Failed UNAIDS Prevention Policies
vs.
Evidence-Based Solutions

Myth 1: Condom Distribution and Promotion Prevents AIDS

Much of the UN’s efforts, related to HIV/AIDS prevention, has focused on the widespread distribution and promotion of condoms. However, there are several evidence-based reasons why this approach has failed.

Fact: Condoms Have Significant Failure Rates and Thus Fail to Adequately Protect

Since condoms sometimes fail due to defects or inappropriate use, condoms can only provide partial protection and do not provide 100 percent protection as many claim. Over the course of a year, for those who use condoms every time (and statistics show this rarely occurs), there is only an 80 to 85 percent reduction in risk (compared to those who never use them).\(^1\) Even among a better informed and better supplied population than most, a Johns Hopkins study in Uganda found that condoms reduced risk of infection by only 65 percent.\(^2\)

Since condom failures can result in an often deadly disease (which is an unacceptable result), condoms should not be relied on to prevent HIV infections. Prevention approaches should seek to eliminate risk, not just to reduce it. The benefits of condoms are only attainable by those who use condoms \textit{every time}, yet studies show that couples fail to use condoms consistently even when they are highly motivated to use them. Surprisingly, even most discordant couples (where one of the partners is known to be HIV positive) report failing to use condoms each time they have sex. For example, in Rwanda, only nine out of fifty-three discordant couples reported using a condom every time.\(^3\)

High risk groups cannot be forced to use condoms. Among Cambodian sex workers, who were “forced” by their government to use condoms 100 percent of the time, the prevalence of STIs in 2005 was comparable to 2001. In addition, condom use among sex workers in Kampala rose to more than 90 percent in the early 2000s, yet HIV rates climbed during that same period.\(^4\)

Advocates of condom use often cite Thailand as a “condom success story.” In the early 1990s Thailand’s government required condom use between prostitutes and their customers, and then the prevalence of HIV fell from 2 percent in 1995 to 1.6 percent in 2001. However, during that same time period (i) male traffic to sex workers dropped from 22 percent to 10 percent; and (ii) male premarital and extramarital sex fell by roughly 50 percent. This would suggest that a decrease in promiscuous sex, not condom use, was responsible for Thailand’s success.

A 2002 UNAIDS study in four African cities found that condoms had virtually no effect on HIV levels. Another study “found no evidence that condoms alone had played a major role in HIV prevalence decline, anywhere in Africa.”

In fact, increased condom use often correlates with greater HIV risk. According to Edward Green, an American anthropologist, research scientist and author of Broken Promises: How the AIDS Establishment Has Betrayed the Developing World, “More condom use is associated with more casual and commercial sex and often higher – not lower – HIV infection rates.” If you want to protect them, you [need to] use something other than a condom.” Mr. Green further posited, “Condoms remained as ineffective by 2010 as they were in 1994 or 2001 or 2007. Indeed, the high-quality studies still show that none of the Western-conceived ‘best practices’ have ever had any effect on generalized epidemics.” (For a list of studies cited as support, see footnote.)

**Fact: ABC is the Answer, Not Condoms**

AIDS first appeared in Uganda in 1982. By 1988, Uganda had the highest percentage of HIV infections in the world. In 1991, 15 percent of the total population was infected (21 percent in urban areas). As a result of this pandemic, in 1986 Uganda started a revolutionary program (without any input from the West) known as ABC - Abstain (delay sexual debut), Be Faithful, then Condoms.

---

9 *Broken Promises: How the AIDS Establishment Has Betrayed the Developing World* (2001), p. 209. Mr. Green was a Senior Research Scientist at the Harvard School of Public Health and served as director of the AIDS Prevention Research Project at the Harvard Center for Population and Development Studies. He was appointed to serve as a member of the U.S. Presidential Advisory Council on HIV/AIDS (2003–2007), served on the Office of AIDS Research Advisory Council for the National Institutes of Health (2003–2006), and serves on the board of AIDS.org and the Bonobo Conservation Initiative. He has worked for over 30 years in international development. Much of his work since the latter 1980s has been in AIDS and sexually transmitted diseases, primarily in Africa, but also in Asia, Latin America, the Caribbean, the Middle East and Eastern Europe. He has served as a public health advisor to the governments of both Mozambique and Swaziland.
According to President Museveni, Uganda’s ABC program consisted of:

- Extensive public promotion of fidelity and delay of sexual debut (behavior change);
- Bold leadership at the highest level;
- Community participation, with open, face-to-face discussions about AIDS;
- Involvement of religious leaders;
- Involvement of people living with HIV;
- Deliberate use of “fear appeals” to spur behavior change;
- Fight against AIDS-associated stigma;
- AIDS education in primary schools, to reach children before they become sexually active; and
- Special targeting of women and youth.\(^{11}\)

What was the result of the ABC approach in Uganda? According to WHO and UNAIDS, from 1989 to 1995 both men and women saw a remarkable drop in the reported number of casual partners (35 percent to 15 percent, and 16 percent to 6 percent, respectively). More surprisingly, men reporting three or more partners declined from 15 percent to 3 percent. Additionally, a study of urban youth found a two-year delay in sexual debut among those people between 15 years old to 24 years old.\(^{12}\)

But, how did the ABC approach affect HIV rates? Uganda’s program cut its AIDS rate by two-thirds, from 15 percent to 5 percent between 1991 and 2004, before condoms were widely available within the country. Rand Stoneburner, a former WHO epidemiologist, estimated that had the ABC program been implemented in South Africa alone, it might have saved 3.2 million lives between 2000 and 2010. Further, 80 percent of all HIV infections in sub-Saharan Africa might have been prevented.\(^{13}\)

In 2004, The Lancet printed a consensus statement which recommended ABC programs for populations with general epidemics, emphasizing fidelity and delay of sexual debut.\(^{14}\) This consensus statement enjoyed the support of leading HIV researchers, such as Helene Gayle (former head of the CDC), Ward Cates (president of Family Health International), and more than 140 other experts from 36 different countries. The statement included these principles:

1. **On Fidelity** – “When targeting sexually active adults, the first priority should be to promote mutual fidelity.”

2. **On Partner Reduction** – “Partner reduction is of central epidemiological importance in achieving larger-scale HIV incidence reduction.”

---


In further support of the ABC approach, a 2005 UNAIDS study concluded that HIV prevalence in Zimbabwe had fallen due to a reduction in rates of sexual partners,\textsuperscript{15} an approximation to the ABC approach to “Be Faithful.” Regarding the results in Zimbabwe, former U.S. AIDS ambassador, Mark Dybul, stated, “Perhaps one of the most interesting things is that the greatest behavior change was abstinence and fidelity. The relative change in condom use was not as remarkable.”\textsuperscript{16} Even UNAIDS conceded in a 2009 regional report that fidelity deserves higher priority than condom promotion.\textsuperscript{17}

Sadly, in the late 1990’s, Western advisers began flooding into Uganda, heavily promoting condom distribution, and undoing the remarkable progress which had taken place there. In the early 2000s, the HIV incidence began to rise again in Uganda. The Uganda AIDS Commission posited on the situation: “There is a strong possibility that the negative HIV trends are at least partially attributable to phasing out of ‘zero grazing’ and other partner reduction/fidelity-focused campaigns of the late 1980s.”\textsuperscript{18}

\textbf{Myth 2: Decreasing Violence Against Women Decreases HIV Infection Rates}

One myth that has garnered a lot of support, without evidence, is that violence against women spreads HIV/AIDS.

\textbf{Fact: There is No Direct Correlation Between Violence and HIV Infection Rate}

In 2005, WHO researchers surveyed 24,000 women from 10 different African countries. The results were astonishing. In Namibia, HIV prevalence is high (15.1 percent among urban women), yet they had the lowest reported levels of intimate violence. Ethiopia had the most violence (with 58.6 percent of rural women reporting intimate violence), yet it had the lowest HIV prevalence among rural women (0.6 percent).\textsuperscript{19} These studies show the dangers of confusing correlation with causation, as one could conclude from these studies that wife-beating prevented HIV.\textsuperscript{20}

The problem of disempowered women is real, but it is a separate issue altogether from HIV/AIDS. The error (and potential danger) of pushing “women empowerment causes” as a means to combat HIV/AIDS is evident by these findings: “Greater women’s emancipation repeatedly correlates with higher HIV rates. Women are freer in Kampala than in the low-HIV countryside. They are freer in high-HIV Botswana and South Africa than in low-HIV Somalia and Ethiopia. They are freer in the top fifth of wealth than in the bottom, and have three to four times the HIV rate. They are freer with primary or secondary education than without and have twice the infection rate.”\textsuperscript{21}

\textsuperscript{16} Mark Dybul as quoted in Erika Check, “HIV Infection in Zimbabwe Falls at Last,” \textit{BioEd Online} (February 2, 2006).
\textsuperscript{17} UNAIDS, “Strategic Considerations for Communications on Multiple and Concurrent Partnerships,” March 2009.
The bottom line is that HIV/AIDS prevention, not empowerment of women, should be the focus of programs dedicated to combating the disease.

**Myth 3: Poverty Spreads HIV/AIDS**

Another common myth is that the poorer the society, the higher the prevalence of HIV/AIDS. However, data clearly show this is not the case.

**Fact: Wealth is Correlated With Higher HIV/AIDS Rates**

“If we look within nations, we see the same phenomenon: the more wealth (and usually education, which correlates with wealth), the more AIDS. We’ve known of this correlation since 1983, and [Edward C. Green] discussed it at length in *Rethinking AIDS Prevention*.”22 In fact, evidence from the Departments of Health Services in Kenya and Tanzania demonstrates that poverty is not a risk factor for HIV/AIDS.23

**Myth 4: Marriage Spreads HIV/AIDS**

In 2008, Stephen Lewis, the former ambassador for UNAIDS, declared: “It has been repeatedly pointed out that one of the riskiest propositions for a woman today in Africa is to be married.”

**Fact: The Data Show the Opposite – Marriage Correlates with Lower HIV/AIDS Rates**

The data are clear: “Married women always have a lower HIV prevalence than unmarried women (single, divorced, widowed). For instance, the 2004-05 Demographic and Health Survey found that HIV prevalence among married women was 6.3 percent, far lower than infection rates among widowed (31.4 percent) or divorced (13.9 percent) Ugandans.”24

**Myth 5: Voluntary Counseling and Testing (VCT) Help Prevent HIV/AIDS**

Much effort and resources have been spent to make counseling and testing available to those at risk of HIV/AIDS infection with the hope that such programs would decrease infection.

**Fact: Counseling Has Had no Impact and Testing May Give a False Sense of Security**

Two studies have shown that Voluntary Counseling and Testing (VCT) programs in rural Uganda had virtually no impact on behavior change, and additional studies have shown that VCT programs did not affect the infection rate.25 However, VCT also appears to have a darker side. There is some

---

25 These studies are discussed in E.C. Green, *Rethinking AIDS Prevention: Learning from Success in Developing Countries* (Westport, Conn.: Praeger, 2003). See also J.K.B. Matovu, et al., “Repetitive VCT, Sexual Risk Behavior,
evidence to show that VCT programs encourage condom usage, but these programs also appear to lead participants into riskier behaviors. When people repeatedly test negative, they tend to believe they are either difficult to infect, or they have some unique ability to choose “clean” partners. The result is that sexual behavior can become uninhibited.26

More ominous still is that VCT programs can actually lead to a higher prevalence of HIV/AIDS, as those who test negative might wrongfully assume they are not infected with HIV. Green noted that “traditional HIV testing can’t identify people in the super-contagious stage right after infection, before antibodies are visible.”27 Even U.S. Ambassador Richard Holbrooke has acknowledged that VCT programs only help get people into treatment; VCT does very little to actually prevent HIV/AIDS.28

VCT programs are also the most expensive non-drug methods for preventing HIV infections, at about four to five hundred dollars per infection avoided.29

**Myth 6: Destigmatizing the Groups Involved in High Risk Sexual Behavior Will Reduce HIV/AIDS Infection Rates**

In his speech to the International AIDS conference on 3 August, 2008, UN Secretary General Ban Ki-moon called for the decriminalization of prostitution, drug use, and homosexual sex, claiming that “In countries without laws to protect sex workers, drug users, and men who have sex with men, only a fraction of the population has access to prevention.” The *International Guidelines on HIV/AIDS and Human Rights*, sponsored by the joint United Nations program on HIV/AIDS and the Office of the United Nations High Commissioner for Human Rights, claim that any stigmatization or legal restraints on sexual activity will increase infection rates by driving high risk people into hiding and beyond the reach of HIV prevention and treatment efforts.30

**Fact: Stigmatization of Risky Behaviors May Help Control HIV/AIDS**

There is no evidence that destigmatizing or decriminalizing the sexual behavior of high-risk groups decreases HIV/AIDS rates, despite the fact that a number of UN agencies and officials claim it will. Two well known epidemiologists have noted that stigma can actually have a positive effect on a society’s health.31 While the cost of stigma is always some individual suffering, the benefit can

---

actually be saved lives (which is ultimately the goal, isn’t it?). Consider the social stigma associated with smoking, drinking and driving, or pedophilia. The results of these social stigmas, while at the cost of individual suffering, are ultimately a healthier society, the protection of our children, and lives saved.

HIV/AIDS researcher Edward Green has stated: “…stigma can be a potent ally in fighting HIV. Although the price would be hurt feelings to the promiscuous, the gain would be countless lives saved.” Green points out the dangerous irony in wrongheaded prevention approaches: “. . . in the AIDS World, we’ve stigmatized those who recommended sexual caution, and the price has been hurt feelings too, plus countless preventable deaths.”

There are more effective ways to minimize any actual or potential stigmatization of “at risk” or infected individuals than to embrace and support the behaviors that caused the disease in the first place. Such individuals should receive effective counseling, medical treatment (where necessary), and compassionate care by their families.

Is There Any Good News?

Some (not all) of UN consensus language accurately recognizes certain factors that could help lower the incidence of HIV/AIDS. For example, paragraph 8.35 of the International Conference on Population and Development or ICPD (1994) notes that “Responsible sexual behaviour, including voluntary sexual abstinence, for the prevention of HIV infection should be promoted and included in education and information programmes.” Likewise, ICPD Paragraph 13.14(c) states that the “promotion of voluntary abstinence and responsible sexual behavior” should be part of the “sexually transmitted diseases/HIV/AIDS prevention programme component.”

Paragraph 108(l) of the Fourth World Conference on Women in Beijing (1995) requires governments, UN agencies and other stakeholders to “Design specific programmes . . . for the prevention of HIV/AIDS and other sexually transmitted diseases through, inter alia, abstinence….” Five years later, similar UN consensus language was published. (Beijing + 5, Par. 103(b)).

Lastly, the 2001 Declaration of Commitment on HIV/AIDS states that “a wide range of prevention programmes” should be implemented by 2005, including those “aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity…. ” (HIV/AIDS (2001), 52. Similar language is repeated in Paragraph 22 of the 2006 Political Declaration on HIV/AIDS.

Unfortunately, other UN consensus language supports and even promotes programs (e.g., widespread condom distribution) that have been shown to be ineffective.

Should we not focus on prevention and treatment programs that have been shown to work rather than trying to legally protect and support the very behaviours that spread HIV/AIDS? UN member states should reorient UN agency priorities by developing new policies that promote proven HIV/AIDS prevention strategies aimed at behavioural change such as fidelity, partner

reduction and the delay of sexual debut. UN member states should not succumb to pressure from sexual rights activists, donor countries, and certain UN agencies who are exploiting the AIDS pandemic to advance sexual rights. In this way millions more lives could be saved.