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AFRICA Insight

# Rethinking Aids prevention:

Statistics released ahead of World Aids Day this year showed a resurgence of HIV infections in Uganda and a decline in a few countries, including Kenya. **Curtis Abraham** examines the trends and the assumptions in the fight against the disease

**Aids activists hand out pamphlets to slum dwellers in Johannesburg during a campaign to raise awareness ahead of World Aids Day.** Photo/REUTERS

Attempts to halt the spread of the HIV virus in sub-Saharan Africa have failed because wrong models are being used to fight Aids on the continent. That's the controversial verdict reached by a US Aids scientist who says he is now convinced that Africa's homegrown initiatives, rather than Western prescriptions, have a better chance of success.

The scientist, Dr Edward C. Green, a senior researcher at the Harvard Centre for Population and Development Studies, says "evidence is mounting that the global model of Aids prevention, designed by Western experts, has been largely ineffective in Africa." Green is author of *Rethinking Aids Prevention* and also a board member of US President George W. Bush's Presidential Advisory Council for HIV/Aids.

The prevention strategy, according to scientists such as Green, has been unsuccessful in sub-Saharan Africa because it is based largely on "risk reduction" remedies and interventions, which reduce but do not eliminate the risk of sexual transmission. These include: using condoms, treating sexually transmitted infections and diseases with antibiotics, providing clean needles to intravenous drug users, and prevention of mother-to-child transmission using the drug Nevirapine (Viramune).

Instead, sub-Saharan African governments and the international donor community should be focusing more on approaches that emphasise "risk avoidance" or "risk elimination" behaviour, which amounts to primary prevention.

## Global Model

Recent statistics coming out of Uganda, a country seen as the global model for rolling back the HIV-Aids scourge, may be further confirmation of Green's controversial conclusion. The Joint United Nations Programme on HIV/Aids in its *Aids Epidemic Update 2006* says Uganda's prevalence rate has swelled from slightly over 6 per cent in 2005 to nearly 8 per cent in 2006.

Some experts attribute this increase to more Ugandan's being tested for the virus, hence more known individuals have been found to carry HIV. Others, however, claim anti-retroviral drugs (ARVs) are lulling people into a false sense of security and thus more people are engaging in risky behaviour.

Green, however, sees the increase as the result of the refusal by foreign donors to support the abstinence and fidelity elements of Uganda's HIV-Aids prevention programme.

According to the UNAids 2006 Report, "Africa remains the global epicentre of the Aids pandemic."Although sub-Saharan Africa has only 10 per cent of the global population, it accounts for about 60 per cent of the world's HIV-infected people. By the end of 2005, there were an estimated 24.5 to 26 million Africans living with the deadly disease. Over the course of that year about 2 million people had died of Aids and as a result 12 million African children were orphaned.

Dr Green and his colleagues, senior researcher Daniel Halperin of the Harvard Centre, anthropologist Priscilla Reining and epidemiologist Prof Robert C. Bailey, say risk avoidance strategies such as mutual monogamy/fidelity between two uninfected sex partners, abstinence or delaying the age of first sexual contact have proven successful in Uganda and Senegal, and of late Kenya and Zimbabwe.

"The Western Aids prevention paradigm that was exported to Africa in the latter 1980s was developed for high-risk groups," such as gays in US cities like San Francisco, Green explains. "Central to this risk reduction medical paradigm was to not address sexual behaviour, to not constrain or interfere with sexual behaviour in any way. It was argued that this would amount to making value judgments, which is unscientific and would only drive away those who needed to be reached."

The false assumption that human behaviour is something difficult or impossible to change has lead Western Aids experts to settle for risk reduction strategies. There was (and is) no discouragement of any form of sexual behaviour or intravenous drug addiction. Aids experts applauded themselves for their open-mindedness and realism, says Green.

> CULTURAL ATTITUDES TOWARDS SEXUAL BEHAVIOUR WERE IGNORED

Although the Western risk reduction model for HIV-Aids prevention worked well in San Francisco (as well as in Thailand and Brazil), when it was applied to sub-Saharan Africa's epidemic, however, there was little to no effort on the part of the Aids experts to adapt the model to other cultural settings or epidemic patterns. Aids experts see a very real difference in epidemiological patterns (the way the HIV-virus spreads) and cultural environment, which dictates different approaches to the prevention of the deadly virus.

Cultural attitudes towards sexual behaviour are certainly a major factor in the spread of HIV in sub-Saharan Africa. Yet Western Aids experts turned a blind eye to this, says Green, who spent part of the mid-1980s promoting the use of condoms while working in the family planning sector in Nigeria. "Perhaps it is only those of us like myself who have spent years actually promoting condoms in Africa who know this and can really acknowledge this publicly," Green explains.

HIV-Aids infection in Africa is quite distinct to that of the rest of the developed and developing world. In the US, Europe and most of Asia, for example, HIV infections are concentrated in a few fairly well-defined high risk groups such as gays, intravenous drug users and commercial sex workers. In sub-Saharan Africa, however, most infections are found in the general population.

Critics are indignant about this distinction, claiming that high risk groups needn't be singled out for fear of stigmatising them and making the general public feel that they are not at risk.

For Green and his colleagues, this preferred "risk avoidance" or "risk elimination" approach simply reflects the straightforward nature of the spread of the HIV virus in sub-Saharan Africa. The pandemic, the evidence suggests, is driven by people having multiple sexual partners, particularly if these are concurrent partners. Thus the inescapable solution to the problem is *not* to have multiple concurrent sex partners.

Yet most Aids prevention programmes before the US President's Emergency Plan for Aids Reduction (PEPFAR) did not actively or noticeably discourage any form of sexual behaviour, however, risky.

On the contrary, most Western "risk reduction" models have largely focused on condoms. However, a quarter century later (and 50 years after family planning efforts) there is no evidence to date that mass promotion of condoms has paid off in the decline of HIV infection rates at the population level.

"Condoms as a public health strategy (as distinct from an individual strategy) have largely failed in Africa," says Green. "Surveys do not show an association between higher levels of condom use and lower levels of HIV infection, rather we see the opposite."

Take the case of Uganda. The greatest decline in HIV-infection rates in that country occurred during the late 1980s and early 1990s prior to the mass social marketing of condoms. No country in the world has experienced such a decline to date, not even the United States where, sadly, HIV-infection rates among gays are once again on the rise. Furthermore, no one has achieved consistent condom use by all Africans in ages 15 to 49 above 5 per cent in any country.

> Condoms as a public health strategy (as distinct from an individual strategy) have largely failed in Africa

Promotion of condoms alone has not been shown to be an effective strategy to lower infection rates in generalised epidemics, such as those found in Africa, writes Norman Hearst and Sanny Chen in their 2004 paper, *Condom Promotion for Aids Prevention in the Developing World: Is It Working?* Condoms have been shown to reduce HIV prevalence in concentrated epidemics, as in Thailand and Cambodia, where most HIV infections are found among high-risk groups. Among certain high-risk groups high levels of consistent condom use have been achieved. For populations outside of high-risk groups, inconsistent condom use is the norm rather than the exception.

## Low Demand

There is a belief among some Aids experts that the widespread promotion of condoms might backfire and result in disinhibition. Individuals who are disinhibited, according to experts, may feel safer than they should when using condoms and therefore engage in riskier behaviours such as having several concurrent sex partners, than they would were they using no "protection".

Others engaging in high-risk behaviours (such as commercial sex, sex with multiple partners, or sex with a person known or likely to be infected with HIV) are more likely to use condoms, especially when condoms are promoted effectively and made readily available. Promoting condom use to those with high risk behaviours is also strategic in that they are more likely to be "core transmitters" within a population.

Contrary to popular thinking, access to condoms is *not* the problem in sub-Saharan Africa. The simple fact is that condoms are generally unpopular with Africans. This is the real reason behind the low demand in this part of the world, according to the Population Service International (PSI), the largest condom marketing programme in the world.