

Improving U.S. Global HIV Prevention for Youth

A Critique of the Office of Global AIDS Coordinator's ABC Guidance

Introduction

In March 2005, the Office of the Global AIDS Coordinator (OGAC) issued a policy directive entitled “ABC Guidance #1: 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.” The purpose of the guidance was to clarify the implementation of the Abstinence, Be Faithful, Condoms (ABC) approach within the President’s Emergency Plan for AIDS Relief (PEPFAR) while taking into consideration the abstinence-until-marriage earmark mandated by Congress in the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003.¹

The ABC Guidance states:

To limit the progression of the HIV/AIDS pandemic, there must be dramatic reductions in new infections. The Emergency Plan is committed to evidence-based best practices in prevention interventions to achieve the Plan’s prevention objectives.

Yet, underlying the OGAC guidance regarding programs for youth are the following scientific inaccuracies:

- Segmenting programs for youth is a proven HIV prevention strategy.
- Providing young people with information about condoms will confuse youth and encourage them to have sex.
- Promoting abstinence-until-marriage will increase abstinence and secondary abstinence for those who already have had sex.
- Marriage is an effective HIV prevention tool.

These myths are not supported by public health science and ignore the realities of young people’s lives in PEPFAR countries. Advocates for Youth urges OGAC to revise the ABC guidance to more accurately reflect evidence-based best practices. Revising the guidance will enhance PEPFAR’s efficacy and will encourage PEPFAR implementing partners to replicate effective strategies for HIV prevention among youth.

GAO Report Findings

An April 2006 GAO report, “Spending Requirement Presents Challenges for Allocating Prevention Spending under the President’s Emergency Plan for AIDS Relief,” found that the guidance presented challenges for country teams.¹ The report states:

“Lack of clarity in the ABC guidance has created challenges for a majority of focus country teams. Although a number of the teams told us that they found the guidance clear or easy to implement, 10 of the 15 focus country teams cited instances where elements of the guidance were ambiguous and confusing, leading

to difficulties in its interpretation and implementation. For example, although the guidance restricts activities promoting condom use, it does not clearly delineate the difference between condom education and condom promotion, causing uncertainty over whether certain condom-related activities are permissible.” (p.5)

“Six focus country teams and some implementing partners expressed uncertainty regarding the populations that should be considered at-risk in accordance with the ABC guidance. Five of these teams expressed concern that certain populations that need ABC messages in their countries might not receive them because they do not fit the ABC guidance definition of at-risk. For example, one team noted that the majority of HIV infections in its country are transmitted from one partner to another in either married or stable, cohabitating relationships. However, this team told us that they understood the ABC guidance on high-risk groups to be relevant only to a “limited epidemic” (unlike the generalized epidemic in which they were working) and that married couples do not count as high-risk under PEPFAR. As a result, they believed that a program designed to reach these individuals through ABC messages to a broad population would not be allowed. In addition, three teams questioned how to apply the definition of at-risk in a generalized epidemic.” (p.32)

“The ABC guidance prohibits PEPFAR-funded programs in schools from providing condom information to youths younger than 15, but the guidance does not discuss the application of this age cutoff to groups that include youths younger and older than 15. Four focus country teams noted that the age cutoff for providing condom information to youths presents challenges because classrooms and out-of-school programs often include mixed-age groups. Two teams told us that, in these situations, only AB messages are typically provided to the entire group and, as a result, some older youths who need ABC messages may not receive them.” (p. 33)

The GAO report also gave the impression that the guidance would be revised.

“OGAC officials told GAO that they plan to clarify the guidance.” (p.2)

“OGAC officials acknowledged that certain components of the guidance can be confusing and told us that they are working to clarify them.” (p.5)

However, in a briefing held for NGOs by OGAC on July 20, 2006 at the U.S. Peace Corps, the Assistant Director for OGAC, Ambassador Jimmy Kolker, stated that there would not be revisions to the guidance.

Advocates for Youth believes that clarifications must be provided in the form of revised guidance due to the scientific inaccuracies underlying the current guidance. These inaccuracies lead OGAC to provide guidance based in commonly held misperceptions, not grounded science-based practice.

Current OGAC Guidance and Scientific Inaccuracies

The OGAC Guidance states that the ABC approach to HIV prevention need only be comprehensive at the country level, and that sub-populations within a country should be targeted with specific components of the approach (A, B, or C) based upon OGAC’s perception of their needs. Young people are identified as a sub-population that need not be provided with all three components of the ABC approach. The guidance states:

The ABC approach employs population specific interventions that emphasize abstinence for youth and other unmarried persons . . . (p.2)

Young people who have not had their sexual debut must be encouraged to practice abstinence until they have established a lifetime monogamous relationship. (p.5)

For those youth who have initiated sexual activity, returning to abstinence must be a primary message of prevention programs. (p.5)

Implementing partners must take great care not to give a conflicted message with regard to abstinence by confusing abstinence messages with condom marketing campaigns that . . . encourage sexual activity or appear to present abstinence and condom use as equally viable, alternative choices. Thus, marketing campaigns that target youth and encourage condom use as the primary intervention are not appropriate for youth and the Emergency Plan will not fund them. (p.5)

Segmenting the ABC approach by population is fundamentally flawed, defeats its effectiveness, and is not supporting by public health science. A sole “AB” strategy for preventing HIV infection for young people is effectively an abstinence-only approach.

OGAC’s Guidance to implementing partners serving youth is founded in four scientific inaccuracies and therefore flawed.

Scientific Inaccuracy #1: Segmenting prevention programs for youth is a proven HIV prevention strategy.

The guidance states that abstinence or a return to abstinence must be the primary message for youth in PEPFAR countries, and that information about correct and consistent condom use should be provided only to youth who engage in risky sexual behaviors. But assuming that implementing partners will be able to distinguish between youth who are engaging in risky sexual behaviors and those who are not is unrealistic. It is unreasonable to believe that youth will readily disclose such personal information or that implementing partners will be able to ascertain the distinction simply through their interactions with the young people they intend to serve.

The guidance provides no data to support a segmented approach. In fact, research clearly indicates that all young people—abstinent or not—benefit from a comprehensive approach that includes full disclosure of medically accurate, age appropriate information about both abstinence and condoms. One example is a program in Nigeria, *HIV Prevention Education for High School Students*, a comprehensive sexual health education and HIV/STI prevention curriculum in Nigeria targeting youth ages 13-20. The program showed delays in initiation of sexual intercourse, reduction in number of sex partners, and increased use of condoms. The program evaluation showed that at six month follow-up, 76 percent of intervention students reported no sexual experience versus 62 percent of comparison students.² Providing comprehensive information about HIV that is linked with sexual and reproductive health that includes honest, accurate information about condoms is a proven strategy for reducing HIV infection in young people.^{2,3,4,5,6,7,8,9,10,11}

If implementing partners cannot determine which youth are engaging in risky sexual behaviors, and the guidance mandates a segmented approach, prohibiting the provision of condom information or the distribution of condoms to those who have not initiated sex, then the partners, in fear of losing their funding, may err on the side of caution and not provide information about or access to condoms. The guidance puts an unfair burden on implementing partners and may prevent them from providing youth with the knowledge and services they may desperately need.

Scientific Inaccuracy #2: Providing young people with information about condoms will confuse youth and encourage them to have sex.

This assumption may be the most egregious inaccuracy in the guidance. The belief that the provision of information about condoms promotes sexual activity is just plain wrong. Numerous rigorous evaluations examining the impact of sexuality education on sexual activity both domestically and in developing nations have found that the provision of information about condoms does not increase sexual activity, lower the age of first sexual debut, or increase the number of partners among young people when they do have sex.^{18,19,20,21,22,23,24}

Further, those programs that have successfully reduced the age of first sexual debut and/or increased abstinence among youth are programs that provide information about both abstinence and condoms as well as increase young people’s communication and decision making skills.^{2,3,4,5,6,7,8,9,10,11}

There is no scientific evidence that programs that deny young people access to and information about condoms demonstrate efficacy in delaying initiation of sexual intercourse. Research shows comprehensive HIV education to be more effective

than abstinence-only-until-marriage programs in assisting young people to make healthy decisions to prevent HIV infection. Both domestically and in developing nations, studies have shown that adolescents who receive comprehensive reproductive health and HIV education that includes accurate information about contraception and condoms are more likely than those who receive abstinence-only messages to delay sexual activity and to use contraceptives when they do become sexually active. Comprehensive reproductive health and HIV education programs do not encourage adolescents to start having sexual intercourse; do not increase the frequency with which adolescents have intercourse; and do not increase the number of partners with whom an adolescent has sex.^{18,19,20,21,22,23,24}

At the heart of the assumption that condoms cause sex is a systematic attack on public confidence in condoms. The guidance encourages implementing partners to conduct activities for youth focused on the A and B components of the ABC approach, and prohibits Emergency Fund use for condom campaigns that would help sexually active young people obtain condoms and learn to use them more consistently and correctly. The Centers for Disease Control (CDC) recommend condoms as highly effective in preventing HIV transmission and has found that condoms reduce the risk of other sexually transmitted infections including gonorrhea, chlamydia, and human papillomavirus (HPV).²⁸ To withhold condoms from sexually active youth (or those who will become sexually active in time) is unethical, both medically and politically, and represents poor public health practice.

Young people themselves have urged the global community to provide comprehensive reproductive health and HIV prevention information and services. At the June 2006 UN High Level Meeting in New York, approximately 60 young people from 30 countries convened for a Youth Summit. They communicated a Youth Message to the attendees of the High Level Meeting that stated,

“We, young people, demand that education be a collaborative effort between governments and young people.

Education must include the discussion of sexual orientation, gender issues, sexual and reproductive health, and work in partnership with religious and community leaders when necessary to ensure that all initiatives are evidence-based.

While abstinence and being faithful are critical, male and female condoms are the most effective prevention tools for sexually active youth.”²⁵

Scientific Inaccuracy #3: Promoting abstinence-until-marriage will increase abstinence and secondary abstinence for those who have already had sex.

The assumption that abstinence-until-marriage programs increase abstinence may appear on the surface to be a logical one. However, after ten years of federally-funded domestic abstinence-only-until-marriage programs, the claim remains unproven.²⁶ No credible, peer reviewed study has demonstrated conclusively that these programs have had any long-term positive impact on reducing adolescent sexual risk taking.²⁹ In fact, some domestic abstinence-only programs have been shown to have detrimental effects on young people’s health, increasing negative attitudes about condoms as well as participants’ risk for engaging in unprotected sexual intercourse when they do have sex.²⁷

The Society for Adolescent Medicine (SAM) recently published a review paper of domestic abstinence-only-until-marriage education in the Journal of Adolescent Health. SAM found that an abstinence-only approach to education “is flawed from scientific and medical ethics viewpoints” and “should be abandoned.” SAM further stated that these “programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers.” SAM also drew an important distinction between abstinence as a personal health strategy and as public health policy, noting that for abstinence-only education, “studies suggest that, in actual practice, efficacy may approach zero.”¹²

While PEPFAR does not define abstinence-until-marriage with the same 8-point legal definition found in the domestic programs, it does appear that many international programs are following the model of U.S. based abstinence-only programs. In 2004, Uganda developed government policy on abstinence and fidelity. The definition of abstinence education in “Uganda National Abstinence and Being Faithful Policy and Strategy on Prevention of Transmission on HIV” is modeled almost

verbatim after the eight point definition of “abstinence education” in the U.S. Personal Responsibility and Work Opportunity Reconciliation Act of 1996.¹³

Abstinence is the safest option for youth who are not yet sexually active and should be included in all comprehensive HIV prevention programs for young people. However, programs must take into account the fact that a large share of unmarried adolescents in PEPFAR countries are already sexually active, and require programs that will provide full information to enable them to make informed choices and to protect themselves if they choose to remain sexually active.

Scientific Inaccuracy #4: Marriage is an effective HIV prevention tool.

This assumption is built on a disregard for data and a failure to acknowledge the realities of young women’s lives in many Sub-Saharan African countries. The report implies that abstinence until marriage will mean a delay in first sexual experience for young women, desirable since early debut is associated with higher rates of HIV infection. Yet in a number of developing countries, a majority of young women are married before age 18—and significant numbers are married before they are 15. The husbands of these married adolescents are likely to be older and more likely to be infected with HIV than the boyfriends of unmarried adolescents.¹⁴

Meanwhile, married young women are statistically very unlikely to have protected sex; in fact, they consider marriage and monogamy to be their primary HIV prevention strategy.¹⁴ Furthermore, studies have shown that married women are more likely to have been coerced or forced into sex than their unmarried counterparts;¹⁶ and that men who rape or physically harm their partners are more likely to be HIV positive.¹⁵ In such a climate marriage is hardly the safe haven from disease that the guidelines make it out to be. In fact, in some developing countries, married women have higher rates of HIV infection than their unmarried, sexually active peers; in Kenya, for example, married adolescents’ HIV rate is 6.5%, vs. a rate of 2.5% for their unmarried sexually active peers.^{14,17} Yet the guidelines insist on an emphasis on abstinence until marriage as the primary HIV prevention strategy for youth.

We concur with OGAC that reduction in number of partners is critical to preventing the transmission of HIV; and a monogamous relationship between uninfected partners is guaranteed protection. However, promoting marriage and faithfulness within marriage as the sole strategy for HIV prevention in developing countries is unethical, deluded, and dangerous. Partner reduction and condom use should be promoted equally, to both young men and young women.

Suggested Revisions in Priority Interventions: Abstinence and Behavior Change for Youth

OGAC should revise its guidance to reflect evidence-based best practices for the prevention of HIV among youth. Abstinence should be emphasized as the only 100 percent effective method of HIV prevention, but young people should also be provided with age appropriate, medically accurate sexual health information, access to confidential sexual health services, and a secure stake in the future.

Below is a chart of the current guidelines as well as suggested revisions that better reflect public health research and encourage implementation of effective HIV prevention strategies for youth.

Current Guidance	Suggested Revisions
For 10-to-14 year olds, the Emergency Plan will fund age-appropriate and culturally appropriate “AB” programs that include promoting (1)dignity and self-worth; (2) the importance of abstinence in reducing the transmission of HIV; (3) the importance of delaying sexual debut until marriage; and (4) the development of skills for practicing abstinence.	For 10-to-14-year-olds, the Emergency Plan will fund age-appropriate and culturally appropriate “ABC” programs that promote (1) dignity and self-worth, (2) focus on the importance of delaying sexual debut, (3) build self-esteem, (4) foster communication and decision-making skills, and (5) provide age appropriate information about how HIV can be prevented, including partner reduction and condom use.

<p>For older youth (above age 14) the Emergency Plan will fund ABC programs that promote (1) dignity and self worth; (2) the importance of abstinence in reducing the transmission of HIV; (3) the importance of delaying sexual activity until marriage; (4) the development of skills for practicing abstinence, and where appropriate, secondary abstinence; (5) the elimination of casual sexual partnerships; (6) the importance of marriage and mutual faithfulness in reducing the transmission of HIV among individuals in long-term relationships; (7) the importance of HIV counseling and testing; and (8) provide full and accurate information about correct and consistent condom use as a way to significantly reduce—but not eliminate—the risk of HIV infection for those who engage in risky sexual behaviors.</p>	<p>For older youth (above age 14) the Emergency Plan will fund ABC programs that promote (1) dignity and self worth; (2) build self-esteem, (3) foster communication and decision making skills; (4) focus on the importance of delaying sexual debut for youth not yet sexually active; (5) focus on partner reduction and correct and consistent condom use for those who are already sexually active; and (6) provide information the importance of HIV counseling and testing as well as links to Voluntary Counseling and Testing Services.</p>
<p>Emergency Plan funds may be used in schools to support programs that deliver age appropriate “AB” information to young people age 10-14.</p>	<p>Emergency Plan funds may be used in schools to support programs that deliver age-appropriate “ABC” information to young people age 10-14.</p>
<p>Emergency Plan funds may be used in schools to support programs that deliver age appropriate “ABC” information for young people above age 14.</p>	<p>Emergency Plan funds may be used in schools to support programs that deliver age-appropriate “ABC” information, including condom provision for young people above age 14.</p>
<p>Emergency Plan funds may be used to support integrated ABC programs that include condom provision in and out-of-school programs for youth identified as engaging in or at high risk for engaging in risky sexual behaviors.</p>	<p>Emergency Plan funds may be used to support integrated ABC programs that include condom provision in out-of-school programs for youth, as well as linkages to reproductive health services.</p>
<p>Emergency Plan funds may not be used to physically distribute or provide condoms in school settings.</p>	<p>Emergency Plan funds may be used to physically distribute or provide condoms in school settings for youth above age 14.</p>
<p>Emergency Plan funds may not be used in schools for marketing efforts to promote condoms to youth.</p>	<p>Emergency Plan funds may be used for marketing campaigns that target youth and encourage abstinence, partner reduction and condom use as primary interventions for HIV prevention.</p>
<p>Emergency Plan funds may not be used in any setting for marketing campaigns that target youth and encourage condoms use as the primary intervention for HIV prevention.</p>	<p>Emergency Plan funds may be used for marketing campaigns that target youth and encourage abstinence, partner reduction and condom use as primary interventions for HIV prevention.</p>

Conclusion

Evidence-based practice does not support the implementation of the ABC strategy as outlined in OGAC's current guidance. In particular, the AB approach for youth is shortsighted and based on the unscientific fear that information about condoms or the provision of condoms will increase sexual activity among youth. The failure to include in PEPFAR, behavior change communications strategies, such as condom marketing campaigns for sexually active youth is shortsighted and dangerous and undermines public confidence in condoms. OGAC should revise its guidance to better reflect public health science and should fund programs that provide all young people with tailored, culturally relevant, age appropriate information and services to promote abstinence, partner reduction and normalization of condom use when sexually active.

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