Prevention – is it as easy as ABC?

Report on the XVI International AIDS Conference

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The conference was huge by any international standards with 31,000 delegates who represented all facets of the response to HIV and AIDS. In a conference of this magnitude my report cannot do justice to all the presentations and cannot claim to be a comprehensive review of the topic. It is unashamedly one person's view and an attempt to share with a broader South African readership highlights of the proceedings. This report focuses on the information, discourse and debates around prevention.

The South African government

In South Africa the conference received media attention for the much publicized promotion of vegetables such as garlic, beetroot and the African potato by the government exhibition stand– although I have to say this passed me by in Toronto. The South African government's official stance however came under much criticism throughout the conference from conference delegates (see picture 1 - Khomanani stand) and speakers such as Mark Heywood [1] who called for the resignation of Minister of Health, Manto Tshabalala-Msimang and the UN Special Envoy on AIDS in Africa, Stephen Lewis, who in the final plenary address said [2]:

"And while I'm on the issue of treatment, I am bound to raise South Africa. South Africa is the unkindest cut of all. It is the only country in Africa, amongst all the countries I have traversed in the last five years, whose government is still obtuse, dilatory and negligent about rolling out treatment. It is the only country in Africa whose government continues to propound theories more worthy of a lunatic fringe than of a concerned and compassionate state. Between six and eight hundred people a day, die of AIDS in South Africa. The government has a lot to atone for. I'm of the opinion that they can never achieve redemption."

Treatment and prevention

An important message that was echoed by many speakers was concerning the link between treatment and prevention. At the opening ceremony Bill Gates shared his view that globally even though the price of first-line HAART treatment per year has come down to $130 per person the exponential increase in the number of people needing treatment makes it almost impossible for available funding to catch up.[3] Universal access to treatment for those infected can only be achieved if preventative measures are also successful in slowing the number of new infections. On the other hand it has also been shown that HAART results in a decreased transmission of HIV and is itself a useful preventative measure.[4] The conference view seemed to be that it is "time to deliver" an integrated treatment and prevention strategy. Currently South Africa provides HAART to 13% of those in need, which is significantly behind our neighbours, such

as Namibia and Botswana, who reach more than 50%.[4]

Gender, economics and androcracy
Imagine the following scenarios

In a fishing community on the banks of Lake Victoria in Kenya female participation in the fishing industry and ability to earn money is dependent on buying fish from the men who expect sex as part of the transaction. Sex is the only leverage women have to compete with large scale traders. Sex has become ritualized and condom use is not acceptable. In fact the men say that "a cow dies with grass in its mouth" - the future potential consequences of HIV infection are overshadowed by the present real risk of dying on the lake in a fishing accident.[5]

In rural South Africa a pregnant mother attends the PMTCT programme and discovers she is HIV positive. In the same post-test counselling session, while the woman is trying to come to terms with her new HIV status, the counsellor is pushing her to make a decision about how she will feed her baby in order to prevent HIV transmission. In this community if she chooses not to mix feed her baby she will be going against what is normal and may inadvertently disclose her HIV status. She is worried that her husband will be violent if she is found to be HIV positive and may even abandon her. Her husband is the only breadwinner. In this situation she cannot make her husband use a condom and does not know if he has other sexual partners.[6]

In southern Africa marriage is one of the drivers of the pandemic along with inter-personal violence, early sexual debut, concurrent relationships and sexual patterns resulting from migrant labour.[7] The high number of concurrent partners as opposed to consecutive partners creates huge sexual networks within which the virus can spread.[8] These scenarios make it clear that the junior position of women in relationships as well as their precarious economic status makes the simple messages of abstain, be faithful or use a condom both naïve and simplistic. The ABC approach erroneously assumes that women are in control of sex, can control their partners faithfulness and can influence the decision to use a condom.[9] In addition in an androcratic society [10] mothers and women are often seen as the "victims, vessels and vectors of disease".[9]

Although these gender issues are not unique to southern Africa the HIV pandemic puts them under the spotlight. How do we move towards more gylanic societies– based on partnership between men and women?[10] In Africa several initiatives, to empower women[9] and incorporate 'men as partners' [11], are already underway.

Re-visiting ABC
The support of abstinence-only programmes by PEPFAR funding received a lot of criticism at the conference. This was partly from a human rights perspective in that these programmes deny youth access to information about other forms of prevention, but also in terms of religious freedom when government policy endorses specific religious viewpoints.[12] One systematic review of abstinence messages concluded that they have a small but significant effect on sexual behaviour (OR 1.4 , CI 1.1-1.7).[13] However in my view this meta-analysis assumes that behavioural interventions act in a predictable way regardless of the socio-cultural system and context. Nevertheless one study in an American context did present results showing that abstinence-only interventions were more effective than safe sex or combined messages.[14]

One study from Kenya showed that even when youth were aware of the ABC messages their understanding of them might be flawed.[15] Being faithful was also understood as a desirable character trait – someone who is loyal and has a lot of faith in their partner's faithfulness! Condoms were frequently perceived negatively as ineffective, easily broken, immoral or as actually transmitting HIV. It was also pointed out that current condom supplies to Africa provide on average 3 condoms per year per man. Barriers to the ABC message were seen as the giving of mixed and conflicting messages, the belief by boys that they cannot control their sexual behaviour and by girls that they are powerless, as well as fatalism that "it doesn't really matter what I do".

In conclusion the ABC messages, if used, should be clear and consistent,

the barriers and difficulties of people actually implementing them should be acknowledged and negative beliefs about condoms should be addressed. Peer education programmes may be the best model when interacting with youth.[15]

Individual versus collective approaches to prevention
In addition to preventative messages and interventions dealing with behaviour on an individual basis the conference emphasised that as behaviour is often socially constructed and supported, change should involve collective as well as individual interventions.[16] Building new social identity, social capital and critical consciousness may be important. [17]

New technologies and medications
Microbicide research attempts to develop an intra-vaginal gel that prevents transmission of HIV. Significantly this puts one form of sexual risk reduction into the hands of women and a number of research studies will report on microbicide efficacy next year.[18]

Circumcision in a much publicized South African study is also poised to receive recognition as an efficacious means of prevention.[18] If proven the challenge will be to provide access to circumcision and convince men that it is a worthwhile procedure.

Cervical protection devices, suppression of genital herpes and sexual exposure prophylaxis with anti-retrovirals are also being researched.[18]

The 'holy grail' of prevention research, the HIV vaccine, unfortunately appears to still be an elusive 10-years away.[19]

Table I: Recommendations from "Steady, ready. Go…" report.

Go – should be implemented widely	
Setting	**Intervention type**
School	Curriculum-based interventions with characteristics that have been found to be effective in developed countries and are led by adults
Health services	Interventions with service providers that include making changes either to the structure or functioning of the facilities themselves and are linked to interventions in the community to promote the health services for young people
Media	Interventions with messages delivered through the radio and other media (i.e. print), except TV Interventions delivered with messages through the radio and television and other media (i.e. print)
Ready – should be implemented with careful evaluation	
Health services	Interventions with service providers and in health facilities and in the community that involve other sectors
Geographically defined communities	Interventions targeting youths using existing youth service organisations
Young people most at risk	Facility based programmes that also have outreach and provide information and services

Prevention of mother to child transmission

Current figures suggest that an HIV positive baby without treatment has a 35% mortality at 1-year and 53% mortality by 2-years of age.[20] However full HAART regimes during pregnancy and labour offer a less than 5% transmission rate.[20] The risk of death in childhood is significantly decreased if the mother is alive and the morther's needs for care and treatment should not be forgotten.[20] Infant feeding issues received little attention at the plenary sessions, although the need to improve the quality of counseling was the focus of my own research interest at the conference, as part of the Infant Feeding Research Project. Inspite of PMTCT mixed feeding remains the norm and counseling often focuses more on HIV testing and providing pre-packaged information, than on guiding decision making. [21] Counsellors, who are often women and share the same challenges as their clients, find it difficult to maintain healthy professional boundaries.[22] As a result mothers often find counsellors judgmental, stigmatizing and blaming. A new model of counselling based on motivational interviewing skills and woman-centredness was presented.[23]

Steady, ready, go…

The incidence of HIV increases dramatically in the late teens and early twenties and one of the major challenges is to prevent infections amongst youth. Globally less than 50% of young people have sufficient knowledge on HIV and AIDS.[16] A large systematic review of the evidence was presented at the conference where interventions were categorized as "go" (should be implemented widely), "ready" (should be implemented with further evaluation) and "steady" (should be further evaluated before widespread implementation).[24] There was also a category for "do not go" for interventions that are ineffective or even harmful. The "go" and "ready" conclusions are shown in Table I

Re-construction and development

Finally, it is clear that HIV is a pandemic that feeds on poverty, malnutrition and lack of education. Employment, alleviation of poverty, food security, adequate nutrition and unimpeded access to primary education are all vital components of prevention. [25]

Conclusion

In 2006 the XVI International AIDS Conference was held 25-years after the discovery of HIV. The theme of the conference was Time To Deliver as we now have a range of proven interventions for both prevention and treatment. In this report I have purposefully focused on the current issues around HIV prevention as this is a key aspect of the response, which often gets forgotten in the recent emphasis on ARV roll-out. Both prevention and treatment are needed, and urgently, if we are to respond to the call of this conference.

References

1. Heywood M. Plenary address: The price of political denial. Thursday 17th August 2006, XVI International AIDS Conference, 13-18th August 2006. www.aids2006.org
2. Lewis S. Closing address by the UN Special Envoy on HIV/AIDS in Africa. Friday 18th August 2006, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
3. Gates B & Gates M. Keynote address 13th August 2006, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
4. Montaner, J. Plenary address: Re-evaluating the cost-effectiveness of HAART – The case for expanding treatment access to curb the growth of the epidemic. Wednesday 16th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
5. Sharma A, Bukusi E, Kwena Z, Buffard A, Agot B, Muga C, Holmes K. "A cow dies with grass in it's mouth" – Fisherman's responses to "zero grazing" in Kisumu, Kenya. THAX0302. Presented Thursday 17th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
6. Magagula, N. and Mkhatshwa, H. Women themselves define access to PMTCT programmes - a dilemma. 2004. UNAIDS-XV International AIDS Conference, Bangkok.
7. Beyrer C. Plenary address: HIV epidemiology update and transmission factors: Risks and risk contexts. Monday 14th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
8. Halperin D, Andersson N, Mavuso M, George B. Assessing a national HIV behaviour change campaign focusing on multiple concurrent partnerships in Swaziland. MOAC0201. Monday 14th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
9. Binder L. Plenary address: From programmes to policies – Now: positive changes for women and girls. Monday 14th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
10. Esler R. The chalice and the blade. 1988. San Francisco: Harper Collins.
11. Engender Health. Engender Health Works to Advance Men As Partners® in Reproductive Health 2006 http://www.engenderhealth.org
12. Cohen J, Tate T. Using human rights standards to assess HIV-prevention programmes for children and youth: A case study of Uganda. MOAX0502. Monday 14th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
13. O'Reilly K, Medley A, Dennison J, Sweat M. Systematic review of the impact of abstinence-only programmes on risk behaviour in developing countries (1990-2005). THAX0301. Thursday 17th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
14. Jemmott III J, Jemmott L, Fong G. Efficacy of an abstinence-only intervention over 24 months: A randomized controlled trial with young adolescents. MOAX0504. Monday 14th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
15. Pulerwitz J, Lillie T, Apicella L, McCauley A, Nelson T, Ochieng S, Mwarogo P, Kunyanga E. How well do Kenyan youth understand ABC messages for HIV prevention. MOAX0503. Monday 14th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
16. Pimenta C. Plenary address: Conceptual framework and HIV/AIDS prevention paradigms. Tuesday 15th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
17. Campbell C, MacPhail C. Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. Social Science & Medicine 55 (2002) 331–345
18. Ramjee G. Plenary address: Microbicides and other prevention technologies. Tuesday 15th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
19. Barre-Sinoussi F. Plenary address: Dynamics of HIV/AIDS vaccine research: From dream and nightmare to reality and hope. Tuesday 15th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
20. Nduati R. Plenary address: Children and AIDS. Wednesday 16th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
21. Buskens I. How To Counsel Infant Feeding Practices In Southern Africa In Times Of HIV/AIDS? 2004 XV Bangkok International AIDS Conference
22. Menell K. Beyond victimization: towards a paradigm shift in PMTCT counseling training. TUPE0776. Tuesday 15th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
23. Buskens J. Woman's inhumanity to woman in infant feeding counseling in southern Africa. THPE0605. Thursday 17th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
24. Dick B. Review of the current evidence of what works for prevention. THSY0102. Thursday 17th August, XVI International AIDS Conference, 13-18th August 2006 www.aids2006.org
25. Lewis S. Race against time: Searching for hope in AIDS-ravaged Africa. 2005. Toronto: Anansi.