online at http://www.safeschoolscoalition.org.au/uploads/1dd74255c1091bb724ea0c7aa03292a4.pdf; see also Jones, 10.

[9] US Department of Health and Human Services, *Sexual Orientation and Health among U.S. Adults: National Health Interview Survey, 2013*. National Health Statistics Report 77 (15 July 2014), at 3, online at http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf; Smith et al. found that only 2.5% of adult men and 2.2% of adult women in Australia self-identify as gay, lesbian or bisexual.

[10] Ibid, 3,

[11] Savin-Williams et al, 387.

[12] Ibid.

[13] Ott et al, 12; Mock et al, 646.

[14] Savin-Williams et al, 393. This fluidity casts serious doubt on the strategy of the 'Safe Schools Coalition' that by-passes education authorities and appeals directly to secondary school students to promote what it claims to be a 'safe schools' agenda – see Safe Schools Coalition Australia, *Safe schools do better.* The data on non-heterosexual instability among adolescents suggest that this strategy is seriously misguided.

[15] Mock et al, 645 attributes the stability of heterosexuality to its normative status, but the data also support the alternative hypothesis: that heterosexuality is normative because it is the most stable sexual orientation for adults.

[16] This claim underpins the proposals of Jones and the Safe Schools Coalition.

[17] There seems to be no agreed objective basis for including all of these in a single amorphous category, yet the LGBTI designation is a commonplace in the literature. 'Intersex' refers to a range of recognised objective medical conditions which may require a variety of treatments up to and including surgery; 'gay', 'lesbian' and 'bisexual' are subjective self-reports which may be based on a range of shifting criteria as discussed in the text; 'transgender' can refer to an intersex person who has undergone a form of 'gender reassignment,' or one who deals with gender dysphoria of a more or less psychological nature by adopting the dress, behaviour and other characteristics associated with another gender. Despite this confusion, the 'LGBTI' designation will be retained here for the sake of convenience; it should be interpreted as referring to students who, at particular moment in their adolescent development, believe themselves to be same-sex oriented.

[18] A range of data on the incidence and effects of sexuality-based bullying are presented in Guasp, and Jones.

[19] Guasp, 4.

[20] Some notable contributions include: Peter Norden SJ, *Not So Straight: A national study examining how Catholic Schools can best respond to the needs of same sex attracted students* (Richmond, VIC: Jesuit Social Services, 2006), online at http://www.nordendirections.com.au/presentations/NSS.pdf; Education Commission of the Ontario Conference of Catholic Bishops, *Pastoral Guidelines to Assist Students of Same-Sex Orientation* (Ontario: Ontario Conference of Catholic Bishops, 2004, online at http://acbo.on.ca/englishdocs/Pastoral%20Guidelines.pdf; United States Conference of Catholic Bishops, *Ministry to Persons with a Homosexual Inclination: Guidelines for Pastoral Care*, 2006, online at http://www.usccb.org/issues-and-action/human-life-and-dignity/homosexuality/upload/minstry-persons-homosexual-inclination-2006.pdf; and Barbara L. Frankowski et al, "Sexual Orientation and Adolescents: Clinical Report – Guidance for the Clinician in Rendering Pediatric Care," *Pediatrics* 113 (2004): 1827-1832, online at http://pediatrics.aappublications.org/content/113/6/1827.full.pdf. These very considered, professional and highly nuanced contributions stand in marked contrast to those of Guasp, and Jones.

[21] Norden, Recommendations 6.2, 6.4, 6.5 and 6.6.

[22] Norden, Recommendations 6.3, 6.9, 6.14-6.17.

[23] See Second Vatican Council, *Gaudium et spes,* Pastoral Constitution on the Church in the Modern World (7 December 1965), nn. 12-18, online at Holy See, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html

[24] Frankowski et al, 1828.

[25] Frankowski et al, 1830.

[26] For a fuller discussion of clinical issues, see Frankowski et al, passim, on which these considerations are based. On pastoral support for parents and families of students who 'come out', see Bishops Committee on Marriage and Family, United States Conference of Catholic Bishops (USCCB), *Always Our Children: A Pastoral Message to Parents of Homosexual Children and Suggestions for Pastoral Ministers, Origins 28, no. 7 (2 July 1998): 97, 99-102, online at USCCB,* http://www.usccb.org/issues-and-action/human-life-and-dignity/homosexuality/always-our-children.cfm

[27] See Norden, Recommendation 6.21; Jones, 35 & 38; Guasp, 13 -14, 27.

All online references accessed 3 September 2014

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Preventing the Sexual Transmission of HIV/AIDS

There was once a strong belief amongst global HIV/AIDS organisations that the key to the prevention of the sexual transmission of HIV was condom (C) use. Other measures such as abstinence (A) and being loyal (B) to one partner were seen as beneficial, but secondary. Thirty years later, the evidence is mounting that behavioural change (A and B) is much more effective in halting the spread of HIV than condoms.

Since the HIV/AIDS pandemic was declared in the 1980s, control of the spread of HIV infection[1] has been variable. In 2012, there were 2.3 million new infections recorded. HIV is spread through blood, semen, pre-seminal fluid, rectal and vaginal fluids and breast milk. It is mainly transmitted through sexual intercourse, exposure to infected blood or blood products,[2] and perinatally through pregnancy and breastfeeding. The predominant mode of transmission is sexual intercourse.[3] Factors which influence the risk of transmission include the frequency and type of sexual activity,[4] male circumcision, and some sexually transmitted infections (STIs). These in turn are impacted by social, cultural and environmental factors.[5] This paper will focus on the sexual transmission of HIV. It will argue that the key to addressing the HIV/AIDS pandemic is not solely nor primarily condom use, but changing perceived sexual behavioural norms.

There are essentially two competing views about sexual intercourse. The first holds that the only proper 'place' for sexual intercourse is within a lifelong committed relationship. Within that relationship, sexual intercourse expresses the total self-giving of each person to the other. It should also be open to procreation. The second view sees sex simply as a pleasurable activity, irrespective of the

relationship of the two individuals involved, as in the sex trade. These two different moral perspectives have led to different emphases in approaches to preventing HIV transmission through sexual intercourse.

The Sexual Act as an Expression of Total Self-giving Love

This view of sexuality was and is the cultural norm in many societies – including pre-colonial South Africa[6] and Uganda.[7] It is the vision of sexuality expressed in many of the religions of the world – including the Catholic Church. The Catholic Church teaches that sexual intercourse is the ultimate expression of union between a husband and a wife, who "become in a way one heart and one soul, and together attain their human fulfilment."[8] It is part of the spouses' total self-giving and faithful love of each other until death. This perspective calls for abstinence until commitment is made to another through marriage. It also calls for fidelity to one's spouse throughout the marriage.

This vision of sexuality honours and respects the dignity of the human being, and affirms the meaning and purpose of life as human flourishing. It calls for self-restraint and responsible behaviour resulting in the good of self, other, family and society.[9] Respecting the dignity of each person is not confined to Catholicism. Correctly understood, it is a moral imperative. This is why it was and is the cultural norm of so many societies.

Within this vision, there is no risk of spreading HIV if both partners are not infected. However, there may be a risk of spreading HIV when one partner is infected and the other not. From this perspective which recognises sexual intercourse as the expression of ultimate union, it is understandable that promiscuity is viewed as the 'banalisation of sexuality.'[10]

The Sexual Act as a Pleasurable Activity

When the sexual act is viewed solely as a pleasurable activity without moral constraints, there is no necessary call to abstinence and fidelity. Promiscuity may become the norm. Without respect for the other, the sexual act may become an act of power-over-another, and this in turn may lead to physical, verbal or psychological abuse.[11] Being trapped in a cycle of such violence can lead to loss of dignity and self-respect, and a sense of powerlessness. When such behaviours are entrenched in the culture, and promiscuity and abuse become the norm, it is hard to regain a sense of dignity and selfhood. Poverty may also lead to the use of one's body as a commodity rather than the sacred vessel it is.

HIV infection would not have reached such pandemic proportions if there was not already fertile ground to enable it to happen in the form of widespread promiscuity and the socio-economic determinants that support it. Fear of being infected with HIV may not be enough to stop sexual transmission. Indeed, the partial security of condom use (and other measures that mitigate the transmission of HIV) may instead encourage what Edward Green calls "risk compensation" behaviour: that is, increasing promiscuity with a false sense of security.[12]

Because their personnel tend to see sexual intercourse merely as pleasurable activity, some Western aid organisations and governments tend to think that the best approach to the prevention of HIV transmission is harm minimization. This explains the emphasis on condom use in their strategies.

Medical Approach

The medical management of disease begins with the diagnosis of an ailment based on a comprehensive history and examination. In the case of this 'ailment' which is HIV infection, the sexual transmission of HIV occurs predominantly outside the fidelity of a monogamous relationship. Those who become infected by HIV commonly have multiple and concurrent sexual partners. The prevalence of HIV infection is significantly higher in promiscuous and polygamous cultures, in men-who-have-sex-with-men (MSM), and in the sex trade. The likelihood of transmission is heavily affected by social, cultural, and environmental factors that often differ markedly between and within regions and countries. The obvious medical management is firstly, primary prevention according to the physical determinants of HIV transmission; and secondly, treatment with antiretroviral treatment (ART) for those who have become infected.

Physical Determinants

As HIV is transmitted through contact with infected body fluids in the sexual act, abstinence guarantees non-transmission. Only one contact with infected body fluids is needed to be infected. Being faithful to one partner, who is HIV negative and faithful as well, guarantees that there will be no sexual transmission of HIV. Even when the number of sexual partners is small, the risk of contact with infected body fluids increases as the number of infected people within the community rises. Concurrent multiple partners, whose HIV status is positive or unknown,[13] increase the likelihood of transmission. There may be some genetic predisposition to increased risk of HIV infection. When someone is exposed to infected body fluids, the presence of other STIs increases the chance of infection.[14] Abstinence guarantees non-transmission of STIs, as does monogamy in non-infected individuals. Male circumcision is associated with a decrease in HIV transmission of approximately 60%.[15] Early and effective ART that results in undetectable viral load, significantly decreases the risk of sexual transmission but does not eliminate it.[16]

ABC

Based on the science of HIV transmission, the *ABC* prevention strategy was proposed in the early management of the HIV pandemic. *A*bstinence,[17] *B*eing faithful[18] to one partner and, if these are not possible, consistent and correct *C*ondom usage, have effectively decreased the spread of HIV. While it is unclear whether one component is more effective than the others, it is obvious that condom use alone cannot be *the* answer to HIV prevention. Shelton et al determined that in almost every country where there was a decrease in HIV incidence, there was an associated reduction in the number of sexual partners.[19] For example, a programme in Thailand which required sex workers to use condoms certainly reduced HIV transmission. This intervention also led to a two-fold decline of men engaging in commercial and casual sex.[20]

In contrast to this, until recently the strategies of what is

sometimes called the AIDS Establishment[21] have emphasised the promotion of condom use and other prophylactic devices as primary prevention, alongside voluntary counselling and testing (VCT) and the treatment of STIs. These strategies are either unproven or disproven.[22] It is only in recent years that the need for a combination approach has been acknowledged by the AIDS Establishment.[23] However, even though behavioural change, especially partner reduction, has been shown to be a most effective component,[24] condom use, despite its variable success rate,[25] continues to be flagged as the most significant method.[26]

... The long-term strategy for the prevention of HIV transmission.... surely requires extensive (and probably intensive) education about HIV/AIDS, sexuality, and the reasoning behind attitudinal and behavioural change. It also necessitates ongoing support. Such a strategy is most effective when planned and executed at grassroots level involving the local leaders and the whole community....

The long-term strategy for the prevention of HIV transmission would involve different emphases according to the situations, urgencies, cultures and moral stances of the target population. It surely requires extensive (and probably intensive) education about HIV/AIDS, sexuality, and the reasoning behind attitudinal and behavioural change. It also necessitates ongoing support. Such a strategy is most effective when planned and executed at grassroots level involving the local leaders and the whole community, and resourced by multinational non-governmental and governmental organisations.

The question as to whether behavioural change is an effective and feasible measure is addressed by Hanley and de Irala in *Affirming Love, Avoiding AIDS: What Africa Can Teach the West.* They argue for the urgency of behavioural change - abstinence and fidelity - as very effective and feasible means of prevention, whilst highlighting the inadequacies and dangers of condom promotion, VCT and treatment of STIs[27] as promoted by the AIDS Establishment. Citing numerous articles, they argue that there has been a strong association between the reduction in prevalence of HIV and behavioural change in countries such as Kenya, Zimbabwe, Haiti, Rwanda and Ethiopia.[28] It is only when *A* and *B* cannot be acceded to that *c*ondom use, male circumcision and other proven strategies might be considered at least in the short term. This may be, as Benedict XVI said, "a first step in a movement towards a different way, a more human way, of living sexuality."[29] Even if this is granted, however, it must be emphasized that if long-term prevention is the aim, condom use is not the answer. Why?

Condoms

Condoms have been shown to be an ineffective long-term solution in the prevention of the sexual transmission of HIV. For one thing, the inability to ensure consistent and correct use of condoms makes them an unreliable method of preventing HIV sexual transmission.[30] Their effectiveness is dependent on the material of the condoms (latex is most effective), the quality of their manufacture, consistent and appropriate use (avoiding breakage and slippage), and accessibility. Even then, condoms do not guarantee full protection. Their use may also imply a questioning of the fidelity of the partner. Condoms are also associated with HIV, which carries a stigma of disgrace and abhorrence, and can lead to prejudice and discrimination. This may discourage their use. Whilst their use may have been effective in the sex trade as a 'stop-gap' measure, it is obviously more effective to stop the sex trade through behavioural change, thus not only preventing the transmission of disease but also remedying the abuse, indignity and exploitation of people, along with the significant human trafficking[31] that often accompanies the sex trade. Risk compensation is also a reality. And whilst the evidence is not strong, the question as to whether concentrating on condoms hinders the success of other more effective strategies[32] also needs to be considered.

Socioeconomic Determinants

A holistic medical approach would also assess the socioeconomic context of HIV transmission. The challenges involved in changing the behaviour of a society are enormous. In societies where sexuality and fertility is inherent in people's identity, self-esteem, and socio-acceptability, change is difficult. Where polygamy, sex regarded as pleasurable recreation, and pregnancy as indicative of one's fertility and hence marriageability, are accepted cross-generational norms, it is difficult for many to accept the teaching that promiscuity is wrong. Even if infection with HIV and death is a possibility, some will still choose promiscuous sex, perhaps out of a mistaken idea that they will be loved for having done so. Further, whilst HIV infection remains a social stigma, there is little encouragement to be tested for it. Poverty, food insecurity, years of drought, low levels of education, unemployment, illness, abandonment and abuse issues, poor self-esteem and distrust of foreign aid are significant issues that can impede the acceptance of behavioural change.[33] It is through loving fidelity, respecting the dignity of individuals, being inclusive and non-judgemental, providing integrative, comprehensive services which address social, physical, mental and spiritual health, and "reuniting and strengthening families who have been overwhelmed by sickness, death and loss,"[34] that change can eventually happen.

Conclusion

UNAIDS approximates[35] that 35.3 million people are living with HIV worldwide.[36] The impact of this goes beyond the infected individual, to the family and community. Children are orphaned and possibly infected themselves; grandmothers become the sole parents; life-expectancies are shortened, resulting in a limited workforce, and communities without food. If we are serious about preventing the sexual transmission of HIV infection, we must first address the foundational issue of human sexuality and its expression in sexual intercourse. Our sexuality is integral to who we are as human beings and how we relate to each other. Ultimately, the choice lies in whether we

relate to each other with respect and love, intending the good of self and others, and ultimately reach our highest good; or instead seek limited and short-term often insatiable self-fulfilment, without moral constraints, that result in the destruction of self and society. The HIV pandemic is an example of the effect of promiscuity and the banalisation of sexuality. The evidence is strong that pre-lifetime-commitment abstinence and mutual fidelity in a monogamous relationship is the key to the prevention of sexual transmission of HIV.

Changing entrenched behaviour and attitudes can be both a short- and long-term endeavour depending on the individual and society. Where it becomes a long-term endeavour, shorter term responses to the HIV pandemic may become necessary. These might involve such strategies such as ABC, VCT, treatment of STIs, male circumcision, and early and continued ARTs.[37] If the ABC strategy is considered, evidence now strongly indicates that the emphasis must be not abC but ABc – that is, that the greatest priority must be to promote the behavioural change of abstinence and fidelity.

Whilst education is key, it is only possible and effective if the conditions are right for its reception, integration and application. Gender inequality, social stigma, alienation, discrimination, partner abuse,[38] poverty, unemployment, racism, inadequate nutrition, poor access to health services, and cultures and traditions that reinforce physical, psychological and sexual abuse, powerlessness and poor self-esteem, all mitigate against behavioural change.

...The evidence is strong that pre-lifetime-commitment abstinence and mutual fidelity in a monogamous relationship is the key to the prevention of sexual transmission of HIV....

Ultimately it is people at grassroots who work with the community, and who have gained an understanding of their philosophies and values, who will effect the greatest change. Through loving fidelity, they gain the trust of the people. Resourced by multinationals, not demanding unreasonable conditions, they are able to not only treat those infected with HIV but also address the social determinants that mitigate healing. In doing so, they provide the fertile ground in which necessary behavioural change can happen and so prevent the transmission of HIV.

ENDNOTES

[1] Infection with the Human Immunodeficiency Virus (HIV) can eventually lead to the development of the Acquired Immunodeficiency Syndrome (AIDS). Anti-Retroviral Treatment (ART) introduced in the 1990s has improved the life expectancy of infected individuals from a few years to a nearly normal life expectancy if diagnosed and treated early. For further information on the basics of HIV infection, see Centers for Disease Control and Prevention (CDC), "About HIV/AIDS," CDC, February 12, 2014, http://www.cdc.gov/hiv/basics/whatishiv.html.

[2] Examples include intravenous drug use, reception of intravenous blood and blood products and organ transplantation not screened for HIV.

[3] Worldwide, sexual intercourse accounts for approximately 80 percent of infections. See Ian Askew and Marge Berer, "The Contribution of Sexual and Reproductive Health Services to the Fight against HIV/AIDS: A Review," *Reproductive Health Matters* 11, no. 22 (2003): 51–73. Sexual intercourse accounts for more than 90 percent of infections in sub-Saharan Africa.

[4] Anal intercourse is the highest risk with receptive anal sex riskier than insertive anal sex. In penile-vaginal intercourse, male-to-female transmission is more likely than female-to-male transmission. See Centers for Disease Control and Prevention, "HIV Transmission," CDC, February12, 2014, http://www.cdc.gov/hiv/basics/transmission.html and Rachel Royce et al., "Sexual Transmission of HIV," *New England Journal of Medicine* 336, no. 15 (1997): 1072-78.

[5] Poverty, for example, impacts on the nutritional status of the individual and access to health care, food, clean water and sanitation; socio-cultural "enforcement" of polygamy encourages promiscuity for social acceptability.

[6] Philippe Denis, "Sexuality and AIDS in South Africa," *Journal of Theology for Southern Africa* 115 (March 2003): 63-77 at 68 and 74; Peter Delius and Clive Glaser, "Sexual Socialization in South Africa in an Historical Perspective," *African Studies* 61, no. 1 (July 2002): 27-54.

[7] In a speech to the 1991 International AIDS Conference, President Yoweri Kaguta Museveni of Uganda called his people "to return to the time-tested culture of no premarital sex and faithfulness." For this, see Matthew Hanley and Jokin de Irala, *Affirming Love, Avoiding AIDS: What Africa Can Teach the West* (Ballan, VIC: Connor Court Publishing, 2011), 35. Also, one limited study found that while polygamy is currently accepted as a cultural norm in middle Africa, the practice of monogamy is more widespread. For this, see James Fenske, "African Polygamy: Past And Present," Centre for the Study of African Economies Working Paper, University of Oxford, 2012), http://www.economics.ox.ac.uk/materials/papers/12544/csae-wps-2012-20.pdf

[8] Paul VI, *Humanae Vitae*, Encyclical Letter (1968), #9. The encyclical teaches that sexual intercourse is both unitive and procreative, and that these two ends cannot be separated.

[9] *Humanae Vitae*, #10.

[10] Benedict XVI, *Light of the World: The Pope, the Church, and the Signs of the Times*, trans. Michael J. Miller and Adrian J. Walker (San Francisco: Ignatius Press, 2010), 119.

[11] This is especially so in situations of gender inequality where women are subordinate to men including their husbands who in turn may also have other sexual partners.

[12] Edward C. Green, *Broken Promises: How the AIDS Establishment Has Betrayed the Developing World* (Sausalito, CA: PoliPointPress, 2011), 51.

[13] HIV antibodies can be detected as early as 2 weeks in a few people and by 12 weeks in more than 99.9% of people. A final test 6 months after exposure is recommended to ensure a negative status for those whose risk of infection is greater. Hence it is difficult to determine an individual's HIV status at the time of the sexual act especially if multiple partners are involved.

[14] Although the evidence is mixed, it is likely that the presence of genital ulcers and syphilis chancroid increases the risk of the virus entering the blood stream of the individual through breaks in the skin. See Centers for Disease Control and Prevention, "HIV Transmission," CDC, April 12, 2014, http://www.cdc.gov/hiv/basics/transmission.html.

[15] In one meta-analysis, uncircumcised males were twice as likely to have HIV infection. For this, see Helen A. Weiss, Maria A. Quigley, and Richard J. Hayes, "Male Circumcision and Risk of HIV Infection in Sub-Saharan Africa: a Systematic Review and Meta-analysis," *AIDS* 14, no. 15 (Oct 2000): 2361-70. For a report on three randomised controlled trials which included prevention counselling, see Helen A. Weiss et al., "Male Circumcision for HIV Prevention: From Evidence to Action?" *AIDS* 22, no. 5 (March 2008): 567-574. These trials showed that "male

circumcision reduces the risk of HIV acquisition by approximately 60%," 567. A total of 10,908 uncircumcised HIV-negative men were randomised to intervention and controlled arms and followed up for 2 years. The study was stopped after two years by independent Data and Safety Monitoring Boards, when it became clear that HIV seroconversion was significantly less in those circumcised.

[16] Centers for Disease Control and Prevention, "Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection," CDC, September 2009, http://www.cdc.gov/hiv/pdf/prevention_art_factsheet.pdf.

[17] Abstinence education counsels people either to postpone their first sexual act until they are committed to another for life or to abstain entirely from sexual intercourse.

[18] Education in fidelity counsels people to be committed and faithful within a monogamous relationship – or at least to reduce the number of their sexual partners and to avoid high-risk partners. For this, see James D. Shelton et al.,"Partner reduction is crucial for balanced 'ABC' approach to HIV prevention," *British Medical Journal* 328 (10 April 2004): 891-3.

[19] Ibid.

[20] Ibid., 891.

[21] The AIDS Establishment is the term Edward Green uses for "global authorities like the World Health Organization and UNAIDS (the Joint United Nations Program on HIV/AIDS) and governmental donor agencies like USAID (the U.S. Agency for International Development) and its European counterpart." See Hanley and de Irala, *Affirming Love,* 1. Critique of the AIDS Establishment's focus on condom promotion, voluntary counselling and testing, and treatment of STIs, includes noting the profiteering in a multibillion dollar industry which manufactures condoms and tests. For this, see Ibid., 36-7.

[22] David Wilson and Daniel T. Halperin, ""Know Your Epidemic, Know Your Response": a Useful Approach, If We Get It Right," *The Lancet* 372, no. 9637 (August 2008): 423-6, http://dx.doi.org/10.1016/S0140-6736(08)60883-1.

[23] In a 2009 press release, for example, UNAIDS stated: "Condoms are an essential part of combination prevention which includes among other elements: access to information about HIV, access to treatment, harm reduction measures, waiting longer to become sexually active, being faithful, reducing multiple partners and concurrent relationships, male circumcision, ensuring human rights and the reduction of stigma." For this, see UNAIDS. "Press Release," UNAIDS, March 18, 2009, http://www.unaids.org/en/Resources/PressCentre/Pressreleaseandstatementarchive/2009/March/20090318ComprehensivePrevention. See also The White House Office of National AIDS Policy, "National HIV/AIDS Strategy for the United States," July 2010, http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf, viii.

[24] Malcolm Potts et al., "Reassessing HIV Prevention," *Science* 320, no. 5877 (May 2008): 749-750; James D. Shelton, "Confessions of a Condom Lover," *The Lancet* 368, no. 9551 (December 2006): 1947-8.

[25] A meta-analysis by Davis and Waller estimated the latex condom effectiveness of reducing HIV transmission to be 87%, but varying from 60% to 97%. See Karen R. Davis and Susan C. Weller, "The Effectiveness of Condoms in Reducing Heterosexual Transmission of HIV," *Family Planning Perspectives* 31, no. 6 (Nov/Dec 1999): 272-279. Pinkerton and Abramson suggested that with consistent use condoms are 90-95% effective. See Steven D. Pinkerton and Paul R. Abramson, "Effectiveness of Condoms in Preventing HIV Transmission," *Social Science and Medicine* 44, no. 9 (1997): 1303-1312.

[26] UNAIDS, *Press Release*, xxi. As Hanley and de Ira highlighted in *Affirming Love*, this is also evident in many of the documents and websites of the AIDS Establishment, where condom use is highlighted and emphasized. Other measures are recommended but arguably without the same emphasis as condom use.

[27] Hanley and de Irala, *Affirming Love*, 23-35.

[28] Ibid., 40-41.

[29] Benedict XVI, *Light of the World,* 119. The Catholic Church accepts that condom use "with the intention of reducing the risk of infection, can be a first step in a movement towards a different way, a more human way, of living sexuality." At the same time, the Church insists that "the provision of condoms does not constitute 'the real or moral solution' to the problem of AIDS," for this problem can ultimately be solved only by embracing a more human and life-affirming vision of sexuality. For this, see Congregation for the Doctrine of Faith, "Note on the Banalization of Sexuality Regarding Certain Interpretations of 'Light of the World'," December 27, 2010, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20101221_luce-del-mondo_en.html

[30] High rates of sexual transmission of HIV have been reported despite high rates of condom use. Hearst and Chen suggest that "inconsistent use…, low use among those at highest risk, and negative interactions with other strategies, such as partner reduction" may decrease the impact of condom use. See Norman Hearst and Sanny Chen, "Condom Promotion for AIDS Prevention in the Developing World: Is it Working?" *Studies in Family Planning* 35, no. 1 (March 2004): 39-47 at 39.

[31] UN GIFT, "Human Trafficking - The Facts," United Nations Global Impact, 2008, http://www.unglobalcompact.org/docs/issues_doc/labour/Forced_labour/HUMAN_TRAFFICKING_-_THE_FACTS_-_final.pdf.

[32] Giuseppe Benagiano et al., "Condoms, HIV and the Roman Catholic Church," *Reproductive BioMedicine Online* 22 (June 2011): 701-709, http://dx.doi.org/10.1016/j.rbmo.2011.02.007.

[33] Cabrini Ministries Swaziland, *Program Report 2012-2013* (Manzini, Swaziland: Cabrini Ministries Swaziland, 2013), 1-64.

[34] Ibid., 13. This report is an example of the importance of grassroots planning that is specific to a particular culture, tradition and place. It involves gaining the trust of the people. I am very grateful to Cabrini Sisters Diane DalleMolle MSC and Barbara Staley MSC for sharing the wisdom and insights they have gained from personal experience in Swaziland.

[35] It is impossible to accurately determine the number of HIV-infected people in many parts of Africa and other remote regions in the world, especially those places with poor infrastructure.

[36] UNAIDS, "AIDS by the Numbers" UNAIDS, 2013, http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2571_AIDS_by_the_numbers_en.pdf.

[37] Provision of ART to HIV-1 infected patients could be effective in reducing HIV sexual transmission. Its effect in vertical transmission between mother and baby has been shown. HIV transmission from mother to baby declined from an estimated 1,650 a year in 1991 to fewer than 200 per year by 2004. See Deborah Donnell et al., "Heterosexual HIV-1 Transmission After Initiation of Antiretroviral Therapy: a Prospective Cohort Analysis," *The Lancet* 375, no. 9371 (June 2010): 2092-8.

[38] "There is a 50% increase in likelihood of acquiring HIV among women who have experienced intimate partner violence." UNAIDS, *AIDS by the Numbers,* 6.

All online resources accessed 15 May 2014

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