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Renewing a Focus on Prevention in U.S. Global AIDS Policy

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The world's response to the AIDS pandemic is now at a crossroads. In recent years, the global community—stimulated by the President's Emergency Plan for AIDS Relief (PEPFAR) and the World Health Organization's (WHO's) "3 by 5 Initiative"—has responded with an appropriate sense of urgency that has driven the rapid expansion of treatment services worldwide. Yet, even as life-saving drugs become more widely available, the rate of new HIV infections continues to climb, outpacing the capacity to treat people living with HIV and threatening the whole AIDS response.

Faced with this stark reality, leaders in the global AIDS community are calling for a paradigm shift in thinking about AIDS—from a short-term emergency to a long-term challenge requiring sustained effort. In large part, this means renewing a focus on HIV prevention. In recent years, the lion's share of resources for AIDS has been committed to services for people living with HIV. With nearly three million people each year still losing their lives to the disease, and four million newly infected, it is now widely conceded that the only way to stem the pandemic is by jointly scaling up prevention and treatment efforts.

Effectively reinvigorating a global prevention agenda, however, will require confronting HIV primarily as a sexually transmitted infection and accepting that the culture of silence surrounding sexuality makes two particular groups more vulnerable to HIV. Young people aged 15–24, for one, account for 40% of all new cases of HIV (not including mother-to-child transmission). It is clear that most men and women begin to have sex during their teenage years. Avoiding this fact, or thinking that young people need only to be told not to have sex until they marry, not only puts people at risk of infection while they are young, it does little to prepare them for adulthood and their prime years for sexual activity. The second vulnerable group is women, particularly those in countries where HIV has spread to the general population and, thus, the primary mode of transmission is heterosexual contact. All over the world, greater efforts are needed to break the chains of gender inequality and norms that help the disease to spread.

In 2003, Congress enacted the United States' first comprehensive strategy to combat the pandemic in the developing world. The United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, which formally authorized the PEPFAR program, expires at the end of September 2008. It is widely agreed that transitioning PEPFAR from a strategy that focuses on emergency relief to one that supports sustainable HIV programs is the fundamental issue facing policymakers during reauthorization. A congressionally mandated PEPFAR evaluation by the Institute of Medicine (IOM) made the case for supporting sustainable country programs, including intensifying HIV prevention. According to the IOM, "the initiative cannot afford to conceptualize prevention narrowly or as distinct from treatment and care, and needs to support countries in seizing the abundant opportunities for prevention throughout people's lives and regardless of their HIV status; across the full spectrum of health and social services; and in all settings, from the street to the school to the home to the clinic."

Securing political support for effective and evidence-based interventions to prevent the spread of HIV, however, will be a challenge. HIV prevention is often less emotionally compelling than treatment and care programs, in which there is an immediate, tangible impact. More than that, prevention necessarily requires confronting sexuality—something policymakers are often loath to do. When Congress passed the Leadership Act in 2003, prevention interventions were compromised to win the support of social conservatives, for whom abstinence-until-marriage promotion is a top priority. But although support for HIV prevention is politically very dicey, it is abundantly clear that it represents the only long-term, sustainable way to turn the tide against AIDS. According to the Office of the U.S. Global AIDS Coordinator (OGAC), which oversees PEPFAR implementation, treatment and care are vital, life-extending services, but "unless the world can reduce the number of new infections, we will continue to face an expanding need for treatment and care, running a race we can neither sustain nor win."

Focus on Youth

Perhaps the most important element of any long-term HIV prevention strategy is how it deals with young people. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), young people are both the "most threatened" by AIDS and the "greatest hope for turning the tide against AIDS." Approximately 10 million young people aged 15–24 are living with HIV; of those, most are in Sub-Saharan Africa. Young women are more greatly affected than young men: In Sub-Saharan Africa, the prevalence rate for females is almost three times that for males.

Sexual activity. In countries where HIV is spreading throughout the general population, the vulnerability of youth depends to a large extent on their sexual behavior. Few very young teens are sexually experienced, but adolescence is a time of rapid change, and sexual experience is common by the late teen years. By their 20th birthday, roughly three in four young women and six in 10 young men in Sub-Saharan Africa (the region of the world with the highest levels of HIV) have had sex. (This proportion is surprisingly similar to that of teens in the United States, where three in four teens have had sex by age 20.) For many young women worldwide, their first sexual experience is in marriage, whereas for the majority of young men, it occurs prior to marriage; however, premarital sex is common even among females. In most of the developed world and Sub-Saharan Africa, a third or more of unmarried adolescent females have had sex. (In Asia, Eastern Europe and Latin America, somewhat smaller proportions have had intercourse.)

The challenge, then, is to empower teens to delay sexual initiation, while also preparing them with information and skills to prevent HIV transmission when they do become sexually active. This is no small task. Rather, it requires societal leaders at all levels—parents, educators, health care providers and policymakers—to be willing to meet young people's needs not only for the very short term, but for the longer-term future as well. Today's youth are tomorrow's adults, and the behaviors they establish as teenagers are often perpetuated into adulthood and passed on to the next generation.

Behavior change. Multiple interventions support young people in making healthy and responsible decisions for themselves and their partners. First among these is sex education. Evidence indicates that comprehensive programs that urge teens to postpone having sex, but also promote protective behaviors, are effective at achieving both. In a recent review of 80 studies that measure the impact of comprehensive sex and HIV education programs on the sexual behaviors of young people throughout the world, two in three programs significantly improved one or more sexual behaviors. Many either delayed or reduced sexual activity, or increased condom use. At least 10 interventions had long-term behavioral effects lasting two or more years; some lasted as long as the effects were measured—three or more years.

Importantly, the evidence is strong that sex education programs that promote abstinence as well as the use of condoms do not increase sexual behavior. Studies show that when teens are educated about condoms and have access to the

method, levels of condom use at first intercourse increase while levels of sex stay the same. Moreover, it appears that teens who use contraceptives, including condoms, when they first begin to have sex develop a prevention mentality that is long lasting. Research from the United States shows that teens who practiced contraception consistently in their first sexual relationship are more likely to continue doing so than those who used no method or who used a method inconsistently.

Finally, research indicates that condom promotion efforts around HIV prevention should also be mindful of young women's strong interest in preventing pregnancy. According to a multiyear, multicountry study of adolescents in Sub-Saharan Africa conducted by the Guttmacher Institute, pregnancy prevention is the primary motivating factor behind most young women's use of condoms. In the study's four focus countries (Burkina Faso, Ghana, Malawi and Uganda), a higher proportion of sexually active women aged 15–19 using condoms did so mainly to prevent pregnancy than mainly to prevent HIV.

Young people and PEPFAR. Rather than provide young people with the full complement of tools to prevent HIV, however, the current PEPFAR strategy goes in the opposite direction, limiting the kinds of information and services they can receive. PEPFAR is designed around a population-specific approach. High-risk groups are defined as commercial sex workers and their clients, mobile male populations, men who have sex with men and sexually active people living with HIV. The priority interventions for individuals in these high-risk groups are comprehensive prevention messages, including the provision of condoms.

By implication, the remainder of the population—including even unmarried, sexually active young people living in countries with high HIV prevalence—is not at high risk. PEFPAR's primary message for youth and other unmarried persons is abstinence until marriage. In recognition of the fact that large proportions of young people engage in sex before marriage, PEPFAR's answer is "secondary abstinence." Social marketing campaigns that target youth and encourage condom use, on the other hand, "are not appropriate for youth" because these interventions "give a conflicting message" and "appear to encourage sexual activity." As a result, recipients of U.S. HIV funds may provide teens 15 and older with information about condoms under certain circumstances, but they cannot use these funds to promote condom use or to provide condoms in most situations. Teens younger than 15 may not receive any information about condoms in school settings.

The "abstinence-until-marriage" spending requirement. PEPFAR programming is also shaped by a legislative mandate that at least one-third of all prevention funds be set aside for abstinence-until-marriage programs. In FY 2006, PEPFAR provided just over $130 million for these programs, despite evidence that they have had a stifling effect on other critical prevention efforts. According to a 2006 report by the Government Accountability Office, the statutory requirement has forced PEPFAR country teams to cut support for proven programs, such as those to prevent mother-to-child transmission. The IOM has called for the removal of the abstinence-until-marriage requirement (and other allocation requirements) to "enhance the quality, accountability and flexibility" of prevention efforts. In a pointed indictment of U.S. policy, the IOM concludes, "Contrary to basic principles of good management and accountability, the budget allocations have made spending money in a particular way an end in itself rather than a means to an end—in this instance, the vitally important end of saving lives today and in the future."

Continuation of the mandatory abstinence allocation would be particularly troubling in light of the fact that abstinence-until-marriage programs have not been demonstrated to be effective at stopping or even delaying sex. Researchers at the Centre for Evidence-Based Intervention at the University of Oxford evaluated a range of HIV-prevention programs in high-income countries. The results, published in the August 4 issue of the *British Medical Journal,* indicate that programs that exclusively encourage abstinence are "ineffective for preventing or decreasing sexual activity among most participants." That review is

in keeping with the conclusions of a major program evaluation by Mathematica Policy Research released earlier this year. Conducted over nine years at a cost of almost $8 million, this congressionally mandated examination of four U.S. programs considered to be especially promising found that none had a statistically significant beneficial impact on young people's sexual behavior. Those who participated in the programs were no more likely to abstain than those who did not.

Overarching issues. Beyond sex education and other behavior change strategies, it is widely recognized that a comprehensive HIV prevention strategy must address the structural, social and cultural factors that put youth at increased risk. School attendance, for example, offers a certain level of protection against HIV: Young women enrolled in school are less likely than their out-of-school peers to report having had sex, and those who have had sex are more likely to report having used condoms. Policymakers must do more to increase school attendance, especially among disadvantaged groups, and to improve school quality. Support is also needed for community programs designed to raise awareness about the risks of early marriage and childbearing, and for interventions targeting poverty and social norms that drive the marriage-timing decision.

Focus on Gender

As difficult as it may be to address the underlying social and cultural conditions that put young people at increased risk of HIV, it is all the more challenging to confront the factors that contribute to women's vulnerability. Globally, the proportion of individuals aged 15 and older living with HIV who are women has risen from 35% to 48% between 1985 and 2005. In countries with high HIV prevalence rates, women are infected more often and earlier in their lives than men. For decades, the AIDS community has known that gender norms make it difficult for women to protect themselves from HIV. Notions that women are not themselves interested in sex or are appropriately subservient to men have meant that women often have little authority to negotiate condom use, let alone determine if, when and with whom they will engage in sex. In addition, traditional gender roles affect men's attitudes and behaviors. Cultural expectations of masculinity—including notions that men have strong, uncontrollable sex drives—have encouraged men to have multiple partners and to take greater risks, and may mean they are less likely to seek health information and services. Accordingly, for many women, including married women, their male partners' sexual behavior is their most important HIV-risk factor.

Of course, gender disparities go far beyond the purely sexual aspects of relationships. In many places, women do not own property, drop out of school at a young age and lack economic resources—all of which makes them more dependent on men for support, and more susceptible to HIV. Women may stay in abusive, even violent, relationships because they have nowhere else to go, and they may give in to male demands for unprotected sex, for fear of abandonment.

In FY 2006, PEPFAR contributed $442 million to gender strategies across prevention, treatment, care and support programs. To strengthen its approach to gender, OGAC initiated a gender consultation in 2006 that resulted in the allocation of a small pot of money, $8 million, for gender-specific activities focused on three priority areas: changing male norms and behaviors, strengthening services for gender-based violence within the health setting and addressing vulnerability of female orphans aged 13–19.

Research indicates that specific programs can be effective in changing men's attitudes and behaviors around sexual and reproductive health, interaction with their children and their use of violence. According to a 2007 review conducted by WHO of 58 programs with men and boys, programs that include deliberate discussion of gender and masculinity are most effective, as are those that reach beyond the individual level and deal with the larger circumstances of people's lives through community outreach, mobilization or mass media campaigns. Most of the programs evaluated, however, were small in scale and short in duration. Little is known about what is required to scale up and sustain these efforts. In addition to specific programs, it is widely

accepted that systemic changes are also needed to address the factors that drive the pandemic for women. This means tackling the larger and interrelated economic, social and legal dimensions of gender inequality: from ensuring that women have access to HIV prevention information and services to providing women with credit and saving opportunities to promoting women's property and inheritance rights. Although addressing these larger issues is often difficult to do, gender and AIDS experts contend that it can and must be done, especially as PEPFAR transitions from emergency to sustainability.

Two recently released reports highlight the specific needs of women for HIV prevention, treatment, care and support, and detail steps that Congress and OGAC can take to strengthen AIDS programs for women and girls. Both *It Can Be Done: Addressing Gender in the AIDS Epidemic through PEPFAR Programs,* from the International Center for Research on Women, and *Priorities for Action: Gender and PEPFAR Reauthorization,* from the Center for Strategic and International Studies (CSIS), call for the elimination of policies that impede women's and girls' access to information and services, including the abstinence-until-marriage spending requirement. According to Janet Fleischman, author of the CSIS report, PEPFAR has made solid strides to address gender in its efforts, but "we have to move beyond consensus statements and ad hoc projects to a more comprehensive and sustainable response."

Looking Ahead

Although still far from adequate, the global response to the AIDS pandemic is finally growing, thanks in large part to PEPFAR's rapid expansion of services in countries hardest hit by the pandemic. PEPFAR is widely credited for the speed with which it has implemented HIV programs and services, especially in the expansion of treatment, and for challenging other donor governments, multilateral organizations and private foundations to follow its lead with increased funding. In part because of this rapid response, the global community has made significant progress in a relatively short time: The number of people receiving HIV treatment in low- and middle-income countries increased five-fold between 2003 and 2006, from 400,000 to two million, and global spending in 2007 reached $10 billion.

As Congress prepares to reauthorize PEPFAR next year, it is clear that the global response must now put greater emphasis on long-term strategic planning to support countries' fight against HIV for the long haul. Experts often talk of AIDS as a chronic infection, requiring lifelong treatment for those living with HIV. The same may be said of prevention and behavior change. Prevention programs must be continually supported, renewed and updated, or risk behaviors will return and the incidence of HIV will increase again.

OGAC recognizes the importance of HIV prevention, at least on paper. Its recent report to Congress asserts that the aim of its prevention programs is to "not only provide information about how to prevent infection, but also encourage people to make positive and lasting changes in behavior." Three years since the implementation of PEPFAR, however, it is clear that the current U.S. approach to HIV prevention is failing to live up to its goals.

As a first step, public health and AIDS experts are calling for the elimination of the requirement that one-third of all U.S. global HIV prevention funds be reserved for abstinence-until-marriage programs. This fall, Congress did just that—at least for the short term—when, during consideration of the FY 2008 foreign aid spending bill, it voted to nullify the abstinence-until-marriage spending requirement, thereby giving country programs greater flexibility in tailoring prevention efforts. It remains to be seen whether, when PEPFAR is reauthorized next year, policymakers will be willing to go further and set aside their ideological agendas in favor of proven, evidence-based prevention measures for youth and also address the gender issues that impede HIV prevention. www.guttmacher.org