

# Improving U.S. Global AIDS Policy for Young People

Assessing the President's Emergency Plan for AIDS Relief



**Advocates**  
For **Youth**

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# Acronyms and Abbreviations

<b>AB</b>	abstinence and be faithful
<b>ABC</b>	abstinence, be faithful, use condoms
<b>ABC Guidance</b>	ABC Guidance #1: For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually Transmitted Infections with the President's Emergency Plan for AIDS Relief
<b>AIDS</b>	auto-immune deficiency syndrome
<b>ART</b>	anti-retroviral therapy
<b>CDC</b>	(U.S.) Centers for Disease Control & Prevention
<b>COPS</b>	country operational plans
<b>CSIS</b>	Center for Strategic & Intelligent Studies
<b>DHS</b>	Demographic and Health Surveys
<b>FHI</b>	Family Health International
<b>FP</b>	family planning
<b>FY</b>	fiscal year
<b>GAO</b>	U.S. Government Accountability Office
<b>GH</b>	Global Health, a bureau within USAID
<b>GLP</b>	global leadership priority, established under PRH (see below)
<b>HIV</b>	human immunodeficiency virus
<b>HPV</b>	human papillomavirus
<b>IDU</b>	injecting drug use
<b>IEC</b>	information, education, and communication
<b>IMAI</b>	Integrated Management for Adolescent and Adult Illness Basic Therapy (WHO clinical course)
<b>IOM</b>	Institute of Medicine, in Washington, DC
<b>NGO</b>	nongovernmental organization
<b>OGAC</b>	Office of the Global AIDS Coordinator
<b>OVC</b>	orphans and other vulnerable children
<b>OVC Guidance</b>	Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PIDC</b>	Pediatric Infectious Diseases Clinic
<b>PRH</b>	Population and Reproductive Health, an office within USAID
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>RH</b>	reproductive health
<b>STI</b>	sexually transmitted infections
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Fund for Children
<b>USAID</b>	United States Agency for International Development
<b>U.S. Leadership Act</b>	United States Leadership against HIV/AIDS, Tuberculosis and Malaria Act of 2003
<b>VCT</b>	voluntary counseling and testing
<b>WHO</b>	World Health Organization

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# Executive Summary:

## Improving U.S. Global AIDS Policy for Young People

President George W. Bush introduced the President's Emergency Plan for AIDS Relief (PEPFAR) in January 2003.<sup>1</sup> Responding, Congress passed the *U.S. Leadership against HIV/AIDS, Tuberculosis, and Malaria Act* and authorized \$15 billion for PEPFAR over five years.<sup>2</sup> PEPFAR has made gains against HIV/AIDS, mostly by providing life-extending anti-retroviral therapy (ART) in the 15 focus countries and 100 plus other bilateral countries receiving its funds. Including young people—both infected and uninfected—as critical target groups is essential; yet, PEPFAR inadequately addresses the pandemic among youth.

PEPFAR's current authorization will expire in fiscal year (FY) 2008, and the 110th Congress has begun scrutinizing its policy structure, funding earmarks, and impact. Reauthorization offers an opportunity both to examine how PEPFAR affects youth and also to make important changes.

*Why the concern about youth?* Every day, more than 6,000 young people ages 14 through 24—more than two million youth each year—become infected with HIV.<sup>3</sup> The global community, including the United States, made commitments to youth regarding the HIV/AIDS pandemic:

- ◆ By 2005, reduce HIV prevalence by 25 percent among youth ages 15 to 24 in the most affected countries; by 2010, reduce HIV prevalence 25 percent among youth worldwide.<sup>4</sup>
- ◆ By 2005, ensure that at least 90 percent of youth ages 15 to 24 have the information, education, and services they need to reduce vulnerability to HIV infection; by 2010, ensure access for 95 percent of the world's youth.<sup>5</sup>
- ◆ Expand youth-friendly, sexual health education and strengthen reproductive and sexual health programs.<sup>6</sup>

Unfortunately, the targets for 2005 were not achieved, and 2010's targets seem farther away than ever. Despite rapidly growing numbers of HIV infections among youth, the world community has not yet implemented effective prevention. Around the globe, the vast majority of youth have little understanding of HIV transmission or how to protect themselves against HIV infection.<sup>7</sup>

PEPFAR aims at large-scale, rapid impacts on HIV/AIDS in 15 focus countries where the pandemic is particularly severe: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.<sup>8</sup> Congress set PEPFAR's goals. Commonly referred to as '2, 7, 10', they are to: provide ART to two million HIV-infected people; prevent seven million new HIV infections (60 percent of those expected in the focus countries over five years); and provide care for 10 million HIV-infected people and orphans and other vulnerable children (OVC).<sup>9</sup> These goals set PEPFAR's three-pronged intervention strategy of prevention, treatment, and care. By law PEPFAR's funding priorities include: 55 percent for treatment; 15 percent for palliative care; 20 percent for prevention; and 10 percent for OVC.<sup>10</sup>

U.S. government policies severely limit PEPFAR's use of effective, science-based, public health strategies to reduce HIV transmission among youth. This report discusses three major shortcomings of policies under PEPFAR and the Office of Global AIDS Coordinator (OGAC):

- 1) Ideology trumps science in PEPFAR's HIV prevention strategy for young people.
- 2) OGAC resists linking HIV prevention with reproductive health care and services.
- 3) HIV-positive adolescents receive inadequate attention as a vulnerable population.

# 1) Ideology Trumps Science in HIV Prevention for Youth under PEPFAR

Public health experts have criticized PEPFAR since passage of the U.S. Leadership Act because of its requirement that 33 percent of all HIV prevention dollars be spent on abstinence-until-marriage programs.<sup>11</sup> Under OGAC's ABC Guidance, youth may receive only A and B of the ABC components—(Abstinence, Be faithful, use Condoms). In regard to HIV prevention education and services, this section identifies nine specific problems with PEPFAR's youth HIV prevention strategy:

1) *PEPFAR ignores public health science regarding effective HIV prevention strategies and programs for youth.* Extensive research and global consensus support *comprehensive* HIV prevention programs, linked with reproductive health care.<sup>12,13,14,15,16</sup>

2) *The abstinence-until-marriage policy rests on four unscientific assumptions.*

- ◆ *Inaccurate assumption #1:* Delivering abstinence-until-marriage programs for youth is a proven HIV prevention strategy. *The facts:* There is *no evidence* to show that abstinence-until-marriage programs are effective.<sup>17,18,19</sup>
- ◆ *Inaccurate assumption #2:* Providing young people with information about condoms will confuse youth and encourage them to have sex. *The facts:* A wealth of public health research clearly demonstrates that providing young people with complete, accurate education about condoms does *not* encourage them to have sex.<sup>20,21,22,23</sup>
- ◆ *Inaccurate assumption #3:* Promoting abstinence-until-marriage will increase abstinence and will also increase secondary abstinence for those who have had sex. *The facts:* After 11 years of federal funding of domestic abstinence-only-until-marriage programs, there is no evidence that abstinence-until-marriage is effective.<sup>24,25,26</sup>
- ◆ *Inaccurate assumption #4:* Marriage is a protective factor against HIV. *The facts:* UNAIDS flatly states: *Marriage on its own offers no protection against HIV for young women, especially if their husband is much older.*<sup>27</sup>

3) *Segmenting the ABC approach undermines its effectiveness.* In an April 2007 report, the Institute of Medicine (IOM) said, *The Committee has been unable to find evidence for the position that abstinence can stand alone.*<sup>28</sup> *...There is little evidence to show that ABC when separated out into its components is as effective as the comprehensive approach.*<sup>29</sup>

4) *PEPFAR undercuts effective, comprehensive programs.* Under OGAC's reporting requirements, comprehensive ABC programs cannot count toward the two-thirds abstinence-only earmark.<sup>30</sup> In-country staff have reported cuts to comprehensive programs in order to meet the reporting requirements of the earmark.

5) *PEPFAR creates a culture of fear around condoms.* The Government Accountability Office (GAO) said that a lack of clarity in the ABC Guidance in regard to condom activities creates a culture of fear among PEPFAR's partners.<sup>31</sup> This also runs counter to language in the U.S. Leadership Act calling for "promoting the effective use of condoms."<sup>32</sup>

6) *PEPFAR prevents young people from learning that condoms are highly effective in preventing HIV.* PEPFAR's refusal to teach young people about the benefits of condom use implies that condoms are not effective in preventing HIV infection. Yet, the Centers for Disease Control and Prevention (CDC) asserts that condoms, when used correctly and consistently, are *highly effective* in preventing HIV transmission.<sup>33</sup>

7) *PEPFAR ignores the local context and cultural and psychosocial factors that fuel the HIV epidemic.* Factors that underlie the pandemic include culture, poverty, and high rates of unemployment among youth. The IOM found that *all* of PEPFAR's budget allocations—not just the abstinence-until-marriage earmark—have created major challenges for country teams working to develop programs tailored to the local epidemic.<sup>34</sup>

8) *PEPFAR's flawed policy creates serious problems for implementing partners and U.S. government field staff.* The GAO reported: *Lack of clarity in the ABC Guidance has created challenges for a majority of focus country teams... Ten of the 15 focus country teams cited instances where elements of the Guidance were ambiguous and confusing, leading to difficulties in its interpretation and implementation.*<sup>35</sup>

9) *PEPFAR exports unsuccessful U.S. domestic programs and policies.* An AB-only strategy for preventing HIV infection among young people in PEPFAR countries is much the same as the United States' abstinence-only programs. Yet, these heavily funded domestic programs have been *unsuccessful* and should not be copied in other nations. A major review of

the research concluded, *Although it has been suggested that abstinence-only education is 100 percent effective, these studies suggest that, in actual practice, efficacy may approach zero ... 'Abstinence-only' as a basis for health policy and programs should be abandoned.*<sup>36</sup>

## Recommendations

For Congress

- ◆ Repeal the abstinence-until-marriage funding mandate in the U.S. Leadership Act.
- ◆ Consider IOM's recommendation to remove all PEPFAR funding mandates or, at least, make all earmarks non-binding to allow country teams flexibility to meet local needs.

For OGAC

- ◆ Revise the ABC Guidance to reflect evidence-based best practices for HIV prevention among youth. Emphasize that abstinence is the only 100 percent effective method of HIV prevention so long as it is used consistently and correctly and also ensure that young people receive: 1) age appropriate, medically accurate, complete information about condoms and other contraception; and 2) access to confidential sexual health services, including condoms. (See Table 2 for suggested revisions to the Guidance.)

## 2) OGAC Resists Linking HIV Prevention with Reproductive Health Care and Services

Most nations agree that linking HIV prevention with reproductive health care is crucial. UNAIDS' official HIV prevention policy states, *Both HIV and sexual and reproductive health are driven by many common root causes and stronger linkages between [HIV prevention and reproductive health education and services] will result in more relevant and cost effective programs with greater impact.*<sup>37</sup> The greatest challenge to linking reproductive health and HIV prevention is OGAC's political aversion to reproductive health care—despite the fact that HIV is mostly transmitted sexually. Linkage is most critical for youth. Young people who do not perceive themselves to be at risk of HIV may seek reproductive health care (such as contraception or diagnosis and treatment of sexually transmitted infections (STIs), giving reproductive health programs the opportunity to provide HIV prevention services as well. At the same time, voluntary counseling and testing (VCT) sites can provide reproductive health services.

*PEPFAR is well-positioned to link reproductive health with HIV/AIDS services.* Recently, the Center for Strategic and Intelligent Studies (CSIS) reported, *There is an increasing international consensus, including within the U.S. government, about the imperative to target women and girls ... PEPFAR is well-positioned to build on this consensus and make integration of reproductive health (RH) and family planning (FP) and HIV/AIDS services a major new priority.*<sup>38</sup> The benefits of linkage for PEPFAR include: expanding the number of entry points for people needing HIV or AIDS services; increasing efficiency and cost effectiveness of programs; addressing a shortage of health care workers; and enhancing long-term, sustainable outcomes. Because youth generally view the prevention of pregnancy and HIV/STI as two sides of the same coin, integrating information and services aligns with young people's perspectives and makes services more useful and acceptable to youth.

*Separate funding streams represent a great challenge for linking reproductive health and HIV/AIDS.* The limited resources available for family planning make linkage difficult. In fact, it is not easy to compare funding because PEPFAR dwarfs the resources available for family planning. Many population officers at USAID missions have shifted their work entirely to activities under PEPFAR. Others face pressure when managing both accounts due to separate funding streams and different budget cycles. Few USAID missions gained additional staff to handle the increased workload and resources generated by PEPFAR. Another problem is that priority countries for USAID's Office of Population and Reproductive Health (PRH) often differ from PEPFAR's focus countries.<sup>39</sup>

## Recommendations

For Congress

- ◆ Increase appropriations for family planning through USAID's Office of Population and Reproductive Health. Assert the critical need to link reproductive health to PEPFAR's programs. At a minimum, maintain current funding levels.

For OGAC

- ◆ Adopt CSIS' recommendations on integrating reproductive health care with HIV/AIDS prevention and services.
  1. Offer written instructions on the importance of integrating reproductive health with HIV/AIDS services; provide guidance on managing different funding streams.
  2. Solicit successful examples of integrated services. Document successful or innovative programs and encourage the wide sharing of this information.
  3. Support evaluation. Collect information on integrated programs in order to inform the scale-up and adaptation of effective programs.
- ◆ Improve donor coordination. Recognize that linking HIV prevention and family planning is a high priority for many bilateral and multi-lateral donors.

For Country Teams

- ◆ Prioritize grants for HIV prevention for youth to organizations with expertise in both reproductive health care and HIV prevention.

### 3) HIV-Positive Adolescents Receive Inadequate Attention as a Vulnerable Population

There are two groups of young people living with HIV—those infected: 1) **from their mothers** (perinatally) during pregnancy, labor, and delivery or through breastfeeding; or 2) **during adolescence** through unprotected sexual intercourse or injecting drug use (IDU). The way they were infected determines the needs of each group. Youth who were infected perinatally and who survive into adolescence usually have advanced disease and are in regular contact with a health care system.<sup>40</sup> In contrast, young people infected after the onset of puberty generally develop symptoms and become ill more slowly than do adults.<sup>41</sup> This second group is much harder to identify and track. They may not seek health services regularly; may not have visited any health care provider since childhood; and may have just learned their HIV status or, more likely, remain unaware of their status.

*Young people living with HIV face many challenges.* A meeting on strengthening the health sector's care, support, and treatment for young people living with HIV identified major challenges facing HIV-positive youth. These include: lack of information; barriers to health care; lack of psychosocial support; problems adhering to treatment; difficulty disclosing their HIV status; stigma, discrimination, and isolation; fears about consent and confidentiality; and problems moving from pediatric to adolescent or adult care.<sup>42</sup> Staff may need training in order: not to discriminate against youth; to understand that parental consent may keep youth from seeking health care; to realize that young people usually lack the means to pay for services; and to cope with youth's difficulties in adhering to treatment.<sup>43</sup>

PEPFAR's response includes three major problems for HIV-positive young people.

- ◆ **HIV-positive youth are invisible in OVC policies and programs.** OGAC's *OVC Guidance* overwhelmingly assumes that most orphans and vulnerable children (OVC) are HIV-negative, an incorrect assumption. There is also a myth that most OVCs are small children although nearly half of all orphans who have lost one parent and two-thirds of those who have lost both parents are aged 12 through 17.<sup>44</sup> As orphans grow older, they face higher risks of acquiring STIs, including HIV, than do non-orphans.<sup>45</sup> Yet, *OVC Guidance* does not acknowledge orphans' age or vulnerability.<sup>46</sup>
- ◆ **Prevention for young positives is missing.** In addressing HIV-positive youth, PEPFAR pays no attention to positive prevention—strategies to increase youth's self-esteem and confidence; to support youth in protecting their own sexual health and in avoiding infecting others; and to involve HIV-positive youth in planning and implementing HIV strategies and policies.<sup>47</sup> Nor does PEPFAR acknowledge that reproductive health services and comprehensive life skills education are critical for positive prevention.
- ◆ **Psychosocial support systems need far more emphasis.** Psychosocial support involves issues that “impact on the daily functioning of a young person living with HIV, both at a structural and emotional level.”<sup>48</sup> Structural issues include housing, nutrition, food, security, and income. Emotional issues include accepting the diagnosis, disclosing one's status, isolation, stress, facing stigma and discrimination, healthy coping, and negotiating relationships in regard to one's HIV status.<sup>49</sup> Psychosocial supports are critical for children moving into adolescence and for adolescents recently aware of their status.

## Recommendations

### For Congress

- ◆ Require OGAC to improve monitoring and evaluation of programs using more precise age data.

### For OGAC

- ◆ Revise the *OVC Guidance*. The *Guidance* does not adequately recognize the increased risk OVCs face for HIV/STIs. The *Guidance* does not recognize that many OVCs may be HIV-positive. It should prioritize HIV-positive youth's need for positive prevention. [See Table 5 for suggested revisions to the current *Guidance*.]
- ◆ Encourage countries to collect age-desegregated data, based on the following age ranges: 0-9, 10-14, 15-19 and 20-24.
- ◆ Solicit examples from country teams of successful programs that link prevention and treatment for youth or that integrate separate youth-focused interventions.
- ◆ Convene a technical working group on HIV-positive adolescents. From the lessons learned at the consultation, issue new guidance on HIV-positive youth's needs.
- ◆ Invest in a center of excellence regarding HIV positive-adolescents. Support research to develop science-based best practices about serving this population.

### For Country Teams

- ◆ Convene in-country consultations with implementing partners and relevant stake holders to develop strategies to address HIV-positive adolescents for the next COP cycle.
- ◆ Work with national governments to support the optional course, "*One-day Orientation on Adolescents Living with HIV*," a training for first-level facility health care workers.
- ◆ Increase funding for psychosocial interventions at treatment sites, especially for peer support groups and for training peer counselors.
- ◆ Request partners to explain how they will respond to HIV-positive youth in the next COP cycle. Begin now preparing partners to expand programs to address HIV-positive youth.
- ◆ Solicit examples from implementing partners on successful interventions reaching HIV-positive adolescents. Invest in innovative HIV testing for youth by expanding program locations beyond primary care sites.

## Conclusion

PEPFAR cannot succeed without targeting youth. Yet so far, PEPFAR has largely ignored the realities of young people's lives and the state of the epidemic among them. This is the time for serious reflection on PEPFAR, a time to pay special attention to youth's need for: 1) comprehensive, science-based HIV prevention education and services; 2) linkages between HIV prevention and reproductive health care; and 3) services for HIV-infected youth and for AIDS orphans. Without serious reflection and change, current policies will hinder PEPFAR from attaining its laudable goals and will leave a generation defenseless against HIV/AIDS. Advocates for Youth urges members of Congress and staff as well as OGAC, the Administration, and colleague organizations to consider seriously the recommendations in this report and to ensure that youth are not, once again, ignored by PEPFAR.

# I. Improving U.S. Global AIDS Policy for Young People: An Introduction

President George W. Bush introduced the President’s Emergency Plan for AIDS Relief (PEPFAR) in his State of the Union address in January 2003.<sup>50</sup> In response, Congress passed the *United States Leadership against HIV/AIDS, Tuberculosis and Malaria Act of 2003*, authorizing \$15 billion in funding over five years.<sup>51</sup> When President Bush signed it in May 2003, the U.S. Leadership Act became Public Law 108-25.

PEPFAR has made extraordinary gains in the fight against HIV/AIDS, most notably through its commitment to provide life-extending anti-retroviral therapy (ART) in resource poor settings. As such, PEPFAR has the potential to have a profound impact on the 15 focus countries and 80 bilateral countries receiving its funds. However to reach its full potential, PEPFAR must include young people—both infected and uninfected—as critical target groups. Unfortunately, PEPFAR inadequately addresses the pandemic among youth.

Adolescents are invisible in many development programs, perhaps in part because adults view them as ‘difficult’. They are often caught in a ‘no man’s land’ between childhood and adulthood—that is, adults may treat them like children who have no rights and who cannot be trusted with sexual health information, yet at the same time, may expect youth to act like responsible adults. Advocates for Youth’s vision of *Rights, Respect, Responsibility*<sup>®</sup> aims for societies in which young people have the right to accurate and complete sexual health information; are respected as partners rather than stereotyped as ‘problems’; and receive all the tools they need to safeguard their sexual health. *Rights, Respect, Responsibility*<sup>®</sup> forms the basis for the recommendations in this report.

Definitions of *adolescents*, *young people*, and *youth* can vary widely. The World Health Organization (WHO) defines *young people* as those ages 10 to 24 years of age; *youth* as those ages 15 to 24; and *adolescents* as those ages 10 to 19 years.<sup>52</sup> This report focuses mostly on adolescents but also on young people ages 10 to 24. Its concern is the need of all young people for comprehensive prevention programs, links to reproductive health services, and attention to the special needs of HIV-positive adolescents. Throughout, this report uses the terms *young people*, *adolescents*, and *youth* interchangeably in order to underscore that their needs cannot be sharply identified with particular ages.

U.S. government policies severely limit PEPFAR’s use of effective, science-based, public health responses to reducing HIV transmission among youth. Such policies include a mandate by Congress to spend 33 percent of prevention dollars on abstinence-until-marriage programs as well as various guidance directives from the Office of Global AIDS Coordinator (OGAC). This paper identifies some of the severe limitations of these policies as well as how the policies contradict public health science.

The Institute of Medicine (IOM), in a March 2007 evaluation,<sup>53</sup> said, *The Committee has been unable to find evidence for the position that abstinence can stand alone or that 33 percent is the appropriate allocation for such activities even within integrated programs.*<sup>54</sup> IOM found *no* evidence to justify the 33 percent abstinence-until marriage earmark and recommended that Congress remove all earmarks from PEPFAR.<sup>55</sup>

This report discusses three major shortcomings of PEPFAR and OGAC in addressing HIV/AIDS and young people:

- ◆ Ideology has trumped science in PEPFAR’s HIV prevention strategy for young people.
- ◆ OGAC resists linking HIV prevention with reproductive health care and services.
- ◆ PEPFAR does not pay adequate attention to HIV-positive adolescents as a vulnerable population.

While PEPFAR raises other challenges as well, these three issues arose over and over during research the author conducted for this report. The author conducted field research in South Africa and Kenya in December 2006, in addition to at-

tending a WHO/UNICEF technical consultation on young people living with HIV in Malawi.

PEPFAR's congressional authorization will expire in fiscal year (FY) 2008. Already, the 110th Congress has begun to scrutinize PEPFAR's policy structure, funding earmarks, and program impact. The reauthorization process offers an ideal opportunity to examine how PEPFAR affects youth and to make important changes to reform the program for its next phase. Advocates for Youth urges members of Congress and staff as well as OGAC, the Administration, and colleague organizations to consider seriously the recommendations in this report and to ensure that youth are not, once again, ignored by PEPFAR. Without serious reflection and change, current policies will hinder PEPFAR from attaining its laudable goals and will leave a generation defenseless against HIV/AIDS.

## II. Why Are Young People a Concern?

Today's generation of young people is the largest in history. Almost three billion people—nearly half of the world's population—are under the age of 25,<sup>56</sup> giving them a powerful role in shaping the world's future. Yet, every day, over 6,000 youth ages 14 through 24 – more than two million each year – become infected with HIV.<sup>57</sup> This generation has never known a world without AIDS.

In June 2001 in the *Declaration of Commitment on HIV/AIDS*, the global community, including the United States, committed itself to respond to the HIV/AIDS pandemic.<sup>58</sup> As such, the United States and 188 other nations made several commitments to youth, including:

- ◆ By 2005, reduce HIV prevalence by 25 percent among young men and women ages 15 through 24 in the most affected countries; by 2010, reduce HIV prevalence by 25 percent among youth worldwide.<sup>59</sup>
- ◆ Ensure that by 2005, at least 90 percent of young men and women ages 15 through 24 have access to the information, education, and services they need to reduce their vulnerability to HIV infection; by 2010, ensure access for 95 percent of the world's youth, ages 15 through 24.<sup>60</sup>
- ◆ Expand good-quality, youth-friendly, sexual health education and counseling services and strengthen reproductive and sexual health programs.<sup>61</sup>

Unfortunately, the targets for 2005 were not achieved, and 2010's targets seem farther away than ever. Despite a flood of information on rapidly growing numbers of HIV infections among young people, the global community still has not implemented effective prevention strategies. Around the world, the vast majority of youth have little understanding of HIV transmission or how to protect against HIV infection. Globally, only one in three young men and one in five young women ages 15 through 24 can correctly identify ways to prevent HIV infection.<sup>62</sup> Surveys show that no country succeeded in fully educating more than half of its youth about HIV transmission and prevention.<sup>63</sup>

In sub-Saharan Africa, most new HIV infections among youth ages 15 through 24 are sexually acquired.<sup>64</sup> Moreover, more than two-thirds (67 percent) of infected youth are young women.<sup>65</sup> High rates of new infections in young people and the success of life-extending ART cause growing concern about the needs of HIV-positive youth. Few know or understand the magnitude of the numbers of HIV-positive young people living today, primarily because there is a lack of age-specific data and because of youth's low use of voluntary counseling and testing (VCT). For example in Ethiopia in 2005, less than two percent of young women ages 15 through 24 had been tested for HIV.<sup>66</sup> In Nigeria in 2003, just over two percent of young men the same age had been tested.<sup>67</sup>

Data is better for those who are known to have been infected perinatally (during pregnancy, delivery, or birth or through breastfeeding) because most have been connected to the health care system from an early age. Moreover, perinatally-infected youth who receive health care are living longer today than in the past. For example at the PEPFAR-funded Pediatric Infectious Diseases Clinic (PIDC) in Kampala, Uganda, experts reported that more than 15 percent of 5,200 HIV-positive patients in care were between the ages of 10 and 23.<sup>68</sup> Experts reported that, in Botswana and Uganda, most HIV-positive adolescents who are in contact with the health system were infected perinatally.<sup>69</sup>

South Africa provides the best data available on young people living with HIV. In 2003, the Reproductive Health Research Unit of the University of the Witwatersrand partnered with LoveLife in a large, nationally representative, household survey of young South Africans. The survey found that HIV prevalence among:

- ◆ **15- to 24-year-old youth was over 10 percent;**
- ◆ **15- to 24-year-old females was nearly 16 percent;**
- ◆ 15- to 24-year-old males was almost five percent;
- ◆ 15- to 19-year-old teens was almost five percent; and
- ◆ 20- to 24-year-old young adults was nearly 17 percent.<sup>70</sup>

In South Africa in 2003, females accounted for 77 percent of HIV infections among 15 to 24-year-old youth. Moreover, among 20- to 24-year-old youth, nearly one in four females was HIV-positive compared with one in 14 males.<sup>71</sup> The high rates of infection among young women are of great concern and suggest the need to focus greater attention on the social, cultural, and economic vulnerabilities that place young women at higher risk than their male peers.

The statistics make a compelling case and logic also dictates that a focus on young people, particularly young women, is crucial to PEPFAR's success in fighting the HIV/AIDS pandemic.

## III. Background of PEPFAR

PEPFAR's objective is to make large-scale, rapid impacts on HIV/AIDS in 15 focus countries where the pandemic is particularly severe. These countries include Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia. PEPFAR also provides funding to more than 100 other bilateral countries.<sup>72</sup>

The U.S. Leadership Act sets the goals of PEPFAR. Commonly referred to as '2, 7, 10', they are to:

- ◆ Provide anti-retroviral treatment to two million HIV-infected people;
- ◆ Prevent seven million new HIV infections—60 percent of those expected in the 15 focus countries over five years; and
- ◆ Provide care for 10 million HIV-infected people and orphans and other vulnerable children (OVC).<sup>73</sup>

These goals set PEPFAR's three-pronged intervention strategy of prevention, treatment, and care. Funding priorities, as set by law, include:

- ◆ **Treatment**  
**Fifty-five percent** allocated to the treatment of people living with HIV or AIDS (a hard earmark as of FY06); of this
  - ◆ at least **75 percent** to be expended for the purchase and distribution of anti-retroviral pharmaceuticals and
  - ◆ at least **25 percent** to be expended for related care
- ◆ **Palliative Care**  
**Fifteen percent** allocated for palliative care of individuals living with HIV or AIDS
- ◆ **Prevention**  
**Twenty percent** allocated to HIV prevention; of this
  - ◆ at least **33 percent** to be expended for abstinence-until-marriage programs (a hard earmark as of FY06)
- ◆ **OVC**  
**Ten percent** allocated to orphans and vulnerable children (a hard earmark as of FY06); of this
  - ◆ at least **50 percent** to be provided through nongovernmental organizations (NGOs) including faith-based organizations working at community levels<sup>74</sup>

PEPFAR has no explicit strategy for young people; nevertheless, youth are a much discussed target group in policy and strategic documents. Several documents outline PEPFAR's aims regarding young people:

- ◆ U.S. Five-Year Global HIV/AIDS Strategy
- ◆ *ABC Guidance #1: For United States Government In-Country Staff and Implementing Partners Applying the ABC*
- ◆ *Approach to Preventing Sexually-Transmitted HIV Infections within the President's Emergency Plan for AIDS Relief* [hereafter, *ABC Guidance*]
- ◆ *Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners* [hereafter *OVC Guidance*]
- ◆ USAID's *Annual Program Statement: HIV/AIDS Prevention through Abstinence and Healthy Choices for Youth: President's Emergency Plan for AIDS Relief*. [APS No. M/OP-04-812]
- ◆ *Guidance for United States Government In-Country Staff and Implementing Partners for a Preventive Care Package for Children Ages 0-14 Years Old Born to HIV-Infected Mothers #1.*

Collectively, these documents designate youth as a critical population for the success of PEPFAR's HIV prevention goals. Various OGAC documents cite high rates of transmission among young people and state that their vulnerability arises from various psychosocial factors, many beyond their control, such as 'high risk' social norms. PEPFAR's vision is to cause large scale behavior change among youth, primarily through information campaigns to promote abstinence until marriage

and faithfulness within marriage as the only effective ways that youth can prevent HIV. Hereafter, this document considers three primary problems with PEPFAR's policies regarding youth:

- ◆ Ideology has trumped science in PEPFAR's HIV prevention strategy for young people.
- ◆ OGAC resists linking HIV prevention with reproductive health care and services.
- ◆ PEPFAR does not pay adequate attention to HIV-positive adolescents as a vulnerable population.

## IV. Youth and HIV Prevention in PEPFAR: Ideology Trumping Science

### In Brief

This section considers the fiscal mandate, established under the *U.S. Leadership Act*, to emphasize abstinence-until-marriage for HIV prevention among youth. It summarizes the scientific findings regarding *effective* HIV prevention, looks at problems with OGAC's *ABC Guidance* and the implementation of prevention programs for youth, and makes recommendations for Congress, OGAC, and country teams.

### PEPFAR's abstinence-until-marriage funding mandate

Public health experts have criticized PEPFAR ever since passage of the *U.S. Leadership Act* because of its requirement that 33 percent of all HIV prevention spending *must* be allocated to 'abstinence-until-marriage programs'. HIV prevention is only 20 percent of PEPFAR's total budget; yet, the 33 percent earmark applies to that *entire* 20 percent, not just to the portion allocated for sexual transmission.<sup>75</sup> This means that abstinence-until-marriage programs garner one-third of *all* prevention dollars, including funds for blood safety, prevention of mother-to-child transmission (PMTCT), condoms and other prevention, and injection safety.

For fiscal years 2004 and 2005, the 33 percent earmark was non-binding (soft); however, it has been binding (hard) since fiscal year 2006.<sup>76</sup> In order to meet the funding earmark, OGAC issued new guidelines in August 2005 requiring countries to allocate *half* of their prevention budget to preventing sexual transmission. Of that, *two-thirds*—66 percent—must go to abstinence-until-marriage programs.<sup>30</sup> This requirement applies to funding in the 15 focus countries and the five other bilateral countries that receive at least \$10 million annually in PEPFAR funding.<sup>77</sup>

### Guidance from OGAC on implementing abstinence-until-marriage programs

Congress provided no guidance on implementing the abstinence-until-marriage earmark and so implementation has been at the discretion of OGAC. OGAC created a one-size-fits-all approach to HIV prevention with its policy directive, *ABC Guidance*. The *Guidance* states that the overall approach to HIV prevention at the country level should be comprehensive (that is, include all three components—Abstinence, Be faithful, use Condoms) and that sub-populations within each country should receive only some components of the approach (*A* and *B* or *C*), based upon OGAC's assumptions about each group's needs. The *Guidance* states:

*The ABC approach employs population-specific interventions that emphasize abstinence for youth and other unmarried persons, including delay of sexual debut; mutual faithfulness and partner reduction for sexually active adults; and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV.*<sup>78</sup>

OGAC identifies young people as a population that should not be provided with all three components. In fact, *ABC Guidance* says:

*Young people who have not had their sexual debut must be encouraged to practice abstinence until they have established a lifetime monogamous relationship.*<sup>79</sup>

*For those youth who have initiated sexual activity, returning to abstinence must be a primary message of prevention programs.*<sup>80</sup>

## Consequences of PEPFAR's funding mandate and OGAC's ABC Guidance

PEPFAR's funding mandate and OGAC's *ABC Guidance* are problematic for U.S. government in-country staff and implementing partners and have negative results for young people. They:

1. Ignore public health science regarding effective HIV prevention strategies and programs for young people.
2. Rest on unscientific assumptions.
3. Segment the ABC approach, seriously undermining its effectiveness.
4. Undercut effective, comprehensive programs.
5. Create a culture of fear around condom education and condom provision.
6. Prevent youth from learning that condoms are highly effective in preventing HIV.
7. Ignore the local context and cultural and psychosocial factors that fuel the HIV epidemic.
8. Cause serious problems for PEPFAR's implementing partners.
9. Encourage the exportation of failed U.S. domestic programs and policies.

The remainder of this section considers these issues in more detail.

### 1) PEPFAR ignores the science concerning effective HIV prevention for young people.

Scientific research shows that HIV prevention is most effective among young people when programs:

- ◆ Create a safe social environment for participating youth;
- ◆ Focus on clear health goals of preventing HIV, other sexually transmitted infections (STIs), and pregnancy;
- ◆ Focus narrowly on specific behaviors leading to these *health* goals, that is, on abstaining from sex or on using condoms and contraceptives;
- ◆ Address the many psychosocial factors—both risk and protective—that affect sexual behaviors, factors such as knowledge, perceived risk, values, attitudes, norms, and self-efficacy;
- ◆ Include many activities to change targeted risk behaviors and to promote protective behaviors;
- ◆ Use teaching methods that actively engage and involve the participants; and
- ◆ Use activities, methods, and messages appropriate to the culture, developmental age, and sexual experience of participating youth.<sup>81</sup>

In 2005, Advocates for Youth published, *Science and Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections (hereafter, Science and Success)*. Advocates conducted an exhaustive literature review of nearly 200 programs in developing countries, identifying 10 rigorously evaluated programs that have been highly effective in reducing behavioral risks for pregnancy and STIs, including HIV, among youth. Results included: delays in sexual initiation; an increase in abstinence; a reduction in numbers of new sexual partners; and an increase in the use of condoms. *All* of these effective programs include *comprehensive* sexuality or HIV prevention education. That is, each provides information about abstinence *and* the use of contraception and condoms.<sup>82</sup>

Of the ten successful programs identified in *Science and Success*, eight also provide sexual health services, contraceptive supplies, and/or referral to sexual health services. Seven programs involve community members—including parents, religious leaders, health care providers, or others—in designing and supporting programs for youth. Six programs directly involve youth in program planning and operations. Six programs rely, at least in part, on IEC (information, education, and communication) and/or mass media strategies, including two programs framed within national social marketing programs.<sup>83</sup>

Also in 2005, Douglas Kirby conducted a review of 83 sexuality and HIV prevention education programs. His review looked for changes in the sexual behavior of youth in both developed and developing countries. The study found that effective programs were *far* more likely to have a positive than a negative impact on one or more of six aspects of sexual behavior. Effective programs: delayed the initiation of sex; reduced the frequency of sex; reduced the number of new sexual partners; increased condom use; increased contraceptive use in general; and/or reduced sexual risk-taking among program participants in relation to their non-program peers.<sup>84</sup>

Finally, UNAIDS recognized young people as a core part of its strategy in its official HIV prevention policy, *Intensifying*

*HIV Prevention*. UNAIDS asserted that:

*There is a need to provide young people with a full complement of tools to prevent HIV transmission including comprehensive, appropriate, evidence- and skills-based sexual education in schools; youth friendly health services offering core interventions for the prevention, diagnosis and treatment of sexually transmitted infections and HIV; interventions to prevent transmission through unsafe drug injecting practices; services targeted to other vulnerable groups at high risk; mass media interventions; and consistent access to male and female condoms, readily available to all who need them.*<sup>85</sup>

UNAIDS, the premier institution responding to the global HIV/AIDS crisis, recognizes that providing comprehensive sex education, linked with youth-friendly health services, is critical for preventing HIV among youth. Both the evidence from research and also international consensus support *comprehensive* HIV prevention programs linked with reproductive health care. This is the most effective strategy to encourage youth to delay sexual debut and, among sexually active youth, to decrease their number of partners and increase their use of condoms.

## 2) OGAC's *ABC Guidance* rests on unscientific and baseless assumptions.

OGAC bases its *ABC Guidance* on four scientifically inaccurate assumptions:

- ◆ *Inaccurate assumption #1*: Delivering abstinence-until-marriage programs for youth is a proven HIV prevention strategy. *The facts*: There is absolutely *no evidence* to show that abstinence-until-marriage programs are effective and there is extensive evidence that such programs are *ineffective* in reducing risky sexual behaviors. Abstinence-only programs are considerably less effective than comprehensive sex education/life skills programs in promoting abstinence.<sup>e.86,87,88</sup>
- ◆ *Inaccurate assumption #2*: Providing young people with information about condoms will confuse youth and encourage them to have sex. *The facts*: A wealth of public health research clearly demonstrates that providing young people with complete, accurate education about condoms and other contraception does *not* encourage them to have sex.<sup>89,90,91,92</sup> Moreover, research also demonstrates that young people who learn about condoms and other contraception prior to initiating sex are more likely to use condoms when they eventually initiate sex than are their peers who remain uneducated about condoms and other contraception.<sup>93,94</sup>
- ◆ *Inaccurate assumption #3*: Promoting abstinence-until-marriage will increase abstinence and will also increase secondary abstinence for those who already have had sex. *The facts*: The assumption that abstinence-until-marriage programs increase abstinence may appear on the surface to be a logical one. However, after ten years of federal funding of domestic abstinence-only-until-marriage programs, the claim remains *unproven*.<sup>95</sup> In fact, some domestic abstinence-only programs have been shown to have detrimental effects on young people's health by promoting negative attitudes about condoms and by promoting participants' risk of engaging in unprotected sexual intercourse when they do have sex.<sup>96,97</sup>
- ◆ *Inaccurate assumption #4*: Marriage is a protective factor against HIV. *The facts*: in a number of developing countries, a majority of young women are married before age 18 – and significant numbers are married before they are 15.<sup>98</sup> A married adolescent's husband is likely to be older and more likely to be infected with HIV than the boyfriend of an unmarried adolescent. In fact, in some developing countries, young married women have higher rates of HIV infection than their unmarried peers. In Kenya, for example, married adolescents' HIV rate is nearly seven percent versus less than three percent for their unmarried peers.<sup>99</sup> UNAIDS flatly states: *Marriage on its own offers no protection against HIV for young women, especially if their husband is much older.*<sup>100</sup>

## 3) Segmenting the ABC approach undermines its effectiveness.

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

In its report on PEPFAR, the Institute of Medicine (IOM) could find no evidence to justify OGAC's segmented ABC ap-

proach (or to justify Congress' 33 percent budget allocation for abstinence-until-marriage programming). The report stated,

*The Committee has been unable to find evidence for the position that abstinence can stand alone or that 33 percent is the appropriate allocation for such activities even within integrated programs.*<sup>101</sup>

*There is, however, little evidence to show that ABC when separated out into its components is as effective as the comprehensive approach.*<sup>102</sup>

*Given the reported early age of average sexual debut (and sometimes marriage) in many countries, PEPFAR may wish to re-examine its exclusive AB focus for younger adolescents.*<sup>103</sup>

Research clearly indicates that all youth—whether abstinent or not—benefit from full disclosure of medically accurate, age appropriate information about both abstinence and condoms. A program in Nigeria, *HIV Prevention Education for High School Students*, targets youth ages 13 to 20, with a comprehensive sexual health education and HIV/STI prevention curriculum. The program showed delays in initiation of sexual intercourse, reduction in numbers of new sex partners, and increased use of condoms. The program evaluation showed that, at six month follow-up, 76 percent of intervention students reported no sexual experience versus 62 percent of comparison students.<sup>104</sup> Providing comprehensive information about HIV and linking this education to sexual and reproductive health care, including honest, accurate information about condoms, is a proven strategy for reducing HIV infection in young people.<sup>105,106,107,108,109,110</sup>

Proponents often claim that PEPFAR's implementation of a segmented ABC approach is based on the successful Uganda model. Yet a 2003 report from the Guttmacher Institute found positive changes in all three behaviors (abstinence, monogamy, and condom use), not just in increased abstinence, between 1988 and 1995.<sup>111</sup> Uganda was successful with: *a range of complementary messages and services delivered by the government and a wide diversity of NGOs. To be sure, these messages included the importance of young people both delaying sexual initiation and [practicing] 'zero grazing' ... There is no evidence that abstinence-only education programs were even a significant factor in Uganda between 1988 and 1995.*<sup>112</sup> In short, it is a misrepresentation for PEPFAR to assert that its segmented prevention policy is based on Uganda's successful, earlier model.

#### 4) PEPFAR undercuts effective, comprehensive programs.

Under OGAC reporting requirements, comprehensive ABC programs—that is, programs that provide all three elements (A, B, and C) to the same individuals—cannot count toward the two-thirds abstinence-only earmark.<sup>113</sup> This has led to cutbacks in comprehensive prevention programs, including integrated ABC programs that target the general public, and has resulted in lop-sided messages and programs.

*We know from our work in the field that isolated interventions are rarely successful—accounting for AB resources separately reinforces the 'island effect' of U.S. prevention programming and ignores the synergistic value of more balanced, integrated approaches. – Helene Gayle, CEO of CARE USA<sup>114</sup>*

*One country team stated that, because of the abstinence-until-marriage spending requirement, it had limited funding for comprehensive ABC messages to the general public. In this focus country, the AIDS epidemic is generalized but is largely fueled by populations determined to be most at risk of contracting HIV, such as commercial sex workers and truck drivers. Most of this country's 'other prevention' funding is reserved for its most-at-risk populations. However, because one-third of prevention funding must be reserved for AB programs, the team had little sexual transmission prevention funding to deliver integrated ABC messages to those in the general population who, although at risk for contracting HIV, are not among the most-at-risk populations. – GAO<sup>115</sup>*

*A focus country team told us that, to meet the spending requirement, it had to cut 'other prevention' funding by 50 percent. Team members explained that, as a result, services for married discordant couples, sexually active youth, and commercial sex workers were reduced. In general, this team noted that allocating funding in accordance with the spending requirement is not appropriate for the country's epidemic and has reduced the quality of the team's prevention programming. – GAO<sup>116</sup>*

Lucy Nkya, Executive Director of Faraja Trust Fund in Tanzania, testified on the organization’s experience with PEPFAR before the House Government Reform Subcommittee on National Security, Emerging Threats, and International Relations. Faraja, a community-based NGO, received a grant in 2004 to “promote youth’s behavioral change, abstinence until marriage, condom promotion, and the promotion of voluntary counseling and testing.”<sup>117</sup> Faraja’s program was highly successful.

Nkya noted that: *knowledge about HIV/AIDS and sexually transmitted infections increased by about 90 percent among youth in the intervention while information about condoms and condom use increased by 80 percent.* But, she added that in receiving its second PEPFAR grant in 2005, Faraja was forced to change to a *focus on abstinence until marriage, behavioral change, promotion of VCT and ‘no condom’ promotion.*<sup>118</sup> *A number of youths reported that they were confused by the new approach where Faraja seemed to have abandoned the previous focus of advocating behavioral change, abstinence and condoms, and switched to a new moralistic approach of encouraging youth to abstain until marriage [and] no condom use and family planning.*<sup>119</sup> This program shift led young people to ask: *What will happen to the sexually active youth and adolescents who are living with HIV?*<sup>120</sup>

Other PEPFAR recipients reported problems as well. *One reported that the focus on abstinence may be causing an increase in anal sex.*<sup>121</sup>

Another said: *This [PEPFAR funding] has resulted in communities, in particular young people, questioning the 20 years of investment [in] prevention mechanisms.*<sup>122</sup>

Lastly, U.S. government field staff reported cuts to comprehensive programs because *We’re not going to put more money into ‘other prevention’ since it means that we have to put more money into AB.*<sup>123</sup>

## 5) PEPFAR creates a culture of fear around condoms.

When the U.S. Government Accountability Office (GAO) issued its report on the impact of PEPFAR’s abstinence-until-marriage earmark, it cited a lack of clarity in the *ABC Guidance* in regard to condom activities. GAO found that this lack of clarity has created a culture of fear among PEPFAR’s implementing partners, saying partners felt concern *about crossing the line between providing information about condoms and promoting or marketing condoms.*<sup>124</sup> One PEPFAR implementing partner said that *although the organization views condom demonstrations as appropriate in some settings, it believes that condom demonstrations, even to adults, are prohibited under PEPFAR.*<sup>125</sup>

U.S. government field staff confirmed this fear. *We’ve found that in the field, some of the partners aren’t saying anything about condoms in their AB programs.*<sup>126</sup> Fearful partners have, instead, submitted requests that overemphasize A and B programming. *We have had to go back to implementing partners to ask them to do condom work.*<sup>127</sup>

This confusion is not surprising considering the *ABC Guidance*’s statements regarding condoms and youth:

*Implementing partners must take great care not to give a conflicting message with regard to abstinence by confusing abstinence messages with condom marketing campaigns that appear to encourage sexual activity or appear to present abstinence and condom use as equally viable, alternative choices. Thus, marketing campaigns that target youth and encourage condom use as the primary intervention are not appropriate for youth and the Emergency Plan will not fund them.*<sup>128</sup>

As one PEPFAR implementing partner stated: *PEPFAR requires you to present everything about condoms very negatively. You ... shoot yourself in the foot before you start.*<sup>129</sup>

The *ABC Guidance* strictly prohibits the use of PEPFAR funds for condom campaigns or school condom availability programs that would help sexually active young people to obtain condoms and to learn how to use them consistently and correctly.<sup>130</sup> Such restrictions feed the myth that providing young people with information about condoms will encourage them to have sex.

Additionally, the *ABC Guidance* prohibits condom information for school youth under age 15, presumably on the wishful thought that no one under age 15 has sex and on the equally inaccurate view that younger students do not need to know how to protect themselves. In fact, research shows that a significant number of adolescents under age 15 in PEPFAR countries have had sex. Eight percent of youth surveyed in South Africa reported their first sex at age 14 or younger (12 percent of males and five percent of females).<sup>131</sup> Data from UNAIDS showed that more than one-quarter of male teens in Gabon, Haiti, Kenya, Malawi, Mozambique, and Tanzania reported having had first sex before age 15.<sup>132</sup> Research also shows that when youth are educated about condoms prior to initiating sex, they are more likely to use condoms when they eventually have sex than are youth who have not been educated about condoms.<sup>133,134</sup>

Finally, the *ABC Guidance* ignores the fact that many classes or programs contain mixed age groups with young people both older and younger than 15. The GAO report addressed this issue:

*The ABC Guidance prohibits PEPFAR-funded programs in schools from providing condom information to youths younger than 15, but the guidance does not discuss the application of this age cutoff to groups that include youths younger and older than 15. Four focus country teams noted that the age cutoff for providing condom information to youths presents challenges because classrooms and out-of-school programs often include mixed-age groups. Two teams told us that, in these situations, only AB messages are typically provided to the entire group and, as a result, some older youths who need ABC messages may not receive them.*<sup>135</sup>

Since implementing partners err on the side of caution in potential mixed age group settings in order not to jeopardize their funding, the *ABC Guidance* leaves many older, sexually active youth without the information they need to prevent HIV infection. At the same time, it deprives younger students of HIV prevention information that can, in the future, protect their health and save their lives. This is especially problematic since numerous rigorous evaluations examining the impact of sex education on sexual activity, both domestically and in developing nations, have shown that providing youth with information about condoms does **not** increase sexual activity, does **not** lower the age of first sexual debut, and does **not** increase the number of sex partners among young people.<sup>136,137,138,139,140,141,142</sup>

## 6) PEPFAR prevents young people from learning that condoms are highly effective in preventing HIV.

PEPFAR's reluctance to teach young people about the benefits of condom use may imply to in-country partners that condoms are not effective in preventing HIV infection—something that is totally untrue. The Centers for Disease Control and Prevention (CDC) asserts that condoms, when used correctly and consistently, are *highly effective* in preventing HIV transmission.<sup>143</sup> CDC also asserts that condoms reduce the risk of other sexually transmitted infections including gonorrhea, chlamydia, and human papillomavirus (HPV).<sup>144</sup>

**To withhold condoms and complete, accurate and positive information about the health benefits of condoms from young people—whether they are sexually active or not—is bad public health practice, unethical medical practice, and a violation of basic human rights.**<sup>145,146,147</sup>

## 7) PEPFAR ignores the local context and cultural and psychosocial factors that fuel the HIV epidemic.

Faraja's experience with PEPFAR demonstrates how the AB approach ignores fundamental factors that underlie HIV transmission. Factors that underlie the HIV pandemic include culture, poverty, and high rates of unemployment among youth. Seventeen of the 20 PEPFAR country teams that must meet the abstinence-until-marriage spending earmark reported that it *presents challenges to their ability to respond to local epidemiology and cultural and social norms*.<sup>148</sup>

PEPFAR ignores the local context and cultural and psychosocial factors that influence youth's ability and willingness to reduce risky sexual behaviors. For example:

- ◆ According to one PEPFAR-funded South African NGO: *PEPFAR prevention programs that target youth ignore the context. At home, a teenage girl is hearing from her mother and aunty that she has to have a baby to prove she is a woman. ... Post-apartheid democratization has created tensions for youth. They have their family and cultural obligations on the one hand, and on the other, they see the opportunity for a different world. Basically, they are stuck between two worlds. Society and the family expect different things of the young person.*<sup>149</sup>

- ◆ GRIP, a community-based organization in Nelspruit, South Africa, that does not receive PEPFAR funding, ran a two-and-a-half-year program for boys between the ages of 13 and 18, using the ABC approach. GRIP found that the ABC approach did not work when taking into account the cultural norms and mixed messages within South Africa. For example, boys encounter pressure from girls to have sex and mockery from girls when the boys want to abstain. At the same time, girls experience social pressure to get pregnant in order to prove their fertility. Barbara Kenyon, GRIP’s Executive Director, stated that *a societal context in which polygamy and casual relationships are not only culturally and religiously sanctioned but also to a large extent socially acceptable ... makes a mockery of the ‘be faithful’ message.*<sup>150</sup>
- ◆ Research funded by USAID in Namibia found that most youth did not understand the concepts of abstinence or faithfulness for HIV prevention. Namibian youth believed that ‘abstinence’ meant ‘to be absent’ and ‘faithfulness’ meant faith in religion; 75 percent of the study population had never heard the word ‘monogamy.’<sup>151</sup>
- ◆ Another PEPFAR grantee noted that to be successful in positive behavior change for an individual: *You have to target the community to change attitudes. A young person may want to change behavior, but the environment might not allow them to.*<sup>152</sup>

One South African PEPFAR recipient believed that *the country operational plan system is developed more as a response to PEPFAR’s earmarks [than to] local needs.*<sup>153</sup>

Indeed, PEPFAR includes broad structural barriers that impede a flexible and locally tailored response. IOM found that *all of PEPFAR’s budget allocations—not just the abstinence-until-marriage earmark—have created major challenges for country teams trying to develop programs that are tailored to the local epidemic because “the budget allocations do not allow program implementers sufficient flexibility to respond to change.”*<sup>154</sup>

In interviews for its report, IOM found that: *confusion and frustration in the field caused by the abstinence-until-marriage allocation (funding mandate) have persisted . . . staff indicated that the allocation did not allow them sufficient flexibility to create the appropriate prevention portfolio based on the available data.*<sup>155</sup>

The budget allocations force PEPFAR’s programs to be categorized broadly into prevention, treatment, or care interventions. IOM stated that these categories and subcategories *fragment the natural continuum of needs and services, often in ways that do not correspond to global standards, do not align with an individual focus country’s perspective, and do not permit optimal management of patients and their families.*<sup>156</sup>

On prevention, IOM said: *The proportions of total PEPFAR prevention funding allocated to each subcategory—abstinence/be faithful (30 percent), condoms and other prevention (22 percent), prevention of mother-to-child transmission (22 percent), blood safety (14 percent), and medical injection safety (12 percent)—are not well-aligned with the estimated proportions of new infections from the major routes of transmission.*<sup>157</sup>

In her testimony before the House Government Reform Subcommittee on National Security, Emerging Threats, and International Relations, Dr. Gayle said: *PEPFAR’s work is often too clinical, disease-specific, and narrowly medical in focus. Despite its medical and public health context, HIV and AIDS is not a health issue alone. The underlying causes of the spread of HIV reflect a combination of many non-health factors such as poverty, gender inequality, stigma and social and cultural norms.*<sup>158</sup>

PEPFAR does not allow country teams the flexibility they need to adapt to constantly changing local contexts. Without recognizing the broader social and cultural realities of young people’s lives, PEPFAR’s one-size-fits-all, AB-only approach will fail to curb the growing HIV epidemic among people under the age of 25 and will, therefore, fail to reach its goals.

## 8) PEPFAR’s flawed policy creates serious problems for implementing partners and U.S. government field staff.

The *ABC Guidance* causes problems and hinders effective HIV prevention in PEPFAR countries. Dr. Gayle discussed the experience of CARE USA with PEPFAR prevention policies: *Our country offices express deep concern that messages about abstinence or faithfulness, de-coupled from the broader reality that most individuals in resource-poor countries face every day, are not effective in influencing high risk behaviors or promoting safer practices over the long term.*<sup>159</sup>

According to another PEPFAR recipient, *PEPFAR's effects have been surely negative because the truth is that the policy denies the right of individuals to choose how to avoid the virus.*<sup>160</sup>

Overall, many implementing partners and U.S. government field staff in PEPFAR countries said that the *ABC Guidance* has caused major confusion and challenges. GAO found that: *Lack of clarity in the ABC Guidance has created challenges for a majority of focus country teams. Although a number of the teams told us that they found the Guidance clear or easy to implement, 10 of the 15 focus country teams cited instances where elements of the Guidance were ambiguous and confusing, leading to difficulties in its interpretation and implementation.*<sup>161</sup>

For example, although the *Guidance* restricts activities promoting condom use, it does not clearly delineate the difference between condom education and condom promotion, causing uncertainty over whether certain condom-related activities are permissible.<sup>162</sup>

*CARE concurs with the finding of the Government Accountability Office that OGAC guidance explaining the ABC approach lacks clarity. In our experience with country office teams, OGAC's lack of specific, understandable guidance on its primary prevention approach results in uncertainty of scope and overly conservative interpretations by PEPFAR country teams about what prevention interventions can be included in implementing partners' programs.*<sup>163</sup>

This all runs counter to language in the *U.S. Leadership Act* calling for “promoting the effective use of condoms.”<sup>164</sup>

## 9) PEPFAR exports unsuccessful U.S. domestic programs and policies.

An AB-only strategy for preventing HIV infection among young people in PEPFAR countries is much the same as the United States' abstinence-only programs. Such programs in the United States are heavily funded by the federal government and conform to a narrow, eight-point definition as provided in the *U.S. Personal Responsibility and Work Opportunity Reconciliation Act of 1996*.<sup>165</sup> While the *ABC Guidance* for PEPFAR's abstinence-until-marriage programs lacks the eight-point definition of domestic abstinence-only programs, it appears that PEPFAR implementers and other governments are influenced by the United States' domestic model.

For example in 2004, Uganda developed a government policy on abstinence and fidelity. The definition of abstinence education in *Uganda National Abstinence and Being Faithful Policy and Strategy on Prevention of Transmission on HIV*<sup>166</sup> is almost verbatim from the eight-point definition of 'abstinence education' in the *U.S. Personal Responsibility and Work Opportunity Reconciliation Act of 1996*. See **Table 1, opposite page**.

The important point is that these heavily funded domestic programs have been *unsuccessful* in achieving their stated goal and should *not* be copied in other nations. A major review of the research on domestic abstinence-only-until-marriage programs, concluded, “Although it has been suggested that abstinence-only education is 100 percent effective, **these studies suggest that, in actual practice, efficacy may approach zero.**...Schools and health care providers should encourage abstinence as an important option for teenagers... **‘Abstinence-only’ as a basis for health policy and programs should be abandoned.**”<sup>169</sup>

## In Summary

If PEPFAR is to be effective in preventing the spread of HIV among young people, it must change to ensure that prevention efforts are based on public health models and community needs rather than on arbitrary limits set by policy makers in Washington, DC. Young people are the victims of ideological policies that cause cutbacks to comprehensive programs, promote fear of condom education and programs, and create difficulties in program implementation. To that end, Advocates for Youth makes the following recommendations to ensure young people's access to comprehensive, science-based HIV prevention programs.

**Table 1: Comparative Definitions of Abstinence Education in the United States and Uganda**

Section 510(b) of Title V of the Social Security Act, P.L. 104-193 <sup>167</sup>	Uganda National Abstinence and Being Faithful Policy <sup>168</sup>
<p>For the purposes of this section, the term "abstinence education" means an educational or motivational program which:</p> <ol style="list-style-type: none"> <li>1. Has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;</li> <li>2. Teaches abstinence from sexual activity outside of marriage as the expected standard for all school-age children;</li> <li>3. Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;</li> <li>4. Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity;</li> <li>5. Teaches that sexual activity outside the context of marriage is likely to have harmful psychological and physical side effects;</li> <li>6. Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;</li> <li>7. Teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and</li> <li>8. Teaches the importance of attaining self-sufficiency before engaging in sexual activity.</li> </ol>	<p>Abstinence education means an educational or motivational approach which:</p> <ol style="list-style-type: none"> <li>1. Has as its exclusive purpose, teaching, supporting and empowering the social, psychological, and health gains to be realized by abstaining from premarital sexual activity;</li> <li>2. Teaches abstinence from sexual activity outside marriage (or "faithfulness") as the expected standard;</li> <li>3. Teaches that abstinence from sexual activity is the only certain way to avoid sexually transmitted diseases, and other associated health problems;</li> <li>4. Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;</li> <li>5. Teaches that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects;</li> <li>6. Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; and</li> <li>7. Teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances</li> </ol>

## Recommendations

### For Congress

- ◆ Immediately repeal the abstinence-until-marriage funding mandate in the U.S. Leadership Act.
- ◆ Consider the IOM's recommendation to remove all PEPFAR funding mandates. At a minimum, make all earmarks non-binding (soft) in order to allow country teams the flexibility to respond to local needs.

### For OGAC

- ◆ Revise the ABC Guidance. OGAC should revise its guidance to reflect evidence-based best practices for the prevention of HIV among youth. The guidance should emphasize that abstinence is the only 100 percent effective method of HIV prevention so long as it is used consistently and correctly, but the Guidance should also ensure that young people receive: 1) age appropriate, medically accurate and complete information about condoms and other contraception; and 2) access to confidential sexual health services, including condoms. **See Table 2, opposite page, for a chart showing both the current guidelines and also suggested revisions that better reflect public health research.**

### For Country Teams

- ◆ Expand access to youth-friendly health services by prioritizing grants to train health care workers, particularly those working at VCT centers, and to support youth centers.
- ◆ Encourage wrap-around programs that link HIV prevention, reproductive health, and life skills.
- ◆ Communicate to primary partners to prioritize sub-grants to youth-run and youth-serving organizations, particularly those that link reproductive health and HIV.

**Table 2: Suggested Revisions to OGAC’s ABC Guidance**

Current Guidance <sup>170</sup>	Suggested Revisions
<p>For 10-to-14 year olds, the Emergency Plan will fund age-appropriate and culturally appropriate “AB” programs that include promoting (1) dignity and self-worth; (2) the importance of abstinence in reducing the transmission of HIV; (3) the importance of delaying sexual debut until marriage; and (4) the development of skills for practicing abstinence.</p>	<p>For 10-to-14-year-olds, the Emergency Plan will fund age-appropriate and culturally appropriate comprehensive HIV prevention programs that (1) promote dignity and self-worth, (2) focus on the importance of delaying sexual debut, (3) build self-esteem, (4) foster communication and decision-making skills, and (5) provide age-appropriate information about how HIV can be prevented, including partner reduction and condom use.</p>
<p>For older youth (above age 14) the Emergency Plan will fund ABC programs that promote (1) dignity and self worth; (2) the importance of abstinence in reducing the transmission of HIV; (3) the importance of delaying sexual activity until marriage; (4) the development of skills for practicing abstinence, and where appropriate, secondary abstinence; (5) the elimination of casual sexual partnerships; (6) the importance of marriage and mutual faithfulness in reducing the transmission of HIV among individuals in long-term relationships; (7) the importance of HIV counseling and testing; and (8) provide full and accurate information about correct and consistent condom use as a way to significantly reduce—but not eliminate—the risk of HIV infection for those who engage in risky sexual behaviors.</p>	<p>For older youth (above age 14) the Emergency Plan will fund comprehensive HIV prevention programs that (1) promote dignity and self worth; (2) build self-esteem, (3) foster communication and decision making skills; (4) focus on the importance of delaying sexual debut for youth not yet sexually active; (5) focus on partner reduction and correct and consistent condom use for those who are already sexually active; and (6) provide information on the importance of HIV counseling and testing as well as links to Voluntary Counseling and Testing (VCT) services.</p>
<p>Emergency Plan funds may be used in schools to support programs that deliver age appropriate “AB” information to young people age 10 – 14.</p>	<p>Emergency Plan funds may be used in schools to support programs that deliver age-appropriate comprehensive HIV prevention to young people age 10-14.</p>
<p>Emergency Plan funds may be used in schools to support programs that deliver age appropriate “ABC” information for young people above age 14.</p>	<p>Emergency Plan funds may be used in schools to support programs that deliver age-appropriate comprehensive HIV prevention information, including condom provision, for young people above age 14.</p>
<p>Emergency Plan funds may be used to support integrated ABC programs that include condom provision in and out-of-school programs for youth identified as engaging in or at high risk for engaging in risky sexual behaviors.</p>	<p>Emergency Plan funds may be used to support integrated HIV prevention programs that include condom provision in out-of-school programs for youth, as well as links to reproductive health services.</p>
<p>Emergency Plan funds may not be used to physically distribute or provide condoms in school settings.</p>	<p>Emergency Plan funds may be used to physically distribute or provide condoms in school settings for youth who require them</p>
<p>Emergency Plan funds may not be used in schools for marketing efforts to promote condoms to youth.</p>	<p>Emergency Plan funds may be used in schools for marketing campaigns that target youth and that encourage abstinence, reduction in the number of partners, and condom use as primary interventions for HIV prevention.</p>
<p>Emergency Plan funds may not be used in any setting for marketing campaigns that target youth and encourage condoms use as the primary intervention for HIV prevention.</p>	<p>Emergency Plan funds may be used for marketing campaigns that target youth and that encourage abstinence, reduction in the number of partners, and condom use as primary interventions for HIV prevention.</p>

# V. HIV Prevention and Reproductive Health Care: The Political Phobia Against Linkage

## In Brief

The greatest challenge to improving links between reproductive health and HIV prevention for young people is OGAC's political aversion to reproductive health services—despite the fact that HIV is transmitted primarily by sex. According to one USAID staff member: *OGAC is deeply fearful of family planning funds. They don't want to be hit with the political ramifications of the gag rule.*<sup>171</sup> At the same time, partnering with OGAC could force family planning and other reproductive health organizations to endorse the 'prostitution loyalty oath' which requires that U.S. and foreign NGOs receiving USAID funding must adopt a policy that explicitly opposes prostitution and sex trafficking throughout their programs. In short, both family planning and HIV programs work under separate political constraints. Neither is keen to be burdened with the constraints of the other.

## The Consensus On Linkage

Most HIV infections in young people result from sexual transmission, and there is an emerging global consensus that linking HIV prevention with reproductive health education and services is crucial to effective prevention. UNAIDS' official HIV prevention policy states, *Both HIV and sexual and reproductive health are driven by many common root causes and stronger linkages [between HIV prevention and reproductive health education and services] will result in more relevant and cost effective programs with greater impact.*<sup>172</sup>

This is particularly critical for youth. Young people who do not perceive themselves to be at risk of HIV may still seek reproductive health services, such as contraception or diagnosis and treatment of STIs. At such times, reproductive health programs have the opportunity (and ethical responsibility) to provide HIV prevention services, such as VCT. In many countries, where social marketing campaigns have been successful at educating youth about VCT, young people may accept VCT when it is allied with other health care they already seek. VCT sites can also provide reproductive health counseling and services along with HIV prevention services. Clear synergies exist between the two areas, but many challenges remain.

In 2003, USAID issued guidance that recognized the potential benefits of linking family planning and HIV prevention services. The guidance states that *for countries with high fertility and HIV/AIDS prevalence above one percent in the general population, the overall well-being of families can be promoted through HIV and pregnancy prevention.*<sup>173</sup> Most PEPFAR countries have high fertility rates (see **Table 3, opposite page**) and can benefit from linking HIV and pregnancy prevention.

The guidance also recognizes that: *the key to successful behavior change in youth appears to be a multi-pronged approach recognizing that youth are a diverse group and that many factors influence young people's behaviors.*<sup>176</sup>

## PEPFAR is Well-Positioned to Link Reproductive Health with HIV/AIDS Services

The Center for Strategic and Intelligent Studies (CSIS) covered this issue extensively in a July 2006 report, *Integrating Reproductive Health and HIV/AIDS Programs: Strategic Opportunities for PEPFAR*. The report stressed that: *there is an increasing international consensus, including within the U.S. government, about the imperative to target women and girls ... PEPFAR is well-positioned to build on this consensus and make integration of reproductive health (RH) and family planning (FP) and HIV/AIDS services a major new priority.*<sup>177</sup>

The benefits for PEPFAR of linking HIV prevention with reproductive health services include:

- ◆ Expanding the number of entry points for people to access HIV and AIDS services;
- ◆ Increasing efficiency and cost effectiveness of programs;

**Table 3: Rates of Fertility and Adult HIV Prevalence in PEPFAR Focus Countries**

PEPFAR Focus Country	Fertility Rate <sup>174</sup>	Adult HIV Prevalence Rate <sup>175</sup>
Botswana	2.79	24.1
Ethiopia	5.22	.9 – 3.5
Guyana	2.04	2.4
Haiti	4.94	3.8
Ivory Coast	4.50	7.1
Kenya	4.91	6.1
Mozambique	4.62	16.1
Namibia	3.06	19.6
Nigeria	5.49	3.9
Rwanda	5.43	3.1
South Africa	2.20	18.8
Tanzania	4.97	6.5
Uganda	6.71	6.7
Vietnam	1.91	0.5
Zambia	5.39	17.0

- ◆ Helping to address the shortage of health care workers; and
- ◆ Enhancing the probability of long-term, sustainable outcomes.

Because youth generally view the prevention of pregnancy and HIV/STI as two sides of the same coin, integrating information and services aligns with young people’s perspectives, making linked services more useful and acceptable to youth.

PEPFAR has made some strides in linking family planning to HIV services for women, as seen at the 2006 PEPFAR Implementer’s Meeting in Durban, South Africa. However, there is a dearth of linked programs for *young people*. The cutbacks to comprehensive prevention programs for youth, already noted in Section IV, make it no surprise that linking to reproductive health programs has been a challenge. One recipient stated that PEPFAR’s current youth prevention policy has resulted in *an absence of condoms and aggressive inattention to STI education and clinical services [for youth] ... this inattention is unethical and disgusting*.<sup>178</sup>

### A Firewall Between HIV and Reproductive Health Funding

Separate funding streams present a great challenge for linking reproductive health and HIV/AIDS services. An embassy official in Zambia described a ‘firewall’ between HIV and reproductive health, making it difficult to make important synergies between the two.<sup>179</sup> It is difficult even to compare funding streams because PEPFAR dwarfs the resources available for family planning. See **Table 4, below**.

**Table 4: Comparison of PEPFAR Funding Versus Population Funding in 12 PEPFAR Focus Countries for FY 2006**

PEPFAR Focus Country	PEPFAR funding <sup>180</sup>	Population funding
Botswana	\$54,925,022	\$0.00
Ethiopia	\$115,257,744	\$9,100,000 <sup>181</sup>
Haiti	\$51,785,021	\$7,159,000 <sup>182</sup>
Kenya	\$142,937,153	\$6,306,000 <sup>183</sup>
Mozambique	\$60,217,090	\$3,600,000 <sup>184</sup>
Namibia	\$42,508,508	\$0.00
Nigeria	\$110,250,097	\$12,738,000 <sup>185</sup>
Rwanda	\$56,909,487	\$1,200,000 <sup>186</sup>
South Africa	\$148,187,427	\$1,313,000 <sup>187</sup>
Tanzania	\$108,778,095	\$9,300,000 <sup>188</sup>
Uganda	\$148,435,327	\$4,800,000 <sup>189</sup>
Zambia	\$130,088,605	\$3,164,000 <sup>190</sup>

The limited resources available for family planning make it difficult for country teams to link reproductive health consistently to HIV/AIDS services. In fact, PEPFAR creates a vast imbalance at the field level, resulting in a shift by staff to managing PEPFAR over smaller but critical USAID health accounts, such as population.

## Difficulties for Staff

Many population and reproductive health officers at USAID missions have shifted their work entirely to activities under PEPFAR or have been ordered to manage both family planning and PEPFAR accounts. This has put undue pressure on in-country staff because the separate funding streams have different budget cycles, reporting requirements, and administrative responsibilities.

Few USAID missions gained additional staff to handle the increased workload and resources generated by PEPFAR. Thus, staff has been overwhelmed and overworked. Some country mission directors have even decided to avoid family planning assistance as an unnecessary headache.<sup>191</sup> Additionally, USAID staff increasingly finds that contracting agencies receiving both family planning and PEPFAR funds are slow to implement the family planning programs. *They are so focused on HIV that they don't think about the family planning.*<sup>192</sup>

Another problem is that most of the priority countries for USAID's Office of Population and Reproductive Health (PRH) differ from PEPFAR's focus countries. Thus, there are problems linking reproductive health and family planning programs to HIV prevention in PEPFAR focus countries where family planning programs are under-funded or simply do not exist. Additionally, OGAC's reputation is poor regarding partnering with USAID's non-HIV/AIDS programs. *Trying to work with OGAC is crazy. The process gets lengthened enormously and they want control of the whole project.*<sup>193</sup>

## Closing YouthNet

In 2001, USAID awarded Family Health International (FHI) a five-year contract for a program called YouthNet.<sup>194</sup> Intended to improve reproductive health and HIV prevention among young people, YouthNet received funding from both HIV/AIDS and family planning divisions within USAID's Bureau of Global Health (GH). YouthNet had a broad mandate to improve programs and services, conduct research, and disseminate best practices regarding evidence-based approaches for reproductive health and HIV prevention among youth.

The project concluded in December 2006, and USAID decided not to open a new competitive bid for similar work. Instead, youth became a Global Leadership Priority (GLP) within PRH. This meant that services for youth were to be mainstreamed into the work of all of the contracting agencies working in family planning. It is too early to tell whether this change in strategies will be effective. Yet, the end of the YouthNet project may well cause even greater difficulty in implementing integrated HIV prevention and reproductive health services for young people.

Furthermore, the current foreign assistance reform may negatively affect family planning, in general, simply due to the U.S. State Department's lack of commitment to health funding. President Bush's FY08 budget request proposes a 25 percent cut for family planning, despite his promise when he reinstated the 'global gag rule' to maintain funding levels. The impact of these cuts, along with reorganization, may result in *losing money for new contraceptive research and operational research*,<sup>195</sup> including research on female condoms and other new contraceptives. These losses would be particularly hard on young people.

## In Summary

For the health and well-being of young people, PEPFAR should encourage links between HIV prevention programming and reproductive health and family planning programs. To youth, the links between preventing HIV and other STIs and preventing pregnancy are apparent and logical. But there are many obstacles to such linkages, particularly ideological policies

that constrain both PRH and OGAC. In order for OGAC and USAID projects to improve linkages between HIV prevention and services and reproductive health care, Advocates for Youth makes several recommendations.

## Recommendations

### For Congress

- ◆ **Increase appropriations for family planning** through USAID's Office of Population and Reproductive Health and recognize the critical need to link reproductive health to PEPFAR's programs. At a minimum, ensure the maintenance of current funding levels rather than permitting them to decrease, as the President requested in his FY08 budget.

### For OGAC

OGAC should adopt the recommendations of CSIS on integrating reproductive health care with HIV prevention and services, particularly the following:

- ◆ Formulate written instructions and guidance to PEPFAR country teams and partners outlining the importance of programs that integrate reproductive health with HIV prevention and services. Provide information about how to meet the reporting requirements for different funding streams that go to support integrated programs.
- ◆ Solicit from country teams successful examples of integration and/or wraparound services. The Coordinator's office can help document successful or innovative programs and encourage the wide sharing of this information.
- ◆ Support evaluation and the collection of strategic information on integrated programs to inform the scale-up and adaptation of effective programs.

Additionally, Advocates for Youth recommends that OGAC:

- ◆ Improve donor coordination in order to leverage investments made for reproductive health by other nations and international organizations. Recognize that linkage between HIV prevention and family planning is a high priority for many bilateral and multi-lateral donors that do not face the same political and funding constraints as does the United States.

### For Country Teams

- ◆ Prioritize youth HIV prevention grants to organizations with background in both reproductive health care and HIV prevention.

# VI. HIV Positive Adolescents: The Invisible Cohort of the AIDS Epidemic

*I think being an HIV-positive youth would be a very lonely place to be. They are invisible.*<sup>196</sup>

## In Brief

This section discusses: HIV-positive adolescents, the challenges they face, and their special needs; the role of the health sector in meeting those needs; and the gap in PEPFAR's response. Specifically, PEPFAR's response is lacking in three areas: HIV positive young people are invisible in OVC policies and programs; prevention for young positives is missing; and psychosocial support systems need far more emphasis.

## The Special Needs of HIV-Positive Adolescents

*The major challenges we face as young people are similar to those faced by young people all over the world: peer pressure, surviving in a changing world, and coping with our growing minds and bodies. The major difference is that we happen to be HIV-positive... thus facing more challenges, which are stigma and discrimination, loss of parents or having single parents, lack of education due to poverty or no support, being abused, defiled, and denied many rights.*<sup>197</sup> Brian Nganwa, 15-year-old HIV-positive youth, Uganda

HIV-positive adolescents are, first and foremost, adolescents. They are no different from their uninfected peers in the sense that this period of life is characterized by a sense of immortality, risk-taking, an increasing sense of autonomy and independence, peer pressure, sexual experimentation, the desire to challenge authority, and many other factors. There are two groups of young people living with HIV: 1) those **infected from their mothers** (perinatally) during pregnancy, labor, and delivery or through breastfeeding; and 2) those **infected during adolescence** through unprotected sexual intercourse or injecting drug use (IDU).

The way they were infected is important in determining the needs of each group. For example, youth who were infected perinatally and who survive into adolescence usually have advanced disease.<sup>198</sup> Relative to their peers, these youth often experience slower growth and delayed puberty. At the Yopougon Child Program in Abidjan, Côte d'Ivoire, physical development has been a primary concern among 19 HIV-positive adolescents ages 13 to 17. Girls who have not reached puberty are unable to participate in traditional rituals and worry that they will never marry or have children. They also worry about showing physical signs of HIV, such as weight loss.<sup>199</sup> Most youth in this group have been in the health care system since birth or early infancy. However, a small percentage of perinatally-infected youth survive into adolescence without diagnosis and treatment.

In contrast, young people infected after the onset of puberty generally develop symptoms and become ill more slowly than do adults.<sup>200</sup> Because of their lack of symptoms, this group is much harder to identify and track. They may not seek health services regularly. They may not have visited any health care provider since childhood. They may have just learned about their HIV status or, more likely, they may be unaware of their HIV status.

As more children and youth receive ART through funding from PEPFAR and the Global Fund, experts believe that a growing number of HIV-positive infants will survive into adolescence. Because of the low uptake of PMTCT services in many countries, it is likely that many more HIV-positive children will be born in the future. These children may need ART services well into adolescence and even adulthood. Additionally, efforts to increase HIV testing may well increase the numbers of young people who know that they are infected. The demand for ART services is likely to grow enormously.

## Challenges Facing Young People Living with HIV

In November 2006, WHO and UNICEF convened a global consultation in Blantyre, Malawi, on strengthening the health sector's contribution to HIV/AIDS care, support, and treatment for young people living with HIV. The consultation identified

the following as the main challenges that HIV-positive young people face:

- ◆ Lack of relevant and appropriate information;
- ◆ Multiple barriers to health care, including a lack of integrated services;
- ◆ Lack of psychosocial support;
- ◆ Problems with treatment adherence;
- ◆ Difficulties with disclosing their HIV status;
- ◆ Stigma, discrimination, and isolation;
- ◆ Fears about consent and confidentiality; and
- ◆ Transitions from pediatric to adolescent care and from adolescent to adult care.<sup>201</sup>

While most of these challenges could face anyone living with HIV or AIDS, these issues have a heavier impact on adolescents. One youth from Zambia living with HIV shared this story:

*A 16-year-old HIV-positive girl went to a clinic for an STI test. The doctor told her she was too young to suffer from STI. She decided to go to someone else at the same clinic for help, to no avail. From there she went to the ART officer who told her they only offer ART services and not SRH [sexual and reproductive health] services. She had no other options and had to go to a private clinic even though she was unable to afford it.<sup>202</sup>*

Adolescents living with HIV have additional difficulties that differentiate them from children living with HIV. Youth often face blame for what others assume to have been ‘risky behavior’; younger children are treated as ‘innocents’. Adolescents may avoid seeking care out of fear that their parents will learn of their status or because health care workers require parental consent. In most societies, the transition from childhood to young adulthood is difficult, and young people can easily ‘fall through the cracks’. They may be too old for pediatric care, yet too young to use adult services.<sup>203</sup>

It is unwise to move HIV-positive youth into an adult HIV care facility whose staff has not been trained to work with adolescents. Staff often needs training so that young clients are not discriminated against within the facility. Staff often must let go of the attitude that young people living with HIV have been ‘bad’ (to have had sex). Health care workers often need training to understand that requiring parental consent may keep youth from seeking important health care. Many clinics require some payment for services, however modest, and young people seldom have financial means of their own. Finally, staff that normally works with adults may be unprepared for youth’s difficulties in adhering to treatment regimens.<sup>204</sup>

## Role of the Health Sector

The health sector has many responsibilities in supporting HIV-positive young people. Treatment is only one component of the comprehensive care and prevention package that young people living with HIV require. In fact, many young people infected in adolescence may not require ART for several years but need care, support, information, and advice about preventing transmission to partners and about preparing for ART.<sup>205</sup>

Most adolescents prefer to attend adolescent-focused ‘youth clinics’. The Adolescent Working Group in Kampala, Uganda, found that 92 percent of adolescents interviewed in a needs assessment preferred a clinic separate from both pediatric and adult clinics. This assessment resulted in the creation of an adolescent HIV clinic that currently serves more than 500 youth between the ages of 12 and 18.<sup>206</sup> However, this clinic is an exception; the reality is that few specialized adolescent care centers exist.

Many HIV-positive youth must visit different clinics for different health services. Yet, they actually need comprehensive care within a single facility. Health care programs can create youth-friendly programs to serve adolescents within pediatric or adult clinics. This means a space set aside, solely for adolescents, that offers, for example, extended hours, privacy, staff trained in serving adolescents, confidentiality, and free or very low cost services.

## PEPFAR's Response

There are three major problems in PEPFAR's response for HIV-positive young people:

- 1) HIV-positive youth are invisible in OVC policies and programs.
- 2) Prevention for young positives is missing.
- 3) Psychosocial support systems need far more emphasis.

Although PEPFAR has made tremendous strides in increasing the availability of ART for adults, it remains unclear how many young people are being served within adult programs since implementing staff does not generally collect limited age-desegregated data on ART recipients. Nevertheless, PEPFAR's success or failure in reaching young people who live with HIV should be judged on the quantity and quality of care interventions rather than on the numbers treated.

### 1) HIV-Positive Young People are Invisible in OVC Policies and Programs

HIV-positive children and youth ages 0-17 are considered 'vulnerable' and are included in the category of OVC. HIV status is only one of several factors that qualify a young person as vulnerable. In fact, the *OVC Guidance* does not acknowledge the increased vulnerability of HIV-positive children, barring a scant reference to health care for them. Rather, the *OVC Guidance* overwhelmingly assumes that most OVC are HIV-negative. Given the likelihood that a large number of OVCs are HIV-positive, this is naive and dangerous.

According to one PEPFAR implementer: *We know that many of the children are HIV-positive but due to the stigma, we cannot test them.*<sup>207</sup> Also, many children are unaware their parents have died of AIDS. *The grandparents or aunts tell them that it was cancer or TB- anything but AIDS. The communities are still silent.*<sup>208</sup> Thus, many children and youth who qualify as OVC may be left out of programs intended for them.

There is a myth that most OVCs are small children. Yet, almost half of all orphans who have lost one parent and two-thirds of those who have lost both parents are aged 12 through 17.<sup>209</sup> As such, they may be living on the street, supporting siblings, and/or forced into survival sex. They are at high risk for HIV infection. Research additionally shows that as orphans grow older, they face higher risks of acquiring STIs, including HIV, than do non-orphans.<sup>210</sup> In a survey in Zimbabwe, 15- to 18-year-old girls who were orphaned and girls who had parents infected with HIV were found to have higher rates of HIV infection and pregnancy and more symptoms of STIs than their non-orphaned peers who had healthy parents.<sup>211</sup> Older OVC may have acquired HIV through sexual transmission in early or mid adolescence.

The OVC Guidance is extremely short-sighted in not acknowledging this vulnerability. The Guidance should address critical links to VCT and to reproductive health services in order to determine youth's HIV status, link infected youth with ART and other care, and help them to prevent unintended pregnancies and STIs.

### 2) Prevention for Young Positives is Missing

In addressing HIV-positive young people, PEPFAR is severely lacking in its attention to positive prevention. Positive prevention includes all strategies that increase youth's self-esteem and confidence. Positive prevention aims to support youth in protecting their own sexual health and in avoiding infecting others. Finally, positive prevention requires the meaningful involvement of adolescents who live with HIV in planning and implementing HIV strategies and policies.<sup>212</sup>

Reproductive health services and comprehensive life skills education are critical for positive prevention. Perinatally infected adolescents may not yet be sexually active, but many intend to have sex someday. Youth infected as adolescents may already be sexually active and need to consider the implications of their diagnosis and sexual activity. Adolescent females face family and cultural pressure to have children, regardless of their HIV status. HIV-positive youth urgently need education, services, and support so they can make healthy decisions.

In critical policy documents, PEPFAR ignores the crucial need for positive prevention among HIV-positive adolescents.

In two of its documents, *OVC Guidance* and *Guidance for a Preventive Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers*, OGAC could, but does not, address the role of positive prevention.

OGAC's *OVC Guidance* makes the following reference to health-care for HIV-positive children:

### **3.B.4.b Health Care for HIV-Positive Children**

*Without appropriate treatment, over 50 percent of children born HIV-positive die within the first two years. The Emergency Plan considers the provision of HIV-related health care to exposed or infected infants a high priority. When ill or suffering from the onset of AIDS, children supported under OVC programs should have timely access to appropriate ART. Programs should make available other health care for children born to HIV-infected mothers and known HIV-positive children, and related support either through direct access to health providers, or, preferably, with arrangements and referrals established with programs such as providers of interventions to prevent the transmission of HIV from mothers to their children (PMTCT), or specialized pediatric ART providers. Monitoring skin, weight and vital signs, periodic CD4 and/or HIV testing for children and youth, and pediatric ART and ART adherence interventions for HIV-positive OVC are among the essential health care required for HIV-positive children. For further information on this topic, please refer to the Guidance for a Preventive care Package for Children Aged 0-14 Year Old Born to HIV Infected Mothers and to the Emergency Plan Report on Pediatric AIDS.<sup>213</sup>*

In referring to *Guidance for a Preventive Care Package for Children Aged 0-14 Year Old Born to HIV Infected Mothers*, OGAC ignores the health-care needs of HIV positive adolescents aged 14 through 17 years. Since the *OVC Guidance* is meant to address those under the age of 18, this is clearly a serious gap. Beyond that, there is *no* mention of the critical need for positive prevention services—such as comprehensive life skills education or sexual and reproductive health services—for HIV-positive adolescents. The *Guidance* makes a scant reference to prevention of HIV on the assumption that all OVC served by implementing partners are HIV-negative. It refers partners to OGAC's *ABC Guidance* for further clarification.

### **3.B.4.c. Prevention of HIV**

*Prevention of HIV is a priority health intervention in regions where the risk of infection is high. Programs should provide age-appropriate prevention activities to OVCs, including PMTCT intervention, as well as communication for behavior change targeted to appropriate age groups. OVC programs need to ensure vulnerable children get age-appropriate effective HIV prevention messages, including abstain, be faithful, and, as appropriate, correct and consistent use of Condoms (ABC), as well as avoiding injecting drugs and alcohol abuse. This is particularly true for programs that target adolescents and older youth. For additional guidance on the appropriate use of Emergency Plan funds to address preventive behaviors that help OVC avoid infection, please see the PEPFAR Guidance on Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections, 2005.<sup>214</sup>*

The *ABC Guidance* makes no reference to the likelihood of HIV-positive adolescents in OVC programs. Nor does it consider the potential emotional impact on HIV-positive youth and on orphans of the HIV epidemic in being put through moral-laden AB programming. New innovations in prevention programming are crucial to allow for mixed groups of HIV-positive and HIV-negative youth and those whose parents have died of AIDS.

OGAC's *Guidance for a Preventive Care Package for Children Aged 0-14 Year Old Born to HIV Infected Mothers* is equally disappointing. It could provide a menu of interventions for perinatally infected children. Instead, it focuses on delaying disease progression and preventing illness or death in potentially exposed or newly infected infants.<sup>215</sup> While this is a critical and crucial component of pediatric AIDS measures, it is not appropriate as a guide to care for children who are beyond the infant and toddler stage, including those up to age 14. Positive prevention efforts are crucial for delaying disease progression in older children and young adolescents, particularly those who have lost one or both parents and/or who may be engaged in risky behavior in order to support themselves and their families.

## **3) Psychosocial Support Systems Need Far More Emphasis**

Psychosocial support means addressing issues that *impact on the daily functioning of a young person living with HIV, both at a structural and emotional level.*<sup>216</sup> Structural issues include housing, nutrition, food, security, income, and other

basic necessities of life. Emotional issues include: accepting the diagnosis; disclosing one's status; isolation; stress; facing stigma and discrimination; healthy coping; and *negotiating relationships relative to HIV status*.<sup>217</sup> One PEPFAR implementing partner from Uganda believes that, *PEPFAR should prioritize the psychosocial needs, such as peer support groups for youth, and not focus entirely on the drugs*.<sup>218</sup>

In interviews conducted for this report with those involved in treatment programs for children and adolescents, respondents consistently voiced concerns that PEPFAR's over-emphasis on treatment numbers is potentially detrimental to the quality of programs. For example, efforts to increase the number of people being treated *can lead to reduced resources available to provide psychosocial support for those in treatment. PEPFAR provides much needed funding for the treatment but they don't support our youth peer group. Fundraising to support stipends for the youth counselors is always a struggle*.<sup>219</sup>

Psychosocial supports are critical for children who are moving into adolescence and for adolescents who have become recently aware of their status. But an emphasis on numbers crowds out this critical component of care. It can also result in less attention and resources to newly infected adolescents who do not yet need ART but who do need psychosocial support and links to other health care services.<sup>220</sup>

## Lessons From the Field

Some innovative programmatic interventions exist for HIV-positive adolescents, such as one in Kisumu, Kenya. Tuungane, a PEPFAR-funded organization that runs youth centers providing STI services and AB programs in Kisumu's urban slums, found that a high percentage (about 18 percent; 24 percent of females and 12 percent of males) of youth using VCT between May and December, 2005, tested positive for HIV.<sup>221</sup>

Out of concern that these young people were not using adult-dominated patient support centers, Tuungane partnered with Family AIDS Care and Education Services, another PEPFAR-funded program, to provide free and youth-friendly care and treatment at Tuungane's clinics. Almost immediately, the program was a success. Within a few short months, it began to enroll about five new patients per clinic each day. Twenty-two percent of new patients were eligible for ART.<sup>222</sup> Staff anticipates that this program will encourage more young people to use VCT services. This is an excellent example of collaboration in order to serve HIV-positive youth.

PEPFAR should use the experience and lessons from such partners to address the urgent needs of HIV-positive young people. Lessons learned from the field should inform the development of best practices. These best practices will then have a broader impact even than PEPFAR programs.

## In Summary

Providing appropriate treatment and care to HIV-infected youth is essential to stemming the epidemic. Youth may be infected perinatally and live into adolescence or be infected during adolescence through unprotected sex or injected drug use. Depending on the mode and timing of their infection, young people will have very different treatment and support needs. PEPFAR's response to HIV-positive young people is lacking in the following areas: (1) HIV positive young people are invisible in OVC policies and programs; (2) prevention for young positives is missing; and (3) psychosocial support systems need far more emphasis.

Attention to the needs of HIV-positive young people from the highest levels at OGAC will help to ensure that vulnerable youth are not overlooked in programming. Advocates for Youth recommends several actions that will allow PEPFAR to meet the needs of HIV-positive adolescents.

## Recommendations

For Congress

- ◆ Require OGAC to **improve monitoring and evaluation** of programs through age-desegregated data.

For OGAC

- ◆ Revise the *OVC Guidance*. PEPFAR's *OVC Guidance* does not adequately recognize the increased risk for STIs

and HIV facing OVC. A prevention strategy based on the current *ABC Guidance* ignores the urgent needs of orphans and other vulnerable children and increases their risk for poor sexual health. The *Guidance* also does not recognize the likelihood of many OVCs being HIV-positive and should prioritize HIV-positive youth's need for positive prevention. **See Table 5, opposite page, for suggested revisions to the current *Guidance*.**

- ◆ Immediately begin encouraging countries to collect age-desegregated data, based on the following age ranges: 0-9, 10-14, 15-19 and 20-24. These ranges fit with existing, routine WHO data collection.<sup>224</sup>
- ◆ Solicit examples from country teams of successful interventions that link prevention and treatment programs for young people or that integrate separate adolescent interventions at pediatric or adult treatment settings.
- ◆ Convene a technical working group on HIV-positive adolescents. Issue new guidance to country teams on meeting the needs of HIV-positive young people, based on lessons learned from the consultation.
- ◆ Invest in the development of a center for excellence for HIV positive-adolescents. Support operational research in order to help develop best practices and to contribute to the global community's knowledge about serving this population. Provide a base of knowledge for PEPFAR and others that seek to address this population.

#### For Country Teams

- ◆ Convene in-country consultations with implementing partners and relevant stake holders to develop strategies to address HIV-positive adolescents for the next COP cycle.
- ◆ Work with national governments to support the optional, *One-day Orientation on Adolescents Living with HIV*, a training for first-level facility health care workers who have already completed WHO's *Integrated Management for Adolescent and Adult Illness* (IMAI) basic therapy clinical course. The training is critical to strengthening the ability of health care workers to respond to the needs of HIV-positive young people.
- ◆ Increase funding for psychosocial interventions at treatment sites, especially for peer support groups for young people and for the training of peer counselors.
- ◆ Request implementing partners to include information about how they will respond to HIV-positive youth as part of prevention and OVC programs for the next COP cycle. In the interim, begin preparing partners to expand programs to address HIV-positive youth.
- ◆ Solicit examples from implementing partners for a best practices manual on successful interventions reaching HIV-positive adolescents.
- ◆ Invest in innovative HIV testing to reach youth by expanding program locations beyond primary care sites. Consider using mobile units, school-based health clinics, family planning programs, and recreational youth centers.

**Table 5: Suggested Revisions to *OVC Guidance***

Current Guidance <sup>223</sup>	Suggested Revisions
<p><b>3.B.4.b Health Care for HIV Positive Children</b>            Without appropriate treatment, over 50 percent of children born HIV-positive die within the first two years. The Emergency Plan considers the provision of HIV-related health care to exposed or infected infants a high priority. When ill or suffering from the onset of AIDS, children supported under OVC programs should have timely access to appropriate ART. Programs should make available other health care for children born to HIV-infected mothers and known HIV-positive children, and related support either through direct access to health providers, or, preferably, with arrangements and referrals established with programs such as providers of interventions to prevent the transmission of HIV from mothers to their children (PMTCT), or specialized pediatric ART providers. Monitoring skin, weight and vital signs, periodic CD4 and/or HIV testing for children and youth, and pediatric ART and ART adherence interventions for HIV-positive OVC are among the essential health care required for HIV-positive children. For further information on this topic, please refer to the <i>Guidance for a Preventative care Package for Children Aged 0-14 Year Old Born to HIV Infected Mothers and to the Emergency Plan Report on Pediatric AIDS</i>.</p>	<p><b>3.B.4.b Health Care for HIV Positive Children</b></p> <p>The following paragraph should be added:</p> <p>OVC programs should ensure that positive prevention efforts for older children and adolescents are made available as part of the preventive care package. Priority positive prevention efforts supported by the Emergency Plan include linkages to reproductive health and family planning programs, life skills education, comprehensive sexuality education, and livelihood support.</p>
<p><b>3.B.4.c. Prevention of HIV</b>            Prevention of HIV is a priority health intervention in regions where the risk of infection is high. Programs should provide age-appropriate prevention activities to OVCs, including PMTCT intervention, as well as communication for behavior change targeted to appropriate age groups. OVC programs need to ensure vulnerable children get age-appropriate effective HIV prevention messages, including abstain, be faithful, and, as appropriate, correct and consistent use of Condoms (ABC), as well as avoiding injecting drugs and alcohol abuse. This is particularly true for programs that target adolescents and older youth. For additional guidance on the appropriate use of Emergency Plan funds to address preventive behaviors that help OVC avoid infection, please see the PEPFAR <i>Guidance on Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections, 2005</i>.</p>	<p><b>3.B.4.c. Prevention of HIV</b>            Prevention of HIV is a priority health intervention in regions where the risk of infection is high. Recognizing that OVCs are at higher risk of HIV infection and may likely be infected already, the Emergency Plan prioritizes interventions that addresses OVCs’ vulnerabilities by linking or providing reproductive health and family planning services, life skills, comprehensive sexuality education, drug and alcohol abuse education, violence prevention programs, and livelihood assistance. Additionally, for those OVCs whose HIV status is known to be positive, supporting positive prevention efforts and support groups are effective strategies to helping HIV-positive OVCs remain healthy and avoid passing the infection to others.</p>

## VIII. Conclusion

Young people are critical to PEPFAR's success. Yet PEPFAR has, so far, largely ignored the realities of young people's lives and the state of the epidemic among youth. Congress, OGAC, and country teams have the power to greatly improve the situation for young people and to reform PEPFAR's response to one that is science-based and respectful of youth's rights to comprehensive HIV prevention that is linked with reproductive health services.

This year, 2007, is a time for serious reflection on PEPFAR, a time to pay special attention to youth's need for: 1) comprehensive, science-based HIV prevention; 2) linkages between HIV prevention and reproductive health care; and 3) services for HIV-infected youth and for AIDS orphans. Without serious consideration to the needs of both infected and uninfected young people, PEPFAR will fall seriously short of attaining its laudable goals and will leave a generation defenseless against HIV/AIDS. Advocates for Youth urges members of Congress and staff as well as OGAC, the Administration, and colleague organizations to consider seriously the recommendations in this report and to ensure that youth are not, once again, ignored by PEPFAR.

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