

Flexible But Comprehensive: Developing Country HIV Prevention Efforts Show Promise

By Susan A. Cohen

Slowing the spread of HIV in the developing world is hardly “as simple as ABC.” Still, “Abstinence,” “Be faithful” and “use Condoms” are the so-named key elements of an integrated behavior-change approach to HIV prevention that many countries are adopting—and one that the United States, at least for now, is promoting through its foreign aid program.

In the various settings in which the model is being adapted, emphasis on any particular component—A, which translates to efforts to delay sexual initiation among young people; B, which focuses on reducing the number of sexual partners; and C, which promotes safer sex practices and condom use among people who are sexually active—varies according to such factors as age-group, gender, marital status and the cultural traditions of the target populations. What is widely recognized as essential, though, in successfully implementing the model—especially among adolescents and young adults where HIV infection has been spreading most rapidly—is that the approach be not only flexible but also comprehensive.

There is no reason to believe that the U.S. Agency for International Development (USAID) is currently supporting ABC as anything other than a comprehensive program. However, given the domestic politics driving the Bush administration’s aggressive support for a program model in the United States that focuses exclusively on promoting abstinence outside of marriage and either ignores or actively denigrates contraception and condom use, advocates are questioning how long U.S.-supported ABC programs will be

allowed to function unfettered by these same political winds.

Origins and Impact

In the early years of the AIDS pandemic, USAID and most other major donors concentrated their prevention efforts on promoting condom access and condom use, interventions that fit with their traditional service models and were regarded as tangible and concrete. And, indeed, targeted condom-promotion programs, and correct and consistent condom use, have proved to be extremely effective. In Thailand, for example, condom promotion to female sex workers, and what is now virtually universal condom use among them, is widely considered to account for a significant proportion of the decline in HIV prevalence. Still, experts have increasingly acknowledged that condom-based efforts alone cannot halt the spread of HIV, and certainly not the heterosexual, general-population epidemics that characterize Sub-Saharan Africa, for example. As a result, the search for additional interventions has led to a greater emphasis by USAID and other donors over the years on encouraging delayed sexual debut and fewer sexual partners.

In testimony to Congress earlier this year, USAID’s assistant administrator for global health, Anne Peterson, explained the current U.S. “multi-pronged” approach in terms of two basic principles of HIV/AIDS prevention. The first aim, she said, is to “reduce the frequency of risky acts,” which includes delay of sexual debut and partner reduction; the second is “to decrease the efficiency of HIV transmission—by treating sexually

transmitted infections and using condoms.” Peterson noted that “all of these interventions require behavior change by individuals, communities and societies.”

In fact, the comprehensive, behavior-change approach to primary HIV prevention—dubbed ABC by the former Global Program on AIDS, now UNAIDS—was first developed in Uganda a little over a decade ago. And while ABC-based programs have since been implemented in many countries, it is the program in Uganda that once again is attracting worldwide attention. Uganda experienced significantly reduced HIV prevalence rates during the 1990s, and while there is debate over the actual extent of the decline, there is also widespread excitement over the idea that Uganda somehow found a way to dramatically slow the spread of HIV.

Not surprisingly, scientific and policy experts around the world are scrutinizing the data in hopes of understanding what has worked so well and whether that formula can be replicated elsewhere. Also not surprisingly, perhaps, U.S.-based “profamily” and “abstinence-only” advocates have seized on the Uganda success story, claiming that it was an increase in abstinence that accounted for the turnaround in HIV rates. These advocates were buoyed earlier this year by an article in *The New Republic* in which author Arthur Allen wrote, “Uganda’s experience suggests that abstinence and fidelity may be the keys to whipping AIDS in Africa.” In “Sex Change: Uganda vs. Condoms,” Allen asserted further that “condoms had relatively little to do with it.”

An analysis of national-level survey data by The Alan Guttmacher Institute, however, concludes that delays in sexual debut, a reduction in the number of sexual partners and increases in condom use all played a part but that, if anything, increased abstinence by itself may

Uganda Slashes HIV Rates: A Matter of A, B and C

In August 2002, The Alan Guttmacher Institute (AGI) reviewed available research to assess the relative contributions of sexual abstinence, multiple-partner reduction and condom use in reducing HIV prevalence rates in Uganda.* While noting that “several studies have documented the levels and trends in abstinence, behavior change and condom use for particular geographic areas and population groups,” this report analyzed data from nationally representative Demographic and Health Surveys of reproductive-age women conducted in 1988, 1995 and 2000, and of men, in 1995 and 2000, because “they provide evidence on key factors for the country as a whole, and may therefore more appropriately be applied to understanding changes in the national rates of HIV prevalence and incidence than would studies of particular areas of the country.”

Abstinence. Young women aged 15–17 were less likely to have ever been sexually active in 2000 than in 1988 (34% vs. 50%); among 18–19-year-olds, the proportion dropped from 81% to 77%. Among men, a decline occurred only among 18–19-year-olds; 59% were sexually active in 2000 compared with 71% in 1995. Somewhat countering these developments, however, the proportion of sexually active 15–17-year-old females who were unmarried was higher in 2000 (59%) than in 1988 (46%). As a result, young adolescent women were less exposed to infection within marriage, but an increased proportion were exposed while unmarried. Between 1988 and 2000, the proportion of sexually experienced young women 15–17 who said they were currently in a sexual relationship declined from 72% to 67%; among those 18–19, the proportion remained steady at 80%. However, a greater proportion of sexually experienced young men reported that they were in a sexual relationship in 2000 than did so in 1995 (44% vs. 34% among 15–17-year-olds, and 67% vs. 56% among 18–19-year-olds). Conclusion: “Delay in initiation of sexual activity is a moderately important contributing factor to reduction in the risk of HIV infection. Abstinence among those who have ever been sex-

ually active is not a significant factor.”

Multiple-Partner Declines. The proportion of unmarried sexually active women who said they had more than one sexual partner within the past year declined among all age-groups between 1995 and 2000, the years for which data are available; overall, the proportion decreased from 10% to 4%. Only 4% of young married women (15–17 years old) reported multiple sexual partners in 2000, compared with 9% in 1995. There was virtually no change for men overall (the proportion was stable at about 14%), but among unmarried men 18–19, the proportion decreased from 32% to 28%. Conclusion: “Increased monogamy, especially among unmarried women, is a significant contributing factor for the period 1995–2000.”

Condom Use. Condom use among unmarried women, for preventing either pregnancy or sexually transmitted diseases (STDs), rose substantially—for pregnancy prevention, from negligible levels in 1988 to 24% by 2000, and for STD prevention, from 7% in 1995 (the first year for which data are available) to 13% in 2000. Among unmarried men also, condom use rose significantly, from 39% in 1995 to 57% in 2000. Condom use remained negligible among married men and women. Conclusion: “Increased use of the condom among the unmarried sexually active population, both men and women, is a significant contributing factor.”

While the AGI report acknowledges that available data are insufficient to provide “a precise assessment or ranking of the relative importance of each of the different factors,” the analysis demonstrates that progress on all three fronts clearly contributed to reduced exposure to HIV—although reductions in the number of sexual partners and increased condom use may be playing a more significant role in reducing HIV risk than sexual abstinence by itself.

*Singh S, Darroch JE and Bankole A, *The role of behavior change in the decline in HIV prevalence in Uganda, memo to interested parties, The Alan Guttmacher Institute, New York, October 15, 2002.*

have made the smallest contribution to lowering the risk of HIV in Uganda; notably, condom use and the reduction in the number of casual sexual partners both increased substantially more than did the proportion of young people abstaining from sex (see box). Moreover, even with regard solely to the observed increase in abstinence over the period, it is worth remembering that to whatever extent the government’s ABC-based program

was responsible (among the myriad other societal factors at play), that program employed a comprehensive, not an abstinence-only, approach.

A World of Differences

USAID’s Peterson endorses an approach that “promotes abstinence, fidelity as well as condom use,” as one that seeks “common ground among diverse political, religious, public health, and other constituen-

cies [to] facilitate a more concerted and unified prevention effort.” Indeed, USAID’s current indicators for monitoring and evaluating HIV prevention programs include median age of sexual debut among a given population, percentage of people reporting nonregular partners and condom use with nonregular partners.

Still, reproductive health and HIV advocates are looking to the future
(Continued on page 14)

HIV

Continued from page 2

with caution. In August, the Department of Health and Human Services (DHHS) led a team to Uganda, the sole stated purpose of which was “to better understand the role of abstinence education in the battle against HIV/AIDS.” DHHS is an agency where social conservatives hold sway and where the domestic programs that promote abstinence until marriage and exclude medically accurate information on the benefits of risk reduction strategies are housed. This year, DHHS gained new authority to begin operating HIV prevention and treatment programs in developing countries. Meanwhile, USAID, along with DHHS, is more overtly than ever before recruiting so-called faith-based organizations as partners, and an internal USAID working group is in the process of documenting the extent to which USAID promotes abstinence in the field.

One thing should be clear, however. Neither Uganda’s experience nor current research from the United States on the efficacy of abstinence-only versus comprehensive sex education programs reasonably can be used to justify a single-focus, absti-

nence-only approach to HIV prevention—either in the United States or for overseas export (“Abstinence Promotion and Teen Family Planning: The Misguided Drive for Equal Funding, *TGR*, February 2002, page 1). Furthermore, even the terms of the U.S. debate may be inapt in other country cultures. For example, Elizabeth Serlemitsos, chief of party for the communication component of Zambia’s Integrated Health Programme, explains that “abstinence” simply means “delay” in her country—not until marriage but “maybe just until tomorrow.” Even among adults, the notion of marital fidelity may not always translate; in many countries, for example, extramarital sexual relationships are common and tolerated for many different reasons.

Leaders of the “profamily” movement, apparently undeterred by such complexities, seem eager to reduce the debate to one that fits their ideological agenda. Promoting nonmarital chastity earlier this year while touting the Uganda story as he wished to see it, Family Research Council President Kenneth L. Connor opined that “responsible moral behavior is the first and best line of defense against AIDS, and is the *only* message we should send young people worldwide” (emphasis added).

In September, Human Rights Watch called such an approach “ignorance only” in a report of the same name examining how abstinence-only programs are operating in Texas. “Taking such a dubious, even harmful, proposition to developing countries where so many young people’s lives literally are at stake would be incomprehensible and immoral,” says Nils Dauilaire, president of the Global Health Council.

But in describing the ABC-based program targeting 10–19-year-olds in Jamaica—a group that includes very young as well as older adolescents, those married and those unmarried, and those sexually active and those not—Pauline Russell-Brown, chief of party for the Jamaican Adolescent Reproductive Health Project, may have said it best: “The religious leaders unequivocally advocate for abstinence,” she explains “but they also understand the reality that here in Jamaica, for many, there may be a gap of several years between when an adolescent initiates having sex and when he or she enters a stable union. With the likelihood that these young people may have had several different sexual partners during that interim time, the religious leaders understand they have to talk also about safer sexual practices.” ☉



October 2002

120 Wall Street, 21st floor
New York, NY 10005

ADDRESS SERVICE REQUESTED

PRSR
First Class
U.S. Postage
PAID
Binghamton, NY
PERMIT No. 588