

U.S. Global AIDS Policy and Sexually Active Youth: A High-Risk Strategy

By Susan A. Cohen

The strategy for preventing the sexual transmission of HIV/AIDS under the President's Emergency Plan for AIDS Relief (PEPFAR) is designed around a population-specific approach. High-risk groups are defined to include commercial sex workers and their clients, intravenous drug users, mobile male populations, sexually active couples in which one partner is HIV-positive or in which one or both partners' HIV-status is unknown, men who have sex with men and sexually active people living with HIV/AIDS. The priority interventions for individuals in these high-risk groups are comprehensive prevention messages, including the provision of condoms.

By implication, the remainder of the general population is not at high risk, including the large numbers of people who are sexually active, young and unmarried and living in countries with high HIV prevalence. Under PEPFAR, these individuals are to receive a narrower range of interventions. PEPFAR's primary message designated for youth and unmarried people is the promotion of abstinence until marriage. In recognition of the fact that some young people will engage in sex before marriage, PEPFAR's answer is that sexually

active youth should be encouraged to achieve "secondary abstinence," to become abstinent again.

Buried in the fine print, U.S. policy under PEPFAR does allow for the provision of condoms and information about condom use under certain circumstances, coupled with the message that only abstinence can provide 100% protection against HIV. Yet, that message may not be translating overseas. Reports from the field indicate that many believe that the United States only will support programs that exclude or deemphasize information about condom use even for unmarried young people who are already sexually active. To the extent that this perception takes hold, PEPFAR's approach to preventing the sexual transmission of HIV/AIDS itself becomes a high-risk strategy.

Youth and Risk

Today's youth represent the largest generation in history. In Sub-Saharan Africa, where 12 of PEPFAR's 15 focus countries are located,* 44% of the population is under age 15—more than twice the proportion in the United States. And the fact that so many young people are living and beginning to make the transition to adulthood in settings with high HIV prevalence is a formula for disaster, one that is already playing out in many African countries. Seven percent of 15–24-year-olds in Sub-Saharan Africa are already living with HIV/AIDS; indeed, this age-group accounts for half of all new cases of HIV infection worldwide. In large part, this is because so many

are sexually active, although not always by choice. More than half of unmarried 15–19-year-old men are already sexually experienced in many of the focus countries. Also, among unmarried 15–19-year-old women, substantial minorities are sexually experienced. At the same time, HIV prevalence rates for the general population in the African focus countries range from 4% in Uganda to 37% in Botswana (see table).

Despite widespread awareness about HIV/AIDS, fewer than half of older teenagers in selected Sub-Saharan African countries cite any of the A (abstain), B (be faithful) or C (use condoms) behaviors as a means of protecting themselves against the risk of infection, according to a recent analysis by the Guttmacher Institute. And according to that 2004 report, *Risk and Protection: Youth and HIV/AIDS in Sub-Saharan Africa*, adolescents and young adults who are sexually active are at even greater risk than adults of HIV exposure, partly because of this lack of knowledge. They are apt to change partners frequently or engage in simultaneous sexual relationships, and too few use condoms or use them correctly and consistently. In addition, numerous other social and physiological factors contribute to young people's increased vulnerability to HIV, which is compounded by the fact, as the report notes, that in the few places "where reproductive health care for adolescents is available, many young people do not know where to obtain it or are unable to pay for it."

What the United States Says

In January 2005, the administration issued its *Guidance to United States Government In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infection Within the President's Emergency*

*PEPFAR targets assistance to 15 countries where the HIV prevalence rate for the general population exceeds 1%: Botswana, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia in Sub-Saharan Africa; Guyana and Haiti in the Caribbean; and Vietnam in South Asia. Together, these countries account for half of all HIV infections worldwide.

**SEXUALLY ACTIVE YOUTH: AT HIGH RISK OF HIV
AND UNINTENDED PREGNANCY**

U.S. HIV/AIDS FOCUS COUNTRIES IN SUB-SAHARAN AFRICA	HIV RATE, AMONG 15–49- YEAR-OLDS, 2003 (%)	SEXUALLY EXPERIENCED UNMARRIED 15–19-YEAR-OLDS (%)		PREMARITAL BIRTHS BY AGE 20, AMONG 20–24-YEAR-OLDS (%)
		WOMEN	MEN	
BOTSWANA	37.3	NA	NA	NA
CÔTE D’IVOIRE	7.0	53	55	24.2
ETHIOPIA	4.4	10	14	0.9
KENYA	6.7	33	53	20.0
MOZAMBIQUE	12.2	44	65	13.5
NAMIBIA	21.3	NA	NA	30.4
NIGERIA	5.4	22	25	5.8
RWANDA	5.1	7	20	3.8
SOUTH AFRICA	21.5	43	NA	32.5
TANZANIA	8.8	37	56	15.7
UGANDA	4.1	33	34	13.6
ZAMBIA	16.5	44	63	17.8

Note: na=not available. *Sources:* HIV rates—UNAIDS, *2004 Report on the Global AIDS Epidemic*, Geneva: UNAIDS, 2004. Sexual experience data—The Alan Guttmacher Institute (AGI), *Risk and Protection: Youth and HIV/AIDS in Sub-Saharan Africa*, New York: AGI, 2004. Premarital birth data—National Research Council and Institute of Medicine, *Growing Up Global: The Changing Transition to Adulthood in Developing Countries*, Panel on Transitions to Adulthood in Developing Countries, Cynthia B. Lloyd, ed., Washington, DC: National Academies Press, 2005.

Plan for AIDS Relief. This policy document specifies that individuals whom the United States considers to be in high-risk groups should receive a range of information and services to help them eliminate their risk entirely, if possible, or reduce their risk by promoting correct and consistent condom use, providing greater access to condoms and increasing access to HIV counseling and testing and to screening and treatment for sexually transmitted infections (STIs).

Young people aged 10–24, meanwhile, fall at the other end of the spectrum. PEPFAR programs for younger adolescents (those under age 15) are to promote self-worth, enhance skills for practicing abstinence and stress the importance of delaying sexual debut until marriage. U.S. programs aimed at older adolescents and young adults (through age 24) should emphasize the same messages, but may include information about the effectiveness of condoms “as a way to significantly reduce—but not eliminate” the risk of HIV.

Thus, PEPFAR theoretically allows for the possibility that the United

States will fund programs that provide some older teenagers and young adults with information about condoms. Any information about condoms must be accompanied by abstinence-promotion messages, however, for those who are not yet sexually active. For that substantial subgroup of youth who, as the guidance acknowledges, “either by choice or coercion, engage in sexual activity,” U.S. prevention programs must emphasize “returning to abstinence” as the primary message. The guidance cautions, “Implementing partners must take great care not to give a conflicting message with regard to abstinence by confusing abstinence messages with condom marketing campaigns that appear to encourage sexual activity or appear to present abstinence and condom use as equally viable, alternative choices.”

The United States will not fund the dissemination of condoms to sexually active youth through any programs that are school-based or that include any school-based marketing component. PEPFAR will not fund condom marketing campaigns that target youth generally or “encourage

condom use as the primary intervention for HIV prevention.” The United States will fund “integrated ABC programs that include condom provision in out-of-school programs for youth identified as engaging in or at high risk for engaging in risky sexual behaviors.”

What the World Hears

All the qualifiers and caveats the United States is communicating to the field are, at best, resulting in confusion about exactly what kind of information young people are entitled to hear to protect themselves and their partners from HIV. Reports from the field indicate that this confusion is undermining programming on the ground and, by extension, the ability of individuals—especially youth—to protect themselves and their partners. “They want us to do capital A, capital B, little c,” even though “we see condoms as an essential part of the array,” said an official at a nongovernmental organization in Mozambique who wished to remain anonymous, as reported in a *Slate.com* article in May. “I didn’t even put condoms in my [U.S.] budget,” commented the spokesman for

Project HOPE in Mozambique, reflecting the chilling effect that the U.S. policy is having on designing programs for youth.

Human Rights Watch (HRW) researcher Jonathan Cohen, author of the March 2005 report, *The Less They Know the Better: Abstinence-only HIV/AIDS Programs in Uganda*, commented to *Salon.com* in June that “groups know the more they talk about abstinence, the more they’ll get U.S. funding. And they fear that if they talk about condoms, they’ll lose funding.” And ultimately, it is the young people themselves who pay the price. As Cohen’s HRW report notes, “Providers of youth-friendly services added that judgmental attitudes toward premarital sex dissuaded young people, especially girls, from seeking health services and information. Abstinence-only messages, linking pre-marital sex with immorality, are only likely to make things worse. ‘The girls are involved in sex when they are young, so when they go to health centers they get judged a lot,’ said [a Ugandan] social worker.... ‘So they don’t go, and it’s easier for men to deceive them because they lack information.’”

Gill Gordon, a health promotion expert working with a large international HIV/AIDS nongovernmental organization, expressed her personal frustration along similar lines. The top-line U.S. message that condoms are not 100% effective is coming across to young people as “condoms don’t work sufficiently well to make them worth using,” she wrote in a personal communication. Gordon added that the U.S. emphasis essentially on reserving condoms for high-risk groups, as the United States narrowly defines them, is having the effect of stigmatizing those young people who are sexually active and trying to reduce the risk to them-

selves and their partners. She points out that one of the obstacles to obtaining correct and consistent condom use is that people commonly stop using condoms—if they used them at all—as a way of demonstrating their trust in and commitment to their partner. “By targeting condoms to particular groups, the message is going out that they are not for ‘ordinary’ (loving, moral) people who want to protect themselves or each other or plan their family. We have been working to make condoms morality-neutral for 10 years and had succeeded well. The new climate is negating all this work.”

A Crossroads

A panel of experts engaged in a three-year project convened under the auspices of the National Academy of Sciences (NAS) summarizes the situation facing young people today in the 2005 publication, *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*: “In much of the developing world, adolescence is a stage of life that is gaining in significance. In the past, young men and women tended to move directly from childhood to adult roles. But today, the interval between childhood and the assumption of adult roles is lengthening.” This is partly attributable to the fact that compared with 20 years ago, young people—women in particular—are more likely to delay marriage and childbearing. Spending a longer period of time unmarried, however, has meant an increased likelihood of premarital sexual activity, which is reflected in the significant amount of childbearing that now occurs before marriage (see table, previous page, and “Delayed Marriage and Abstinence Until Marriage: On a Collision Course?” *TGR*, June 2004, page 1).

The NAS report concludes that the sheer size of the youth cohort com-

bined with these new facts of their lives suggest an even greater “need for education, as well as for reproductive and other health services” to enable young people to “acquire the information and skills necessary to become effective participants in decisions about their own lives and futures.”

On some occasions and in some forums, U.S. officials do “talk the talk.” At last summer’s International AIDS Conference in Bangkok, for example, U.S. Global AIDS Coordinator Randall Tobias asserted that “Abstinence works, being faithful works, condoms work. Each has its place.” But there is no clearly articulated place in the U.S. global AIDS strategy for honestly and openly addressing the needs of the increasing numbers of sexually active youth. Given that the administration’s approach is to deem high-risk groups as representing those mostly on the fringes of mainstream society, it may not make sense to add sexually active youth to this list. At the same time, implying that they are not at high risk of exposure to HIV, especially in PEPFAR focus countries, is at odds with reality. Moreover, the refusal to admit that they are in need of more, not less, information and services not only increases their risk of contracting this deadly disease, but increases their risk of other STIs and unintended pregnancy as well. ☹

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