



*HIV Prevention
From the Perspective of
A Faith-Based Development
Agency*

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AN UNDERSTANDING OF HIV PREVENTION FROM THE PERSPECTIVE OF A FAITH-BASED DEVELOPMENT AGENCY

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Introduction

The factors fanning the HIV pandemic and making individuals and communities vulnerable to infection with this virus are many and complex. HIV prevention strategies, if they are to be effective in the immediate as well as the long-term, need to take account of this complexity and to mobilise multi-faceted responses involving all sectors of society. UNAIDS identify five domains of context that are virtually universal factors in communications for HIV preventative behaviour: government policy, socio-economic status, culture, gender relations and spirituality.³

In practice however, prevention strategies have, from the outset, tended to be reduced to “magic bullet” initiatives seeming to offer instant solutions. Such approaches place their protagonists in “pro-condom” or “abstinence/fidelity only” groups which become diametrically opposed and mutually antagonistic. Discussions, strategies and prevention programmes become polarised and confrontational. They also reduce an understanding of prevention to being wholly concerned with sexual transmission of the virus and with promoting free choices by autonomous, empowered individuals. The complex range of issues driving the pandemic is lost from sight as proponents of these “one-liner” over-simplistic solutions hold sway. The solutions proposed from either end of this polarised and reductionist approach can themselves become hijacked by covert political, religious or cultural agendas and fuelled by mutual distrust and prejudices.

This paper proposes a more comprehensive understanding of HIV prevention and a framework within which the complexity of issues is recognised and addressed. It also calls for complementarity, mutual acceptance and collaboration between all those engaging in HIV prevention responses. The understanding presented has been developed from CAFOD’s experience of almost 20 years of supporting community-based HIV programmes and from its reflection as a faith-based development agency on the wider issues posed by the AIDS pandemic.

Framework for a More Holistic and Comprehensive Understanding of HIV Prevention

The framework is effectively described using the “problem tree”, a recognised participatory learning tool frequently used in community-based analytical processes. This tool has been modified in CAFOD’s work to analyse the causes and effects of the

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³ UNAIDS “HIV/AIDS and Communication for Behaviour and Social Change: Programme Experiences, Examples and the Way Forward”. June 2001

HIV pandemic (some of which are captured in Fig 1) and to identify possibilities for programme responses.

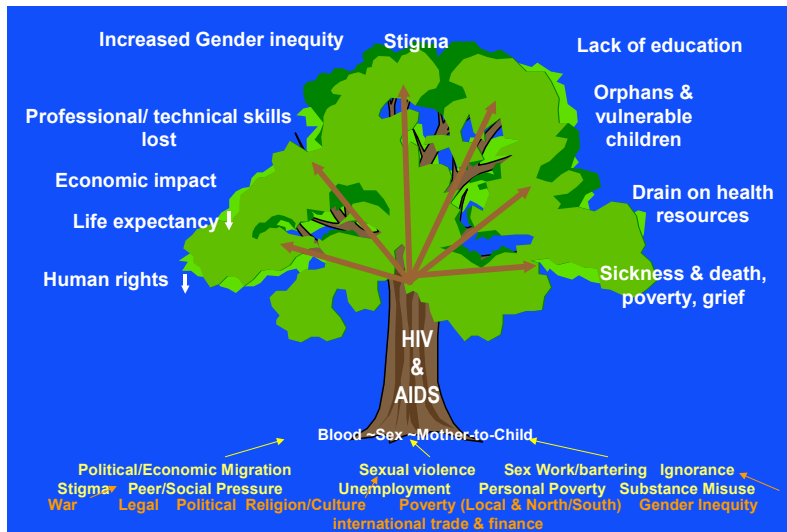


Figure 1. The Problem Tree

The trunk of the tree represents the problem which is the HIV pandemic. The impact of the pandemic is illustrated in the leaves and branches, which indicate effects for individuals such as, sickness, death, stigma, increased poverty etc as well as the wider social and economic effects on services,

infrastructures and general development in countries worst affected by the pandemic. The roots depict the causes of HIV infection. The most superficial roots indicate the immediate sources of risk, the body fluids that act as vectors of infection. Below these, the deeper roots symbolise the personal factors that increase an individual's vulnerability to infection and, deeper still, the society-wide factors that increase this vulnerability. The tool thus illustrates three layers; impact, risk and vulnerability.

The understanding of HIV prevention proposed herein requires a combination of initiatives that tackle all three layers. HIV prevention must be concerned with mitigating the impact, reducing the risks and decreasing the vulnerability factors that place people at risk (Fig 2). An understanding of prevention that excludes any of these layers is incomplete and can only be of limited effectiveness, even in the immediate term. Given the magnitude of the task implied and the variety of expertise required, no single project can hope to adequately address all three layers. This framework therefore calls for a collaborative, multi-sectoral response by diverse actors, each working to their particular strengths while interacting in concerted fashion with the complementary expertise of others.

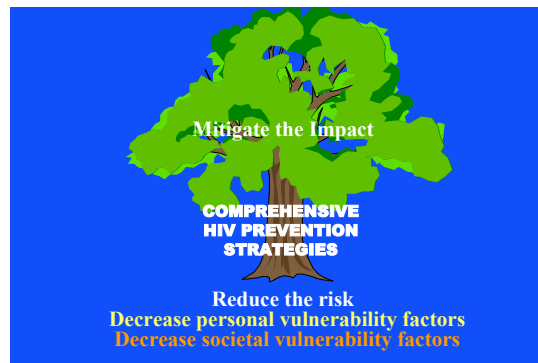


Figure 2. HIV Prevention Framework

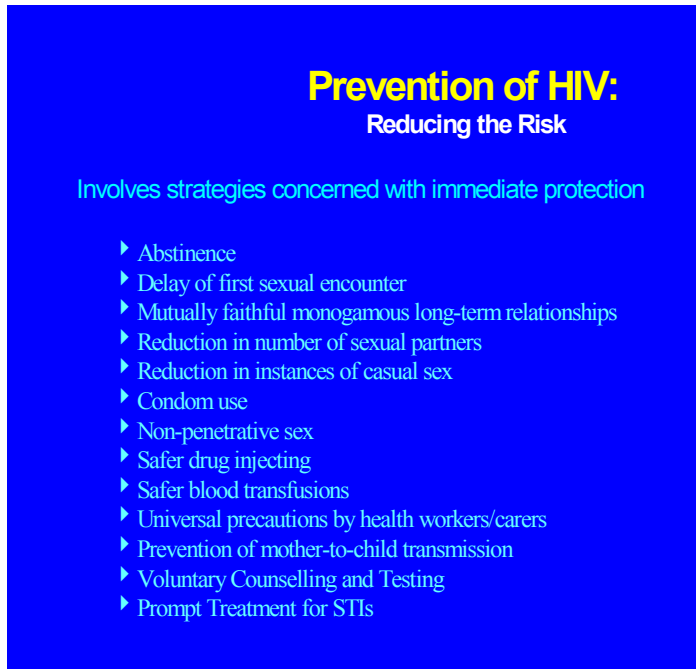
Mitigating the Impact

In making this an essential component of the framework, CAFOD stresses the inextricable link between prevention and care. Any care, treatment, psycho-social support or livelihood initiatives that improve the physical health and economic and emotional well-being of people infected and affected by HIV must be seen as valid and valuable prevention efforts. Such initiatives enable people living with HIV to contribute to the stability and further development of families and wider communities

thereby preventing the decline into poverty and stigmatisation that so often fan the pandemic.

Reducing the Risk

Risk reduction initiatives seek to provide individuals and communities with an accurate and full understanding of the risks to them and others of HIV infection. They also enable individuals to acquire the skills and resources to implement changes in



their personal or professional lives in order to minimise these risks. Such initiatives are concerned with enabling individuals to adopt measures that afford them immediate protection, be it partial or complete. Typical risk reduction strategies are listed in Fig. 3. In practice the term “HIV prevention” is most often used to refer to one or a number of these risk reduction strategies. Such reductionist use of the term should be avoided, both because it denies the breadth and complexity of response that is needed if HIV prevention is to be

Figure 3: Typical Risk Reduction Strategies

effective, and because it far too readily leads to the polarisation of factions that becomes obstructive and destructive.

The listing in figure 3 might misleadingly suggest that risk reduction is about choosing one or other option, more or less at random or in rigid adherence to the dictates of social, cultural or religious pressures. This framework proposes a different interpretation.

It requires us instead to think of a risk reduction continuum running from high-risk activities in an individual’s personal or professional life, to those carrying low or even no risk of HIV infection. (See fig 4⁴) Developing an appropriate risk reduction strategy becomes a process whereby an individual identifies their actual levels of risk and what changes are possible or desirable given their circumstances, which will reduce the level of risk.

⁴The examples given are not placed in accordance with any mathematical calculation of precise risk. Rather the diagram is simply a schematic illustration of the principles underpinning this process.

Any strategy that enables a person to move from a higher risk activity towards the lower end of the risk reduction continuum is a valid risk reduction strategy. With appropriate support, the individual is enabled to establish the goal they can (or choose to) realistically aim for and to identify what level of risk this still carries for them (and perhaps how they might work at minimising this further, over time).

A personal risk reduction strategy modelled on this idea of moving along a continuum is both scientifically valid and compatible with sound theological principles. Faith-based organisations might more typically tend to espouse a once-and-for-all move to an ideal, no-risk behaviour strategy. However, despite discourse to the contrary, even traditional theological tools within Roman Catholicism (singled out because this is the context within which CAFOD’s theological reflection is located) allow for a gradual approach within which individuals aspire to clearly identified ideals but sometimes have to make choices that fall short of these. More recent theological thinking⁵, illuminated by the challenges from HIV, offers an approach more fully able to affirm this continuum model. Thus from a programmatic viewpoint it can be demonstrated effectively that a risk reduction continuum is compatible with the theology and moral codes of Christian faith-based organisations as well as with sound health promotion principles.

Decreasing the Vulnerability

Risk reduction strategies alone will not be sufficient to effectively prevent HIV, because an individual’s personal strategies are conditioned by their social context. Hence the need to incorporate this third layer within a fuller understanding of HIV prevention

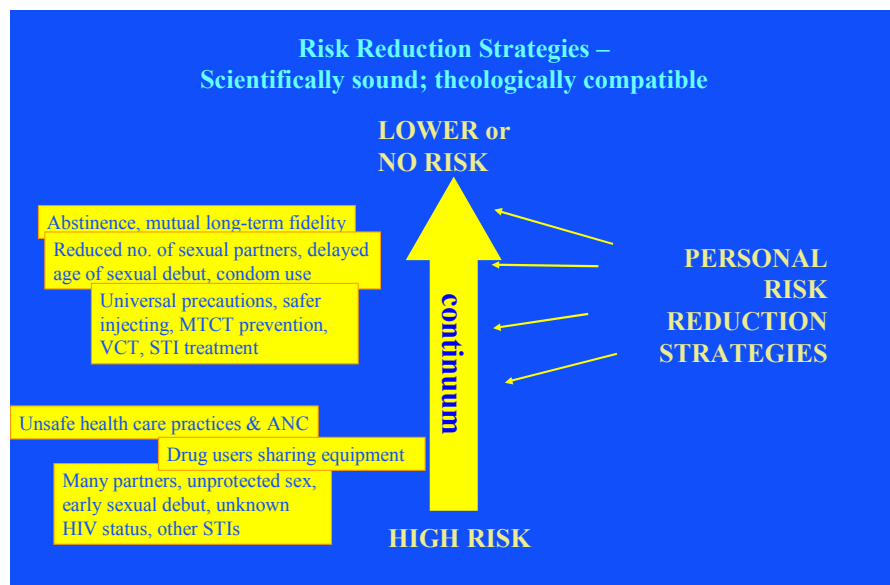


Figure 4: Risk Reduction Continuum

⁵ McDonagh Enda, “Theology in a Time of AIDS” Irish Theological Quarterly Vol 60 No 2, 1994.
Kelly Kevin “New Directions in Sexual Ethics. Moral Theology & the Challenge of AIDS” Cassell, 1999

Keenan James F. (Ed) Catholic Ethicists on HIV/AIDS Prevention” Continuum Publications, 2000
Bate Stuart C (Ed) Responsibility in a Time of AIDS. A pastoral Response by Catholic Theologians and AIDS Activists in Southern Africa” Cluster Publications, 2003

Smith Ann & McDonagh Enda “The Reality of HIV/AIDS. Christian Perspectives on Development Issues” Trócaire/CAFOD/Veritas, 2003

The deepest roots of the problem tree describe personal and societal factors that influence, and even dictate, the behaviours of individuals and communities. A key feature common to all of these roots is that they arise from and generate imbalances of power between individuals, communities and countries. Such imbalances significantly curtail the behaviour choices of those who are disempowered and make them more vulnerable to HIV. Thus an overall HIV prevention strategy must also include initiatives that redress these imbalances of power that exist at personal or societal levels. To date, even where the influence of these factors is recognised, HIV prevention strategies are still too often interpreted as being solely concerned with immediate risk reduction. These deeper causative factors are consigned to completely separate response strategies by governments, international agencies and local civil society groupings alike. The result is a disjointed “parallel track” approach which fails to make the connection in practical terms between HIV risks and the vulnerability factors augmenting those risks.

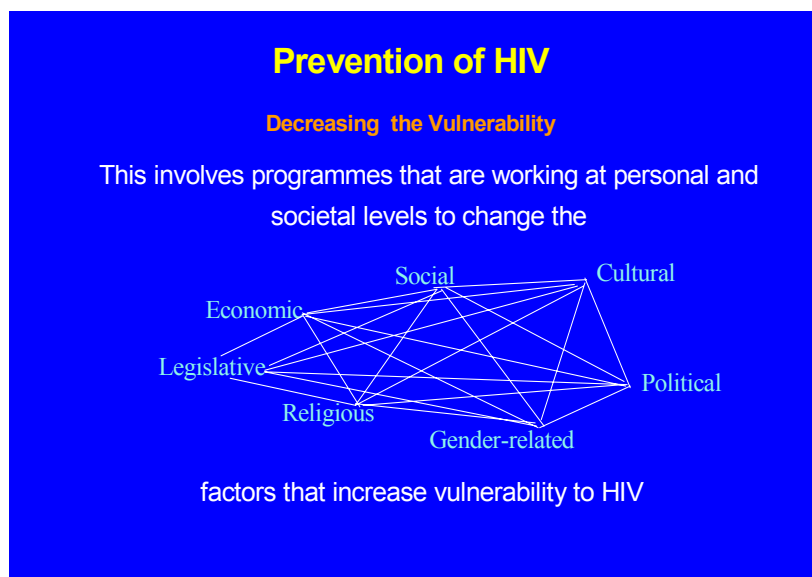


Figure 5: The interconnectedness of key vulnerability factors

Any initiative that seeks to address one or other of these vulnerability factors is, and must be recognised as an essential component of a wider HIV prevention strategy. Fig 5 indicates some of the key vulnerability factors and also illustrates that these can rarely be addressed as isolated issues. They are irretrievably intermeshed and connected indicating once again the need for complementary and concerted responses.

Commitment to this layer of HIV prevention is strongly endorsed theologically. The doctrinal and scriptural heritage of most faith-based organisations is charged with enjoinders to denounce injustice and oppression and to defend the weakest and most marginalised.

In summary, HIV prevention programmes will only be effective longer term when they comprise the three layers described here and when initiatives are woven together to mitigate the impact of the pandemic, reduce the immediate risks of infection and address the root causes that increase the vulnerability of individuals and communities. This combination becomes a prevention cycle. Decreasing the vulnerability reduces risk, which mitigates impact, which in turn decreases vulnerability. A single project will not normally address all aspects of this cycle. The challenge is for each to identify its part in the cycle and to know who else is contributing to it. In this way each project’s role and limitations can be clearly defined and respected, and projects

can work together as complementary, multi-sectoral initiatives contributing to a single HIV prevention programme.

Specific Questions to consider within this Understanding of Prevention

Within this three-layered framework for HIV prevention the following questions need more detailed attention:

1. What does behaviour change mean in this context?
2. What is the role of education within this prevention model?
3. Does this understanding of prevention accommodate the ABC approach and if so how? How does it relate to the Uganda experience?

1. What does Behaviour Change mean in this context?

The term behaviour change has been misused and abused when applied to the context of the HIV pandemic. Too often it is invested with the meaning that prevails in the West/North, where behaviour change is believed to be a clear-cut matter of personal and informed choice; decisions taken by autonomous individuals based on in-depth understanding of the facts and a total ability to govern their own lives. This individualist view fails to recognise that behaviour is influenced by circumstances and context and that for the majority of people affected by HIV in the South, and indeed in the North, the “solution” is not so simple. The term behaviour change is also occasionally invested with judgmental overtones implying fixed notions of what constitutes “good” and “bad” behaviour. This can sometimes be the case for programmes inspired by a specific cultural or religious ideal. In such situations the only acceptable behaviour change is that which complies with the ideal, and anything else is deemed unacceptable, even in the short term.

Individualist and judgmental interpretations of behaviour change are both incompatible with the HIV prevention framework proposed here. In this framework, behaviour change for individuals is concerned with their capacity to identify and adopt risk reduction strategies appropriate to their circumstances, i.e. strategies that are realistic and sustainable. In practice, the term “behaviour change” is often applied only to some risk reduction strategies. Thus people speak of e.g. “behaviour change or condom use”. This fails to recognise that an individual’s decision to use condoms where they did not heretofore is a change in their behaviour. Thus, this paper asserts that any successful implementation by an individual of their chosen risk reduction strategy constitutes behaviour change, whether it be e.g. abstaining/delaying the age of sexual debut, reducing the instances of casual sex, not sharing drug injecting equipment, consistent use of condoms etc.

Programmes addressing behaviour change need to enable and support individual risk reduction strategies while working for the necessary contextual changes i.e. the obstacles that block the possibility of individual behaviour change. Figure 6 attempts to illustrate this schematically. It captures the risk reduction continuum depicted in figure 4 and superimposes a “brick wall” formed by contextual factors, to indicate that the personal behaviour change sought by individuals (i.e. their chosen risk reduction strategy) will be blocked by factors such as the examples given. Behaviour change programmes must seek to remove the contextual blocks as well as supporting a person’s chosen risk reduction/behaviour change strategy. Thus behaviour change programmes must be directed at two layers, risk reduction and vulnerability.

With regard to risk reduction, programmes will need to offer individuals the information and skills they need to discern what strategies are most appropriate for their situation. Such skills are frequently referred to as life skills, though the term is too often reduced to infer skills in applying condoms, or skills in promoting abstinence. A fuller interpretation of life skills would be concerned with enabling people to identify and implement the choices that are realistic for their present context, that support their aspirations for the future, and are consistent with whatever core values shape their identity.

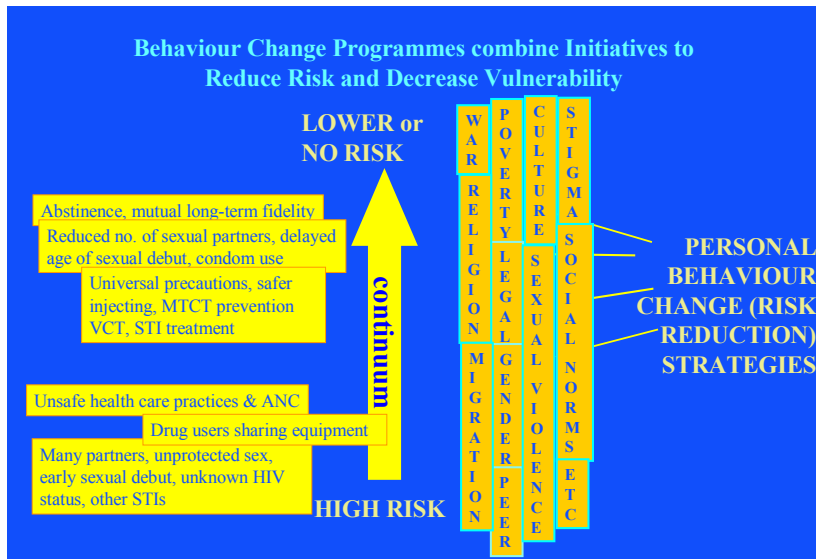


Figure 6: Behaviour Change Programmes support personal behaviour change/ risk reduction strategies while working to overcome contextual obstacles

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With regard to the vulnerability layer, behaviour change programmes will need to be engaged in lobbying for whatever contextual changes are called for. This interpretation emphasises once again the importance of complementarity between different initiatives. If an individual project cannot support all risk reduction strategies it must ask who else can help. If it cannot affect the factors increasing vulnerability it must ask who can. If the combination of all local or regional initiatives cannot support wide-ranging risk reduction strategies and bring about the required contextual changes then the hoped-for behaviour change will be unrealistic and unrealizable, and will need to be modified

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2. What is the role of education within this prevention model?

Information, Education and Communication (IEC) initiatives abound and often constitute the sole or main activity of a supposed HIV prevention programme, in the mistaken belief that provision of information alone will result in behaviour changes required to prevent infection with the virus. IEC programmes provide accurate factual information that increases people’s understanding, dispels myths and helps overcome fears. In so doing, IEC is valuable in reducing stigma and discrimination associated with HIV and in enabling people to identify the factors in their personal or professional lives that put them at risk of infection.

However, of themselves, IEC initiatives cannot affect the deeper roots heightening people’s vulnerability. Experience over the last two decades has shown that information does not bring about sustained behaviour change. IEC should be viewed as a preparatory step, leading to initiatives that provide the skills, resources and contextual changes required for effective prevention programmes to be established. In themselves, IEC initiatives should not be regarded as HIV prevention programmes. At

their best, behaviour change communication initiatives move beyond IEC and engender processes that identify the social and economic circumstances affecting behaviour and indicate how change can be brought about. Such initiatives are effective in making IEC a valuable component within wider HIV prevention initiatives.

3. Does this understanding of prevention accommodate the ABC approach and if so how? How does it relate to the Uganda experience?

The ABC approach (Abstain, Be Faithful, use a Condom) has been widely touted in the last two years or so, and by a strikingly diverse range of individuals and groups.⁶ In large part this has been as a consequence of Uganda's success in significantly reducing the incidence of HIV and the perception that this was due to their promotion of ABC.

The ABC approach has also been treated with suspicion in some quarters as being a cover for abstinence only programmes and in others as being conservative and irrelevant to modern lifestyles. As a development agency, CAFOD contends that the ABC approach as currently promulgated is overly simplistic and suffers from the same "one-liner" reductionist flaws mentioned earlier. It is being endorsed as *the* solution without any reference to a wider context as described in this paper.

CAFOD also contends that there *is* place for an ABC approach if two central requirements are fulfilled. ABC must be viewed as an aspect of risk reduction, which in turn is located within the wider three-layered prevention framework, and a more nuanced interpretation of ABC must be promoted than the simplistic solutions currently gaining favour. The following paragraphs summarise the more nuanced interpretation called for:

3.1. Abstinence

Abstinence has become a dirty word, partly because it has been invested with undertones of a judgmental dogmatism typical of groups that would claim a high moral ground, but also because it has been denigrated or ridiculed as "un-cool" by secular (i.e. non-faith-based) agencies and groups. Consequently some programmes choose to abandon the term completely. As a more acceptable alternative it can be reclaimed and invested with a wider meaning, which is based on sound health promotion principles and can also be reconciled with faith-based ideals and attendant theology. In this context, abstinence can be used to mean:

- Delaying the age of first sexual encounter. Evidence suggests that the abstinence aspect of ABC campaigns has been most successful among young people, for whom delaying the age of sexual debut was an important risk reduction strategy⁷
- Not having sex until the person is in a more stable relationship
- Choosing to have sex only within a long-term committed relationship
- Not having sex until marriage

⁶More notable proponents include Edward Green, Harvard anthropologist, Elaine Murphy, Global Health Specialist, George Washington University, Ray Martin, Christian Connections for International Health, USA, Anne Peterson, USAID Director of Global Health, US President George W. Bush, Norman Hearst, Epidemiologist, University of California, San Francisco

⁷Bessinger R, Akwara P, Halperin D, "Sexual behaviour, HIV and fertility trends; a comparative analysis of six countries. Phase I of the ABC Study". Chapel Hill NC. Measure Evaluation, 2003

- As a mutually agreed and free choice (one of a number of possible options) by and between HIV discordant couples
- As a preferred option for a specified period in a person's life

If the term is to reclaim this wider meaning then abstinence must be unambiguously offered as part of an ABC option and not be made into an abstinence only campaign. Although there is very little documented analysis of such initiatives, anecdotal evidence suggests that abstinence only campaigns often dilute and confuse prevention messages, or provide information that is less than complete. They can also fail to engage with the circumstances facing people most at risk of HIV and to provide the much-needed support for people who cannot choose abstinence and who need to consider other risk reduction options. Moreover, if couched in moralistic overtones, abstinence only campaigns can make people feel unclean if they have been sexually active, and as a result people may hide this fact and thus neglect an important aspect of their sexual health needs. Likewise, people may be reluctant to seek voluntary counselling and testing out of a fear that they will be told to abstain.

Such pitfalls illustrate the fallacy of abstinence only campaigns and of a US policy of allocating 33% of all prevention monies to these initiatives. Abstinence will only be a commendable option if it is invested with the wider meaning described here, and if it is viewed as one of a tri-partite (A, B, C) risk reduction strategy.

3.2. *Be Faithful*

In a more nuanced interpretation of ABC, this second option might mean fidelity to:

- A single, mutually faithful partner, whether in marriage or in a long-term committed relationship
- Serially monogamous relationships (provided a degree of stability exists within these relationships. What this means for individuals will vary, depending on current practices and alternative possibilities)
- A strategy of reducing the number of partners
- A strategy of reducing the instances of casual sex
- A strategy of *consistency* in condom use if this is a person's risk reduction option, given that condom failure is more often attributable to their inconsistent or incorrect use.

This second component of an ABC strategy has been the most neglected⁸ as discussions more readily become polarised around the A or C components. Yet evidence suggests that fidelity, including to a strategy of reducing the number of partners, and of reducing instances of casual sex, has been the most effective component in countries where the ABC has been used.^{9 10 11} Again the strength of an effective B component comes from giving it this wider interpretation rooted in sound epidemiological principles and free of any moralising overtones.

⁸ Shelton James D., Halperin Daniel T et al "Partner Reduction is crucial for balanced ABC approach to HIV Prevention". British Medical Journal, 328:891-893. April 2004

⁹ Hogle James, Green Edward, Nantulya Vinand, Stoneburner Rand, Stover John "What Happened in Uganda: Declining HIV Prevalence, Behaviour Change and the National Response", Sept 2002

¹⁰ "Declines in Casual Sex in Lusaka, Zambia: 1996-1999" Agha Sohail, AIDS; 16. 291-93. 2002

¹¹ Green Edward, Conde Aldo "Sexual Partner Reduction and HIV Infection" (Dominican Republic), Sexually Transmitted Infections vol 76(2), p. 145. 2000

3.3. Condom Use

Epidemiological data confirm that condoms, when used consistently and correctly, reduce but do not completely remove the risk of HIV infection¹² and this scientific fact cannot be excluded from or misrepresented in any information on risk reduction strategies, regardless of a group's cultural or religious ideology¹³. The available evidence suggests that condom promotion has been particularly effective for identifiable groups at highest risk of HIV infection (e.g. sex workers) and who may have few if any other options for reducing risk. This evidence also indicates that, thus far, condom promotion for the general population has been less effective as a public health strategy.^{14 15} Thus an important component of this third strand of a nuanced ABC must be that C also stands for Choice. An imperative that becomes "Choose what you *can* change today; choose what you *want to* change for tomorrow" is informed by sound epidemiology and also compatible with the gradualist theological understanding referred to earlier.

This nuanced interpretation of the C component cannot support a "condoms only" or even a "condoms mainly" campaign. Such campaigns, often promoted with the same dogmatism as "abstinence only" campaigns, are equally flawed, and for many of the same reasons mentioned in section 3.1 above.

This was recognised by UNAIDS in 1999, following detailed consultations in Africa, Asia and Latin America. Among the chief weaknesses identified for response to date was "*a nearly exclusive focus on condom promotion to the exclusion of the need to address the importance and centrality of social contexts, including government policy, socio-economic status, culture, gender relations and spirituality*"¹⁶. In a report just published (June 2004) UNAIDS reiterates the importance of ensuring that condom programming is an integral component in a range of HIV prevention strategies and not promoted as the sole or main option¹⁷. Yet, in a visit by this author to a neighbouring Asian country just a few weeks ago, the UNAIDS country representative still insisted that condom promotion must be the mainstay of that country's prevention strategy "an emergency response for an emergency HIV/AIDS situation", while NGOs complained that their multi-faceted prevention programmes (which included condom promotion) had been refused government or Global Fund monies because they were not sufficiently weighted towards condom distribution. It would seem that lessons learnt elsewhere are being lost from sight as yet another country pursues the same flawed strategy. We can only ask; why? Noteworthy too is the fact that the UNAIDS 2004 publication (footnote no. 17) is no longer included among the website's best practice collection. Rumour has it that this was listed for just one day before pressures from "pro-condom" zealots forced UNAIDS to remove the reference. Again, we can only ask why?

¹² cf e.g. Hearst Norman and Chen Sanny "Condoms for AIDS Prevention in the Developing World. A Review of the Scientific Literature". Report commissioned by UNAIDS, January 2003

¹³ cf e.g. "HIV Prevention, Condoms and Catholic Ethics" CAFOD's Policy statement www.cafod.org.uk/policy_and_analysis/policy_papers/hiv_aids/hiv_prevention_condoms_and_catholic_ethics and "When Dogma Costs Lives" The TABLET, 26th June 2004

¹⁴ cf Hearst et al. and Hogle et al

¹⁵ PANOS, "Missing the Message? 20 Years of learning from HIV/AIDS", 2003

¹⁶ UNAIDS "A Communications Framework for HIV/AIDS: A New Direction, Penn State". 1999

¹⁷ UNAIDS Best Practice Collection "Making Condoms work for HIV Prevention" June 2004

This paper asserts then, that a nuanced interpretation of the ABC approach does have a place within the wider HIV prevention framework proposed, i.e. within a risk reduction strategy of a multi-layered model. In affirming this, CAFOD also asserts that a second ABC must also apply, not to individuals but to governments, other leaders and public figures, and to all engaged in programme responses. This second ABC is located within the vulnerability layer of the framework and compels actors at this level to:

- Advocate for changes to legislation, culture, attitudes or practices that promote imbalances of power
- Break the silence that colludes with situations of denial, stigmatisation, isolation or discrimination
- Challenge specific instances of discrimination and injustice that occur in legislation, cultures, attitudes or practices

Here too the teachings of most faiths, among them the tradition of Catholic Social Teaching that spans over 100 years and is inspired in turn by Jewish and Christian scriptures, leave faith-based leaders well placed to unambiguously and publicly implement this vulnerability ABC.

3.4. Uganda's Success Story and ABC

The much publicised success story of Uganda has been instrumental in promoting interest in, and political support for, the ABC approach¹⁸. A detailed analysis of all of the factors that might have contributed to Uganda's success is beyond the scope of this paper. However some recognition of the breadth and diversity of the wider factors, within which an ABC campaign was located, is essential. Among the key factors at play between 1986 and 1995 were:

- Prompt recognition of and openness about HIV by President Museveni and his government, at every level of public life, which helped raise awareness and reduce stigma
- Concomitant investment of funds and other resources in addressing HIV
- Openness and commitment from people in the public eye, celebrities, artists, community and religious leaders and the like
- Rapid provision of voluntary counselling and HIV testing (VCT) centres and prompt treatment for other sexually transmitted infections (STIs)
- Early establishment of care and support services by and for people infected and affected by HIV, which soon became models of good practice far beyond Uganda
- Development of locally led, community-based, culturally acceptable and "home grown" responses using local expertise and with minimal influence from Western/Northern donors, policy makers or advisers
- Implementation of cultural changes related to e.g. wife inheritance, property rights, ritual scarring etc.
- Early establishment of a multi-sectoral Uganda AIDS Commission
- Use of interpersonal communication channels in place of mass media, in order to provide HIV education
- Peace and increased political stability after 15 years of war. With this came increased employment opportunities in rural and urban settings

¹⁸ cf USAID Office of HIV/AIDS Summary Paper "The Urgent Priority for Primary ("ABC") HIV Prevention" September 2002 and President Bush's State of the Union speech, January 2003

- Decreased gender inequity. Employment opportunities also increased for women and with greater financial independence came a greater degree of negotiating power in sexual relations. Women’s participation in political life and in higher education also increased and legislative changes gave women greater protection from gender violence and sexual coercion (although some aspects of this are moving only slowly)

Within this diversity of responses a nuanced version of ABC also featured, in which B was the most influential, followed by A and lastly C. Thus, Uganda’s success must be attributed to the interplay of all of these factors (and others not listed here). The ABC approach (prioritised to BAC by locally informed strategies) can only have been so successful because it was one (important) component within this diversity of factors.

If these factors are applied to the “problem tree” analytical tool used in this paper we find that the Ugandan response encapsulates the HIV prevention framework proposed herein (Fig. 7). Uganda’s HIV Prevention Programme drew on many and varied responses, at all levels of society, which between them worked to mitigate the impact, reduce the risk and decrease the vulnerability factors fanning the epidemic in their country. Within this comprehensive 3-layered approach to HIV prevention, ABC was located, as a key component, among a wider range of risk reduction strategies.

Conclusions

The complexity and diversity of factors affecting people’s vulnerability to HIV have, until very recently, rarely been acknowledged. Understandings of HIV prevention most widely promulgated, even now, fail to identify these deeper causative factors and consequently fail to include these as key components to be addressed within HIV prevention strategies. Rather, such strategies for the past two decades, have – regardless of geographic, cultural or socio-economic setting- tended to focus on a

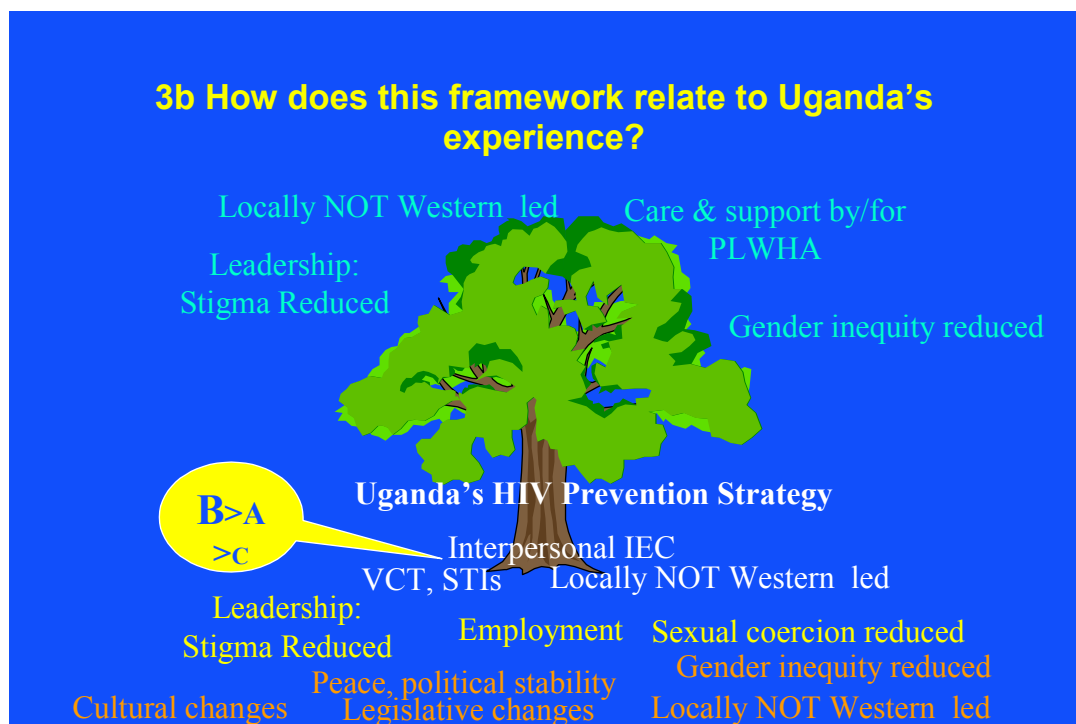


Figure 7: Uganda’s HIV Prevention Strategy mitigated the impact, reduced risks and decreased vulnerabilities

much narrower interpretation of HIV prevention (in effect equating this with risk reduction) and to replicate wholesale the “quick-fix” measures believed (but not always proven) to have been successful in countries of the North/West. Indeed, worldwide responses based on this narrower interpretation have frequently been driven by technical experts and policy makers from these countries of the West/North.

In tandem with this pattern, the HIV prevention agenda has also been hijacked, too frequently, by groups motivated by religious or cultural beliefs and ideals and for whom behaviours making people vulnerable to infection are dogmatically categorised as good or evil, right or wrong. Such groups have no less zealously promulgated their “quick-fix” solutions, equally narrowly focussed and equally inattentive to the geographic, cultural and socio-economically diverse context within which the pandemic is located.

Because of the narrowed focus promoted by zealots from both the secular and religious/cultural camps HIV prevention has increasingly been dismissed by many as a failure and prevention strategies deemed totally ineffectual. A consequence of this, at least in part, is that attention and resources have been diverted away from prevention and towards an exclusive focus on provision of treatment and care. A more balanced approach, identifying the necessary interconnectedness of prevention and care and articulating a fuller interpretation of HIV prevention, is only slowly emerging.

CAFOD’s experience of working with, challenging and being challenged by programme partners in countries of the South, and its reflection on wider development concerns and theological challenges has led it to promote a wider understanding of HIV prevention as described in this paper. The HIV framework proposed is based on the following conclusions:

- HIV prevention cannot be reduced to one-line simplistic “quick fix” solutions of whatever ilk. To do so renders prevention initiatives inadequate and totally ineffectual in the immediate as well as the longer term
- An effective prevention response calls for the more comprehensive approach advocated in this paper and which comprises initiatives to mitigate the impact, reduce the risk and decrease vulnerability, all as part of a single, concerted prevention strategy
- The proposed framework allows diverse actors from every level of society to contribute to a shared strategy, each acting to their strengths and identifying their specific role or niche within a multi-faceted, multi-sectoral response. No one aspect of this response can be regarded as an absolute in itself.
- This understanding calls for complementarity and collaboration, for dismantling of mutual prejudices and an acknowledgement of the contributions and limitations of the various actors. It denounces the obstructive positioning and dogmatism of opposing factions that too often feature in whichever of the “one-liner” interpretations of HIV prevention
- Prevention strategies based on this understanding will and must be developed first and foremost within the geographic context for which they are designed, by local people who are expert, experienced and attuned to their reality, and supported and validated by the wider international community North and South.

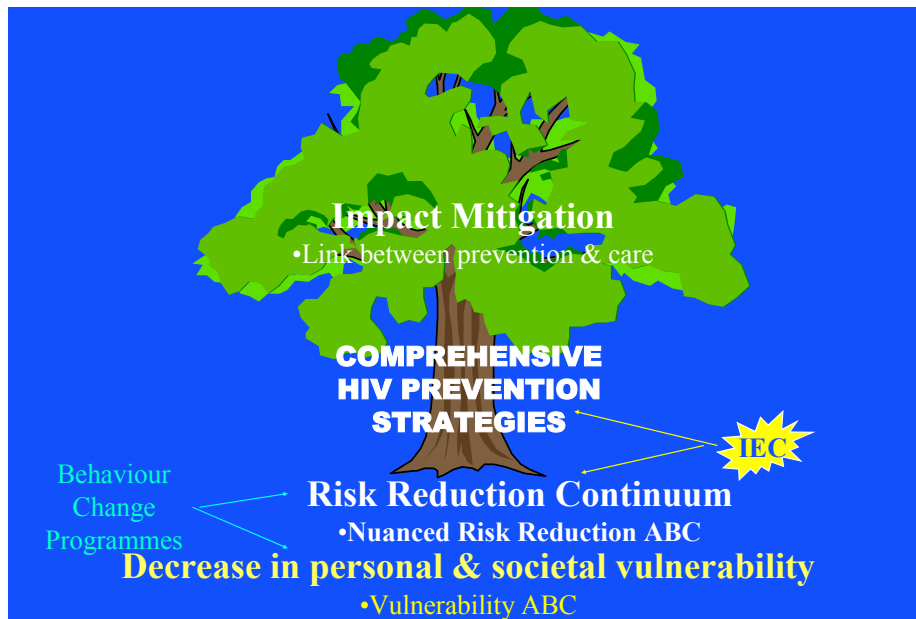


Figure 8: Summary of CAFOD’s framework for a comprehensive HIV prevention strategy

- The proposed framework reconciles good scientific and development practice with established and evolving theological thinking within the Catholic Church, as with other Christian traditions
- It nullifies claims by some that they are exempted from “doing prevention” because of cultural or religious beliefs and that they will concentrate instead on provision of care, and efforts by others to exclude such groups from prevention programmes, on similar grounds
- It asserts that national and international strategies that divert resources exclusively or mainly to providing care and treatment are ill-founded
- Within this proposed framework there is place for an ABC approach, as a specific component of one of the three layers, i.e. within the risk reduction layer, provided that:
 - A, B and C are each invested with the more nuanced meaning proposed in this paper
 - None of them is presented, either overtly or covertly, as the only option, nor promoted to the detriment of the other. The strengths and limitations of each option need to be made clear.
 - Such campaigns are rooted in good epidemiology and not driven by dogmatic political or religious agendas
 - A, B and C as risk reduction strategies are set alongside initiatives to mitigate impact and reduce vulnerability, all as intertwined components of national or regional HIV prevention strategies

HIV prevention can and does work but only if strategies embrace and address all 3 layers of the proposed framework and in the nuanced manner proposed (summarised in Fig 8). This is the key lesson emerging from CAFOD’S experiences and reflection of the past twenty years and from recent success stories such as that emanating from Uganda. It is the only understanding of HIV prevention that CAFOD as a faith based development agency would advocate at this conference and more widely.