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UK Working Group on Education and HIV/AIDS

HIV AIDS & EDUCATION

The abstinence debate: condoms, the President's Emergency Plan for AIDS Relief (PEPFAR) and ideology

Policy & Research: ISSUE 4

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The abstinence debate: condoms, the President's Emergency Plan for AIDS Relief (PEPFAR) and ideology.

This paper was developed on behalf of the Working Group on Education and HIV/AIDS and summarises issues raised by a meeting to discuss the contribution of abstinence-only HIV/AIDS education.

The summary presents the key arguments for and against abstinence-only education that were presented at the meeting, as well as the ensuing discussions. Trevor Stammers argued in favour of abstinence-centred programmes, such as those incorporated in the ABC (Abstain, Be faithful, use a Condom) approach in Uganda,[1] and Roger Ingham and Susannah Mayhew argued for a comprehensive approach.

In order to illuminate the underlying tensions in the debate, we present some polarised viewpoints and consider their implications.

As a meeting conducted under Chatham House rules, the identities of the NGOs and individuals putting forward particular viewpoints in the discussion are not revealed.

[1] Please note that Trevor Stammers did not argue in favour of the abstinence-only approach that is the focus of most of this paper.

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1 Introduction

One of the most frustrating dimensions to the current HIV/AIDS crisis is that, while much is known about how to prevent the further spread of the virus, globally some 13,000 new infections occur daily. Despite increasing amounts of money being spent on school-based HIV/AIDS education, the results have been disappointing for a number of reasons. These include:

- lack of understanding of the factors that affect sexual behaviour – especially in different cultural contexts;
- structural barriers (such as poverty and gender inequality which hamper behaviour change);
- low-quality and under-resourced educational institutions, undermining the quality provision of HIV/AIDS education;
- insufficient funding to equip AIDS educators with the skills and resources they need;
- the pedagogical basis to HIV/AIDS education is weak;
- insufficient attention given to international evidence about the characteristics of effective HIV education programmes.

However, another crucial factor often gets ignored in the wider policy debates – the fundamental disagreement over which messages about sexual behaviour should be delivered in schools. An ideological battle is being fought under the banner of HIV prevention – a battle that has come to the fore through the explicit funding by the USA of abstinence-only HIV/AIDS education. On the one side are those who stress that sexual abstinence is the only 100%-safe way to prevent HIV infection; on the other side are those who argue that not only is abstinence-only education failing, it is also unrealistic and constitutes an abuse of human rights.

Discussion during the meeting revolved around six broad, key issues. For the sake of simplicity, those arguments made generally in favour of abstinence-only education are termed 'the abstinence viewpoint' while those in favour of a more comprehensive approach to HIV/AIDS education are termed 'the comprehensive viewpoint'.

2 Key issues

2.1 Effectiveness of approach

The 'abstinence' viewpoint

The abstinence-only approach offers risk elimination rather than risk reduction. It is the only HIV-prevention strategy that works 100% of the time.[2] Condom use is not 100% effective and evidence shows that, up to one third of the time, condoms are not used properly, thus providing a false sense of protection against HIV.[3] Even if condoms are 99% effective, the probability of acquiring HIV infection will depend not only on the condom but also on the HIV status of the partner.

[2] Crosby RA, DiClemente RJ, Wingood GM, Salazar LF, Rose E, Levine D, Brown L, Lescano C, Pugatch D, Flanigan T, Fernandez I, Schlenger W and Silver BJ. Condom failure among adolescents: implications for STD prevention, *Journal of Adolescent Health*, 2005, 36, 534-6.

[3] Richens J, Imrie J and Copas A Condoms and seat belts: the parallels and the lessons, *Lancet*, 2000, 355, 400-3.

Promoting condoms is inappropriate for the vast majority of people who are living in conditions of extreme poverty where they can hardly afford their next meal – let alone a condom. In addition, promoting condoms does not take into account the realities of sex, especially when people have been drinking alcohol and are less likely to use a condom properly – if at all.

Only about 10% of people have multiple sex partners, so why should a strategy of condom promotion, which is directed at this minority, be used for everyone? Strategies for high-risk groups are inappropriately being used for everyone out of a sense of 'political correctness' in not wanting to identify specific high-risk groups. Nobody wants to say some groups are at more risk so they say 'everyone is at equal risk' which is not true, because it is actually more about choice of partner. The two groups (high and low risk) need different approaches and messages.

Moreover, there are unknown effects of promoting condom use. For example, not enough is known about the possible extent to which people change their sexual behaviour in response to using condoms – it is possible that they are engaging in higher risk sexual behaviour to restore 'risk homeostasis'.

The 'comprehensive' viewpoint

Condoms greatly reduce the risk of HIV infection during sexual intercourse. Young people need to be offered a range of choices on how to prevent HIV. For those who are already engaging in sex, promoting the use of a condom is the best way to reduce the chances of acquiring or transmitting a sexually transmitted infection, as well as avoiding an unplanned pregnancy. If abstinence-only is promoted then young people only have the option of not having sex, which runs the risk of excluding the many young people who have already started having sex.

It does not make sense to say condoms are only useful as a strategy for high-risk groups when the reality is that most young people in many parts of the world have sex before marriage. In high-prevalence countries, where more than one in five adults are HIV positive, everybody is at high risk.

2.2 Research

The group discussed research on three key areas:

1) Uganda's decreasing HIV rates
2) the efficacy of pledging to abstain until marriage
3) decreasing pregnancy rates in the USA.

The 'abstinence' viewpoint

Evidence from Uganda and the USA suggests that primary sexual behaviour change (abstinence and faithfulness) have played a significant role in reducing the spread of HIV and teenage pregnancy.

Uganda

Evidence shows that Uganda's 'zero grazing' policy (monogamous relationships) was the main cause of the reduction in HIV incidence – the proportion of men reporting having had sex with one or more casual partner in the previous year decreased from 21% in 1991 to 9.8% in 1998.[4] Further, there is no evidence that condom promotion has had any effect in reducing the spread of a generalised epidemic anywhere else in the world.[5]

Abstinence pledges

Virginity pledges are considered important by many in the USA who want to promote abstinence until marriage, and various studies in the USA have shown that such programmes lead to teenagers delaying their first sexual encounter.

Pregnancy

In the USA, there has been a 30% decrease in teenage pregnancy over the past decade. One peer-reviewed article on this subject shows that around 50% of the decrease is the result of primary behaviour change.[6] Another has indicated that two thirds of the reduction in unmarried teenage girls is also due to delayed sexual debut.[7]

The 'comprehensive' viewpoint

Uganda

The evidence from Uganda is confusing, because different researchers show different strategies as being most effective in reducing HIV incidence. Everybody wants to take the credit for Uganda's success, but because a wide range of factors affect sexual activity, no research can show exactly which strategy worked best. A recent review shows that a reduction in HIV rates was associated with both partner reduction and increased condom use.[8] It is likely that condom use played a role in Uganda's success, but so too did primary behaviour change. Even if behaviour change has occurred, it is by no means clear that this is as a result of abstinence-only approaches.

Abstinence pledges

In some studies, pledging to abstain until marriage has been associated with delayed sexual debut. However, the largest cohort study of over 12,000 young people shows that the majority of 'pledgers' do indeed have sex before marriage, and are one-third less likely to use a condom at first sexual intercourse. Further, and most importantly, they have the same rates of sexually transmitted infections as non-pledgers.[9]

[4] Low-Beer D and Stoneburner R Behaviour and communication changes in reducing HIV: is Uganda unique? *African Journal of AIDS Research* 2003, 2, 9-21.

[5] Stammers TG As easy as ABC? Primary prevention of sexually transmitted infections *Postgraduate Medical Journal*, 2005, 81, 273-275.

[6] Santelli JS, Abma J, Ventura, Lindberg L, Morrow B, Anderson JE, et al. Can changes in sexual behaviors among high-school students explain the decline in teen pregnancy rates in the 1990s? *Journal of Adolescent Health* 2004, 35, 80-90.

[7] Mohn JK, Tingle LR, Finger R. An analysis of the causes of the decline in non-marital birth and pregnancy rates for teens from 1991-1995 *Adolescent and Family Health*, 2003, 3, 39-47.

[8] Kirby D. Presentation at UN IATT on Education Meeting. London 2006.

[9] Brückner, H and Bearman, P (2005) After the promise; the STD consequences of adolescent virginity pledges. *Journal of Adolescent Health*, 36, 271-278.

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The same study looked at why virginity pledges might be working and concluded that people make pledges because they want to feel part of a minority identity movement – and thus, in colleges where there were too few or too many pledgers, individuals were less likely to keep to their pledges. The implication from the research is that virginity pledging is restricted in potential as its efficacy lies in it not being universal. Further, since those who pledge are self-selecting, no inferences can be drawn from the evidence that their first intercourse occurs later than that among non-pledgers.

Pregnancy

The only research that claims to show that abstinence-only programmes are effective stems from the USA – this raises serious doubts as to how applicable these results would be to resource-poor countries. In any event, the claims made on the basis of the results of such studies are disputed.[10]

Furthermore, some research on teenage pregnancy in the United States shows a reduction in sexual activity not to be the main factor in reducing pregnancy rates. A recent paper has used careful analysis of available data to demonstrate that over 85% of the reduction in teenage pregnancy rates can be attributed to improved contraceptive use, rather than to reductions in sexual activity.[11]

2.3 Ideological positions

The 'abstinence' viewpoint

Those who promote condoms are not doing so purely from a scientific basis, but from an ideological standpoint of sexual liberalism and relativism in which all forms of sexual behaviour are equally acceptable. The assumption is that teenagers have a right to sex. This amoral and irresponsible approach has contributed to the spread of HIV and other STIs, as well as to a great deal of psychological distress.

The 'comprehensive' viewpoint

The abstinence-only lobby is part of a wider movement towards social conservatism based on religious beliefs; there is a great overlap between those who lobby for abstinence-only approaches and those who support creationist theories, oppose abortion and argue that healthy families and societies are based on monogamous heterosexual relationships.

Although the advocates for abstinence-only approaches use the language of public health and evidence, their starting point is a religious belief in the sanctity of heterosexual marriage, together with virginity before marriage and faithfulness after it. As part of this ideological belief, sex workers and homosexuals are reviled.

[10] Kirby D. (2002) *Do abstinence-only programs delay the initiation of sex among young people and reduce teen pregnancy?* Washington DC: The National Campaign to Prevent Teen Pregnancy.

[11] Santelli J, Lindberg, L, Finer, L and Singh, S. (2007) Recent declines in adolescent pregnancy in the United States; more abstinence or better contraceptive use? *American Journal of Public Health*, 97 (1), 150-156.

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In practice, this has led to the introduction of the global 'gag rule' which prevents organisations from working with sex workers. Although the global gag rule is a separate policy to abstinence-only funding, both are part of the same religious agenda.

The comprehensive viewpoint is ideologically based on respect of the rights of individuals to make their own choices about their sexual behaviour and to be supported to do so responsibly. Abstinence may be one such choice but it should not be the only one.

2.4 Sexual health and rights

The 'abstinence' viewpoint

There is a wide range of sexually transmitted infections, and sex education should not just focus on HIV. Of these infections, human papilloma virus (HPV) is one of the most serious and is the main cause of cervical cancer, penile, vulval and anal cancers. As condoms do not protect against HPV, the only prevention strategy to date that is effective is abstinence.

The 'comprehensive' viewpoint

The abstinence-only model actively discourages condom use through misrepresentation of information. In a recent review, Waxman concluded that over 80% of abstinence-only curricula contains false, misleading or distorted information about reproductive health.[12] Such misinformation is in direct contradiction to the UN Convention on the Rights of the Child, which, in the context of HIV, states:

> "Effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information including sexual education and information."[13]

In addition, abstinence-only education violates the following international rights:

- The right to the highest attainable standard of health[14]
- The right to life[15]
- The right to seek and impart information of all kinds[16]
- The right to non-discrimination[17]
- The right to freedom of speech[18]

2.5 Pedagogy

The 'abstinence' viewpoint

Comprehensive sex education is based on a teaching approach that assumes that young people can understand two contradictory pieces of advice at the

[12] US House of Representatives. *The Content of Federally Funded Abstinence-only Education Programs* (the Waxman Report). Washington DC: US House of Representatives, Committee on Government Reform – Minority Staff Special Investigations Division; 2004.

[13] UN (1989) UN Convention on the Rights of the Child, Geneva: UN High Commission for Human Rights.

[14] Convention on the Rights of the Child, International Covenant on Economic, Social and Cultural Rights.

[15] Universal Declaration of Human Rights.

[16] International Covenant on Civil and Political Rights.

[17] Ibid.

[18] Universal Declaration of Human Rights.

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same time. It does not make logical sense to say to young people 'do not have sex but if you do have sex, use a condom'. By providing the second message, the first message is being undermined; it is like saying, 'do not eat any sweets but if you do eat one, eat an orange one'.

Another problem with a comprehensive approach is that it is overly mechanical, with a focus on sex rather than on relationships. Sex education needs to go beyond safe sex to talk about safe relationships. Condom promotion is a mechanical solution to a problem that should really be dealt with by discussing human relationships and values.

The 'comprehensive' viewpoint

The teaching approach underlying abstinence-only education is based on fear, guilt and shame. The assumption is that guilt is an effective behaviour control mechanism and that those who do not abstain should feel guilty. However, such feelings of guilt are likely to stop teenagers from seeking the support they need – for example, they might be less likely to seek support from professionals or attend clinics for testing and treatment for sexually transmitted infections.

2.6 Assumptions on gender and agency

The 'abstinence' viewpoint

Promoting abstinence rests on increasing female empowerment and developing the abilities of women to exercise individual choices about whether and when they want to have sex.[19]

The 'comprehensive' viewpoint

It is unrealistic to think that young people always have 100% control over their sexual behaviour. Those who promote abstinence focus overly on the individual and ignore the wider contexts in which individuals make decisions. Promoting abstinence also ignores cultural contexts in which sexual initiation can play an important part in becoming an adult, as well as the many and various pressures that young people experience from partners, peers, and other sources.

In terms of gender, the abstinence-only approach is arguably disempowering for women as it draws upon traditional stereotypes in which women are often seen as pure, passive and virginal.

The abstinence-only programme is intrinsically linked to the USA's Healthy Families Initiative that promotes a two-parent model where the father has financial responsibilities and the mother takes on care responsibilities. This is an outdated model of gender relations and, again, restricts women's freedom to take control of their own lives.

3 Could there be a convergence of viewpoints?

The two sets of (albeit simplified) viewpoints outlined above appear contradictory in a number of fundamental ways. In some cases, it is a matter of evidence being used in different ways;

[19] Rankin W and Wilson C African women with HIV, *British Medical Journal*, Dec 2000, 321, 1543-4

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in other cases, however, there are substantial differences in perceptions about how sexual behaviour can and should be changed.

In reality, it is possible that these positions may not be as divided as they seem. There may be points of convergence for those who are neither vehemently in favour of abstinence until marriage (or who recognise that it is often an unattainable ideal), nor can fully support comprehensive sex and relationships education (which can sometimes appear to be an 'anything goes' approach).

This convergence may become apparent if various meanings of the term 'abstinence' are deconstructed. At a simple level, the term can be (and often is) used in two different ways: sexual delay amongst children and young people; and delayed sex until marriage.

An opportunity for consensus potentially arises when 'abstinence' is taken to mean the first of these concepts – indeed, very few educators or practitioners would argue against encouraging sexual delay for children. From a medical point of view, there are good physical and psychological health reasons for encouraging and/or enabling children to delay sexual debut, but there exist no parallel health-related reasons for delaying until marriage (despite the US government's claim to the contrary).

There is nearly universal consensus that children should not be having sex until they are physically and emotionally mature, although the term 'child sex' itself will depend on cultural definitions of childhood and the age of transition to adulthood.

With young people, however, the situation is not so clear. There is abundant evidence that some early sex is coercive, resulting from peer and/or partner pressure – often affecting girls and boys differently – financial necessity, and other demeaning forces. In these cases, delay until individuals are empowered to make fully informed and mutually respectful choices – at any age – is welcomed from many points of view.

On the face of it, therefore, there appears to be a consensus of opinion that delay in early sexual initiation is to be encouraged. However, such an apparent consensus is illusory. A separation needs to be made between public health concerns and those that are driven by particular ideological positions. The two major constituencies advocating abstinence-only education (the Catholic Church and the US government) are referring explicitly to a second interpretation of delay – complete sexual abstinence until marriage – which is clearly ideologically motivated.

Closely related to these two approaches lies the issue of what sort of sex and relationships education are most appropriate. The abstinence-only supporters are clear in claiming that information on contraception (and many other topics) is not required, since it is not needed if young people are not having sex, and it dilutes the message around abstinence if alternatives are offered.

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Given the overwhelming international evidence[20] that comprehensive sex and relationships education programmes are not associated with (nor lead to) earlier sexual initiation, there are no reasons whatsoever to withhold such information from young people. Indeed, it can be argued that being in possession of the necessary knowledge and skills will increase their ability to make informed choices; these may, of course, be to delay their sexual activity according to their particular religious and/or cultural values.

There was overwhelming consensus among the Working Group on Education and HIV/AIDS that such an ideologically driven abstinence agenda is to be opposed. Such views masquerade under the guise of 'public health' and yet there is no public health reason why abstinence should be encouraged specifically until marriage. Panic about HIV has – unfortunately – allowed such viewpoints to gain scientific legitimacy through the use of slogans such as 'risk elimination versus risk reduction' in which it becomes impossible to argue that abstinence does not eliminate risk to HIV. Certainly, if people abstain from sex then risk of HIV is eliminated but the bigger question is: can and should people be told to abstain and be provided with little else, or should they be fully informed and empowered to make choices (one of which may be to abstain)?

The confusion between the different meanings of 'abstinence' and 'delay' is taken advantage of by the more conservative advocates of abstinence-only, who base their arguments around child sex when in fact, their motive is actually centred on the sanctity of heterosexual marriage.

4 The impact of abstinence–only policies and PEPFAR on the HIV response

Abstinence until marriage is being promoted around the world through the US government's funding for HIV/AIDS, known as The President's Emergency Plan for AIDS Relief (PEPFAR). This will provide $15 billion for HIV/AIDS over a five-year period. Of this money, 20% has been earmarked for prevention and, within prevention, at least one third must be spent on 'abstinence until marriage' programmes.

The overarching criticism by the Working Group was that PEPFAR undermines wider efforts to improve aid as it is excessively tied, bilateral rather than multilateral and, finally, interferes with the independence of governments and NGOs.

The aid sector has increasingly come under pressure to untie aid because tied aid is inefficient, disrespects the autonomy of recipient countries and thus distorts local priorities. PEPFAR is an example of this. PEPFAR conditions impose an ideological position on other countries and dictate who organisations should work with, as well as what they should and should not say.

The Working Group discussed a number of ways in which their own programmes

[20] Grunseit A, Kippax S, Aggleton P, Baldo M and Slutkin G Sexuality education and young people's sexual behavior: A review of studies, *Journal of Adolescent Research*, 1997, 12(4), 421-53

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had been impacted upon by the new PEPFAR regulations. These can be summarised as follows:

- **increase in bureaucracy**

In order to ensure compliance to the new conditions, the level of reporting and auditing seems to have increased significantly. In some cases, NGOs have had to make huge efforts to ensure that they and their partners have signed the relevant conditions.

- **increase in self-censorship**

The new conditions are ambiguous in their scope. They have also created a climate of fear in which organisations interpret the conditions in an overly restrictive manner in order to avoid the negative impact of an audit by the US government.

The implications of being audited for PEPFAR funding are grave. Small organisations cannot even afford the costs of the accountant to prepare for an audit. Several examples were given of organisations that were audited and subsequently asked to return funds, rendering these organisations financially unviable. Informally, it seems that the US government may be using the threat of an audit on organisations that are seen to be opposing the new PEPFAR conditions.

Because of the ambiguity, many organisations are left confused; does accepting PEPFAR money in one country mean the conditions apply to programmes in another country? Does accepting money for working with orphans rule out the possibility of working with sex workers? Out of fear of having to return funds, organisations are applying self-censorship and probably being overly restrictive in the ways in which they are interpreting and applying the conditions.

- **decrease in language of rights**

Several organisations claimed that they had been told to remove words such as 'reproductive rights' from reports and proposals, with any mention at all of 'rights' being discouraged. The Working Group was extremely concerned about this, and feels that some of the gains made from the Cairo Consensus in 1994 are being eroded (the Consensus asserted that gender equality and women's reproductive rights must form the basis of work in population and development). Although the abstinence-only movement claim that its programmes are empowering for women, this is clearly not the case, since the rights of women to make decisions about their own bodies is being denied; for example, in relation to abortions or in selling sex commercially.

- **decrease in supply of condoms**

As the US government massively increases funding for abstinence-only programmes, it is cutting funding for condoms. In 1991, USAID funded more than 40 million condoms. In 2000, this figure had plummeted to 25 million. Many countries - including Ethiopia and Uganda - have been highlighting the

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shortage of condoms. People have reported having to use cling film or plastic bags as no condoms were available. Even Stephen Lewis, the usually diplomatic UN Special Envoy on AIDS in Africa, has spoken out:

"There is no doubt in my mind that the condom crisis in Uganda is being driven by [(US policies] to impose a dogma-driven policy that is fundamentally flawed and is doing damage to Africa," (The Guardian, 30 August 2006).

Not only has the actual supply of condoms been cut through PEPFAR, organisations reported that the reputation of condoms as a form of HIV prevention is being systematically undermined:

- One organisation says it has been besieged with emails from US citizens asking long questions about pores in condoms. This has been interpreted as a deliberate attempt to waste time and create distraction.
- American scientific institutions such as the Centers for Disease Control have been accused of removing materials from their website that seen to be promoting condoms.
- In many African countries, NGOs report no longer being able to discuss condoms with young people.
- Peer educators in one African country have been handing out cards saying 'don't use condoms'.
- The failure rates of condoms are being exaggerated and HIV messaging is focussing on the failure rates rather than the high success rates.

● decrease in services

HIV is intrinsically linked to reproductive health. Yet, in order to qualify for PEPFAR, organisations are forced to cut reproductive health services such as abortion services. The US government seems set on divorcing the HIV response from reproductive health services and yet, when the International Planned Parenthood Federation is forced to close down 76 clinics in one year alone, countless opportunities for providing HIV/AIDS education are similarly cut. HIV is not a stand-alone issue – it is a matter of sexual health and it is a hugely wasted opportunity if the response to HIV is not integrated within sexual and reproductive health services more generally.

5 Responses of NGOs

NGOs have responded to the PEPFAR conditions in a number of ways. In terms of funding, organisations have three choices:

● refuse to accept PEPFAR funding

The impact of rejecting PEPFAR funding is amplified if the rejection is highly publicised, such as the Brazilian government's refusal in 2004. The objective of this type of public refusal is that if enough organisations reject funds then it becomes embarrassing for the US government. On the negative side, rejecting funds may lead to a reduction in services and force NGOs to break existing commitments with partners.

- **accept funding and 'fly under the radar'**

This approach is based upon working around the conditions and taking advantage of the ambiguity that exists in the policy. In some cases, organisations are gambling that, although they have signed up to the conditions, the chances of being caught contravening the rules are small. However, this approach has two pitfalls; first, if an organisation is found to be breaking the rules then they may be forced to return all the monies, as well as having to go through the lengthy and expensive process of defending themselves. Another criticism is that 'flying under the radar' demonstrates complicity with the conditions, such that organisations forfeit their chance to oppose the conditions.

- **accept funding and adhere to the conditions**

This is the most common response of organisations but is problematic for the reasons mentioned throughout this report.

Other suggestions on how to oppose the PEPFAR conditions include taking legal action, creating solidarity across organisations, and lobbying African and other governments over the conditions. Resistance to PEPFAR conditions can also take place through political action such as lobbying respective governments to take a lead in challenging the abstinence-only approach and PEPFAR more generally.

6 Summary

This paper has highlighted some of the rather extreme viewpoints that exist at either end of debate about abstinence-only education. On the whole, the Working Group agreed that ideology should not dictate what is covered in sex and relationships education. HIV/AIDS education needs to offer different options to cater for the range of choices and preferences among young people. Support needs to be offered to those who choose (and are able) to delay their sexual debut. However, the discourses of narrow morality that some are attempting to impose on all young people is an abuse of their rights, ignores the research and is likely to lead to poorer sexual health outcomes.

Sexual abstinence as a concept is confusing and needs to be redefined into two separate categories – namely sexual delay and abstinence until marriage. Sexual delay is a response that, in many ways, can fit into public health goals as long as the justifications for this approach are made clear. Abstinence until marriage is falsely advocated as a public health response despite it being clearly derived from a set of fundamental religious and ideological beliefs.

The negative impact of the US government's explicit funding of abstinence until marriage programmes has yet to be formally assessed. Anecdotal evidence suggests that the reputation of condoms is being eroded, reproductive health services are being

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cut and the HIV response is being divorced from sexual and reproductive health rights and services.

Organisations need to show solidarity in opposing PEPFAR conditions, and lobbying needs to take place in countries before governments accept the conditions.

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UK Working Group on Education and HIV/AIDS

Education for All (EFA) will not be achieved unless we, the international education community, recognise the HIV/AIDS epidemic to be a global emergency and react accordingly.

The Working Group on education and HIV/AIDS consists of researchers, practitioners and policymakers working in the fields of education and sexual health. The group provides an informal opportunity for UK-based partners to discuss and build upon research on the interfaces between education and HIV/AIDS.

The purpose of the Working Group is three-fold. First, it aims to build upon current research. Second, it aims to engage people working on education at all levels to prioritise HIV/AIDS as an issue that should not be ignored. Finally, it strengthens the links between education and HIV/AIDS networks.

This paper summarises discussion from the fourth meeting of the Working Group.

For more information:
http://www.aidsconsortium.org.uk/Education/educationworkinggroup.html

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Acknowledgements:

We would like to thank the following people for their help in preparing the paper: David Archer, Akanksha A. Marphatia, Neelanjana Mukhia, David Clarke, Susannah Mayhew, Aditi Sharma and Trevor Stammers.

We would also like to thank the following people for the contribution to this meeting on abstinence: Dr Stuart Kean, Felix Holman, Lorna Robertson, Dr Halima Begum, Sandra MacDonagh, Marge Berer, Annabel Kannabus, Christina Patterson, Fionnula Murphy, Jim Simmons, Gill Gordon, Sam Guy, Clare Mckeever, Heather Jarvis, Aoife Doyle, Lynsey Boother, Alan Whiteside, Nancy Kendal, Sheila Aikman, Penny Bloore, Tania Boler, Peter Aggleton, Roger Ingham, Trevor Stammers, Susannah Mayhew and Nicola Swainson.

For citation purposes:

Boler, T. and R. Ingham (2007). The abstinence debate: condoms, the President's Emergency Plan for AIDS Relief (PEPFAR) and ideology. London, ActionAid International.

See other issues from UK Working Group on Education and HIV/AIDS:

Boler, T. (2003). Approaches to examining the impact of HIV/AIDS on teachers. London, ActionAid International and Save the Children Fund.

Boler, T. and K. Carroll (2003). Addressing the educational needs of orphans and vulnerable children. London, ActionAid International and Save the Children Fund.

Boler, T. and P. Aggleton (2005). Life skills education for HIV prevention: a critical analysis. London, ActionAid International and Save the Children Fund.

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Edited by Angela Burton

Designed by mcreative

June 2007