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Biomedical and Behavioral Approaches

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Foreword

Globally, action to prevent HIV spread is inadequate. Over 16,000 new infections occur every day. Yet we are not helpless in the face of disaster, as shown by the rich prevention experience analyzed in this valuable new compendium. "Best practice" exists—a set of tried and tested ways of slowing the spread of HIV, of persuading and enabling people to protect themselves and others from the virus.

Individually, features of best practice can be found almost everywhere. The tragedy, on a world scale, is that prevention is spotty, not comprehensive; the measures are not being applied on anywhere near the scale needed, or with the right focus or synergy. The national response may concentrate solely on sex workers, for example. Elsewhere, efforts may go into school education for the young, but ignore the risks and vulnerability of men who have sex with men. Action may be patchy geographically. AIDS prevention may not benefit from adequate commitment from all parts and sectors of society, compromising the sustainability of the response. In some countries matters are still worse—there is still hardly any action at all against AIDS and scarcely any effort to make HIV visible. It is no wonder that the epidemic is still emerging and in some places is altogether out of control.

Fortunately, many communities and some countries have managed to stabilize their HIV rates or achieve an actual downturn. It is by looking closely at their responses, and at the corresponding achievements, that we can pinpoint correlates of success.

Overall, UNAIDS analyses indicate that there are at least ten important features that are common to effective AIDS programs. To begin with, effective programs are those that receive political commitment stretching up from the community to the highest political level. This kind of commitment makes it possible to bring in all the sectors and players required, along with the necessary resources for interventions. It is also crucial for making the hard political choices often involved in AIDS prevention—applying best practices that may be considered controversial in some countries but that do work, from AIDS education and needle exchange for drug users to sexual health education in schools.

To be effective, programs need to make HIV visible and sex discussable. They have to make people aware that HIV exists and why it exists, and make them comfortable enough to talk about the epidemic and cope with it. This also involves

dissipating fear and prejudice against people who are already living with HIV or AIDS.

Programs must be guided by a national strategy that is firmly grounded in national realities. It is essential to find out where people in the country are already infected, where they are exposed to HIV risk, and why. Epidemiological surveillance combined with a mapping of behavioral risk and socioeconomic vulnerability is the best basis for drawing up a national strategy.

Effective programs are characterized by focused but steadily expanding coverage. To begin with, action should be focused on locally important vulnerable populations and geographic areas where HIV is an emergency. Of course, planners must take into account the need to reach many different populations of this kind, including those who will become exposed tomorrow; after all, individual risk and vulnerability change over the life cycle as children mature into adolescence and adulthood. Action must be focused in the second sense—focused on achieving success through multiple, complementary interventions of known effectiveness. Gradually, without losing focus, the program must expand steadily until complete country coverage is achieved.

As a complement to focused action, programs must create general awareness and knowledge in the rest of the population, especially among young people, who represent more than half of all those infected after infancy. The idea is to impart knowledge, counter stigma, create social consensus on safer behavior, and boost AIDS prevention and care skills. This can be accomplished cost-effectively through mass-media campaigns and through peer/outreach education and life-skills programs in schools and workplaces. Too much emphasis on vulnerable groups can inadvertently stigmatize them and generate an "I'm not at risk" attitude in the rest of the population.

Both prevention and care interventions are crucial for effectiveness. Health care services have benefits that extend even beyond the human rights and needs of people who are ill with HIV-related conditions. They can help convince others that the threat of HIV is real and make prevention messages more credible. Some interventions, such as voluntary counseling and testing, and programs to reduce the risk of mother-to-child transmission of HIV through zidovudine administration and the provision of safer infant-feeding options for HIV-positive women, straddle the conventional divide between prevention and care.

Because the epidemic is highly dynamic, programs have to be flexible enough to keep pace with the changes. This calls for careful monitoring of HIV and of the evolving risks and vulnerabilities of the population, as well as the evaluation of interventions.

For effective AIDS action, the challenges of the epidemic need to be routinely factored into the individual and joint agendas of government and civil society so that a true multisectoral and multilevel partnership results. Government sectors, community-based organizations (CBOs), businesses, and communities must

understand that they each stand to suffer if HIV prevention is not effective. Not only do they have a stake in participating — they have valuable contributions to make. Ministries of labor can mandate workplace prevention programs in the private sector. The defense establishment can use its budget to implement programs for the military, and the education sector for schoolchildren. Private firms can contribute in cash and in kind. CBOs, who are trusted by and have access to vulnerable populations, are best positioned to mount prevention programs in collaboration with their communities.

A corollary of the preceding feature is mainstreaming and resource mobilization. It is a fallacy to assume that because designated AIDS funding is limited, so must AIDS action be. Instead of blindly accepting resource limitations, effective programs seek out opportunities to involve partners with similar goals. They capitalize on synergies between AIDS and other programs. If the action needed for risk-reduction and vulnerability-reduction becomes part of the mainstream of national life, direct costs will be lower, programs will become more sustainable, and there will be many spinoffs beyond AIDS prevention. For example, incorporating HIV/AIDS into a school curriculum involves only marginal costs but the resulting decision-making skills among the nation's youth will bring about extra benefits such as declines in sexually transmitted disease, unwanted pregnancy, and drug use. Similarly, boosting the educational and economic opportunities of young girls in rural areas, to discourage their entry into commercial sex, raises their status — a matter of social justice — and promotes rural development.

Lastly, effective programs are those that take a long-term approach and build up societal resistance to HIV. There will be no quick fix to this epidemic. Societies and especially the younger generation must be encouraged to adopt safer attitudes and behaviors that will gradually fortify them and ultimately offer serious resistance to the spread of HIV.

To sum up, just as we apply combination therapy for maximum effectiveness, so must we apply combination prevention. In AIDS, we face a disaster that is far larger than the wars or natural catastrophes that fill the headlines. Fortunately, it is a disaster that we know how to mitigate, as this welcome new volume on AIDS prevention shows. While we work on the longer-term goal of developing a vaccine, we can act to avert human suffering and societal devastation by applying existing best practices intelligently, durably, and above all in combination.

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Preface

The impetus for this volume was a seemingly simple query by an Asian Minister of Health, In 1995, two of the editors of this volume met with the minister who articulated his desire to take action to prevent an HIV epidemic in his country, but stated that he did not know what course of action to take. He asked for information on what had been tried and proven successful elsewhere.

This mirrored situations encountered in other contexts where academicians, governmental officials, and activists in nongovernmental organizations have been eager to learn more about prevention programs tried elsewhere, particularly those programs that have "worked." A common response to such requests for information has been to refer them to various academic articles reporting intervention results. This, however, has not always been the most helpful response. The people most engaged in HIV prevention often have limited time to read, and in some cases are without easy access to academic publications or have insufficient academic experience to enable them to easily read scholarly articles. Further, most journal articles focus on interventions that have been implemented in industrialized nations. And while much can be learned from those interventions, the relevance and applicability of their insights may be mitigated by the different economic and cultural contexts of developing nations.

We felt, therefore, that it would be helpful to have a single volume that reviewed notable interventions implemented to date in developing countries, with the aim of describing the strategies they have employed, implementation problems and opportunities encountered, and successes or failures in terms of results achieved. Such a volume would be particularly helpful if written in a style accessible to diverse audiences and if an effort were expended to make it available to those working on HIV prevention in developing countries.

The rationale for focusing specifically on interventions in developing countries is that program planners in the developing world, with fewer resources than those in more industrialized nations, might derive important insights from interventions tried in other countries with certain socioeconomic similarities. An additional reason for focusing on interventions in developing countries is that while there is an extensive body of published literature on interventions in North American and European nations, the literature is far more sparse for nations in Africa, Asia, and Latin America.

The dearth of published literature is due in part to the fact that since the beginning of the global HIV/AIDS pandemic, it has been activists in nongovernmental and governmental organizations who have spearheaded HIV prevention efforts in developing nations, generally without the involvement of researchers. As a result, the motivation and skills to publish findings have not been strong, making it difficult for insights from these interventions to be shared with organizations and individuals engaged in HIV prevention in other developing countries.

Taking the view that much can be learned from these interventions, *Preventing HIV in Developing Countries* brings together researchers and activists in the field of HIV prevention to review the content and findings of behavioral and biomedical interventions implemented primarily in developing countries. The contributors have consulted both published and unpublished literature. While an emphasis has been placed on interventions that have been evaluated, the dearth of such interventions for certain target groups has led to the inclusion of nonevaluated interventions as well. The latter cannot provide evidence of results, but can offer important insights into approaches being utilized and into implementation issues in HIV prevention programs in developing countries.

It should be noted that we use the terms *developing countries* and *developing world* reluctantly. The terms are vague, lump highly divergent countries into one category, and imply that while certain countries are "developing," other countries have already reached the penultimate stage of being "developed." We reject the latter implication, recognizing that development is a continuous process and there exists a broad and multifaceted developmental continuum. Yet while we acknowledge the limitations of this terminology, we have retained the use of these terms for the simple reason that they have broad public recognition and can be used easily and effectively in literature searches.

Our hope is that this volume will provide a forum for insights from important and creative HIV prevention efforts undertaken in the developing world to be shared with others whose work is inspired by the common desire to prevent the transmission of a virus that is responsible for untold suffering and devastating losses to individuals, families, communities, and nations. To a greater or lesser degree, in a direct or indirect fashion, and with more or less acute awareness, we have all experienced loss as a result of this pandemic. Preventing its further spread remains a matter of urgency for us all; learning from each other's successes and failures may contribute to our achieving this end.

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