

Beyond Slogans: Lessons From Uganda's Experience With ABC and HIV/AIDS

By Susan A. Cohen

Between the late 1980s and mid-1990s, at a time when HIV/AIDS was well on its way toward ravaging Sub-Saharan Africa, Uganda achieved an extraordinary feat: It stopped the spread of HIV/AIDS in its tracks and saw the nation's rate of infection plummet. As word of the "Uganda miracle" spread, journalists, researchers, policymakers and advocates all descended to try to ascertain how it was accomplished.

By now, Uganda's success story has become virtually synonymous with the so-called ABC approach to HIV/AIDS prevention, for Abstain, Be faithful, use Condoms. And, indeed, it is clear that some combination of important changes in all three of these sexual behaviors contributed both to Uganda's extraordinary reduction in HIV/AIDS rates and to the country's ability to maintain its reduced rates through the second half of the 1990s. Beyond that, however, the picture becomes considerably less clear.

ABC refers to individual behaviors, but it also refers to the program approach and content designed to lead to those behaviors. Researchers and public health experts continue to study both and to delve into the many and varied complex relationships among them. This information is critical to determining to what extent the Uganda experience really is replicable and what from that experience productively might be exportable to other countries. At the same time, much more research is needed into the relevance of the ABC approach for the prevention of other sexually transmitted diseases

(STDs) as well as unintended pregnancy and the abortions or unplanned births that inevitably follow, both in Sub-Saharan Africa and in other parts of the world.

Meanwhile, U.S.-based social conservatives in and out of government—even as they pay homage to the ABC mantra—continue to confuse all of these issues. For them, ABC has become little more than an excuse and justification to promote their long-standing agenda regarding people's sexual behavior and the kind of sex education they should receive: A for unmarried people, bolstered by advocacy of B, but for most people, "anything but C."

Uganda and ABC

Measuring sexual behavior change. Among public health experts, it is by now generally agreed that during the critical time period between the late 1980s and mid-1990s, positive changes in A, B and C behaviors occurred and that all of these changes played a role in reducing HIV rates. Uganda's HIV prevalence steadily increased until about 1991, when it peaked at about 15% (30% among pregnant women in urban areas). It then turned sharply downward through the mid-1990s and reached 5% (14% for pregnant urban women) by 2001.

The findings of an analysis released by The Alan Guttmacher Institute in November 2003, *A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline*, are consistent with the current consensus. Between 1988 and

1995, the time period during which HIV prevalence was declining, key changes in behavior occurred.

- Fewer Ugandans were having sex at young ages. The proportion of young men who had ever had sex decreased substantially and the median age at which young women began having sex rose from 15.9 in 1988 to 16.3 in 1995. Importantly, however, among those people who were having sex, overall levels of sexual activity did not decline.
- Levels of monogamy increased. Sexually active men and women of all ages, particularly the unmarried, were less likely to have more than one sexual partner in a 12-month period in 1995 than in 1989. Other research has found that the proportion of men reporting three or more sexual partners also fell during the period.
- Condom use rose steeply among unmarried sexually active men and women. Among unmarried women who had had sex in the last four weeks, the proportion who used condoms at last intercourse rose from 1% in 1989 to 14% in 1995; among unmarried men, condom use rose from 2% to 22%.

Additional risk factors and epidemiological impact. The relationship between individual sexual behavior and HIV risk is further complicated, however, by many other factors that overlay a simple A, B and C analysis. The risk of exposure is greater, for example, in the presence of other STDs and it appears to be lower for circumcised men. The number of a man or woman's sexual partners matters, but so does the duration of relationships, the extent to which relationships might overlap, frequency of sex, specific sexual practices, how consistently and correctly condoms are used with different partners, and the stage of infection of an HIV-positive partner.

In high-prevalence settings, ascertaining exactly which behavior change or combinations of changes can have the most impact in reducing HIV infection among the population as a whole is the focus of more recent studies. Indeed, based on the Uganda experience and drawing on an understanding of the epidemiology of STDs more generally, scientists are now concluding that other things being equal, even if absolute monogamy is not attained, having fewer sexual partners, especially concurrently, may be the most significant behavior change for a population overall. (Whether this is always the most significant protective factor at the *individual* level may be another matter.)

Creating behavior change. It is not possible to make a direct and simple link between the changes that took place in Uganda and the policies or programs that may have caused them to happen. The widely held view among Ugandans and outside analysts, though, is that increases in all three of the ABC behaviors led to reduced HIV rates following a comprehensive national message that HIV prevention was of the utmost importance to the country and the responsibility of all of its citizens. The message was delivered in different ways through a multiplicity of approaches, programs and types of organizations and was buttressed by a level of political commitment to forthrightly addressing the AIDS crisis that was unique among African governments. President Yoweri Museveni himself exhorted Ugandans, and still does, to practice A, B and C. Further, as Harvard medical anthropologist Edward Green observed recently, “ABC is far from all that Uganda has done.” Uganda, he noted, “pioneered approaches towards reducing stigma, bringing discussion of sexual behavior out into the open, involving HIV-infected people in public education, persuading individuals and couples

to be tested and counseled, improving the status of women, involving religious organizations, enlisting traditional healers, and much more.”

The evidence, therefore, points to the existence of a range of complementary messages and services delivered by the government and a wide diversity of nongovernmental organizations. To be sure, those messages included the importance of both young people delaying sexual initiation and “zero grazing” (monogamy). But contrary to the assertions of social conservatives that the case of Uganda proves that an undiluted “abstinence-only” message is what makes the difference, there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995.

Beyond Uganda

Encouraging signs also are beginning to emerge from other countries where HIV/AIDS had become a generalized epidemic. In Zambia, for example, HIV rates appear to be declining, at least among urban youth. The U.S. Agency for International Development (USAID) notes that “clear, positive changes in all three ABC behaviors” have taken place. Indeed, it would seem that the HEART (Helping Each Other Act Responsibly) program, a major USAID-funded media campaign there, may deserve much of the credit. This program, which was designed for and by youth, promotes both abstinence and condom use. One year after the campaign’s initiation, indications are that young people exposed to its comprehensive messages are 46% more likely to be delaying or stopping having sex and 67% more likely to have used a condom the last time they had sex, compared with those who were not exposed.

In Jamaica, where HIV rates are still relatively low but sexual activity at

early ages is prevalent, a similar media campaign is beginning to show results. According to a recent summary from the USAID-sponsored YouthNet project, “More than half of the youth who recalled the ads said the ads had influenced how they handle boy/girl relationships through abstaining from sex, not giving into sexual pressure, and always using a condom/contraceptive when having sex.”

HIV/AIDS rates also are declining in Cambodia, Thailand and the Dominican Republic, three other countries where various combinations of ABC behavioral changes appear to have played an important role. In Cambodia and Thailand, the epidemic spread mainly through prostitution. Both countries are adopting a “100% condom use” policy in brothels, and it is yielding positive results. In the Dominican Republic, meanwhile, the infection rate has slowed mainly due to men having fewer sexual partners as well as to increased condom use.

Finally, Brazil has so successfully stemmed the tide of HIV/AIDS that only half the number of Brazilians are infected today as the World Bank had predicted only a few years ago. Brazil’s case may be atypical in one sense because of the government’s decision to make free antiretroviral drugs available to anyone who qualifies for AIDS therapy. But it is equally atypical within Latin America because of the government’s decision to promote frank talk about sex as well as condom distribution programs. Indeed, the Brazilian Health Ministry announced plans in August 2003 to distribute condoms to sexually active high school students in five Brazilian cities to prevent not only HIV/AIDS but also teenage pregnancy. Officials are particularly concerned about preventing HIV-positive teenage girls from becoming pregnant and then transmitting HIV/AIDS to their newborn infants.

Beyond HIV and ABC

Despite the evidence from Uganda and these other countries, U.S. HIV prevention policy is focused on promoting abstinence. Indeed, Global AIDS Coordinator Randall Tobias personally endorsed a provision in recently enacted U.S. law requiring that at least one-third of all U.S. assistance to prevent HIV/AIDS globally be reserved for “abstinence-until-marriage” programs (“U.S. AIDS Policy: Priority on Treatment, Conservatives’ Approach to Prevention,” *TGR*, August 2003, page 1). In effect, this makes “abstinence-until-marriage” advocacy the single most important HIV/AIDS prevention intervention of the U.S. government.

Social conservatives pressed for this result because, at least with regard to the general population, they dismiss the effectiveness of risk-reduction strategies such as those that promote correct and consistent condom use. Some, like Joseph Loconte of the Heritage Foundation, go further, denouncing even those programs that target particular high-risk groups with risk-reduction messages on the grounds that they “legitimize promiscuity, prostitution and illegal drug use.” Instead, he and others advocate a strict “risk elimination” approach—which itself must be regarded as a risky strategy, given that risk elimination depends on 100% compliance 100% of the time (see related story, page 4).

Conservatives further assert that the availability of condoms has a “disinhibiting” effect on people’s sexual behavior. By that logic, what could be more disinhibiting than the promise, and increasing reality, of HIV treatment? Certainly, correct and consistent contraceptive and condom use is difficult for ordinary people to maintain over long periods of time. But if reports on the recent rise in HIV incidence in the United States pointing to “prevention fatigue” as one of the contributors

have merit, should not strict “abstinence fatigue” be considered a clear and present danger?

To be sure, living in the midst of high HIV/AIDS prevalence can be a strong motivator for behavior change. As Harvard’s Green wrote recently, in countries “where infection rates exceed 30% and funerals for family and friends are held several times a week, abstinence and faithfulness are attractive alternatives to death.”

Presumably, more and more-careful condom use would be an attractive alternative in the face of these circumstances as well—and the experience of high-prevalence communities in the United States from roughly the same time period during which Uganda turned its rates around indicates that, indeed, this was so. The critical questions, therefore, become: What behaviors may be more or less realistic for individuals to both achieve and sustain—especially as the imminent crisis begins to ebb? And how best can they be encouraged to do so?

Finally, that Brazil and Jamaica, to name just two countries, have linked HIV/AIDS prevention strategies with the prevention of unintended pregnancy is a reflection of the complex realities of life and sexual relationships. Women, especially, often are trying to prevent both simultaneously. How useful or relevant is the ABC approach for the broader range of reproductive health-related conditions individuals face in everyday life—especially a segmented approach that targets different messages to different groups of people rather than recognizing that the same people may need different messages at different stages of life? Even if a woman abstains until marriage, for example, she is likely to still want and need “C”—be it Condoms or other Contraception—in order to be able to plan her child-bearing. Alternatively, how can a married woman who wants to become pregnant protect herself

from the risk of HIV/AIDS from her husband who may have other sexual partners? And for a young woman who has so far abstained from sex altogether, must she wait until she is already sexually active until she is entitled to the full and accurate information necessary to protect herself from unplanned pregnancy and disease? These are just some of the questions raised by the ABC approach to sexual risk reduction.

“What happened” in Uganda between the late 1980s and mid-1990s happened in a specific place and time and under very specific circumstances. There is much to be learned from it. But advocates and policymakers seeking the simplicity of a single program model to replicate should be cautioned that Uganda’s experience may have limited implications—even for making further gains in that country, let alone for other countries, other time periods and the range of reproductive health concerns beyond HIV that women and men face. Public health experts and researchers, meanwhile, have a special responsibility to recognize and explicate the complexities of these questions, even as they redouble their efforts to answer them. ☯

This is the third in a series of articles examining emerging issues in sex education and related efforts to prevent unintended pregnancy and sexually transmitted diseases. The series is supported in part by a grant from the Program on Reproductive Health and Rights of the Open Society Institute. The conclusions and opinions expressed in these articles, however, are those of the author and The Alan Guttmacher Institute.