AIDS PREVENTION IN AFRICA
Dealing with Risk
By Dale O'Leary

This is an update of an article written four years ago. It was very gratifying to see how, under the Bush administration, the concerns of Edward Green and others received positive attention. As a result, strategies aimed at the prevention of malaria have increased dramatically and money for abstinence was made available. However, there is now a new administration – one that listens to different voices. During his 2009 trip to Africa, Pope Benedict XVI set off a firestorm of criticism when he said that the distribution of condoms only "increases the problem." The reaction demonstrates how the controversy over HIV/AIDS prevention strategies continues unabated. While many people continue to believe that condoms are the only "scientific" solution to the problem, the evidence points in a very different direction. Before positive programs are abandoned in favor of failed strategies, international funders and African leaders need to be reminded of the facts.

Introduction

The HIV/AIDS pandemic has caused immeasurable suffering, but prevention is possible. The disease does not strike randomly – we have identified the virus that causes AIDS, and we know the pathways the virus can take. The question for the people of Africa is: What is the most effective strategy for preventing transmission?

The protection of public health in the face of deadly epidemics has always required a balance between respecting freedom and saving lives. Governments are given three options from which to build a strategic response: *risk elimination*, *risk avoidance*, and *risk reduction*. Even the most devastating epidemics can be stopped if the government is willing to abridge its citizens' freedom by employing draconian *risk elimination* strategies such as mandatory testing and quarantine. Such strategies are normally only employed for deadly, fast-moving epidemics. *Risk avoidance* strategies prevent infection by motivating the public to avoid all possible sources of infection and enforcing public health regulations. *Risk reduction* strategies allow people to continue to engage in behaviors that could expose them to infection while encouraging a reduction – but not elimination – of the risk of infection.

Early in the epidemic, various nations made different choices with differing results. When Cuban soldiers returned from fighting in Angola, the government realized that some were infected with HIV. The regime responded with mandatory testing and quarantine. The epidemic was blunted.[1]

The U.S. opted for *risk reduction.* Mandatory testing and quarantine were suggested but ruled unacceptable. Standard public health measures that were used to control sexually transmitted infections (STIs) such as syphilis and gonorrhea were also rejected. Instead, prevention focused on educating people on the ways in which they could protect themselves by using condoms. The result: twenty-five years after the threat was identified, over a half million citizens have died of AIDS and three times that many are living with HIV.[2] In 2006 in the U.S. 56,300 people were

[1] http://www.cybercuba.com/os.htm
[2] http://www.cdc.gov/hiv/topics/surveillance/basic.htm#hivest

newly infected – the majority of them being men who have sex with men (MSM).[3] The U.S. strategy with some modifications has been exported to other countries as the preferred method for controlling the epidemic.

Africa's leaders and those who fund AIDS prevention programs in Africa need to consider the full range of options available. The following is a review of what is known about how HIV is transmitted, standard public health strategies, the prevention strategy presented to Africa as the "scientific consensus," the agendas of those who created this consensus, the challenges to that consensus, alternative strategies, and the effect of the choice of prevention strategy on the culture.

I Pathways from Infected to Uninfected

Prevention strategies must take into account all the ways in which infection can spread. In the case of HIV, these ways are well known. HIV is not air borne, water born, or food borne. Humans do not catch it from animals or insects – they are infected by other humans. It is not transmitted by touch or sneezing, but by bodily fluids, particularly blood and semen. HIV requires a direct path from the body of the infected person to the body of the uninfected person.

In order to become infected with HIV, an uninfected person must engage in a behavior that exposes him to an open pathway, which begins with an infected person. Different pathways carry different levels of risk.

Blood, blood products, and body parts

Blood transfusions, transplanted organs, hemophilia-fighting drugs made from blood, and semen that is used for artificial insemination each provide an efficient path for the virus to travel from one person to another. If the donor is infected, there is a high probability that the recipient will become infected. Tests are available to assure that all blood products, transplants, and other human tissue used on another human being is HIV-free.

Medical personnel are also at risk through inadvertent needle sticks. If medical personnel working with HIV+ patients are exposed to the patient's blood, prompt cleaning of the wound plus treatment with antiretrovirals can prevent infection. A needle has been developed which prevents this kind of accidental needle sticks and health care workers have lobbied for the universal use of this type of needle. [4]

Mother to Child Transmission (MTCT)

An HIV+ mother can transmit the virus to her unborn baby. Where prenatal testing and treatment of the mother and/or delivery by caesarian section are employed, this transmission pathway can be reduced to almost zero.[5]

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[3] Lawrence Altman (2008) "HIV study finds rate 40% higher than estimated," *New York Times,* Aug. 3
[4] http://www.premierinc.com/quality-safety/tools-services/safety/topics/needlestick/index.jsp
[5] Marc Santora (2005) "U.S. is close to eliminating AIDS in infants, officials say," *New York Times,* Jan. 30.

Medical Contamination

The HIV virus can find a pathway from the infected person to the uninfected person through improperly sterilized medical equipment or multiuse vials of injected drugs or vaccines. In facilities where the procedures for sterilization are followed, and meticulously and/or disposable equipment is used, there is virtually no risk of infection. If a needle or syringe used on an HIV+ patient is not properly sterilized, it can become contaminated with the HIV virus. If a vial of medicine is used for a number of patients, the virus from an infected person could be introduced into the bottle through an improperly sterilized needle and/or syringe. The entire bottle would thus be contaminated and everyone treated from that bottle subsequently would be exposed to the virus.

Quasi-Medical Procedures

Not all injections and invasive procedures are done in medical settings. Traditional African healers frequently give their clients injections, often with improperly sterilized equipment.

Illegal Intravenous Drug Use (IDU)

Persons who inject illegal drugs often do not sterilize their equipment and often share equipment with other addicts. If one participant in such unsanitary sharing becomes HIV+, the risk is high that those with whom he shares equipment will become infected. A number of jurisdictions have chosen to dispense disposable needles to addicts in an attempt to eliminate this problem. Sexual partners of infected drug users are also at risk and by extension their unborn children.

Sexual Transmission

The HIV virus can be transmitted through sexual contact. While vaginal sex between a man and a woman can transmit the virus, the risk of a woman contracting HIV from a single act of vaginal intercourse is lower than for other STIs and the risk for man contracting it during vaginal intercourse is even lower.[6]

There is evidence that persons with open sores in the genital area are more susceptible to sexually transmitted HIV, since these sores provide an entry point for the virus into the blood stream. Persons with STIs (such as gonorrhea) are at higher risk of being infected if they have sex with an infected person. Women suffering from bacterial vaginitis may also be more susceptible in infection.[7] Men who are not circumcised also appear to be at higher risk.[8]

Anal sex provides an efficient pathway for the virus, perhaps because the act causes small breaks in the tissue, perhaps because the intestinal track is more absorbent than the cervix and uterus. It is also possible to transmit the virus through oral sex, although this appears to be rare.

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[6] Robert Biggar (1986) "The AIDS problem in Africa," *Lancet,* Jan. 11, 1986, p. 79-82.
[7] http://www.urologychannel.com/std/gardnerella.shtml
[8] B**.** Williams B et al. (2006) "The potential impact of male circumcision on HIV in Sub-Saharan Africa<" PLoS Medicine, 3, 7, p. 262.

The more sexual partners a person has, the greater the risk that one of those partners will be infected with HIV. Prostitutes and their clients are, therefore, at high risk, as are men who have sex with men (MSM) because they often have many sexual partners.[9] A MSM who has only one partner can be at high risk if his partner is not also monogamous.

> It seems obvious but there would be no global AIDS pandemic were it not for multiple sexual partnerships. The rate of change of sexual partners – especially concurrent partners – is a crucial determinant in the spread of sexually transmitted infections including HIV.[10]

There are other factors. The younger a person is, particularly the younger a woman is when she begins to engage in sexual relations, the greater the risk she will have multiple partners over her lifetime and therefore be at greater risk for exposure. There is also evidence that young women are physically more susceptible to the virus.[11] Women who use oral contraceptives, Depo-Provera [12] or the spermicide Nonoxynol-9 appear to be at greater risk.[13]

While the potential pathways for the HIV virus to pass from an infected person to an uninfected person are known, because the time between when the person is actually infected and when the first symptoms of the disease appear can be as long as 10 years, it is difficult to determine precisely how a particular individual was infected. However, because the virus can mutate slightly as it moves from person to person, sophisticated tests can determine which form of the virus infected a particular person and link that form of the virus to another infected person. These tests are expensive and rarely done. In most cases, health care workers simply question HIV+ patients about their behaviors and make assumptions as to how they were infected. Because HIV/AIDS is classified as an STI, those taking histories of the infected usually, consider sexual activity as the probable pathway. In some cases, patients who insisted that they had not engaged in sexual activity at all or at least not with an infected person have been dismissed as lying.[14] In one case early in the epidemic, a young woman insisted that she was a virgin and had not engaged in an activity that could have exposed her to the virus. After much investigation it was determined that she had probably been infected by her dentist, who had died of AIDS. When records were checked, several other patients of the dentist were also infected with the same variation of HIV, but because these patients were sexually active it had initially been assumed that they had been infected sexually.

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[9] C. H. Mercer, et al. (2009) "Behaviourally bisexual men as a bridge population for HIV and sexually transmitted infections? Evidence from a national probability survey," *International Journal of STD & AIDS,* 20, p. 87-94.

[10] James Shelton et al. (2004) "Education and debate: Partner reduction is crucial for a balance 'ABC' approach to HIV prevention," *British Medical Journal,* April 10, p. 891-893.

[11] http://www.globalhealthreporting.org/diseaseinfo.asp?id=254

[12] J. M Baeten, et al. (2001) "Hormonal contraception and the risk of sexually transmitted disease acquisition: results from a prospective study," *American Journal of Obstetrics and Gynecology,* 185, 2, p. 380-85: A prospective cohort study involving 948 Kenyan sex workers found that the use of oral or injectable hormonal contraception was associated with susceptibility to STIs: Users of OCs were at greater risk of acquiring chlamydial infection and vaginal candidiasis than women not using hormonal contraception, while women using DMPA had a significantly increased risk of chlamydial infection.

[13] Helene Gayle (2000) "Nonoxynol-9 Trial- The implications" Department of Health and Human Services, August 2000. www.cdc.gove/HIV/ppubs/mmwr11aug00.htm.

[14] Randall Packard , Paul Epstein (1991)"Epidemiologists, Social Scientists, and the structure of Medical Research on AIDS in Africa," *Social Science Medicine*, 7, p. 221.

Given all that is known, prevention is possible: **A person who is chaste before marriage, who is faithful to his or her spouse, who marries a person who is HIV-free and also committed to fidelity, who receives health care that includes proper sterilization protocols, testing of any blood products, and all other proper procedures, who doesn't inject illegal drugs, who isn't exposed to non-sterile non-medical invasive procedures, and who is not a health care worker exposed to HIV-positive patients has a virtually zero risk of becoming infected with the HIV virus. This is true whether the person lives in the North America or Africa.**

Prevention would seem therefore to be relatively straightforward:

- warn people about the risks of various behaviors;
- discourage or restrict high-risk activities;
- mandate that all medical procedures are conducted in properly sterile conditions; and
- ensure that all blood and body parts are tested and HIV-free before transfer.

Co-Infections

Those living in sub-Saharan Africa do suffer from additional risks. Malaria, genital herpes, and tuberculosis are more common, and people are less likely to receive prompt effective medical care. These diseases may make a person more vulnerable to infection with HIV and in turn HIV makes the person more susceptible to these diseases.[15]

> Diagnosis with TB may be the first sign that a person is HIV positive. People infected with both MDR TB and HIV appear to have a more rapid and deadly disease course than do those with MDR TB only. If no medicines are available, as many as eight out of ten people with both infections may die, often within months of diagnosis.[16]

At one time DDT was sprayed widely to control malaria, which is the biggest killer in Africa. Subsequently, international pressure against DDT eliminated widespread spraying and malaria resurged. New efforts to combat malaria with spraying of the inside of houses and bed nets are proving helpful.

Not only did the HIV/AIDS hit those already sick, the epidemic also drained scarce resources away from general health care and into condom distribution, further undermining the health care system.

II Standard Public Health Strategies

AIDS is not the first deadly epidemic with which public health officials have had to deal. Over the centuries they have developed a wide range of responses. When countries are faced with a deadly epidemic, public health officials frequently are given sweeping power to close down every pathway the infectious agent might take. Public health strategies have taken into consideration the social problems associated with STIs. Standard strategies for dealing with epidemics have included:

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[15] Laith J. Abu-Raddad, Padmaja Patnaik, James G. Kublin (2006) "Dual Infection with HIV and Malaria Fuels the Spread of Both Diseases in Sub-Saharan Africa," *Science*, 314, p. 1603-1626.
[16] National Institutes of Health, http://www3.niaid.nih.gov/topics/tuberculosis/Understanding/tbHIV.htm

- Educating the public and health care workers about the risks and measures required to prevent transmission;
- Instituting stringent sterilization procedures and other preventive measures in all healthcare facilities, including when possible the use of disposable needles and syringes and other appropriate equipment;
- Testing blood and blood products, screening blood donors, and when blood is found to infected notifying donors and tracing their contacts;
- Mandatory or routine testing of those thought to be exposed or at-risk groups, including hospital patients, those diagnosed with other STIs, pregnant women, applicants for marriage licenses, prisoners, and prostitutes. Routine testing means that people who present themselves for health care and who are considered at risk are tested unless they sign a paper opting out;
- Contact tracing and partner notification. The standard procedure for dealing with STIs is to ask those inflected to provide the names and addresses of all their sexual partners, so that these persons can be warned about the risk, tested, and treated if infected;
- Isolation and quarantine – Patients in health care facilities infected with a contagious disease are often isolated in special wards, where extra precautions against infection of staff and other patients are employed. In some case people have been quarantined if it is determined they pose a risk to others. For example, HIV+ prisoners could be housed separately from the general prison population. Persons who knowingly infect others could be quarantined or even jailed;
- Closing venues – During many epidemics public health officials prohibited public gatherings and closed locations where people were presumed to have been infected. For example, during the polio epidemic swimming pools and children's camps were closed;
- Personal protective measures – Hand washing, disposable gloves for food services workers, masks in the case of airborne viruses, condoms to prevent transmission during sexual relations. It should be noted that personal protective measures are generally not particularly effective methods of managing an epidemic and are usually not used as the first line of defense.

The response to the HIV/AIDS epidemic has focused on changing sexual behavior, but there has been substantial debate about the kind of change that should be encouraged. Prevention programs have moved in two different directions

> 1) Condom Use – Educating everyone to use a condom during every sexual act – a *risk reduction* strategy.
> 2) Abstinence and fidelity (Positive Behavior Change) – Encouraging abstinence before marriage, delaying initiation of sexual activity, fidelity in marriage, and monogamy – risk *avoidance* strategies.

III THE AIDS Consensus

In the late 1980s a number of non-government organizations (NGOs), governmental agencies, and UN agencies began to work together to prevent, treat, and find a cure for or vaccine against HIV/AIDS. These groups constitute the "AIDS Establishment." They came to a consensus as to the proper strategy to deal rapidly spreading HIV/AIDS epidemic in sub-Saharan Africa: condom

education, condom provision, and social marketing of condoms -- accompanied by other medical interventions. The AIDS Consensus was based on the following flawed assumptions:

1) HIV in Africa is transmitted almost exclusively through heterosexual vaginal sexual relations. Other pathways such as anal intercourse, homosexual relations, non-sterile medical transmissions, blood transfusions, and mother to child transmissions constituted only a small fraction of cases.
2) The condom promotion campaign among MSM in the U.S had dramatically reduced new infections in that population and should be the model for controlling AIDS in Africa.
3) There was no need to employ standard public health measures such as routine testing, contact tracing, and partner notification. Instead, those at risk should be encouraged to accept voluntary counseling and testing (VCT) and the results kept secret.
4) Condoms are the only effective weapon in the battle to prevent infection. Prevention programs should focus on condom education and distribution. Program success should be judged by how many condoms are supplied and the percentage of sexually active people using condoms.
5) The epidemic continues to spread because the African people do not have enough condoms and did not use condoms consistently.
6) Programs that emphasize abstinence and fidelity will not work in Africa because Africans are naturally promiscuous.
7) Condom education should focus on presenting condom use as modern and fun. Fear-based campaigns do not work.
8) Adolescents should be encouraged to engage in non-penetrating sexual activity and masturbation.
9) Discrimination against AIDS victims and stigmatizing of persons who have multiple sexual partners endangers prevention campaigns. Faith-based organization should be involved in AIDS prevention only if they did not moralize about sexual behavior and if they agree to promote condoms.
10) Women should be empowered through education about how to negotiate condom use and/or by supplying them with female condoms.
11) Treating other STIs can reduce sexual transmission.
12) Prostitutes should be supplied with condoms and required to use a condom every time.
13) Poverty and marginalization drive the AIDS epidemic.

The AIDS Establishment insisted that the “AIDS Consensus” was the only “scientific” approach to AIDS prevention and anyone who disputed this consensus was irresponsible, ignorant of established scientific facts, and therefore causing the disease to spread and Africans to die.

Other experts challenged every assumption behind the AIDS Consensus. These experts questioned why HIV/AIDS was exempted from standard public health strategies, why non-sexual paths of transmission were not considered, why Africa was sold a ***risk reduction*** rather than a ***risk avoidance*** strategy, and why failed programs received funding and successful programs were ignored.

How did the AIDS Establishment react to these challenges?

1) They accused the critics of the AIDS Consensus of ignoring science, although each challenge was supported by carefully analyzed research.
2) They accused those who challenged the AIDS Consensus of being dangerous "fundamentalists" who were trying to impose "Victorian morality" on Africa.
3) They insisted that their condom programs had only failed because they were under-funded and what was needed was more money for more condoms.
4) They blamed the African people for being too ignorant or stubborn to use condoms or for engaging in bizarre cultural practices that contributed to the spread of the disease.
5) When all else failed, they tried to co-opt the successful ABC programs (A for abstinence, Be Faithful, and C for use condoms if one partner is infected and other not) using the language of abstinence and fidelity, but directing all the funding to condoms. When the diluted programs failed, they blamed the A and B components.
6) They sent out press releases accusing those who did not accept the AIDS consensus of "killing Africans."

IV The AIDS Establishment

In order to understand how the AIDS Establishment arrived at the AIDS Consensus and why they defend it so fiercely, one needs to understand the history of AIDS prevention and the various constituencies that make up the AIDS Establishment:

1) Public Health Officials

Local, national and international public health officials are charged with controlling epidemics. In the U.S., states and municipalities respond to local outbreaks of disease, but the Centers for Disease Control (CDC) has primary oversight in this area. The World Health Organization (WHO) is a UN-affiliated agency concerned with the international responses to epidemics.

The history of the U.S. response to AIDS was reported by Randy Shilts, in his book *As the Band Played On: Politics, People, and the AIDS Epidemic.* Shilts, who later died of AIDS, reported on the interplay between the politics of sexual liberation and the efforts to track the epidemic, identify the cause, develop treatment and produce a vaccine. Shilts documented how from the beginning public health officials were impeded in their efforts to contain the epidemic by militant gay activists who refused to sacrifice their sexual freedom to stop a deadly disease.

Even before the HIV virus entered the bloodstreams of men engaged in sex with other men, the gay male community was in the midst of an epidemic of sexually transmitted diseases. MSM frequented bars and bathhouses where they engaged in sexual relations with multiple partners. In 1980 Dr. Selma Dritz, the infectious disease specialist for the San Francisco Department of Public Health, warned that among MSM: "We've got all these diseases going unchecked. There are so many opportunities for transmission that, if something new gets loose here, we're going to have hell to pay."[17] Unfortunately, the warning was too late. The HIV virus was already

[17] Randy Shilts, (1987) *And the Band Played On,* NY: St. Martins Press, p.40

spreading among MSM. In June of 1981, the first cases of what would become known as AIDS were reported.

The public health officials put forward the standard measures for controlling a sexually transmitted infection: partner notification, contact tracing, closing venues where transmission was known to occur, warning people to avoid high-risk behavior (in this case, anal sex), encouraging monogamy, and using condoms for all sexual activity. Once the virus that causes AIDS was identified, public health officials recommended that MSM be tested so that their partners and sexual contacts could be notified that they were at risk. They further recommended that HIV+ men refrain from unprotected sex with HIV- men. Even though case histories revealed that many of the first victims had had 100s, some 1000s of sexual partners and many of these were strangers, the hope was to contact as many of those at risk as possible, encourage them to change their behavior, and stop the spread of the disease. As the nature of the epidemic among MSM became clear, the public health officials recommended closing the bathhouses since these were clearly venues where infection was being spread.

The gay community strenuously opposed virtually all standard public health practices for dealing with an STI epidemic. According to Ronald Bayer,

> U.S. officials had no alternative but to negotiate the course of AIDS policy with representatives of a well-organized gay community and their allies in the medical and political establishments… In this process, many of the traditional practices of public health that might have been brought to bear were dismissed as inappropriate. [18]

Routine testing and reporting was rejected as a strategy, even for those who were not part of the gay community. For example, tests were done to determine how many babies were infected, but the names were not reported to the government, nor were the mothers told of their babies and their own condition. Over time public health officials who did not accept the AIDS consensus left the field and were replaced by those who did.

On the other hand, public health officials were successful in dealing with other pathways of infection. Problems with the blood supply were addressed. Sterilization procedures were strictly enforced.

2) The Gay AIDS Activists

Although MSM are less than 2% of the population, from the beginning the majority of those infected in the U.S. were MSM. The community was immediately hit hard. A study conducted in the Baltimore STI clinic in 1984 found that HIV sero- prevalence among MSM was 58%.[19] Similar findings were reported in other major metropolitan areas. The gay community responded by setting up a number of organizations, such as the National Gay Task Force and the Gay Men's Health Crisis. Local and national groups came together to lobby for spending on research and

[18] quoted by Chandler Burr (1997) "The AIDS Exception: Privacy vs. Public Health," *The Atlantic Monthly,* June, p. 59.

[19] A. Rompalo (1990) "Sexually Transmitted Causes of Gastrointestinal Symptoms in Homosexual Men" *Medical Clinics of North America*, 74, 6, p. 1633 - 1645.

treatment and to oppose public health initiatives they viewed as unacceptable. Given the death and disease all around them, it was hoped that MSM would act prudently to protect themselves and others.

Gay AIDS activists were, however, concerned about stigmatization and discrimination if test results were revealed, and thus opposed all mandatory or routine – and at first, even voluntary – testing. They opposed all reporting by name of infected persons, even though this had been done for years with other STIs, and despite laws subsequently passed to protect patient confidentiality. They decried negative, fear-based condom promotion, insisting on "sex positive" condom campaigns instead. The Gay AIDS Activists felt it was their duty to their community to protect their recently won right to absolute sexual liberation. They opposed closing the bathhouses, insisting that condom education would solve the problem. They insisted that all references to limiting partners or avoiding anal sex be eliminated, and AIDS prevention strategies were tailored to fit all of these demands.

In the late 1980s the number of new infections among MSM dropped significantly. Gay AIDS Activists took this as proof their strategy had worked. They put themselves forward as experts on prevention and became influential in the formulation of prevention strategies in other areas of the world.

3) Population Control Advocates

For several decades before the beginning of the AIDS epidemic, a number NGOs such as International Planned Parenthood Federation and the Pathfinder Fund had worked with governmental agencies and the United Nations Population Fund (UNFPA) on strategies to reduce population growth in the developing world. These organizations convinced many that high birth rates were a major cause of chronic economic problems in developing countries and that dramatically cutting the birth rate would improve conditions and speed development. (It should be noted that while Africa has a number of crowded urban centers, the continent as a whole is relatively under populated. Furthermore, many other experts dispute the theory that cutting the birth rate is the solution to underdevelopment.)

The population control movement is well-funded. In Africa, it focused on setting up clinics and dispensing IUDs, offering sterilization, condoms, and other contraceptive measures. Where abortion was illegal, they lobbied for legalization. When the AIDS epidemic hit Africa, these groups claimed to have expertise in providing sexual and reproductive health care services and took an active part in condom education and distribution. The condom campaign forwarded their interest in population control since condoms are a form of contraceptive.[20]

4) Sexual and Reproductive Health and Rights Community (SRHR)

The Sexual and Reproductive Rights and Health Community (SRHR) is loose coalition of NGO's and UN agencies which has worked closely with the Population Control Advocates, to promote contraception and abortion around the world. The coalition includes groups such as Women's

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[20] David Gisselquist et al (2003) "Let it be sexual: how health care transmission of AIDS in Africa was ignore," *International Journal of STD & AIDS,* 14, p. 148-161.

Environment and Development Organization (WEDO), Catholics for a Free Choice (CFFC), Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy) and Center for Health and Gender Equity (CHANGE).

While there is broad support for creating societies where women have equal protection under the law, equal access to education, equal rights to participate in the political process, and equal economic opportunities and where women are protected from violence and sexual exploitation, the SRHR community has focused on freeing women from religious, cultural, and social restrictions on their sexual freedom. Their aims include promoting an unlimited right to abortion, the sexual liberation of women, and lesbian rights. They are strongly influenced by the Radical Feminist ideology, which regards traditional marriage, family, and religion as oppressive to women. It should be noted that this attitude does not reflect the concerns of the majority of African women who, while they want their fundamental human rights protected, also value family, marriage, and faith.

5) Advocates for Western Technology

There are also a number of experts involved in AIDS prevention who see Africa's problem as primarily a lack western technology and expertise. These experts often fail to value local expertise and local low-tech solutions. In many cases, technological solutions that are effective in developed countries fail in places where basic health care, clean water, electricity, communications, transportation, and financial resources are luxuries.

The AIDS Establishment is drawn from people in these five communities. They bring different concerns to the table, but they are united in the conviction that condoms are the best hope for AIDS prevention. Any approach that does not focus on condom use is viewed as denying "science." They are willing to combine other technological approaches with condoms (such as Voluntary Counseling and Testing (VCT), prevention of mother to child transmission (MTCT), treatment of STIs, circumcision, prophylactic treatment of those exposed to possible infection, antiretroviral treatment, and aggressive treatment of opportunistic infections, but only if there is no decrease in funds and effort allotted for condom education, provision, and marketing.

The AIDS Establishment is led by people whose priority is establishing an absolute right to sexual pleasure – with as many partners as one desires, regardless of one's sex or marital status – without shame or stigma. For decades they have battled traditional morality in the West, and likewise they insist that it not be reinforced in Africa. In a very real sense, gay and sex-positive activists regard absolute sexual freedom as a right worth dying for.

For example, American anthropologist Douglas Feldman argues that "appealing to religious fundamentalism and sex-negative messages in Africa is not the answer."[21] Feldman opposes:

> …utilizing an archaic Victorian standard of morality for Africa largely discarded in the West. For those African societies: where multipartnering behavior and sex-positive

[21] Douglas A Feldman, (2003) "Problems with the Uganda Model for HIV/AIDS Prevention," *Anthropology News*, Oct. p. 6.

> attitudes are common, applying the pejorative label “promiscuous” is an ethnocentric affront.[22]

Most of those in the AIDS Establishment have been engaged in battles with various religious organizations on other issues. As a result, the AIDS Establishment as a group is generally hostile to religions they consider to be “fundamentalist.” By their definition, any religion which will not modify the fundamentals of its faith to conform to the agenda of the AIDS Establishment is “fundamentalist.” They are particular hostile to Catholicism and frightened at the possible rise of the “religious right” in Africa.

It is not clear whether the African governments understood the extent to which “sex-positive” anti-religious attitudes shaped the AIDS Consensus.

V Challenging the AIDS Consensus

Before the AIDS Consensus had been firmly established, President Yoweri Museveni of Uganda recognized the threat the HIV/AIDS posed to his country – a country that had recently emerged from decades of oppression and strife. Under the leadership he shared with his wife, the ABC program was initiated.

Dr. Edward Green, Senior Research Scientist at the Harvard Center for Population and Development Studies and a member of Presidential Advisory Council on HIV/AIDS, had been actively involved in population control and AIDS prevention in Africa. In his book *Rethinking AIDS Prevention: Learning from Successes in Developing Countries* he recounts how he came to recognize the deficiencies inherent in the AIDS Consensus and the positive results of the ABC approach used in Uganda.[23] Green had observed first-hand the determination of the AIDS Establishment to promote condoms as the prevention method of choice – even when it was clear that the strategy was not working. He had observed how faith-based organizations were able to achieve reductions in new infections with low-cost intervention strategies, and yet when these succeeded, the AIDS Establishment interfered in ways that undermined their successes. Green made it clear that he is not a member of the “religious right,” but he was shocked to discover the undisguised hostility shown by members of the AIDS establishment toward faith-based organizations. Green’s book is essential reading for anyone who wishes to understand AIDS prevention in Africa. Green pointed out that those countries which have adopted the strategies recommended by the AIDS Establishment have not seen a reduction in new infections. His work, along with that of others, convinced the U.S. government to move funding to ABC strategies, thereby provoking a collective cry of outrage from the AIDS Establishment.

The AIDS Establishment insists that the AIDS Consensus has been scientifically proven to be the only way to prevent HIV infections. Each assumption behind the AIDS Consensus has, however, been challenged by other equally qualified experts:

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[22] Douglas Feldman (1991) “Comments on Packard and Epstein,” *Social Science Medicine,* 35, 7, p. 784.
[23] Edward Green (2003) *Rethinking AIDS Prevention: Learning from Successes in Developing Countries*, Westport CT: Praeger.

Assumption #1: AIDS in Africa is transmitted through heterosexual relations. Other pathways such as MSM, IDU, non-sterile medical transmission, and MTCT constituted only a small fraction of cases.

In 2002, the WHO's World *Health Report* stated, "current estimates suggest that more than 99% of HIV infections prevalent in Africa in 2001 are attributable to unsafe sex."[24] A number of experts questioned how the WHO arrived at this estimate. Given the lack of disposable injection equipment and effective sterilization in many areas of Africa, it seemed reasonable to assume that transmission in health care settings was a major pathway for HIV infection.

In a three articles published in the *International Journal of STI & AIDS* in 2003, David Gisselquist, John Potterat, Devon Brewer, Stephen Minkin, and their associates presented evidence that this claim was not supported by the research. They suggested that early in the epidemic medical transmission may have been responsible for a significant percentage of HIV infections. The titles of their articles explain the burden of their complaint, the first being "Let it be sexual: How health care transmission of AIDS in Africa was Ignored." This work discusses how it was in the interests of certain groups in AIDS Establishment to ignore evidence of medical transmission.[25]

> First it was in the interests of AIDS researchers in the developed countries – where HIV seemed stubbornly confined to MSMs, IDUs, and their partners – to present AIDS in Africa as a heterosexual epidemic; "nothing captured the attention of editors and news directors like the talk of widespread heterosexual transmission of AIDS."[26]

Secondly, population control advocates saw condom promotion as "coinciding with pre-existing programmes and efforts to curb African's rapid population growth."[27] Thirdly, the World Health Organization worried that discussion of health care risks might adversely affect immunization programs.

The second article, "Heterosexual transmission of HIV in Africa: An empiric estimate," argues that the consensus view that 90 to 99% of adult HIV in Africa is from sexual transmission was neither derived from nor tested against the evidence, and doesn't fit with what is known about STI epidemics.[28]

The third article, "Mounting anomalies in the epidemiology of HIV in Africa: Cry of the beloved paradigm," argues that, "Africans deserve scientifically sound information on the epidemiologic determinants of the calamitous AIDS epidemic."[29] Their concern is that the AIDS Consensus was reached without such research.

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[24] World Health Organization, (2002) *The World Health report 2002: Reducing risks, promoting healthy life*, Geneva: WHO.
[25] Gisselquist, "Let it be sexual."
[26] Ibid.
[27] Ibid.
[28] David Gisselquist and John Potterat (2003) Heterosexual transmission of HIV in Africa: an empiric estimate" *International Journal of STD & AIDS,* 14, p. 162-175.
[29] Brewer "Mounting anomalies in the epidemiology of HIV in Africa: cry of the beloved paradigm," *International Journal of STD & AIDS,* 14, p. 144-147.

This was not the first time the issue had been raised. In 1991, Randall Packard and Paul Epstein challenged what they considered to be “a premature closure of African AIDS research.”[30] They pointed out that the explosive increases in HIV infections in some areas were not consistent with what is known about other STIs. For example, in Nairobi between 1981 and 1983 the HIV infection rate among one group of prostitutes rose from 4% to 61% and eventually reached 85%.[31] [32] Since prostitutes are routinely tested for STIs and the syringes for drawing blood in STI clinics are not always sterile, it is possible that the infection was spread in the clinic, with the infected prostitutes subsequently spreading it sexually to their clients. In a similar manner, those seeking treatment for an STI at such a clinic could become infected with HIV through the very testing or treatment procedures.

This challenge to the AIDS Consensus was not left unanswered. George Schmid and associates rejected the claim that unsafe injections caused 20 to 40% of HIV infections in Africa, while admitting that 18% of injections in Africa are given with non-sterilized equipment.[33]

In other areas of the world, HIV infection through non-sterile medical procedures has been reported. Use of non-sterilized injection equipment among intravenous drug users is known to be major pathway for infection. It is reasonable to assume that use of non-sterile injection equipment in health care settings, STI clinics, and by traditional healers in Africa could also pose a significant risk. Transmission of other diseases by non-sterile injections had long been a problem in Africa. In a poor area of Dakar, Senegal tetanus and infected abscesses from injections are the third leading cause of death among children under five.[34]

Preventing medical transmission in Africa is complicated by the fact that a substantial portion of the African population continues to rely on traditional healers – who may use injections or invasive procedures to treat a variety of ailments – including AIDS and STIs. If these traditional healers are not using disposable needles and syringes or are not correctly sterilizing equipment, the chances are very high that they could spread HIV among their clients. The possibility that traditional healers are responsible for spreading infection has been acknowledged in the case of other diseases – such as Marburg hemorrhagic fever. According to an article in the *New England Journal of Medicine*, “Home-based treatments involving the use of unsafe syringes have become an important route of transmission. Cases of Marburg disease have been confirmed in traditional healers.” [35]

The article on Marburg also points out “procedures for infection control at provincial hospitals are not rigorously followed.” Many clinics lack disposal needles and syringes and sterilization equipment. In some areas electric power is unreliable rendering the sterilization equipment useless. There is also concern that the very clinics set up to provide sexual and reproductive

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[30] Packard, p. 782

[31] J. Pepin, et al. (1989("The interaction of HIV infection and other sexually transmitted disease : and opportunity for intervention. 3, p. 3-9.

[32] Packard, p. 787.

[33] George Schmid et al. (2004) “Transmission of HIV-1 infection in sub-Saharan Africa and effect of elimination of unsafe injections,” *Lancet*, 363, p. 482-88

[34] Packard, p. 789; O. Lontaine et al. (1984) La diarrhea infantile au Senegal. *Medicine. Troicale,* 44, 1, p. 27-31.

[35] Nestor Ndayimirije, MaryKay Kindhauser (2005) “Marburg hemorrhagic fever in Angola – Fighting fear and a lethal pathogen,” *New England Journal of Medicine*, May 26, 21.

health care in remote areas may not use proper sterilization methods during examinations, tests, injections, or insertion of IUDs.

In the U.S., stopping the medical transmission of HIV through sterilization and the testing of blood has proven extremely effective. There is no reason why with sufficient resources directed toward this effort and sufficient awareness of the risk this pathway of infection cannot eliminate in Africa. However, if the basic protocols of health care are neglected and all the money goes towards distributing condoms, then healthcare transmission may be an ongoing concern.

Since reducing the stigma attached to HIV seemed to be of primary concern to its initial victims, it should also be noted that focusing attention on the transmission through non-sterile injections could help in this area. An HIV+ wife with an HIV- husband could reasonable argue she had been infected by medical treatment not adultery.

Assumption # 2: The condom promotion campaign among MSM in the U.S dramatically reduced new infections in that population, and should be the model for controlling AIDS in Africa.

It is true that in the late 1980s the number of new infections among MSM in the U.S. decreased dramatically. This decrease was attributed to a massive condom education campaign, however it now appears that the dramatic decrease was the result epidemic saturation.[36] By the late 1980's the majority of sexually active MSM were infected with HIV. In San Francisco in one cohort, the infection rate reached 72% by 1988. The epidemic was burning itself out. It was a mathematical certainty that because the percentage of non-infected MSM had shrunk, the number of new infections had to decrease. In order to evaluate the effect of condom education program it is necessary to track new infections among young men entering the gay community. Study after study found that among MSM 17 to 22 years of age, the infection rate did not decrease.

By 2006 the CDC was reporting alarming increases in the number of young MSM newly infected with HIV. In the 13 to 24 age group, the number infected was increasing every year. In 2006 it increased 18% from the previous year – in spite of massive condom education in the schools and a generally more tolerant attitude toward men who have sex with men.

Why hadn't the intensive condom education campaign worked? Research on the behavior and HIV status of MSM in the US during this period found that no matter how intensive the initial educational process, how easy it was to obtain condoms, or how vigorous the follow-up, condom use remained inconsistent – falling off over time, with frequent lapses.[37]

> The efficacy of health education interventions in reducing sexual risk for HIV infection [among MSM] has not been consistently demonstrated. More education, over long periods of time, cannot be assumed to be effective in inducing behavior changes among chronically high-risk men.[38]

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[36] Gabriel Rotello (1997) *Sexual Ecology: AIDS and the Destiny of Gay Men*, NY: Dutton.
[37] K. Sack (1999) "For Gay Men, HIV Peril and Rising Drug Use," *New York Times*. Jan. 29.
[38] R. Stall, T. Coates, C. Hoff (1988) "Behavioral Risk Reduction for HIV Infection among Gay and Bisexual Men," *American Psychologist,* 43, 11, p. 878 - 885.

Even if it had been effective, there is no reason to assume that a strategy designed for a high-risk group – such as MSM in a developed country – was appropriate for an epidemic among a generally heterosexual population in a developing country.

Of even more concern is the fact that the virus is mutating and becoming resistant to the newer drugs, and that men infected with HIV and on medication are engaging in unprotected sex and spreading resistant strains of the virus to uninfected men.[39]

Assumption #3: There was no need to employ standard public health measures such as routine testing, contact tracing, and partner notification. Condom education will solve the problem.

This approach is known as **AIDS Exceptionalism**. The gay AIDS activists argued that AIDS should be exempted from standard public health procedures because:

> 1) condom education was working (although it actually wasn't) and therefore there was no need to resort to more restrictive public health measures;
> 2) the stigma associated with the disease (meaning the association of the disease with homosexuality) would lead to discrimination, stigmatization, or even violence.

Therefore, there should be no mandatory or routine testing, no revelation even to public health officials of the names of those infected and no notification of the partners or family members. This led to situations where wives were not told their husbands had died of AIDS and mothers were not told their babies were HIV+ and they were therefore probably infected.

Some questioned AIDS Exceptionalism. Chandler Burr, a gay man, suggested, "It's time to stop granting 'civil rights' to HIV – and to confront AIDS with more of the traditional tools of public health." He pointed out that "an absence of routine testing, reporting, and notification" means that "a lot of undiscovered AIDS and HIV cases are festering in the larger society."[40]

In 2003 Charles Karel Bouley, a San Francisco talk-show host who lost his partner to AIDS, asked, "What if HIV had been treated like SARS?" He pointed out that:

> If someone who knew they had SARS decided to hop into a crowded bus or airplane and cough on everyone, wouldn't they be dragged away in handcuffs and quarantined? Oh, but not HIV: Today we have parties in bigger cities where people actually go to have sex with HIV-positive people: bug chasing parties. It's criminal."[41]

AIDS Exceptionalism influenced the choice of prevention strategies in Africa. For example, although patients are tested for other diseases as part of ordinary health care at pre-natal clinics and STI clinics, routine testing for HIV was rejected as a strategy – even though such testing would have identified infected persons and protected babies and sexual partners. Instead, voluntary counseling and testing (VCT) was recommended, despite the known fact that those persons most at risk often refused to present themselves for voluntary testing.

An article in *The Lancet* argued for "a serostatus-based approach to HIV/AIDS prevention and care in Africa" under which routine testing for HIV would be "done as an integral part of a

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[39] T. Maugh (1998) Transmission of drug resistant HIV Reported. *Los Angeles Times.* July 1.
[40] Chandler Burr (1997) "The AIDS Exception: Privacy vs. Public Health" *The Atlantic Monthly*, June, p. 57- 67.
[41] Charles Karel Bourly, (2003) "Who's Sar-ry Now?" posted on Advocate.com, April 23.

preventive health service."[42] The article pointed out that clients at STI clinics are routinely tested for syphilis or other infections, and it is reasonable to include routine HIV testing – particularly since STI clinic patients are at high risk for HIV infection.

The public health community in Africa appears to be committed to VCT even though it appears to be ineffective. Medicine is available even to prevent mother-to-child transmission, yet in Africa many mothers refuse VCT when offered.[43] The results: babies born infected. Some have suggested that, since at-risk children are currently being "held hostage to the inherent complexity of establishing testing services," perhaps the testing should be eliminated and all pregnant women be given Nevirapine to prevent possible HIV transmission. While routine treatment would prevent many infections, it would not provide treatment for the mother or the father or other possibly infected children; it is simply a way to cope with one of the problems created by AIDS Exceptionalism.

As for routine testing, contract tracing and partner notification, these elements had actually proven extremely effective in finding infected persons and in warning those who had been involved sexually with an HIV+ person of their risk, often prompting changes in behavior.[44]

Assumption #4: Condoms are the only effective weapon in the battle to prevent infection. Prevention programs should focus on condom education and distribution. They should be judged on how many condoms they supply and the percentage of sexually active people using condoms.

Condoms used consistently and correctly can reduce the risk infection during vaginal intercourse. A meta-analysis of condom effectiveness found that:

> Consistent use of condoms results in 80% reduction of HIV incidence. Consistent use is defined as using a condom for all acts of penetrative vaginal intercourse… Thus, condom effectiveness is similar to, although lower than, that for contraception.[45]

Condoms have long been considered the least effective form of contraception. Of married women who rely on condoms for one year, 15% become pregnant. The failure rate for pregnancy prevention is higher for unmarried women. Even when people intend to use them correctly, condoms can leak, break, or slip off during use.

While correct use decreases the probability that an individual sexual act will transmit the virus, with consistent use 20% of infections are not prevented. According to an article in *The Lancet*:

> Massive increases in condom use worldwide have not translated into demonstrably improved HIV control in the great majority of countries where they have occurred.[46]

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[42] Kevin deCock et al. (2003) "A serostatus-based approach to HIV/AIDS prevention and care in Africa," *Lancet*, 362, p.1847-1849.

[43] Jeffrey Stringer, et al. (2003) "Nevirapine to prevent mother-to-child transmission of HIV-1 among women with unknown serostatus. *Lancet,* 362, p. 1850 - 1853.

[44] Chandler Burr, p. 57.

[45] S. Weller, K. Davis (2002) "Condom effectiveness in reducing heterosexual HIV transmission," http://www.update-software.com/abstracts/ab003255.htm.

[46] John Richens, John Imrie, Andrew Copas, (2000) "Condoms and seat belts: the parallels and lessons," *Lancet*, 355, p. 400.

According to review of the literature on condom promotion:

> In many sub-Saharan African countries, high condom use has yet to produce demonstrable benefit… sad experience shows that high HIV transmission can coexist with high condom use.[47]

Consistent and correct condom use is the exception. Even when people receive extensive education, know that they are at risk for infection and begin to use condoms, few continue to use a condom every time. A study in Malawi reported that:

> Consistent condom use peaked at 62% in the first 6 months, but declined to as low as 8% in the second year of follow-up.[48]

Several studies have found that inconsistent condom users have higher rates of STI and/or HIV infections than condom non-users.[49] Studies found that among MSM found that those who did not use condoms were less likely to be infected than those who did.[50] A study of HIV in Zimbabwe found that: "HIV risk was elevated among those who had used condoms consistently with their most recent partner."[51] This may be because the non-users were less likely to have a number of different partners. On the other hand, condom users experience a false sense of security and go on to engage in sexual encounters with a number of partners, but fail to use a condom every time, either because they were high on drugs or alcohol or simply because they didn't want to be bothered "this one time."

A study of HIV incidence and sexually transmitted disease prevalence in Uganda found that:

> Irregular condom use was not protective against HIV or STI and was associated with increased gonorrhea/Chlamydia risk.[52]

The Lancet article warned:

> A vigorous condom-promotion policy could increase rather than decrease unprotected sexual exposure, if it has the unintended effect of encouraging greater sexual activity.[53]

Country by country, studies found that condom distribution and use was not associated with lower infection rates, but rather in some cases with higher infection rates.[54] Condom education

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[47] Norman Hearst, S. Chen (2003) "Condom Promotion for AIDS Prevention in the Developing World: Is it Working?" Geneva: UNAIDS, p. 7.

[48] T. E. Taha *et al*. (1996) "Lack of association between reported condom use and rates of sexually transmitted diseases in Malawi," *AIDS,* 10, p. 207-212.

[49] W. W. Darrow et al. (1989) " Condom use effectiveness in high–risk populations," *Sexually Transmitted Diseases,* 16, p. 157-160; Hearst op. cit.

[50] Green, p. 108, referencing J. M. Zenilman *et al.* (1995) "Condom use to prevent incident STIs: The validity of self reported condom use," S*exually Transmitted Disease,* 22, p. 15-21: "A prospective study of condom use in Baltimore found no differences in STI infection rates among those who reported using condoms 100 percent of the time versus 0 percent of the time."

[51] S. Ahmed *et al* (2001) "HIV Incidence and sexually transmitted disease prevalence associated with condom use: A Population study in Rakai, Uganda." *AIDS*, 15, p. 2171-2179.

[52] Ibid.

[53] Richens, op. cit.

[54] Green, op. cit.

did not work among MSM in the U.S. and there is mounting evidence that in spite of years of valiant effort and vast expenditures it will not work in Africa.

Female condoms have been recommended as a “woman-controlled” form of protection, and yet these have lower effectiveness rates than male condoms and are substantially more expensive. In poor countries, women are tempted to wash and reuse them.

Assumption #5: The epidemic was spreading because the African people did not have enough condoms and did not use condoms consistently.

It is generally accepted that STI epidemics are driven by multipartner sexual activity.[55] Consistent condom use has been impossible to achieve among persons who engage in sexual activity with multiple partners. In addition, condom use – whether consistent or inconsistent – has not proven effective in reducing infection rates. In light of these statistics, the AIDS Consensus blames the victims for the failure of their strategy. It assumes that Africans are unable or unwilling to act in their own best interests, locked into destructive traditions and oversexed. The article by Packard and Epstein points out how such racist stereotypes about Africa have affected health care in the past and why they are negatively affecting it today. [56]

According to Green, when the African people recognized they were faced with a new and deadly sexually transmitted disease, many spontaneously began to modify their sexual behavior – to limit the number of sexual partners or to delay sexual activity. They chose to act prudently in their own self-interest. Since the majority of Africans marry young and want children, using a condom every time was not a reasonable strategy. On the other hand, the social marketing of condoms as “safe” convinced many young people that sexual restraint was unnecessary and they could engage in sexual relations with multiple partners. Where social marketing was prevalent, condom use increased, but infections did not decrease.

An article on condom use in Uganda found that increased condom use resulted in more rather than less high-risk behavior:

> The authors note that whilst the uptake of condoms was much higher among the intervention group, proving that the intervention had overcome barriers to access, this improvement in uptake actually appeared to be associated with an increase in behavior that may paradoxically increase the rate of HIV transmission in sexual networks with high levels of partner change.
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> Men in the intervention group reported a significantly higher number of partners during the six month follow-up period when compared with the six months prior to joining the study.[57]

On the other hand, encouraging positive behavior change has proven effective:

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[55] Green, p. 75

[56] Packard , p. 221.

[57] P. Kajubi et al. (2005) "Increasing condom use without reducing HIV risk: results of a controlled community trail in Uganda," *Journal of Acquired Immune Deficiency Syndromes* Sept. 1.

> Uganda provides the clearest example that human immunodeficiency virus (HIV) is preventable if populations are mobilized to avoid risk. Despite limited resources, Uganda has shown a 70% decline in HIV prevalence since the early 1990s, linked to a 60% reduction in casual sex. The response in Uganda appears to be distinctively associated with communication about acquired immunodeficiency syndrome (AIDS) through social networks. Despite substantial condom use and promotion of biomedical approaches, other African countries have shown neither similar behavioral responses nor HIV prevalence declines of the same scale. The Ugandan success is equivalent to a vaccine of 80% effectiveness. Its replication will require changes in global HIV/AIDS intervention policies and their evaluation.[58]

Assumption #6: Programs that emphasize abstinence and fidelity will not work in Africa, because Africans are naturally promiscuous.

Unfortunately, stereotypes about African sexuality have influenced the prevention strategies offered in sub-Saharan Africa. Contrary to this assumption, many Africans have been willing to modify their sexual behavior to avoid infection. Even before organized educational campaigns began, as soon as people understood that AIDS could be transmitted sexually they began to respond by choosing a form of behavior appropriate to their life situation. The success of the ABC campaign in Uganda – particularly abstinence and fidelity – proves that when told the truth about a deadly epidemic and its risks, Africans can make prudent decisions about how to protect themselves. Young women have come to see the advantages of continuing their education and waiting until marriage, and Africans are as capable as any other people in controlling their sexual desires.

Those promoting ABC also stressed how abstinence and fidelity are not simply positive personal strategies but also patriotic choices protecting the country's economic future.

Assumption #7: Condom education should focus on presenting condom use as modern and fun. Fear based campaigns do not work.

Condom campaigns that emphasize fun and safety have not been shown to increase condom usage sufficiently to stem the spread on HIV. There is evidence that such campaigns may have the unintended effect of glamorizing risky multi-partner sex, giving young people a false sense of security and thereby increasing risk of HIV infections.[59] Conversely, fear-based campaigns have proven effective in increasing positive behavior change.

In Thailand, where brothels are common, the government instituted a campaign to force 100% condom use. The percentage of men using a condom every time they visited a prostitute increased, however the corollary effect was that the percentage of Thai men visiting prostitutes dropped.[60] It is entirely possible that the campaign meant to impress upon Thai men the importance of using a condom with a prostitute actually impressed upon them the risk of having

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[58] Rand L. Stoneburner, Daniel Low-Beer (2004) "Population-Level HIV Declines and Behavioral Risk Avoidance in Uganda," *Science*, April, 304, 5671, p. 714-718.
[59] Richens, op cit.
[60] Green, p.114.

relations with a prostitute, thereby creating a fear of visiting prostitutes. Subsequently, any decrease in new infections could be attributed the decrease in visits to prostitutes rather than increased condom use.

Assumption #8: Adolescents should be encouraged to engage in non-penetrating sexual activity and masturbation.

Those who believe that adolescents who are encouraged to engage in various non-penetrating forms of sexual activity will have the self control to stop at that or "always" use a condom demonstrate a serious lack of understanding of adolescent psychology. Not only that but this kind of activity usually involves girls providing sexual services for boys. Such exchanges are rarely emotionally satisfying for the girls, who are expected to give and get little in return.

Assumption #9: Discrimination against AIDS victims and stigmatizing of persons who have multiple sexual partners endangers prevention campaigns. Faith-based organizations should be involved in AIDS prevention only if did not moralize about sexual behavior and agree to promote condoms.

While discrimination against and stigmatization of persons with HIV was initially a problem, the threat has diminished. Faith-based organizations in Africa have demonstrated that it is possible to treat the victims compassionately while at the same time speaking forcefully against the behaviors that exposed them to infection. Unfortunately, while faith-based organizations provide a significant portion of health care in Africa, the AIDS Establishment has repeated excluded faith-based organizations from planning and funding for AIDS prevention.

One way to encourage people to change their behavior is to tell them that what they are doing is wrong, could kill them, injure the people they love, and damage their community and their nation. Religious groups can send a strong unambiguous message to the members of their congregations that certain behaviors are not only dangerous, but also contrary to God's laws. These groups cannot compromise their fundamental beliefs and there is certainly no reason for them to do so in order to accommodate a strategy that at best promises only *risk reduction*. What makes faith-based organization effective is that they can preach behavioral change as part of a consistent view of the human person and promise divine assistance as well as community support.

Many religious leaders have refused to endorse condom use for unmarried persons, stressing instead the need for abstinence before marriage and fidelity in marriage. Encouraging religious leaders to speak frankly about HIV/AIDS has proven to be a low cost and very effective way of promoting positive behavior change without increasing discrimination against those living with AIDS.

Assumption #10: Women should be empowered by educating them on how to negotiate condom use and/or by supplying them with female condoms.

One of the frightening things uncovered in the research on sexual transmission of HIV in Africa is the high percentage of young African women who reported that their first sexual experience

was not voluntary – in other words they were raped or in some way coerced into sexual activity.[61] Empowering women must begin with preventing sexual abuse, sexual harassment, statutory rape, and rape. These crimes against women have too often gone unpunished or worse the women have been punished for "losing their honor."

Protecting women from all forms of sexual exploitation is a key part of the abstinence strategy. While girls should be instructed about the importance to their health and future prospects of waiting until marriage for sexual intimacy, they should also be protected from situations where they are vulnerable to seduction or rape. All girls' schools, chaperoned social activities, and parental supervision are well-established strategies for protecting young girls.

The very modern idea that girls as young as 12 can protect themselves if left alone with sexually mature males has proven unworkable and should be replaced with a combination of abstinence education and prudent supervision. Teaching a young woman how to negotiate condom use does not protect her from sexual exploitation and only exposes her to numerous other STIs such as HPV.

Women also have the right to demand that their husband be faithful. Most African women marry and desire children. Using a condom – whether a male condom or a female condom – is simply not a workable strategy.

Assumption #11: Treating other STIs can reduce sexual transmission.

Several studies have linked STIs, which cause open sores, with HIV infection and have concluded that treating STIs will reduce HIV infections. STIs are epidemic in Africa. The treatment of STIs should be a normal public health priority – not simply a means to preventing HIV infection. Several STIs cause infertility, which can have devastating social consequences in a society where the elderly are dependent on their children. Therefore aggressive treatment of STIs should be the rule and should include routine testing for HIV, followed by the standard public health procedures of partner notification and contact tracing. Treating STIs has limited success if those treated often continued high-risk activity.

Assumption #12: Prostitutes should be supplied with condoms and encouraged to use a condom every time.

In countries where prostitution is legal or tolerated, the AIDS Consensus recommends that prostitutes be carefully monitored and treated for STIs, supplied with condoms and encouraged to use them every time. There are two difficulties with this strategy. First, there is ample evidence that clients are willing to pay extra not to use a condom, and that these are the very clients most likely to be infected. Prostitutes understand that they will suffer economically if they insist on condom use.

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[61] Hygean/ FHI (2001) *Enquete de Surveillance du Comportement ESC* , Senegal Ministry of Health and Prevention. quoted in Green, p. 231: "85% of women who reported a sexual debut said that the debut was involuntary against their will and wishes."

The second problem is with prostitution itself. It is difficult to imagine a more egregious abuse of women. In some countries women are sold into prostitution by families. Some women fall into prostitution because of poverty, sexual abuse or drug addiction. Others are lured away from home with promises of an employment or kidnapped by those involved in the sex trade. Once a woman is caught up in prostitution it is difficult for her to escape. Prostitutes, even those monitored by the government, are at high risk of contracting a deadly or incurable diseases and passing them on to clients.

Many people feel that tolerating prostitution is condoning the exploitation of women and the proper response to the spread of STIs by prostitutes is to so far as possible to eliminate prostitution and rehabilitate the prostitutes.

Campaigns to encourage prostitutes' clients to use condoms may reduce the numbers of men frequenting prostitutes, but does not protect prostitutes over the long run. Given the health risks not only to the prostitutes and their clients, but also to the wives and children of clients, from a purely public health point of view cracking down on prostitution by closing venues, arresting clients and detaining prostitutes is a reasonable strategy. Short of that, governments could consider an anti-prostitution campaign that portrayed men who frequent prostitutes as weak, unpatriotic, guilty of exploiting women, and endangering the lives of their wives and children.

It should be noted that boys are also lured into prostitution and are at high risk for HIV infection. Sex tourism – the business which encourages men from wealthy countries travel to poor countries for the purpose of sex – is a growing industry. Sex tourists include men who are interested in sex with children and adolescent boys. There is growing outrage against such activities and against the governments that tolerate these abuses. Such activities pose significant threats to public health because in the modern world they spread diseases quickly from continent to continent.

Assumption #13: Poverty and marginalization drive the AIDS epidemic.

While eliminating poverty and the oppression are worthy goals, prevention campaigns need to focus on what can be done today. AIDS prevention cannot wait until Africans solve all their myriad problems; indeed, there is every reason to believe that the AIDS epidemic will prevent development and increase poverty and political instability. Prevention strategies must take into account the extreme poverty of some parts of Africa and the lack of development.

Furthermore, the assumption that the AIDS in Africa is driven by poverty is not borne out by the research. The well educated, better off, and those living in urban areas are more likely to be HIV positive than those living in extreme poverty in isolated areas.

VI Funding and Results

There is an old saying that beggars can't be choosers. Presently, Africa has been forced to accept these inadequate programs because the only alternative would be to receive no programs at all. If only condoms were offered, they accepted them – and yet many African leaders have been

angered by the refusal of funding organizations to allow Africans to define their own needs and to choose strategies that respected their values and culture.

African leaders were particularly frustrated by the fact that during the 1990s all the funding was going to HIV/AIDS, while diseases that could be successfully treated with a fraction of the funding were ignored. People who could be saved were dying. The Global Fund for AIDS, Malaria and Tuberculosis set up to respond to this concern. By lumping, these three killer diseases together, the hope was at least some money would be directed to projects that would actually save lives. As the Bush administration became aware of the success of ABC in Uganda, it began to direct its funding toward faith-based organizations, to programs that stressed positive behavior change, and to uncontroversial areas such as treatment and malaria prevention.

The AIDS Establishment let out a collective howl. Bush was linked with the Vatican as a killer of Africans. An article in *The Guardian*, Stephen Lewis, the UN secretary general's special envoy for HIV/AIDS in Africa, accused President Bush of "doing damage to Africa by cutting funding for condoms."[62]

It would seem obvious that prevention strategies that have a proven record of success should be funded and those that have failed should be defunded. The argument that programs have failed because they did not receive enough money and the answer to failure is more money may be a typical government method of avoiding accountability, but given the limited resources, the immense need, and the existence of proven prevention strategies, the money should go to proven programs not failed ones.

International funding should be directed to interventions that are acceptable to the local population. Success should not be gauged by the sheer number of condoms distributed or used, but by a significantly lower infection rate.

***The Philippines: A success story no one wants to talk about*.**

Given the level of poverty in the Philippine's in addition to its other problems, the AIDS Establishment has year after year predicted a massive wave of infections unless the nation adopts aggressive condom promotion. However, twenty-five years into the epidemic only 0.09% of the population is living with AIDS. Health care, a left over from the period of American control, employs high standards of sterilization. The influence of the Catholic Church is strong. Instead of seeing the Philippines as example of how to prevent an epidemic, the AIDS Establishment continues to push the government to distribute condoms.[63]

VII The Cultural Impact

It is clear that the debate over prevention strategies in Africa is not just about what will work. It is also about how implementing the various strategies will affect the culture. Some strategies – such as providing sterile conditions and HIV free blood – are culturally neutral. Other strategies

[62] http://www.guardian.co.uk/world/2005/aug/30/usa.aids.

[63] Seth Mydans, (2003) "Low rate of AIDS virus in Philippines is a puzzle," *New York Times,* April 20.

require that substantial portion of the population change not only their behavior, but also their beliefs about right and wrong.
The AIDS Establishment supports prevention strategies that strictly coincide with their own beliefs about right and wrong, which revolve around the view that sexual pleasure is an inalienable human right. The members of the AIDS Establishment, with few exceptions, believe that AIDS prevention strategies must in never inhibit sexual liberation – even at the cost of human lives. The AIDS Establishment accepts multi-partnering (promiscuity), commercial sex work (prostitution) and the right to privacy (the right not to be tested and not inform sexual partners about HIV status) as fundamental to personal liberty. They not only want people to be free to engage in sexual activity, but to be able to do so without shame, discrimination, or embarrassment.

Conversely, those promoting the ABC approach see sexual pleasure as the servant, not the master. For them, postponing sexual intimacy until after marriage and then being faithful within marriage not only have pragmatic benefits, they also strengthen families which subsequently enhance the wider society. Strong families produce economic and social benefits as well as providing an emotional and spiritual richness to the community. In addition, abstinence and fidelity are in accord with traditional religious teachings.

It is this last part that particularly offends many in the AIDS Establishment. The AIDS Establishment rightly recognizes that traditional religions oppose the ideology of sexual liberation. Where ABC is successful, religious institutions will become more influential. Common sense tells them that positive behavioral changes combined with standard public health strategies works. Social marketing of condoms has been tried and failed.

Western nations may have the economic resources to deal with the pandemic of sexually transmitted diseases, out-of-wedlock pregnancies, and disintegrating families, but Africa cannot afford the grievous price of sexual liberation. The African people have a duty to consider all the facts, all the possible strategies and the predictable consequences of each strategy – and they should be able to decide what is in their best interests.

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