01/JC2825-7-1.pdf

3. HIV Prevention 2020 Road Map: Accelerating HIV Prevention to reduce new infections by 75% . UNAIDS Available at http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf

4. Members of the Global Prevention Coalition report on condoms as part of a prevention scorecard, which is available online. https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/

About ARASA

The AIDS and Rights Alliance for Southern Africa (ARASA) was established in 2002 as a regional partnership of civil society organisations working in 18 countries in southern and East Africa. Between 2019 and 2021, the partnership will work to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and wellbeing in southern and East Africa.

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ARASA AIDS & Rights Alliance for Southern Africa

The Partnership to Inspire, Transform and Connect the HIV response (PITCH) enables people most affected by HIV to gain full and equal access to HIV and sexual and reproductive health services.

The partnership works to uphold the sexual and reproductive health and rights of lesbian, gay, bisexual, and transgender people, sex workers, people who use drugs and adolescent girls and young women. It does this by strengthening the capacity of community-based organisations to engage in effective advocacy, generate robust evidence and develop meaningful policy solutions.

PITCH focuses on the HIV response in Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam and Zimbabwe. Partners in these countries also share evidence from communities to influence regional and global policies that affect vulnerable populations.

PITCH is a strategic partnership between Aidsfonds, FrontlineAIDS and the Dutch Ministry of Foreign Affairs.

PITCH Partnership to Inspire, Transform and Connect the HIV response

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FRONTLINE AIDS

Ministry of Foreign Affairs

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