PANCAP

Pan-Caribbean Partnership Against HIV/AIDS

Regional Model Condom Policy

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List of acronyms

ABC	HIV prevention: Abstinence, Be faithful, Condom use
AGM	PANCAP Annual General Meeting
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
CAIC	Caribbean Association of Industry and Commerce
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARISMA	Caribbean Social Marketing to prevent HIV & AIDS
CBO	Community-Based Organisation
CCC	Caribbean Conference of Churches
CCHAI	Core Caribbean HIV/AIDS Indicators
CCNAPC	Caribbean Coalition of National AIDS Programme Coordinators
CDC	Centre for Disease Control and Prevention
CFPA	Caribbean Family Planning Affiliation
CHART	Caribbean HIV/AIDS Regional Training (UWI)
CHOGM	CARICOM Heads of Government Meeting
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
CIMT	Caribbean Indicators and Measurement Tools
COHSOD	CARICOM Council for Human and Social Development
COIN	Centro de Orientación e Integración Integral
COPRESIDA	Consejo Presidencial del SIDA
CPR	Contraceptive Prevalence Rate
CRN+	Caribbean Regional Network of People Living with HIV/AIDS
CRSF	Caribbean Regional Strategic Framework
CSW	Commercial Sex Worker
CVC	Caribbean Vulnerable Communities (network)
CYA	CARICOM Youth Ambassador
DFID (UK)	Department for International Development
EU	European Union
FBO	Faith-Based Organisation
FC	Female Condom
FP	Family Planning
FPA	Family Planning Association
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHARP	Guyana HIV/AIDS Reduction and Prevention Project
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAPU	OECS HIV/AIDS Project Unit

HARP	HIV/AIDS Response Programme (UWI)
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
IPPF/WHR	International Planned Parenthood Federation / Western Hemisphere Region
ISO	International Organisation for Standardisation
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
M&E	Monitoring and Evaluation
MARP	Most at risk population
MSM	Men who have sex with men
MSPP	Ministère de la Santé Publique et de la Population
NAC	National AIDS Commission
NACC	National AIDS Coordinating Committee
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
NHAC	National HIV/AIDS Commission
OECS	Organisation of Eastern Caribbean States
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organisation
PANCAP	Pan Caribbean Partnership on HIV/AIDS
PCR	Polymerase Chain Reaction
PCU	PANCAP Coordinating Unit
PEPFAR	President's Emergency Plan for AIDS Relief
PHCO	PAHO HIV Caribbean Office
PLACE	Priorities for Local Control Efforts
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission of HIV
PPS	Pharmaceutical Procurement Service (OECS)
PSI	Population Services International
RCM	PANCAP Regional Coordinating Mechanism
RH	Reproductive Health
S&D	Stigma and Discrimination
SESPAS	Secretaría de Estado de Salud Pública y Asistencia Social
SMO	Social Marketing Organisation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TMA	Total Market Approach
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
UWI	University of West Indies
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation

Executive summary

In Caribbean countries, low condom use has been identified as one of the major factors impeding the control and prevention of HIV and AIDS. Yet correct and consistent use of male and female condoms is unanimously recognised as a vital tool within comprehensive HIV prevention programmes. This is particularly true for the Caribbean where the majority of HIV transmissions is heterosexual. Without sexually active people most at risk using condoms, increasing HIV prevalence rates may overwhelm other efforts such as antiretroviral treatment. However, some Caribbean countries continue to maintain laws and policies that undermine universal access, use and education about condoms.

In view of such weaknesses and given the strategic importance of condoms in reducing the challenges, which the AIDS epidemic poses for Caribbean countries, CARICOM-PANCAP has initiated the development of a model condom policy for the region with a grant from the International Development Association. This overarching model policy shall assure that condoms are given the attention they deserve as a cost-efficient and effective means to secure sexual and reproductive health for all.

This policy document displays the Caribbean background and context for the spread of HIV and other sexually transmitted infections. Worldwide, the Caribbean region reports the second highest HIV prevalence rates. The average of 1% HIV prevalence among adults is surpassed by a number of countries with up to more than 3%. Much higher prevalence rates are observed among special high-risk groups.

Despite relatively wide condom distribution mechanisms, the accessibility and acceptance of condoms remains limited in most Caribbean countries for those populations that are most at risk of infection or unintended pregnancy. Access to condoms is difficult for sex workers and men who have sex with men due to societal stigma and discrimination. Collective disapproval, adverse legislation and service norms are among the main causes hampering condom access for sexually active adolescents. Gender relationships, sexual culture and sex education in the Caribbean do not sufficiently support preventive behaviour based on a realistic personal risk assessment.

The vision of the model condom policy is to protect the rights of all sexually active people in the Caribbean by creating an environment which enables them to acquire condom related information and skills, and access and use condoms as an option to prevent the transmission of sexually transmitted infections (STIs), including HIV, and undesired pregnancies.

The overall goals of the model policy have been determined as to

(1) Contribute to the achievement of universal access to STI/HIV prevention, treatment, care and support services by ensuring availability of and access to quality condoms.

(2) Create an enabling legislative environment to increase availability and access to condoms for all people in need.

(3) Strengthen knowledge and skills concerning options for safer sex.

Elements and strategic issues of the model condom policy have been developed with the aim to assure that male and female condoms are of good quality, readily and consistently available, universally accessible to all in need, and accepted by the sexually active population. They should be taken into consideration by national policy makers and stakeholders when reviewing existing legislation and regulation with regard to condoms.

Key element is a strategic comprehensive condom management that involves all sectors procuring, promoting and distributing condoms. Various governmental sectors should make their coordination and cooperation more efficient. It is imperative to continue or increase the cooperation with the non-governmental not-for-profit and the private commercial sectors in order to assure a wide range of coverage and targeted interventions. The participation of the civil society, faith-based organisations and advocacy groups is vital.

The policy document gives strategic information on products and quality assurance, condom procurement, import duty and taxation, condom accessibility and distribution. With regard to behaviour change communication, special emphasis is placed on the need to facilitate an open dialogue about fundamental issues that influence individual and societal attitudes and behaviour. Advocacy for universal access to condoms as well as target group specific interventions are required in order to encourage and maintain preventive behaviour. It is crucial to monitor the implementation of the condom policy and to evaluate behaviour change in condom use among the general population and among specific high-risk populations.

Finally, suggestions are given with regard to strategic governmental responsibilities in order to reach a satisfying level of preventive behaviour and condom use among vulnerable populations. Recommendations are also provided concerning PANCAP and the regional level to get approval for the regional model policy and the respective Caribbean countries for its national adaptation.

1. Introduction

Mandate and Terms of Reference

In 2001, the Caribbean Community (CARICOM) established the Pan Caribbean Partnership against HIV/AIDS (PANCAP), a coalition of public and private national, regional, and international organisations. In its strategic framework, PANCAP's priorities include ensuring that national level policy decisions reflect international standards and best practices and that they are consistent with international guidelines.[1] It also comprises advocacy for HIV prevention and "improved access to basic medication for prevention".

In February 2006, the Caribbean Regional Consultation on Universal Access to HIV/AIDS Prevention, Treatment, Care and Support recommended to "Improve availability, accessibility, coverage, appropriateness and acceptability of HIV/AIDS diagnostic, prevention, protection, treatment, care and support services through, for e.g., free HIV/AIDS testing, first line medicines in primary health care, improved services hours, particular attention to populations in crisis, unsupervised access to condoms, youth friendly services, respect of the dignity of individuals, provision of low cost, high quality prevention commodities."

Since the beginning of PANCAP, low condom usage had been identified as one of the major factors impeding the control and prevention of HIV in the region. Thus, the CARICOM Secretariat, with a grant from the International Development Association, initiated the development of a regional model condom policy, to assist the Caribbean partners in reducing the spread of HIV and other sexually transmitted diseases.

The terms of reference for a consultancy on the regional model condom policy stipulated that the policy should be developed in a broad participatory consultation process involving important national, regional and international stakeholders. The content areas to be covered are represented in the following document. (Terms of Reference – cf. Annex 1)

Reasons for the model condom policy

Male and female condoms are a vital tool in all efforts to prevent HIV infection and they are essential to maintain sexual and reproductive health, such as the prevention of sexually transmitted infection or of unintended pregnancy. Worldwide, condoms have played a decisive role in HIV prevention efforts in many countries. Condoms have helped to reduce HIV infection rates where AIDS has already taken hold and curtailed the broader spread of

[1] Caribbean Regional Strategic Framework for HIV/AIDS 2002-2006 (CRSF), 2002

HIV in countries where the epidemic is still concentrated in specific populations. Condoms have also encouraged safer sexual behaviour more generally. Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. But on average, only 9 percent of risky sexual acts are undertaken while using a condom.[2] To have an impact on infection rates, condom use must expand significantly beyond the current level.

Caribbean countries strive to curb the AIDS epidemic by securing access to prevention, treatment, care and support services. But the commitment to meet the high demand for antiretroviral treatment (ART) for infected people, causes an imbalance to the detriment of prevention and comprehensive care.[3] Yet the trend of still increasing new infections[4] poses a major threat for the Caribbean AIDS response. If new infections continue to rise at the current rate, investments in assuring universal access to treatment will result in an increasing need to commit government funding to this medical service. By reducing the death toll, prevalence rates will increase, meaning that increasing numbers of PLWHA will legitimately demand medicines for life – an unaffordable situation for many Caribbean countries.[5]

On the other hand, ART access for people at high risk of HIV infection offers significant opportunities to provide prevention programmes for hitherto hard-to-reach population groups (e.g. sex workers, work migrants, men who have sex with men, prison inmates). There is evidence[6] that sustained progress in the response to AIDS will only be attained by intensifying treatment and HIV prevention simultaneously.

But despite widely offered prevention programmes, most people at risk still have little or no access to prevention services or commodities. In the Caribbean, heterosexual HIV transmission is now the main mode of transmission and women account for an increasing percentage[7] of the 230,000 adults estimated to live with HIV.[8] New generations of young people are growing up with HIV infection as a social reality.

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[2] Taking Action against HIV

[3] PAHO 2007

[4] In 2007, there were still more newly infected people in the Caribbean than AIDS related deaths among adults and children: estimated 17,000 new HIV infections against 11,000 deaths (UNAIDS Epidemic Update 2007)

[5] PAHO 2007

[6] Salomon J.A.et al. (2005) Integrating HIV prevention and treatment: From slogans to impact. PLoS Med 2: e16 – cited in UNAIDS: Intensifying HIV prevention – Policy position paper, 2005

[7] In the Caribbean**,** 43% of adults living with HIV in 2007 were women (compared with 37% in 2001).

[8] UNAIDS 2007, PAHO 2007

A comprehensive HIV prevention package includes, but is not limited to, delaying sexual debut, mutual fidelity, minimising the number of sexual partners, safer sex including correct and consistent male and female condom use and avoiding penetrating sex practices, voluntary counselling and HIV testing (VCT), and early and effective treatment for sexually transmitted infections (STIs).[9]

Successful HIV prevention programmes respond to the realities of population groups at risk without restriction. Basic sex education is a prerequisite with positive impact on present or future sexual behaviour and must start at an early age. The complete 'ABC'[10] of prevention should be widely promoted and applied. But in many Caribbean countries, the "C" (condom) is not easily accepted for and by groups most at risk. Some countries continue to perpetuate laws and policies that undermine access, use and education about condoms. If not supported by all feasible means, condom use among people at risk is unlikely to become correct and consistent.

Condoms need to be a safe quality product, affordable and accessible to all those who are sexually active and at risk of STI/HIV infection or unwanted pregnancy. Condoms are an essential pharmaceutical consumer good to be distributed by all sectors – public, not-for-profit NGO and commercial sector. Condoms need promotion in order to be attractive and utilised.

An overarching condom policy shall assure that condoms are given the attention they deserve as a cost-efficient and effective means to secure sexual and reproductive health - for which legal regulation, coordination and control is necessary. The condom policy offers the potential to streamline a country's (or a region's) overall condom provision and promotion and make appropriate use of government resources, household income and international aid.

The HIV epidemic imposes important social and economic challenges on most Caribbean countries such as the loss of revenues in the tourism sector, loss of labour force in important sectors due to HIV-related illness and death, school drop-outs, social problems, decreasing life expectancy, increasing expenditures on health and social welfare. The tourism sector as a key factor for economic growth in the region is particularly vulnerable to the threat of HIV and AIDS due to the high mobility of both tourists and personnel and yet depends entirely on an untainted image on the world market.

Without intensifying all appropriate measures to curb the HIV epidemic, these costs are likely to dissipate economic growth in the Caribbean. AIDS is a social and economic development

[9] UNAIDS Feb 2008

[10] ABC = Abstinence, Be faithful, Condom use

issue, neither national development nor people's well-being will be attained if the young, productive human capital is under constant threat of dying. Therefore acting today will have an impact beyond health and individual well being.

Hence leadership is needed to support and strengthen comprehensive, human rights based and evidence informed HIV programmes that include universal access to condoms. Wide condom promotion can be controversial and uncomfortable for individuals, societies and governments. However, the value of condom use as a public health measure to reduce the impact of HIV and AIDS on the individual, family and society has to be considered. Leadership is also needed to remove legal restrictions that, coupled with societal stigma and discrimination, drive vulnerable populations underground and thereby making HIV programmes and condoms inaccessible to them.

Methodology

As determined in the Terms of Reference (cf. Annex 1) of the consultancy, a participatory consultation process of developing the model condom policy was applied. Important leaders, organisational and individual stakeholders from various areas involved in HIV and AIDS programmes, and particularly in prevention, were sought to contribute their views. (List of Contributors – cf. Annex 5)

The process of developing the PANCAP Regional Model Condom Policy started in September 2007. After the review of technical documents, strategies and policy guidelines, stakeholders were identified in all Caribbean countries. In the beginning, about 120 stakeholders in the Caribbean region and among international partners were informed about objectives and envisaged content of the policy. After invitation to participate in the first consultation round via Internet, a number of responses were sent back. There was a generally positive feedback with many suggestions for the policy to become a model for Caribbean governments. A first consultant's report was submitted in October 2007.

In November 2007, a second consultation round comprised personal stakeholder interviews in seven Caribbean countries as well as in a regional stakeholder meeting with 19 representatives from various sectors and countries.

The countries to be visited were selected based on socio-cultural distinction and population size. The major Caribbean language areas were represented (English, French, Spanish) and countries with a concentration of relevant stakeholders were given a certain priority. Thus, the consultant visited Barbados, Dominican Republic, Guyana, Haiti, Jamaica, Saint Lucia and Trinidad and Tobago. On average, 1 to 1 1/2 days were spent in each country.

Personal interviews were held in November 2007 with about 70 stakeholders in seven Caribbean countries aimed at getting feedback on the PANCAP initiative to develop a model policy on condoms for the region. Issues and concerns to be addressed in the policy were appreciated and discussed. It was obvious that condom management strategies and/or policies are a current concern among many stakeholders. Many felt that the PANCAP initiative is timely and can serve the respective national efforts.

Based on these two consultation rounds from mid-September to mid-November 2007, a first draft of the PANCAP model condom policy was developed. The document was presented to the meeting of stakeholders on November 27-28, 2007 in Port of Spain. In general, the draft was highly appreciated as a valuable working document. The stakeholder meeting resulted in a revision of the policy outline and convened to edit core elements of the policy in a collective manner during and after the workshop. The resulting revisions provided the basis for the second draft of the PANCAP model condom policy, which was subsequently commented by a number of stakeholders from various Caribbean countries and organisations. A second consultant's report was submitted in December 2007.

The following third draft of the regional model condom policy was presented to the PANCAP Regional Coordinating Mechanism (RCM) on April 16, 2008. Based on RCM recommendations and subsequent input from individual members, the present final version was edited. It is planned to be submitted to the next RCM and thereafter to the CARICOM Council for Human and Social Development (COHSOD) for approval. Dissemination of the PANCAP model policy on condoms to national governments will follow thereafter.

2. Background and context of the regional model condom policy

The following chapter aims to place the regional model condom policy into the characteristic Caribbean context(s) to which it should respond in order to help enhancing condom use significantly. It provides general background information supported by available studies and does not intend to give specific details about countries, population groups or programmes.

Caribbean sexual culture

The Caribbean region presents a large historical, political, cultural and linguistic diversity so that it is impossible to refer to a common sexual culture all over the region. But it is often stated that the countries have in common a large discrepancy between the public sexual culture and the private sexual culture. The public sexual culture is dominated by the myth that Caribbean people are naturally endowed with sexual skills and sexual potency. In contrast, private sexual practice is hampered by numerous cultural, moral and religious beliefs and sexual taboos, which hinder an open communication about sex.[11] This leads also to a lack of life skills and practical health education related to sexual activity.

Gender relations in reproduction and sexuality are widely dominated by a male perspective. It has been globally affirmed that gender norms strongly influence sexual behaviour. As in other regions, young Caribbean men are socialised to believe that asserting manhood involves proving strength and virility. Thus young males often view sexual initiation as a way to prove that they are real men.[12] Multiple partnering is perceived as normal for men but not or much less for women. Machismo is an overall observed kind of behaviour.

Cultural and socially ascribed roles contribute to men's demand for paid sex and certain situations enhance these behaviours, such as men who migrate for work, seafarer men, fishermen, male truckers, and sex tourists, making these groups particularly vulnerable.[13]

The Caribbean is one of the world's leading tourism regions which is not only attractive because of its formidable climate, nature and hospitality. For many tourists, the perspective of sexual pleasure is an important factor in deciding upon a Caribbean country as a holiday

[11] Terborg J.R.: Gender- and sexual ideology, root causes of AIDS. Some reflections from experience and research on gender and sexuality in Suriname. Int Conf AIDS. 2004 Jul 11-16; 15: abstract

[12] Sources cited in PAHO 2007: Singh, S., D. Wulf, R. Samara, & Y.P. Cuca. Gender Differences in the Timing of First Intercourse: Data from 14 Countries. International Family Planning Perspectives 2000; 26(1): 21-28; UNAIDS. Men and AIDS – A Gendered Approach. World AIDS Campaign. Geneva: UNAIDS; 2000 ; Barker, G. Growing up Poor and Male in the Americas. The Other Half of Gender, eds. Bannon, I. and M.C. Correia. Washington DC 2006

[13] PAHO HIV in the Americas 2007

destination. A study carried out in Jamaica and the Bahamas[14] shows that a significant proportion of visitors actually visit the two destinations to engage in sexual activity with locals or with commercial sex workers.

All over the region, popular social events (e.g. carnival) are known to be highly associated with or even promoting free casual sex. A generalised youth culture promotes lifestyles with sexy role models that encourage early (premarital) sexual activity. In Jamaica, the average age of sexual initiation stands at 15 for girls and 13 for boys. By age 16, the vast majority of adolescents (71%) have begun having sex.[15] Forced sexual debut is an issue affecting approximately 20% of young people[16].

Economic constraints have an impact on sexual relations like transactional sex (exchange sex for gifts or basic necessities), age mixing (intergenerational transactional sex - "sugar daddies"), or migration for sex work on special occasions.[17] Gender inequity leads to a widespread inability among women to negotiate relations without penetrating sex or with safer sex practices, such as condom use. Many sexually active people with non-regular partners show a low personal risk assessment of their own and their partners' vulnerability regarding STI and HIV transmission.

As part of Caribbean boys' socialisation, a polarised notion of what is masculine and what is feminine is prevalent. Consequently, there is little room for the acceptance of those who diverge from these norms, including men who have same-sex partners. Such traditional concepts bear an increased risk of transmission of HIV and STIs, not only for young men but also for young women.

The public (and legal) disapproval and discrimination of homosexuality (particularly men who have sex with men - MSM) forces the concerned to hide their sexuality. Homosexuality is a criminal offence in some Caribbean countries and is highly stigmatised in most. Most churches in the Caribbean express high intolerance in this regard. The widespread homophobia increases stigma and marginalisation. As a consequence, MSM are driven underground and gain social acceptance often by adopting a visible heterosexual lifestyle in bisexual relations. This increases the likelihood that individuals engage in high-risk

[14] Boxill, Ian et al.: An exploratory study of the relationship between tourism and HIV/AIDS in Jamaica and the Bahamas. UWI, Mona, 2004

[15] Hope Enterprises Ltd., Adolescent Condom Survey: Jamaica, 2001

[16] PAHO 2006: Behavioural Surveillance Survey (BSS) in 6 OECS countries

[17] PAHO 2006: BSS in 6 OECS countries

behaviour. Unsafe practices among MSM are common, as studies show a low percentage of condom use, high number of sexual partners and low perception of risk.[18]

HIV and AIDS and sexually transmitted infections [19]

Overview

The Caribbean region reports the second highest HIV prevalence rates after Sub-Saharan Africa. At the end of 2007, HIV prevalence in the Caribbean is estimated at 1% of the adult population. There are 230,000 [range between 210,000–270,000] people living with HIV in the Caribbean, including the 17,000 [15,000–23,000] who were newly infected in 2007. An estimated 11,000 [9,800–18,000] people in the Caribbean died of AIDS in this year and AIDS remains one of the leading causes of death among persons aged 25 to 44 years.

However, the Caribbean average masks substantial differences in the extent and intensity of the epidemics, as the estimated national adult HIV prevalence surpasses

- 1% in Barbados, Dominican Republic, Jamaica and Suriname,
- 2% in Guyana and Trinidad and Tobago,
- 3% in the Bahamas and Haiti.

The Dominican Republic and Haiti together account for nearly three quarters of Caribbean people living with HIV. In Cuba, on the other hand, HIV prevalence is yet to reach 0.2%.[20]

Much higher HIV prevalence rates are observed in high risk groups whose sexual activity is illegal in most Caribbean countries, e.g. commercial sex workers - CSW, men who have sex with men - MSM, and prison inmates. HIV prevalence rates among CSWs vary from 9% to 31% in Jamaica, Suriname and Guyana. Prisoners show higher HIV prevalence rates than the general population; e.g. 2% to 4% in six OECS countries.[21]

Young people, minors included, are particularly at high risk of HIV infection. A large gap exists between knowledge and use of condoms. About one third of in-school youth aged 10 to 18 years in nine English-speaking Caribbean countries[22] reported to have had sexual intercourse. Over half of sexually active boys and about a quarter of females stated that the

[18] International HIV/AIDS Alliance: Latin America and the Caribbean Strategic Framework 2004 – 2007, PAHO 2007 p. 49 citing De Groulard M. et al. 1998

[19] The following chapter is based on two recent publications: UNAIDS Epidemics Update, December 2007 and PAHO HIV and AIDS in the Americas 2007 Report, September 2007.

[20] UNAIDS Sep 2007

[21] CAREC & PAHO: The Caribbean HIV/AIDS Epidemic and the Situation in Member Countries of the Caribbean Epidemiology Centre (CAREC), February 2007.

[22] PAHO 2006: BSS in the following countries: Antigua, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, St. Lucia

age of first intercourse was 10 years or younger; and almost two-thirds had intercourse before the age of 13. Only 53% used a condom during their most recent intercourse.[23] Among sexually active in-school youths (aged 10 to 14 years) in six OECS countries, 98% of boys knew about condoms but only 31% made use of a condom the last time they had sex.[24] 71% of Jamaican adolescents have begun having sex by the age of 16 and about 40% of them did not use any protection at their last sexual intercourse.[25]

Modes of HIV transmission

The primary mode of HIV transmission in the Caribbean is unprotected sexual intercourse. Sex between sex workers and clients is a significant factor in the transmission of HIV. Among female sex workers, HIV prevalence of 3.5% has been found in the Dominican Republic, 9% in Jamaica and 31% in Guyana.[26]

Unsafe sex between men is another important factor for HIV transmission but is largely hidden because of associated stigma. Little research has been conducted in the Caribbean among men who have sex with men, but the available data suggest that about 12% of reported HIV infections are the result of unsafe sex between men.[27] In Cuba, although the HIV prevalence is very low, the epidemic is mainly driven by male-to-male sexual activity.[28]

Unsafe injecting drug use is responsible for a minority of HIV infections in the Caribbean, but contributes significantly to the spread of HIV in Bermuda and Puerto Rico. However, drug use in general is associated with high-risk behaviour and a higher probability of HIV infection.

Selected country specific data

Haiti still accounts for the largest HIV burden in the Caribbean. Among pregnant women attending antenatal clinics, HIV prevalence declined from 5.9% in 1996 to 3.1% in 2004. However, results of sentinel surveillance among pregnant women in 2006 show a stabilisation in HIV prevalence. A national population-based survey estimated adult national

[23] Halcón, Linda et al. : Adolescent Health in the Caribbean: A Regional Portrait. *In: Adolescent Health* 93(11):1851-57.2003

[24] PAHO 2006: BSS in 6 OECS countries

[25] Hope Enterprises Ltd., Adolescent Condom Survey: Jamaica, 2001

[26] Sources cited in UNAIDS 2007 : Gupta et al., 2006; SESPAS de República Dominica, 2005b; PAHO, 2007; Gebre et al., 2006; Allen et al., 2006

[27] Sources cited in UNAIDS 2007 : Caribbean Commission on Health and Development, 2005; Inciardi, Syvertsen & Surratt, 2005

[28] Sources cited in UNAIDS 2007 : PAHO 2007, PAHO Cuba country report 2006

prevalence at 2.2% in 2005. The declining trend is largely related to decreasing infection levels in the capital, Port-au-Prince, and other cities, where HIV prevalence among 15–44-year-old women fell from 5.5% to 3% between 2000 and 2005. Modelling of the epidemic indicates that besides mortality, protective behaviour changes were at least partly responsible for those declines. Behavioural surveys have shown a 20% drop in the mean number of sexual partners between 1994 and 2000, while condom use increased, especially during sex with non-regular partners.[29]

The HIV epidemic in the Dominican Republic appears to have stabilised. As in most other countries of the Caribbean, commercial sex is a key factor in the epidemic. One study found that condom use increased from 75% to 94% in 12 months among sex workers who participated in a community solidarity prevention project in the capital, Santo Domingo.[30]

The HIV epidemics in Jamaica, the Bahamas, and Trinidad and Tobago have also been stable over recent years.[31] But caution is requested as, due to the limited number of tested persons e.g. in Trinidad and Tobago, it can only be stated that HIV positive cases are still increasing, but at decreasing rates.

In Barbados, the number of persons newly diagnosed with HIV each year has remained relatively stable since the late 1990s.[32]

HIV transmission in Guyana is occurring primarily through unprotected sexual intercourse. The latest antenatal clinic survey shows HIV prevalence of 1.6% among pregnant women. This is lower than the 2.3% prevalence found in a similar survey in 2004, but due to methodological differences, comparing the two sets of data should be done with caution.[33]

In contrast to the rest of the region, injecting drug use is the key factor in HIV transmission in Bermuda and Puerto Rico. Very high HIV prevalence is still being found among injecting drug users in Puerto Rico, where the rate of HIV infection (26 per 100,000) is twice that of the United States mainland and where more than two thirds of HIV infections have been among men.[34]

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[29] Sources cited in UNAIDS 2007 : Ministère de la Santé Publique et de la Population, 2007; Cayemittes et al., 2006; Hallet et al., 2006; Gaillard et al., 2006

[30] Sources cited in UNAIDS 2007 : SESPAS República Dominica, 2007; Kerrigan et al., 2006

[31] Sources cited in UNAIDS 2007 : Ministry of Health Jamaica, 2007; Ministry of Health The Bahamas, 2006; PAHO & WHO, 2006; Ministry of Health Trinidad and Tobago, 2007

[32] Source cited in UNAIDS 2007 : Ministry of Health Barbados, 2007

[33] Source cited in UNAIDS 2007 : Ministry of Health Guyana, 2007

[34] Source cited in UNAIDS 2007 : AIDS Action, 2007

Sexually transmitted infections (STIs)

There is considerable evidence that STIs pose an increased risk of HIV transmission. Particularly ulcerative STIs lead to an estimated 12-fold increase in transmission of HIV. Surveys conducted in some Caribbean countries found that STI patients are seriously affected by the HIV epidemic. In several instances, HIV prevalence rates are 2 to 6 times higher in STI patients than in the general population. In Guyana, in 2002, the prevalence had increased to 15% among males and 12% among females with STIs.[35] In Jamaica, approximately one of two cumulative HIV cases had a history of STI and among patients with STIs in 2005, 4.6% had HIV.[36]

But the true magnitude of the STI epidemic in the region is difficult to measure because of the lack of effective surveillance systems. In many countries, few routine data on STIs are available and underreporting is a common problem. A study of genital herpes in Jamaica estimated that total genital herpes was 2.5 times that estimated in STI clinics and 5 times the number of reported cases.[37]

Although many countries have national policies to routinely screen pregnant women for syphilis, these data are often not collected, reported, or sufficiently analysed. Similarly, blood donors are screened for HIV and syphilis but this information is rarely used. Through universal antenatal screening and a system of contact investigation, syphilis rates in Jamaica declined from 90 per 100,000 in 1987 to 10 per 100,000 in 2000.[38]

A random sample of 382 adults (18-35 years of age) in one electoral district in Barbados using urine specimens for PCR (Polymerase Chain Reaction) for detecting gonorrhoea and chlamydia found that 14% of them had these two STIs. [39]

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[35] Sources cited in PAHO 2007: CAREC/PAHO/WHO. Status and trends analysis of the Caribbean HIV/AIDS epidemic 1982-2002. Port of Spain (Trinidad and Tobago): Caribbean Epidemiology Centre, Pan American Health Organisation/World Health Organisation; 2004.

[36] Sources cited in PAHO 2007: Jamaican Ministry of Health: Health Promotion & Protection Division. National HIV/STI prevention & control program facts and figures HIV/AIDS Epidemic update January to June 2006. Jamaican Ministry of Health: Kingston (Jamaica); 2006.

[37] Sources cited in PAHO 2007: Brathwaite A. STI: annual cases of genital herpes: Jamaica 1995-2002. Kingston (Jamaica): Jamaica National HIV/STI Programme; 2002. [cited 23 May 2007]; Available from: URL:http: www//jamaica-nap.org

[38] Sources cited in PAHO 2007: Figueroa JP. An Overview of HIV/AIDS in Jamaica. Strengthening the Response. West Indian Med J 2004; 53: (5) 277.

[39] PAHO 2007 citing: Adams OP, McIntyre G, Prussia P. Risk Behaviour, Health Care Access and Prevalence of infection with Chlamydia trachomatis and Neisseria gonorrhoea in a population based sample of adults in Barbados. The University of the West Indies, Cave Hill, Barbados. Unpublished study 2004. PAHO. Regional HIV/STI Plan for the Health Sector 2006-2015.Washington (DC): PAHO; 2005.

Sexual and Reproductive Health

Sexual and reproductive health (SRH) is a comprehensive understanding that comprises all related aspects of human well being, sexually transmitted infections like HIV included. The SRH concept also embraces the aspect of sexual and reproductive rights as endorsed by the International Conference on Population and Development (ICPD) in 1994. Due to the devastating nature of the AIDS epidemic, SRH aspects like contraception are often neglected in the current reflections. But condoms can be a dual-benefit method for both pregnancy prevention and HIV prevention, particularly for people engaging in high-risk sexual behaviour.

Across the Caribbean region, a relatively high percentage of women of reproductive age (15 to 49 years) accept contraception as a means for family planning and exert the right to make fertility choices. While 62% use any contraceptive method, there are 58% who accept modern contraceptive methods[40]. The contraceptive prevalence rates (CPR) of some countries are well above this average, such as Puerto Rico (all methods 78 / modern methods 68), Cuba (73 / 72), the Dominican Republic (70 / 66), and Jamaica (66 / 63). In the middle range are the Bahamas (62 / 60) and Barbados (55 / 53) followed by Belize (47 / 42) and Suriname (42 / 41). Less developed are the CPRs in Trinidad and Tobago (38 / 33), Guyana (37 / 36) and Haiti (28 / 22).[41]

Unwanted pregnancy is an issue for many women as abortion is reported to be widespread all over the Caribbean region, although confirmed data are unavailable. Unsafe abortion is a major cause for maternal deaths and for hospital admissions.

Early pregnancies among teenage girls due to unprotected sexual intercourse are a major challenge and they often occur at the first sexual encounter and under forced conditions. Reproductive Health Surveys in Jamaica showed a fertility rate of 112 births per 1,000 live births among youth (age 15 to 19) in 1997, which was among the highest in the Caribbean, but had decreased to 79 in 2002. In Haiti, 12% of young women below the age of 20 had at least one child and 2% were pregnant with their first child.[42] These data underline the need for adolescent sexual and reproductive health (ASRH) services that enable young people to dispose of the necessary information and skills to make risk-reducing decisions.

[40] Modern contraceptive methods include condoms, oral contraceptives (pill), injectables, spermicides, implants

[41] UNFPA State of the World Population Report 2007

[42] Haiti EMMUS-IV 2005-06

Access to condoms

Mechanisms to make condoms accessible

In all Caribbean countries, the public health system distributes male condoms on a regular basis through its health service facilities. In addition, condoms are made available at special occasions (e.g. World AIDS Day, carnival processions, sports events) and/or through vertical programmes (e.g. awareness campaigns, activities focussed on special target groups). Depending on the national programme, these are no logo or commercial brand condoms which are distributed for free.

As an additional prevention option especially for women, female condoms are not yet distributed in large quantities, but are getting increasing attention by governments and international partners. The so far limited accessibility of female condoms was largely due to inconsistent supply and high costs. The fact that they are still unfamiliar for providers and potential users[43] is also due to health providers' biases and lack of detailed knowledge, cultural barriers (men should be in charge of condoms), and individual discomfort levels with cultural sensitivities on touching body parts. The ongoing Female Condom Initiative in the English- and Dutch-speaking Caribbean initiated by UNFPA in 2007[44] aims at promoting and distributing a lower cost female condom (FC2) within the Caribbean region.

Non-governmental organisations (NGO) are important partners for the governments in order to access especially vulnerable groups that are hard to reach for the public health system. Specialised Social Marketing Organisations (SMOs) have a key role in promoting and providing condoms. Social marketing approaches in the Caribbean vary, but the promotion of condoms is part of generic campaigns targeting barriers to behaviour change. All SMOs cooperate with the private sector with its commercial distribution and retail network. In some Caribbean countries, socially marketed condoms are subsidised and sold as SM branded products[45], in other countries SMOs support the sales of commercial condom brands[46].

[43] Evidence from 6 Caribbean countries (Belize, Guyana, Jamaica, Trinidad and Tobago, Saint Lucia, Suriname) presented at the Regional Condom Programming Workshop September 2007

[44] Based on experiences in 2007, UNFPA OEDSC is working in the framework of a 2008 Action Plan. Important components are (i) Female condom (FC) programming as essential component of national SRH and HIV policies and strategic plans, (ii) Enhanced accessibility of FCs through improved procurement, stock management and distribution systems, (iii) Advocacy for FCs as the only female-initiated STI/HIV prevention commodity. Special emphasis is placed on conducting an assessment of client feedback about FCs. UNFPA May 2008

[45] SM brands in the Dominican Republic, Belize and Haiti

[46] SM-support to commercial brands: Jamaica, Belize, Antigua & Barbuda, Barbados, Dominica, Grenada, St. Kitts & Nevis, St Maarten, St. Lucia, St. Vincent & the Grenadines, Trinidad & Tobago, Guyana

Private commercial distributors are important condom suppliers in the majority of Caribbean countries, sometimes in partnership with governments and SMOs. However, the informal sector (e.g. suitcase sellers) seems to have a certain share of the condom market, which is difficult to assess. Condom prices vary from low to high cost depending on the brand.

Throughout the Caribbean, the manifold mechanisms for condom distribution offer a unique opportunity to apply the "total market approach" (TMA), a concept that makes use of the complementary profiles of all condom suppliers and distributors in order to increase the overall coverage through targeting specific population segments.

Barriers to condom access

All over the Caribbean, there are reportedly problems with regard to the accessibility of condoms, which is considered under various aspects. To be accessible for condom users (consumer level), condoms need to be made available at the peripheral level in sufficient quantities and without stock-outs. For public and private sector alike, this requires reliable availability at the central level. An unreliable provision of condoms hampers consistent condom use, which should be achieved as much as possible in high-risk groups.

Actual access to condoms is influenced by a number of convenience factors such as selling price, opening hours, geographical distance, provider support, etc., which are not always in favour of the respective sexual active consumers. For many migrants in the region condom access is difficult due to high mobility and language barriers. Underserved areas are observed where no reliable source of condoms is established, which affects populations in suburban slum areas and indigenous groups in remote areas alike. Access is also limited during typical Caribbean emergency situations such as hurricanes.

Societal disapproval and legal restrictions have a major impact on condom accessibility especially for vulnerable groups in many Caribbean countries. As sexual activity is disapproved for certain population groups, the protection of sexual intercourse is made difficult for those who do not adhere to mainstream societies' norms.

Access to condoms is constrained for those who have developed psychological barriers in fear or by experience of stigma and discrimination. Judgmental and discriminatory attitudes among retailers is generally felt to be an important barrier to purchase condoms. In addition, missing monetary incentives along the supply chain hamper condom availability in outlets serving areas with high risk populations.

Homophobia is widespread in the Caribbean and in some countries it is legally supported. This makes it particularly difficult for men who have sex with men to access condoms in their

living environment. The same applies to sex workers in some Caribbean countries where sex work is illegal, but is difficult for anybody who is in need of hiding his/her sexual activity. Populations under especially difficult circumstances such as prison inmates who are known to be often forced into sexual activity do not have the right to access condoms in their situation (with the exception of prisons in Jamaica).

Youth specific barriers to condom access

As research shows (cf. previous chapters), many adolescents and youth engage in premarital sexual activity and start their sexual life at an early age, often unplanned. As a result, many adolescents have their first sexual encounter without protection.[47] Adolescents and young unmarried women in particular are confronted with an environment neglecting their need for protection in many forms.

Condom distribution is prohibited to underage adolescents by age based restriction and protection laws (i.e. age of consent, child protection), particularly in English-speaking Caribbean countries. Health service providers are under the threat of punishment if they hand out condoms to minors despite obvious STI, pregnancy or motherhood. This contributes to create or reinforce provider biases against a generalised accessibility of condoms. This also applies to non-medical retailers.

Condom promotion is almost non-existent in the educational system of Caribbean countries, neither information about the correct use of condoms nor training of negotiation skills for safer sex are provided. Condom distribution is generally banned from school grounds and boarding schools.

The widespread fear to raise children's premature interest in sexuality by starting sex and family life education at an early age leaves many adolescents unprepared for the socio-cultural realities of modern life.

Condom use and risk behaviour

Condom use

Although numerous HIV prevention programmes have succeeded in communicating information on prevention strategies, a gap between knowledge and practice is still evident among many groups of Caribbean societies. Consistent condom use is particularly advised for sexual encounters with high-risk partners, i.e. non-regular or multiple partners or

[47] CAREC/PAHO – OECS Behavioural Surveillance Surveys in 6 countries 2005-06, 2007

commercial sex workers, as well as for HIV infected couples or discordant couples where one partner is infected. As data about condom use in Caribbean countries are not universally available, overall reporting on comparable population groups is not yet possible.

In six OECS countries, a recent behavioural surveillance (BSS) survey[48] among various adult sub-groups showed that condom use during commercial sex encounters is rather high. But many engage in "non-regular" partnerships in which condom use is much lower (55% to 73%). The survey also covered more than a thousand in-school youth aged 10 to 14 years among whom about three-fourths knew about the ABC of HIV prevention (abstinence 83%, be faithful to one partner 75%, and consistent condom use 79%). But only 39% of those who had sex in the past 12 months reported condom use [49]. The BSS survey shows a significant gender disparity because men are more knowledgeable about consistent condom use and report more actual condom use at last sex.

In the Dominican Republic, the comparison of data from population-based Demographic and Health Surveys in 1996 and 2002[50] shows that condom use has increased but is still sub-optimal. The use of condoms at the last high risk sexual encounter was reported by 51% of men in 2002 against 44% in 1996, whereas women reported only 25% and 12% respectively. Condom use with a commercial sex worker was reportedly much higher (74% in 2002). Another study found that condom use increased from 75% to 94% in 12 months among sex workers who participated in a community solidarity prevention project. The percentage of young people having used condoms in their first premarital sexual relations is also low comparable to those of the adult population, but with a higher increase among young women (1996 to 2002: young men 48% to 52%, young women 12% to 29%).

In Guyana, Georgetown sex workers have been surveyed between 1997 and 2004[51] and 84% reported that they always used condoms with their clients (compared to 65% in 1997), 91% had used a condom with their last client (up from 87%). 37% said they always used a condom with their regular partners compared to 12% in 1997. In a Guyana BSS survey [52] undertaken in 2004, only 66% of out-of-school youth aged 15–24 reported using a condom at

[48] CAREC/PAHO – OECS Behavioural Surveillance Surveys in 6 countries 2005-06, 2007

[49] It is noteworthy that most in-school youth reported never having had sexual intercourse, which means a great potential for promoting delayed sexual debut as well as empowerment around safer sex before these children become sexually active.

[50] Measure DHS: Encuesta demográfica y de salud: ENDESA, 2002

51 Government of Guyana: Biological and Behavioural Surveillance System 2004, 2004 – HIV prevalence rate decreased from 46% of sex workers in 1997 to 26.6% in 2004

52 Guyana Ministry of Health: Behavioural Surveillance Surveys: Executive Summary, Round I – 2003-04, 2004

their last sex with a non-regular sexual partner; the number was slightly higher among young men (68%) than among young women (65%).

In Haiti, various surveys have indicated mixed results regarding evolving behavioural trends in condom use. A study among female sex workers in Port-au-Prince found that 98% had reported using condoms the last time they sold sex. A youth study conducted in Cerca-la-Source found that 28% of sexually-active youths (aged 14-25 years) did not know what condoms were, and the 50% that did have knowledge of condoms did not use them regularly.[53] Behavioural surveillance surveys have shown that the percentages of young men and women (15-19) who were knowledgeable about AIDS grew by around 20% from 1999 to 2003, while their participation in casual sex decreased substantially. Condom use at last contact with occasional partners increased among 20-24 year olds but decreased among females 15-19 year old.[54] The Haiti national surveys (EMMUS[55]) 2000 and 2005-06 show an increase in condom use at the last high risk sexual encounter both in women (15-49 years) from 14% to 26% and in men from 26% to 42%. However, in rural areas only 16% of rural women and 30% of rural men used a condom at last high risk sex, with rates only slightly better for 15-24 year olds.

In Jamaica, a survey on healthy lifestyles[56] among adults aged 15 to 65 years showed in 2000 that 47% of men and 33% of women used a condom during their last sexual act. A second-generation surveillance survey among sex workers[57] showed that 84% were using a condom with their most recent client. Another Jamaican study at high-risk sites for HIV transmission[58] showed that only 20% of men and 3% of women had a condom with them. Condom use might be increasing among women with some studies showing a doubling from 1992 to 2000 in the percentage of women that said they used a condom in the last sex with a casual partner. In 2004, in youth aged 15-24, condom use at last sexual encounter was 74% in males and 66% in females[59], suggesting continued gender inequalities and reduced negotiation capacities among females.

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[53] UNAIDS/WHO: AIDS Epidemic update, December 2006

[54] Ministère de la Santé Publique - FHI / CERA: Premier tour de l'enquête de surveillance comportementale à Port-au-Prince ESCI I Haiti, 1999 et ESCI II, 2003

[55] EMMUS - Enquête Mortalité, Morbidité et Utilisation des Services III / 2000 et IV / 2005-06

[56] Jamaica Ministry of Health: The Jamaica Lifestyle Survey 2000 – findings. 2001

57 Hope Enterprises: HIV/AIDS 2nd generation surveillance: BSS among female sex workers; country Jamaica, 2005

[58] PLACE. PLACE in Jamaica: monitoring AIDS prevention at the parish level, 2003. 2004

[59] Hope Enterprises Ltd. Highlights of KABP survey country. 2004

A study carried out in Jamaica and the Bahamas[60] shows that a significant proportion of visitors actually engaged in sexual activity with locals or with commercial sex workers. Condoms were only used by less then half of the tourists (Jamaica) or 70% in the Bahamas. In both countries, most of those respondents, who classified themselves as bisexuals or homosexuals, and who had sex with locals or commercial sex workers, did so without the use of a condom.

The majority of available data on condom use among population groups engaging in risky sexual encounters show that people are getting more and more conscious about safer sex for HIV and STI prevention. But despite a certain increase, the percentage of condom users is not yet satisfactory in view of its potential positive impact on the spread of the epidemic. In addition, data on the consistency of condom use are almost unavailable.

Risk behaviour

Numerous studies have proven that the appropriate use of condoms is influenced by a number of factors that are entrenched in personalities and societies.

A basic prerequisite for condom use is to know about condoms and the possibilities of provision. In addition, practical skills how to use a condom need to be applicable under particular conditions related to sexual encounters, e.g. excitement, influence of alcohol. Knowledge and skills of proper condom use are still not universal in the Caribbean.

A key influential factor is the personal risk assessment related to a sexual encounter or relationship. This is to value the risk to get infected against emotional or material benefits while not using a condom. Unrealistic risk assessment often leads to inconsistent condom use, e.g. many sexually active people do not perceive themselves at risk while having sex with a loved and trusted partner although mutual fidelity is not guaranteed. Assessing the risk of unprotected sexual pleasure is another issue as condoms are often felt to irritate or annoy.[61]

The adoption of risk reducing attitudes and behaviour is the next step to follow the risk assessment, which is further influenced by psychological and socio-cultural factors. Caribbean societies hold multiple barriers that discourage condom use.[62] Condom use is not always perceived as a responsible behaviour to protect oneself and the sex partner from

[60] Boxill, Ian et al., An exploratory study of the relationship between tourism and HIV/AIDS in Jamaica and the Bahamas. UWI, Mona, 2004

[61] Examples to be found in: Options Consultancy Services and Hope Enterprises Ltd.: Peer study: Young women and sexual relationships in Kingston, Jamaica. 2007

[62] cf. chapter 2.1 – Caribbean sexual culture

disease. Disapproval of condom acquisition and use in mainstream societies, legal constraints, societal stigma and discrimination of particularly vulnerable groups have important impact on an individual's capacity to adopt risk reducing behaviour.

Adolescents are particularly vulnerable to risk behaviour as many Caribbean youths have unplanned first sexual encounters where a condom is not at hand or the barrier to negotiate its use is too high.

Lack of skills and power to negotiate condom use is a major barrier for many young people and particularly female. Gender inequities such as economic and emotional dependency of women contribute to a risk behaviour not only among sex workers, but among female students and housewives as well.

Caribbean responses and strategic gaps

The response to fight the spread of the AIDS epidemic in the Caribbean region and in individual countries is manifold. Apart from governmental responses, numerous initiatives and networks have been created by the civil society, HIV and AIDS affected people, churches and faith-based organisations, business and industry, scientific communities and health professionals. While they all recognise preventive behaviour as a means to reduce the risk of infection, condom use is not yet unanimously promoted for all sexually active persons.

Pan Caribbean Partnership against HIV/AIDS (PANCAP)

The Caribbean region has a long history of regional cooperation, which helps to compensate for the fact that many countries and territories have small populations with often limited capacity to respond to the AIDS epidemic. In addition, the high mobility of Caribbean people within the region makes cooperation vital.

In February 2001, Caribbean Heads of State and Government created the Pan Caribbean Partnership against HIV/AIDS (PANCAP) as a commitment to jointly respond to the AIDS epidemic. The fight against HIV and AIDS is an important regional priority, also included as one of the regional health priority areas in the Caribbean Cooperation in Health Initiative (CCH-III). The number of national, regional and international PANCAP associates has constantly grown since its inception and counts presently more than 80 partners.

Up to 2008, PANCAP's activities are based on the Caribbean Regional Strategic Framework for HIV and AIDS (CRSF), which covered the years 2002 to 2006 (extended to 2007) in its first phase. Based on an independent review, the second phase strategic framework to cover the years up to 2012 is currently being developed (beginning of 2008).

The Caribbean Regional Strategic Framework for HIV/AIDS 2002-2006 (CRSF) considers the areas of law, ethics and human rights as priority areas. In its Action Plan (Oct 2002), a strategic objective was determined to ensure that national level policy decisions reflect international standards and best practices and are consistent with international guidelines. With regard to condoms, the CRSF Action Plan 2002-06 states the following:

"For lack of political commitment, lack of openness regarding sexually sensitive issues and lack of targeted interventions, the speed of behaviour change and increases in condom use have been outpaced by the rate of the spread of the epidemic. Targeted interventions particularly those geared towards vulnerable but hard-to-reach groups, men who have sex with men (MSM), sex workers, mobile populations, young school children and social drop-outs, institutional populations such as prisoners, and uniformed groups, such as the police and the military, are needed. … The success of both general and more specific prevention efforts depends also on an "enabling" policy environment that openly acknowledges both the reality of the epidemic and its underlying social and economic causes and consequences. For much of the Caribbean, national leaders have yet to be really mobilised to openly speak about the epidemic, much less introduce policy and legislative frameworks, or commit national resources to the issue. … A realistic allocation of resources to prevention among highly vulnerable groups are technical matters as well as ones of policy and legal frameworks."[63]

National HIV and AIDS policies and strategic plans

All Caribbean countries have developed national responses to HIV and AIDS through National AIDS Commissions / National AIDS Secretariats, visible in strategic plans, legislation, programmes, services, and participation in regional networks. National HIV and AIDS strategic plans have adopted a multisectoral approach in order to encourage a coordinated national response to the epidemic. All countries are aiming at assuring universal access to HIV and AIDS prevention, treatment, care and support.

The trend of still increasing new infections pose a major threat to the Caribbean response to the AIDS epidemic. If new infections continue to rise at the current rate, investments in assuring universal access to treatment will result in an increasing need to commit government funding to this medical service. Reducing the death toll will increase prevalence

[63] The Caribbean strategic framework for HIV/AIDS 2002 – 2006

rates, meaning that increasing numbers of PLWHA will legitimately demand medicines for life – an unaffordable situation for many countries.[64]

With regard to condom promotion and distribution, Caribbean national strategies are primarily covering the public health system, other line ministries (e.g. tourism) and national HIV and AIDS programmes. Civil society organisations and faith-based organisations play an important role and often receive condoms for distribution from the public sector. Additional condom provisions come from the commercial sector as well as from NGOs such as Family Planning Organisations or Social Marketing Organisations. In most countries, these contributions are not systematically coordinated at government level. However, condom management strategies and/or policies seem to be a current concern in a number of Caribbean countries as a lack of comprehensive approach resulting in under- or over-coverage of certain populations is felt. Some countries (i.e. Trinidad and Tobago, Belize) are working on an overall condom management strategy. In Haiti, a common strategy has been developed for segmenting the target groups for public sector and social marketing condom distribution. The government of Trinidad and Tobago has established a multisectoral subcommittee for Reproductive Health (RH) commodities including condoms. Other countries are working on or interested in developing special national condom policies (The Dominican Republic, Haiti, Belize).

Strategic gaps with regard to condoms

Overall, is must be stated that Caribbean countries do not yet sufficiently support the positive impact of increased and consistent condom use as a key public health measure to reduce the spread of HIV.

The following gives an overview on major gaps regarding male and female condoms across the majority of Caribbean countries:

- Condom access, acceptance and use is particularly difficult for population groups that are at highest risk of HIV infection.
- Recognition and political and social mobilization around condom use has low priority on the (political) agenda of Caribbean countries.
- Legislative and societal disapproval, discrimination and marginalisation are particularly affecting weak and vulnerable members of the society for whom condom use can be vital.

[64] PAHO 2007

- Socio-cultural biases and taboos still hamper a widespread acceptance of condom use free from stigma and discrimination.
- Lack of information, skills and self-efficacy, economic dependency and unequal gender relations often hinder risk reducing sexual behaviour.
- Strategic condom management of the overall condom supply is not yet well developed at governmental level.
- Partnerships among all sectors involved in condom supply and promotion are not functional enough to enhance condom access and use in a cost-efficient way.
- The potential of condom promotion and supply to meet the specific needs of diverse consumer groups and in underserved areas is not yet exploited to its feasible extent.
- Strategic condom programming lacks comprehensive data on condom availability and accessibility and condom acceptance and use.
- Regional and inter-country cooperation is weak with regard to common challenges, such as target groups in the tourism sector and among work migrants where language barriers add to the mobility of the populations.

The above listing provides a general overview of gaps observed throughout the Caribbean region. In addition, each country or sub-region has to deal with specific problems to which specific responses need to be further developed. While in some countries adolescents are encouraged to develop risk reducing skills and to use condoms, they are legally denied its access in a number of others. Underserved populations are different at country level, such as indigenous people in remote areas in some countries or underprivileged urban slum populations in others.

The following chapters aim to provide policy guidelines that should help to close the observed gaps with regard to condom accessibility, acceptance and use.

3. Framework and scope of the PANCAP model policy on condoms

3.1. Vision statement

The vision of this regional policy on condoms is to protect the rights of **all sexually active people** in the Caribbean by creating an environment which enables them to acquire condom related information and skills, and access and use condoms as an option to prevent the transmission of STIs, including HIV, and undesired pregnancies.

3.2. Goals

The overall **goals** of the model policy on condoms are to

(1) Contribute to the achievement of universal access to STI/HIV prevention, treatment, care and support services by ensuring availability of and access to quality condoms.

(2) Create an enabling legislative environment to increase availability and access to condoms for all people in need.

(3) Strengthen knowledge and skills concerning options for safer sex.

3.3. Specific objectives

The model condom policy shall achieve the following **specific objectives:**

1. Expand the use of male and female condoms among sexually active people.
2. Ensure sustainable and widespread availability and accessibility of quality condoms across all sectors of the condom market.
3. Intensify the promotion of condoms to reduce the gap between knowledge and practice, specifically among vulnerable groups.
4. Review, adjust and/or remove legal obstacles related to availability and use of condoms.
5. Encourage open discussion on human sexuality, gender, personal responsibility and reproduction.
6. Contribute to reduce socio-cultural and psychological barriers to acquire and utilise condoms.
7. Contribute to on–going research related to sexual behaviour, and to condom accessibility and use.

3.4. Guiding principles

In view of preventing adverse public health impact, the general principles of the model condom policy are as follows.

The **condom policy** recognises

1. the **human right** of all individuals to lead a safe (and satisfying) sexual life, which is to be protected by law in order to keep harm away from the population and assure the well-being of all.
2. the **public health evidence** about the positive impact of protected sexual activity on the reduction of STIs, HIV and AIDS and unwanted pregnancies. It thus aims at ensuring condom use as part of effective prevention options.
3. the importance of an **enabling environment** that promotes multiple prevention strategies for the individual and the population at large.
4. the importance of **correct and consistent condom use** as an effective prevention strategy.
5. the need for young people to access prevention methods as soon as they become sexually active.
6. the importance of **empowering individuals and groups** especially those from underserved and most at risk communities to access the resources necessary for leading healthy and productive lives.
7. that sexual activity also takes place in **especially difficult circumstances** that increase an individual's social and health risks and that condoms should be available.
8. the importance of **participatory involvement** of all stakeholders, particularly vulnerable groups, in the planning and implementation of measures to lower the risk associated with unprotected sex.

4. Elements and strategic issues of the model condom policy

4.01 As a life saving device and critical backbone for the prevention of HIV and AIDS, STIs and unwanted pregnancies, condoms require special attention in order to be of good quality, readily available, accessible and affordable to all in need, and accepted by the sexually active population. The regional model condom policy provides elements and strategic issues that need to be taken into consideration by national policy makers and stakeholders when reviewing existing legislation and regulation with regard to condoms.

4.02 For the condom policy to be fully effective, the following strategic issues have to be pursued:

(1) Make quality male and female condoms readily available and accessible wherever and whenever they are needed.

(2) Facilitate active participation, i.e. condom uptake and use, particularly by people at risk of infection.

(3) Ensure that the aims of the policy are met, i.e. monitor, control and evaluate, revise the policy and sanction violations if necessary.

4.1. Strategic condom management

4.03 Public health objectives in HIV and STI prevention can be achieved if populations at risk have consistent access to condoms without interferences due to inhibiting factors such as low condom quality, high prices, product stock outs at public health services or commercial retail level, provider bias and judgmental attitudes, lack of confidentiality, misconceptions and rumours, lack of knowledge and skills, stigma and discrimination, etc.

4.04 Functional strategic condom management is paramount in order to minimise such interferences. National (or sub-regional) condom management needs to be cross-sectoral, i.e. involve all sectors promoting, procuring and distributing condoms. Sectors to be involved are the public sector at central and peripheral level (Health and other concerned departments), private commercial manufacturers and distributors, social marketing organisations (SMOs), NGOs and civil society (particularly key consumer groups), advocacy groups and faith-based organisations (FBOs).

4.05 The specific development of the condom distribution mechanisms in Caribbean countries allows to apply the comprehensive “Total market approach” (TMA), meaning that all condoms distributed or sold are part of the overall condom market place where consumers make their individual choice of condoms and providers. Strategic condom

management can profit from this holistic view in order to coordinate overall condom provision in the most efficient way and respond to the particular needs and habits of target groups to be reached.

4.06 Strategic condom programming is crucial and in the interest of governments in order to cover different population groups and balance the role of free, commercially priced and subsidised condoms in planning and implementation of HIV prevention programmes. Strategic condom management is the backbone of cost-effective and sustainable programmes. If the commercial sector's condom provision is taken into consideration in national condom management, governments or international partners can better target their contributions for free or subsidised condoms to those most in need. Within existing structures overseeing health and/or pharmaceutical commodities, a multisectoral condom sub-committee can be established at national or sub-regional level.

4.07 Tasks of strategic condom management include the following issues:

- Coordinate forecasting of national (or sub-regional) condom needs, for male condoms and increasingly for female condoms
- Coordinate concerned government departments, particularly between HIV and AIDS, STI and Family Planning programmes
- Coordinate all partners involved, including NGOs and international development partners
- Coordinate condom procurement including guidance on import regulation and handling
- Solicit the private commercial sector to fully contribute to the social purpose of condom promotion and sales, e.g. condom manufacturers and distributors, tourism industry
- Develop a condom action plan based on the assessment of all programmes in relation to condoms (i.e. HIV and AIDS, STI, Family Planning, ASRH)
- Initiate and exploit consumer and market research and behavioural studies in order to improve the response to actual condom demand, e.g. based on a segmentation strategy
- Initiate new strategies for condom promotion and distribution for underserved population groups, e.g. youth, marginalized populations, migrants
- Advocate for increasing acceptance of condom promotion and condom use among political leaders, special interest groups and the society at large

- Exploit monitoring and evaluation data about condom procurement and provision
- Take action in case of major programme shortfalls or other crises related to condoms

4.1.1. Products and quality assurance

4.08 As a general rule, condoms made available in the framework of national HIV programmes shall allow a choice of products that can meet the particular prevention needs and circumstances of each condom user. Provision shall be made for both male condoms and female condoms. In addition, national programmes should encourage a wide range of condom types to be available for distribution and in the market place so that there are options for every lifestyle. Condom related products such as lubricants shall be included in the product range[65]. The participation of key consumer groups may help to keep the product range updated.

4.09 The emergence of low quality condoms (e.g. breaking or leaking condoms, damaged packaging, exceeded expiry date) has adverse effects on consumer's health and confidence and general condom acceptance in the society at large. Poor-quality products can cause negative publicity and endless logistical problems. It is therefore essential to assure that substandard condoms do not get into distribution and that a high quality of condom products is maintained until they reach the ultimate consumer. Appropriate sealed packaging is a necessity under Caribbean tropical climate conditions.

4.10 For the sake of consumer protection, the registration of condoms to be imported shall be regulated by the authorities concerned (e.g. bureau of standards) in a way that products and packaging meet internationally approved standards. The basis is the international standard for male latex rubber condoms: ISO 4074:2002 — Requirements and Test Methods. Other regulations may concern issues such as adequate protection against harsh environmental conditions, establishment of requirements for stability data (both real time and accelerated) to support stated shelf-life and expiry dates, allowance for inadequate systems of storage and distribution. Condom manufacturers or importing companies need to provide proof of the manufacturer's compliance with WHO/UNAIDS and ISO standards[66]. International agencies provide assistance in this respect.

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[65] Using an additional lubricant with a condom may be useful in some cases. Research suggests that this is particularly true in anal intercourse among MSMs. It should be noted that many household products are used as sexual lubricants. Some have a highly damaging effect on latex and should not be used with condoms.

[66] WHO = World Health Organisation, ISO = International Organisation for Standardisation - available at http://who.int/reproductive-health/publications/m_condom/index.html, http://www.iso.org

4.11 Prior to tender, ordering and importation, specifications for condoms with regard to performance and design requirements are set. Appropriate length, width and strength of the condom in relation to effectiveness, comfort and size need to be specified as well as appropriate packaging and information on how to use condoms. For quality assurance, it is advisable to oblige proof of independent performance testing prior to shipment for large quantities. Costs for testing must be included in price quotations. Independent certified test laboratories are internationally available.[67]

4.12 Consumers shall be provided with information about the product and its use on each individual condom package. As a minimum, the expiry date has to be clearly visible on the outside.

4.13 The quality of condoms needs to be regularly monitored at all possible level of the logistics system. At central level warehouses, inspections have to be carried out as a standard procedure. Frequent recording of stock status and visual inspection of products and storage conditions should be undertaken. Sample testing might be appropriate. But it is equally important to do sample tracking at public service and commercial retail level.

4.14 Appropriate legal sanctions against substandard condoms need to be applied in all sectors. The quality of condoms on informal markets (e.g. suitcase traders) should be tracked like formal market products. Retailers shall be held responsible for low quality. Damaged or expired condoms have to be destroyed. Respective regulations and enforcement structures have to be in place. However, over-regulation without capacity for law enforcement should be avoided.

4.1.2. Condom procurement [68]

4.15 Condom procurement is generally managed by specialised government institutions, commercial distributors, NGOs and international agencies. Guiding principle is that condom procurement shall be well planned, monitored and controlled in order to assure timely arrival of the product in the required specification and without damage.

4.16 Pre-qualification of condom manufacturers and sample compliance testing of products shall be mandatory. The performance of condom manufacturers and importers shall be closely monitored so that mutual confidence can be built up.

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[67] Compliance testing costs about 6% to 10% of the condom cost. Cf. WHO / UNAIDS Fact sheet 3 on The Male Latex Condom

[68] Reference: WHO/UNAIDS “The Male Latex Condom – Specification and guidelines for condom procurement” 2004, available at http://who.int/reproductive-health/publications/m_condom/index.html

4.17 Condom importation can be hampered by tedious procedures at customs clearance, often the cause for product damage and programme insecurity. Condoms are an essential pharmaceutical consumer product that requires special attention. Therefore, customs authorities and related departments shall introduce and adhere to priority clearance procedures for all condom imports, be they commercial or not.

4.18 Directives for minimum storage conditions in the Caribbean climate should be given for all involved in warehouse or retail storage, such as customs, importers, distributors, Ministry of Health, retailers, etc. As a general rule, condoms should not be exposed to excessive heat or humidity or to direct sunlight. Research findings show, however, that properly packed good-quality condoms do not perish in tropical countries.[69]

4.1.3. Import duty and taxation

4.19 A number of Caribbean countries levy taxes on condoms if not directly procured by government or external donating agencies. If commercial or subsidised condoms are subject to taxes, higher consumer prices or less financial resources for other HIV programme activities are likely to be the result. Governments should commit themselves to the high priority of condom use and appreciate all sectors providing condoms. Male and female condoms should be exempted from import duties and other taxes so far applied. In some Caribbean countries, classified essential pharmaceutical products and contraceptives are already free from import or VAT levies.

4.20 When considering removal of tax barriers, it is crucial to analyse and determine the desired strategic effect, i.e. increase the availability and use of condoms. Strategic decisions shall be based on complete import data of all sectors, pricing schemes, and distribution mechanisms. Various government departments need to be involved in this decision, first and foremost Finance and Customs.

4.21 Options include exemption from duties and taxes on condom imports and exemption or preferential rate for VAT on condoms. A positive effect might be reached by linking the application of tax exemption to the assurance of price stability and product quality or the pro-active involvement of the commercial suppliers in national HIV prevention programmes.

[69] Cf. TGPSH/GTZ – PSI Tanzania: Condoms

4.1.4. Condom accessibility

4.22 Wide accessibility of condoms is a key prerequisite of condom use for all people who wish to protect their sexual activity against STIs, HIV and unwanted pregnancy. Universal access is one of the recognised aims of HIV and AIDS related programmes in the Caribbean, including prevention commodities and services.

4.23 Access to condoms needs to be assured at convenient times and sites, outside 'normal' operating hours of government services, at non-traditional outlets, at events associated with promiscuity and sex, etc. The choice of places and conditions where condoms are offered needs to assure that the particular habits of vulnerable target groups are actually met. Innovative strategies shall be awarded.

4.24 Making condoms accessible also means that the condom price "must be payable" for all users, i.e. affordable condoms must be in reach of population groups in need. Consumer preferences should be recognised, which can best be done by assuring that a variety of condoms is on offer. Brand appeal can be a motivating factor when considering to use a condom.

4.25 Governments should minimise the existence of health care provider biases to restrict condom access to most vulnerable population groups. This can be done through training for public, NGO and private sector, supervision, dialogue, revision of adverse service norms and standards and broad dissemination of condom supporting regulations.

4.26 Legal and socio-cultural barriers to introduce condoms in the educational system should be removed to give way to prevention programmes that take care of real problems faced by adolescents. Legal barriers that exclude sexually active minors from access to condoms should be removed with respect to foster preventive behaviour at an early age. School curricula on sex and family life education shall include options for safe sexual behaviour and condom demonstration. Schools and youth centres need to introduce condoms through appropriate channels, such as trained nurses and school ASRH services, guidance teachers, and peer counsellors.

4.27 Legal, socio-cultural and psychological access barriers need to be reduced for population groups that are subject to stigma and discrimination such as sex workers and MSM. General advocacy and targeted retailer training may help remove the barriers.

4.28 Legal barriers to access condoms need to be reviewed and removed for populations under especially difficult circumstances, as in prisons. In this respect, the responsibility to protect the individual's health shall be the guiding principle. Linking condom access to behaviour change programmes is an opportunity to reach these high-risk groups.

4.1.5. Condom distribution

4.29 Efficient condom distribution assures that all segments of the population get access to the condoms of their respective choice. Therefore governments need to assure that condom distribution and sales of all sectors are coordinated in a way that they can complement each other at the consumer level. A segmentation strategy for different consumer groups and lifestyles helps increasing the cost-efficiency of condom distribution, i.e. targeted distribution of condoms either free (no-logo) through the public sector and civil society affiliates, or subsidised (branded) condoms through NGOs, SMOs and private sector, or low and higher priced brand condoms through commercial distributors.

4.30 In the private sector, condom supply (free or on sale) needs to be mandatory in the entertainment and tourism industry, e.g. in night bars, discos, dancing events, hotels, beach parties etc. Condoms need to be accessible to tourists and employees alike. Mass entertaining events shall provide condom promotion sites accessible to all taking part in the event. Apart from pharmacies, supermarkets and convenience stores, condoms shall be openly available at barber shops, hairdressing salons, beauty parlours, gyms and body care facilities. Work place programmes in any private sector company shall include condom distribution.

4.31 Condom distribution shall respond to the habits of each sexually active population group. Innovative[70] distribution strategies shall be encouraged in order to cater for underserved population segments and locations. New distribution channels might be opened through the provision of vending machines, targeted condom promotion tours, cooperation with community centres for community outreach, business and industry as well as international and local tour operators. Condoms need to be available particularly in typical Caribbean emergency situations, e.g. for people in hurricane-stricken areas.

4.32 In the public sector, the condom logistics management shall have in place the necessary strategies and resources to be efficient, i.e. timely distribution with minimal stock-outs and product damage or expiration. All opportunities to offer condoms to clients in public health facilities shall be utilised.

4.33 Tracking of condom distribution is paramount as the product is often neglected in the reporting systems. Therefore sample tracking might be the most cost-efficient methodology.

[70] Unique ways of distributing condoms include games organised by the entertainment department where persons win condoms in adult games such as ‘singles night out’, ‘couples play it safe contests’ and ‘guess the number of condoms and win’ competitions. (cf. Boxill et al.)

Condom tracking should cover all sectors so that the gathered information shows a complete picture of distribution patterns in a geographic area or among particular target groups. This information should be used for refining national distribution strategies and improving logistics management.

4.2. Behaviour change communication and promotion of condom use

4.34 Condoms shall be promoted in ways that help overcome sexual and personal obstacles to their use. Therefore the focus should not be exclusively on condoms. Communication and education shall be placed in the wider context of factors influencing sexual behaviour and personal risk assessment, such as gender, culture, religion, social and economic status, etc. Condom promotion shall provide information about the health benefits of correct and consistent condom use and create broad awareness and acceptance of such evidence in the Caribbean context.

4.35 It is crucial to facilitate an environment enabling broad and open dialogue about human sexuality, personal responsibility, gender, reproduction, sexual and reproductive rights, etc. Equal decision-making powers in interpersonal relationships between women and men need to be encouraged. As many society groups as possible shall be invited to take part in this discussion.

4.36 Multiple prevention strategies shall be promoted including other options such as sexual abstinence, faithfulness to one trusted partner, delay of sexual debut, alternative sexual patterns (e.g. non-penetrating sex). Correct and consistent use of male or female condoms shall be endorsed as a sign of responsible and protective behaviour for people at risk of passing or getting an infection.

4.37 Advocacy for universal access to condoms is paramount, particularly for vulnerable population groups such as sex workers and their clients, sexually active adolescents, men who have sex with men, prison inmates. In this context, there is need to counteract health hazardous taboos, stigma, and discrimination that have adverse effects on the health of most vulnerable groups and hamper condom acquisition and use.

4.38 Whatever the local epidemiological and social conditions, HIV prevention programmes shall prioritise and focus on the intervention needs of people at risk, and focus programme efforts on reaching adequate numbers of these key audiences. These audiences should be segmented[71], and information and services should be tailored to meet each

[71] Segmenting in this sense means identifying subpopulations within each key audience that are different enough to require different approaches or messages (for example, distinguishing

subpopulation's particular needs. However, by segmenting the response it must be ensured that stigmatisation and other unintended adverse consequences do not occur.

4.39 Communication programmes aiming at behaviour change (BCC) shall be designed to encourage realistic personal risk perception and risk-benefit assessment. They should address specific barriers to safe sexual behaviour prevalent in socio-cultural norms and sub-societies. Communication on condoms needs to overcome language barriers that affect particularly indigenous populations and migrants within in the Caribbean region.

4.40 A special focus shall be laid on adolescents and youth and their respective socio-cultural and educational environment. Young girls and women shall be addressed with priority as they are mostly denied information about and access to condoms. Men shall be addressed to overcome personal barriers to condom use. Myths and misconceptions shall be addressed as soon as they occur, e.g. rumours about condom insecurity, about condoms instigating promiscuity or early sexual debut, etc.

4.41 Information shall be disseminated about the availability of condoms across all sectors, e.g. where, when, at what prices, etc. Condom promotion shall be generally reinforced and serve the creation of demand. Generic promotion of condoms should be complemented by brand promotion. Condom use shall be promoted as a normal and trendy behaviour within mainstream (sub)cultures.

4.42 The promotion of female condoms as the only female-initiated STI/HIV prevention, an alternative or dual option for prevention, shall be increased. Strategies need to be developed to improve awareness and visibility of female condoms in order to enhance public sensitivity and knowledge. Biases against the female condom need to be overcome both among health providers and consumers. Skills training for its correct use need to be particularly emphasized. Men should be included in promotional campaigns to gain their requisite support.

4.42 State-of-the-art communication and social marketing techniques should be employed. The media mix shall draw from all available media based on strategic communication strategies. Mass media and interpersonal communication need to be interlinked. Special emphasis is to be placed on peer jargons and up-to-date interactive media use, e.g. using widely available cell phones, user-generated content through web blogs etc.

transgendered persons from MSM, or street-based from brothel-based sex workers). It does not mean singling out those populations for blame or persecution, or stigmatising an HIV prevention measure as only for specified people. UNAIDS HIV prevention Social and behaviour change, Website 2007

4.43 In the framework of services such as voluntary testing and counselling (VCT), antiretroviral treatment (ART), reproductive health including STI and family planning, the promotion of correct and consistent condom use is essential in order to reduce further opportunities for HIV transmission. ART programmes in particular bear the risk of HIV positive patients developing a sense of complacency and perception of low risk that can lead to unprotected sex through reduced or non-consistent condom use. Special communication efforts shall be deployed to promote condom use among HIV positives.

4.43 BCC and condom promotion shall be associated with research studies that provide baseline information and monitor evolution and change of behaviour patterns among the general population and among specific vulnerable groups with regard to condom use and general sexual behaviour, knowledge, attitudes and skills.

4.3. Monitoring and evaluation [72]

4.44 Continuous monitoring and periodic evaluation (M&E) of HIV prevention programmes with regard to condom availability and condom accessibility and use is an imperative task in order to guide national strategies and revise them on a regular basis. M&E provides information on condoms that can be used to support political dialogue and advocacy. M&E is needed for issues like condom management, condom importation, condom availability and quality, and condom use.

4.45 National HIV strategic plans mostly imply studies on condom use among various population groups (such as BSS – Behavioural Surveillance Surveys), but regular monitoring based on agreed indicators is not yet standard in the Caribbean. Regular health sector statistics hardly provide specific information about condom distribution and should be strengthened to provide the necessary data. Indicators and measurement tools are available based on the CIMT (Caribbean indicators and measurement tools) that have been developed with Caribbean countries[73]. (cf. Annex 2)

4.46 Behaviour change in condom use among the general population and among specific target groups shall be monitored and evaluated. Apart from behaviour patterns of using

[72] References: CHRC, Caribbean indicators and measurement tools (CIMT) for the Monitoring and Evaluation of National AIDS programmes, 2004 Revision – accessible at – www.chrc-caribbean.org Evaluating condom programming in Rehle et al. (FHI) Evaluating programs for HIV/AIDS prevention and care in developing countries, 2001

[73] Other tools are utilised by the PANCAP-CARISMA project in 25 Caribbean countries, which assesses general condom availability, equity of access, and affordability (looking at the TCM – Total Condom Market) as well as sales for SMOs and the commercial sector as a proxy for condom use. A cost-efficient way of measuring are MAP surveys (= Measuring Access and Performance)

condoms or not, this should include the (perceived) accessibility of condoms among target populations. Respective qualitative and quantitative research shall be incorporated in a systematic way in all related strategies. Funds for research need to be allocated as part of the overall regular budget.

4.47 Apart from population based surveys, strategic condom management plans need to be evaluated in all their components. As product availability is a prerequisite to condom use, information on the availability of condoms at different levels of the supply system needs to be collected. Tracking condom availability and quality across all sectors, i.e. public, NGO, commercial, shall be organised in a cost-efficient way, e.g. by using sampling methods. In addition, the quality of associated services can be assessed with regard to meeting the needs of particular target groups.

4.48 At central level, it is important to monitor condom imports that are ordered by the government, donor agencies, NGOs and commercial importers and distributors. Regulations for import tracking need to be harmonised so that imported units are easily identified. The number of condom units could be reported at port of entry into the Caribbean. Classification of condoms as a general rubber product to be recorded in terms of merchandise weight does not seem to be useful in this context.

4.49 As M&E on condoms is a regional concern, national governments shall establish links to existing monitoring tools and mechanisms in the region. [74] (List of suggested indicators in relation to condoms – cf. Annex 2)

4.50 M&E results on condom related issues are important data that should be disseminated and published to underscore efforts of HIV prevention programmes. They will show the execution status of the condom policy and can be used for revision. M&E results should be used for advocacy purposes to encourage societal dialogue and to get support for further programme development.

4.4. Strategic responsibilities

4.51 This regional model condom policy aims to protect the right of all sexually active people in the Caribbean to prevent sexually transmitted infections, including HIV, and undesired pregnancy. In this context, condoms are recognised as an effective medical device

[74] For monitoring of condom sales and distribution, PANCAP member countries are assisted by the regional PANCAP-CARISMA project – available at www.carisma-pancap.org . CRHC is assisting in harmonising and monitoring common indicators across the region. PAHO/CAREC, UWI, and other research institutions offer a range of study projects that can be joined or commissioned by individual countries. UNFPA provides tools for the management of RH commodities.

which should be widely known, readily accessible and consistently used by people at risk. In view of the various strategic and programmatic tasks presented in this model policy, it is obvious that the concurrence of numerous government sectors is mandatory to reach a satisfying level of preventive behaviour and condom use among vulnerable populations.

4.52 In all Caribbean countries, lead agencies with regard to HIV and AIDS programmes have been appointed, i.e. NACs, NAPs, etc. Responsibility for condom procurement and distribution in the public sector lies in most cases with a Ministry of Health department. In other cases, there are National Family Planning bodies that are leading commodity procurement. Coordination with regard to condom logistics outside the health sector is reportedly not always optimal, e.g. between lead agency for HIV and AIDS and MoH. In addition, other sectors (NGOs, SMOs, commercial distributors) are barely integrated despite their important role for condom provision and behaviour change communication in each country.

4.53 The regional model condom policy shall stimulate a consolidated strategic condom management approach in Caribbean governments. Governments should appoint a high level focal point for condom management in charge of coordinating the country-specific adaptation of the model condom policy and its further implementation.

4.54 A key task is to establish as early as possible a comprehensive management and coordination of all condom related issues in the country or the (sub-)region. Strategic condom management committees should comprise all relevant sectors within the government, the civil society, NGOs and the private commercial sector.

4.55 Fundamental legal changes will only be reached through sound technical and political consultation and decision making processes. The condom policy shall be used to underscore advocacy and public debate, assure and monitor continuity and progress towards achieving universal access to condoms for all sexually active people.

4.56 All concerned government sectors have to be involved in reviewing, integrating, revising and ultimately applying related standards, procedures, service norms etc. for the national condom policy to become effective.

4.57 The following list comprises a number of governmental sectors to be called upon, but does not claim to be exhaustive:

- National AIDS Council, Commission or Programme
- Ministry of Health, i.e. departments in charge of STI, HIV and AIDS, FP/RH, population, pharmaceuticals, procurement, health promotion, etc.
- Bureau of Standards

- Customs Authorities
- Ministry of Finance
- Ministry of Planning and Development
- Ministry of Education
- Ministry of Youth Affairs
- Ministry of Industry and Commerce
- Ministry of Tourism
- Ministry of Legal Affairs
- Ministry of Gender Affairs
- Statistical Offices
- Ministry of Social Security

5. Recommendations for implementation of the model condom policy

The CARICOM-PANCAP regional model condom policy is supposed to serve all Caribbean governments as a reference to adopt and draw from in view of the adaptation of national legislation with regard to condoms. The policy is designed as a tool for national, sub-regional and regional decision makers to assure that the increasing need for consistent accessibility of male and female quality condoms among Caribbean populations is being met in a way that allows universal access as part of comprehensive programmes against HIV and AIDS.

Two major phases will be needed for the model condom policy to become effective:

(1) Approval by PANCAP partners and ultimately by CARICOM authorities

(2) National adaptation of the model

These phases may overlap each other so that improvements at country level can be achieved in a relatively short time.

PANCAP as the initiator of this model policy shall continue to lead the process of approval and adaptation among the various partners in a systematic and continuous way until the document is finalised and widely agreed upon by Caribbean stakeholders, governments and international partners. It should be equally involved in supporting individual governments to adapt the model into national legislation.

A prerequisite will be to appoint a regional facilitator, preferably at PANCAP PCU, with sufficient allocation of time and resources for meetings and travel.

It might be useful to include the regional model condom policy and its approval and adaptation into the next Regional Strategic Framework on HIV and AIDS.

Phase (1) Approval of the regional model condom policy by PANCAP partners and ultimately by CARICOM authorities

PANCAP shall present and execute an implementation plan for the regional model condom policy comprising the following steps:

- Present and get approval of policy at the next RCM (PANCAP Regional Coordinating Mechanism)
- Get countries to identify national partner agencies to lead the condom policy process at country level, but assurance that correspondence involves the two major national agencies – NAP/NAC and MoH

- Establish a regional condom taskforce with in-country focal points to work towards consensus and final model policy
- Create an interactive web-based platform for exchanges about the model policy and condoms in general
- Translate English version of the model policy into Spanish and French
- Wide stakeholder sensitisation and consultations at country level and briefing of the international donor community (invite various concerned national authorities)
- Presentation and approval of final model policy at the COHSOD (CARICOM Council for Human and Social Development)
- Presentation and approval of the model policy at the CHOGM (CARICOM Heads of Government Meeting)
- Publish the model policy
- Assure wide circulation and dissemination of the model policy with utmost publicity

Phase (2) National adaptation of the model policy

This phase of national adaptation calls for the national governments to pursue the following priority tasks:

- Approve the CARICOM-PANCAP Model Policy on Condoms [75]
- Establish comprehensive condom management mechanisms including specific M&E
- Assure synergy between different national policies (e.g. HIV and AIDS, family planning, tourism, workplace, education, youth), also with regional policies and strategies
- Review and revise, if necessary, condom related legislation, regulation, norms and standards across all relevant sectors in order to facilitate accessibility, quality and choice
- Advocate for widespread condom use as a responsible protective behaviour pattern for all sexually active population groups
- Adjust / remove legal barriers to condom access and use, particularly among vulnerable groups most at risk

[75] The process towards national approval may need a concerted advocacy strategy in each country.

- Make condom availability compulsory in most affected sectors (e.g. tourism industry)
- Integrate (mainstream) condom related issues into all sector policies and legislation

During this process of national adaptation, PANCAP shall provide regional guidance and support to Caribbean countries in cooperation with international partners, e.g.

- Promote and achieve approval of the condom policy at the member countries' highest level
- Assure / provide technical assistance for national / sub-regional strategic advocacy measures addressing policy makers and civil society
- Determine condom related priorities to be pursued by CARICOM at regional level
- Mainstream the dissemination of the model condom policy and related strategic issues into PANCAP and CARICOM committees, conferences etc.
- Partner with relevant institutions such as UN agencies, research institutions, regional coalitions to support and synchronise condom related research, dissemination of results and advocacy
- Advocate for synergy between different national and CARICOM policies (e.g. HIV and AIDS, youth, human rights, workplace, tourism)
- Establish technical support mechanisms for the development of condom policies
- Facilitate inter-country and (sub-)regional exchange
- Establish and maintain a forum / platform to exchange information about condom related issues (best practice, trouble shooting, etc.)

Annex 1 Terms of Reference / Scope of Work

CONSULTANCY FOR THE DEVELOPMENT OF A REGIONAL MODEL CONDOM POLICY AIMED AT REDUCING HIV/AIDS AND OTHER SEXUALLY TRANSMITTED INFECTIONS

BACKGROUND

The Conference of Heads of Government of the Caribbean Community in Nassau, The Bahamas in 2001 identified HIV/AIDS prevention and control as a matter of priority.

It is estimated that approximately 2.6% or 500 000 of the Region's population is infected with HIV/AIDS. In fact, outside of Sub-Sahara Africa, the Region has the highest prevalence rate of HIV/AIDS in the world and the highest incidence rate among women in the Americas. AIDS is the leading cause of death for men and women between the ages of 15 – 45 years in the Caribbean. There is a ninety per cent treatment gap in the Caribbean Community (CARICOM) Member States.

The regional response to the HIV/AIDS pandemic has resulted in the elaboration of the Regional Strategic Framework on HIV/AIDS and the establishment of the Pan Caribbean Partnership against HIV/AIDS (PANCAP). Low condom usage has been identified as a major factor impeding the control and prevention of HIV in the region. The reduction of the incidence of HIV is a priority area for the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP).

The CARICOM Secretariat, with a grant from the International Development Association, wishes to develop a regional model condom policy, to help reduce the spread of HIV and other sexually transmitted diseases.

GOAL

To provide a regional policy framework for condoms that would serve as a model for CARICOM Member States and the Dominican Republic

SCOPE OF WORK

1. The Consultant will prepare a work plan and methodology for developing the regional model condom policy.
2. The Consultant will review previous studies and reports that are relevant to the current project.

3. Interview key stakeholders including policy makers at the regional and national levels.
4. Convene a regional stakeholders meeting to discuss the draft regional model condom policy.
5. Develop a draft regional condom policy framework to include elements as specified in the Appendix to this Annex.
6. Make a presentation to COHSOD on the draft regional model condom policy.

APPROACH AND METHODOLOGY

Issues concerning condom policy

In February 2006, the Caribbean Regional Consultation on Universal Access to HIV/AIDS Prevention, Treatment, Care and Support recommended to "Improve availability, accessibility, coverage, appropriateness and acceptability of HIV/AIDS diagnostic, prevention, protection, treatment, care and support services through, for e.g., free HIV/AIDS testing, first line medicines in primary health care, improved services hours, particular attention to populations in crisis, unsupervised access to condoms, youth friendly services, respect of the dignity of individuals, provision of low cost, high quality prevention commodities."

Condoms are a vital tool in all efforts to prevent HIV infection. They are also essential to the maintenance of other elements of sexual and reproductive health, such as the prevention of unwanted pregnancy and of sexually transmitted infection. According to UNAIDS, condoms have played a decisive role in HIV prevention efforts in many countries. Condoms have helped to reduce HIV infection rates where AIDS has already taken hold and curtailed the broader spread of HIV in settings where the epidemic is still concentrated in specific populations. Condoms have also encouraged safer sexual behaviour more generally. Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment.

Access to condoms is widely accepted as a human right. National governments and their regional and international partners have an obligation to provide accurate information on condoms as well as ensuring an adequate supply. But lack of political will and condom programming often results in weak condom procurement and distribution systems. Consistent condom use is often undermined by laws and policies that restrict their supply and use.

Prevention programmes need to ensure that high-quality male and female condoms are available to all those who need them, when they need them, and that people have the

knowledge and skills to use them correctly. Yet social and cultural norms make negotiating condom use and safe sex difficult. Conservative beliefs can stigmatise sex and condom use making it difficult for people to speak openly and honestly about their realities and their desires. Misinformation about condom effectiveness, the denial of education on sexual risk and the stigmatisation of marginalised groups makes condom use less likely. All these factors lead to unsafe sex.

In the given situation of HIV/AIDS prevention needs in CARICOM member states and the Dominican Republic, the above statements justify a special policy focus with the aim to provide a broad legal basis for individuals' ability to have safe sex by using condoms and thus help reduce the risk of spreading HIV/AIDS. The envisaged regional condom policy framework will provide guidance on how to deal with the relevant areas that need to be regulated in order to finally assure consistent and unsupervised access to condoms. Two major areas are BCC (Behaviour Change Communication) as well as a comprehensive (or total) market approach. A special condom policy shall help to acquire commitment from all sectors of the societies including political, religious, business and commercial, social interest and civil society, family, community and academic leaders and young people in particular.

However, in view of the variety of legal systems in the Caribbean region, a limitation has to be mentioned that an overall regional condom policy can serve as an applicable model for all respective national policies. Therefore, the condom policy will be developed in a way that individual countries can draw key elements to improve their own particular policy areas concerning condoms. The participatory process of the consultancy is expected to give the necessary overview of condom related national regulations and to present options for policy development in individual countries.

Research topics and methodology

With regard to the content to be covered in the model condom policy (cf. PANCAP ToR), the following topics will be subject to the Consultant's research and consultation activities:

(1) Respective national and regional and condom situation with regard to

- Condom utilization and access
- Products and quality assurance
- Forecasting and resource mobilization for condoms
- Condom procurement
- Import duty and taxation for condoms
- Condom pricing

- Condom distribution
- Monitoring and evaluation (M&E) of total condom market and of condom utilization

(2) Context of Reproductive Health and HIV/AIDS in the Caribbean

- Caribbean sexual culture
- HIV/AIDS
- Family Planning
- Regional and national responses

It is envisaged to develop the PANCAP condom policy framework in a participatory process that strives for input from key stakeholders representing as many concerned parties as possible. The following methodology will be applied:

- Examination and analysis of
    - research studies
    - national policy documents
    - regional and national strategic documents
    - project documents
    - M&E data
- Development of a questionnaire addressing the above mentioned research topics
- Enquiries via questionnaire to be exchanged with stakeholders at national, regional and international level
- Consultation through
    - telephone interviews
    - personal in-country meetings
    - presentation and discussion in a key stakeholder meeting
    - presentation and discussion at the COHSOD

Participatory consultation process

As determined in the Terms of Reference, the process of developing the model condom policy will be as participatory as possible. Important leaders and individual stakeholders from various areas involved in HIV/AIDS prevention and the medical community of the region will be sought to contribute their views. Given the large variety of PANCAP member countries and the high number of stakeholders representing different sectors, the development process

will strive to get as many contributions as possible but limit the time to be spent for personal in-country consultation.

Therefore, it will be essential to involve regional institutions in the consultation process. Among all, the CCNAPC (Caribbean Coalition of National AIDS Programme Coordinators) will play a crucial role in getting access to national HIV/AIDS programme leaders and their respective government departments (such as Health, Pharmacy, Finance). Another important facilitating partner will be CARISMA as this project is directly concerned with condoms under various aspects, particularly monitoring the total condom market in the region. It is hoped that the Stakeholder meeting on the condom policy can be combined with the Consultative Monitoring Group and Technical Working Group in order to profit from their expertise and reduce travel time and costs for participants.

With regard to stakeholder input and feedback, regional entities will be consulted, such as the Caribbean Council of Churches, CRN+ (Caribbean Regional Network of PLWHA), the umbrella organization of Family Planning Associations, regional research institutions like CAREC and CRHC, the Pan Caribbean Business Coalition on HIV/AIDS. Funds permitting, it would be advisable to participate in already planned meetings of regional organizations to get maximum input.

An important contribution is expected from private sector companies procuring and distributing condoms throughout the Caribbean region or in individual countries only. Organizations managing social marketing programmes in the region will be interviewed, i.e. Population Services International (PSI) and Family Planning Associations as well as Constella Futures and Howard Delafield International. UN organizations, above all UNAIDS, will be consulted at regional and national level. Last but not least, the international donor community involved in HIV/AIDS prevention in the Caribbean region will be consulted, to name the World Bank, GFATM, KfW, USAID, and CIDA.

Countries to be visited for personal stakeholder consultation

Communication with stakeholders would best be organized in personal interviews and small meetings. It would therefore be desirable to visit as many countries as possible in the region. But in view of the limited budget, it is strongly hoped that email and telecommunication will work as a practicable communication means.

A pre-selection of countries to be visited is based on socio-cultural distinction and population size. The major Caribbean language areas should be represented (English, French, Spanish). Countries with a concentration of relevant stakeholders should have priority. Thus,

it has been agreed upon to visit Guyana, Saint Lucia, Barbados, Dominican Republic, Haiti, Trinidad and Tobago, and Jamaica.

Annex 2 Suggested indicators on condoms [76]

The following indicators are suggested to be monitored with regard to the implementation of a national condom policy. In their majority, they are suggested for National HIV and AIDS programmes as Caribbean Indicators and Measurement Tools (CIMT) by the Caribbean Health Research Council (CRHC). At regional level, these country data should be compiled and used for measuring overall progress.

1. **Condoms available** for distribution nationwide across all sectors
   (import statistics – Total number of condoms available for distribution nationwide during the preceding 12 months, divided by the total population 15 to 49 years)
2. Retail and service outlets with **condoms in stock**
   (targeted sample survey – The proportion of randomly selected retail outlets and service delivery points that have condoms in stock at the time of the survey, of all retail outlets and service delivery points selected for the survey)
3. **Quality of condoms** (non expired, visually intact) at retail and service outlets [77]
   (The percentage of condoms in central stock and in retail and service outlets that meet WHO quality specifications)
4. **Knowledge** of at least one formal **source of condoms** among men and women aged 15-24 years (Population-based or targeted sample survey)
5. **Knowledge** of HIV prevention **methods**, including condoms (Population-based survey)
6. **Obstacles to acquire condoms** among men and women aged 15-24 years (qualitative KAP[78] study in key at risk population groups)
7. **Condom use**
   - Percentage of **young people aged 15 – 24** reporting the use of condoms during sexual intercourse with a **non-regular sexual partner**
   - Percent of **women and men aged 15 – 49** who say they used a condom the last time they had **sex with a non-marital, non-cohabiting partner**, of those who have had sex with such a partner in the last 12 months

[76] Further readings on the evaluation of condom programming: UNAIDS – various documents; Evaluating condom programming, Chapter 5 in Rehle et al. Evaluating programs for HIV/AIDS prevention and care in developing countries. FHI

[77] This indicator is not included in the CIMT

[78] KAP = Knowledge, Attitude, Practice

- Percent of **men reporting sex with a sex worker** in the last 12 months who used a condom during last paid intercourse
- Percent of **sex workers** who report using a condom with their most recent client, of sex workers surveyed having sex with any clients in the last 12 months
- Percent of men who used a **condom at last sex with a male partner**, of those who have had sex with a male partner in the last 6 months

Annex 3 Priority target groups of the model condom policy

Engaging in unprotected sexual intercourse with partners of unknown HIV status is still a prevalent behavioural pattern among Caribbean people. Therefore, target groups of the PANCAP model policy on condoms are all sexually active people in the Caribbean region, without restriction of gender, age, sexual orientation or legal status.

Primarily, the policy concerns vulnerable population groups with a high risk to engage in unsafe sexual practices. Across the region, the following groups have been identified[79] as a priority in HIV and AIDS prevention programmes:

- Young people
- Sex workers (CSW)
- Men who have sex with men (MSM)
- Populations in correctional settings (e.g. prison inmates)

In addition, all mobile populations and uniformed groups shall be targeted.

Young people

A variety of factors place young people at the centre of HIV vulnerability, including:

- lack of information on sexuality and HIV and AIDS
- low perception of personal risk for HIV
- lack of access to prevention and HIV testing services
- low adoption rate of known prevention methods

School based surveys conducted in 2005 among youths aged 10 to 14 years old in the Eastern Caribbean show that 6% were sexually active, with some having had their first experience as early as 7 years old. Condom use at last sex was reported by approximately 4 out of 10 sexually active respondents. Approximately 2 in 10 boys and girls stated that they were forced the first time they had had sexual intercourse.

[79] CAREC: The Caribbean HIV/AIDS Epidemic and the situation in member countries of the Caribbean Epidemiology Centre. February 2007

Sex workers

Sex workers, both male and female, are at special risk for HIV infection by virtue of the work that they do which involves multiple sex partners, and monetary transactions which make the recipient more likely to take risks e.g. forgoing condoms. In addition, the illegality of sex work in most Caribbean countries and the associated discrimination towards sex workers can serve as barriers for access to HIV prevention, care and treatment services.

Surveys conducted in Jamaica, Suriname and Guyana over the past five years have shown HIV infection rates among sex workers ranging from 9% to 31%.

Men who have sex with men (MSM)

This sub-population of men are at high risk for HIV for a variety of reasons, including:

- the biological risk of the sex act itself
- multiple sex partnerships
- reduced power for men who engage in same sex relations for economic reasons
- to negotiate for condom use with their partners
- reduced access to prevention, HIV testing and treatment due to fear of stigmatisation and discrimination

These realities are compounded by the moral and legal environment in most Caribbean countries which views these members of society as conducting illegal and immoral activities. Surveys within and outside of the Caribbean region have typically shown very high HIV infection rates among men who have sex with men . Specifically in the Caribbean, the few studies done in countries such as Jamaica, Trinidad and Tobago and Suriname have revealed HIV infection rates ranging from 6% to 66%, depending on the profile of the men surveyed and the survey methodology.

Prison inmates [80]

HIV is increasingly affecting the most disadvantaged groups in society, groups that are over-represented in correctional settings such as prisons. Prison inmate populations are considered by many to be at greater risk of infection than the general population due to the high prevalence of behaviours that facilitate HIV transmission including:

[80] PAHO: HIV and AIDS in the Americas 2007 Report, September 2007

- unprotected sexual activity –
  male-male, female-female, non-consensual and transactional sex
- tattooing
- injection drug use with needle/syringe sharing

Other potential routes of transmission are razor sharing, fights with blood contact and sharing piercing equipment. Prisons are considered by some to be reservoirs of HIV amplification with risk of further spread to the general population through spouses and other sexual contacts.

HIV prevalence surveys of prison inmates in six Eastern Caribbean countries in 2004/2005 revealed rates ranging from a low of 2% to a high of 4%. These rates are approximately three times higher than the estimated OECS population prevalence in 2003 and slightly higher than the prevalence among incarcerated males in the US in 1999 (2%). A survey conducted in the Belize Central Prison in 2004 revealed an HIV infection rate of approximately 5%, or 1 in 20 surveyed inmates. This was higher than the estimated HIV prevalence of 2% in the general population at the end of 2004.

These figures reinforce the public health principles that preventative intervention services/programmes, voluntary counselling and testing, and appropriate care and treatment should be made available to all prison inmates as this would be an opportunity for many who may not otherwise access these services. This may also serve to reduce spread of HIV within the institutions as well as to the wider population when the prisoners complete their sentences and rejoin society.

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