



ADOLESCENT HEALTH AND DEVELOPMENT

PANEL QUESTIONS – PANEL #4

ABC & SEXUAL HEALTH

1. Why is there a belief that adolescents should not have sex? If they protect themselves what are the consequences (i.e. are there psychological or physical consequences)? Is the promotion of fidelity and abstinence "an unwarranted infringement in people's personal lives"?
2. What is the role of condoms in the reduction of HIV prevalence in Uganda? Who is using condoms, just the high risk individuals (sex workers, truckers) or is it the average single person in a premarital monogamous relationship?
3. What are the different patterns and dynamics of transmission between HIV in America and Africa?
4. Why has the abstinence movement been received differently in the United States versus Uganda? Why has abstinence education and the abstinence portion of ABC had different results on teenage sexual behavior?
5. Does education about condoms or abstinence change adolescents' sexual behavior or is it already determined by their social, economic, and family situation?
6. In working with youth, one of the changes I have seen since I was a teenager is the increased "popularity" of condoms. The youth I work with, who are sexually active, wouldn't leave the house without one and in my day we only used them if there was no other means of preventing pregnancy. I can't help but think that this is partially due to the ease with which they can be obtained and often at no cost to the young person. Would you agree that getting young people comfortable and familiar with condoms is an effective way to prevent unwanted pregnancy and STI's in adulthood?
7. It seems logical to me that a trifold approach would be most effective anywhere for most any public health problem. Especially, a problem that has human behavior at its core. What is at the root of the argument about promotion condom use as a viable means for preventing the transmission of AIDS?
8. In his writings, Dr. Green has made the argument that at least some segments of the "AIDS prevention industry" are more interested in profiting from their programs than in creating effective HIV-prevention interventions. What is the evidence to back up this claim? Aren't the majority of prevention programs run by nonprofits and governments?
9. AIDS orphans are a particularly vulnerable subpopulation who is at high risk for experiencing coerced or forced sex. Since abstinence, being faithful, and condom use are

often not options for this population--or for other vulnerable groups--what can be done to extend national policies beyond A, B and C?

10. Both panelists have written about the need for a balanced approach to HIV prevention that utilizes all components of the ABC strategy. Are there ANY contexts in which only 1 or 2 of the three components should be emphasized?
11. What do you think health professionals and policy makers must do to help the field of HIV/AIDS prevention get beyond the polarized debate of abstinence versus condoms?
12. **What ways has the "Coming Out of the Closet" era been harmful or helpful in reducing the isolation and marginalization of homosexual individuals? Was there another approach that could have been taken? And was it the role of Public Health to support openness without being for or against homosexuality?**
13. If it has been scientifically proven that homosexuality is a normal alternative why is society so inherently against this sexual preference? It seems that society's homophobia is magnified in schools, how do we address the school's environment to embrace differences as a whole? How do we then stem the pride and prejudice of family, peers and society?
14. If you believe homosexuality is a sin, I realize then you should provide help for adolescents to opening express their preference so they can get help, just like we want alcohols to be open and get help. Then what is the inherent fear driving the fabric of societies?
15. Considering experimentation with same-gender sexual contacts is often part of health adolescent development and accepting alternative sexual preferences it would seem a whole shift in how Human biology is taught or Human sexuality has to be addressed not only with health care providers but with society as a whole? Just as we are engaging people in discussion of discovery of genetics shouldn't we engage them in the discussion of human sexuality?
16. Since the psychosocial antecedents are most strongly related to sexual behavior why shouldn't the education system be equipping teens with informational skills, behavioral skills, motivational skills and decision making skills? It would seem the educational system needs revision and the countries goals needs to be revisited, America is sending people to war and equipping them, spending billions to destroy lives, should they not spend billions to build the country by investing in the lives of those who may be called to fight in the future?
17. The Uganda ABC approach, with a specific focus on the A, has been touted as a global model for HIV-prevention. Is it reasonable to promote an approach in various other contexts (example: U.S. Title X program) that may have only been extremely successful based on a specific set of changes in cultural practices at a specific time?
18. Both authors seem to agree that all three, A, B, and C had an impact. However the primary conflict is over the relative contribution of "C"-condoms- to the overall decline. In the current conservative, anti-family planning and contraception political climate, what are the policy implications for making the assumption that "C" had less impact than "A" and "B"?

19. Kirby's "historical factors affecting behavior" included a discussion of increased incidence of HIV infection in certain populations—including truck drivers, sex workers, and widows of men who died of AIDS in Rakai and Masaka who moved to Kampala. As public health professionals, is it an ethical violation to vilify condoms, and condom use, to these especially vulnerable populations?
20. To what extent does socioeconomic background relate to health behaviors of gay and bisexual youth?
21. What has been the effectiveness of media campaigns in reducing rates of sexually transmitted diseases among adolescents?
22. What is the long-term effectiveness of abstinence programs in maintaining abstinence among adolescents?
23. The approach to HIV prevention in Uganda that was most effective used the ABC campaign. That is, it encouraged abstinence, but was not an "abstinence only" campaign. Given the success of this approach and the marked decline of HIV among the population, what are the reasons opposing the United States to take a similar approach in the sex education of adolescents?
24. Since most adolescents are likely to either engage in sexual behavior during their teenage years (or at least before marriage) shouldn't condoms be available in areas (such as the nurse's office or health office of high schools) or in bathrooms in dorms that are easily accessible to college age students?
25. Most Americans, if asked, would probably not support an "Abstinence Only" campaign for sex education for adolescents. Since there is a considerable difference between "abstinence only" and "abstinence first" education, how can we encourage policy makers to frame the abstinence education policy so that it prioritizes this method but not excludes or minimizes education on condom use and STDs?
26. Although the cultural norms are different in Uganda than here in the West, heightened sexual curiosity, desire and risk-taking behavior is the same for all adolescents regardless of culture. Therefore, what are the reasons why school teachers, religious and community organizations cannot become more involved in educating young people with the ABC methods (similar to the implementation in Uganda)?
27. By limiting condom availability and access, many adolescents will be confronted by more barriers to engaging in protected intercourse. It is unlikely that all teenagers, or even the majority of them, will remain abstinent. Therefore, since teenagers will likely become sexually active naturally, shouldn't we empower them to make safe decisions regarding their sexual behavior?
28. Youth-friendly sexual and reproductive services are created with the purpose of encouraging youth to seek help to make sex safer, through the treatment of STI's, access to condoms and other contraceptives, and pregnancy information. Do you believe the provision of such services is contrary to abstinence-only education? And if so, how do you suggest dealing with sexually-active youth?

29. How do you think opinion surrounding the ABC approach and abstinence-only education affects funding and support for Title X (public funding for family planning and preventive health screening services)? Is it right that the two issues are mixed? In your opinion, how does this hurt or help the program?
30. One of the main arguments for abstinence-only education is the moral argument that youth cannot be taught a message that abstinence is the correct choice in conjunction with other options for contraception, HIV protection, etc. But clearly, the Uganda example shows that several factors came into play in controlling and mitigating the spread of HIV. With this evidence at hand, should our goal be based on morals, or on evidence on what works to minimize the spread of HIV? As a society, and as public health professionals, where should our values lie?
31. 1. Since STDs and teen pregnancy rates are higher among African American and Hispanic teens than white teens, should classes and programs which teach sexual education to this minority population really be focusing more on abstinence or on safe sex? If the sexual education program's main focus is abstinence, at what age should schools begin teaching this concept to children? If the program's main focus is on safe sex, at what age should the children begin to learn about this subject? Should minorities and whites be taught sexual education differently?
32. Given that 3 million teenagers acquire an STD every year and that the U.S. teen pregnancy rate is very high, do you think that contraceptives are being utilized properly? If not, what methods of contraceptive should we be focusing on to cut down on the pregnancy and STI rates in the United States?
33. Have condoms contributed significantly to the decrease in teen pregnancy here in the United States? If so, how do we get teenagers to consistently use condoms as they get older and more sexually experienced?
34. As Dr. Blum strongly emphasized in class, does condom usage have a disinhibiting effect on sexual behavior? Does the effect depend on age or culture?
35. With a growing awareness of HIV and AIDS, how are people with HIV/AIDS treated by others? Are they isolated or helped?
36. The Uganda HIV/AIDS intervention appears to have come from the top down. Meaning that the intervention began with the President who further initiated the involvement of the community, schools, and family. Do you think that public awareness and interventions would have been as quick and successful as it was if it began at the community level?
37. The class was given papers on HIV/AIDS prevalence and its associations with gay and lesbian youth. Does this suggest that the U.S. still regards HIV/AIDS with gays and lesbians? Should interventions be targeted towards gays and lesbians?
38. Does regulating condom use have a role in improving adolescent health?

39. Should government regulate media portrayal of sex to promote healthy adolescent sexual behavior? Or, can media be used as a powerful tool to promote healthy sexual adolescent behavior?
40. Adolescent sexual and reproductive health is a complex and multifactorial issue. If you had to choose one intervention to devote all your resources to, what would the intervention be?
41. If the lesson learned from Uganda is the need for a comprehensive, multi-faceted approach to HIV prevention, supported by the government, donors, the media, civil society, and leaders who are willing to speak the truth about HIV/AIDS, why has the U.S. reserved (at minimum, under law) 1/3 of its global HIV funding for "abstinence until marriage" programs? Could this be another example of the U.S. ("Westerners") dictating the priorities and agenda of HIV prevention in other countries?
42. If in fact, marriage is not a protective factor (...but possibly a risk factor) for HIV transmission in young women in sub-Saharan Africa, what are the implications for ABC? How does the ABC approach account for gender inequalities? How does ABC apply to discordant couples, especially women who may not have a say in A, B, or C with their husbands or partners?
43. Is it possible to simplify a topic as complex as HIV prevention to A, B, & C? Where does HIV testing come in?
44. In the context of HIV prevention, what is the risk of focusing only on abstinence? Or only on condoms?
45. If we are to look at countries that have been successful in reducing the spread of HIV, we must also consider Thailand, the Dominican Republic, and Brazil. How do HIV prevention approaches compare/contrast in Thailand, the Dominican Republic, Brazil, and Uganda?
46. How might the lessons learned from the Uganda ABC campaign be transferred to other country settings? How might different cultural influences affect the programming implications and outcomes?
47. Research shows that many family planning providers in developing countries will not provide contraception to unmarried, sexually active adolescents due to personal beliefs and biases regarding a minimum age for family planning and marital status. Because puberty is occurring earlier and age at marriage is occurring later, this leaves many unmarried, sexually active adolescents at risk for pregnancy, pregnancy-related complications, and STIs, including HIV/AIDS. How might a program target such medical barriers to increase contraceptive access for adolescents?
48. Which is of greater concern for adolescents in developing countries--protection against HIV/AIDS or pregnancy prevention? Which issue is of more concern to policy makers? How can programs address the importance of dual protection for adolescents?
49. How does the HIV/AIDS epidemic affect where and how adolescents learn about sex? For example, many adolescents in sub-Saharan Africa traditionally received information about

sex from a relative. Because of the HIV/AIDS epidemic, however, many social structures are being radically altered in sub-Saharan Africa and the traditional "sex educators" are no longer present to fulfill that role. What are the effects of this shift on the sex education of adolescents?

50. Does promoting tolerance of LGBT youth in communities, encourage youth to explore this lifestyle and perpetuate the psychosocial affects that may result?
51. Have studies been conducted that look into the differences in quality of life between LGBT youth in conservative areas versus liberal areas (i.e. rural Midwestern LGBT youth vs. LGBT youth in San Francisco)? Should more programs focus on educating and building a more tolerant community?
52. Should sexual education programs incorporate information regarding LGBT issues? Do programs of this quality exist? Has the effectiveness of such programs been assessed?
53. The Green article brings up an interesting argument about the financial interests of all the players involved in "fighting" the AIDS epidemic in Africa. It is clear that big businesses like pharmaceutical corporations drive the market for drugs in the US as well as in countries who receive US aide. Do you believe that those with large investments are standing in the way of progress toward eliminating, or significantly decreasing the AIDS epidemic, to protect their profits?
54. The Ugandan behavioral change programs have shown to be effective in reducing the number of new AIDS cases in the country, yet it is still not widely implemented. The article credits the success of the program to locally driven and culturally appropriate public interventions. What is preventing other countries in Africa from adopting this model?
55. Have the infection rates in Uganda continued to decline at a fairly steady pace? If so, has the Ugandan model effectively modified the behavior of its citizens?
56. How Does Uganda compare to other countries in Africa? Is there a different population demographic that would explain why this program was so successful in Uganda, and why it may not be so effective elsewhere?
57. Who funded the Ugandan ABC campaign? Based on this model, do you think financial supporters, such as the US, should allow countries to design their own culturally-specific AIDS campaigns, and thus play a less significant role other than financial support?
58. Is there any evidence to support the effectiveness of Abstinence in HIV prevention among adolescents and if there is none, on what basis is abstinence a national policy?
59. What role did abstinence play in the reduction of HIV prevalence rate in Uganda?
60. Since more females seem to be having sex earlier than males, we can conclude that they are having sex with older men (adults). Should intervention be targeted at improving negotiation skills in female adolescents? Is this already being done domestically and internationally and if so are there effects of its effectiveness?

61. If age of sexual debut is decreasing among adolescents, at what age should sex education start, middle school? elementary school? and what should it consist of?
62. Data from other research including the Rakai Project has shown that HIV prevalence rates is higher among married or ever married individuals (In the Rakai data only 11% and 6.3% of HIV positive women and men respectively) were never married. Further, given that a significant proportion of sexually active individuals in Uganda are married, to what extent can we credit Abstinence only for the reductions in HIV prevalence in Uganda. Can we as public health professionals responsibly rely on abstinence only in a population where marriage and cohabitation is prevalent and nearly 50% of men are polygamous?
63. While the age at sexual initiation in Uganda has increased, there is evidence to suggest that there was no reduction in the number of sexual partners sexually active youth had over the period during which HIV prevalence declined (Alan Guttmacher Institute, 2003, The Approach to HIV Prevention: A Policy Analysis). Further, age at sexual initiation has increased in other African countries that didn't have programs targeting abstinence. How does this affect our understanding of the role of abstinence education in HIV prevention based on the Uganda experience?
64. While the proportion of sexually active youth in the US has dropped, a meta-analysis of evaluated abstinence only programs in the US has found very limited effectiveness in the ability of such programs in reducing sexual activity (Monica Silva, 2002, The effectiveness of school based sex education programs in the promotion of abstinent behavior: a meta-analysis, Health Education research, 17:4). What other evidence is there in support that abstinence works? Further is it ethical to promote an abstinent only approach knowing that it is not consistent with what many young people are going through?
65. Determination of what factor contributed most to the reductions in Uganda is highly dependent on the time when HIV incidence began falling. However, it does not seem like researchers can pinpoint the exact time. Further, researchers from the Rakai project have argued that the decline in the prevalence rate is highly influenced by mortality. Can you comment.
66. The national survey (NSFG2002) revealed that more adolescents (aged 15-19) practice abstinence, postpone the first intercourse until later age, and when they engage in sexual activities they are more likely to practice contraception than 5 years ago. The survey also revealed that adolescents aged 15-17 and 17-19 behave differently, and as a result there seems to be a threshold in age in first intercourse in the US. Consistent contraception practice is strongly positively correlated with the age of sexual initiation, and when they become sexually active at later age, they are better contraceptive users. Can we suggest a policy to mandate 12 years education? This could be a cheaper alternative than spending over \$ 150 million of federal funding for abstinence-only –until marriages and spending of >\$ 7 billion /year for teenage pregnancy. Coupled with the delayed age of first marriage, abstinence-only –until marriage is not realistic, but if 12 years education for everybody may help avoiding many adolescents engaging sexual intercourse before 17.
67. Countries where condom is not a norm of contraception/STI prevention because it has not existed, how introducing it would affect on people's behaviors? Does condom represent sex as risky business? These were questions raised in the today's class. Countries where

condom has been perceived as main contraceptive method because of national history of contraception (OC was FIRST approved in 1999 in Japan), there is no discrimination of condom use. However, STIs prevalence is not negligible in Japan because women often wait to see OBGYN until something actually happened, not because they switched methods from condom to OC immediately after it became available. In fact, OC use among Japanese women has not changed since its approval. Also, OCs have been perceived to represent women's sexual liberty, or even promiscuity. Both examples above suggest that the cultural or normative boundary against new contraception must be significant in anywhere. Without a single contraceptive method that works both STIs and preventing pregnancy, eliminating discriminations against any new method is important. What kind of research can identify developmentally-culturally-locally appropriate programs to work better in the US not to disinhibiting adolescent sexual behaviors? Isn't a state too big to treat as a unit of geographic area to operate its own program, knowing ethnic diversity and income inequality within a state is big?

68. Whether or not the first sexual intercourse was forced, adolescents repeat sex in 6 month. (I have a reference on this) Family and social environment are critical factors of event of forced sex. If an abstinence-only is the national policy, this policy must target not only adolescents (as victims), but address factors and what happening within a family where perpetrators often reside. What kind of policy/program, which is nested in abstinence-only program, can target parents and family members not to abuse their kids or protect from outsiders?
69. How are inability to separate the effects of A B or C cloud our views of the programs and how we fund HIV program?
70. What are the policy implications for supporting one aspect of the program over another? what are the health implications?
71. What are the implications for the future practice of public health and health communication if we are constantly changing the message and contradicting ourselves? What effect does the politicalization of HIV programs have on our ability to be effective?
72. Why must we prove that only AB or C worked better? why can't we see it as a multipronged program that is integrated, with each part supporting the other and that no one piece is better but as a whole it is a very effective program.
73. Edward Green's paper on the ABC model in Uganda argues that the ABC model has worked in Uganda because the ideas of fidelity and abstinence paralleled African ideals and values and that Western ideologies that aim to promote condom use reflects a culture clash that plays out in HIV/AIDS prevention. Where else in the world do you see a culture clash in our prevention/public health strategies?
74. To whom should condom usage be promoted? What are the effects of condom use on sexual behavior, sexually transmitted infections, particularly HIV/AIDS?
75. There is a broad range as well as variable definition of abstinence-only programs in the United States. Which aspects of abstinence-only programs work and what haven't?

76. There exists a large divide between "left-wing" and "right-wing" approaches to attacking issues related to sexuality, such as teenage pregnancy, abortion, and HIV/AIDS. Can any type of middle ground be struck? Do you foresee an agreement that two sides can reach?
77. There is great fear and concern about sexuality among adolescents in the United States. The most hotly debated controversies currently center on parental notification of abortion and over-the-counter access to emergency contraception. While the current administration wants to assume that encouraging abstinence and marriage are the best practices for prevention, how do these programs meet the needs of all adolescents? Where then should sexually active adolescents receive information about contraception?