Overview: Prevention of HIV and AIDS

Do we need a National Health Promotion Foundation[1]

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Commissioned by Soul City

[1] Collinge J. Confronting HIV and AIDS through Mass Media and Community Action. Gray A, Govender M, Geniah T, Singh J. Health Legislation, In: Ljumba P, Barron P, editors. South African Health Review 2005. Durban Health Systems Trust; 2005.

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Executive Summary

This document is an attempt to provide an overview of prevention campaigns in the context of the AIDS epidemic. It will survey literature on key issues related to prevention, sexuality and campaigns. As an overview, the document attempts to be as comprehensive as possible.

Global Context

It is important to situate the crisis of HIV and AIDS in the context of what is happening internationally- both economically and socially. In an article written by Lesley Doyal[2] the following points are made:

- What is happening to welfare issues in the context of globalisation?
- The need to explore the impact of economic and social restructuring on the well being of individuals and communities.

This paper is of particular relevance because the issues being raised need to be taken into account when we interpret prevalence of HIV, the impact of various campaigns to change people's sexual; behavior and attitudes and to control the spread of HIV. This article illustrates the fact that nothing exists in a vacuum.

Doyal uses the example of maternal mortality to illustrate this point. She states that:

> *A change in the maternal mortality rate, for example, will represent a series of biological events with their own internal logic. However, these deaths will also be related to the social, economic, and cultural configuration of the communities within which they occur, which in turn will be linked in complex ways with aspects of global restructuring.*

The general impact of HIV and AIDS on education and especially on women and young girls is well documented. In line with the arguments being made by Doyle when she speaks about the social,

[2] Doyal L. [2004] Putting Gender into Health and Globalisation Debates.Global Health and Governance HIV/AIDS. Ed. Poku NK, Whiteside A.Third World Quarterly Series.

economic, and cultural configuration of the communities is the role that education plays in increasing the ability of particularly women, to protect themselves against HIV infection.

Education for Women

Literature reveals that women who have had some access to education have lower rates of infection compared to illiterate women. This is obviously a direct consequence of socio-economic conditions that women live under. Most surveys reviewed reveal this pattern of the link between education and the ability of women to have greater control over their sexuality and their bodies[3]. The United National issued a document to mark International Women's Day in 2004. The following is a quote from this document[4]:

More than a health crisis, HIV/AIDS is a global development challenge. Discriminatory property and inheritance rights, and unequal access to education, public services, income opportunities and health care, as well as ingrained violence, render women and girls particularly vulnerable to HIV infection. Women living with HIV/AIDS suffer the additional burdens of stigma, discrimination and marginalisation.

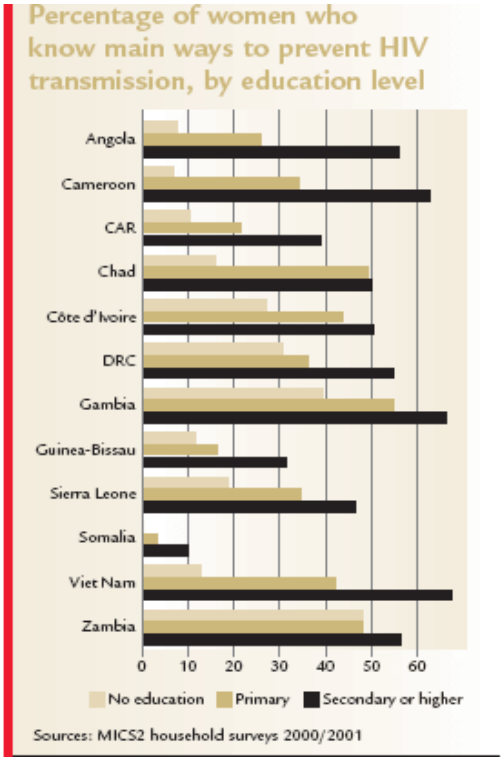

Fig One-Percentage of women who know main ways to prevent HIV transmission, by education level.[3]

[3] UNAIDS/UNFPA/UNIFEM.[2003] Women and HIV/AIDS: Confronting the Crisis.

4 United Nations. 2004. International Women's Day 2004. Women and HIV/AIDS: Advocacy, Prevention and Empowerment.

Rob Noble[5] illustrates this point in an article looking at prevalence patterns of HIV in Zambia. The article states "HIV has spread throughout Zambia and to all parts of society. However, some groups are especially vulnerable – most notably young women and girls. Noble then states that "there is good evidence of a significant fall in HIV prevalence among young Zambian women in the 1990's. The most dramatic findings concern pregnant women aged 15-19 years. A survey in Lusaka shows that among this group, the proportion living with the virus almost halved from 28,4% in 1993 to 14,8% in 1998. The greatest reduction were found among well-educated women, while prevalence among least educated remained stable or increased[6].

This aspect of the overview serves to illustrate the point that in order to make an impact on the spread of HIV, and inform sexual health messages, a more comprehensive approach is required that ensures that socio-economic factors – especially as they impact on developing countries are taken into account. Essentially prevalence of HIV in this instance is not just informed by the nature of the message and the manner in which it is conveyed. Other factors including whether or not the person has a job, a house, or has had access to education etc all contribute to the way in which HIV spreads.

Know your HIV Status

The other issue to be highlighted is that of the critical need for people to know their status. The overview draws on a number of papers that confirm the need to get people to test for HIV. Testing should not be tainted with moral issues of sleeping around or have negative connotations as is the case with condoms currently. If people associate testing with control over their lives and living healthily then this will contribute to stemming the spread of HIV as it will be possible to detect HIV infection almost as soon as it occurs – this is critical in prevention work. People are most at risk of HIV infection if they have unprotected sex with a person who has been infected recently. And surveys show that most people living with HIV are not aware of their status. What is needed is testing tools that enable quick and early detection of HIV infection. The key is carrying out this intervention while respecting the basic human rights of all people.

Social, political and financial capital for AIDS prevention

International costing of HIV prevention suggests behaviour change is largely delivered through contact with specific HIV services and resources, for example Voluntary Counselling and Testing (VCT), clinical care, media spending or peer education (Stover et al., 2002).

Key Trends

1. More than a quarter of the world's population – 1.7 billion people – is between the ages of 10 and 24.[7]

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[5] Noble R. HIV/AIDS in Zambia: The Epidemic and its Impact 2001. Avert.org

[6] Declining HIV Prevalence and risk behaviour in Zambia. Surveillance and Population Based survey. Knut Fylkesness et al. AIDS, Vol. 15. May 2001/

7 James-Traore,T, Magnani R, Magnani, Murray N, Senderowitz J, Speizer I, Stewart L.Intervention Strategies that Work for Youth – Focus on Young Adutls. Family Health International 2002

2. Globally puberty is occurring earlier for both boys and girls, and the age at which people marry is rising.[8]
3. It is possible to deal with men's resistance to condom use within stable relationships and this resistance may even be over exaggerated.
4. That HIV prevention programmes should address the reproductive health needs of couples in stable relationships – including those that are married and those cohabiting and the associated difficulties of sustaining long-term preventative behaviour[9].
5. A disturbing theme running through literature on the topic is the association of sexuality and sex with pain, suffering, mourning and death (in the context of HIV/AIDS and sexual violence in Africa.
6. Need for education to promote the message of consistent condom use[10].
7. South African children have a high prevalence.[11]
8. An interage analysis of the HSRC report referred to above revealed a trend towards earlier sexual debut amongst younger respondents.
9. Condom use as a method of safe sex has increased significantly. However, overall levels of use, consistency of use and practice in certain age groups are not yet adequate to change infection patterns[12]
10. The need to know your HIV status. That this be the central tool in the prevention campaign.

Overview

What the Experts say!

"Indications are that some of the treatment gaps will narrow further in the immediate years ahead, but not at the pace required to effectively contain the epidemic... gaining the upper-hand against AIDS epidemics around the world will require rapid and sustained expansion in HIV prevention. Public information campaigns about sexually transmitted infections and the spread of HIV should be strengthened. Awareness of the epidemic is on the rise, but specific knowledge about HIV still is inadequate.

Young people account for 1/2 of the total HIV infection rate in the world. About 6000 infections occurs everyday among this age group of 15-24 years. The HIV/AIDS epidemic has had devastating effects on African youth, most of whom lack access to information and services in the area of HIV/AIDS, STIs, and reproductive and sexual health. This calls for a holistic approach in using young people as an entry point to their peers. In sub Saharan Africa many youth are getting

8 Ibid

9 Maharaj P, Cleland J. Risk Perceptions and Condom Use Among Married Or Cohabiting Couples in KwaZulu-Natal, South Africa. International Family Planning Perspectives. Vol 31, No. 1 March 2005.

10 Shisana O, Rehle T, Simbayi LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste S, Pillay V et al. (2005) South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Cape Town: HSRC Press

11 Ibid

12 Gray A, Govender M, Geniah T, Singh J. Health Legislation, In: Ljumba P, Barron P, editors. South African Health Review 2005. Durban Health Systems Trust; 2005. Page 202

involved in issues that affect them. One of such means is participation at national, international forums in order to build their skills and capacity. "[13]

People living with HIV ..... 40.3 million (36.7–45.3 million) New HIV infections in 2005 ..... 4.9 million (4.3–6.6 million) Deaths due to AIDS in 2005 ..... 3.1 million (2.8–3.6 million)[14].

Human development Report –2005[15]

- Twenty years ago somebody born in Sub-Saharan Africa could expect to live 24 fewer years than a person born in a rich county, and the gap was shrinking.
- Today, the gap is 33 years and growing.
- HIV/AIDS is at the heart of the reversal.
- Looking at the future, Africa faces the gravest HIV/AIDS –related risks to human development.
- The international response to HIV/AIDS has been profoundly inadequate.

Assessment of Prevention Campaigns- where are we?

If we had to have a sober, and harsh analysis of the current situation with respect to the HIV/AIDS epidemic, then one could sum it up in the words of journalist and lecturer Tim Trengove Jones, who said in an recent article[16] that

> *" We must note that United Nations agency UNAIDS figures indicate that SA has the highest number of HIV-positive people in any country in the world. Also, our rate of new infections last year, though down, remains alarmingly high. This indicates a catastrophic incapacity on the part of government and citizens to address adequately the causes – economic, cultural, psychosocial, and gendered –of infection".*

He was writing about the debacle and media frenzy about what he termed "gay blood wars". In this article Jones says that while the number of sero-conversions from transfusions is encouragingly low, this must not divert attention from the sad incapacity of prevention and treatment programmes in SA."

13 Youth visibility at international forum: experience sharing of youth in Africa. Int Conf AIDS 2004 Jul 11-16; 15:(abstract no. TuPeC4736)
Okoro OD, Ajayi OO, Elliot B, Wakesho P, Eugene Ntreh K, Mmokele Tebogo S, Dunjwa K, Neema M, Kamau C, Mohamud A Youth Action Rangers of Nigeria, Lagos, Nigeria

14 Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) 2005. AIDS Epidemic Update. Special Report on HIV Prevention

15 Extract from Human Development report 2005 P 25.

16 Jones, TT. "More heat than light in debate". Business Day 27/01/06.

Acquired Immunodeficiency Syndrome (AIDS) has killed more than 25 million people since it was first recognized in 1981, making it one of the most destructive epidemics in recorded history.[17]

We have failed to produce an effective prevention campaign in South Africa[18], particularly in the light of the social drivers of the epidemic (such as extreme poverty, poor nutrition, unstable family life, high levels of unprotected sex and gender power imbalances); the prevention of mother-to-child transmission has been poorly handled; the split between the President and the Department of Health on the nature and extent of the problem and the most appropriate response has been damaging (in spite of this we now have in place a useful and comprehensive national strategic plan); the antiretroviral (ARV) roll-out has taken far too long to arrive (and is behind schedule); the demand for social grants has risen dramatically; levels of stigma are still high; and, there is a significantly increased workload resulting in stress and exhaustion in health care workers, up to 16% of whom may be HIV positive themselves[19]

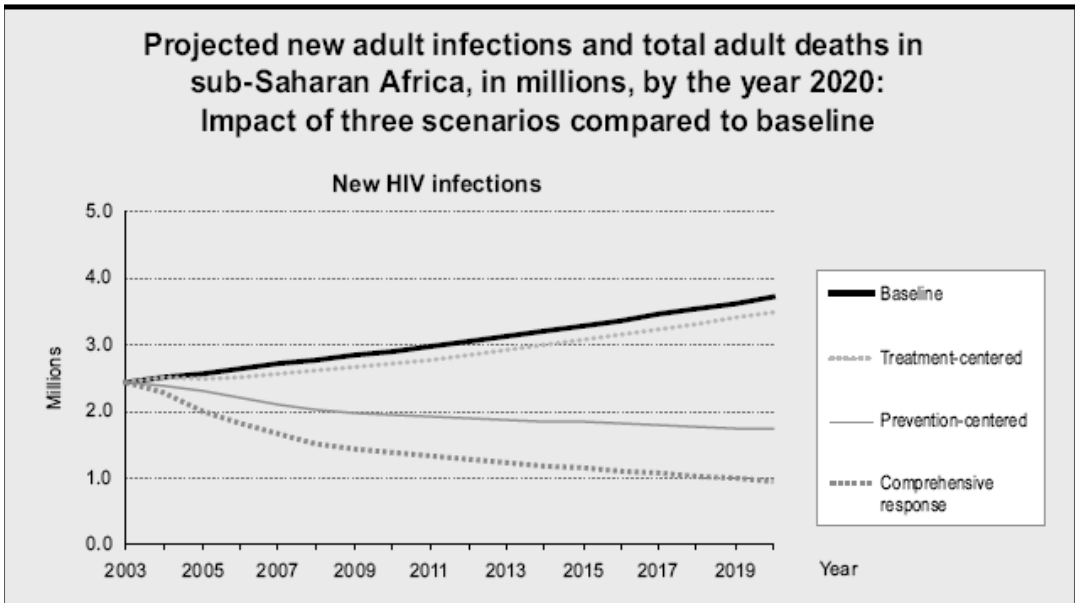

Fig 2 -In sub-Saharan Africa, a comprehensive prevention and treatment package would avert 55% of the new infections that otherwise could be expected to occur until 2020 (see Figure above from Salomon et al., 2005).

An overview of literature/surveys which indicate trends and impact on behaviour of key campaigns

17 Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) 2005. AIDS Epidemic Update. Special Report on HIV Prevention .

18 Brouard P,2005, THE NEED FOR THE INTEGRATION OF psychosocial support within the context of the primary health care system with a focus on HIV/ AIDS, the ARV roll-out and drug. Centre for the Study of AIDS, University of Pretoria.

19 Benatar SR. Health care reform and the crisis of HIV and AIDS in South Africa. NEJM 2004; 351: 81 - 92.

This section will do one of the following:

1. It is look at specific interventions or tools for preventing the spread of HIV and assess its effectiveness in impacting on the spread of the disease.
2. It will assess messages intended to change people's sexual practice and behaviour.
3. It will speak directly to various campaigns including the effectiveness of LoveLife and a critique of its methodology and the Department of Health's prevention campaign including a critique of the ABC message.
4. International Experience

New prevention methods: innovation for Universal Access

The following sections appeared in a paper looking at Adolescents and sexuality[20].

Female condoms

Although shown to be effective in prevention of pregnancy and acceptable to users, the female condom has not achieved its full potential in national programmes because of its relatively high cost. A new version of the Reality® female condom is made of synthetic nitride, which makes it considerably less expensive. The new device has the potential for wider acceptability and utilization. It is hoped that, if high utilisation rates of the new device can be achieved, it will make a substantial contribution to prevention of unwanted pregnancy and sexually transmitted infections, including HIV. In addition to the new female condom, trials are also under way to test the effectiveness of diaphragms and other methods of protecting the cervix for HIV/STI prevention.

Male circumcision

A recent study in South Africa found that circumcised men were at least 60% less likely to become infected than uncircumcised men. These promising results must be confirmed in ongoing studies if male circumcision can be promoted as a specific HIV prevention tool. If proven effective, male circumcision may help increase available proven options for HIV prevention, but should not cause the abandonment of existing effective strategies such as correct and consistent condom use, behavioural change and voluntary testing and counselling. Male circumcision does not eliminate the risk of HIV for men and the effects of male circumcision on women's risk of HIV are not known. It also remains to be demonstrated whether and to what degree circumcision could reduce HIV transmission in cultures where it is not currently practiced.

20 Angelo LJD, Samples C, Rogers AS, Peralta L, Freidman L. HIV Infection and AIDS in adolescents: An update of the position of the Society for Adolescent Medicine. Journal of Adolescent Health. 2005

Microbicides

Microbicides offer the best promise of prevention tool women can control. They could have a substantial impact on the epidemic. Currently, the HIV microbicide field has four candidate microbicides entering or in phase III trials, five in phase II, and six in phase I. They include soaps, acid buffering agents, seaweed derivatives and anti-HIV compounds. Modelling indicates that even a 60%-efficacious microbicide could have considerable impact on HIV spread. If used regularly by just 20% of women in countries with substantial epidemics, hundreds of thousands of new infections could be averted over three years (Rockefeller, 2001).

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) to prevent sexual–and possibly parenteral–transmission of HIV holds promise for sero-discordant couples, sex workers, men who have sex with men and injecting drug users who may be exposed to HIV despite using precautions. Small-to-medium sized phase II trials are under way in Atlanta and San Francisco, with larger phase II/III studies under way or planned in Botswana, Ghana, and possibly Thailand. Some of these studies have been dogged by controversy. The main issues were the adequacy of pre-trial community consultation and informed consent, linkages to HIV treatment programmes for those found to be infected at baseline or in the course of the study, and–in the case of Thailand–the lack of access to sterile needles in a study designed to examine HIV transmission among injecting drug users.

Vaccines

A vaccine to overcome HIV is our most compelling hope. But developing a vaccine remains an enormous challenge for reasons related to inadequate resources, clinical trial and regulatory capacity concerns, intellectual property issues and scientific challenges. There are now 17 vaccine candidates in phase I trials and four vaccines in phase I/II (including the promising Merck adenovirus vector vaccine now in phase IIb, which may stimulate anti-HIV cell-mediated immunity). There is only one in phase III (the NIH/Department of Defense's ALVAC vCP 1521 canary pox vector/AIDSVAX prime-boost vaccine trial now under way in Thailand). The Global HIV Vaccine Enterprise has rallied scientists, activists, funders and others worldwide around a Strategic Scientific Plan to rapidly advance progress towards effective HIV vaccines, the world's best long-term hope for bringing the global HIV epidemic under control.

Tried and Tested Interventions

Sexually Transmitted Diseases

What follows is a summary of a review of scientific data on the role of sexually transmitted diseases (STDs) in sexual transmission of HIV and the implication of these findings for HIV and STD prevention policies.[21]

21 Fleming DT, Wasserheit JN, (1999)From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sti.bmjjournals.com

- Available date leave little doubt that other STDs facilitate HIV transmission through direct, biological mechanisms and that early STD treatment should be part of a high quality, comprehensive HIV prevention strategy.
- Policy makers, HIV prevention programme managers, and providers should focus initial implementation efforts on three key areas:

1. Improving access to and quality of STD clinical services
2. Promoting early effective STD related healthcare behaviours and
3. Establish surveillance systems to monitor STD and HIV trends and their interrelations.

Voluntary counselling and testing (VCT)

Utilisation of VCT services

Voluntary counselling and testing (VCT) for HIV allows individuals to know their HIV status and serves as the gateway for both HIV prevention and for early access to treatment, care and support. Knowing one's status provides for the choice to - for those who are negative, remain negative; and for those who are positive, seek access to treatment, care and support, and to reduce the risk of HIV transmission to future children and partners.
Many studies have found that VCT is effective as a strategy for facilitating behaviour-change around both preventing HIV and early access to care and support[22]

Comprehensive HIV counselling and testing is seen as central to prevention and treatment efforts. The Society for Adolescents[23] makes the following critical points on VCT:

- That youth, who reside in areas with high prevalence rates, should be identified and urged to undergo testing. This is a very pro-active way of dealing with VCT.
- It also states that testing and effective risk reduction counselling and assistance should be part of the routine care of sexually active youth.

An interesting interview with Dr Susan Allen done by Simon Noble appears on the International AIDS Vaccine Initiative [IAVI Report] website. The article was first published in 2004. In this interview Allen points out that 60% to 70% of transmissions that happen everyday in Africa occurs between spouses. So while many people focus on higher risk groups, like sex workers and truck drivers, they do not constitute the largest at-risk group that account for most of the transmissions. The challenge is to get couples who assume that they are in a monogamous relationship to test for HIV.

Strategies to get more men enrolled in VCT programmes:

22 Allen et al, 1992; Campbell et al, 1997; Kamenga et al, 1991; Van der Straten et al, 1995; Voluntary HIV-1 Counseling and Testing Efficacy Study Group 2000, UNAIDS 2001 ; The impact of Voluntary Counseling and Testing: A global review of the benefits and challenges, Geneva, UNAIDS 2001
23 Angelo LJD, Samples C, Rogers AS, Peralta L, Freidman L. HIV Infection and AIDS in adolescents: An update of the position of the Society for Adolescent Medicine. Journal of Adolescent Health. 2005

If we start on the premise that transmission of HIV is highest between couples, then a starting point in any prevention campaign is to ensure that all couples know their status. Allen says in the interview referred to above that one strategy to get men involved in VCT is for health care workers to offer VCT to any person who is married. She states examples of instances to include when someone donates blood, or any sick person, a TB patient, a pregnant women, and generally most adults. So VCT must be offered to the person's partner, on the assumption that he or she is living with someone in a relationship.

She also states that there is not sufficient awareness in developing countries in particular of the phenomenon of marriage as a risk factor. Finally she states that the key goal for HIV/AIDS prevention in her opinion is to apply behavioural strategies that we know work including couples testing and counselling works. She concludes that this should be a number one promotional strategy. She says that we need to popularise the fact that the largest risk group on the planet is cohabiting couples in sub Saharan Africa, and the only thing that is known to work with them is couple testing.

Use of VCT services in SA

The South African Health Review states that there is limited data on the utilisation of VCT services and on the prevalence of HIV amongst users of VCT services. The National Baseline Assessment of STI and HIV services[24] provides some data on utilization of VCT services. The survey shows that overall 0.8% of all Primary Health Care [PHC] clients accessed HIV counseling and testing services at PHC facilities during the period of the survey (July 2002).

Of significance is the result of the baseline assessment of STI and HIV services which compares levels of access to VCT in general compared to the number of clients who tested for HIV in PMTCT sites. The results show that 23 tests per month at sites linked to PMTCT services and 11 tests per month at other VCT sites

Nucleic Acid Testing

One recommendation made by the Society for Adolescent medicine is of particular relevance for SA. Nucleic Acid testing is a test that can be made available at the point of care and is non invasive. It offers an opportunity to identify the virus during symptomatic seroconversion. With high prevalence rates in South Africa and given the fact that during the period of early infection, a person's viral load is very high, this means that the more people there are in the early stage of infection the greater the chance of effective transmission between people. So if there is a test that is easily accessible and can detect the virus at an early stage, this can ensure that people are encouraged to test, and are counseled.

The problem is that people only become aware of their HIV status much later on and the key to an effective prevention campaign is to convince all sexually active people that they are at risk and the importance of knowing one's status. Of people living with HIV only one in ten has been tested and knows that he or she is infected[17].

24 Ramkissoon A, Kleinschmidt I, Beksinska M, Smit J, Hlazo J, Mabude Z. National Baseline Assessment of Sexually Transmitted Infection and HIV services in South African public sector health facilities. Summary Report. Reproductive Health Research Unit, 2004. URL: http://www.rhru.co.za/images/Docs/

VCT is an important prevention tool as it provides an important opportunity to speak to people at risk of HIV infection about how to ensure that they do not spread HIV if the person is diagnosed with HIV and to council those testing negative on how to stay negative.

Impact of PMTCT –

According to the SA Health Review -Many health facilities were unable to collect sufficient data and consequently the data that were received were frequently of poor quality. The Review indicates that of a total of 1907 live infants born to HIV-positive women in the PMTCT pilot sites between April 2001 and March 2002 –of these totals 949 infants were seen and tested for HIV in the pilot sites which translates to a follow up rate of 50%. Of these 18% tested HIV positive[25].

The issue of PMTCT will be analysed further under the section looking at the Government's National Prevention Campaign.

Peer education

In recent years a number of publications have come out about the peer education method used as a tool in HIV prevention for young people Evidence from peer education programmes indicates that giving young people access to accurate information, as well as the opportunity to discuss sexual and reproductive health issues, can bring about changes in behaviour which lead to risk reduction. Evaluations of various programmes show improvements in student attitudes and knowledge about abstinence and condom use, as well as behavioural changes including increased use of contraception and decreased sexual activity.

However, evidence from the US suggests that peer educators had no greater influence on young people than adult educators. Wider evidence also indicates that peer education programmes have not been cost effective or sustainable, and that their main impact has been on the peer educators themselves.

Community involvement

A very useful booklet dealing with prevention campaigns and the role of communities provides very useful information including peer education.[26] In this booklet the authors argue that "The aim of many HIV/AIDS-awareness campaigns is to pass on knowledge. This assumes that people – particularly young people – practice unsafe sex and become infected with HIV because they lack the necessary information. But it is now clear that even with the right information; many young people do not take steps to protect themselves from infection. As a result they are often blamed for the problems facing HIV/AIDS prevention. However, this book argues that blaming youth is not fair and that it is not just youth who need to change. Social circumstances often make it very difficult for youth to take precautions and it is these social circumstances that need to change as well.

25 Doherty T, Besser M and Donohue S. An evaluation of the PMTCT initiative in South Africa: Lessons and key recommendations. Durban: Health Systems Trust, 2003. URL: http://www.hst.org.za/publications/599/

26 Campbell C, Foulis C, Maimane S, Sibiya Z. SUPPORTING YOUTH: Broadening the approach to HIV/AIDS prevention programmes. Centre for HIV/AIDS Networking (HIVAN) University of KwaZulu. 2004

Knowledge is only one component – or part – of a number of components that are essential for behaviour change and HIV/AIDS prevention."

Mass media HIV awareness and behaviour change

Health promotion campaigns conducted through mass media, such as radio, television, video, posters and magazines, have been shown to raise awareness of HIV risk and the importance of abstinence, faithfulness and condom use. There is evidence that mass media and social marketing campaigns have been most effective when combined with educational materials, sexual and reproductive health services, and interpersonal interventions.

Youth development programmes

Pioneered in the United States, youth development programmes focus on helping young people build on their strengths and assets. Those programmes that combine a variety of strategies, including abstinence and contraceptive use, have been assessed as most promising for HIV prevention and reduction of teenage pregnancy. Key components of youth development programmes include:

- Involving adults and members of the community
- Building relationships with adults who can act as mentors
- Providing opportunities for young people to pursue their interests
- Engaging youth as active leaders and partners in the community
- Providing sexual health education.

International Experience

Uganda:

This section looks at an article entitled *"Condoning or condemning the condom: Lessons learned from Uganda*[27]*"*

In this article the author provides the following key points: That:

- At the end of 2002, the national HIV prevalence rate was estimated at 6.2%, following a history of declining trends from a national average of 18% (with about 30% in the worst hit areas) in the early 1990s.
- Although the Ugandan Government's well-known ABC prevention programme ("A" for Abstinence, "B" for Being faithful, and "C" for Condom use) has been criticized many people argue that it has been imperative in explaining Uganda's success.

27 Farrell M. "Condoning or condemning the condom: Lessons learned from Uganda27" Maureen Farrell. Sexual Health Exchange 2004-1

- According to a USAID study, religious organisations have played an instrumental role in raising the country's awareness on HIV/AIDS, not only by promoting abstinence and marital faithfulness, but also by not openly condemning condom use.[28]

According to the Uganda AIDS Commission Secretariat some of the lessons learned by the country's relative success are[29]:

- Political support and commitment from the highest level of leadership is the pillar for strong and sustainable action.
- An understanding of local and religious values of various communities is essential for any successful strategy.
- Sustained advocacy for effective leadership in HIV/AIDS at all levels is difficult but necessary.
- The involvement of civil society, faith-based organisations and PLWHAs is invaluable due to their direct contact with communities.
- The support and participation of development partners in planning, resource mobilisation and guiding implementation is crucial.
- It is more cost effective to mobilize all available efforts and resources to fight the epidemic before it becomes unmanageable.
- AIDS cannot be handled by one sector alone. There is a need for concerted efforts, each sector acting within its mandate. Areas of intersection should be handled in partnership to complement capacity and avoid duplication of resources.
- AIDS respects no territorial borders. Progress can only be achieved through combined efforts at regional and global levels.

It must be pointed out that as reflected in an article entitled: "Human Rights And HIV/AIDS In The Commonwealth[30]" that "The determinants of the HIV/AIDS epidemics in the countries of the Commonwealth are largely economic and social.[31] Generally, in those Commonwealth countries where people have access to information, health services and employment, and where women have greater economic opportunities and a relative degree of sexual autonomy and control, HIV is limited to 'groups' whose behaviour creates an added risk of HIV infection. By contrast, in those countries where these conditions do not exist, 'ordinary' sexual behaviour can carry the risk of HIV infection in whole populations. This explains high HIV prevalence in Africa, Asia and increasingly the Caribbean. However, this paper will endeavour to show that not only are there huge variations in the epidemiology of the HIV epidemic between countries of the Commonwealth, sometimes there are also extreme variations in prevalence and incidence within countries". It goes on to say

28 Hogle, J., ed. What happened in Uganda? Declining HIV prevalence, behaviour change, and the national response, USAID, 2000,

29 Source: HIV/AIDS in Uganda: The epidemic and the response, Uganda AIDS Commission Secretariat, 2002, www.aidsuganda.org/pdf/hiv_aids_impact.pdf

30 Prepared for the CHRI by Cathi Albertyn and Mark Heywood of the Centre for Applied Legal Studies, University of the Witwatersrand. undated

31 See Grassly NC & Garnett GP, The Epidemiology of HIV in the Commonwealth: an Overview; Tembo G, An Overview of the epidemiology of HIV in Africa; O'Leary M et al, An Overview of the Epidemiology of HIV in the Pacific; all in *HIV/AIDS in the Commonwealth, 2000/01*:

that “African countries in the Commonwealth currently experience the world’s worst HIV epidemics”. Of particular relevance to this section of the overview are the comments on the epidemic in Uganda. It states that: “While Uganda has reduced its prevalence from a peak of 14% in the early 1990s to 8% in 2000, South Africa (ante-natal prevalence: 24,5%)[32] and Botswana (adult prevalence 35.8%)[33] have the worst HIV epidemics in the world.[34] Both countries are characterised by very high HIV incidence, high prevalence, and high rates of HIV morbidity and mortality”.

Europe and North America

The number of people living with HIV in North America, Western and Central Europe rose to 1.9 million [1.3–2.6 million] in 2005, with approximately 65 000 people having acquired HIV in the past year. Wide availability of antiretroviral therapy has helped keep AIDS deaths comparatively low, at about 30 000. (AIDS Epidemic Update: December 2005)

“Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic.”

On April 17, 2003, the Centers for Disease Control and Prevention (CDC) announced a new initiative, “Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic.” Its aim is to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for HIV-positive persons and their partners. The AHP initiative represents a multi-agency collaboration within the Department of Health and Human Services (DHHS). As described in the April 18, 2003, issue of the *Morbidity and Mortality Weekly Report*, the initiative consists of four new strategies for HIV prevention:

- Make HIV testing a routine part of medical care
- Implement new models for diagnosing HIV infections outside medical settings
- Prevent new infections by working with persons diagnosed with HIV and their partners
- Further decrease perinatal HIV transmission

Quick Facts: Perinatal April 2003 – March 2005

Rapid HIV Testing and Opt Out policy vs Opt In

An estimated 6,000 to 7,000 HIV-infected women give birth each year in the United States, resulting in 280 to 370 new perinatal infections. Approximately 40% of mothers whose infants are perinatally infected have no documentation of HIV status, despite recommendations that all pregnant women be tested for HIV prenatally. About 40% of women of childbearing age are unaware that treatment is available to prevent perinatal transmission.

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[32] 13th Ante-natal survey of Women attending ante-natal clinics, October/November 2000

[33] UNAIDS, Report on the Global HIV/AIDS Epidemic, June 2000

[34] *Report on the Global HIV/AIDS Epidemic,* June 2000

Although the acceptability and feasibility of rapid HIV screening in labour and delivery have been demonstrated by the CDC-supported MIRIAD research study (JAMA 2004; 292 219-223), only about 1/3 of U.S. hospitals have rapid HIV testing available to women in labour, and less than half of those have policies or protocols to routinely offer rapid HIV testing to women with undocumented HIV status (CDC unpublished data).

Studies show that an opt-out testing approach (i.e., pregnant women are told that an HIV test will be included in the standard group of prenatal tests and that they may decline the test) results in higher testing rates than an opt-in approach (i.e., pregnant women receive pre-test HIV counselling and must provide HIV test consent.) However, opt-out testing has not been implemented in many prenatal settings.

As stated earlier, it is important to qualify this approach with the caution that every effort must be made to ensure that the person's rights are not infringed in any way. The other caution is that we need to ensure that routine HIV testing does not keep people away from services that provide health care and support.

Men who have sex with Men [MSM]

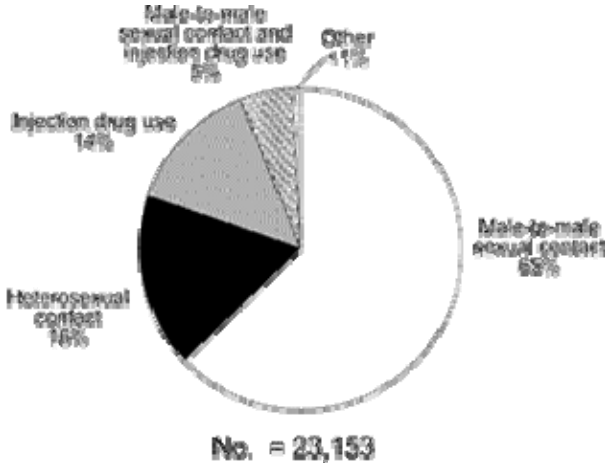
In the United States, HIV and AIDS have taken a heavy toll among men who have sex with men (MSM)[35].

Statistics

- AIDS has been diagnosed for more than half a million MSM.
- Almost 300,000 MSM with AIDS have died during the past 20 years.
- In the 35 areas with long-term, confidential name-based HIV reporting, half of all HIV infections (in men, women, and children) diagnosed during 2004 were in MSM.
- In the 35 areas with long-term, confidential name-based HIV reporting, almost 70% of HIV infections diagnosed for males during 2004 were in MSM.

Transmission categories of male adults and adolescents given a diagnosis of HIV infection, 2004

35 Centers for Disease Control and Prevention-2006. Fact Sheet



Note. Based on 35 areas with long-term, confidential name-based HIV reporting.

Risk Factors

MSM are at high risk for HIV infection. The main ways MSM get HIV are by

- having sex partners who are HIV-positive
- not using a condom during anal sex
- sharing needles to inject drugs

Prevention

MSM should get tested. The logic being that if you know your HIV status then you will protect your health and the health of others. Sexually active MSM should get tested for HIV at least once a year. But this message can also be generalised to all sexually active people.

- The surest way for MSM not to get HIV is not to have sex or to be in a long-term mutually monogamous relationship in which both partners have been tested and are not infected.
- If MSM choose to have sex outside a steady relationship, they should always use a condom. These MSM should know their HIV status and that of their partner(s).
- If both partners are HIV-positive, they should use condoms to prevent other sexually transmitted infections and possible infection with a different strain of HIV.
- If MSM inject drugs, they should use clean needles and never share needles or works.

New Research and Expanded Treatment Delivery Offer Opportunities for Improved HIV Prevention

This section is a transcript of statements made by key participants and is taken from a document with the following introduction: “IAS Conference Participants Describe Potential to Advance HIV

Prevention through Research on Immune Responses, Genetics, and Integration of AIDS Treatment and Prevention Services"[36]

HIV Pathogenesis and Treatment

Research advances in the areas of host immunology and genetics may lead to improvements in HIV prevention efforts. One researcher described the potential impacts of expanded AIDS treatment delivery on HIV prevention, and noted opportunities and risks for HIV prevention in the future.

"Expanding the number of prevention options and improving the delivery of existing interventions are top priorities in the global response to AIDS," said Dr. Helene Gayle, President of the International AIDS Society (IAS)

Impact of treatment expansion on prevention efforts

Dr. Salim Abdool Karim discussed the potential impact of expanded delivery of anti-retroviral therapy (ART) on HIV prevention. Karim is Interim Deputy Vice-Chancellor (Research) at the University of KwaZulu- Natal in Durban, South Africa,

Introduction of ART in resource-limited settings will affect HIV prevention in three important ways, according to Karim. At the biological level, ART provision reduces viral load in bodily fluids, making people living with HIV less likely to pass on their infection. On the behavioral level, availability of ART encourages individuals to come forward for voluntary counseling and testing, but it may also lead to "behavioral dis-inhibition" in which people become less likely to practice safer sex and needle use. Finally, on the operational health systems level, treatment delivery is likely to lead to overall improvements in health systems and better integration of AIDS care with reproductive health and TB services. Karim said that it is essential for AIDS treatment services to be accompanied by expanded prevention programming so that AIDS deaths and new HIV infections decrease in tandem. He warned that without expanded prevention efforts alongside treatment scale up an increase in HIV incidence may occur.

Results of New Study on Male Circumcision Presented

Dr. Bertrand Auvert and co-investigator Dr. Dirk Taljaard presented results of an ANRS-sponsored study testing male circumcision as an HIV prevention intervention. The study showed a dramatic reduction in HIV incidence among circumcised men, and it may signal a major advance in HIV prevention. However, experts cautioned that the results from this single study must be confirmed by others that are currently underway, and also underscored the need to ensure that male circumcision be performed safely by well-trained practitioners.

Campaigns, surveys and Key messages

36 Rio de Janeiro, 26 July 2005 – International leaders in AIDS research and policy participating in the 3rd IAS

The National Prevention Campaign- The South African Department of Health.

What follows is an extract of a presentation by the then Director HIV AIDS and STDs in the South African Department of Health, dr Nono Simelela on the government's prevention strategy for HIV and AIDS.

Prevention Programmes

"It is internationally acknowledged that prevention efforts need to be the first line of defence against the further spread of the HIV/AIDS epidemic. The prevention programme in Government focuses mainly on the following areas:

- Procurement of high quality male and female condoms
- STI management
- Life skills and HIV/AIDS education
- TB Control and integration with HIV/AIDS
- Prevention of Mother-to-Child HIV transmission (PMTCT)
- Vaccine development
- Blood safety

The Department of Health has a long-standing commitment to the provision of preventive barrier methods. In 2000 the Department distributed approximately 250 million free male condoms in the public sector. In terms of female condoms the Department in 2001 expanded the number of sites where female condoms are available from 27 to 114.

Syndromic Management of STIs

It has been shown that the effective management of STIs, using the syndromic management approach, plays a central role in reducing the risk of HIV transmission. This programme is driven through the development and distribution of resource materials to healthcare workers and the training of healthcare workers on the syndromic management of STIs. One of the outcomes of this emphasis is the steady decline in syphilis amongst pregnant women attending our public sector clinics (from 11.5% in 1997 to 4.9% in 2000).

Ensuring that the youth of South Africa have as much information available to enable them to make informed choices regarding their sexuality and sexual behaviour is an important prevention strategy. This is achieved mainly through the life skills and HIV/AIDS education programme in primary and secondary schools. This programme is managed primarily by the Department of Education.

MTCTP

An important arm of the prevention programme is the prevention of mother-to-child HIV transmission (PMTCT) programme. Following research studies presented at the 13th International AIDS Conference in 2000 (SAINT and HIVNET 012), the Department of Health conceived and

implemented operational research to study the extent to which the HIVNET 012 findings could be replicated in real life situations. This included the study of adherence to chosen feeding practices and follow up on mother's resistance profile as well as the well-being of the infant-mother pairs over time. Implementation started in the first of the 18 national sites and its 260 access points (clinics and hospitals) in May of 2001. (The number of access points increased from 153 in July 2001 to 260 in December 2001.) Since implementation started approximately 66 000 women have presented for antenatal care at these access points, of which approximately 36 000 agreed to voluntary and confidential HIV counselling and testing. At last count more than 3 000 babies had been provided with Nevirapine.

Vaccine Initiative

Another prevention activity to highlight is the support of Government for the South African AIDS Vaccine Initiative (SAAVI) that was established in 1999 to develop and test an effective, affordable and locally relevant vaccine for South Africa within ten years. Since then good progress has been made. Currently SAAVI is preparing for the first clinical trial with the VEE (Venezuelan Equine Encephalitis) vaccine.

Impact

It was difficult to find documents and information which provided an analytical appraisal of the key messages and methodology that informs the government's prevention strategy. What follows is a summary of various documents which refer to the government's programme and provide some analysis of various initiatives.

The Department of Health produced the following information in its recently published Annual Report[37] .

- More than 80% of all public health facilities offer VCT and
- 60% offer PMTCT.

The 2005 edition of the South African Health Review[38] dedicates a chapter to an assessment of what it refers to as "major communication initiatives on HIV and AIDS – Soul City, LoveLife and Khomanani". The period under review is between 1999-2004. These organisations receive a substantial proportion of their funding from the Department of Health.

What follows is extracts from the document written by Jo-Ann Collinge which is a reflection of research findings which 'reflect on the impact of these initiatives over the years.

- A growing trend over the five years has been the expansion of face-to-face communication, which is used in combination with mass media initiatives.
- The paper states that "although combined efforts of these (and other) initiatives have not secured a downturn in HIV prevalence, specific impact studies show that they are, variously, associated with positive shifts in:

[37] Department of Health. Annual Report 2004-2005.

[38] Gray A, Govender M, Geniah T, Singh J. Health Legislation, In: Ljumba P, Barron P, editors. South African Health Review 2005. Durban Health Systems Trust; 2005.

- *Knowledge, attitudes and safe sex behaviours, which are conducive to curtailing HIV infection.*
- *Knowledge, attitudes and supportive activities that serve to reduce the stigma that attaches to HIV and AIDS, to promote health seeking behaviour and to build a more caring environment.*

- Condom use as a method of safe sex has increased significantly. ***However, overall levels of use, consistency of use and practice in certain age groups are not yet adequate to change infection patterns.***
- Generally, studies indicate that there is a greater degree of openness about HIV and AIDS and growth in acceptance of those living with the virus.

In a section looking at "Models, methods and messages, Collinge assesses each of the campaigns:

Soul City

The Soul City Institute takes the view that formative research is the foundation of its work and it transforms pure entertainment into edutainment.[39]

Collinge provides a good description of what Soul City is doing. She states that the work of Soul City reflects "the intention both to convey information and dispel myths, in order to meet established audience needs.

LoveLife

Collinge has this to say about the LoveLife campaign. That "in an age where commercialism reigns supreme, Lovelife has attempted to present the lifestyle which it advocates as a "brand" – as a commodity for young people.

Khomanani

- Soul City participates in Khomanani in an advisory role and as a partner in specific projects. Khomanani has largely followed the Soul City model of mass media communication, emphasising formative research as a basis for setting objectives and formulating messages.

Collinge states that while all three programmes face difficulties in measuring change and establishing causality, it is only LoveLife that has not undertaken an overall independent impact study.

Soul City	Khomanani	LoveLife
Research showed a number of significant shifts from baseline evaluation and, in many cases, a significant association of this change with exposure to Soul City.[40] The "bottom line" in terms of	The average age of first sexual experience –16 years for males and 17 years for females – did not change between baseline and evaluation surveys –	The findings of the survey commission by LoveLife reflect a significant association between exposure to LoveLife and both knowledge of HIV

[39] Usdin S, Christofides N, Malepe L, Maker A et al. The value of advocacy in promoting social change. Implementing the new Domestic Violence Act in South Africa. Reproductive health Matters Journal November 2000; 8(16): 55-65.

[40] Goldstein S and Scheepers E. Soul City IV Impact evalusation: AIDS. Johannesburg. Soul City Institute for Health and Development Communication 2000.

prevention as a shift inone of the key safe sex behaviours: Delaying or abstaining from sex, reducing sexual partners; and consistent condom use. Exposure to Soul City was associated with significant increase in condom use, both as a consistent practice and on a less-than-consistent basis. Qualitative research pinpointed Soul City as a direct factor in increasing regular condom use. Exposure tp Soul City 4 was associated with positive attitude shifts to gender and sex.	period too short-However the follow-up survey showed significantly more positive attitudes among young people in delaying sex and a stronger perception that their friends think likewise.	prevention and behaviour intended to have a protective effect. More specifically the figures reveal some gains in family communication relating to HIV and in uptake of HIV testing among young people.

Collinge makes the following important recommendations:

Improved Coordination

- Coordination and some sort of informal structure could look at the interface between service provision in the area of HIV and AIDS, like counselling and testing services, treatment programmes, and administration of grants; and campaigns that place demands on these services.

Minimum standards

- The use of African Languages
- Ratios of spending on brand advertising to HIV messing
- Process to be followed for materials testing and evaluation.

Streamlining of research

The comment made by Collinge with respect to this issue is of critical importance and this is a undercurrent in most of the literature reviewed.

- Better coordination could create the preconditions for more cost-effective research.
- The potential to share formative research and to track change across key indicators, similarly measured and analysed, has not been exploited to date.
- Present research is so specific that it is difficult to get results to “talk to each other”.
- Research tends to be very tightly tied to evaluation of specific interventions and there is insufficient research of the type that gives long-term strategic direction particularly with regard to method.

HSRC Survey

In 2005 the HSRC issued its findings of its second national survey of HIV/AIDS as commission by the Nelson Mandela Foundation and conducted in partnership with CADRE.[41]

41 Shisana O. 2005

This first survey was conducted in 2002 and it is the first time that similar surveys using the same methodology was repeated at a national level. This is significant as the second survey allows for comparison. Some of the objectives of the survey of relevance include:

- Identifying risky behavioural and cultural determinants of HIV.
- Explore the reach of HIV/AIDS communication and the relationship of communication to response.

Summary of Findings:

Prevelance:

- HIV prevalence amongst persons aged two years and older is estimated to be 10.8%, with a higher prevalence in females (13,3%) than in males (8.2%).
- HIV prevalence increases with age from 3.3% in children 2-14 years of age to 16.2% in adults 15-49 years of age.
- In people 50 years and older the HIV prevalence is estimated to be 5.7%.
- HIV prevalence by province shows that KwaZulu –Natal, Mpumalanga and Free State have the highest HIV prevalence in SA. The lowest prevalence levels were in the Western Cape and Northern Cape.

HIV Prevalence by sex and age

- HIV prevalence increases dramatically among young females and peaks at 33.3% in the 25-29 age group.
- In males the increase in HIV prevalence is more progress, and peaks at a lower level than for females (23.3% in age groups 30-34 and 35-39) from age group 35-39 onwards HIV prevalence is higher in males than in females.
- From age group 35-39 onwards HIV prevalence is higher in males than in females.

Behavioural Determinants of HIV/AIDS

A key section of the survey looked at behavioural determinants of HIV/AIDS.

- The most common mode of HIV transmission in SA is heterosexual intercourse.

Sexual behavioural risks

Sexual debut –

- Very few children in the 12-14 year age group reported engaging in sex.
- The median age at first sex for youths aged 15-24 was 17.

Sexual Partners

- Young males (27%) reported more multiple partnerships than all older males (14.4% for 25-49 year-olds, and 9.8% for those 50 years and older.)

Age Mixing

- While nearly two thirds of sexually active males (66.2%) female respondents (65.3%) had a sexual partner with an age difference within five years of their own age;
- Nearly one third of males (32%) had partners who were more that five years younger than themselves while among the females the opposite was found (33.2% had partners who were at least five years older than themselves.

Perceived susceptibility to HIV Infection

The report makes the point that an individual's belief in his or her personal susceptibility to illness or disease is an important element in nearly all models of preventative health behaviour give that it influences the adoption of risk-reducing behaviour and or preventative strategies.

- The majority of the adult and youth respondents (66%) in the survey believed that they would not get infected with HIV while 34% believed they probably or definitely would.

Recommendation of HSRC Study

- HIV/AIDS campaigns and programmes must address the false sense of security in the general population.
- South Africans must be encourages to find out their HIV status. Counselling and other services also need to be expanded to provide additional support to persons who discover that they are HIV positive.
- Stigmatising attitudes are decreasing.
- Integration of family planning and HIV/AIDS services is vital. The survey recommends that it is critical that government targets pregnant women and women in the child-bearing age group through strengthening of family planning programmes as follows:
  - All women in the reproductive age group (15-49) must be encourages to use a contraceptive method.
  - Those who use injectable contraceptives and contraceptive pills must also be encouraged to use condoms consistently with both regular and non-regular partners as long as they do not know their own or their sexual partner's HIV status.
  - All couples, whether married or not, must be encouraged to find out and share their HIV status.
  - Urgent action be taken on a national scale to make women aware of the risks of HIV infection during pregnancy and breastfeeding so they can make an informed choice of how best to protect themselves and their offspring from becoming infected.
- HIV/AIDS campaigns should also target "would be" parents to encourage them to:
  - Plan pregnancy
  - Get an HIV test before trying to conceive
  - Share HIV results between partners.

- Periodic HIV testing is crucial
- Young people should be encouraged to delay sexual debut.
- Avoiding high partner turnover and concurrent sexual partnerships.
- Prevention campaigns and programmes must emphasise that sexually active persons should:
  - Avoid engaging in unprotected sex with any person whose HIV status they do not know.
  - Access and consistently use condoms.
  - Avoid frequent turnover of sexual partners and concurrent sexual partners.
- Sexual partners amongst youth should be within a five-year age range.
- Inform women that they are more t risk and encourage self-protection.
- Getting tested for STIs and abstaining from sex when one has an STI.
- Warn older South Africans that they too are at risk of HIV
- HIV infection among children is real and needs emphasis
- Include children in surveillance and modelling the HIV/AIDS epidemic.
- Safe make circumcision is vital to prevent HIV in South Africa.
- Positive prevention is an important tool for HIV prevention:
  - There is a need to use other interventions to complement the behavioural risk reduction strategies offered through VCT. Two potentially useful intervention models that could be adopted to target this specific group include:

        - "Healthy Relationships" used mainly with existing support groups and
        - "Options for Health" provided by health providers such as doctors, nurses and VCT counsellors, mainly in clinical settings providing HIV treatment.
- Refocus Communication Strategy
    - Need a systematic and co-ordinated approach to addressing key knowledge areas of prevention, treatment, care, support and rights.
    - There is a need for accountability of programmes to an overarching communication strategy that is related to the national comprehensive plan.
    - There should be an emphasis on addressing issues of risk and vulnerability directly. This applies to gender vulnerability and rights.
    - Approaches to supporting local-level communication and dialogue.
    - There is an urgent need for national campaigns and programmes on prevention that also target non-youth audience.
    - Need for conveying knowledge of the basic science of HIV.

The Reproductive Health Research Unit [RHRU]

The Reproductive Health Research Unit [RHRU] published its findings in 2004[42] of a national survey of 15-24 year olds. The stated objectives of this survey were as follows:

- The first objective is to identify trends in HIV infection and related determinants of infection among young people.
- The second objective is to try and gauge the relative impact of loveLife on HIV and related risk behaviours.

These objectives were set against the following aims:

- To establish the prevalence of HIV and related behaviours among young people aged 15-24 years
- assess young people's sexual attitudes
- examine the extent of young people's exposure to loveLife
- undertake this data collection with sufficient accuracy to permit monitoring of trends over time

Relevant findings:

HIV Prevelence:

42 Pettifor AE, Rees HV, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I, HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand, 2004.

- The survey found that among 15-24 year old South Africans the HIV prevalence was 10.2% [95% CI 9.3-11.3].
- Prevalence was significantly higher among women (15.5%) than among men (4.8%) as well as in the 20-24 year old age group (16.5%) compared to the 15-19 year old age group (4.8%).Young women are disproportionately affected by HIV.
- Among the 10% of South African youth who are HIV positive, 77% are women. Nearly 1 in 4 women aged 20-24 are HIV positive compared to 1 in 14 men of the same age.
- The highest HIV prevalence was found in KwaZulu-Natal province (14.1%) and the lowest in Limpopo province (4.8%). In terms of geographic area, youth living in urban informal areas had the highest HIV prevalence (17.4%).
- This was followed by rural formal areas (13.5%), urban formal areas (9.8%) and rural informal areas (8.7%).

LoveLife

The Survey Results provides the following description of the Lovelife Campaign:

"*The largest youth focused intervention is loveLife, which is a national HIV prevention campaign for young people that combines a sustained multi-media awareness and education campaign with a nationwide drive to develop youth-friendly sexual health and outreach services. Its aim is to achieve significant behavioural change among South African teenagers for the purposes of HIV reduction, as well as reductions in other sexually transmitted infections (STI) and teenage pregnancy. As a joint initiative between government, NGOs and an academic institution, loveLife is national in both scale and scope, and complements other prevention efforts in South Africa"*

The Research Report under review makes an important comment on the limitation with respect to the data reported on as it represents information collected on self-reported behaviours. Researchers have questioned the validity of self-report measures in data collection, given that respondents often provide socially acceptable answers rather than reality[43].
In 2005 Warren Parker of CADRE wrote a paper entitled: "*Claims and realities in HIV programme evaluation"* article commenting on the Lovelife campaign in South Africa.[44] In this article Parker questions the impact of Lovelife Campaigns and questions the manner in which the impact of this campaign has been measured. The paper confirms the fact that of concern to South Africans is that the HIV prevalence rates are increasing. This is not just confirmed by Anti Natal surveys reviewed above but have been confirmed as pointed out by Parker in the national population-based surveys showing high rates of prevalence amongst youth- one in twenty 15-19 year olds were found to be HIV positive in 2003 in a survey conducted by the Reproductive Health Research Unit (RHRU) and also reviewed in this overview.

43 Weinhardt L, Forsyth A, Carey M, Jaworski B, Durant L. Reliability and Validity of Self-Report Measures of HIVRelated Sexual Behaviour: Progress since 1990 and Recommendations for Research and Practice. Archives of Sexual Behavior 1998,27:155-179

44 Parker,W.Claims and realities in HIV programme evaluation. CADRE. 2005.

More recently Parker once again made very salient points on the current LoveLife messages which serve to increase stigma associated with HIV as opposed to attempting to inform people and change sexual behaviour and attitudes.

Kylie Thomas[45] provides a critical analysis of the LoveLife Campaign. Her argument is that LoveLife and its messages are not problematic only because of their vagueness in a country which is still dealing with AIDS denialism. So she says that while the messages work to confuse rather than clrify issues about HIV/AIDS, but more that this, the campaign obscures the social factors that shape gendered identities. It also sets up a binary opposition between HIV-positive and negative individuals. *By focusing its prevention efforts on effecting change in behaviour at an individual level, the lovelife campaign elides the multiple socioeconomic factors that are determining factors in the spread of HIV.*

Thomas's suggestion is that no single awareness and prevention campaign can address and transform the complex range of social issues that shape the course of the HIV/AIDS epidemic. She then makes reference to a quote from Helen Epstein[46] who in referring to the LoveLife campign points out that:

People like the colourful, frank advertising and the basketball games sponsored by LoveLife. But its programmes may well be reinforcing the denial that poses so many obstacles to preventing HIV in the first place. A more realistic programme to prevent AIDS should pay greater attention to the real circumstances in people's lives that make it hard for them to avoid infection. It should also be more frank about the real human consequences of the disease.

Abstinence and Abstinence-only education

What follows is a review of a very good paper looking at various aspects of prevention and which includes commentary on research and evaluation of these messages. The paper is entitled: Abstinence and abstinence-only education: A review of US policies and programmes and was produced in the Journal of Adolescent Health in 2005[47].

The paper under review makes the important point that abstinence from sexual intercourse is an important behavioural strategy, for preventing HIV and other sexually transmitted infections (STIs), and pregnancy among adolescents. But the paper states that controversy arises when abstinence is provided to adolescents as a sole choice and where health information on other choices is restricted or misrepresented [my emphasis]. How do we define abstinence? Abstinence may be defined, according to the paper in behavioural terms such as "postponing sex" or "never had vaginal sex" or refraining from further sexual intercourse if sexually experienced.

While it is obvious that abstinence from sexual intercourse is fully protective against pregnancy and sexually transmitted infections, as a message on its own, this is misleading and potentially harmfully because it conflates theoretical effectiveness with the actual practice of abstinence. As

45 Thomas K, (2004). A bteer life for some: the LoveLife campaign and HIV/AIDS in South Africa. Agenda No.62 2004

46 Epstein H, (2003) "AIDS in South Africa: The Invisible Cure", in New York Review of Books, 50, 12.

47 Santelli, J, Ott MA, Lyon M, Rogers J, Summers D, Schleifer R. Abstinence and abstinence-only education: A review of US policies and programmes.Journal of Adolescent Health. 2005

pointed out, abstinence is not 100% effective in preventing pregnancy or STIs as many teens fail to remain abstinent.

Which approach is more effective in preventing HIV infection among young people and reducing teenage pregnancy: abstinence only or broad-based sexual health promotion? The debate on this issue has gained prominence following the US government's increased funding of abstinence only programmes for young people. However, despite the US federal government's 20-year support for abstinence-only-until-marriage programmes for American adolescents, there is no peer-reviewed research proving that these have had a positive impact on behaviour. Those advocating a broad-based sexual health promotion approach argue that programmes delivering a clear, sustained message of abstinence as one option alongside the use of condoms and other forms of contraception are the most effective in reducing risky behaviour among young people.

The guide under review looks at the arguments for and against both approaches, providing a review of the evidence base and summaries of research on the key issues:

Abstinence only programmes

Abstinence only approaches usually have a strong moral basis, promoting specific religious values and typically teaching abstinence from all sexual activity outside marriage. This often involves censorship of information on condom use as well as on other forms of contraception. Proponents argue that:

- Sex education encourages early sexual activity
- Education on contraception encourages sexual activity and makes teenage pregnancy more likely
- Condoms and other kinds of contraceptives frequently fail.

The most thorough evaluations of abstinence only programmes have been done on those in the United States. Several studies have shown some evidence of behavioural and attitude change as a result of these programmes. However, a recent review of evaluations of abstinence only programmes that claimed success concludes that, with the exception of the mass communications programme 'Not Me, Not Now', none of the evaluations produced credible evidence of effectiveness, and evidence form the Not me, Not Now' was limited as well.

However, two studies comparing abstinence only programmes with safer sex programmes conclude that the latter have better long term results, including higher levels of abstinence as well as increased condom use. Evidence from surveys conducted in Zimbabwe also suggests that unless young people receive full factual information, serious misconceptions and misunderstandings about abstinence may result, increasing the chance of risky sexual behaviour. The role of abstinence in reducing HIV rates in Uganda is disputed. Data suggests that a combination of factors is responsible for the decline, rather than one single intervention approach. These factors include increased condom use, faithfulness and abstinence.

Achieving and assessing behaviour change

There are significant barriers to behaviour change in young people. A range of social factors contributes to young people engaging in unprotected sex, despite knowing that abstinence and condom use prevent HIV infection. Evidence also suggests that young people often recognise

promotion of abstinence only programmes, or programmes advocating delayed sexual activity, as a 'moral agenda' dressed up as health promotion. Key social factors hindering behaviour change include:

- Lack of access to condoms
- Young people's lack of confidence in their own capacity to abstain from sexual activity, or their feeling that they cannot insist on condom use with partners
- Male control and the fear of violence in sexual relationships make it difficult for young women to negotiate when, with whom and how sex takes place.
- Evidence suggests that women tend to respond more positively than men to abstinence messages

Sexual health and HIV education programmes

Proponents of a broad-based sexual health promotion approach focus on providing accurate information on the risks of sexual activity and advising young people about ways of protecting against pregnancy and sexually transmitted infections (STIs), often using peer education and participatory teaching methods.

Key arguments are as follows:

- Whether or not adults find it morally acceptable, millions of young people throughout the world are sexually active; they therefore need access to information and health services to help them make responsible decisions about their sexual behaviour
- There is no evidence to support the claim that sex education increases sexual activity
- There is evidence to suggest that young people who receive sex education begin sexual activity later and have fewer partners.

The following interesting comments were made on studies conducted in developing countries on this issue.

In developing countries, studies have shown that the impact on young people's behaviour has been stronger from programmes which combine abstinence, monogamy and information about safer sex. Safer sex education has a positive influence on reproductive health knowledge and attitudes and evidence shows that it can also lead to greater abstinence and decreased sexual activity. However, an assessment of the effectiveness of 21 broad-based school programmes covering youth reproductive health and HIV/AIDS prevention concluded that HIV/STI (sexually transmitted infections) programmes had a greater impact on behaviour change than the other broad-based programmes.

The literature concludes that the following constraints on the effectiveness of broad-based programmes exist:

- lack of funding,
- lack of teacher training,
- low level of involvement by youth and parents,
- and the fact that the primary focus of the programmes was on older youths who were already sexually active.

Behaviour Change Communication (BCC)

Definition: *Behavior Change Communication*[48] *(BCC) is a multi-level tool for promoting and sustaining risk-reducing behavior change in individuals and communities by distributing tailored health messages in a variety of communication channels.* The key components of BCC include:

- Increase Knowledge. BCC should ensure that people have the basic facts in a language, visual medium or other media that they can understand and relate to. Effective BCC should motivate audiences to change their behaviors in positive ways.
- Stimulate Community Dialogue. Effective BCC should encourage community and national discussions on the underlying factors that contribute to the epidemic, such as risk behaviors, risk settings and the environments that create these conditions. BCC should create a demand for information and services, and should spur action for reducing risk, vulnerability and stigma.
- Promote Advocacy. Through advocacy, BCC can ensure that policy makers and opinion leaders approach the epidemic seriously. Advocacy takes place at all levels, from the national down to the local community level.
- Reduce Stigma and Discrimination. Communication on HIV/AIDS should address stigma and discrimination and attempt to influence social responses to them.
- Promote Services for Prevention Care and Support. BCC can promote services that address STIs, orphans and vulnerable children (OVC), voluntary counselling and testing (VCT) for HIV, mother-to-child transmission (MTCT), support groups for people living with HIV/AIDS (PLHA), clinical care for opportunistic infections, and social and economic support. BCC can also improve the quality of these services by supporting providers' counselling skills and clinical abilities.

The goals of behaviour change communication

BCC strategies in HIV/AIDS aim to create a demand for information and services relevant to preventing HIV transmission, and to facilitate and promote access to care and support services. Some specific BCC objectives include:

- Increasing the adoption and continued use of safer sex practices;
- Promoting visits to clinics treating STIs and opportunistic infections, including tuberculosis;
- Increasing the demand for VCT, for MTCT prevention services, and for OVC care and support;
- Increasing the adoption and continued use of safer drug-injecting practices;
- Stimulating dialogue and discussion on risk, risk behaviour, risk settings and local solutions; and
- Reducing stigma and discrimination for those living with HIV/AIDS.

Essential steps to develop behaviour change communication strategy

48 Behavior Change Communication Handbook Series: Assessment and Monitoring of BCC Interventions: Reviewing the Effectiveness of BCC Interventions. AIDSCAP/Family Health International, 1996. Arlington, VA. [published in English, French and Spanish]

- BCC should be integrated with overall program goals and specific objectives. BCC is an essential element of HIV/AIDS prevention, care and support programs, and providing critical links with other program components. BCC should be linked to policy initiatives and service provision.
- BCC should encourage individual behaviour change and also help create environmental conditions that facilitate personal risk reduction.
- Formative assessment or audience research must be conducted to better understand the needs of the target population and the barriers to behaviour change that its members face.
- All BCC in HIV/AIDS should contribute to stigma reduction.
- The target population and the related community should participate in every phase of BCC development.
- Using a variety of communication channels is more effective than relying on any one. For example, peer education should be promoted by mass media, counselling and other approaches.
- Pre-testing is essential for developing effective BCC materials.
- Monitoring and evaluation should be incorporated at the start of any BCC program.
- Objectives for change after exposure to the communication should be specified. These may be changes in actual behaviour or shifts in the precursors to behaviour change, such as in knowledge, attitudes or concepts.
- Fear campaigns do not work. They contribute to an environment of stigma and discrimination.

Because society-wide change is slow, changes achieved through BCC will not be seen overnight.

The Family Health International Institute [FHI][49]produced a document on BCC. This document provides a concise definition of the relevance of BCC in the context of the AIDS epidemic. It states that: “BCC is an essential part of a comprehensive programme that includes both services (medical, social, psychological and spiritual) and commodities (eg. Condoms, needles and syringes)” It provides the following important proviso viz. that “before individuals and communities can reduce their level of risk or change their behaviours, they must first:

- Understand the basic facts about HIV/AIDS
- Adopt key attitudes
- Learn a set of skills
- Be given access to appropriate products and services.
- Finally they must perceive their environment as supporting behaviour change and the maintenance of safe behaviours and
- Supportive of seeking appropriate treatment for prevention, care and support.

Of importance in this approach is the emphasis on the need for a supportive environment. The paper lists the following prerequisites for the development of a supportive environment:

- It requires national and community-wide discussion of relationships,
- Of sex and sexuality,
- Of risk, risk settings, risk behaviours and

49 Family Health International Institute for HIV/AIDS. Behaviour Change Communication (BCC) for HIV/AIDS –A Strategic Framework. 2003

- Of cultural practices that may increase the likelihood of HIV transmission.
- One that deals at a national and community level with stigma, fear and discrimination
- And deals with policy and law.

BCC can also produce insight into the broader socioeconomic impacts of the epidemic and mobilise the political, social and economic responses needed to mount an effective programme.

Theory Driven Behavior Change Communication

Ideation
Need to Identify/influence ideational factors related to desired behaviors

- Abstinance
- Being faithful to one partner
- Consistent condom use
- Delaying sexual debut
- Seeking treatment for STIs
- Seeking VCT
- Preventing MTCT

Social legitimization: improving social environment

- Breaking the silence
- Improving policy environment/strengthening political will
- Overcoming stigma
- Agenda priority setting
- Increasing public understanding of HIV impact

Social network

- Stimulating couple & community discussions
- Influencing community norms
- Developing community capacities

Social learning/modeling

- Modeling individual and collective self-efficacy
- Modeling health provider behaviors
- Scaling up entertainment education programming

Indicators for Community Empowerment and Change

- Leadership
- Degree & Equity of Participation
- Information Equity
- Collective Self-Efficacy

- Sense of Ownership
- Social Cohesion
- Social Norms

Community Based Prevention and Education Campaigns:

According to a paper produced by the Society for Adolescent Medicine[50] core components of community based prevention and education campaigns include:

- Activities that take place in schools and youth-serving organisations.
- Activities that is scientifically grounded and evidence-based.
- Information that is provided must focus on developing both resilience and decision-making and be inclusive of ethnically and behaviourally diverse youth of all types of sexual orientation or behaviours.
- Abstinence and delay of sexual initiatives should be an important component of all preventative education approaches, especially for young adolescents and for adolescents of all ages who are already infected.

But abstinence is not endorsed as an exclusive approach. It is recommended that concrete education and training about the use of barrier methods and safer sex negotiations skills for all modes of sexual contact must remain the essential component of prevention education for youth.

Analytical Literature on Prevention and Sexuality

The Feminisation of HIV/AIDS

Increasingly, "the face of HIV/AIDS is a woman's face"[51] Women have greater susceptibility than men to infection due to social, cultural and physiological reasons, and are now being infected at a higher rate than men[52]. Though the epidemic initially affected mostly men, today approximately half of the 40 million people living with HIV are women. The highest female infection rates are in countries where the epidemic has become generalized and where transmission is primarily heterosexual, often in the context of marriage.[53] Fifty-seven per cent of all people living with HIV in

50 Angelo LJD, Samples C, Rogers AS, Peralta L, Freidman L. HIV Infection and AIDS in adolescents: An update of the position of the Society for Adolescent Medicine. Journal of Adolescent Health. 2005

51 Annan,K.29 December 2002. "In Africa, AIDS has a Woman's Face." The New York Times/International Herald Tribune.

52 State of World Popuation 2005-UNFPA

53 UN Millennium Project 2005a.

sub-Saharan Africa and 49 per cent in the Caribbean are women, with young women facing the highest risks.[54] Seventy-seven per cent of all HIV-positive women in the world are African.[55]

"The toll on women and girls… presents Africa and the world with a practical and moral challenge, which places gender at the centre of the human condition. The practice of ignoring gender analysis has turned out to be lethal.[56]"

At The Epidemic's Core: Poverty, Violence And Gender Discrimination.

Physiologically, women are at least twice as likely as men to become infected with HIV during sex.[57] Women and girls are often ill-informed about sexual and reproductive matters and are more likely than men to be illiterate. They often lack negotiating power and social support for insisting on safer sex or rejecting sexual advances. Gender based violence is a major risk factor for contracting HIV

In addition, poverty forces many women into subsistence sex work or transactional relationships that preclude negotiating condom use. Often these women are unable for economic reasons to leave a relationship, even if they know their partner has been infected or exposed to HIV[58].

Some harmful practices—such as female genital mutilation/ cutting, child marriage, and "widow inheritance" (the union of the widow to a relative of the deceased husband)—compound women's risks.

Many people are still unaware of how to protect themselves from HIV. Only about 8 per cent of pregnant women and 16 per cent of sex workers worldwide were reached by prevention efforts in 2003.[59] Though most countries, including those in sub-Saharan Africa, have adopted national strategies to combat the epidemic, millions of women and men—indeed, the vast majority—are still without services or treatment.

Gender Matters.

Gender-sensitive approaches to preventing HIV are central to halting the epidemic. They can also catalyse broader social transformation. Women can gain more control in decisions affecting their lives with the support and cooperation of male partners, providers, communities and governments. Young men who learn to respect women and understand their responsibilities in halting HIV/AIDS are more likely to use a condom. Husbands can be enlisted to protect their wives and future children against HIV and other sexually transmitted infections.

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54 Ibid., and UNAIDS, UNFPA, and UNIFEM.2004. Women and HIV/AIDS: Confronting the Crisis. New York and Geneva: UNAIDS, UNEPA and UNIFEM.

55 UNAIDS, UNFPA, and UNIFEM 2004

56 Lewis S, UN Secretary-General's Envoy to Africa, Barcelona International AIDS Conference

57 UNAIDS. 2004a. "Fact Sheet: Women and AIDS: A Growing Challenge." Geneva: UNAIDS.

58 Ibid

59 Based on the Policy Project of the Futures Group for USAID and UNAIDS. Cited in: UN Millennium Project 2005a

Preventing HIV among women of childbearing age is crucial. Voluntary family planning should be integral to any and all strategies to halt the epidemic: Ethics and human rights demand that women who are HIV-positive can make informed family planning choices, including preventing unwanted pregnancy. Access to antiretroviral treatment can help safeguard a woman's well-being and prevent the tragedy of HIV transmission to her children.

Prevention, care and treatment programmes have gradually opened up discussions on gender, sexuality and reproductive issues. In 2004, UNAIDS launched the Global Coalition on Women and AIDS, a worldwide alliance of civil society groups, networks of women living with HIV/AIDS, governments and UN organizations. Its platform calls for education, literacy and economic rights for women; equal access to antiretroviral treatment; access to sexual and reproductive health services; changes in harmful gender stereotypes; and zero tolerance for gender-based violence.[60]

HIV/AIDS: What Does Gender Have To Do With It?

About three quarters of all new HIV infections are sexually transmitted between men and women. The attitudes and behaviours of men are critical to prevention efforts: Men hold overwhelming power in decisions on sexual matters, including whether to use condoms. In many societies, women are expected to know little about such matters, and those who raise the issue of condom use risk charges of being unfaithful or promiscuous. Violence against women and adolescent girls, and the fear of it, further erode women's negotiating position.

AIDS emerged in the 1980s as a disease that primarily affected men; but the proportion of infected women compared to men has risen steadily, from 35 per cent in 1990 and 41 per cent in 1997, to 48 per cent in 2004.

Among HIV-positive women, many are married and have had only one partner—their husbands. In parts of Africa and the Caribbean, the two regions with the highest HIV prevalence, young women (ages 15 to 24) are up to six times more likely to be infected than young men their age. Young women are the most affected group in the world: They represent 67 per cent of all new cases of HIV among people aged 15 to 24 in developing countries. In sub-Saharan Africa, young women represent 76 per cent of young people living with HIV. Up to 38 per cent of unmarried adolescents ages 15 to 19 years have engaged in sex for money or goods in some sub-Saharan African countries where AIDS is rampant.

Marriage: Safety or Risk for HIV?

Most people think marriage is "safe", but in many places it poses significant risks of HIV infection for women. The following figures, from both national studies and smaller-scale surveys of women, are indicative:

- More than four fifths of new HIV infections in women occur in marriage or long-term relationships with primary partners.

60 UNAIDS. 2004b. "A UNAIDS Initiative: The Global Coalition on Women and AIDS" Geneva: UNAIDS.

- In sub-Saharan Africa, an estimated 60 to 80 per cent of HIV-positive women have been infected by their husbands—their sole partner.
- At least 50 per cent of Senegalese women living with HIV reported only one risk factor—living in a "monogamous" union.
- In Mexico, more than 30 per cent of women diagnosed with HIV discover their status after their husbands are diagnosed.
- In India, some 90 per cent of women with HIV said they were virgins when they married and had remained faithful to their husbands.
- In Cambodia, 42 per cent of all new HIV infections occur from transmission by husbands to their wives. One third of new infections are to the babies of these women.
- In Thailand, 75 per cent of women living with HIV were likely to have been infected by their husbands.
- In Morocco, up to 55 per cent of HIV-positive women were infected by their husbands.

Studies show that married women would often rather risk HIV infection than ask their husbands to use a condom, thereby confronting them over infidelity. In two districts of Uganda, only 26 per cent of women said it was acceptable for a married woman to ask a husband to use a condom.

"I didn't understand how I, as a submissive woman, could be infected, having been faithful to the one man in my life."
— HIV-positive woman from Burkina Faso

It's Not as Simple as "ABC"

The "ABC" approach to HIV prevention counsels people to Abstain from sex, Be faithful to one partner, or use Condoms. ABC programmes have indeed expanded awareness. However, unless both women and men can make free and informed decisions, "ABC" messages may overlook critical factors that millions of women must confront:

- Can an adolescent girl insist that her older husband use a condom or be faithful?
- Can a battered woman who depends on her partner or husband to support her and her children raise the subject of fidelity or condom use?
- Can a young wife insist on condom use when she is pressured to produce a child in order to be accepted by her new husband and in-laws?
- Can a sex worker struggling to feed her children refuse a client who does not want to use a condom, especially if he pays twice or more the usual rate?
- Can an adolescent girl who is sexually coerced or raped protect herself from infection?

Does counselling abstinence until marriage keep young people safe when most are sexually active before they turn 20?

Gender Power Inequalities

What follows is a summary of a paper looking at Sexual Power and HIV Risk in South Africa[61].

…HIV activists and researchers have highlighted the role gender inequality may play in placing women at increased risk of HIV infection. While this exploratory study did not find an association between sexual power and HIV serostatus, it did confirm an association between two measures of sexual power, relationship control and forced sex, and condom use constancy.

Disproportionate Vulnerabilities, Disproportionate Burdens

Women and adolescent girls face high risks of HIV infection. They also provide much of the care for others who have acquired or are affected by the disease, including husbands and orphaned children. Women and girls represent 75 per cent of those caring for people living with AIDS. Taking care of the sick erodes the ability of women to generate income, thus limiting their opportunities for economic participation. The impact is especially severe in countries where women comprise the majority of farmers and produce most of the food. In the United Republic of Tanzania, women caring for sick husbands spent half as much time farming as they had previously. The loss of a husband's income, the costs of health care for ill relatives, and additional responsibilities can plunge women and their children deeper into poverty. Women with AIDS are also the last and least likely to seek or receive care. By the time a husband dies, family resources have usually dwindled to the point where women are either unable or unwilling to seek medical care. Inheritance laws and customs that favour the husband's relatives may leave widows and their children impoverished. The additional financial pressure may force women and girls into exploitative and risky sex work or relationships, further fuelling the epidemic.

Reproductive Health And Rights Of HIV-Positive Women.

Most HIV-positive women in developing countries have no access to antiretroviral treatment, neither for themselves nor to prevent transmission to their children. In addition, many assume that HIV-positive women will not have sexual relations and should not have children.[62] As a result, these women are often denied information and services to prevent pregnancy and mother-to-child HIV transmission, as well as access to quality prenatal and obstetric care. In societies where women are expected to produce children, HIV-positive women who opt to have none must contend with both the social disapproval of being childless and the suspicions and prejudice surrounding their status. Protecting the reproductive rights of HIV-positive women, including preventing coerced abortions or sterilization, is a critical human rights issue.

The International Community of Women Living with HIV/AIDS, created to address the lack of support provided to HIV-positive women, has led a Voices and Choices initiative in Central America, West Africa, Thailand and Zimbabwe that promotes women's rights to sexual and reproductive health.[63] In Argentina, FEIM, a leading women's NGO, disseminates the women's Bill

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61 Pettifor AE, Measham DM, Rees HV, Padiant NS. (2003) Sexual Power and HIV Risk South Africa. Emerging Infectious Diseases.Vol.10, No 11, Nov 2004.

62 International Community of Women Living with HIV/AIDS. 2004. Visibility, Voices and Visions: A Call for Action from HIV Positive Women to Policy Makers. London: International Community of Women Living with HIV/AIDS;

63 International Community of Women Living with HIV/AIDS 2004

of Rights developed at the 2002 International AIDS Conference and trains health personnel on human rights and contraception for HIV-positive women.[64]
In Kenya and South Africa, the "Mothers 2 Mothers 2 Be" project links HIV-positive new mothers with HIV-positive pregnant women for advice on issues from family planning to income generation.[65] Such "peer-led" counselling has helped HIV-positive women understand their reproductive health options and to cope with the challenges they face.

Transforming Lives In Swaziland

In the drought-stricken Lumombo region of Swaziland, women's active role in food distribution has led to benefits for the whole community. Non-governmental organizations supported by UNFPA and the World Food Programme trained women who led food distribution projects to address issues affecting the rural poor: sexual abuse, exploitation, AIDS and family planning. Community Relief Committees, which were 80 per cent women, reached out to men through discussion on these issues in community meetings, on food distribution days, at church, during home visits and when visiting the sick. The project resulted in increased reporting to police by women and children of sexual abuse, a surge in requests for HIV testing, and a ten-fold increase within a year in the number of people receiving antiretroviral treatment. One major success is that rural leaders now give women authority to speak in community meetings—which is unprecedented— because women are seen not only as food distributors but also as sources of knowledge.
"I have never felt so important in my community. Before I was chosen to be a member of the food distribution committee, I was a nobody, and now people come to me for advice and help," said a woman who is now a recognized community leader.

Women's Access To HIV/AIDS Treatment.

Programmes to prevent mother-to-child HIV transmission provide the only access to antiretroviral drugs for many HIV-positive women. In developing countries, most programmes focus on preventing transmission to the child and offer no benefits to the mother. In 2003, only 2 per cent of pregnant women testing HIV-positive worldwide received antiretroviral drugs to improve their own health.[66]

In Africa, only 5 per cent of pregnant women are offered HIV prevention services.[67] Some emerging programmes emphasize the health and well-being of both child and mother.[68]
For wealthy people living in wealthy countries, antiretroviral drugs have largely transformed HIV into a manageable, chronic disease. But only 12 per cent of people in low and middle-income countries had access to treatment by the end of 2004.[69]

Shame, Blame and Aids.

64 Bianco, M. 2003."The Balance of 20 Years Fight against HIV/AIDS in Agentina." Sexual Health Exchange 2003.

65 International Relief Teams. "Mothers 2 Mothers 2 Be." San Diego, California: International Relief Teams.

66 UNSAID, UNAIDS, WHO, UNICEF, and the POLICY Project. 2004. "Coverage of Selected Services for HIV/AIDS Prevention, Care, and Support in Low and Middle Income Countries. 2003.

67 UN Millennium Project 2005, p 43.

68 Columbia University's Mailman School of Public Health's MTCT-Plus Initiative.

69 United Nations. 2005a. Progress Made in the Implementation of the Declaration of Commitment on HIV/AIDS: Report of the Secretary-General.

Stigma kills. The shame associated with AIDS is a major obstacle to its prevention, and the stigma that surrounds people living with HIV is compounded by discrimination against women. Hundreds of thousands of HIV-positive women avoid testing and treatment services for fear of abandonment and other repercussions from husbands, families, communities and health providers.[70] Lack of confidentiality in testing services is a well-grounded concern. Women sometimes discover their HIV status last—after their husbands or in-laws.[71] Only 5 per cent of HIV-positive people are aware of their status,[72]and testing during pregnancy is often the only way that a family learns of HIV in its midst. Even if they contracted HIV from their husbands, women are sometimes blamed for "bringing AIDS home" and may face violence or ostracism as a result.[73] Health care providers sometimes deny HIV-positive women proper care during and following delivery. Women may refuse or discontinue treatment after negative interactions with staff.[74]

Many developing countries are combating stigma by opening up discussions about the disease, a key step in encouraging people to seek testing and treatment. One such programme supported by UNFPA is a regional initiative in seven Arab States on HIV awareness-raising. In Uzbekistan, a popular television soap opera airing since 2003 focuses on issues encountered in daily life, including substance abuse, HIV prevention and discrimination against people living with HIV/AIDS. In eight African and six Asian countries, UNFPA supports partnerships between radio networks and community based health organizations to produce dramas on HIV and AIDS.[75] Multiple partners are supporting many similar initiatives across the developed and developing world, using the mass media and community-based dialogue to overcome the shame and discrimination that perpetuates the epidemic.

The Other Epidemic—Sexually Transmitted Infections.

Sexually transmitted infections (STIs) and reproductive tract infections are among the most common causes of illness worldwide. An estimated 340 million new cases of curable STIs are reported every year.[76] When incurable infections (including HIV) are taken into account that number effectively triples. Women are more susceptible than men to these infections, for sociocultural and physiological reasons, and disproportionately suffer severe consequences, including cervical cancer and infertility. About 70 per cent of women with STIs present no symptoms (compared to 10 per cent of men),[77] making diagnosis in women more difficult. When symptoms do appear, women tend to accept them as unimportant.[78] The presence of STIs can also increase the risk of HIV infection two to nine times.[79] Yet only 14 per cent of people with STIs

70 Ogden and Nyblade 2005; and International Community of Women Living with HIV/AIDS 2004.

71 WHO and UNAIDS 2004, p. 5

72 Nieuboer, I. 2003. Once you Know You can Never Not Know Again: The Effect of a Digital Guide in Persuading Students to go for VCT.

73 Ogden and Nyblade 2005

74 Painter, T., et al. 2004."Women's Reasons for Not Participating in Follow Up Visits Before Starting Short Course ARV Prophylaxis for Prevention of Mother to Child Transmission of HIV: Qualitative Interview Study." British Medical Journal 329(7465):543

75 UNIFPA 2005

76 UNFPA. 2004.2004d. Sexually Transmitted Infections: Breaking the Cycle of Transmission New York: UNFPA

77 UNFPA 2005

78 UNFPA.2004e. The State of World Population 2004: The Cairo Consensus at Ten: Population, Reproduction Health and the Global Effort to End Poverty. New York: UNFPA

79 UNFPA 2004d.

in sub- Saharan Africa had access to treatment in 2003.[80] In addition, because sexually transmitted infections, including HIV, are most prevalent among young people, preventing these infections can have long-term benefits for the labour force and lead to higher productivity.[81]

Psychosocial factors and how they impact on the spread of HIV.

This section looks at other factors that are important determinants of HIV-related behaviours and which must be taken into account and inform any campaign aimed to preventing the further spread of HIV through impacting on sexual behaviour, attitudes and practices.

These factors include perception of HIV risk, confidence to insist on condom use – self-efficacy), and the intention to practice safer sex.

In an article written by Jonathan Berger[82] he speaks to the following issue: Even in the "era of treatment" successful HIV prevention remains an enormous challenge. Berger argues that there is a need to pay more attention to sex and desire in the design of HIV prevention programmes and to move away from stereotyped explanations of vulnerability that ignore agency and desire in the decisions that people make about sex. The article also warns against the continued marginalisation of people who engage in "dirty sex" from access to HIV prevention programmes and services

In response to this article Graham Hayes[83] speaks to the complexities of desire and openness which provide useful insights into what informs sexuality and sexual behaviour. In attempting to provide a basis for "a radical re-thinking of sexual morality and sexual practices" Hayes refers to the fact that the lack of information about HIV infection, cannot adequately account for the range of myths surrounding AIDS. More importantly he states that "Unless one gets to the basis of the formation of sexual morality, as psychoanalysis has the potential to so, there is little prospect of making AIDS a problem which affects us all…a truly social problem…He makes what could be seen as quite a pessimistic observation that while Berger calls for more openness and frank talk of "dirty sex" that this is not simply because it is immoral but has more to do with the complexities of sex and sexuality and that it "has to do with the "beyond language" "beyond speech" dimension of sex and sexuality." He attributes this "beyond speech" theory to certain "inhibitions that are not conducive to open frank discussions about sexuality" and "psychological repression… and that desire is not something easy to talk about".

80 Global HIV Prevention Working Group. 2003. Access to HIV Prevention: Closing the Gap. Menlo Park, California: Kaiser Family Foundation and the Bill & Melinda Gates Foundation.

81 Singh, et al. 2004

82 Berger J – 2004. Re-sexualising the epidemic. Desire, Risk and HIV Prevention. Development Update –Vol. 5 No. 3-From Disaster to Development- Interfund

83 Hayes,G. Desire, and the politics of sexuality. 2005. University of KwaZuluNatal

Research And Methodology Used To Understand Sexual Behavior

In an article entitled "Reframing research on sexual behaviour and HIV[84]" makes a critical point with respect to research and methodology used to understand sexual behaviour and HIV. It is pointed out that "Whereas surveys have provided reliable indicators of behaviour, their validity is uncertain, their correlation with biological indicators tenuous, and the explanations they offer limited. Micro-level research has called into question the rationalising, medically informed, and risk-averse frameworks used in the public health literature on HIV and behaviour, but its impact has been limited. Thus, surveys and qualitative research have proceeded along two separate tracks, and this separation has hampered our understanding of sexual behaviour. A small but growing number of studies, however, provide examples of less-compartmentalized research that avoids oversimplification. They show that expanding the models that drive research in this area is possible and that efforts to combine disciplinary perspectives result in deeper understandings of knowledge, risk perceptions, attitudes, and behavioural change".

What follows is a reproduction of a presentation which illustrates important elements of a BCC as a model.

Africa and Africa Specific Solutions

If we are to focus on Africa and Africa specific solutions, the following extract from the ADEA conference[85].

ADEA's Identifying Effective Responses to HIV/AIDS initiative has set out to identify promising approaches and practices implemented by African education systems to deal with the pandemic. Analysis of the 17 studies that have been conducted within the framework of the ADEA initiative shows that countries have mostly focused on integrating HIV/AIDS into school programs and that they have not looked much into system management and survival issues. The analysis also revealed that:

- Most countries have adopted programs aimed at bringing about changes in individual behavior;
- Because most programs to fight HIV/AIDS in the field of education are recent it is too early to evaluate their impact;
- Countries want programs to be proposed to students before they become sexually active;
- Peer education is an effective means of communicating with students about HIV/AIDS;

84 "Reframing research on sexual behavior and HIV" Obermeyer CM. Department of HIV, World Health Organization, 20 Avenue Appia, 1211 Geneva, Switzerland. obermeyerc@who.int

85 Reaching Out, Reaching All Sustaining Effective Policy and Practice for Education in Africa Fighting HIV/AIDS Proceedings of the ADEA Biennial Meeting Arusha, Tanzania October 7-11, 2001

- Countries should ensure that as many partners and actors are involved in the fight against HIV/AIDS,including representatives of religious groups;
- Broad acceptance of the need to break down the wall of silence surrounding the pandemic and issues related to sex in general is gaining ground.

ABC

Parikh[88] sums up the complexities of youth and sexuality by pointing out that: Understanding the unfolding of HIV/AIDS in the lives of young people requires both a combination of political economy's focus on wider structures of inequalities, and cultural inquiries into multiple meanings of love, emotion, and relationships. Political economy reminds us of the limits of ABC by highlighting the inequalities that structure people's lives. Even so, to not recognize the subversive nature of youth romance misses the crucial characteristics of its existence, however un-internationally harmful its outcomes may be. Finally, to ignore the emotional sides of youth romance is to reproduce sexual health campaigns that are irrelevant to the desire for affection of young people in the era of romance.

It is this desire for affection that puts females at risk. How do youth interpret ABC? Parikh points out that based on research conducted: monogamy and condoms represent two mutually exclusive options for safer sex. She further states that *many young lovers view condomless sex both as an indication of their ability to make wise and independent choices and as an affirmation of monogamy and commitment (*CF, Sobo, 1995)

The FOCUS Report provides the findings of research into three types of interventions:

- Creating a supportive environment for young people
- Improving reproductive health knowledge, attitudes and behaviours
- Increasing young people's use of reproductive health services.

It is important to note that this paper under review highlights results from 39 evaluations of programme interventions for youth in developing countries.

Sex and Sexuality associated with Pain and Violence

In attempting to define sexuality, in Africa it is difficult to reduce the concept to a simple statement. But the disturbing theme running through literature on the topic is the association of sexuality and sex with pain, suffering, mourning and death (in the context of HIV/AIDS and sexual violence in Africa.[86]

In his introductory comments a special edition of Agenda[87] Reddy makes an important point in relation to sexuality, feminism and gender. He points out that by and large *"the views espoused at International World Conferences of Women (Mexico in 1975; Copenhagen in 1980; Nairobi in 1985, Beijing in 1995). These dialogues have primarily centred on strengthening the rights of*

86 Reddy V, Sexuality in Africa:some trends, transgressions and tirades. Agenda No.62 2004.

87 Ibid

women, where a fundamental aspect of rights is linked to women's control over sexuality, the scope of sexual relationships, intimacy, violence, reproductive health and family planning. Sexuality therefore emerges as a distinct marker of social life, one that accentuates a view that the current material conditions of women's lives in particular, are still informed by violence and victimhood. But perhaps a challenge in thinking about sexuality is the necessity to guard against the martyrdom of all women as victims.

In the same edition of Agenda which focuses on empowering women for gender equality, Shanti Parikh[88] makes a point in a similar vein to that of Reddy quoted above. This related to the extent do we overlook female agency when we consider sexuality. She states that: *by primarily focusing on economic inequalities as structuring sexual relationships, what other aspects of sexual negotiation are we un-internationally silencing, ignoring or circumventing?* She then asks the critical question: *What can be learned by repositioning our analytic lens to include gendered expressions of love and sexual strategies?*

Married or co-habiting partners and risk of HIV

Maharaj and Cleland wrote an article along the same vein which was published in 2005[89]. In a paper entitled: "*Risk Perception and Condom Use Among Married Or Cohabiting Couples in KwaZulu, South Africa".* The authors provide the following context: *"Most HIV prevention efforts focus on premarital and extramarital sexual behaviour, but in areas with high HIV prevalence the protective needs of married and cohabiting couples are just as great and often go unmet. Condom use by these couples is generally low, with resistance from men and cultural norms commonly cited as barriers to increased use.*

In conclusion this document states that "the common belief that men's resistance to condom use within stable relationships cannot be overcome may be exaggerated. It goes further to state that HIV prevention should address the reproductive health needs of these couples

In a similar vein an article appears in the PubMed website – which is a service of the National Library of Medicine and the National Institute of Health – is entitled: *Where "being married" may be the greatest risk factor for acquiring HIV.*[90] The article speaks to how the fact that it is socially acceptable for husbands to have other sex partners – puts married women at risk of HIV infection. The concluding remarks of the article are that "underlying social and economic factors which put women at risk for contracting and transmitting HIV must be addressed."

88 Parikh S, Sex lies and love letters: rethinking condoms and female agency in Uganda. Agenda No.62 2004.

89 Maharaj P, Cleland J. (2005) Risk Perception and Condom Use Among Married Or Cohabiting Couples in KwaZulu-Natal, South Africa. International Family Planning Perspectives Vol31. No. 1. 2005

90 Asamoah-odei E. Where "being married" may be the greatest risk for acquiring HIV. Country focus: Ghana. AIDS Anal Afr. 1996 Oct;6(5):4-5.

Recommendations

- To be effective, HIV prevention programmes must address the contexts in which people live their lives.
- The rights and status of women and young girls deserve special attention. In many countries, marriage, and women's own fidelity are not enough to protect them against HIV infection. Among women surveyed in Harare (Zimbabwe), Durban and Soweto (South Africa), 66% reported having one lifetime partner, 79% had abstained from sex at least until the age of 17 (roughly the average age of first sexual encounter in most countries in the world). Yet, 40% of the young women were HIV-positive (Meehan et al 2004).
- Special attention needs to be paid to boys in terms of their socialization towards gender norms (UNAIDS, 2005).
- Prevention programme efforts must also address people of all ages to be fully effective. An emerging trend of rising infection rates among older generations in some countries may point to an important gap in prevention efforts with this age group. In South Africa, the rise in HIV prevalence among women older than 34 years is particularly striking
- HIV stigma and the resulting actual or feared discrimination have proven to be perhaps the most difficult obstacles to effective HIV prevention.
- Those pushed to the margins of society are at particular risk. Preventing infections here can play a significant role in stemming the rate of spread in many parts of the world. Key marginalized populations include sex workers, injecting drug users, prisoners, and men who have sex with men.
- Preventing and treating sexually transmitted infection reduces the risk of HIV transmission.
- Without HIV prevention measures, about 35% of children born to HIV-positive women will contract the virus. The key to protecting children is preventing infection in parents. Prevention of mother-to-child transmission is a crucial entry point for primary prevention, treatment, care and support for mothers, their children and families. Ensuring availability of family planning services, provision of antiretroviral medicines to the mother and the newborn, safe delivery options, infant feeding counseling, and support are the key components of prevention of mother-to-child transmission programmes. Implementation of such a comprehensive approach has virtually eliminated HIV transmission from mothers to their infants in industrialized countries.

The UNAIDS Policy Position Paper for Intensifying HIV Prevention details essential policy and programmatic actions for HIV prevention[17].

Essential policy actions for HIV prevention

- Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate discrimination and combat stigma.
- Build and maintain leadership from all sections of society, including governments, affected communities, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions.
- Involve people living with HIV, in the design, implementation and evaluation of prevention strategies, addressing the distinct prevention needs.
- Address cultural norms and beliefs, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission.
- Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls, involving men and boys in this effort.
- Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted.
- Promote the links between HIV prevention and sexual and reproductive health.
- Support the mobilization of community-based responses throughout the continuum of prevention, care and treatment.
- Promote programmes targeted at HIV prevention needs of key affected groups and populations.
- Mobilising and strengthening financial, and human and institutional capacity across all sectors, particularly in health and education.
- Review and reform legal frameworks to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV.
- Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies.

Essential programmatic actions for HIV prevention

- Prevent the sexual transmission of HIV.
- Prevent mother-to child transmission of HIV.
- Prevent the transmission of HIV through injecting drug use, including harm-reduction measures.
- Ensure the safety of the blood supply.

- Prevent HIV transmission in healthcare settings.
- Promote greater access to voluntary HIV counseling and testing while promoting principles of confidentiality and consent.
- Integrate HIV prevention into AIDS treatment services.
- Focus on HIV prevention among young people.
- Provide HIV-related information and education to enable individuals to protect themselves from infection.
- Confront and mitigate HIV-related stigma and discrimination.
- Prepare for access and use of vaccines and microbicides.

The most updated information on the state of the epidemic and prevention trends are reflected in the recently published report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) 2005 entitled *AIDS Epidemic Update. Special Report on HIV Prevention*. What follows is key aspects of the report which has a direct bearing on the objective of this overview:

- Studies show that HIV prevention efforts work best when they are intensive, i.e. comprehensive and long term. For example, intensive prevention programmes in the Mbeya region of Tanzania led to an increase in the use of condoms and the treatment of sexually transmitted infections between 1994 and 2000. Those changes were accompanied by a decline in HIV prevalence among 15–24 year-old women from 21% to 15% in the same period (Jordan-Harder et al., 2004). But in the Mwanza region of the country, less intensive and isolated HIV prevention efforts did not yield similar results; in fact, HIV prevalence increased in this area from 6% in 1994-1995, to 8% in 1999-2000 (Mwaluko et al., 2003).
- All strategies must also recognize that HIV prevention and treatment are interlinked and that both should be simultaneously accelerated. Evidence and experience show that rapidly increasing the availability of antiretroviral therapy leads to greater uptake of HIV testing.
- All HIV prevention strategies take into account the growing linkages between AIDS and factors that put people at greater risk of HIV infection, such as poverty, gender inequality, and social marginalization of specific populations.
- Equally important is the development and implementation of new technologies—such as microbicides and the improvement of existing products such as the female condom—that will provide additional options for the response and should become part of comprehensive prevention strategies. Longer-term vaccine development is also necessary.

A broad approach across all prevention strategies also requires that stigma and discrimination is addressed, that those most at risk of HIV infection are effectively reached, and that people living with HIV are engaged more fully in the AIDS response.

A position paper by the Society for Adolescent Medicine[91] sets out key areas that need to be addressed as part of any initiative to reduce the risk of young people to HIV infection. These are:

- Accurate and comprehensive monitoring of HIV infection in youth.
- Efforts to expand knowledge of HIV infection to youth from all countries and recognition that priorities in this regard must be based on local needs, not externally developed policies.
- Research into HIV care and treatment initiatives that are focussed on youth.
- Expansion of testing and counselling facilities including links to comprehensive care for positive or concerned youth.
- Community based HIV/AIDS prevention and education that recognises the importance of abstinence but is comprehensive and sensitive to the needs of all adolescents, including those who are gay, lesbian, bisexual, transgender or questioning.
- Continued research focusing on the antecedents of HIV infection and important preventative tools such as microbicides and vaccines.

Intervention Strategies that Work for Youth –

What do young people want?

Studies show that young people generally want information about safer sex including but not exclusively about abstinence. In a regional study conducted by AMREF in four countries in sub-Saharan Africa, communities identified the most critical adolescent sexual and reproductive health needs as:

- Provision of accurate information
- Poverty alleviation
- Comprehensive sex education in schools
- Provision of appropriate health care.

Evidence also suggests that the behaviour and opinions of adults, including parents, other relatives, role models and the wider community, have a strong influence on young people's sexual knowledge and behaviour. One study in Cameroon found that young males who felt they had parental support for condom use were 1.6 times more likely to have used condoms, and young females were 2.6 times more likely.

Summary of FOCUS on Young Adults End of Program Report. Youth Issues Paper 1. 2002 Family Health International.

Of importance in this document is the reference programmes to help young people in developing countries practice healthier behaviours. Healthier behaviour according to the document includes:

91 Angelo LJD, Samples C, Rogers AS, Peralta L, Freidman L. HIV Infection and AIDS in adolescents: An update of the position of the Society for Adolescent Medicine. Journal of Adolescent Health. 2005

- Delaying sexual debut
- Reducing the number of sexual partners
- Increasing the use of methods for preventing pregnancy and sexually transmitted diseases [STIs] including HIV/AIDS.

The paper raises the important point of the need to develop evidence-based strategies and programmes to promote better health for youth. In summary the document provides some context about the lives of young people around the world and how profoundly gender and cultural norms affect their health.

Health Care Facilities and the Youth

- Providing services that will ensure comprehensive care for HIV-infected adolescents and young adults in a setting that best serves them and aids both primary and secondary prevention efforts.

The challenge is to provide services that connect with young people and is able to retain young people in care.

Conclusion

It is important to end on a simple note that "*Prevention is better where there is no cure*"[92]. Usdin provides the following succinct point on the issue of prevention:

> *In the absence of a cure and with no vaccine yet to provide biological protection, it is vital to have programmes preventing people from transmitting HIV. Mass communication campaigns, youth education and condom promotion and distribution are important prevention approaches. As part of a broader response that includes addressing the gender and poverty dimensions of the epidemic, these interventions can make a difference.*

Finally the overview concludes with another quote from Usdin: ***"To beat AIDS the world has to put aside its prejudices, there is no place in prevention work for perceived "moral high ground."***!

92 Usdin,S. No-Nonsense guide to HIV/AIDS. [2003] New Internationalists Publications.