

# Going Beyond “ABC” to Include “GEM”: Critical Reflections on Progress in the HIV/AIDS Epidemic

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A considerable number of studies have sought to identify what factors accounted for substantial reductions in HIV seroprevalence after several countries deployed “ABC” (abstinence, be faithful, condom use) strategies. After much public discourse and research on ABC success stories, the Joint United Nations Programme on HIV/AIDS 2004 epidemic report indicated that nearly 50% of infected people worldwide were women, up from 35% in 1985.

In light of the feminization of HIV/AIDS, we critically assess the limitations of ABC strategies. We provide 3 additional prevention strategies that focus on gender relations, economics, and migration (GEM) and can speak to the new face of the epidemic. Pressing beyond ABC, GEM strategies provide the basis for a stronger central platform from which national efforts against HIV/AIDS can proceed to reduce transmission risks. (*Am J Public Health*. 2007;97:13–18. doi: 10.2105/AJPH.2005.074591)

**MANY STUDIES HAVE** sought to identify what factors accounted for substantial reductions in HIV seroprevalence in Uganda, Thailand, and other countries. A shared characteristic of these HIV/AIDS “success stories” is that these countries deployed specific combinations of “ABC” (abstinence, be faithful, condom use) strategies.<sup>1–13</sup> After much public discourse and research that emphasized the positive outcomes of ABC strategies, the Joint United Nations Programme on HIV/AIDS published its 2004 epidemic report.<sup>14</sup> The report revealed a new face of HIV/AIDS; nearly 50% of infected people worldwide were women, up from 35% in 1985. In nearly every region of the world, the number of women living with HIV/AIDS has risen, and, in most regions of the world, women and adolescent girls represent an increasing proportion of people living with HIV/AIDS.

The Joint United Nations Programme on HIV/AIDS report also detailed that in several countries, 50% of new infections were occurring between spouses and that women were most often at risk from their main male partner. In the 1970s and 1980s, there was the “feminization of poverty,” a phrase used by researchers to convey that women disproportionately lived in poverty.<sup>15–17</sup>; similarly, we now have a “feminization of HIV/AIDS.” The evidence from these studies reinforces the necessity of placing comprehensive, long-term efforts

that focus on gender relations in the forefront of the fight against HIV/AIDS.

Given that the populations being affected by infection are shifting, it is more urgent than ever to press forward with approaches that are long term and gender specific and that attempt to fundamentally change the contexts in which risk occurs. In this article, we first provide a critical analysis of the limitations of ABC approaches. Next, to counter the limitations of ABC, we offer 3 additional prevention strategies that focus on gender, economics, and migration and will assist with the long-term minimization of HIV/AIDS risks. These 3 strategies provide the basis for a stronger central platform from which national efforts against HIV/AIDS can proceed to reduce transmission risks. These prevention strategies are better able to take the new face of the epidemic into account.

## LIMITATIONS OF ABC

It is instructive to examine ABC success stories from a gendered perspective. In Uganda, for example, there were significant reductions in overall HIV seroprevalence from 1997 to 2001. However, in 2002, persistent differences remained between young women and men, with 2.4% of young men and 5.6% of young women aged 15 to 24 years affected by the virus. Furthermore, although there were significant reductions in incidence during the same

period, the male-to-female ratio for new HIV infections in 2002 was 1:5 in Uganda. There are numerous other examples of regional specificities that underscore gender differences.<sup>14</sup> One must therefore ask several key questions to facilitate rigorous examinations of the success of ABC. When HIV/AIDS prevention successes are attributed to some combination of ABC strategies, who actually enjoyed the benefits of success? For how long does a region actually maintain success? If successes begin to recede, what are the reasons for these changes? Do these changes tell us about which strategies we should consider successful in the fight against HIV/AIDS? To be considered successful, HIV/AIDS intervention strategies should critically engage with the reasons for the differences in rates of infection that are found between heterosexually active females and males.

The data just presented underscore the first clear limitation of ABC approaches: the underlying assumption that individual decisionmaking is the key site for risk minimization.<sup>18–22</sup> This assumption ignores or negates the gendered contexts in which individuals attempt to enact behavioral change. Recent research confirms that women’s relationship power level plays a vital role in facilitating or hindering protected sexual intercourse.<sup>23,24</sup> Women’s lack of property rights, differential access to literacy and education,

lower wages, and lack of assets also shape their HIV/AIDS risks.<sup>25–28</sup> Research also confirms that sexual double standards, harmful cultural practices (e.g., widow cleansing, a practice that involves a widow having sexual relations with a relative of her late husband), and sexual violence structure women's HIV/AIDS risks.<sup>25–35</sup> Echoing numerous researchers, the executive director of the United Nations Population Fund, Thoraya Obaid, argued

Abstinence is meaningless to women who are coerced into sex. Faithfulness offers little protection to wives whose husbands have several partners or were infected before marriage. And condoms require the cooperation of men. The social and economic empowerment of women is key.<sup>18(p2)</sup>

A second success story reveals a second limitation of ABC strategies. Thailand experienced much initial success with its structural intervention that enforced 100% condom use in collaboration with brothel owners, sex workers, clients of sex workers, and the police.<sup>1,12,36–39</sup> But the Asian financial crisis caused widespread unemployment, which worsened the economic situation, particularly for women and youths.<sup>37,38</sup> Because of waning economic opportunities, girls and women—particularly sex workers—found it difficult to insist on condom use. Further more, there is evidence that women and girls facing economic duress are more likely to acquiesce to sexual intercourse with no condoms when men offer more money for condomless sexual intercourse.<sup>36,38</sup> In this context, HIV incidence levels began to rise among new sex workers.<sup>37</sup> ABC

approaches do not take into account economic contexts at all, even though prevention researchers have identified the critical intersection of poverty and women's HIV/AIDS risks.<sup>40,41</sup>

A third clear limitation of ABC strategies is that these approaches are for individuals who face static conditions and unchanging geographic locations. However, research clearly underscores that HIV/AIDS risks can be exacerbated by economic destabilization and migration flows in particular. Such movements entail separation from partners and provide opportunities for more sexual interactions, thereby enabling transfer of infection from high seroprevalence areas to lower ones.<sup>42–47</sup> Although dominant migration patterns involve men acquiring HIV when away from home and then returning to rural female partners, there is evidence that women with absent migrant male partners also become infected outside of their primary relationship.<sup>48</sup> The ABC strategies fail to recognize the massive increases in migration around the world—both cross-border and internally.<sup>49–51</sup> Instead, the solutions the ABC approaches offer are reduced to static individualized behaviors and morality (e.g., “be faithful”).

## THE WAY FORWARD

To move beyond the limitations of ABC, and to emphasize longer-term, comprehensive, and gender-focused HIV/AIDS prevention, we propose 3 additional prevention strategies—gender relations, economic contexts, and migration (GEM)—and add these to the current prevention discourse.

## Gender-Specific and Gender-Empowering HIV Prevention Interventions

Researchers made early calls for gender-specific interventions, but it is only over the past decade that HIV prevention programs have recognized and incorporated this perspective. Since then, a crucial transition has occurred from gender-neutral to gender-focused and gender-empowering interventions.<sup>25,28</sup>

Research first pressed beyond the rationalist assumption that women can simply and freely enact condom use, emphasizing that its use is embedded in gender relations and women's relationships with male partners.<sup>25,29,52</sup> Prevention researchers designed interventions to improve women's safer sex negotiation skills and to increase awareness that women's own monogamy does not guarantee the safety of their partners.<sup>53–58</sup> Researchers also sought to understand the relationship between traditional gender roles and risk, examining how men were socialized to initiate and expect sexual intercourse, whereas women tended to be centered on 1 partner and oriented their sexuality toward their partners' needs.<sup>59–60</sup> By applying the knowledge gained from an understanding of relationship contexts, researchers began to successfully intervene directly at the individual and couple level.<sup>53,54,61</sup>

A second key component of gender-specific interventions included an expansion of women's repertoire of methods and skills beyond the male condom to include female-initiated methods (female condom); nonpenetrative sexual contact, or outercourse; and refusal skills. Several of these gender-specific interventions at

the group and couple level were successful and have been reviewed extensively elsewhere.<sup>25,34,56</sup> Gender-focused interventions also identified the dilemmas that arise from the competing wishes of preventing HIV/AIDS and other sexually transmitted diseases and having children, particularly because condoms do not adequately speak to this tension.<sup>25,29</sup>

A third wave of successful interventions, based on Robert Connell's structural theory of gender and power,<sup>56–58</sup> elaborated on how the interrelated domains of labor (both paid and unpaid), power (authority and decisionmaking), and cathexis (emotional investments) shape HIV/AIDS risks.<sup>23,24,56</sup> Most recently, gender-specific prevention interventions have moved beyond an emphasis on women and femininity to theorize about how gender relations and masculinities contribute to risk, targeting heterosexually active men. These types of programs are ongoing and examine how masculinities contribute to risk by focusing on the costs of masculinity, i.e., the harm caused to both men and women when men adhere to narrow and constraining definitions of masculinity, and aim to create more gender-equitable norms while reducing violence against women.<sup>62–64</sup>

## Economic and Educational Contexts and Structural Interventions

Governments, nongovernmental organizations, and community groups are increasingly recognizing evidence suggesting that the relative economic disadvantage of females compared with males significantly increases the likelihood of unsafe sexual contact.<sup>40,65–69</sup> In response, and

in combination with an emphasis on poverty reduction, several governments (e.g., Thailand, India) and nongovernmental organizations have embraced efforts to keep girls in school—or to pay for their fees for school—as a way to diminish the chances of early pregnancies, increase safer sex practices, minimize HIV/AIDS and other sexually transmitted disease risks, and keep girls out of sex work.<sup>65–66</sup>

Worldwide, as many as 100 million children and teenagers—almost two thirds of which are girls—do not attend school at any point in their lives.<sup>67</sup> This shortage of girls in school is often because families give boys priority over girls when allocating their scarce resources for education. Families generally pull girls out of school before boys when families are affected by the impact of HIV/AIDS because girls are responsible for helping families when household crises strike. Some researchers, nongovernmental organization leaders, and community groups argue that eliminating school fees could provide a much-needed structural HIV/AIDS prevention intervention that would contribute to reductions in risk.<sup>65–67</sup>

Although governments and research organizations are slowly incorporating gender-specific structural innovations into their programs,<sup>68,70,71</sup> HIV/AIDS intervention research lags behind in this area.<sup>20,72,73</sup> In “Gender-Specific and Gender-Empowering HIV Prevention Interventions,” we noted several successful interventions that drew upon Connell’s structural theory of gender and power. Although this tripartite theory (labor, power, and cathexis) has certainly aided understandings of HIV/AIDS risks, only 2 of the 3 domains of

Connell’s theory of gender and power have been operationalized and validated to form a scale that formally measures relationship power, called the Sexual Relationship Power Scale. High sexual relationship power has been found to be associated with consistent condom use and is negatively associated with relationship abuse. The first domain of Connell’s theory—labor (both paid and unpaid)—was not included in the measurement of relationship power. Connell’s second domain, power, is defined as decision-making dominance in the Sexual Relationship Power Scale, and the third domain, cathexis, has been defined as relationship control.<sup>23,24</sup> The omission of labor is surprising, as the relationship between economic disenfranchisement and HIV/AIDS risks is already well established.<sup>40,73</sup> New efforts that seek to further define and detail the important connections between resources, women’s empowerment, and health outcomes are promising and sorely needed.<sup>74,75</sup>

Simultaneously, there is growing interest in merging economic interventions with gender equity and HIV/AIDS prevention interventions.<sup>75–79</sup> Such structural approaches are vital, because increased access to financial independence has been linked to bargaining power in relationships, status in the community, and decisionmaking in the family and can offer alternatives to sex work,<sup>72,78,79</sup> all of which may help to minimize HIV/AIDS risks. However, economic (or educational) interventions alone may not assist women in changing male sexual behavior or enforcing monogamy. This fact points to the simultaneous need for educational, economic, domestic violence, and gender-specific

HIV/AIDS prevention interventions that are culturally specific.<sup>70</sup>

### Migration and Population Movements

Few countries explicitly include migrants in their national strategic plan for HIV/AIDS. Protecting the health of migrants will require multisectoral leadership across multiple segments of society and sound policies for workplaces, borders, and informal market activities. As long as national and sectoral policies do not include mobile populations, research and programmatic efforts to assist these populations will surely fall short.<sup>43,80</sup>

To date, HIV/AIDS prevention interventions for migrants have largely focused on men who are truck drivers, sea farers, uniformed servicemen, and traders, assuming that they are the ones who engage in risky sexual behaviors. However, massive numbers of women workers also flow into large industrial centers, particularly for work in domestic service, other service-oriented jobs, or entertainment industries. Some of these women travel to multiple destinations within and across countries; this continual cycling between higher and lower HIV seroprevalence locations can increase women’s and men’s risk of becoming infected. Several program reports clearly delineate how reductions in HIV/AIDS risks for migrants must come from targeting not only the destination points but also the multiple points of entry and return paths of the migration process.<sup>43,45,46</sup>

Programs that attend to migrants are especially needed because globalization and policies of liberalization did not simply open up global trade markets, they necessitated that countries

had to contend with structural adjustment programs. Structural adjustment programs were programs that governments followed to receive International Monetary Fund and World Bank loans that allowed poor nations to substantially increase participation in global trade. Many governments in poor nations tended to respond to structural adjustment programs by spending much of their assets on paying back high-interest debt, leaving little money for health care and education. Structural adjustment resulted in massive migration flows as women and men left economically destabilized areas to search for work. Researchers believe women’s HIV/AIDS risks are exacerbated by structural adjustment programs because poor women in particular suffer even greater economic vulnerability under these policies. Some researchers argue that structural adjustment depressed income among the lowest socioeconomic sectors of the population, where women were often disproportionately located, and increased women’s vulnerability to HIV/AIDS.<sup>81–85</sup> Recently, researchers have theorized that “sexual opportunity structures,” i.e., structural factors that create increased possibilities for sexual interaction, result at the intersection of poverty, migration, and gender relations, leading to unique environments of risk, especially for heterosexually active married women.<sup>86–89</sup>

HIV/AIDS researchers can bolster efforts to help migrants by furthering their understandings of the structural properties of migrant social networks (e.g., size, density, geographies of space) and the networks’ relationship to HIV/AIDS risk.<sup>86,89–91</sup> Evidence suggests that there may also be



value in providing migrants with HIV/AIDS information and negotiation skills and offering additional supports, such as job skills, credit and financial assistance, and integrating sexual and reproductive health needs with HIV/AIDS prevention for both men and women.<sup>38,46,92</sup> Calls for abstinence and faithfulness are largely out of touch with these needs, which require gender-focused and multisectoral strategies to shape individual or group behaviors over time.

## CONCLUSIONS

In a context of burgeoning discourse on stories of ABC success and renewed emphasis on abstinence-only approaches,<sup>19,22</sup> there have also been recent calls from senior HIV/AIDS researchers for the research community to look to the important role that ABC strategies can play, embrace the ABC strategies, end the polarizing debate, and urge the international community to unite around an “inclusive evidence-based approach.”<sup>93(p1913)</sup> These authors<sup>93</sup> offer numerous important strategies to slow the spread of HIV/AIDS. But the face of HIV/AIDS is undoubtedly changing. The virus is no longer confined to high-risk populations; it is becoming increasingly feminized and it is clearly linked to cumulative patterns of gender inequality, economic disruption, and population movements. Around what “inclusive” strategy shall the international community unite?

If the research community moves to rally further around the need for ABC strategies, what will undergird this rallying point? The driving principle underlying ABC strategies is that of scaling individual behavioral

interventions to fit the population level. Just as individually focused HIV/AIDS prevention interventions first ignored gender relations, gender inequality, and the broader forces that shape behavior, ABC is facing similar limitations.<sup>20,21,28,87,94</sup> In the third decade of the epidemic, it remains vital to not just emphasize how individuals need to change and maintain their own behaviors. Rather, we must also emphasize how successful prevention strategies need to take into account gender relations, other relations of social inequality, economic contexts, and migration movements. These strategies will best sustain behavioral changes in the contexts that drive risk. The breadth and the maintenance of success rely on united work in these areas. The new face of the epidemic speaks strongly to the urgency of these efforts. ■

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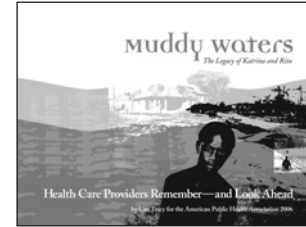
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