

International HIV/AIDS Prevention Programming: Not as Simple as ABC

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The AIDS epidemic has become the most devastating health-related crisis of the 20th century. In response, President Bush committed in his 2003 State of the Union Address to substantially increase U.S. support of worldwide prevention and treatment efforts. Specifically, President Bush called upon Congress to “commit \$15 billion over the next five years, to turn the tide of AIDS in the most afflicted nations of Africa and the Caribbean,” in an effort termed the President’s Emergency Plan for AIDS Relief (PEPFAR). Congress required that PEPFAR funds be allotted in the following way: 55% for the treatment of individuals already infected with HIV, especially for the purchase and distribution of antiretroviral therapy; 15% for the palliative care of infected individuals; 20% devoted to HIV prevention; 10% for assisting AIDS orphans and vulnerable children. The prevention and education component of PEPFAR is based on a model called “ABC”—A for *abstinence*, B for *be faithful*, and C for *condom use*. Foremost, the ABC prevention model promotes abstinence, maintaining that abstaining from sexual activity is the most effective way to avoid infection. ABC also requires that individuals “be faithful” because monogamy not only reduces one’s exposure to HIV, but also creates strong relationships. Lastly, in the event that abstinence and fidelity are unattainable, and for those practicing high-risk behaviors, the ABC model promotes the correct and consistent use of condoms. In keeping with the tenets of this prevention model, of the 20% of funds set aside for HIV prevention, 33% must be spent on abstinence education and another 33%

on dispersing a message of fidelity. Although the President's attention to the AIDS crisis is commendable, PEPFAR raises significant concerns for those invested in the public health struggle against HIV. The ABC model of prevention programming is ideologically flawed and ineffectual because it ignores cultural complexities of the developing world, incorrectly assumes gender equality, and fuels AIDS-related stigma.

A Brief History of the AIDS Epidemic and Our Response

For decades, Kaposi's sarcoma, a cancer of the connective tissues, was considered a rare disease that generally afflicted only elderly men and the recipients of organ transplantations. By March of 1981, however, eight cases of virulent Kaposi's sarcoma had appeared in young, gay men in the New York City area. Almost simultaneously, physicians in both New York and California began to report an alarming increase in cases of a rare lung infection, *Pneumocystis carinii pneumonia*. Within only six months, it became clear that the disease causing these disturbing symptoms was affecting groups other than just youthful men who had sex with men; the injection-drug-using population, hemophiliacs, Haitians, Western Europeans, and patients who had received blood transfusions were becoming ill as well.

This scene marks the dramatic entrance of HIV, a virus that infects human white blood cells, annihilates the immune system, and ultimately progresses to AIDS. Today, twenty-five years following the onset and discovery of the virus, we know that HIV can be transmitted in the following ways: unprotected anal, oral, and vaginal sex; exchange of blood or blood products primarily through injection drug use, surgery, and blood transfusions; from mother to child in utero, during the process of labor and childbirth, and through breast feeding. Essentially, HIV is transmissible through any contact during which

infected human blood, semen, vaginal secretions, or breast milk come into contact with the blood of a noninfected individual. That said, for each of the known modes of transmission, there are steps that an individual can take to reduce or eliminate her risk of infection. With AIDS in its twenty-fifth year, prevention and public health workers continue to reach out to the global community, to insure that all individuals the world over are educated and informed about the virus and equipped with the tools they need to protect themselves and others.

The Case of Uganda: An ABC Success Story?

Uganda, and its president in particular, must be commended for the leadership they have shown in their fight against HIV/AIDS... President Museveni is today rewarded for his openness and uncompromising stand against discrimination and stigmatization. Thanks to these efforts, the epidemic in Uganda is the first in Africa, and in any developing country, to show signs of stabilization...

—Dr. Hiroshi Nakajima (Director-General- World Health Organization)

Diagnosing its first AIDS patient in 1982, only one year after the shocking debut of HIV in the United States, Uganda was among the first few countries in sub-Saharan Africa to encounter the unfamiliar virus. Because HIV/AIDS remained mysterious and misunderstood, and the modes of transmission were unknown, the incidence of HIV in Uganda increased uncontrollably and the country began to experience the devastating impact of the AIDS epidemic. Nevertheless, in these early years, Uganda was fortunate. While the Reagan administration, like many worldwide, distanced itself from the disease, even failing to mention the word AIDS, Uganda was united under President Yoweri Museveni, a unique leader who made it his personal mission to prevent the spread of HIV

in his country.

President Museveni launched, in the mid 1980s, a nationwide tour to educate Uganda's citizens about AIDS. The tour was based on a prevention campaign that encouraged abstinence, "zero-grazing" or fidelity to one partner, and correct and consistent condom use in order to minimize sexually transmitted infection.¹ Nearly twenty years later, this policy is credited for reducing Uganda's adult HIV prevalence from about 16% in the early 1990s to 6% at the end of 2001—the greatest decline of HIV prevalence ever documented.² Also, the Bush administration and other ABC supporters readily cite the success of Uganda's prevention campaign as evidence that the ABC model is culturally relevant and well substantiated. The White House insists that the following lessons can be learned from Uganda's achievements: "high-risk behaviors can be modified or supplanted by healthier lifestyle choices; faith-based organizations are fundamental participants in HIV prevention; abstinence and marital fidelity seem to be the most critical factors in the struggle against AIDS; condoms do not play a key role in reducing the transmission of HIV."³ But for a multitude of reasons, this assessment of Uganda's success is flawed and scientifically unsupported.

Most notably, the reported 10% decline in adult HIV prevalence may not actually reflect positive changes brought about as a result of prevention programming. Prevalence is a statistical term, which in this instance represents a ratio of the total number of HIV positive individuals in relation to the total number of individuals present in the given population. Incidence, on the other hand, is defined as the number of new cases of disease occurring in a population during a given period of time. Stated more simply, prevalence is a proportion, whereas incidence is a rate. The results of a long-term study in the Rakai district of Uganda suggest that, in fact, most of the waning in prevalence is due to AIDS-

related deaths rather than prevention efforts.⁴ A significant escalation in mortality rates during the 1990s is a predictable corollary of the extreme upsurge in HIV infections that occurred shortly after the local epidemic's onset, particularly in the absence of effectual therapies. Ultimately, the *prevalence* rates frequently cited in support of Uganda's success do not necessarily reflect the results of Uganda's prevention campaign, nor do they reflect any decrease in HIV infection. HIV *incidence* rates, on the other hand, would be particularly useful, because they would signify, unequivocally, whether the number of new HIV infections steadily decreased in the 1990s as a result of prevention programming and subsequent behavior change. Curiously, statistical information reflecting Uganda's adult HIV incidence is absent from reports touting the triumphs of the first "ABC" prevention model, and is actually quite difficult to find in the literature overall.

What is more, results from the same study, conducted in Uganda's Rakai district, indicate that the packaged messages of abstinence and "zero-grazing" did not effectively influence Uganda's young people. The research found that new cases of HIV are increasing yearly among youth nationwide.⁵ Considering that the face of AIDS has morphed in the past decade, so that the modern epidemic has largely centralized among heterosexual young people, this is hardly surprising. On the other hand, evidence of a burgeoning incidence rate among youth hardly owes to the effectiveness of abstinence-only-until-marriage prevention campaigns. Likewise, the Rakai data indicates that, ten years following the implementation of Musaveni's prevention tour, young people are engaging in first sex earlier and have more sexual partners.⁶ Although pro-abstinence-only-until-marriage organizations continue to cite Uganda as an example of the victories achieved by their prevention methods, this is inappropriate, since data suggests that these programs have had little long-term impact on teenagers' sexual behavior.

Condom use, on the other hand, has escalated among adolescents and adults throughout the country.⁷ Indeed, despite the Bush administration's efforts to prove otherwise, the high efficacy of condom use for prevention of HIV/AIDS is the "most likely explanation for Uganda's successes."⁸ Since 1990, a UNAID-subsidized campaign promoting condoms—involving public health education, social advertising, and the widespread distribution and sale of condoms for free or at reduced prices—increased condom use from "7% nationwide to over 50% in rural areas and 85% in urban areas" today.⁹ The decline of HIV prevalence rates in this nation was clearly not due to the promotion of abstinence and fidelity alone. It seems that the Bush administration and affiliated think tanks have selected information and construed statistical findings to support a U.S. ABC model with an emphasis on the AB.

Beyond critically altering the ABC model to fit a more conservative paradigm, the United States has, in effect, "hijacked" Uganda's success story.¹⁰ In the early hours of the nation's AIDS epidemic, Museveni launched an effective HIV prevention campaign by engaging all echelons of the populous, and a multitude of collaborators, including faith-based organizations, traditional leaders, and NGOs. The extraordinary caliber of "political commitment to HIV prevention and care" demonstrated by the Ugandan government produced an unparalleled, all-encompassing national effort that certainly contributed to the nation's success in "stemming the tide" of HIV/AIDS. In addition, Uganda's approach to HIV prevention, at the time unique to the developing world, included the promotion of correct and consistent condom use, the social marketing of Clear-Seven®, a self-treatment kit for sexually transmitted infections (an individual with certain existing sexually transmitted infections may be at greater risk for HIV infection), and the accessibility of voluntary HIV testing centers that offered same-day results and individual counseling

services.¹¹ Each of these components indicates an HIV prevention approach based in communication, destigmatization, and innovation, and explains Uganda’s achievements in combating the AIDS epidemic. Sadly, an obsessive focus on proving the efficacy of abstinence-only-until-marriage and marriage fidelity programming has, to a large extent, overshadowed Uganda’s actual successes.

How a Conservative Agenda Turned “ABC” into “AB”

We had the ABC proposal, which is the Ugandan model—abstinence, be faithful, and then if that doesn’t work—it is really AB—and then if that fails condom distribution as a third part of it.

—Senator Sam Brownback (Republican-Kansas)

I have met President Bush personally twice, and he strikes me as a very, very passionate and very caring person. But when I contrast the President Bush I have met with the policies and practices that are coming out of the U.S., I cannot reconcile the two. The message that the U.S. is sending out with regard to prevention, the ABC, “Abstinence and Be faithful,”...and there is some kind of campaign to be quiet on the condom discussion which is a disaster.... Yes, abstinence works for some people, for some time. But you can’t say that abstinence works for everybody all of the time.

—Noerine Kaleeba, Uganda (Founder- The AIDS Support Organization)

On the surface, it seems that the A, B, and C of the ABC model of international HIV prevention are “mutually complementary and not competitive strategies.”¹² Unfortunately, a more thorough examination of U.S. promoted HIV/AIDS policy reveals that this is not the case. Because the majority of abstinence-based education supporters

have strong faith-based beliefs about sexuality, they often view the main objective in sexuality education as encouraging young people to refuse or avoid sex entirely. In the case of ABC, an obsessive moral focus has resulted in an abstinence-only model that rejects any other prevention programming, thereby censoring the social distribution of potentially more appropriate information. A report from the Office of the U.S. Global AIDS Coordinator (OGAC), primarily responsible for PEPFAR administration, illustrates this point nicely. The guidance states that the Emergency Plan supports abstinence, or a return to abstinence, as the primary message for youth through “age-appropriate and culturally appropriate ‘AB’ only programs”.¹³ Information regarding correct and consistent condom use is reserved only for youth engaging in high-risk behavior. Essentially, correct and consistent condom use is promoted among injection drug users, sex workers and their clients, and couples in which one partner is known to be HIV positive. Individuals who are not deemed high-risk, in contrast, are targeted by strong abstinence-only-until-marriage and fidelity campaigns. Low-risk individuals often receive no information or education about proper condom use, nor are they granted easy access to a supply of condoms or other barrier methods. In fact, the conservative-influenced “AB” approach regularly fails to mention condoms at all or purposefully conveys the message to teenagers that they should avoid condoms because they don’t work.¹⁴ Proponents of this sort of prevention model contend that condom promotion effectually endorses teen sex and therefore negates the positive impact of abstinence. However, there simply exists no concrete information indicating that abstinence-only programming is effective in curbing the spread of HIV. Innumerable studies reveal that abstinence-only-until-marriage education rarely succeeds in preventing premarital sex in the long term and violates young people’s basic human right to complete information about HIV/AIDS and all effective prevention strategies.

Also, by failing to provide young people with adequate information about condom use, abstinence-only programming ultimately leaves individuals at a greater risk of contracting HIV.^{15 16 17 18}

Moreover, international HIV/AIDS prevention programs receiving funding from the Emergency Plan often fail to include sufficient basic information about the virus and sexual transmission, particularly to youth. Because the ABC model implemented abroad mirrors the Bush administration's recommended abstinence-only sexual health education for American youth, lessons learned in the United States are particularly useful for assessing the applicability of ABC internationally. Although more than two-thirds of all adolescents report being sexually active, only one-fifth are aware that HIV can be transmitted through oral sex.¹⁹ This is just one example of many indicating that although sexually active young people can readily recall messages of abstinence, many "have misperceptions about the health risks associated with...HIV/AIDS and have incomplete information on safer sex practices, the relative effectiveness of condoms versus other forms of birth control in preventing disease, and the frequency and availability of testing for...HIV."²⁰ Most importantly, though, a survey conducted by the Kaiser Foundation found that America's youth wants more information on how to use condoms correctly, how to identify the symptoms associated with HIV infection, and where HIV testing is available and what the experience entails. Also, young people would like education on how to effectively communicate with partners about the sensitive topics associated with sexuality and sexually transmitted infection.²¹ Abstinence-only education—which leaves one-fifth of all high-school-aged youth believing that they would simply "know" if another individual was infected with HIV, even if the individual had not been tested—is evidently not providing crucial background health information regarding HIV, AIDS, and

relationships.

The Ambiguities of Abstinence

In our assemblies and in the classroom, we explain what abstinence is and why it is important But around here, people don't buy this idea of abstinence because in Uganda, many girls are using sex to buy their daily bread.

—A headteacher in Mbale, Uganda

While it is important that abstinence be mentioned during sexual health education, the inherent ambiguity of the term makes abstinence-based prevention models inadequate. Abstinence is often defined in behavioral terms, referring to postponing first sex or to avoiding further intercourse if already sexually experienced. However, the precise definition of abstinence may be interpreted in a variety of different ways. Touching, “outercourse,” dry kissing, wet kissing, mutual masturbation, oral sex, and anal sex are all modes of sexual expression that may or may not be included in a given individual’s perception of abstinence. Case in point: in many areas of the world, young women choose to abstain only from penetrative vaginal sex in order to maintain their culturally cherished “virginity” and to prevent unwanted pregnancies. For instance, in KwaZulu-Natal—a province of South Africa, a nation that received 148 million dollars in PEPFAR funds in the 1995 fiscal year—thousands of young Zulu women and girls engage in a form of abstinence in preparation for their participation in Umhlanga, an annual dance and “rite-of-passage” ceremony celebrating virginity. The physical exam is held in public, and the integrity of small portion of soft tissue is all that maintains the purity and respectability of a young woman in the eyes of her family and her nation. Dr. Jerome Singh, head of Bioethics and Health Law at the Centre for the AIDS Program of Research in South Africa

(CAPRISA) at the University of KwaZulu-Natal, argues that “pressure emanating from virginity testing is resulting in young girls engaging in anal sex in order to keep their status as virgins intact—contributing a greater risk of spreading HIV/AIDS.”²² Likewise, a young woman who avoids all penetrative sex, but who does engage in oral sex, is not protected from the possibility of sexually transmitted HIV infection. Because the definition of abstinence is fluctuating and highly varied, individuals who self-identify as abstinent engage in a variety of sexual behaviors, even those that may lead to the potential transmission of HIV. In the context of this reality, the notion that abstinence is one hundred percent effective in the prevention of HIV is misleading.

In addition, abstinence is an inadequate basis for HIV/AIDS prevention education because it is based on an unrealistic premise that young women and girls around the world have a voice in choosing when and with whom they will first engage in sexual activity. For many young women and girls around the world, coercion and violence characterize their first experience with sex, and many become infected as a result. A recent survey of South African students aged 10-19 found that—in a nation where 10.2 million young people are infected with HIV—71 percent of young females had been forced to have sexual intercourse, and between 30 and 40 percent were forced to engage in their first sexual encounter.²³ Unfortunately, the trend of violence against young women discovered in this sub-Saharan nation is not unique.

Young girls in many African and Asian nations are also vulnerable to ambush and rape by HIV positive men who believe that having sex with a virgin will rid them of their infection—a myth called the Virgin Cure, which has been the root cause of a shocking upsurge in child, and even infant, rape during the past two decades.²⁴ In keeping with the paradigm of violence, Human Rights Watch recently determined that hundreds of young

girls in Zambia were being sexually assaulted by family members or guardians after being orphaned by AIDS.²⁵ Still other young girls are forced to engage in commercial sex work in exchange for goods, services, money, or other basic necessities—even to obtain an education.²⁶ Unfortunately, “poverty, teenage motherhood, family instability, male entitlement, [and] the perception of females as lesser beings all work in concert to create and perpetuate an environment where rape [and forced sex work] is viewed as a forgivable social evil that will always be with us rather than as a major wrong that needs to be stamped out.”²⁷ Even those young women who marry before they ever engage in sexual activity, forced or otherwise, often have no voice in choosing their marriage partner and no choice to use barrier methods as protection against HIV. Abstinence-specific education is ineffective in a world where women lack the freedom of choice to abstain.

In addition, HIV prevention programming focused on promoting the abstinence-only-until-marriage message inherently discriminates on the basis of sexual orientation. Both young people and adults who identify as gay, lesbian, bisexual, or transgender are unable to legally marry in most jurisdictions worldwide; of the fifteen countries receiving PEPFAR funding from HIV prevention, only South Africa recognizes same-sex marriages. Abstinence is simply not a practical solution for those individuals who are legally incapable of marriage. Furthermore, 5-10% of all new HIV infections worldwide occur among men who have sex with men, and in some regions of the world the rate of HIV infection due to sexual contact between men skyrockets to nearly 70%.²⁸ Considering this, as well as the fact that an estimated 6-10% of all adults are “exclusively homosexual” and between 13 and 37% have had some sort of homosexual experience bring them to orgasm,²⁹ it is clear that ignoring and marginalizing the GLBT population by exclusively promoting abstinence-only-until-marrying in worldwide HIV prevention education is

unwise and irresponsible.

The “Be Faithful” Strategy Fails to Acknowledge Gender Discrepancies

More and more, we're seeing the face of HIV is a woman who may be monogamous and may even be married, who's at risk for HIV because of her husband's behavior. If we're serious about saving lives, we need to face the realities and meet people with options that are realistic for their life circumstances.

—Helene Gayle, M.D. (Gates Foundation)

The “be faithful” message falsely assumes that marriage and monogamy inherently provide protection from HIV exposure. Unfortunately, in many countries even marriage does not insure sufficient security against HIV infection, particularly for women. Many areas of the world traditionally accept and even encourage men to have multiple partners outside of marriage or other monogamous relationships. Conversely, cultural norms implore women to abstain or be faithful. Additionally, in regions where HIV prevalence rates are high, common cultural practices often encourage girls to be married in their teens to much older men. Indeed, within the coming decade, “more than 100 million girls in developing countries will be married before their 18th birthdays.”³⁰ At this relatively early stage in their physical development, girls are especially at risk for sexually transmitted HIV infection. Expected to be virginal, pure, and entirely lacking in knowledge about sex and sexuality, young brides often enter into marriage with no understanding of the human immunodeficiency virus or how to prevent its transmission. Many women who are HIV positive, or at risk of becoming infected, practice no high-risk behaviors and are typically married or monogamous; according to UNAID, they are “vulnerable largely because of the behavior of others, through their limited autonomy and external factors, including social

and economic inequities beyond their control.”³¹ A deep commitment to fidelity with her new husband will not help a woman to stay safe from HIV infection if he is the one who infects her—not an unlikely possibility given that the husbands of married adolescents are typically older and more likely to be infected with HIV than the boyfriends of the average unmarried adolescent.³² The ABC model places a severe emphasis on marriage and fidelity, ignoring the fact that the ideals of feminism and women’s rights are not pervasive worldwide.

ABC’s Failure to Address Social Stigma Regarding AIDS

The continuing presence of stigma represents a failure in HIV policy-making and programme design....All HIV policies, programmes and services should address the impact of HIV stigma, and improving the attitude of health workers is particularly important to restoring the element of hope about AIDS.

—Nadine France (Director- Health & Development Networks)

The insistent promotion of abstinence and fidelity as the best methods of HIV prevention stigmatizes those infected with HIV as promiscuous and unfaithful. When HIV becomes associated with actions or behaviors that may be perceived by society as irresponsible and unacceptable, the infection itself becomes stigmatized and prevention efforts are inevitably thwarted. Fear that others may assume they are engaging in socially perceived immoral behaviors keeps people from being tested for HIV. Concern that they may become associated with HIV also keeps many friends and family members from caring for their loved ones who have been infected. Similarly, apprehension that their HIV status may be revealed keeps those who are infected from accessing HIV/AIDS related services. The heavy moral freight associated with the emphasized AB portions of the Bush

administration's HIV prevention policy only furthers these problems.

Even worse than its failure to address the stigma associated with being HIV positive, the ABC model, by disregarding condoms as a safe, effective, and accessible treatment option, ultimately stigmatizes and reduces the incidence of condom use. Because the ABC model has successfully associated condom use with immorality, it is common for many men and women to “feel shame about using—and often refuse to use—condoms”³³ with their sexual partners. Stigma thrives on misinformation and denial, and denigrating the efficacy and importance of condoms is an enormous barrier to HIV/AIDS prevention.

In Defense of Condoms as a Primary Means of HIV Prevention

We were told not to show [pupils] how to use condoms and not to talk about them at our school. In the past, we used to show them to our upper primary classes. Now we can't do that.

—A primary school teacher in Kasese, Uganda

This debate of condom or no condom makes me really angry because I know for a fact that my husband had HIV. I don't have HIV. If you ask me to put it on record what actually protected me from his infection, it was a condom.”

—Noerine Kaleeba, Uganda (Founder- The AIDS Support Organization)

Condoms, when distributed with informative material and in conjunction with additional education about the virus and transmission, are proven to considerably reduce the rate of HIV infection. HIV is transmitted sexually when the blood, semen, or vaginal secretions of an HIV positive partner infect the blood stream of another individual during oral, anal, or vaginal sexual activity. Condoms prevent the sexual transmission of HIV by providing a barrier that prohibits the direct exchange of fluid between partners. Laboratory

studies have indisputably concluded that latex condoms provide “an essentially impermeable barrier to particles the size of HIV pathogens.”³⁴ Polyurethane condoms, an alternative available for those with latex allergy, also offer an effective barrier against the virus.³⁵ In fact, the condom is the only technology currently available to prevent the sexual transmission of HIV to a noninfected partner.

The high efficacy of condoms in preventing the transmission of HIV is most unmistakably exemplified in studies of discordant couples—couples in which one partner is HIV positive and the other is not. A 1994 study of discordant European couples concluded that correct and consistent condom use was effective in preventing HIV transmission to the uninfected partner among all 123 participating couples. Conversely, among 122 discordant couples whose condom use was inconsistent, the incidence of HIV transmission was ten percent, and 12 partners became infected.³⁶ As this study reinforces, it is imperative that condoms be used both correctly and consistently in order to impart maximum protection. Still, epidemiologic studies demonstrate time and again that when the guidelines for proper condom use are followed, condoms are highly effective in preventing HIV infection.

While many proponents of the ABC approach argue that condom promotion and distribution encourages and increases adolescent sexual activity, scientific evidence irrefutably disputes this assertion. Innumerable studies conducted both domestically and internationally concerning the impact of sexuality education on sexual activity have found that educating youth about proper condom use does not increase the frequency of sexual activity or increase the number of sexual partners among young people who are having sex. Moreover, condom education does not lower the average age of first sexual experience. Five U.S. studies of sexual education programs found that those including

information on condoms “either had no effect upon the initiation of intercourse or resulted in delayed onset of intercourse.” Investigations conducted by the World Health Organization, the American Medical Association, the Institute of Medicine, and the Joint United Nations Programme on HIV/AIDS have all corroborated the conclusion that promoting condoms as a component of comprehensive sexual health education does not persuade teens to begin having sex.³⁷

In the Race Against AIDS, Where Do We Go from Here?

Since the onset of the AIDS epidemic twenty-five years ago, the global community has learned many lessons regarding its impact, its transmission, care and treatment for the infected, and the feasibility and effectiveness of various prevention methods. Despite these exciting intellectual strides forward, religion and politics seem to shroud the science-based lessons we’ve learned when it comes to HIV/AIDS policymaking. The ABC model, while perhaps theoretically sound, exemplifies failed HIV prevention policy, lost to the agenda of a conservative government and ignorant of many relevant cultural complexities of the developing world. It is of the utmost importance that the impetus for prevention campaigns be borne out of a true dedication to HIV prevention rather than the desire to advance particular religious ideologies or political agendas. In that light, we must abandon the failed ABC policy and progress towards a global HIV prevention strategy firmly grounded in science rather than ideology.

Moving forward, it is necessary that all HIV prevention efforts recognize and cater to the specific needs of individuals and individual cultures. HIV prevention efforts must be cognizant of the complexity of human sexual relations, including issues of culture, tradition, folklore, authority, and social rank. We must recognize underlying gender

discrepancies and discrimination that leads to unequal power relationships between men and women worldwide, and design prevention programming that specifically addresses these issues and provide women with realistic strategies for avoiding HIV infection. In addition to the heavy social marketing of condoms, HIV prevention funding and campaigns should promote the female/internal condom and microbicides—options for preventing the sexual transmission of HIV that give power to women and allow them to protect themselves without directly engaging their partners.

Future HIV prevention efforts should focus on the proven public health strategy of harm reduction. Harm reduction recognizes that some individuals always have engaged and always will engage in behaviors that are risky for the transmission of HIV. Rather than deny services to those individuals, or promote “all-or-nothing” behavior change, harm reduction endeavors to “meet individuals where they are at” and provide them with realistic strategies and options that are applicable to their lives. In particular, we must avoid imposing particular moral values on behavior, electing instead to empower individuals through choice.

Notes

1. "Uganda: A Complicated Success Story." *The Age of AIDS*. 30 May 2006. WGBH Educational Association, Public Broadcasting Service. 20 Dec. 2006
<<http://www.pbs.org/wgbh/pages/frontline/aids/countries/ug.html>>.
2. Ibid.
3. Loconte, Joseph. *The White House Initiative to Combat AIDS: Learning from Uganda*. Heritage Foundation. 2003. 6 Dec. 2006
<www.heritage.org/Research/Africa/BG1692.cfm>.

4. Sewankambo, N W. "Mortality Associated with HIV Infection in Rural Rakai District, Uganda." *AIDS* 14 (2000): 2391-400. 17 Dec. 2006
5. Sewankambo, N W. "Adolescents, Sexual Behavior and HIV-1 in Rural Rakai District, Uganda." *AIDS* 11 (1997): 791-799. 17 Dec. 2006
<<http://cat.inist.fr/?aModele=afficheN&cpsidt=2657127>>.
6. Ibid.
7. Ibid.
8. Kirungi, W.L., Musinguzi, J., Madraa, E., Mulumba, N., Callejja, T., et al. "Trends in Antenatal HIV Prevalence in Urban Uganda Associated with Uptake of Preventive Sexual Behaviour." *Sex Transm Infect.* 2006;82(Suppl 1):i36–i41. [PubMed]
9. "Success Stories in Developing Countries: Uganda HIV/AIDS." *Health: A Key to Prosperity*. WHO, UNICEF, UNAIDS, World Bank, UNESCO, UNFPA. 19 Dec. 2006
<<http://www.who.int/inf-new/aids2.htm>>.<http://www.who.int/inf-new/aids2.htm>>.
10. "Uganda: 'Abstinence-Only' Programs Hijack AIDS Success Story." *Human Rights News*. 30 Mar. 2005. Human Rights Watch. 12 Dec. 2006
<<http://hrw.org/english/docs/2005/03/30/uganda10380.htm>>.
11. "Success Stories in Developing Countries: Uganda HIV/AIDS." *Health: A Key to Prosperity*. WHO, UNICEF, UNAIDS, World Bank, UNESCO, UNFPA. 19 Dec. 2006
<<http://www.who.int/inf-new/aids2.htm>>.
12. Kyomuhendo, S., et al., "Uganda National Abstinence and Being Faithful Policy," pp. 1, 8-9; see also STD/AIDS Control Programme, Uganda Ministry of Health, "National Condom Policy and Strategy," June 2004.
13. *Focusing on Our Future: Prevention, Diagnosis, and Treatment of Pediatric HIV/AIDS*. Office of the U.S. Global AIDS Coordinator, U.S. Department of State. 2005.

27 Nov. 2006 <www.gao.gov/>.

14. Schleifer, Rebecca. "Ignorance Only: HIV/AIDS, Human Rights, and Federally Funded Abstinence-Only Programs in the United States." *Human Rights Watch* 14 (2002).

9 Dec. 2006.

15. "UNITED STATES: Ignorance Only: HIV/AIDS, Human Rights and Federally Funded Abstinence-Only Programs in the United States." *Human Rights Watch*. New York: Human Rights Watch, 2002. 20 Dec. 2006 <<http://hrw.org/reports/2002/usa0902/>>.

16. Verrilli, Adrienne. "Virginity Pledgers More Likely to Engage in Risky Sexual Behavior." Sexuality Information and Education Council of the United States. 2005. 20 Dec. 2006 <<http://www.siecus.org/media/press/press0094.html>>.

17. Hauser, Debra. "Leading Medical Association Rejects Abstinence-Only Policies— Programs at Odds with Medical Ethics and Basic Human Rights." *Advocates for Youth*. 2006. 20 Dec. 2006 <<http://www.advocatesforyouth.org/news/press/010506.htm>>.

18. "Abstinence-Only-Until-Marriage Programs." *Advocates for Youth*. 20 Dec. 2006. 20 Dec. 2006 <<http://www.advocatesforyouth.org/abstinenceonly.htm>>.

19. Henry J. Kaiser Family Foundation, et al., National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes and Experiences (2003).

20. Ibid.

21. Ibid.

22. "SOUTH AFRICA: Virginity Testing - Absence of a Small Tissue Becomes Big Issue." UN Office for the Coordination of Humanitarian Affairs. IRINnews.org, 2006. 10 Dec. 2006 <<http://www.irinnews.org/report.asp?ReportID=48969>>.

23. Andersson, Neil. "National Cross Sectional Study of Views on Sexual Violence and Risk of HIV Infection and AIDS among South African School Pupils." *British Medical*

Journal 329 (2004). 10 Dec. 2006

<<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=524107>>.

24. Earl-Taylor, Mike. "HIV/AIDS, the Stats, the Virgin Cure, and Infant Rape." *Science in Africa* Apr. 2002. 27 Nov. 2006 <www.scienceinafrica.co.za/2002/april/virgin.htm>.

25. Human Rights Watch. 2002. *Suffering in Silence: The Links Between Human Rights Abuses and HIV Transmission to Girls in Zambia*.

<<http://www.hrw.org/reports/2003/zambia/>>.

26. *How Does HIV/AIDS Affect Girls and Women?* unicef. 2006. 10 Dec. 2006

<http://www.unicef.org/aids/index_hivaids_girls_women.html>.

27. Mikkelson, Barbara. "Rape of Innocents." *Urban Legends Reference Pages*. 11 Dec.

2002. 6 Dec. 2006 <<http://www.snopes.com/inboxer/petition/babyrape.htm>>.

28. *AIDS and Men Who Have Sex with Men*. UNAIDS. UNAIDS, 1998. 20 Dec. 2006

<http://data.unaids.org/Publications/IRC-pub05/msmpv_en.pdf>.

29. "Prevalence of Homosexuality." *The Kinsey Institute*. June 1999. 20 Dec. 2006

<<http://www.kinseyinstitute.org/resources/bib-homoprev.html>>.

30. *Preventing HIV Infection in Girls and Young Women*. The Global Coalition on Women and AIDS. 11 Dec. 2006 <http://data.unaids.org/GCWA/GCWA_BG_prevention_en.pdf>.

31. "Women." *UNAIDS: Joint United Nations Programme on HIV/AIDS*. 26 Nov. 2006

<www.unaids.org/en/GetStarted/Women.asp>.

33. Sinding, Steven W. "Does 'CNN' (Condoms, Needles, Negotiation) Work Better Than 'ABC' (Abstinence, Being Faithful and Condom Use) in Attacking the AIDS Epidemic?"

International Family Planning Perspectives 31 (2005). 5 Dec. 2006

<<http://www.guttmacher.org/pubs/journals/3103805.html>>.

34. CDC. *Male Latex Condoms and Sexually Transmitted Diseases*. Atlanta, GA: CDC,

2002.

35. CDC. *Condoms and Their Use in Preventing HIV Infection and Other STDs*.

Atlanta, GA: CDC, 1999.

36. De Vincenzi, I. "A longitudinal study of human immunodeficiency virus transmission by heterosexual partners." *New England Journal of Medicine* 331(1994): 341-346.

37. Alford, Sue. "Myths and Facts about Sex Education and Condoms." *Advocates for Youth*. 6 Dec. 2006. 6 Dec. 2006

<<http://www.advocatesforyouth.org/PUBLICATIONS/iag/mythsfacts.htm>>.

Works Cited

"Abstinence-Only-Until-Marriage Programs." *Advocates for Youth*. 20 Dec. 2006. 20 Dec.

2006 <<http://www.advocatesforyouth.org/abstinenceonly.htm>>.

AIDS and Men Who Have Sex with Men. UNAIDS. UNAIDS, 1998. 20 Dec. 2006

<http://data.unaids.org/Publications/IRC-pub05/msmpv_en.pdf>.

Alford, Sue. "Myths and Facts About Sex Education and Condoms." *Advocates for Youth*.

6 Dec. 2006. 6 Dec. 2006

<<http://www.advocatesforyouth.org/PUBLICATIONS/iag/mythsfacts.htm>>.

Andersson, Neil. "National Cross Sectional Study of Views on Sexual Violence and Risk of HIV Infection and AIDS Among South African School Pupils." *British Medical*

Journal 329 (2004). 10 Dec. 2006

<<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=524107>>.

CDC. *Male Latex Condoms and Sexually Transmitted Diseases*. Atlanta, GA: CDC, 2002.

CDC. *Condoms and Their Use in Preventing HIV Infection and Other STDs*.

Atlanta, GA: CDC, 1999.

- De Vincenzi I. (1994) 'A longitudinal study of human immunodeficiency virus transmission by heterosexual partners', the *New England Journal of Medicine*; 331:341-346
- Earl-Taylor, Mike. "HIV/AIDS, the Stats, the Virgin Cure, and Infant Rape." *Science in Africa* Apr. 2002. 27 Nov. 2006
<http://www.scienceinafrica.co.za/2002/april/virgin.htm>
- Focusing on Our Future: Prevention, Diagnosis, and Treatment of Pediatric HIV/AIDS*. Office of the U.S. Global AIDS Coordinator, U.S. Department of State. 2005. 27 Nov. 2006 <www.gao.gov/>.
- Hauser, Debra. Leading Medical Association Rejects Abstinence-Only Policies— Programs At Odds with Medical Ethics and Basic Human Rights. *Advocates for Youth*. 2006. 20 Dec. 2006
 <<http://www.advocatesforyouth.org/news/press/010506.htm>>.
- Henry J. Kaiser Family Foundation, et al., National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes and Experiences (2003).
How Does HIV/AIDS Affect Girls and Women? unicef. 2006. 10 Dec. 2006
 <http://www.unicef.org/aids/index_hivaids_girls_women.html>.
- Human Rights Watch. 2002. Suffering in Silence: The Links Between Human Rights Abuses and HIV Transmission to Girls in Zambia.
www.hrw.org/reports/2003/zambia/.
- Kirungi WL, Musinguzi J, Madraa E, Mulumba N, Callejja T, et al. Trends in antenatal HIV prevalence in urban Uganda associated with uptake of preventive sexual behaviour. *Sex Transm Infect*. 2006;82(Suppl 1):i36–i41. [PubMed]
- Loconte, Joseph. *The White House Initiative to Combat AIDS: Learning From Uganda*.

Heritage Foundation. 2003. 6 Dec. 2006

<www.heritage.org/Research/Africa/BG1692.cfm>.

Mikkelson, Barbara. "Rape of Innocents." *Urban Legends Reference Pages*. 11 Dec. 2002.

6 Dec. 2006 <<http://www.snopes.com/inboxer/petition/babyrape.htm>>.

"Prevalence of Homosexuality." *The Kinsey Institute*. June 1999. 20 Dec. 2006

<<http://www.kinseyinstitute.org/resources/bib-homoprev.html>>.

"Preventing HIV Infection in Girls and Young Women." The Global Coalition on Women and AIDS. 11 Dec. 2006

<http://data.unaids.org/GCWA/GCWA_BG_prevention_en.pdf>.

S. Kyomuhendo et al., "Uganda National Abstinence and Being Faithful Policy," pp. 1, 8-9; see also, STD/AIDS Control Programme, Uganda Ministry of Health, "National Condom Policy and Strategy" June 2004

Schleifer, Rebecca. "Ignorance Only: HIV/AIDS, Human Rights, and Federally Funded Abstinence-Only Programs in the United States." *Human Rights Watch* 14 (2002).

9 Dec. 2006

Sewankambo, N W. "Adolescents, Sexual Behavior and HIV-1 in Rural Rakai District, Uganda." *AIDS* 11 (1997): 791-799. 17 Dec. 2006

<<http://cat.inist.fr/?aModele=afficheN&cpsidt=2657127>>.

Sewankambo, N W. "Mortality Associated with HIV Infection in Rural Rakai District, Uganda." *AIDS* 14 (2000): 2391-400. 17 Dec. 2006

Sinding, Steven W. "Does 'CNN' (Condoms, Needles, Negotiation) Work Better Than 'ABC' (Abstinence, Being Faithful and Condom Use) in Attacking the AIDS Epidemic?" *International Family Planning Perspectives* 31 (2005). 5 Dec. 2006

<<http://www.guttmacher.org/pubs/journals/3103805.html>>.

“SOUTH AFRICA: Virginty Testing - Absence of a Small Tissue Becomes Big Issue.”

UN Office for the Coordination of Humanitarian Affairs. IRINnews.org, 2006. 10

Dec. 2006 <http://www.irinnews.org/report.asp?ReportID=48969>

"Success Stories in Developing Countires: Uganda HIV/AIDS." *Health: a Key to*

Prosperity. WHO, UNICEF, UNAIDS, World Bank, UNESCO, UNFPA. 19 Dec.

2006 <<http://www.who.int/inf-new/aids2.htm>>.

Uganda: “ 'Abstinence-Only' Programs Hijack AIDS Success Story." *Human Rights News*.

30 Mar. 2005. Human Rights Watch. 12 Dec. 2006

<<http://hrw.org/english/docs/2005/03/30/uganda10380.htm>>.

"Uganda: a Complicated Success Story." *The Age of AIDS*. 30 May 2006. WGBH

Educational Association, Public Broadcasting Service. 20 Dec. 2006

<<http://www.pbs.org/wgbh/pages/frontline/aids/countries/ug.html>>.

“UNITED STATES Ignorance Only: HIV/AIDS, Human Rights and Federally Funded
Abstinence-Only Programs in the United States.” *Human Rights Watch*. New York:

Human Rights Watch, 2002. 20 Dec. 2006 <<http://hrw.org/reports/2002/usa0902/>>.

Verrilli, Adrienne. “Virginty Pledgers More Likely to Engage in Risky Sexual Behavior.”

Sexuality Information and Education Council of the United States. 2005. 20 Dec.

2006 <<http://www.siecus.org/media/press/press0094.html>>.

"Women." *UNAIDS: Joint United Nations Programme on HIV/AIDS*. 26 Nov. 2006

<www.unaids.org/en/GetStarted/Women.asp>.

[Contents](#)

[Occasions Home](#)

[PWR Home](#)