Family Watch International
Promoting Family Based Solutions to World Problems

Wrongheaded United Nations HIV/AIDS Prevention Policies vs. Evidence-Based Approaches

Myth 1: 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.[1]

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, Danel Reidpath and Kit Yee Chan, have noted that stigma can actually have a positive effect on a society's health.[2] 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.

Edward Green, former Director of the Harvard Research Project on HIV/AIDS Prevention, stated in his recently released book *Broken Promises: How the AIDS Establishment Has Betrayed the Developing World*, "…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."[3]

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[1] *See* Annex 1, "History of the Recognition of the Importance of Human Rights in the Context of HIV/AIDS, International Guidelines on HIV/AIDS and Human Rights, UNAIDS/OHCHR, 1998.

[2] Danel Reidpath and Kit Yee Chan, "HIV, Stigma, and Rates of Infection: A Rumor without Evidence," *PLoS Med* 3, no.10 (2006): e435.

[3] Green, Edward C., "Broken Promises: How the AIDS Establishment Has Betrayed the Developing World," PoliPointPress, LLC (2011), p.90. Dr. 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

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.

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. Violence against women should be condemned in *all* cases, but that is a separate issue from preventing HIV/AIDS.

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).[4] These studies show the dangers of confusing correlation with causation, as one could incorrectly conclude from these studies that wife-beating prevented HIV.[5]

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.”[6]

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 (and Lack of Education) Spreads HIV/AIDS

Another common myth is that the poorer the society (and the lower the education), the higher the prevalence of HIV/AIDS. However, data clearly show this is not the case, at least in Africa, here more income and more education is clearly associated with more sexual partners and higher HIV levels.

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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.

[4] World Health Organization, *Promoting Gender Equality to Prevent Violence against Women* (Geneva: WHO, 2005).

[5] Green, Edward C., “Broken Promises: How the AIDS Establishment Has Betrayed the Developing World,” PoliPointPress, LLC (2011), p.168.

[6] Roger England, “Coordinating HIV Control Efforts: What To Do with the National AIDS Commissions,” *Lancet* 367 (May 27, 2006): 1,786-89.

Fact: Wealth (and Higher Education) 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*."[7] In fact, evidence from the Departments of Health Services in Kenya and Tanzania demonstrates that poverty is not a risk factor for HIV/AIDS.[8] "The presumption, for example, that poverty increases vulnerability to HIV infection is challenged by studies such as an analysis of recent Demographic and Health Surveys (DHSs) from Africa, which shows a strong positive correlation between HIV prevalence and wealth in eight countries examined."[9]

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."[10]

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.[11] However, VCT also appears to have a darker side. There is some 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

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[7] Green, Edward C., "Broken Promises: How the AIDS Establishment Has Betrayed the Developing World," PoliPointPress, LLC (2011), p.178.
[8] D. Halperin and H. Epstein, "Concurrent Sexual Partnerships Help Explain Africa's High HIV Prevalence: Implications for Prevention," *Lancet* 363 (2004): 4-6.
[9] M. Potts, DT Halperin, D. Kirby, A. Swidler, E. Marseille, JD Klausner, N. Hearst, RG Wamai, JG Kahn and J. Walsh, "Public health. Reassessing HIV prevention. *Science*, Volume 320 (May 9, 2008):749-50.; available: http://www.hvtn.org/media/ReassessingPrevention.pdf.
[10] Ministry of Health (Uganda) and ORC Macro, "Uganda HIV/AIDS Sero-Behavioural Survey, 2004-5," Ministry of Health and ORC Macro, Calverton, Md., 2006, p. 106.
[11] 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, and HIV-incidence in Rakai, Uganda," presentation at the Uganda Virus Research Institute, Entebbe, Uganda, November 28, 2003.

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.[12]

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."[13] 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.[14]

VCT programs are also the most expensive non-drug methods for preventing HIV infections, at about four to five hundred dollars per infection avoided.[15]

Myth 6: Condom Distribution and Promotion Prevents AIDS

Much of the UN's efforts, related to HIV/AIDS prevention, have 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

Due to defects or inappropriate use, condoms can only provide partial protection and do not provide 100 percent or near complete protection as many claim. Since condom failures can sometimes result in a 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 **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.[16]

A 2002 UNAIDS study in four African cities found that condoms had virtually no measurable effect on HIV levels.[17] Another UNAIDS study "found no evidence that condoms alone had played a

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[12] J.K. Matovu, et al., "Sexually Transmitted Infection Management, Safer Sex Promotion and Voluntary HIV Counseling and Testing in the Male Circumcision Trial, Rakai, Uganda," *Reproductive Health Matters* 15, no. 29 (May 2007): 68-74.
[13] Green, Edward C., "Broken Promises: How the AIDS Establishment Has Betrayed the Developing World," PoliPointPress, LLC (2011), p.151.
[14] Green, Edward C., "Broken Promises: How the AIDS Establishment Has Betrayed the Developing World," PoliPointPress, LLC (2011), p.151.
[15] A. Creese, K. Floyd, A. Alban, et al., "Cost-effectiveness of HIV/AIDS Interventions in Africa: A Systematic Review of the Evidence," *Lancet* 360, no. 9336 (2002): 880.
[16] Susan Allen et al., "Effect of Serotesting with Counseling on Condom Use and Seroconversion among HIV Discordant Couples in Africa," *BMJ* 304 (June 20, 1992): 1605-9, 1607.
[17] Norman Hearst and Sanny Chen, "Condom Promotion for AIDS Prevention in the Developing World: Is It Working?" *Studies in Family Planning* 35, no. 1 (2004): 39-47.

major role in HIV prevalence decline, anywhere in Africa."[18] Yet UNAIDS continues to promote condom use above all other preventative measures as if these studies had never been done.

In fact, *increased* condom use often correlates with *greater* HIV risk.[19] According to Dr. Edward Green, "More condom use is associated with more casual and commercial sex and often higher – not lower – HIV infection rates.[20] 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.)[21]

Such findings have been replicated over and over again by other researchers. Perhaps the most interesting articles summarizing such findings are from James Shelton, with the Bureau for Global Health at the U.S. Agency for International Development (USAID). In his own words, he notes: "My devotion to condoms spans nearly three decades" and "I have steadfastly helped my agency provide billions and helped develop new ones, including the female condom."[22] Yet Shelton has publicly acknowledged that "**condoms alone have limited impact in generalised epidemics**. **Many people dislike using them (especially in regular relationships), protection is imperfect, use is often irregular, and condoms seem to foster disinhibition, in which people engage in risky sex either with condoms or with the intention of using condoms**."[23]

Shelton's intellectual honesty is based on overwhelming evidence from a variety of countries. For example, Tim Allen and Suzette Heald, from the London School of Economics and Brunel University respectively, found that the promotion of condoms at an early stage proved to be counterproductive in Botswana, whereas the lack (and distaste) of condom promotion during the 1980s and early 1990s helped the relative success of behaviour change strategies in Uganda promoted by its government (i.e., abstention before and fidelity within marriage).[24]

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[18] Norman Hearst and Sanny Chen, "Condom Promotion for AIDS Prevention in the Developing World: Is It Working?" *Studies in Family Planning* 35, no. 1 (2004): 39-47.

[19] P. Kajubi, M. R. Kamya, S. Kamya, S. Chen, W. McFarland, and N. Hearst, "Increasing Condom Use without Reducing HIV Risk: Results of a Controlled Community Trial in Uganda," *Journal of Acquired Immune Deficiency Syndromes* 40, no. 1 (2005): 77-82.

[20] *Broken Promises: How the AIDS Establishment Has Betrayed the Developing World* (2001), p. 209.

[21] Deborah Watson-Jones, et al., "Risk Factors for HIV Incidence in Women Participating in an HSV Suppressive Treatment Trial in Tanzania," *AIDS* 23 (2009):415-22. James D. Shelton, et al., "Partner Reduction Is Crucial for Balanced 'ABC' Approach to HIV Prevention," *BMJ* 328, no. 10 (April 2004): 891-93. Rand L. Stoneburner and Daniel Low-Beer, "Population-level HIV Declines and Behavioral Risk Avoidance in Uganda," *Science*, no. 304 (30 April 2004): 714-18. Halperin and Epstein, "Concurrent Sexual Partnerships Help Explain Africa's High HIV Prevalence," *Lancet* 363 (2004): 4-6. Hearst and Chen, "Condom Promotion for AIDS Prevention in the Developing World: Is It Working?" *Studies in Family Planning* 35, no. 1 (2004): 39-47.

[22] James D. Shelton, "Confessions of a Condom Lover," *The Lancet,* Issue 9551 (2 December 2006):1947-1949; available: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69787-0/fulltext.

[23] James D. Shelton, "Ten Myths and One Truth About Generalized HIV Epidemics," *The Lancet*," Issue 9602 (1 December 2007): 1809-1811; available: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61755-3/fulltext#aff1.

[24] Tim Allen and Suzete Heald. "HIV/AIDS policy in Africa: What has worked in Uganda and what has failed in Botswana," *Journal of International Development*, no. 16 (2002):1141–54; available: http://onlinelibrary.wiley.com/doi/10.1002/jid.1168/pdf. Tim Allen lived, taught and researched in East Africa from 1980–84, carried out doctoral fieldwork in northern Uganda between 1987 and 1991, and has subsequently worked on

A broader study by Rand L. Stoneburner and Daniel Low-Beer found that despite substantial condom use and promotion of biomedical approaches in Malawi, Zambia and Kenya, those countries have shown neither similar behavioral responses nor HIV prevalence declines of the same scale as in Uganda.[25] Shelton, Daniel Halperin, Vinaud Nantulya, Malcolm Potts, Helen Gayle and King Holmes—all experts in HIV prevention with long experience in the developing world—published evidence that where HIV prevalence has declined among pregnant women (Uganda, Thailand, Zambia, Ethiopia, Cambodia, and the Dominican Republic), the primary reported behavior change has been partner reduction and monogamy by men, especially older men, not increased condom use.[26] The list of studies indicating that condoms fail to adequately protect against HIV is long.

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** - **A**bstain (delay sexual debut), **B**e Faithful, then **C**ondoms.

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.[27]

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).

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several research, media and consultancy projects in Uganda and other parts of Africa. Suzette Heald did her initial doctoral fieldwork in Uganda in the late 1960s and has been involved in anthropological research in East Africa ever since. In 1997, she took up a two-year appointment to teach at the University of Botswana and carried out research on AIDS while she was there. Together with Tim Allen, she made a brief return visit to Botswana in July 2003, at the invitation of ACHAP (African Comprehensive HIV/AIDS Partnership).

[25] Rand L. Stoneburner and Daniel Low-Beer, "Population-level HIV Declines and Behavioral Risk Avoidance in Uganda," *Science*, no. 304 (30 April 2004): 714-18.

[26] James D. Shelton, Daniel Halperin, Vinand Nantulya, Malcolm Potts, Helen D. Gayle and King K. Holmes, "Partner Reduction is Crucial for Balanced 'ABC' Approach to HIV Prevention," *BMJ* 328 (2004): 891 (cited in David Wilson, "Partner Reduction and the Prevalence of HIV/AIDS," 328 *BMJ* (2004):848).

[27] Edward C. Green, "Broken Promises: How the AIDS Establishment Has Betrayed the Developing World," PoliPointPress, LLC (2011): 36.

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.[28]

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-Sahara Africa might have been prevented.[29]

In 2004, *The Lancet* printed a consensus statement which recommended ABC programs for populations with general epidemics, emphasizing fidelity and delay of sexual debut.[30] 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,[31] 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."[32] Even UNAIDS conceded in a 2009 regional report that fidelity deserves higher priority than condom promotion.[33]

Sadly, in the late 1990's, Western advisers began entering into Uganda, heavily promoting condom distribution, and undoing the remarkable progress which had taken place there. In the early to mid-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

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[28] G. Asiimwe-Okiror, A.A. Opio, J. Musinguzi. E. Madraa, G. Tembo, and M. Carael, "Change in Sexual Behavior and Decline in HIV Infection among Youhg Preganant Women in Urban Uganda," *AIDS 11* (1997): 1757-63.
[29] Arthur Allen, "Sex Change," *The New Republic*, May 27, 2002, available online at http://www.tnr.com/article/sex-change.
[30] D. T. Halperin, M. J. Steiner, M.M. Cassell, et al., "The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV," *Lancet* 364 (2004): 1,913-15.
[31] UNAIDS, *Evidence for HIV Decline in Zimbabwe: A Comprehensive Review of the Epidemiological Data* (Geneva: UNAIDS, 2005).
[32] Mark Dybul as quoted in Erika Check, "HIV Infection in Zimbabwe Falls at Last," *BioEd Online* (February 2, 2006).
[33] UNAIDS, "Strategic Considerations for Communications on Multiple and Concurrent Partnerships," March 2009.

attributable to phasing out of 'zero grazing' and other partner reduction/fidelity-focused campaigns of the late 1980s."[34]

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 "the three 'established' pillars of HIV prevention: condom promotion and distribution, voluntary counseling and testing (VCT), and treatment of other sexually transmitted infections (STIs)," even though they have all been shown to be ineffective—especially in Africa.[35] For example, prominent researchers, including Malcolm Potts, Daniel Halperin, Douglas Kirby and others, have looked at the three prevention pillars in light of a number of studies and trials, concluding that "the largest donor investments are being made in interventions for which evidence of large-scale impact is

[34] Uganda AIDS Commission, "National HIV and AIDS Strategic Plan 2007/8-2011/12: Moving towards Universal Access," Kampala, December 2007, ix. *See also* Genuis, S J and S K Genuis, HIV/AIDS prevention in Uganda: why has it worked? *Postgrad. Med. J*, Volume 81 (2005): 615-617; Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743381/pdf/v081p00615.pdf ("the recent increase in sexual risk taking behaviour (including a decline in abstinence and increase in multiple partners) since 1994 as well as the increased use of condoms . . . coincides with the recent increase in foreign sex education programmes that emphasise condom use and minimize the original ABC approach of the Ugandan administration.") (citation omitted).

[35] *E.g.,* M. Potts, DT Halperin, D. Kirby, A. Swidler, E. Marseille, JD Klausner, N. Hearst, RG Wamai, JG Kahn and J. Walsh, "Public health. Reassessing HIV prevention. *Science*, Volume 320 (May 9, 2008):749-50.; available: http://www.hvtn.org/media/ReassessingPrevention.pdf. The authors of this study are from the School of Public Health, University of California; Harvard University School of Public Health; ETR Associates, California; Department of Sociology, University of California; R. Lee Institute for Health Policy Studies, University of California; San Francisco Department of Public Health and the Department of Family; and Community Medicine, University of California.

increasingly weak, whereas much lower priority is given to interventions for which the evidence of potential impact is greatest . . . This balance needs to be reassessed."[36]

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 behaviors 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 behavioral 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.

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[36] *Ibid.*