

**A Primer on the
ABC Approach to HIV Prevention**

**Common Questions and Answers
about the ABC Approach to HIV Prevention**

DRAFT

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for International Health



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Conflict of Interest Statement

Dr. Green is on leave from the Harvard School of Public Health. Ms. Herling is employed by Medical Service Corporation International (MSCI). Neither author works for an institution or organization that presents a conflict of interest *vis-a-vis* the subject matter of this publication. Harvard University and MSCI believe in health promotion and scientific research, and support the use of contraceptives for family planning and disease prevention.

Comments and Suggestions

This document is a draft which will receive further peer review before final publication and dissemination. The authors and the CCIH HIV Prevention and Health Behavior Working Group invite your comments, criticisms, and suggestions. You may contact Dr. Green at egreendc@aol.com, and Ms. Herling at aherling@msconline.com. You may contact the CCIH HIV and Health Behavior Working Group at ccih@ccih.org. You may also send comments by mail to Christian Connections for International Health (1817 Rupert St., McLean, Virginia, 22101, USA), or to Medical Service Corporation International (1716 Wilson Blvd., Arlington, VA, 22209, USA).

Abbreviations and Acronyms

ABC	Abstain, Be faithful, or use Condoms
ANC	Antenatal Clinics
ARV	Antiretroviral (drugs)
CSW	Commercial Sex Worker
CCIH	Christian Connections for International Health
DHS	Demographic and Health Surveys
FBO	Faith-Based Organization
OGAC	Office of the United States Global AIDS Coordinator for AIDS Relief
MSCI	Medical Service Corporation International
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	Person Living with HIV/AIDS
PVO	Private, Voluntary Organization
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	US Agency for International Development
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Introduction

The ABC approach to HIV prevention has gained prominence and garnered controversy in recent years, as it has become the policy of the largest AIDS relief plan in the history of the pandemic. In January 2003, the United States pledged \$15 billion to global AIDS under the President's Emergency Plan for AIDS Relief (PEPFAR). In December 2002, the United States Agency for International Development (USAID) had adopted the ABC approach as the model of HIV prevention for generalized epidemics, using Uganda's success as a model. PEPFAR also adopted the ABC approach, and the first PEPFAR strategy document to be released called risk elimination a "cornerstone" of PEPFAR.¹ Risk elimination, also called risk avoidance, refers to sexual abstinence and to mutual fidelity between two uninfected sex partners. The Office of the Global AIDS Coordinator (OGAC) later released further guidance on the ABC approach.² While this guidance has clarified the prevention approach to be followed by programs, considerable confusion and controversy remain. The evidence for and appropriate application of the ABC approach to HIV prevention remain widely misinterpreted and misunderstood.

Christian Connections for International Health (CCIH) and Medical Service Corporation International (MSCI) have recognized a need for a document that explains the ABC approach to HIV prevention, clearly presents the evidence for such an approach, and responds to common critiques with empirical evidence. It is not the intention of CCIH, MSCI, or the authors of this document to be provocative or polemical, although criticisms will be addressed and answered. Our position reflects that of PEPFAR, USAID, and the "Consensus Statement" published in the medical journal *The Lancet* on December 1, 2004 and endorsed by over 150 public health experts and the president of Uganda.³ Stated simply, this position is that all three components of the ABC approach are necessary, and that the application of this approach will vary according to the target groups.

The summary section of this document contains a list of questions and short answers. This summary section is followed by a list of the same questions, with more in-depth answers. The short answers are intended for the reader who wants a quick overview of issues surrounding the ABC approach. For those who want a more in-depth understanding, the full answers provide a more thorough explanation, including relevant research and data.

We hope that all readers will gain a greater understanding of the ABC approach through this document, and that the power of this approach to sharply reduce the sexual transmission of HIV/AIDS will be clearly understood.

¹ Office of the United States Global Aids Coordinator for AIDS Relief. *The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy*. Washington, DC: Feb. 2004

² Office of the United States Global AIDS Coordinator for AIDS Relief. *ABC Guidance For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief*. Washington, DC: March 2005.

³ Halperin DT, Steiner MJ, Cassell MM, et al. The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV. *The Lancet* 2004; 364: 1913-1915.

Summary of Common Questions and Answers about the ABC Approach to HIV Prevention

What is the ABC Approach to HIV prevention? (p. 5)

“A” stands for Abstaining from sex or delay of sexual debut, “B” stands for Being faithful (fidelity) or reducing number of sexual partners, and “C” stands for correct and consistent use of Condoms. Advocates of the ABC approach often use the term to mean a primary emphasis on abstinence (or delay of sexual debut) and faithfulness (or partner reduction), with condom use being a secondary but necessary strategy for those who do not or cannot practice abstinence or fidelity.

What evidence is there for the ABC approach? (p. 5)

An ABC approach has been shown to be effective in generalized epidemics—that is, epidemics in which most infections are found in the general population, rather than limited to high-risk groups such as intravenous (IV) drug users or commercial sex workers. Uganda provides the clearest case study of a successful ABC approach. HIV prevalence peaked in Uganda at 15 percent in 1991, and decreased to 5 percent by 2001. During this period, abstinence increased among youth and condom use increased somewhat. Most critically, B behaviors (fidelity and reduction in number of sexual partners) increased dramatically. Other countries in which an ABC approach has led to a reduction in HIV prevalence include Senegal, Jamaica, Thailand, Zambia, the Dominican Republic, and most recently Kenya and Zimbabwe.

Aren't all parts of the ABC approach important? Why do proponents of the ABC approach often emphasize abstinence and fidelity, and not consider condom use an equally valid choice? (p. 7)

According to a 2004 statement published in *The Lancet* and endorsed by over one hundred public health experts, all the elements of the ABC approach are necessary, “although the emphasis placed on individual elements needs to vary according to the target population.”⁴ For youth, the first priority should be to encourage abstinence or delay of sexual debut. For adults, the first priority should be to promote mutual fidelity with an uninfected partner. Finally, for people at high risk of exposure to HIV, the first priority should be to promote consistent condom use.

Are condoms effective against HIV/AIDS? (p. 8)

Condoms are estimated to be between 80 percent and 90 percent effective against HIV when used consistently and correctly—that is, to reduce HIV transmission by 80 percent to 90 percent compared to non-use. Promotion of condoms alone has not been shown to be an effective strategy to lower infection rates in generalized epidemics, such as those found in Africa. Condoms have been shown to reduce HIV prevalence in concentrated epidemics, as in Thailand and Cambodia, and among high risk groups. Moreover, inconsistent condom use is the norm rather than the exception.

Should condoms be promoted only to high-risk populations such as sex workers and truck drivers? Doesn't everyone need condoms? (p. 11)

Condoms can be promoted to anyone and everyone, yet many years of experience provides persuasive evidence that only those in high-risk groups are likely to use them consistently. Furthermore, mounting evidence suggests that inconsistent condom use does not protect people, possibly because risk compensation or disinhibition⁵ may be causing condom users to take greater risks in their sexual behavior.

⁴ Halperin, Steiner et al., 2004.

⁵ Risk compensation and disinhibition refer to the tendency for a perception of reduced risk to make risk-taking more attractive. People adjust their behavior in response to the increased sense of personal safety that comes with protective behaviors such as wearing a seatbelt or using a condom.

Guidance from the US Office of the Global AIDS Coordinator (OGAC) suggests that condom promotion be targeted to high-risk groups, following Uganda's successful approach during the 1990s. This is for the simple fact that such groups are more likely to use condoms. Targeting programs (and funds) to where they have a good chance of having impact should be a matter of common sense.

Does providing information about condoms lead to earlier or increased sexual activity among youth? (p. 13)

Studies from developed countries as well as developing countries have found that providing information about condoms in sex and HIV education programs that primarily emphasize abstinence does not lead to earlier or more frequent sexual activity.⁶ Such sex education programs can in fact delay sex and increase abstinence (as well as lead to greater condom use among sexually active youth). Demographic and Health Survey (DHS) data show that the majority of adults in sub-Saharan Africa think that youth should be taught about the use of condoms to prevent HIV/AIDS.

Does the ABC approach demand an unrealistic standard of behavior? (p. 14)

Many factors can limit or take away a person's ability to practice abstinence, faithfulness, or consistent condom use. These factors include poverty, illiteracy, instability and displacement, and gender inequalities. Yet data show that more than half of African youth aged 15 to 19 abstained from premarital sex last year, and the great majority of sexually active adults were faithful, meaning that they did not report more than one sex partner in the last year. Not only are most Africans practicing A and B behaviors, but more than 93 percent of Africans aged 15 to 49 are *not* HIV infected. According to UNAIDS, Sub-Saharan Africa now has an average HIV prevalence rate of 7.2 percent, down from 7.3 percent in 2004 and 7.5 percent in 2003.⁷ Furthermore, some of the strongest evidence for effectiveness of an ABC approach comes from situations in which there were high levels of poverty, illiteracy, and instability, such as Uganda during the late 1980s and early 1990s.

Is the ABC approach unrealistic for women? (p. 17)

It is a tragic fact that women who have practiced premarital abstinence and marital fidelity have become infected by unfaithful partners. Some women and girls may be in situations where sex is coerced by various circumstances, such as poverty or a difficult marriage. While many women do not have the power to practice abstinence or use condoms, data show that many women in Africa do have this power. For instance, the majority of women in Africa—ranging from 71 percent of women in Zimbabwe to 87 percent of women in Rwanda—report that they can refuse sex with their husbands for reasons such as knowing that he has a sexually transmitted infection (STI). Along with its ABC approach, Uganda gave women gained increased access to education, economic opportunities, and legal protection. The ABC approach must go hand in hand with empowering women and improving cross-gender communication.

Do the ABCs consider local realities such as gender and social inequalities, poverty, and cultural impediments to behavior change? (p. 18)

The ABC approach focuses on what an individual can do to change (or maintain) behavior, and thereby avoid or reduce risk of infection. It is recognized that not all individuals have control over their sexual behavior. In countries such as Uganda where an ABC approach has been successful, broader goals such as empowering women, increasing access to education, and decreasing poverty, were also pursued. Yet these

⁶ Kirby D, Laris BA, Roller L. *Impact of Sex and HIV Curriculum-Based Education Programs in Schools and Communities on Sexual Behaviors of Youth. Youth Research Working Paper No. 2.* Arlington, VA: FHI/YouthNet, 2005.

⁷ UNAIDS. *AIDS Epidemic Update 2005.* Geneva: UNAIDS, 2005. Available at <http://www.unaids.org/Epi2005/doc/report.html> (accessed 3 Jan 2006).

broader societal and structural goals may not be achievable in the short or even medium-term. In Uganda, HIV prevention was successful even though these broader goals had not been fully met. As changing structural inequalities are usually outside one individual's control, the ABC approach focuses on what an individual can change and control, in the short-term.

Is the ABC approach overly simplistic? Do we need, instead, an “A to Z” approach? (p. 20)

Some argue that the ABC approach is overly simplistic, and that we need to go “beyond ABC” to an approach that includes other interventions such as voluntary counseling and testing (VCT), treatment, destigmatization, reducing poverty, increasing political openness, and improving the status of women. Each of these interventions is important for its own sake and may promote an environment that encourages changes in sexual behavior. Yet they do not in themselves prevent the sexual transmission of HIV. Data show that expanding access to voluntary counseling and testing do not necessarily reduce HIV prevalence in a population.⁸ In some countries HIV prevalence rises—rather than falls—with income level.⁹ We might find political leadership, open discussion of HIV/AIDS, or other factors conducive to fighting AIDS, yet no decline in HIV transmission within a country. The only way to directly influence HIV transmission is through changes in sexual behavior.

Does the ABC approach contribute to stigmatization and marginalization of People Living with HIV/AIDS (PLWHAs)? (p. 21)

In the face of the HIV/AIDS crisis, advocates of an ABC approach do not feel that it is necessarily stigmatizing to promote abstinence, faithfulness, and/or condom use as health-inducing behaviors. To object to the promotion of abstinence and faithfulness because some will not or cannot abstain or be faithful, denies the fact that many—including most Africans—do practice A and B behaviors. .

Has PEPFAR imposed the ABC approach on people in the developing world? (p. 22)

The President's Emergency Plan for AIDS Relief has adopted an ABC approach for generalized HIV/AIDS epidemics, following the Ugandan model of a balanced ABC approach that was successful in reducing HIV prevalence. Uganda's response to HIV/AIDS—the ABC approach—was an indigenous response to the threat of HIV/AIDS and was not an American invention.

Has the PEPFAR's emphasis on an ABC approach led to condom shortages in Uganda and elsewhere? (p. 22)

It has been alleged that Uganda is discontinuing condoms in favor of an “abstinence-only” strategy. A recent condom supply problem has further fueled allegations that Uganda is experiencing a severe shortage of condoms. Ugandan officials have responded by saying that Uganda continues to promote all three components of the ABC approach, and that Uganda has sufficient stocks of condoms.

Should information about condoms be part of PEPFAR-funded programs promoting abstinence and faithfulness? (p. 23)

According to new OGAC guidance for fiscal year 2006, PEPFAR focus countries must spend a minimum of 50 percent of prevention funds on sexual transmission and two-thirds of their funding for prevention of sexual transmission on abstinence-only-until-marriage, secondary abstinence, and faithfulness programs. Critics have alleged that this means PEPFAR is eliminating comprehensive programs in favor of discrete

⁸ Matovu JKB, Kigozi G, Nalugoda F. *Repetitive VCT, Sexual Risk Behavior and HIV-Incidence, Rakai, Uganda*. Presentation at the Uganda Virus Research Institute, Entebbe, Uganda, November 28, 2003.

⁹ Shelton JD, Cassell MM, Adetunji J. Is poverty or wealth at the root of HIV? *The Lancet* 2005; 366: 1057-1058.

AB programs.¹⁰ Rather than interpreting the new OGAC guidance as an attempt to steer away from a comprehensive approach, it should be seen as an attempt to ensure A and B programs receive a fair proportion of prevention resources.

A recent study suggested that condoms and mortality from AIDS—and not abstinence and faithfulness—had caused HIV prevalence to decline. Does this mean that an ABC approach didn't work in Uganda after all? (p. 24)

A 2005 paper presented by Wawer, Gray et al.¹¹ was widely interpreted as proving that condoms and mortality from AIDS—and not abstinence and faithfulness—were responsible for Uganda's decline in HIV prevalence. Another interpretation of these data is that there had been major changes in behavior towards abstinence and faithfulness prior to the study period (1995-2004). This led to a decrease in HIV incidence prior to 1995 and a corresponding decrease in HIV prevalence after 1995.¹² While HIV prevalence declined between 1995 and 2004, incidence did not, suggesting that protective behaviors were not increasing. In fact, between 1995 and 2004 A and B behaviors declined, while condom use increased.

Even if an ABC approach did work in Uganda, is there evidence that it could work in other countries? (p. 25)

An ABC approach has been implemented to varying degrees in Senegal, Jamaica, Zambia, Kenya, and among Thailand's general population, all with positive results. Kenya may provide the most recent example of a successful ABC approach. HIV prevalence in Kenya peaked in the late 1990s at 10 percent, and had declined to 7 percent by 2003. During this period Kenya also saw significant increases in A and B behaviors, and some increase in condom use reported at last higher-risk sex.

In mature epidemics¹³, a large percentage of new HIV infection can occur in sero-discordant couples. How can an ABC approach curb transmission among these couples? (p. 26)

Married people rarely use condoms, and in no African country have consistent condom usage rates higher than 5 percent ever been reported among regular sexual partners. This figure includes known sero-discordant couples. While more intensive condom promotion may increase usage rates among sero-discordant couples, A and B messages can also have great relevance. Evidence from Uganda shows that a large percentage of sero-discordant couples are choosing to abstain from sex. To avoid further transmission of HIV, A "B" message that precludes extramarital partners is also important.

¹⁰ Center for Health and Gender Equity. *Prevention Funding Under The President's Emergency Plan for AIDS Relief: Law, Policy and Interpretation*. December 2005. Available at <http://www.genderhealth.org/pubs/PEPFARpreventionfundingipi.pdf> (accessed 3 Jan 2006).

¹¹ Wawer MJ, Gray R, et al. *Declines in HIV Prevalence in Uganda: Not as Simple as ABC*. Presentation at Conference on Retroviruses and Opportunistic Infections. Boston, MA, February 22, 2005.

¹² Incidence is the number of new cases of a disease over a certain period. Prevalence is the proportion of a population infected with a disease at a given time.

¹³ A mature epidemic is one in which infections have moved beyond the rapid infection of the very susceptible.

Common Questions and Answers about the ABC Approach to HIV Prevention

What is the ABC approach to HIV prevention?

“A” stands for **A**bstaining from sex or delay of sexual debut, “B” stands for **B**eing faithful (fidelity) or reducing number of sexual partners, and “C” stands for correct and consistent use of **C**ondoms. Advocates of the ABC approach to HIV prevention often use the term to mean a primary emphasis on abstinence (or delay of sexual debut) and fidelity (or partner reduction), with condom use being a secondary but necessary strategy for those who do not or cannot practice abstinence or mutual fidelity.

What evidence is there for the ABC approach?

The sexual transmission of HIV can be directly prevented in only three ways: by avoiding the exposure to risk through sexual abstinence; by reducing the risk of exposure through partner faithfulness and reduction in partners; or by blocking the efficiency of transmission through a barrier like a condom. In other words, by practicing A, B or C. The ABC approach therefore addresses the only three ways in which HIV can be sexually transmitted. Treatment of sexually transmitted infections (STIs) (including HIV) and male circumcision can also reduce, though not eliminate, the risk of HIV transmission. In the future, vaginal microbicides may also reduce the risk of HIV transmission, once a safe and effective drug has been approved for use.

The ABC approach offers risk reduction as well as risk avoidance, and options for those at various levels of risk. A broader approach ought to have greater impact than a narrower one, given the variability of human behavior and circumstances. A single preventive approach to something as complex as human sexual behavior will never appeal to all people, let alone influence their behavior. For those who continue to have multiple sexual partners or who are otherwise at risk, the only preventive options may be those classifiable as risk reduction, namely condom use and finding appropriate treatment for STIs.

An ABC approach is appropriate for generalized epidemics, which require a different prevention approach than do concentrated epidemics. World Bank AIDS expert David Wilson provides definitions of concentrated and generalized epidemics that point to appropriate interventions. “Epidemics are concentrated if transmission occurs mostly among vulnerable groups and if protecting vulnerable groups would protect wider society. Conversely, epidemics are generalized if transmission occurs mainly outside vulnerable groups and would continue despite effective vulnerable group interventions.”¹⁴

By definition, one cannot impact HIV prevalence in generalized epidemics by promoting risk reduction measures to vulnerable (or high-risk) groups, however successful those interventions might be. What is effective in one will not necessarily be effective in the other. In the US, Europe and most of Latin America and Asia, HIV infections are concentrated in a few fairly well-defined high-risk groups. In sub-Saharan Africa, most infections are found in the general population. Differences in epidemiological patterns and cultural settings are real, and call for different approaches to prevention.

Because Uganda provides the clearest case study of a successful ABC approach, this document makes frequent reference to Uganda. In Uganda, HIV prevalence decreased from 15 percent to 5 percent between 1991 and 2001.

¹⁴ Wilson D. *A Monitoring And Evaluation Framework for Concentrated Epidemics and Vulnerable Populations*. Washington, DC: The World Bank, 2005.

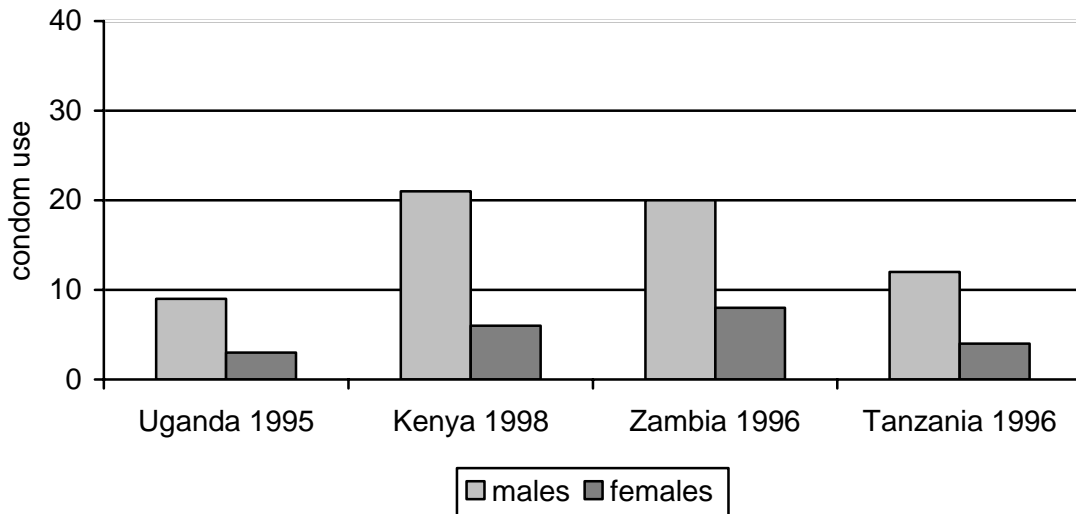
During the same period, the following changes in ABC behaviors occurred:

- The proportion of young males age 15-24 reporting premarital sex decreased from 60 percent in 1989 to 23 percent in 1995. For females, the decline was from 53 percent to 16 percent.¹⁵
- For all age groups, 41 percent of males had more than one sex partner in 1989. This declined to 21 percent by 1995. For females, the decline was from 23 percent to 9 percent. The proportion of males reporting three or more sex partners fell from 15 percent to 3 percent between 1989 and 1995.
- In 1995, about 6 percent of sexually active Ugandans used a condom with some regularity. By 2000, this rose to 11 percent of sexually active Ugandans, or 8 percent of all Ugandans.¹⁶

The main behavior change that occurred in Uganda was increased monogamy and fidelity (mostly marital fidelity). While AIDS prevention programs often focus on youth, evidence shows that it is reduction in the number of sexual partners among those who are sexually active—and not abstinence among youth—that is most critical to curbing an AIDS epidemic.¹⁷ Most Ugandans ages 15 to 49 (the age group in which surveys such as DHS measure both behavior and HIV status) are sexually active, not abstinent. Youth were given information on a range of AIDS prevention options, including condoms, but abstinence (often termed delay of sexual debut) was emphasized as only 100 percent sure option. Adults were targeted with a “be faithful” message that included slogans such as “love faithfully” and “zero grazing.”

Data show that compared to other countries in Africa, it was with regard to B behaviors that Uganda was different. As shown in Figure 1, condom use was not higher in Uganda than in other countries. Rather it is in “Be faithful” behaviors that Uganda stands out. There was far less multi-partner sex in Uganda than in other countries, as illustrated in Figure 2.

Figure 1: Condom Use at Last Sex*



*Percent of sexually active men and women ages 15 to 49 who used a condom at last sex with anyone
Source: Demographic and Health Surveys (DHS)

¹⁵ Stoneburner R, Low-Beer D. Population-level HIV declines and behavioral risk avoidance in Uganda. *Science* 2004; 304: 714–18.

¹⁶ Demographic and Health Surveys (DHS), cf. Green EC. *Rethinking AIDS Prevention*. Westport, CT: Praeger, 2003.

¹⁷ Shelton JD, Halperin DT, Nantulya V, et al. Partner reduction is crucial for balanced “ABC” approach to HIV prevention. *British Medical Journal*; 328: 891-3.

Figure 2: Multiple Sexual Partnerships*



* Percent of sexually active men and women ages 15 to 49 who have had sexual intercourse with more than one partner in the last 12 months

Source: Demographic and Health Surveys (DHS)

There is a clear need for a balance of A, B, and C interventions. Interventions need to be targeted for efficiency and likely impact, and must take into account crucial differences among target groups. A balanced ABC approach might be implemented in the form of A interventions emphasizing sexual postponement to youth; B interventions promoting fidelity or partner reduction to all who are sexually active and especially those not in monogamous relationships (or those in polygamous marriages, as was done in Uganda); and C interventions promoting condom use to those at high risk of exposure to HIV infection. People at high risk include those engaging in commercial sex, multiple partnerships, sex with a person known or likely to be infected with HIV or another STI, and young people who are sexually active. Yet these high-risk groups always comprise a minority of any national population. This is true in Africa today, where recent Demographic and Health Surveys (DHS) show that the majority of men and women do not report more than one regular sex partner in the previous year (see Table 4).

Aren't all parts of the ABC approach important? Why do proponents of the ABC often emphasize abstinence and faithfulness, and not consider condom use an equally valid choice?

According to a statement published in *The Lancet* and endorsed by over 150 public health experts, all the elements of the ABC approach are necessary, “although the emphasis placed on individual elements needs to vary according to the target population.”¹⁸ This article states that for youth, the first priority should be to encourage abstinence or delay of sexual debut. For adults, the first priority should be to promote mutual fidelity with an uninfected partner. This is especially important as evidence from countries where HIV has declined suggests that partner reduction and fidelity were the most important behaviors leading to the decline, both in generalized and concentrated epidemics. Finally, for people at high risk of exposure to HIV, the first priority should be to promote correct and consistent condom use, along with other approaches such as avoiding high-risk behaviors or partners. According to this article, correct information about condoms should be given to all youth and adults, and adults should be

¹⁸ Halperin, Steiner et al., 2004.

encouraged to use condoms if they have a sexual partner of unknown sero-status. Yet the promotion of condoms to youth and adults who are not in a high-risk category should not precede or supersede efforts to promote abstinence and fidelity..

In appropriately targeting AIDS prevention messages, there is a need to distinguish between individual and public health strategies. This distinction has been made by Dr. Norman Hearst, who conducted a review of condom effectiveness for UNAIDS in 2003.¹⁹ To paraphrase Dr. Hearst: *If I am foolish enough to engage in risky sex, it certainly makes sense for me as an individual to use a condom, since this will greatly reduce my risk of infection. But as a public health strategy, promotion of condoms has had a poor record of producing lower HIV infection rates, especially in generalized epidemics.* The Phase One report of the USAID ABC Study concluded that A and B behavior changes are necessary for levels of national HIV prevalence to decline in Africa.²⁰ When abstinence and fidelity are promoted as public health strategies, especially in generalized epidemics, HIV prevalence begins to fall.

Are condoms effective against HIV/AIDS?

There are two questions to consider when it comes to condoms and HIV/AIDS. First, how effective are condoms in preventing the transmission of HIV? Second, how successful have condoms been in curbing the spread of HIV within populations?

Condoms are estimated to be between 80 percent and 90 percent effective when used consistently and correctly—that is, to reduce HIV transmission by 80 percent to 90 percent compared to non-use. Condoms can also reduce the risk of many other sexually transmitted infections, the presence of which can increase the transmission efficiency of HIV.

Promotion of condoms alone has not been shown to be an effective strategy to lower infection rates in generalized epidemics, such as those found in Africa. A 2003 study commissioned by UNAIDS concluded, “Especially in the setting of generalized heterosexual transmission, it is unknown what level of condom use in the population is necessary to have a substantial impact on HIV transmission. Indeed, there are no definite examples yet of generalized epidemics that have been turned back by prevention programs based primarily on condom promotion.”²¹ An article in the medical journal *The Lancet* similarly stated, “Massive increases in condom use world-wide have not translated into demonstrably improved HIV control in the great majority of countries where they have occurred”²²

Evidence for the effectiveness of condoms in reducing HIV rates at the population level comes from countries like Thailand and Cambodia which have different types of epidemic patterns than are found in Africa. In Thailand, which is considered the world’s great condom success story, the epidemic was largely fueled by contact with commercial sex workers. During the early 1990s the number of men reporting consistent condom use when visiting a commercial sex worker increased from 36 percent to 71 percent. During this time period the number of men reporting premarital or extramarital sex was cut in half, and the percentage visiting sex workers was likewise cut in half. All of these trends likely

¹⁹ Hearst N, Chen S. *Condoms for AIDS prevention in the developing world: a review of the scientific literature.* Geneva: UNAIDS, 2003.

²⁰ Bessinger R, Akwara P, Halperin D. *Trends in Sexual and Fertility Related Behavior: Cameroon, Kenya, Uganda, Zambia, and Thailand.* Calverton, MD: ORC Macro, the Measure Project, and United States Agency for International Development.

²¹ Hearst N, Chen S. Condom Promotion for AIDS Prevention in the Developing World: Is It Working? *Studies In Family Planning* 2004; 35: 39-47.

²² Richens J, Imrie J, Copas A. Condoms and seat belts: the parallels and the lessons. *The Lancet* 2000; 29: 400.

contributed to Thailand's declining HIV prevalence during the early 1990s. Data from antenatal clinics showed a decline in HIV prevalence from 2 percent in 1995 to 1.6 percent in 2001.

When HIV infections are concentrated among sex workers and their clients, condom promotion is an effective primary strategy, at least for these groups. In Africa, the vast majority of HIV infections occur outside high-risk groups, in the very groups in which condom usage remains stubbornly low. David Wilson of the World Bank recently observed that generalized epidemics will continue "despite effective vulnerable group interventions."²³ In other words, even if sex workers, truck drivers, soldiers and others at high risk used condoms, epidemics could continue because most infection occurs outside these groups. A different strategy is needed for the majority in the general population—an ABC approach.

Few people are found to use condoms consistently outside high-risk groups. Condom use may be felt to signal a lack of trust within a relationship, to diminish the pleasure of sex, or to in other ways be undesirable. Use of drugs and alcohol can affect a person's ability to use a condom, or to use it successfully. Other barriers to condom use include availability and cost. Even in Thailand, condom use among non-commercial sex workers remained relatively low, according to a survey conducted by Family Health International in which condom use is defined as use during last sex intercourse.²⁴ In Bangkok, where condom use among commercial sex workers reached nearly 90 percent by 1996, reported condom use by women in the general population was only 18.9 percent in 1996. Only 28.5 percent of Bangkok prostitutes reported using condoms with nonpaying sex partners, such as boyfriends.

No country in Africa has ever had rates of consistent condom above 5 percent, among married people or regular sexual partners. Usage rates among all males and females ages 15-49 has also never exceeded 5 percent (Table 1). In some countries, condom usage rates among high-risk groups have increased significantly, even as usage rates among the general population have not. In Kenya, condom use at last higher-risk sex increased between 1998 and 2003, from 44 percent to 47 percent for men, and from 16 to 24 percent for women. In the same period, condom use at last sex among all men and women decreased somewhat. This reflected the fact that while condom use was increasing in higher-risk sex, higher risk sex was on the decline. In other words, an ABC approach was resulting in greater B and C behaviors.

²³ Wilson, 2005

²⁴ Family Health International. *Final Report for the AIDSCAP Program in Thailand November 1991 to September 1996*.

Table 1: Condom Use at Last Sex in sub-Saharan Africa

Country and year	Percent of sexually active adults ages 15-49 using a condom at last intercourse with any type of partner	
	Male	Female
Benin 2001	16	4
Burkina Faso 1998/9	21	5
Cameroon 1998	16	6
Cote d'Ivoire 1998	23	7
Ethiopia 2000	5	1
Ghana 2003	18	9
Guinea 1999	14	3
Kenya 2003	17	5
Malawi 2000	14	5
Mali 2001	10	2
Mozambique 2003	14	6
Namibia 2000	45	28
Nigeria 2003	16	5
Rwanda 2000	6	1
Tanzania 1999 ²⁵	16	8
Togo 1998	19	6
Uganda 2000/01	15	7
Zambia 2001/2	19	12
Zimbabwe 1999	28	9
Average (unweighted)	17	7

Source: all data from DHS unless otherwise noted

While correct and consistent condom use may significantly reduce risk of HIV transmission, such usage does not seem to have reached high enough rates in any African country to impact HIV prevalence at a population level. In fact, the number of condoms per male per year in Africa remains low, and in the countries with the highest usage we also see the highest HIV prevalence. In 2000, Shelton and Johnston determined the annual average number of condoms available in several African countries per male aged 15 to 49 years, computing the average over a 10-year period.²⁶ Figure 3 depicts condom availability by country, as well as national HIV prevalence. This table demonstrates that condom availability in Africa is still very low, largely because of low demand.²⁷ Yet there are differences among countries. Zimbabwe, Botswana, and South Africa have the highest rates of condom availability but are also among the countries with the highest rates of HIV infection. In contrast, during the unprecedented decline of HIV in Uganda from 1989 through 2000, only 4 condoms were used per male annually.

There are several possible explanations for the relationship between condom use and higher HIV or STD infection. The fact that HIV prevalence is highest in the countries with highest condom usage does not mean that there is a causal relationship or that condom use is in any way contributing to greater HIV prevalence. The range of possible explanations and causal associations include:

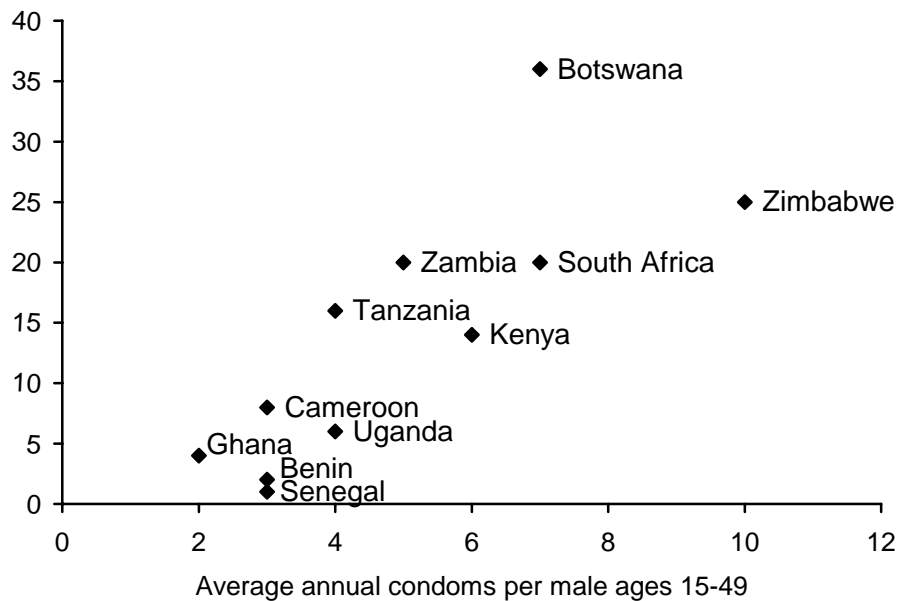
²⁵ Tanzania Reproductive and Child Health Survey, 1999. Available at www.measuredhs.com.

²⁶ Shelton J, Johnston B. Condom gap in Africa: evidence from donor agencies and key informants. *British Medical Journal* 2001; 323: 139.

²⁷ Longfield K, Agha S, Kusanthan T, et al. *Non-use of condoms: what role do supply, demand, & acceptance play in the 'condom gap'?* Presentation at the International Conference on AIDS & STDs in Africa, Ouagadougou, Burkina Faso, December 2001.

- 1) people who know or suspect they are HIV+ are more likely to use condoms (effect-cause);
- 2) people who would have more partners anyway are both more likely to use condoms and more likely to be infected (effect-effect);
- 3) condom promotion might encourage higher risk sex (cause-effect);
- 4) failure to separate out commercial sex (in its various forms) from the data;
- 5) failure to fully adjust for other possible confounders.²⁸

Figure 3: Average Annual Number of Condoms per Male in sub-Saharan Africa



Source: Shelton and Johnston, 2000

Should condoms be promoted only to high-risk populations such as sex workers and truck drivers? Doesn't everyone need condoms?

Condoms can be promoted to anyone and everyone, yet many years of experience provides persuasive evidence that only those in high-risk groups are likely to use them consistently, especially in rural areas where a steady supply of condoms is problematic. As discussed above, *consistent* condom use in Africa is rare and most condom use outside of a very few high risk groups is *inconsistent*. Mounting evidence suggests that inconsistent condom use does not protect people. In fact, now that DHS surveys are including a population-based sero-survey component, it is possible to compare the HIV status of condom users and non-users. In the first countries for which DHS data is available (Tanzania, Kenya, and Ghana) it has been found that condom users are more likely to be infected than non-users, whether the measure is condom use at last sex, last high-risk sex, or last sex with prostitutes.²⁹ These data are being called

²⁸ Hulley SB, Cummings SR, Browner WS et al. *Designing clinical research: An epidemiologic approach*, 2nd Edition. Philadelphia: Lippincott, Williams & Wilkins, 2001.

²⁹ Annie Cross, Macro International., personal communication, 17 Nov 2005, and DHS surveys from 2003 onward (available at www.measuredhs.com).

anomalous, yet they could be explained by factoring in inconsistency of use and the possible disinhibiting effect of condom promotion.³⁰

Other studies have also provided evidence that inconsistent condom use provides little or no reduced risk of HIV. A study in Rakai, Uganda found that while consistent condom use reduced risk of HIV infection by 63 percent, irregular condom use did not reduce risk of HIV at all, after adjusting for demographic and behavioral variables.³¹ Another recent study found that condom promotion can lead to greater sexual risk taking, which when combined with inconsistent condom use, results in higher overall risk to HIV.³² A group of men in Kampala, Uganda, received a condom promotion program that taught condom technical use skills, encouraged condom use, and provided free condoms. Compared to a control group that received only a brief informational presentation about AIDS, the men in the intervention group did use more condoms. The men in the intervention group also increased their number of sexual partners by 31 percent, in comparison to the control group, who decreased their number of partners by 17 percent. The net result was an increase in sexual risk in the intervention group, as “gains in condom use seem to have been offset by increases in the number of sex partners.”

We cannot discount the possibility that risk compensation or disinhibition³³ may be causing condom users to take greater risks in their sexual behavior. Ahmed and colleagues found evidence of this in Rakai, Uganda. The Government of Uganda was aware of this possibility as early as 1988, when it advised, in what may be its earliest booklet on AIDS prevention, “Condoms give people a false idea they are totally safe from AIDS. The best way to avoid AIDS is to avoid casual sex and to stick to a faithful partner.”³⁴

There is nothing in OGAC guidance documents that discourages or restricts the promotion of condoms to adults in a generalized population. OGAC guidance does suggest that condom promotion be targeted to high-risk groups, following Uganda’s successful approach during the 1990s.³⁵ This is for the simple fact that such groups are more likely to use condoms. Targeting programs (and funds) to where they have a good chance of having impact should be a matter of common sense.

If we follow available evidence, it appears that the actual market for condoms is very low in Africa. As observed recently in *The Lancet*, “African men and women often have more than one—typically two or perhaps three—concurrent partnerships that can overlap for months or years. This pattern differs from

³⁰ Richens et al., 2000; Mosley, 2005; Green, 2003

³¹ Ahmed S, Lutalo T, Wawer M, et al. HIV incidence and sexually transmitted disease prevalence associated with condom use: a population study in Rakai, Uganda. *AIDS* 2001; 15: 2171-2179.

³² Kajubi P, Kanya MR, Kanya S, et al. Increasing condom use without reducing HIV risk: results of a controlled community trial in Uganda. *Journal of Acquired Immune Deficiency Syndromes* 2005; 40(1): 77-82.

³³ Risk compensation and disinhibition refer to the tendency for a perception of reduced risk to make risk-taking more attractive. People adjust their behavior in response to the increased sense of personal safety that comes with protective behaviors such as wearing a seatbelt or using a condom.

³⁴ Government of Uganda, National Resistance Movement Secretariat. *Control of AIDS: Action for Survival*. Kampala, Uganda: 1988. p. 33.

³⁵ There have been many recent charges that US pressure has led to a current situation in which Uganda is promoting “abstinence only” to the exclusion of condoms. (For instance, *AIDS in Uganda: the Human-Rights Dimension*, Human Rights Watch, 2005, and *The Lancet*, June 18, 2005.) Yet the broad trend over the past decade—seemingly due to pressure from foreign donors—has been far more emphasis on condom promotion at the expense of AB programs. This can be seen in Ugandan government documents such as: *The National Strategic Framework for HIV/AIDS; The National Monitoring & Evaluation Framework, for HIV/AIDS Activities in Uganda 2003/04-2005/06; The National Condom Policy and Strategy*, which have few references to abstinence or faithfulness. Earlier Ugandan government documents of this sort emphasized AB interventions, especially in the period 1987-9.

that of the serial monogamy more common in the west, or the one-off casual and commercial sexual encounters that occur everywhere.”³⁶

A pattern of concurrent partners unfortunately facilitates HIV transmission far more than serial monogamy. Making the situation worse is the fact that most men (in Africa and elsewhere) rarely use condoms with their wives or other long-term, regular partners. Years of experience in condom promotion suggest that this is unlikely to change easily or at all. On the other hand, there is evidence that commercial sex workers and their clients, truck drivers, soldiers posted far from home, and others are quite likely to use condoms in one-time sex. Yet such one-time sexual experiences are relatively rare and do not add up to a substantial market for condoms. (For example, only 1.6 percent of Ugandan men reported paying for sex during the last year, according to the last DHS.) “Demand” for condoms is simply low in Africa and indeed throughout the developing world. A Population Services International survey that analyzed data from six African countries concluded that the main reasons for not using condoms have to do with poor demand.³⁷

Westerners have criticized Africans for “just not getting” that they must use condoms in each and every sex act—“something very few people on the planet do,” in the words of science journalist Helen Epstein.³⁸ Yet we should look more carefully at the size and characteristics of the potential condom market before we criticize.

Does providing information about condoms lead to earlier or increased sexual activity among youth?

According to the consensus statement in *The Lancet* referred to above, the priority for young people who have not yet started sexual activity should be to encourage abstinence or delay of sexual onset. For young people who have started sexual activity, returning to abstinence or being mutually faithful with an uninfected partner are the most effective ways of avoiding infection. For those young people who are sexually active and not faithful to a single uninfected partner, correct and consistent condom use should be supported.

Many sex and HIV education programs in sub-Saharan Africa and other developing countries emphasize abstinence as the best means to avoid infection with HIV, but also provide factual information about condoms. This indeed is what Uganda did in its pioneer School Health Education Program that began in 1987. Because such programs encourage condom use for young people who are sexually active, they are sometimes criticized for encouraging sexual activity among youth or providing “mixed messages” to youth. Some parents and communities may object to youth receiving information about condoms. DHS data show that the majority of adults in sub-Saharan African countries support condom education for youth, while a minority do not (Table 2). In most countries, approximately two-thirds of adults agree that young people aged 12 to 14 years should be taught about using condoms to prevent HIV/AIDS. A notable exception is Nigeria, where only 39 percent of adults agree that young people should receive condom education.

³⁶ Halperin D, Epstein H. Concurrent sexual partnerships help to explain Africa’s high HIV prevalence: implications for prevention. *The Lancet* 2004; 363: 4–6, p. 4.

³⁷ Longfield K et al., 2001

³⁸ Epstein H. God and AIDS (Letter). *New York Review of Books* 2005; 52(9): 56.

Table 2: Adult Support of Education on Condom Use for Youth in sub-Saharan Africa

<i>Country and year</i>	<i>Percent of adults ages 18-49 who agree that young people aged 12-14 years should be taught about using condoms to prevent HIV/AIDS</i>	
	Male	Female
Burkina Faso 2003	71	-
Cameroon 1998	71	59
Ghana 2003	64	59
Kenya 2003	64	59
Mali 2001	65	63
Mozambique 2003	63	62
Namibia 2000	81	81
Nigeria 2003	43	36
Rwanda 2000	72	67
Tanzania 2003/4 ³⁹	69	61
Uganda 2000/1	59	65
Zambia 2001/2	67	56
<i>Average (unweighted)</i>	<i>66</i>	<i>61</i>

Source: all data from DHS unless otherwise noted

Sex and HIV education programs can delay sexual onset and increase abstinence, as well as lead to greater condom use among sexually active youth. A meta-analysis by Kirby et al. found that such programs that included information on condoms while emphasizing abstinence did not lead to earlier or more frequent sexual activity.⁴⁰ This meta-analysis examined the impact of school and community-based sex and HIV education programs, and included 18 studies from developing countries, and 9 from Africa. All of the programs in developing countries included some information on condoms. While approximately half of the developing country programs had no effect on delay of sexual debut, frequency of sex, or number of sexual partners, about half of the programs impacted these behaviors positively. No developing country programs led to earlier sexual debut or greater sexual activity.

Does the ABC approach demand an unrealistic standard of behavior?

Critics of the ABC approach often make statements such as: "The behavioral bias of the ABC approach is based on the assumption that individuals all have an innate and equal power to make perfectly correct decisions about every issue in their sexual and reproductive health lives,"⁴¹ or, "We all know that abstinence and couples being mutually faithful would be great if they were applicable to everybody's lives, but they're not."⁴² Critics may also argue that African culture is polygamous, and that A and B behaviors are constrained or precluded by various realities in Africa.

³⁹ Tanzania HIV/AIDS Indicator Survey 2003-2004. Available at www.measuredhs.com.

⁴⁰ Kirby D, Laris BA, Rolleri L. *Impact of Sex and HIV Curriculum-Based Education Programs in Schools and Communities on Sexual Behaviors of Youth. Youth Research Working Paper No. 2.* FHI/YouthNet: Arlington, VA, 2005.

⁴¹ Osborne K. The ABCs of HIV: It's not that simple. *AIDSLink*; 82, Nov 1, 2003.

⁴² Cohen J. Prevention cocktails: Combining tools to stop HIV's spread. *Science* 2005; 309(5737): 1002-5.

Many factors can limit or take away a person's ability to practice abstinence, faithfulness, or consistent condom use. These factors can include poverty, illiteracy, instability and displacement, and gender disparity. Is the ABC approach still an effective strategy in such circumstances? In fact, some of the strongest evidence for an ABC approach comes from situations in which there were high levels of poverty, illiteracy, and instability. When Uganda began to respond to HIV/AIDS in the late 1980s and early 1990s, it was just emerging from two decades of war and extreme civil unrest. Far from being passive victims of forces beyond their control, Ugandans mounted an effective response to HIV/AIDS in spite of the difficult situations in which they were living.

Africans are often depicted as starting to engage in sex at a very early age and having numerous sexual partners. Indeed, risk reduction programs are justified by the alleged "reality" that Africans have many sexual partners and women in particular can do nothing about this. Yet the best biological and survey data do not support this image of the promiscuous African. DHS and other survey data show that the great majority of African women and men are already practicing B and A behaviors (in that order). Only 3 percent of African women reported multiple sexual partners in the previous year, and this figure has been quietly decreasing in recent years, beneath the "radar screen" of public discourse about global AIDS.⁴³

The trend in Africa is toward higher levels of monogamy, fidelity, and abstinence,⁴⁴ and the trend in HIV prevalence is incrementally downward. According to UNAIDS, Sub-Saharan Africa now has an average HIV prevalence rate of 7.2 percent, down from 7.3 percent in 2004 and 7.5 percent a year earlier. This means that over 93 percent of Africans ages 15 to 49 are *not* HIV infected.⁴⁵ These welcome trends have come about in spite of the paucity or complete absence of national programs aimed at promoting fidelity and abstinence. The United States is the first major donor to fund such programs. By citing these figures, we are *not* saying we should shift attention and resources away from those at high risk, as discussed further in the Conclusion.

In the few countries where abstinence and fidelity have been promoted at the national level and backed by resources, sexual behavior has changed and rates of HIV and other STIs have decreased. Examples include Uganda, Senegal, Jamaica, Thailand, Zambia in the 1990s, Dominican Republic (after the mid-1990s), and Kenya (after the late 1990s). Data show that abstinence and faithfulness are realistic behaviors for most Africans (see Tables 3 and 4). More than half of African youth aged 15 to 19 years report abstaining from premarital sex in the previous year, according to DHS data. For example, among unmarried youth 15 to 24, 70 percent of Zambian youth and 71 percent of Ugandan youth had no sex partner in the previous year, and in some countries an even higher proportion reported abstinence. Most sexually active adults, whether married or not, report having only one partner in the previous year. In Uganda, this figure was 93 percent, while in Zambia it was 89 percent.

⁴³ Mahy M, Gupta N. *Trends and differentials in adolescent reproductive behavior in sub-Saharan Africa*. DHS Analytical Studies No.3. Calverton, MD: Macro International and MEASURE DHS Project, 2002. Also cf. DHS surveys over past decade, available at www.measuredhs.com.

⁴⁴ Green, 2003

⁴⁵ UNAIDS, 2005

Table 3: Pre-marital Sex Among Youth Ages 15 to 24 in sub-Saharan Africa

<i>Country and date of survey</i>	<i>Percent of youth ages 15-24 reporting premarital sex in last year</i>	
	Male	Female
Benin 2001	53	44
Botswana 2001 ⁴⁶	39	42
Burkina Faso 1998/9	34	24
Cameroon 1998	58	52
Central African Republic 1994/5	58	41
Cote d'Ivoire 1998	61	56
Eritrea 1995	10	1
Ethiopia 2000	16	2
Ghana 2003	24	30
Guinea 1999	52	27
Kenya 2003	41	21
Malawi 2000	49	27
Mali 2001	36	29
Mozambique 2003	67	54
Namibia 2000	59	46
Nigeria 2003	29	32
Rwanda 2000	9	4
Tanzania 1999 ⁴⁷	57	39
Togo 1998	46	53
Uganda 2000/01	31	27
Zambia 2003 ⁴⁸	33	28
Zimbabwe 1999	34	15
<i>Average (unweighted)</i>	<i>41</i>	<i>32</i>

Source: all data from DHS unless otherwise noted

⁴⁶ Botswana AIDS Impact Survey (BAIS), 2001. Available at www.measuredhs.com.

⁴⁷ Tanzania Reproductive and Child Health Survey, 1999. Available at www.measuredhs.com.

⁴⁸ Zambia Sexual Behavior Survey, 2003. Available at www.measuredhs.com.

Table 4: Multiple Partnerships in sub-Saharan Africa

<i>Country and survey date</i>	<i>Percent of sexually active adults ages 15-49 reporting multiple partners in last year</i>	
	Male	Female
Benin 2001	28	2
Burkina Faso 1998/9	23	1
Cote d'Ivoire 1998	42	6
Ethiopia 2000	11	2
Ghana 2003	15	2
Kenya 2003	17	2
Mali 2001	23	1
Mozambique 2003	35	6
Namibia 2000	22	3
Nigeria 2003	22	2
Rwanda 2000	4	1
Tanzania 2003/4 ⁴⁹	27	6
Uganda 2000/01	25	2
Zambia 2001/2	27	3
<i>Average (unweighted)</i>	23	3

Source: all data from DHS unless otherwise noted

Abstinence and fidelity may also have a higher chance of sustained success than condom use, which is often sporadic and inconsistent, and which relies on availability as well as resolve. Condom adoption is sometimes assumed to be a simpler behavior change to adopt than that of abstinence or faithfulness. Yet condom use, especially correct and consistent condom use, is also a difficult and demanding behavior change. Part of the proof of this observation is the disappointingly low levels of consistent condom use after more than 20 years of condom promotion in the developing world. In no African country have consistent condom usage rates higher than 5 percent ever been reported, among regular sexual partners, according to an estimate from Norman Hearst.⁵⁰

Is the ABC approach unrealistic for women?

The argument is often made that women do not have the choice to abstain or practice faithfulness. It is a tragic fact that women who have practiced premarital abstinence and marital fidelity have become infected by unfaithful partners. Some women and girls may be in situations where sex is coerced by various circumstances, such as poverty or a difficult marriage. Condoms are often proposed as the solution for these women, and the ABC approach supports condom use for those at risk of HIV transmission. Yet condom use can be difficult if not impossible to negotiate for a woman in a coercive situation. As for married people, or others in regular sexual relationships, empirical data and anecdotal evidence show that condoms are rarely used by married couples.⁵¹

⁴⁹ Tanzania HIV/AIDS Indicator Survey, 2003/4. Available at www.measuredhs.com.

⁵⁰ Norman Hearst (PI of 2003 UNAIDS-commissioned condom effectiveness review), personal communication, 16 June 2005.

⁵¹ Gray RH, Wawer MJ, Brookmeyer R, et al. Probability of HIV-1 transmission per coital act in monogamous, heterosexual, HIV-1-discordant couples in Rakai, Uganda. *The Lancet* 2001; 357: 1149-53.

African women have more power than they are given credit for—power that must extend to being able to refuse unwanted sex and not just negotiating condom use. Between 75 percent and 92 percent of Ugandan women say they can refuse sex, or sex without a condom, for reasons such as suspecting that their husband has an STI or is unfaithful, according to the DHS. Although this is a greater percentage than in many other African countries,⁵² most women in other countries also report that they have the power to refuse sex with their husbands. For instance, 73 percent of women in Malawi, 87 percent in Rwanda, 82 percent in Tanzania, and 71 percent in Zimbabwe said that they could refuse sex with their husbands if they knew their husbands had STIs.⁵³

What is the solution for women who truly do lack the power to refuse unwanted—and often risky—sex? Women who do not have the power to say no to unwanted sex probably do not have the power to insist on condom use. While much attention has been given to developing products that women can control, female condoms cannot be used without the male partner’s knowledge, and a safe and effective vaginal microbicide is yet to be developed. The best solution is for more men to be faithful and more women to be empowered to be able to refuse sex (or refuse sex without a condom). That is, the B of ABC is urgently needed. The B message must also address cross-generational sex, including the rape and seduction of minor girls by older men.

Uganda provides evidence that far from being insensitive to the needs and status of women, an ABC approach can go hand in hand with raising the status of women and the social responsibility of men. Under Uganda’s ABC approach, women were empowered to leave husbands and boyfriends who were unfaithful and were putting them at risk for infection. More women became economically independent,⁵⁴ and more women and girls went further in their education. Uganda also targeted men and boys with abstinence and “zero grazing” messages, which is crucial to achieving behavior change given prevailing power disparities between genders.

The official guidance provided by the Office of the Global AIDS Coordinator calls for communities to mobilize to reduce the vulnerability of women:

Communities must mobilize to address the norms, attitudes, values, and behaviors that increase vulnerability to HIV, including the acceptance or tolerance of multiple casual sex partnerships, cross-generational and transactional sex, forced sex, the unequal status of women, and the sexual coercion and exploitation of young people. To stimulate such mobilization, there is an urgent need to help communities identify the ways in which they contribute to establishing and reinforcing norms that contribute to risk, vulnerability, and stigma, and to help communities identify interventions that can change norms, attitudes, values, and behaviors that increase vulnerability to HIV.⁵⁵

Do the ABCs consider local realities such as gender and social inequalities, poverty, and cultural impediments to behavior change?

The ABC approach focuses on what individuals can do to change (or maintain) behavior, and thereby avoid or reduce risk of infection. Those who would put their AIDS prevention energies and resources into

⁵² Green, 2003, p. 171-2

⁵³ DHS data, cf. Murphy E, Greene ME, Duong T. Defending the ABCs: A Feminist Perspective on AIDS Prevention. Washington, DC: George Washington University School of Public Health: 2005 (unpublished).

⁵⁴ Murphy, et al., 2005

⁵⁵ Office of the United States Global AIDS Coordinator for AIDS Relief. *ABC Guidance For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President’s Emergency Plan for AIDS Relief*. Washington, DC: March 2005.

calling for structural changes such as eradicating poverty or civil unrest should consider whether these factors can be influenced, and within a reasonable timeframe, within the budget of AIDS programs. In countries such as Uganda where an ABC approach has been successful, broader goals such as empowering women, increasing access to education, and decreasing poverty were also pursued. Yet these broader societal and structural goals may not be achievable in the short or even medium-term. In Uganda, HIV prevention was successful even though these broader goals had not been fully met. As changing structural inequalities are usually outside one individual's control, the ABC approach focuses on what most individuals can change and control, in the short-term.

Table 4 lists the changes (and implicitly, interventions) associated with a broad range of HIV transmission factors. Also listed are the feasibility and probable timetable for achieving desired changes. This framework is a reminder that the broader societal and structural goals may not be achievable before HIV has run its course with particular populations and peaked or declined on its own. At the same time, it shows that goals such as improving the status of women, or increasing job opportunities for women, can be achieved within a "medium" or not-too-distant timeframe. Uganda has shown that such goals are feasible, and that improvements in women's status can help reduce infection rates. These broader social changes should be pursued in addition to—and not instead of—an ABC approach.

When it comes to practical, workable AIDS prevention, what kinds of messages are useful to individuals at risk of HIV? Clearly, we cannot ask an African villager to reduce poverty or change laws to empower women. These things are not within an individual's control. Behavior change messages should focus on things that usually (but not always) *are* within an individual's control, such as remaining monogamous or using a condom. It may also be feasible to begin changing sociocultural norms starting at an individual level. An example would be raising awareness about the seduction of school-age girls by adult men, in order to increase social disapproval of this phenomenon. On the intervention side, this process might involve participatory dramas and role plays reinforced by posters and billboards. Broader, complementary structural changes may also be possible in the short- to medium-term. For example, countries can enact "defilement laws" that make intercourse with a woman under age 18 a criminal offense, as was done in Uganda. Such laws can in turn be influential in changing social norms and lead indirectly to reduced HIV infection rates.

Figure 4: Factors Contributing to Sexual Transmission of HIV

Level & Definition	Examples	Changes required
<i>Individual</i> (factors that directly affect the individual & that the individual has some control in changing)	<i>Biological:</i> history, presence of STDs lack of male circumcision; anal intercourse; sex during menses; traumatic sex; cervical ectopy <i>Behavioral:</i> multiple sex partners; unprotected intercourse; sex with a CSW; sex with infected partner; lack of knowledge of HIV; low risk perception	Prevention, treatment of STDs; avoidance of sex during menses; prevention of traumatic sex abstinence; mutual fidelity; consistent condom use; knowledge and skill of STD/HIV prevention <i>Achievable in the short-term</i>
<i>Societal</i> (factors related to societal norms that encourage high-risk sexual behavior)	High rates of prostitution; multiple partners by men; gender discrimination; poor attitudes toward condom use; low social status of women; extended postpartum abstinence	Improvement of the status of women; promotion of mutual fidelity; changes in societal attitudes toward condoms use <i>Achievable in the short to medium term</i>
<i>Infrastructural</i> (factors that directly or indirectly facilitate the spread of HIV, over which the individual has little/no control)	Poor availability of condoms; poor STD services; high STD prevalence; poor communication services	Changes in health infrastructure; improvement in STD care, behavior-change communication, and condom provision <i>Achievable in the short to medium term</i>
<i>Structural</i> (factors related to developmental issues, over which both the individual and the health system have very little control)	Underdevelopment; poverty; rural/Urban migration; civil unrest; low female literacy rates; laws non-supportive of human rights; unemployment	General economic development programs; appropriate laws; income-generating opportunities; education of women <i>Feasible in the long-term</i>

Source: Cohen and Trussell, 1996

Is the ABC approach overly simplistic? Do we need, instead, an “A to Z” approach?

The argument is sometimes made that we need to go “beyond ABC,” as an ABC approach is simplistic or reductionist. Shouldn’t we be doing everything to prevent AIDS: A, B, C, D (for Drugs, or De-stigmatizing AIDS), E (for Equal opportunity)...all the way to Z?.

In this discussion, it is useful to distinguish between the direct and indirect factors that determine sexually transmitted HIV infection. The former (or “proximate determinants”) have to do with sexual intercourse itself, while the indirect factors include things like increased access to VCT and treatment, diminishing AIDS-related stigma, poverty alleviation, effective political leadership, open discussion about sexual

behavior, and improving the status of women. Each of these interventions is important for its own sake, and may promote an environment that encourages changes in sexual behavior. Yet they do not in themselves prevent the sexual transmission of HIV. For example, creating laws that protect women from sexual exploitation may be a critical measure, but it is only when sexual behavior changes as a result that HIV transmission is directly impacted. The sexual transmission of HIV can be directly prevented in only three ways: by avoiding the exposure to risk through sexual abstinence; by reducing the risk of exposure through partner faithfulness and reduction in partners; or by blocking the efficiency of transmission risk through a barrier like a condom. In other words, by practicing A, B or C.⁵⁶

We might find political leadership, open discussion of HIV/AIDS, or other factors conducive to fighting AIDS, yet no decline in HIV transmission within a country. Uganda was unique in its clear focus on what individuals themselves could do to change or maintain behavior. Uganda pioneered approaches towards reducing stigma, brought discussion of sexual behavior out into the open, involved HIV-infected people in public education, persuaded individuals and couples to be tested and counseled, improved the status of women, involved religious organizations, enlisted traditional healers, and much more. If any country could be said to have promoted "A through Z" to prevent AIDS, it is Uganda. Yet the message for the public was the simple one of ABC.

One additional letter, or pair of letters, should be mentioned here: MC for male circumcision. An association between male circumcision and lower HIV infection rates was first noted around 1989.⁵⁷ Since then over 40 epidemiological studies, several meta-analyses, and a randomized trial in South Africa have investigated this association. The UNAIDS Multicentre study of four African cities found that prevalence of MC was one of the most significant factors explaining levels of HIV infection, with cities with high rates of MC having lower HIV prevalence even when sexual behavioral risk factors were similar.⁵⁸ The first randomized trial of MC, held in South Africa, found that MC has the potential to reduce HIV infection rates by 60 to 70 percent.⁵⁹ As of this writing, two additional randomized trials are underway in Uganda and Kenya. Findings to date are sufficiently strong that the US Presidential Advisory Council for HIV/AIDS is recommending that the MC evidence be carefully followed, with a view toward possible policy recommendations, at least for generalized epidemics.⁶⁰

Does the ABC approach contribute to the stigmatization and marginalization of PLWHAs?

Many public health strategies promote healthy behaviors that not everyone in a population is capable of, or willing to, adopt. Although this may be felt to stigmatize and marginalize those who do not adopt those healthy behaviors, the benefit for those who do adopt healthy behaviors may outweigh the risks of stigmatizing some. Consider the example of smoking. While the best public health campaigns about the dangers of smoking may not persuade all smokers to stop smoking, and may in fact make some smokers feel stigmatized, anti-smoking campaigns have proven to be effective. It is widely believed that the health, economic and environmental benefits of decreased smoking justify some stigmatization of those

⁵⁶ Ahmed S, Mosley H. *ABCDE...Zero HIV/AIDS*. Presentation at the Presidential Advisory Committee on HIV/AIDS, Washington, DC, 4 August 2003.

⁵⁷ Bongaarts J, Reining P, Way P, Conant F. The relationship between male circumcision and HIV infection in African populations. *AIDS* 1989; 3: 373-377.

⁵⁸ Auvert B, Buvé A, Lagarde E et al. Male circumcision and HIV infection in four cities in sub-Saharan Africa. *AIDS* 2001; 15 (Suppl.): S31-40.

⁵⁹ Auvert B, Taljaard D, Lagarde E, et al. Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. *PLoS Medicine* 2005; 2(11): 298.

⁶⁰ Grogan, J, Smith A, Sweeney M, et al. *Achieving an HIV-free Generation: Recommendations for a New American HIV Strategy*. Washington, DC: Presidential Advisory Council for HIV/AIDS (in press).

who continue to smoke. In fact, anti-smoking campaigns in the United States have been largely successful, and rates of lung cancer have fallen.

In the face of the health crisis of HIV/AIDS, advocates of an ABC approach feel that it is justified to promote an approach that has been effective in changing sexual behavior and saving lives. Some people may feel marginalized or stigmatized by an ABC approach, and may face social disapproval for either engaging in or *not* engaging in A, B, or C behaviors. Yet to object to an ABC approach on these grounds ignores the great benefit of such an approach to most people in a population. Specifically, to object to the promotion of abstinence and faithfulness because some will not or cannot abstain or be faithful ignores the fact that this message is appropriate for most people. As shown in Tables 3 and 4, in a given year, a majority of Africans already do practice faithfulness, measured in not having more than one sexual partner, or abstinence.

Faith communities and leaders have been accused of contributing to stigma towards PLWHAs, and some feel that it is inherently stigmatizing when faith leaders promote abstinence and faithfulness from a moral point of view. There have undoubtedly been times and situations in which faith communities and leaders have contributed to stigma. Stigma is often a problem at all levels of society, and faith communities are not immune. Yet in many situations faith communities have effectively addressed stigma, and have effectively promoted A and B behaviors. Uganda and Senegal stand out as African countries with relatively little AIDS-associated stigma. Both countries also promoted A and B behaviors, and partnered with Christian and Muslim FBOs in significant ways. Rather than being seen as part of the problem, faith communities were felt to be part of the solution, and their support was enlisted at a national level.

Has PEPFAR imposed the ABC approach on people in the developing world?

The President's Emergency Plan for AIDS Relief has adopted an ABC approach for generalized HIV/AIDS epidemics, using Uganda's experience as a model. Some observers allege that the ABC approach is driven by the ideology of US conservatives, and that PEPFAR inappropriately imposed it on other countries. In fact, the ABC approach was developed and successfully implemented by Africans, without significant involvement of the US or other large donor organizations. Although Ugandans did not invent the ABC approach or necessarily use the term "ABC" in the beginning of the pandemic, Uganda's response was to promote abstinence, faithfulness, and later, condom use. Other countries in Africa have since adopted an ABC approach, but Uganda still provides the best example of a balanced and successful implementation of the approach.

Far from dictating prevention approaches to Africans, PEPFAR has learned from an indigenous African approach. Africans, and particularly Ugandans, should be given the credit for an approach that was culturally relevant, extremely low cost, and very successful.

Has PEPFAR's emphasis on an ABC approach led to condom shortages in Uganda and elsewhere?

It has been alleged that Uganda has recently been discontinuing condoms in favor of an "abstinence-only" strategy.⁶¹ A recent supply problem (caused by a large batch of condoms that had to be recalled) has also fueled allegations that Uganda is experiencing a severe shortage of condoms. Ugandan officials have responded by saying that Uganda continues to promote all three components of the ABC approach, and

⁶¹ Cohen J, Schleifer R, Tate T. AIDS in Uganda: the Human-Rights Dimension. *The Lancet* 2005; 365: 2075-2076.

that Uganda has sufficient stocks of condoms. At the time of reports of critical condom shortages (summer 2005), Uganda procured 80 million condoms.⁶²

On a global scale, the US Government continues to be the largest single supplier of condoms worldwide. Under PEPFAR annual condom procurement has been steadily rising. In fact, the O/GAC estimates that in 2005 the U.S. Government will have shipped more than 612 million condoms to Africa, Asia and Latin America, the greatest annual figure since 1991.

In Uganda's current national Strategic Framework for HIV/AIDS document, which is a blueprint for all the activities supported in Uganda to combat AIDS, there are virtually no A or B elements. That is, there are no specific objectives or impact indicators related to abstinence or faithfulness. The document is mostly about condoms, testing, STDs, future vaccines, future microbicides, and ARV drugs. The document reflects the medical products and procedures emphasized in a bio-medical approach to HIV prevention rather than a socio-behavioral approach. Examination of other national AIDS documents shows the same trend.⁶³

A survey of AIDS-related media content in Uganda mass media, known as the Steadman Report, shows that in the last three years, most of the AIDS-related media expenditures have been for the promotion of condoms and VCT. Only about 4 percent of content was on abstinence. Proponents of the ABC approach are concerned that Uganda may be turning away from its proven prevention strategy, possibly influenced by advice and funding from international donors.

Should information about condoms be part of PEPFAR-funded programs promoting abstinence and faithfulness?

A recent policy brief from the Center for Health and Gender Equity (CHANGE) criticized prevention funding under PEPFAR, alleging, "PEPFAR-funded programs effectively ignore both reality and public health practice by eliminating comprehensive programs in favor of discrete AB programs."⁶⁴ CHANGE's policy brief raises several important questions, such as whether condom promotion should be part of AB programs. According to new OGAC guidance for fiscal year 2006, PEPFAR focus countries must spend a minimum of 50 percent of prevention funds on sexual transmission and two-thirds of their funding for prevention of sexual transmission on abstinence-only-until-marriage, secondary abstinence, and faithfulness programs. This guidance seems to supersede previous guidance that one-third of *all* prevention funds be used for abstinence programs.

Uganda's ABC approach, which serves as a model for PEPFAR, emphasized abstinence and faithfulness but included information about all possible ways of preventing AIDS. Even primary school students were given information about condoms, in the School Health Education Program begun in 1987. Rather than interpreting the new OGAC guidance as an attempt to steer away from a comprehensive approach, it should be seen as an attempt to ensure A and B programs receive a fair proportion of prevention resources. Condom promotion is still an integral part of prevention under PEPFAR, and receives one-third of funds for sexual transmission under the new guidance. The United States remains the largest provider of condoms in the world. Had there not been powerful resistance to inclusion of A or B programs in AIDS prevention efforts, and had indigenous HIV prevention programs been allowed to

⁶² US Harming Uganda's AIDS Battle. *BBC News*, Aug 30, 2005. Available at <http://news.bbc.co.uk/2/hi/africa/4195968.stm> (accessed Nov 27, 2005).

⁶³ For example, the *National Monitoring & Evaluation Framework, for HIV/AIDS Activities in Uganda. 2003/04-2005/06*, and the *National Condom Policy and Strategy*.

⁶⁴ Center for Health and Gender Equity, 2005

develop naturally as they did in Uganda, it might not have been necessary to have Congressional earmarks or guidance documents designed to ensure that resources actually go to AB.

A recent study suggested that condoms and mortality from AIDS—and not abstinence and faithfulness—had caused HIV prevalence to decline. Does this mean that an ABC approach didn't work in Uganda after all?

In February 2005, Wawer, Gray et al. presented a paper at the Conference on Retroviruses and Opportunistic Infections.⁶⁵ This paper was widely interpreted as proving that condoms and mortality from AIDS—and not abstinence and faithfulness—were responsible for Uganda's decline in HIV prevalence. Major newspapers reported on the story under such headlines as: "Uganda's HIV success has more to do with condoms than abstinence"⁶⁶; "Uganda: Condoms Outshine Abstinence in Aids Battle"⁶⁷; "Uganda's Decline in HIV/AIDS Prevalence Attributed to Increased Condom Use"⁶⁸; "HIV study downplays abstinence in Uganda."⁶⁹

Wawer and Gray suggest that because after 1994 there were higher levels of condom use and lower levels of monogamy and abstinence in Rakai, Uganda, therefore condom use (and mortality rates) had accounted for continuing declines in HIV prevalence. Dr. Henry Mosley makes the following points about the error of this assumption:⁷⁰

The Rakai study intensively covered only a small population in one district of Uganda and thus is difficult to generalize for all of Uganda. Furthermore, the period of intensive observation documenting changes in HIV incidence and prevalence and in trends in sexual abstinence and multiple partners was 1994-95 to 2002-03, well after the major decline in HIV prevalence in most of Uganda.

The data do permit the following two major conclusions regarding the effects of ABC on HIV trends in this district.

1) Over the entire study period A, B, and C did change as follows: men 15-19 reporting sexual abstinence *declined* from 60 percent to 47 percent; men 15-49 reporting 1 or more non-marital partners *increased* from 35 percent to 44 percent; men 15-49 reporting consistent condom use with last non-marital sexual partner *increased* from 18 percent to 73 percent. (Similar trends in ABC were seen among women.) The net effect of these countervailing trends was essentially *no change* in the annual incidence of HIV. Thus there is no evidence that condom use has altered the course of the epidemic during the study period. Rather the compensating effects of changes in A, B and C have kept the incidence stable.

⁶⁵ Wawer MJ, Gray R, et al. *Declines in HIV Prevalence in Uganda: Not as Simple as ABC*. Presentation at Conference on Retroviruses and Opportunistic Infections. Boston, MA, February 22, 2005.

⁶⁶ *The Advocate*, CA, 25 Feb 2005.

⁶⁷ *AllAfrica.com*, Africa, 24 Feb 2005.

⁶⁸ *Medical News Today*, UK, 26 Feb 2005

⁶⁹ *Newsday*, NY, 25 Feb 2005.

⁷⁰ Mosley H. Declining HIV in Uganda Cannot Be Explained by Mortality or Condoms (Letter). *British Medical Journal* 2005; 330: 496-a.

2) Epidemiologically, it can be shown that most of the decline in prevalence during the study period must come from a *decline in incident cases 7 to 8 years earlier*, not from a rise in death rates as reported by the authors. This analysis estimates that incident cases in the period 1987 to 1995 must have declined by about 40 percent. This was period when condom use must have been well below the 18 percent for men and 8 percent for women reported in 1994-95. The only factors reasonably accounting for this dramatic decline in this early period must have been and increase in A and B behaviors.

The countervailing trends in A, B, and C behaviors suggest that what is being observed with increasing condom use is “behavioral disinhibition”. Other protective behaviors are being discarded as condoms are being adopted. This could be an explanation for why condom programs alone have not been associated with any amelioration of population-wide heterosexual AIDS epidemics in many sub-Saharan African countries.

Even if the ABC approach did work in Uganda, is there evidence that it could work in other countries?

The ABC approach has been implemented to varying degrees in Senegal, Jamaica, Zambia, Kenya, and among Thailand’s general population, and elsewhere, with varying degrees of positive results in at least the countries just named.⁷¹ In Zambia, there were significant declines in HIV among youth in the 1990s⁷², but this was not sustained after about 1998.

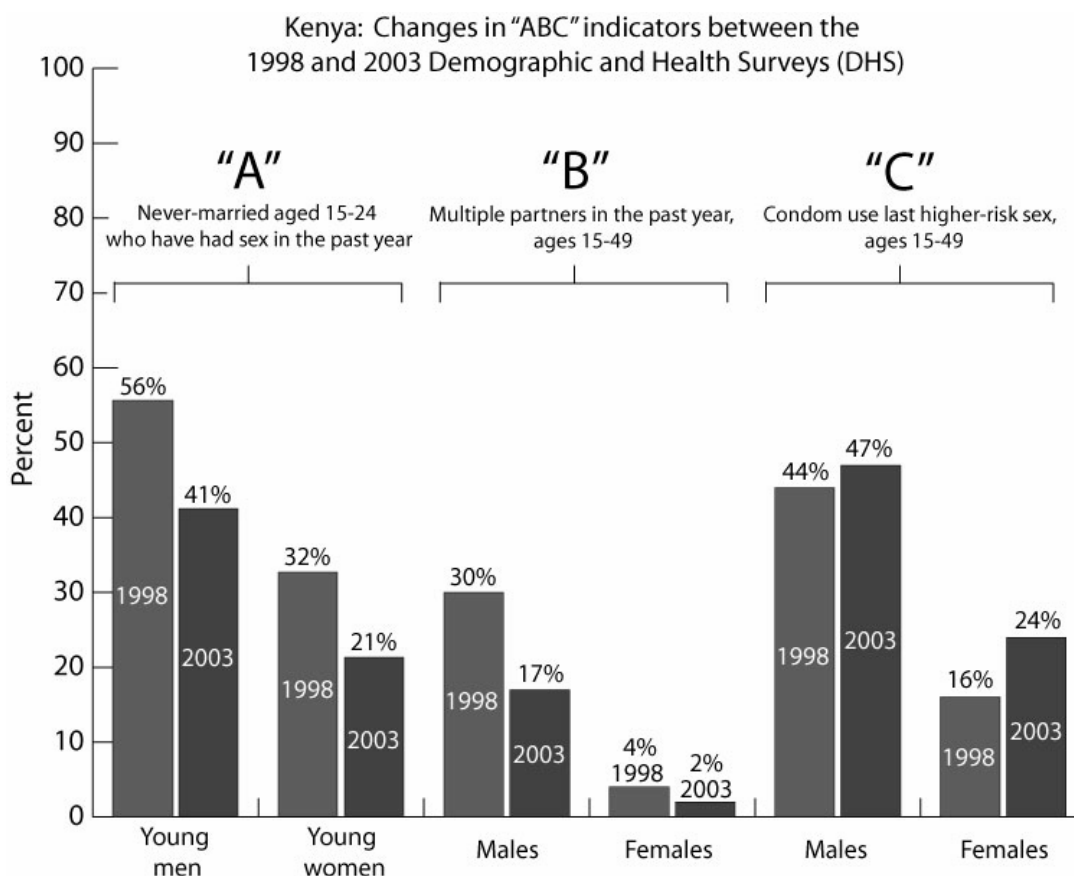
Kenya may provide the most recent example of a successful ABC approach. In Kenya, the major response to AIDS before 1999 was condom supply and promotion. There was little or no impact on the pandemic. Finally, the Kenyan government implemented an ABC approach. In addition, faith-based groups were mobilized. AIDS education was implemented in schools. Educators and officials emphasized the seriousness of the epidemic, and government officials were told that they must mention AIDS every time they had a public meeting.

As illustrated in Figure 5, which compares Kenya DHS data from 1998 and 2003, there was little change in condom use, especially among men. There was a significant increase in proportion of unmarried people reporting no sex in the past year, and a roughly 50 percent decline in the proportion reporting more than two partners in past year, among both men and women.

⁷¹ Green, 2003

⁷² Bessinger et al., 2003

Figure 5: ABC Behaviors in Kenya, 1998 to 2003



Source: Cassell, 2005

What impact did this have? Comparisons between population-based and antenatal clinic (ANC) surveys, using sophisticated statistical techniques, “suggest that the epidemic in Kenya peaked in the late 1990s with an overall prevalence of 10 percent in adults, and declined to 7 percent by 2003.”⁷³ The B component again appears to be the crucial factor associated with national HIV prevalence decline, just as in Uganda. Those reporting two or more partners in the past year in the 2003 DHS were twice as likely to be HIV-infected as those reporting one partner. National prevalence is now slightly lower than that of Uganda, which is estimated at 7 percent using the same population-based method. The fact that 80 percent of Kenyan men are circumcised likely contributes to lower infections rates in Kenya.

In mature epidemics, a large percentage of new HIV infections can occur in discordant couples. How can the ABC approach curb transmission among these couples?

As noted above, married people rarely use condoms, in spite of best efforts at promotion, and this is true even in sero-discordant relationships. This is lamentable but nevertheless the reality. We should keep trying to promote condoms to these couples and hope for better responses. Some HIV positive persons, however, do choose to abstain, so as not to be responsible for infecting others.

⁷³ UNAIDS, 2005

A study conducted by The AIDS Support Organisation (TASO) in Uganda found that over half of the HIV positive Ugandans in TASO reported abstinence as their behavioral response to knowing that they were infected with HIV. This relatively high level is probably due in part to the fact that abstinence is promoted in Uganda. Discordant couples also clearly need the Be faithful message. Even if every uninfected partner became infected, this would not perpetuate the epidemic unless infected people infected more than one partner. (For epidemics to be sustained, the “reproductive number” must be greater than one.) Thus the B message, if followed, has a strong protective effect at the broader population level. Even at the individual level, sex with multiple partners can lead to superinfection⁷⁴, making AIDS worse and complicating the prospect of treatment. Therefore even in the situation of sero-discordant couples, A and B messages can have great relevance.

⁷⁴ Superinfection occurs when a person becomes infected by two different strains of the HIV virus.

Conclusion

This paper has devoted much effort to explaining and defending the AB components of ABC. This is because these components are the least understood and raise the most concerns—not necessarily among the public, but among those who work in key AIDS and reproductive health organizations, including decision makers and program implementers. The major organizations and agencies working in HIV prevention—USAID, UNAIDS, the World Bank, the WHO, the EU, as well as implementers such as Family Health International and Population Services International—have several decades of experience in designing and implementing condom programs. There is no such experience in AB programs. These organizations have not put significant resources into abstinence or faithfulness interventions anywhere in the world, although this began to change in 2002 and 2003 when USAID and PEPFAR adopted an ABC approach for countries with generalized epidemics. Yet even within these agencies, there has been confusion, resistance, fear, rumor, political and ideological debate, misunderstanding and misrepresentation of the Uganda ABC approach, notably the new AB components.

There has also been resistance to, and misinformation about, condoms. This should be addressed, although condom opponents or skeptics are not normally represented in the major AIDS and reproductive health organizations. Until quite recently, those unwilling to promote condoms, such as Catholic organizations, were simply excluded from HIV prevention programs that were funded by major donor organizations. Yet if the United States is following the Uganda approach, it should be realized that the Ugandan government made faith-based organizations key partners as it confronted AIDS. For instance Uganda funneled foreign donor funds to local Catholic NGOs from very early in the epidemic, knowing that Catholics represented nearly 40 percent of the population and were already major players in care and support of PLWHAs, orphans and vulnerable children, as well as in the treatment of PLWHAs. Catholics were also willing and able to promote effectively the AB components of AIDS prevention, and the government realized they would be less likely to oppose condom promotion if they were working collaboratively with major donors and NGOs in prevention.

The authors of this document agree with the consensus statement published in *The Lancet* and endorsed by over 150 scientists, NGO AIDS workers, activists, and President Museveni of Uganda, namely:

All three elements of this approach are essential to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population. Although the overall programmatic mix should include an appropriate balance of A, B, and C interventions, it is not essential that every organisation promote all three elements: each can focus on the part(s) they are most comfortable supporting. However, all people should have accurate and complete information about different prevention options, including all three elements of the ABC approach.⁷⁵

Some observers have suggested that the AB components are no longer relevant in “mature epidemics,” such as that in Uganda. We have addressed this question above, and the most recent public statement from the Ugandan government—the lead author being the official who ran the Uganda’s national AIDS Control program in the earliest years—is that ABC is needed even more in the era of antiretroviral treatment:

⁷⁵ Halperin, Steiner et al., 2004.

Abstinence, being faithful, and condom use are complementary, synergistic, and inseparable components in the country's HIV/AIDS national prevention and control programmes, and we need to roll out these prevention messages with extra urgency now, in the era of ART.⁷⁶

Finally, we wish to stress that we are not arguing for shifting attention and resources away from those at high risk, including the powerless, oppressed, exploited, raped and abused. We *are* saying that it is inaccurate to characterize all people this way (or all Africans, in the context of this paper), and that we can no longer target all HIV prevention resources to this minority group. It is a tragedy that all-or-nothing thinking and polemics have dominated the AIDS debate to date and have deemed the only compassionate response one that targets the most oppressed and treats everyone as equally high-risk. What has been missing in this bitter debate is a calm, even-handed, balanced viewpoint that recognizes that some resources clearly must be targeted to high-risk groups, while some resources must be directed to what survey and epidemiological evidence show are the majority of people. To target only those at high-risk is to effectively ignore most of the population. To target both minority (high-risk) and majority populations need not result in diminished quality or even quantity of prevention resources going to either group. It is only catastrophist, polemical, all-or-nothing thinking that would have us believe otherwise. If Uganda, with very few resources in the early years of its response to AIDS, could design and implement a *balanced and targeted* ABC program, surely the major donors with billions of dollars can do the same.

⁷⁶ Okware et al., Revisiting the ABC strategy: HIV prevention in the era of antiretroviral therapy. *Postgraduate Medical Journal* 2005; 81: 625.

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