A CRITICAL ANALYSIS OF THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR) AND ITS EMPHASIS ON ABSTINENCE-ONLY PREVENTION

by

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Abstract

The President's Emergency Plan for AIDS Relief (PEPFAR) is the most recent in a series of policies aimed at promoting abstinence-only education over comprehensive sex education – those that combine information on abstinence, monogamy, and contraceptive use. United States policies promoting abstinence as the sole option for youth are as old as the AIDS pandemic itself – originating in 1981 with the Adolescent Family Life Act. PEPFAR represents the first "exporting" of abstinence-only education to developing nations besieged by HIV/AIDS.

Numerous evaluations have been conducted on the relative effectiveness of abstinence-only education and comprehensive sex education programs. These studies overwhelming illustrate the failure of abstinence-only programs to achieve their goals, while demonstrating the effectiveness of comprehensive sex education in delaying sex, reducing partners, and increasing contraceptive use. In support of this extensive evidence, several health organizations and associations - including the American Public Health Association, the Society for Adolescent Medicine, and the American Academy of Pediatricians - have generated policy statements supporting comprehensive sex education for youth.

Despite the evidence, PEPFAR requires that two-thirds of funds available for prevention of the sexual transmission of HIV/AIDS be restricted to abstinence-only education interventions. PEPFAR and its supporters claim that abstinence-only education is an "African solution" to HIV/AIDS, citing Uganda's success in lowering its prevalence using what has come to be known as the ABC Model – Abstain, Be faithful, use Condoms. However, PEPFAR has significantly altered – some would say distorted –

the Ugandan model. PEPFAR requires that donor recipients separate "AB" from "C" and remove information on contraception and condom use from their schools - in effect, transforming a model of comprehensive sex education for all into one that is essentially abstinence-only for youth.

There has been an international outcry against PEPFAR and its feared impact on the HIV/AIDS pandemic. Meanwhile, Uganda – which receives more PEPFAR funds than any other country - reported in 2005 that the decline in the country's HIV prevalence rate has stagnated and even increased over the past three years, rising from 6.2 percent in 2002 to 7.1 percent in 2005 (UAC, 2005). Several U.S. policymakers have reexamined PEPFAR and legislation has been introduced in the House of Representatives to amend PEPFAR. *It is critical that the PEPFAR's abstinence-only funding requirements be repealed, and that the ban on condom education for youth be lifted.*

On a larger scale, PEPFAR stands as a glaring example of ideology trumping evidence-based best practice. Clearly, we cannot assume that U.S. policymakers will support evidence-based best practices in HIV prevention. Therefore, health legislation – with its potential for life or death consequences –must be subject to review and approval by an independent panel of health experts.

I. Introduction

It has been twenty-five years since AIDS was first diagnosed in the United States. In this period, worldwide cumulative deaths are estimated at 25 million. In 2005, an estimated 38.6 million people worldwide were currently living with HIV; of these, 24.5 million (63.5%) made their homes in sub-Saharan Africa. New infections in 2005 numbered 4.1 million worldwide, with deaths that same year estimated at 2.8 million (UNAIDS, 2006). Yet, these disturbing numbers do not capture the full devastation of AIDS which has orphaned millions of children, all but destroyed national economies, and impacted nearly every sector of society.

The United States was late to join in the global fight against AIDS. Today, however, the U.S. is among top donors to the cause. In his January 2003 State of the Union address, George W. Bush announced the "President's Emergency Plan for AIDS Relief" (PEPFAR). In May 2003, PEPFAR became law with the passage of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act which provided $15 billion in funding over five years "to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean" (Bush, 2003).

II. Goals and Objectives

This paper provides a critical analysis of PEPFAR's underlying assumptions and approach to the sexual prevention of HIV/AIDS. It will not address aspects of PEPFAR related to the prevention of mother-to-child transmission or the provision of antiretrovirals (ARVs).

This paper has three main goals. The first goal is to evaluate PEPFAR's approach to HIV prevention in the context of evidence-based best practices. PEPFAR asserts that it supports comprehensive sex education while requiring that two-thirds of all monies earmarked for HIV/AIDS prevention be devoted exclusively to "abstinence until marriage" programs, with the remaining one-third of funds available for other prevention methods, including condoms - *provided only high risk groups are targeted.* However, by definition, comprehensive sex education requires that all options - abstinence, monogamy, and contraception - be presented to the same individual. Providing some individuals with information on abstinence/monogamy, and a separate group of individuals with information on condoms and contraception, clearly fails to meet this criterion.

The second goal of this paper is to evaluate PEPFAR's assertion that it is "an African solution to an African problem" based on the Ugandan model of "Abstain, Be faithful, use Condoms" (ABC). Policy documents and studies from Uganda will reveal critical differences between the Ugandan ABC experience and PEPFAR's definition of and requirements for implementing ABC.

The third goal is to provide recommendations for policy changes to PEPFAR based on the findings of the research described above. General recommendations regarding the adoption of health policy in the United States, as well the adoption of HIV prevention policies that will be implemented internationally, will also be offered.

III. Methodology

This paper is the result of an analysis of U.S. and Ugandan government policy documents and program reports; policy statements from groups such as the American Public Health Association (APHA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS); articles and studies on the impact and effectiveness of various HIV/AIDS prevention strategies; and statements from leading AIDS advocacy organizations.

IV. Abstinence-Only Education in the United States

Abstinence-only education as policy in the U.S. has its roots in the Adolescent Family Life Act (AFLA) of 1981. AFLA was designed to reduce teen pregnancy and promote abstinence-only education with an openly religious slant. As a result, the American Civil Liberties Union (ACLU) challenged the Act on the grounds that it violated the separation of church and state. After several years of litigation, the ACLU reached an out-of-court settlement in 1993 which stipulated that AFLA-funded programs must "1) not include religious references, 2) be medically accurate, 3) respect the principle of self-determination regarding contraceptive referral for teenagers, and 4) not allow grantees to use church sanctuaries for their programs or to give presentations at parochial schools during school hours" (Daley, 1997).

The next major act of legislation to promote abstinence-only education was Title V of the Social Security Act (1996). This act provided an eight-point definition of abstinence education as an "educational or motivation program that:

> (A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity" (Social Security Act of 1996, Sec. 510).

Title V set aside $250 million for five years of abstinence-only programming. During this period, all states except California participated in the program. In 2000, additional funding for abstinence-only programming became available to both public and private entities through the Special Projects of Regional and National Significance—Community-Based Abstinence Education Grant Program (SPRANS-CBAE) of the U.S. Department of Health and Human Services. From 1998-2003, almost $500 million in state and federal funds were spent on abstinence-only education programs (Hauser, 2004).

A logic model for abstinence-only education has rarely been articulated by programs that promote this type of HIV prevention, relying instead on "implicit theory" or "program staff's underlying beliefs about the relationship between program activities and program outcomes" (Goodson et al, 2006). In 2006, the results of one of only two known studies to systematically examine the underlying logic model behind abstinence-only programs were reported. Through an examination of sixteen abstinence-only education programs in Texas, Goodson et al (2006) found that these interventions sought

to promote abstinence by targeting various combinations of 23 inter- and intra-personal factors that were believed to affect youths' ability to abstain from sex. These factors include, among others, connection with groups, respect for others, self-esteem, spirituality, knowledge of consequences, and decision-making skills. Program staff asserted that the key to achieving abstinence among youth was raising self-esteem and creating, through community groups, clubs, and other activities, a pro-abstinence environment.

While the findings of Goodson's research indicate that abstinence-only education is based on behavioral theory, this particular study did not examine the effectiveness of these types of programs to achieve their goals. However, numerous evaluations of these and other abstinence-only education programs have been conducted.

V. The Evidence on Abstinence-Only and Comprehensive Sexual Education

Several studies have evaluated the effectiveness of abstinence-only versus comprehensive sex education programs – those that promote abstinence and monogamy, but also teach about contraception, condoms, and sexually transmitted diseases. After the first five years of Title V funding under the Welfare Reform Act of 1996, a handful of states released evaluations of their abstinence-only programs. Pennsylvania's evaluation concluded: "taken as a whole, this initiative was largely ineffective in reducing sexual onset and promoting attitudes and skills consistent with sexual abstinence" (Smith, et al, 2003).

In 2005, the *Dallas Morning News* reported on a state-sponsored evaluation of abstinence programs in Texas conducted by researchers at Texas A&M University. The

evaluation found that 23 percent of ninth-grade girls reported having had sexual intercourse before they received abstinence education, while 28 percent of the same girls reported having had sexual intercourse *after* receiving abstinence education. The study also found that the percentage of 10th grade boys reporting sexual activity increased from 24 to 39 percent after participating in abstinence education. (Medical News Today, 2005).

In 2001, the results of a landmark study of evaluations of programs to reduce teen pregnancy were reported (Kirby, 2001). The analysis concluded that *none* of the abstinence-only programs evaluated "showed a positive effect on sexual behavior, nor did they affect contraceptive use among sexually active participants." On the other hand, "a large body of evaluation research shows that [comprehensive] sex and HIV education programs...do not hasten the onset of sex, increase the frequency of sex, nor increase the number of sexual partners. To the contrary, some sex and HIV education programs delay the onset of sex, reduce the frequency of sex, or reduce the number of sexual partners" (Kirby, 2001).

A recent study by Bearman and Bruckner (2005) compared youth who took "virginity pledges" with peers who did not. They found that while pledges did delay first sexual intercourse for an average of 18 months (though generally not until marriage), these same individuals were 33 percent less likely than their peers to use contraception when they did become sexually active. Furthermore, youth who made virginity pledges were found to have the same rate of sexually transmitted diseases as their non-pledging peers.

The federal government commissioned its own study of abstinence-based education in 1998. Interim results of this study were released by Mathematica Policy Research, Inc., in 2005, with final results expected late this year. Interestingly, the interim report chose not to evaluate *behavior change* among youth, but focused only on youths' *intentions* regarding abstinence. The report concluded that there was "some evidence that programs increased *expectations* (italics mine) to abstain from sex and reduced dating. However, program and control group youth reported similarly on the remaining measures examined, including their views on marriage, self-concept, refusal skills, communication with parents, perceptions of peer pressure to have sex, and the extent to which their friends hold views supportive of abstinence" (Maynard et al, 2005).

VI. Support for Comprehensive Sexual Education: Policy Statements from Leading Government and Health Organizations

Given what many consider overwhelming evidence in support of comprehensive sex education, several highly respected health organizations and international government bodies have issued policy statements on abstinence-only education and the use of condoms in preventing HIV and STDs.

The Joint United Nations Programme on HIV/AIDS (UNAIDS): "To be effective, HIV prevention must utilize all approaches known to be effective, not implementing exclusively one of a few select actions in isolation....HIV prevention actions must be evidence-informed, based on what is known and proven to be effective...." (UNAIDS, 2005)

American Academic of Pediatrics (AAP): "Despite the lack of evidence supporting the effectiveness of abstinence-only-until-marriage programs, as well as

evidence demonstrating the potential harm such programs have on adolescents' sexual health, the federal government continues to increase funding for abstinence-only-until-marriage programs" (AAP, 1999). (See Appendix A: Federal Funding for Abstinence-Only Programs FY82 – 05.)

American Public Health Association (APHA): "All states should require that local school districts and schools plan and implement comprehensive sexuality education as an integral part of comprehensive K-12 school health education. The education must: be scientifically and medically accurate and based on theories and strategies with demonstrated evidence of effectiveness; be consistent with community standards, yet be implemented in a nonjudgmental manner that does not impose religious viewpoints on students; support positive parent/child communication and guidance; be age, developmentally, linguistically, and culturally appropriate; and be taught by well-prepared teachers who have received specialized training in the subject matter" (APHA, 2005).

National Institute for Health (NIH): "Following an extensive review of the scientific literature covering hundreds of studies, scientific presentations by 15 research experts, and public testimony during a 3-day Consensus Development Conference on Interventions to Prevent HIV Risk Behaviors, the panel determined that the evidence is clear that behavioral intervention programs such as needle exchange (which provides sterile needles to drug users so they do not have to share or reuse them), drug abuse treatment, and youth education on safer sex, while controversial politically, are indeed successful scientifically" (NIH, 1997).

Society for Adolescent Medicine (SAM): "Providing abstinence-only or abstinence until marriage messages as a sole option for teenagers is flawed from scientific and medical ethics viewpoints. SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active… Governments and schools should eliminate censorship of information related to human sexual health" (SAM, 2006).

European Union: "We the European Union, firmly believe that, to be successful, HIV prevention must utilize all approaches known to be effective, not implementing one or a few selective actions in isolation….We suggest that the following are critical components of a comprehensive and evidence-based response: universal access to sexual and reproductive health information for women, men, and young people, including persons living with HIV/AIDS, to ensure that they have access to a full range of reproductive choices in accordance with the Cairo/ICPD agenda" (EU, 2005).

In addition to the organizations listed above, hundreds of other organizations have signed their names to petitions supporting comprehensive sex education over abstinence-only education. Appendix B contains an example of one such letter to President Bush signed by 77 health and human rights organizations.

VII. Case Study: Uganda

PEPFAR derives its legitimacy largely through claims that it is based on the ABC model of prevention: Abstain, Be faithful, use Condoms. The ABC model is often described as an "African solution to an African problem" - specifically, the country of

Uganda is credited with inventing the ABC model, and using the approach to reduce its HIV/AIDS prevalence rate from approximately 18 percent in 1992 to just over 6 percent in 2002 (Uganda AIDS Commission, no date).

Upon close examination, it is evident that the restrictions imposed on implementing the ABC model by PEPFAR do not reflect the Ugandan experience. First, the text of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (2003) adds a subtle tag to its definition of ABC – "in priority order" – emphasizing abstinence until marriage over condom use: "Uganda's successful AIDS treatment and prevention program is referred to as the ABC model: 'Abstain, Be Faithful, use Condoms', *in order of priority.*" (italics mine) (Public Law 108-25, Section 2).

This emphasis is reflected in funding priorities for prevention programs, which require that two-thirds of all sexual transmission funds be spent on abstinence-only education. The remaining one-third of funds can be spent on condom education/promotion and other prevention activities; however, these programs must be targeted towards "high risk" groups, which are defined as:

- commercial sex workers and their clients,
- sexually active discordant couples or couples with unknown HIV status,
- substance abusers,
- mobile male populations,
- men who have sex with men,
- people living with HIV/AIDS,
- those who have sex with an HIV-positive partner or one whose status is unknown (GAO, 2006).

Specifically excluded from non-abstinence-only education are youth under 15.

The emphasis on abstinence-only (or abstinence until marriage) programming as *the key* to Uganda's successful decline in its AIDS prevalence rate is in direct contradiction to reports put forth by the Uganda AIDS Commission (UAC) - the

government body legally charged with coordinating the national multisectoral response to the HIV/AIDS epidemic. Documents from the UAC specifically state that Uganda's success was based on a more balanced approach: "Whoever had a proven weapon against AIDS was allowed to bring it forward. It was not one method against the other. All known preventive methods had to be applied without creating conflicts. For instance, religious organizations were allowed to advise young people to abstain from sex and married people to be faithful to their partners, without interfering with those who were promoting condoms" (Uganda AIDS Commission, 2004).

In an article published in the *New Vision* (September 4, 2005), Uganda's leading state-owned newspaper, David Serwadda, Director of the Institute of Public Health at Makerere University, stated: "As a physician who has been involved in Uganda's response to AIDS for 20 years, I fear that one small part of what led to Uganda's success – sexual abstinence – is being overemphasized in policy debates. While abstinence has played an important role in Uganda, it has not been a magic bullet."

These reports and statements are backed by the results of an extensive, longitudinal, population-based study (considered the "gold standard" type of epidemiological research of this nature) led by Columbia University's Mailman School of Public Health, Johns Hopkins University, and Makerere University. This comprehensive study followed 10,000 adults in the Rakai District of Uganda for ten years. At the 12th Annual Conference on Retroviruses in 2005, Maria Wawer of Columbia University reported, "Abstinence and monogamy are good behaviors. On the other hand, the data support that in this setting, the behavior that seems to have been the easiest to increase over time is condom use" (Nyanzi, 2005). Key findings of the study included a declining

rate of HIV infection from 1994 to 2003 (from 20 to 13 percent for women and 15 to 9 percent for men), despite slight *decreases* in age of first sexual intercourse for men and women, as well as an *increase* in men reporting two or more sexual partners in the previous year. During the same ten-year period, marked increases in condom use with non-marital partners was reported by both men (from 10 to 50 percent) and women (from 2 to 28 percent) (Nyanzi, 2005).

PEPFAR further deviates from the Ugandan model in that it bans the use of its funds for condom education in schools for adolescents under 15. However, comprehensive sex education in schools has been standard practice in Uganda since 1987 with the School Health Education Program. School-based prevention programs have been critical to Uganda's success because schools are one of the few places where children can be reached en masse. As Dr. David Apuuli, Head of the Uganda AIDS Commission, stated in a January 2004 interview with UNAIDS: "Primary education in Uganda is free. The number of children enrolled in primary schools in Uganda is about 7 million and Uganda's population is 24 million, so every single day, nearly 30% of the total population are in primary school. If you can reach this 30%, you can have a big impact in the future of the direction of this epidemic" (UNAIDS, 2004).

As the excerpt from the Ugandan Primary School Health Kit on AIDS Control in Appendix C demonstrates, abstinence and monogamy were presented as options to children. However, the use of condoms was also presented in a non-judgmental manner. This is the essence of comprehensive sex education: all options are presented to the same individuals without moral judgment. After the adoption of PEPFAR, the United States Agency for International Development (USAID) funded efforts to revise Uganda's

HIV/AIDS curriculum for primary schools. According to Human Rights Watch, "the new materials omitted information about condoms and safer sex that had appeared in the original versions. Diagrams depicting condoms, safer sex, puberty, and genital hygiene were purged. The final materials omitted the statement that 'condoms will be an important part of your protection plan when you start having sex when you are older,' replacing them with statements such as 'pre-marital sex is risky' and 'for pupils, sex leads to great sadness.'"(Cohen, 2006). Accordingly, the excerpt has been removed from the curriculum. While one teachers' manual for older primary students does include the statement that "used consistently and correctly, condoms protect against HIV/STIs and pregnancy" (Cohen, 2006), none of the students' manuals contain such information.

It is evident that the PEPFAR's HIV prevention strategy and implementation guidelines for ABC differ in important and critical ways from the approach developed in Uganda over the course of two decades. While PEPFAR may seek to legitimize its approach to prevention as "African," it is clear that the Ugandan strategy has undergone significant modification: ABC has become "AB_c", and comprehensive sex education has been removed from school curricula.

What does all this mean for Uganda? While one cannot state definitively that PEPFAR programs are to blame, the news from Uganda is extremely disturbing. In 2005, the Uganda AIDS Commission reported an increase in the country's HIV prevalence rate: "Over the last three years HIV sero-prevalence has stagnated between 6 – 6.5%. However recent estimates from a countrywide sero-prevalence study indicates that prevalence now stands at 7.1%" (UAC, 2005).

Also in 2005, Uganda experienced a controversial condom shortage. Stephen Lewis, the U.N. Secretary General's special envoy for HIV/AIDS in Africa, blamed the shortage on U.S. cuts in funding for condoms: "There is no doubt in my mind that the condom crisis in Uganda is being driven by (U.S. programs). To impose a dogma-driven policy that is fundamentally flawed is doing damage to Africa" (USA Today, 2005).

Leading Ugandan AIDS activists worry that the shift towards abstinence-only education is restigmatizing the disease and undoing years of positive change. Beatrice Were, founder of the National Association of Women Living with AIDS and winner of InterAction's 2003 Humanitarian Award warns: "I look back, at the time when we worked with the U.S. government very well, when we had the U.S. Agency for International Development funding comprehensive prevention, sex education and AIDS care in Uganda, and things went very well. Because at that time, the United States was committed and respectful of the communities. But now what the United States is doing undermines the success that we've had in the past" (Hayes, 2005). If PEPFAR policies remain unchanged and the focus on abstinence-only education continues, Uganda may well be headed for disaster.

VIII. Recommendations

> *"Policy should be based, whenever possible, on science, but so often it's not, and that places the public health in great jeopardy." - Dr. David Reiss, M.D (NIH, 1997)*

The President's Emergency Plan for AIDS Relief has based its legitimacy on mirroring a proven solution: Uganda's ABC model. However, a close examination of the Ugandan experience has shown that PEPFAR has essentially modified Uganda's ABC

model from one of comprehensive sex education to one of abstinence-only for all youth under 15; with comprehensive sex education reserved for commercial sex workers, substance abusers, and members of any other "high risk" group as controversially defined by the U.S. government.

A legislative system that allows government to create policies that defy evidence-based best practices endorsed by reputable professional health associations, other health and human rights organizations, and international government bodies is cause for grave concern and demands immediate attention.

Recommendation 1: Amend PEPFAR to promote comprehensive sex education and to remove abstinence-only funding requirements.

It is imperative that PEPFAR be revised to promote evidence-based best practices in HIV prevention: comprehensive sex education. Congresswoman Barbara Lee (D–California) recently introduced the Protection Against Transmission of HIV for Women and Youth (PATHWAY) Act of 2006 to modify PEPFAR. The new act would strike the abstinence-only funding earmark and would amend PEPFAR as follows: "In order to maximize the impact of United States foreign assistance to combat HIV/AIDS, all sexually active persons in each country must be equipped with all the skills and tools necessary to avoid infection, including information and training on delay of sexual debut and the practice of safer sex, whether sexual activity begins within or outside of marriage" (H.R. 5674. Sec 4).

The passage of this act is critical to the future of HIV prevention. To date, eighty-four Congress men and women have signed on as co-sponsors of the Act. Should this Act not be passed, efforts to amend PEPFAR must continue. At a minimum, the

abstinence-only funding requirement must be removed so that donor recipients can reintegrate ABC and provide culturally and locally appropriate HIV prevention interventions that have proven successful in the past.

Recommendation 2: Amend PEPFAR to remove the ban on condom education and condom social marketing in schools.

Banning the use of PEPFAR funds for condom education and condom social marketing in schools for youth under 15 has drastically altered the Ugandan HIV prevention strategy upon which the policy claims to be based. Condom education has been practiced in Ugandan schools for nearly two decades, and, as previously discussed, is supported by the head of the Uganda AIDS Commission. The revision of Uganda's primary school health education kit on AIDS control represents a major step backward in the fight against HIV/AIDS prevention – effectively eliminating comprehensive sex education in Uganda's primary schools.

A full 50 percent of Uganda's population is under 15 years of age, and 78% of school-age children attend primary school (UNICEF, no date). If the HIV/AIDS epidemic in Uganda is to be controlled, the country cannot afford to forfeit the opportunity to use the school setting to provide youth with comprehensive sex education which includes information on condoms. Therefore, it is critical that amendments to PEPFAR specifically remove the ban on condom education in schools for youth under 15.

Recommendation 3: Require that major health policies be evidence-based and subject to a public and independent nonpartisan review by a panel of health experts.

There is no lack of evidence on best practices in HIV prevention; yet U.S. policymakers have for years supported abstinence-only interventions that have failed the American public. Six years prior to the passage of PEPFAR, the NIH urged:

> "Legislative barriers that discourage effective programs aimed at youth must be eliminated. Although sexual abstinence is a desirable objective, programs must include instruction in safe sex behavior, including condom use. The effectiveness of these programs is supported by strong scientific evidence. However, they are discouraged by welfare reform provisions, which support only programs using abstinence as the only goal...Most urgent is the need to rapidly bridge the serious gap that is widening between clear scientific results and the law and policies of the United States. As this statement has noted forcefully, there is clear scientific evidence supporting needle exchange programs, drug abuse treatment, and interventions with adolescents as essential components of our National program to contain the AIDS epidemic. Even as evidence rapidly accumulates on the success of these programs, however, legislation has been passed to make provision of these interventions extremely difficult. There is no more urgent need than to remedy this dangerous chasm. National leaders, legislators, scientists, and service providers must unite to understand fully this growing catastrophe... What pressures and circumstances of government make it unresponsive to these compelling public health needs and effective programs?" (NIH, 1997b)

This powerful statement and numerous others like it have been ignored for years. There are those that express surprise that evidence-based best practices in HIV prevention – and the expert consensus opinion of reputable professional medical groups such as UNAIDS, APHA, and NIH - have seemingly been ignored by Congress. Rather than engage in a detailed discussion of the US legislative system, a simple analogy can be used to illustrate how a flawed policy such as PEPFAR was approved by the federal legislature.

In courtroom trials, experts witnesses are often called upon to provide evidence. This is not unlike committee hearings where Congressmen and women debate the merits

of a proposed policy, with proponents and opponents bringing in experts to support their views. However, in Congress, no impartial jury is intently weighing the evidence with a commitment to making a decision based on careful consideration of "the facts and only the facts." Instead, voting ultimately falls to members of two political parties and a handful of others, undeniably influenced by their party affiliation, lobbyists, constituents, and others.

It has become exceedingly clear that we cannot assume that U.S. policymakers will "do the right thing" and support evidence-based best practices in HIV prevention. The system of checks and balances must be reinforced to ensure that health legislation – with its potential for life or death consequences - is based on sound scientific evidence. In short, we need an impartial jury. To ensure that population level health policies are evidence-based whenever possible, they should be publicly reviewed by a nonpartisan and independent panel of experts comprised of representatives from major health organizations, such as the APHA, the AMA, and the IOM. For a proposed policy to be endorsed by this body, members must achieve consensus that the policy represents current best practices based on a comprehensive review of available evidence.

The concept of an independent review panel, the selection of members, and other related issues are topics that require considerable expertise and forethought. While the recommendation for some type of independent review panel is made here, it is beyond the scope of this paper to attempt to lay out the full details of how such a panel would function.

Recommendation 4: Require that U.S. grant funding appropriated for HIV/AIDS-related interventions in other countries be *locally appropriate* and subject to a public and independent review by a panel of international health experts.

PEPFAR set aside a record $15 billion for HIV prevention and care. With the passage of PEPFAR, the United States became the single largest donor of international HIV/AIDS aid. And yet, the policy is not grounded in evidence-based best practices in HIV prevention, and ultimately may do more harm than good. This potential for harm is confounded by the fact that culture and gender roles play an enormous role in the transmission of HIV. Therefore, HIV prevention policies aimed at other countries must not only be evidence-based, but must also be locally appropriate.

While commercial sex workers may be at risk for AIDS worldwide, not all categories of "high risk populations" are universal. Several studies have found that gender power differentials increase HIV risk for many women and girls. Numerous studies (Mayer et al, 2000; Glynn et al, 2001; Clark, 2004) have shown that marriage is a significant HIV risk factor for women in sub-Saharan Africa and Asia. While women may practice monogamy in marriage, their husbands often do not. Other studies (Ackermann, 2002) have found that school girls in some sub-Saharan African countries are at increased risk for HIV due to economic situations which force them to seek money from older men in exchange for sex simply to survive. "Many young girls who have financial problems exchange sex for money to buy the basics such as food and soap, and some use this money to pay for their education" (Ackermann, 2002).

It is critical that experts with international experience and knowledge review proposed policies that will be implemented outside the United States. Similar to the nonpartisan panel proposed for review of domestic policy, this panel would be composed

of international experts from such groups at UNAIDS and the World Health Organization, as well as independent leading researchers and practitioners.

X. Conclusion

> *"Access to complete and accurate HIV/AIDS and sexual health information has been recognized as a basic human right and essential to realizing the human right to the highest attainable standard of health. Governments have an obligation to provide accurate information to their citizens and eschew the provision of misinformation; such obligations extend to government-funded education and health care services...an oncologist who presented only the benefits of chemotherapy and only the risks from radiation therapy would be denounced as failing in his or her obligations to the patient. Similarly, we believe that it is unethical to provide misinformation or to withhold information from adolescents about sexual health, including ways for sexually active teens to protect themselves from STIs."* (Santelli et al, 2005)

AIDS has besieged African and other countries for a quarter of a century. Some 25 million human beings are dead from the disease – an average loss of one million lives each year. In the face of such a massive and devastating pandemic, the world cannot afford for ideology to trump the overwhelming, science-based evidence that tells us that comprehensive sex education is the most effective way to prevent HIV.

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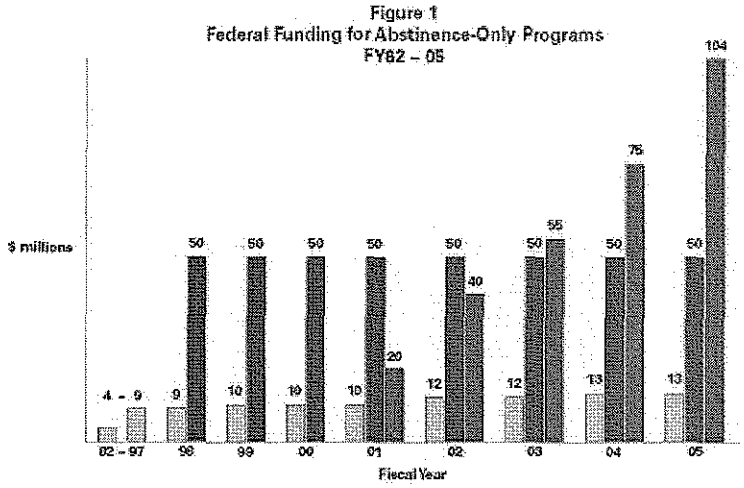
Appendix A



The Adolescent and Family Life Act (AFLA): Passed in 1981, provides for abstinence-only grants administered through the Office of Population Affairs. This program has grown from $4 million in FY 1982 to $13 million in FY 2005.

Title V: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (known as the Welfare Reform Act): Since FY 1998, this program has allocated $50 million per year to states for abstinence-only-until-marriage programs. The law requires a state match of $3 for every $4 of federal funding.

Community-Based Abstinence Education/Special Programs of National and Regional Significance (CBAE/SPRANS): Created in 2001 to provide abstinence-only-until-marriage grants directly to individual public and private entities. Operated by the Administration for Children and Families, this program has grown from $20 million in FY 2001 to $104 million in FY 2005.

PEPFAR (not displayed in Figure 1): International abstinence-only funding is provided primarily through the President's Emergency Plan for AIDS Relief (PEPFAR). One-third of all prevention dollars allocated to the 15 PEPFAR-eligible countries must be earmarked for abstinence-only programs. Many of these combine "Abstinence" and "Be Faithful" components and are referred to as "AB programs." Of the $61.6 million provided for prevention of sexual transmission of HIV during FY 2004, $60.5 million was allocated to AB programs.

Source for domestic funding: U.S. House of Representatives Committee on Government Reform, Minority Staff Special Investigations Division, The Content of Federally Funded Abstinence-Only Education Programs, prepared for Representative Henry A. Waxman, December 2004, pp. 1-3. Source for PEPFAR funding: Expanding Bold Leadership: The President's Emergency Plan for AIDS Relief, First Annual Report to Congress, March 4, 2005, p. 19.

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Appendix B

Letter to President Bush from 77 Organizations Opposing Abstinence-Only Education

February 7, 2002

President George W. Bush
The White House
Washington, DC 20500

Dear President Bush:

The undersigned organizations, committed to responsible sexuality education for young people that includes age-appropriate, medically accurate information about both abstinence and contraception, urge you to reconsider increasing funding for unproven abstinence-only-until-marriage programs.

Research continues to show that a more comprehensive approach to sexuality education, which teaches both abstinence and contraception, is most effective for young people. Those who receive this kind of education are more likely to initiate sexual activity later in life and use protection correctly and consistently when they do become sexually active. Evaluations of comprehensive sexuality education programs found that these programs delay the onset of sexual activity, reduce the frequency of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use. Importantly, the evidence shows that these programs do not encourage teens to become sexually active. In short, responsible sexuality education programs work!

In contrast, there is little scientific evidence that abstinence-only-until-marriage programs that exclude information about contraception, except failure rates, are effective. Even your own Secretary of Health and Human Services, Tommy Thompson, expressed concerns about the 'paucity of evidence of [the] effectiveness' of these programs.

Science and research should be the paramount considerations when evaluating public health interventions. Protecting the lives of America's young people, especially in the era of AIDS, should dictate that we do the best we can based on what the experts tell us works.

The most trusted medical and scientific institutions in our nation, such as the American Medical Association, the American Academy of Pediatrics, the Society for Adolescent Medicine, the Institute of Medicine, the American College of Obstetricians and Gynecologists, the American Nurses Association and the American Public Health Association, all recommend sexuality education that includes age-appropriate and medically accurate information about abstinence and contraception.

In fact, the Institute of Medicine recommends that "Congress, as well as other federal,

state, and local policymakers, eliminate the requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education."

And it is not just the science that supports these programs. Parents overwhelmingly support teaching teens about all aspects of sexuality education, including abstinence and birth control. According to the National Campaign to Prevent Teen Pregnancy, neither parents, by 70.6 percent, nor teens, by 74.7 percent, believe that discussing abstinence and contraception sends a mixed message to young people. They clearly understand that sexuality education is not an either/or proposition, but a successful education program that includes both.

Continued increases to these unproven abstinence-only-until-marriage programs fly in the face of both scientific evidence and the desires of parents. Congress has already allocated over a half billion in federal and state matching dollars since the fall of 1996 to fund unproven abstinence-only-until-marriage programs that exclude accurate information about condoms and contraceptives for the prevention of unintended pregnancy, HIV/AIDS and other sexually transmitted diseases.

We urge you to follow the science, protect the health of America's teens and reconsider your funding request.

Sincerely,

Adolescent Pregnancy Prevention, Inc.
Advocates for Youth
Africa Action
AIDS Action
AIDS Treatment Data Network
Alliance for Young Families
American Association for Health Education
American Association of Sexuality Educators, Counselors, and Therapists
American Association of University Women
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Foundation for AIDS Research
American Public Health Association
American Psychiatric Association
American Psychological Association
American Social Health Association
American Society of Reproductive Medicine
Association of Reproductive Health Professionals
California Family Health Council
Catholics for a Free Choice
Center for Reproductive Law and Policy
Center for Women's Policy Studies

Choice USA
CUSP - Comprehensive U.S. Sustainable Population
Connecticut National Abortion and Reproductive Rights Action League
Family Planning Advocates of New York State
Family Planning Association of Maine
Feminist Majority
Florida Federation of Business and Professional Women
Gay Men's Health Crisis
Girls Incorporated
Health Initiatives for Youth
Human Rights Campaign
Lincoln Chapter of the National Organization for Women
Mexican American Legal Defense and Educational Fund
Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting
Mothers' Voices
Nashville CARES
National Abortion and Reproductive Rights Action League
National Abortion Federation
National Alliance of State and Territorial AIDS Directors
National Association of Nurse Practitioners in Women's Health
National Association of People with AIDS
National Association of School Psychologists
National Center for Health Education
National Coalition Against Censorship
National Council of Jewish Women
National Education Association
National Family Planning and Reproductive Health Association
National Gay and Lesbian Task Force
National Minority AIDS Council
National Native American AIDS Prevention Center
National Organization for Women
National Organization on Adolescent Pregnancy, Parenting, and Prevention
National Partnership for Women and Families
National Women's Health Network
National Women's Law Center
National Youth Advocacy Coalition
Negative Population Growth
NOW Legal Defense and Education Fund
People For the American Way
Physicians for Reproductive Choice and Health
Planned Parenthood Federation of America
Planned Parenthood of Central Washington
Religious Coalition for Reproductive Choice
Religious Institute on Sexual Morality, Justice, and Healing
Search for A Cure
Sierra Club Ohio Chapter Population-Environment Committee

Society for Public Health Education
Society for the Scientific Study of Sexuality
Sexuality Information and Education Council of the United States
Texas School Health Association
The African American AIDS Policy & Training Institute
United Church of Christ, Justice and Witness Ministries
Unitarian Universalist Association of Congregations
Voters for Choice Action Fund
Zero Population Growth

Retrieved 9/24/06 from http://www.advocatesforyouth.org/news/president.htm.

Appendix C

How to prevent the spread of AIDS

Find the poster **"Prevent AIDS"**. Discuss with your pupils what it shows:

1. **"Prevent AIDS:**
   Do not Have sex until you are married, then stay faithful to your partner"

   - AIDS is mostly spread through sex. If you do not have sex at all, you will prevent the spread of AIDS through sex.

   - If you are already having sex, only have sex with a faithful partner. Both partners should be faithful to each other.

   - If a man has many wives (is polygamous), he should have sex only with his wives and they should remain faithful to him. Again the man and all the women in the polygamous group should be faithful.

   - The more unfaithful sexual partners one has, the greater the chance of having sex with someone with the AIDS germ (HIV). As seen by the story even one sexual contact with a person having the HIV germ can pass it on to the person.

2. **"Prevent AIDS: Use condoms during sex"**

   - AIDS is mostly spread through body fluids shared during sex. Condoms can stop body fluids from being shared.

   - Condoms can stop the AIDS germ from passing from a man to a woman or from woman to man.

   - Condoms are fairly effective (safe) in stopping the AIDS germ from being transmitted from one person to another, if used correctly. This means condoms are very much better than no protection at all.

3. **"Prevent AIDS: Treat sexually transmitted diseases early".**

   - Sores from syphilis or gonorrhea allow the AIDS virus to enter our bodies.

   - Pus or blood from sores can carry a lot of AIDS germs (they are high risk body fluids)

   - It is possible to stop the sores, pus and blood, when treatment is obtained.

   - Sexually transmitted diseases can be treated and cured if you contact the nearest clinic or Doctor for treatment.

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Reprinted from the Republic of Uganda, Primary School Health Kit on AIDS Control, Ministry of Education, Ministry of Health, UNICEF Kampala © UNICEF Uganda 1987 & 1992, p. 17.