Essay 2

The need for comprehensive multi-faceted interventions

Johannes Petrus Heath

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The need for comprehensive multi-faceted interventions

Johannes Petrus Heath

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1. No magic bullet

In my five years with the African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+), I have found that there are some issues that are so central to the network's identity that we deal with them on a daily basis. First, for example, it has always been a core focus of the mission of ANERELA+ to challenge stigma, shame, denial, discrimination, inaction and mis-action (a combination that has come to be known as SSDDIM). Second, prevention (including the development of effective prevention messages) remains a constant concern of ANERELA+ and its members. Neither of these issues has been resolved. In 2007, 2.5 million people were newly infected with HIV. Prevention messages and strategies are not getting across as effectively as they need to, and even something as uncontroversial as treatment to prevent mother to child transmission (PMTCT) is only reaching 11 per cent of the women who need it.

The long-term character of these challenges, and the relatively minor progress we have made over the years, act as a warning to any of us who are expecting that the current process or any other will yield quick-fix solutions to the challenge of HIV prevention. On the contrary

(and it pains me to share this with you): *there is no magic bullet*. HIV prevention is a complex and nuanced challenge, which strikes at the heart of human identity, family relationships and community life. This paper, therefore, will address four separate and distinct factors that contribute to the challenges facing prevention. They are:

- prevention messages;
- factors that increase vulnerability;
- the small proportion of people, who are living with HIV, who know their status;
- the complexity of the challenges involved in changing behavior.

The stigma that surrounds HIV and AIDS is a cross-cutting issue, undermining responses to all four of these challenges, and helping to explain why they have proved so intractable. And that is why the first issue I mentioned, in the opening paragraph of this paper, was stigma.

2. Prevention messages

ANERELA+ has long argued that one of the main problems with HIV prevention is that it tends to focus on sex, sex and sex again. This presents a problem for most religious groups, who tend to have major difficulties in talking about sex. One example of this is the widespread and well-advertised use of the ABC approach to prevention, with its descending order of acceptability. What this approach seems to say is: '**A**bstain, since no sex is the best sex; or if you can't abstain, then at least **B**e faithful; if you refuse to be faithful then at least have the decency to use a **C**ondom'.

In practice, there are a variety of problems with the ABC approach. First, it intensifies that stigma round HIV and AIDS by focusing only on sex. Second, it leads people into a false sense of security, since the message becomes: 'As long as you are in a faithful relationship you have no need to worry – you are safe from HIV'. Sadly this is not the case. Dr. Hannu Harponen, who works and teaches in Uganda, analyzes information relating to the most common modes of trans-

mission of HIV. The current figures in Uganda, he says, suggest that the highest area of transmission is within marriage: 42 per cent of all new infections of HIV in Uganda happen within the sanctity and safety of the marriage bed. That means that the riskiest behavior possible in Uganda at the moment is marriage. It is therefore worth looking at what we mean by risk.

My friend and fellow member of ANERELA+, Canon Gideon Byamugisha, who is also a contributor to this volume, has stressed that there is a major difference between risky *behavior* and a risky *environment*. What this essentially means is that if you find yourself in an environment with a high HIV prevalence, behavior that in other circumstances would have been considered safe, suddenly takes on a new risk. Therefore, if you focus only on one element in the transmission chain, without giving full information about all factors, you give people misinformation, and they are not able to judge the risk for themselves. If the aim is to prevent HIV transmission, it is pointless to speak about being faithful in a sexual relationship until after people have learned the importance of knowing their own and each other's HIV status. That information makes it possible for them to take informed decisions as to how best to protect yourself and your loved ones.

3. The SAVE approach

It is for these reasons that ANERELA+ developed the SAVE approach to HIV prevention. This stands for four key principles.

S = Safer practice
When speaking about safer practices we try to address all avenues of HIV transmission. Factors that reduce the risk of HIV transmission would include PMTCT; post-exposure prophylaxis (PEP); abstinence, but also the delay of sexual début; mutual fidelity within a committed relationship; the use of vaginal microbicides; needle exchange; oral substitution therapy; male circumcision; use of condoms; clean and safe blood for transfusion; and sterile implements – not just for hospital or clinic-based surgery but also for cultural scarification.

A = Available medical interventions

One of the most effective prevention methods is the use of antiretroviral therapies (ARVs). This is because where the viral load of the person living with HIV is reduced to undetectable the chances of transmission drop to less than 1 in 25,000. But this is not the only medical intervention we are talking about. There is a need for effective treatment of opportunistic infections, and also all other sexually transmitted infections (STIs). In addition to this, good nutrition may be regarded as a medical intervention. Medical interventions also include the crucial (and seldom provided) access to all necessary blood tests. Without adequate monitoring of the efficacy of ARVs through viral load tests, a person could have developed an undetected drug resistance, compromising not only have their own health but also the health of their sexual partner. The availability of viral load tests for babies is also important. The majority of babies who die from HIV die before they are two years old, because the diagnostic tool most commonly used is the CD4 test, which cannot determine whether a baby is HIV positive until the infant is 18 months old. With a viral load test this can be done at birth.

V = Voluntary Counselling and Testing (VCT)

It is crucial that all people know their HIV status. We need to move from 'AIDS Friendly Congregations' to 'Congregations that know their HIV Status'. Whether this happens through VCT or Provider-initiated testing is less important that getting people to know their HIV status.

E = Empowerment

One of the single biggest challenges we face in increasing the impact of our HIV prevention messages is the limited capacity of many people to respond. For example, it is no good telling a woman to use protection in her sexual relationship if we do not also help her to overcome clearly defined gender inequalities in her domestic, religious or cultural environment that prevent her from doing so. Further, most information about HIV prevention comes in written form when in many areas there are still high levels of illiteracy and, even when people can read, many of the publications use stigmatizing, misleading or often incorrect language. These two examples of the need for empowerment bring me to the next of our four key challenges to prevention.

4. Factors that increase vulnerability

In October 2007 an 'Open Space Meeting' was held in Amsterdam to discuss the global architecture of the response to HIV and AIDS. One of the most significant impacts of that meeting for me was a model put forward by Gracia Violeta Ross Quiroga relating to the streams of vulnerability. In her model, Gracia postulated a landscape that increased people's vulnerability generally. The features of this landscape are:

- laws/ legal framework;
- poverty;
- marginalization;
- conflicts;
- gender inequalities;
- migration;
- violence (sexual, psychological, physical);
- economic imbalances;
- lack of education;
- homophobia;
- racism.

In this model these factors of vulnerability are like the streams of magma that flow together to form the pressure release we know as a volcano. As soon as the pressure rises to a certain level it will explode. The current explosion of this volcano is HIV and AIDS. If we manage by some means to plug this volcano called HIV and AIDS it will simply bubble up and explode in a different place. The only effective long-term solution is to dry up the flow of magma, and that can only happen if we effectively deal with the factors that increase people's vulnerability.

Let me give some examples of how this works. In January 2008 forty people living with HIV came together for the HIV+ Monaco conference. We were there to look at the advocacy agenda around HIV not only leading up to the International AIDS Conference to be held in Mexico City in August the same year, but to take us beyond Mexico. Four themes for advocacy were identified:

- positive prevention;
- universal access to treatment, support and care;
- rights to sexual and reproductive health;
- discrimination and criminalization.

Throughout the conference it was stressed that none of these themes are stand-alone. All are strongly interrelated. You cannot talk about positive prevention without the availability of 'universal access to treatment, care and support', for treatment is an integral part of prevention. We also need to stress the need for these same services to be judged by universal standards (hence the advocacy slogan: 'universal access – universal standards').

The need for universal standards seems so obvious. And yet it is not universally accepted. I will give just two examples. The first comes from the ANERELA+ chapter in Nigeria, where we have just sadly lost our coordinator. One of the reasons was that in Nigeria, as in the rest of Africa, viral load tests are not provided. In Boniface's case what this meant was that even though he was taking his medication correctly and consistently he had developed a resistance to the medication and nobody could pick it up because not all the necessary tests were available. This has left a family without a father, increasing the vulnerability of the whole family.

A second example would be the whole issue of criminalization. In some countries the transmission of HIV is being criminalized. Firstly this means that sexual health is a burden being placed only on the person who is HIV positive. But more worryingly, in countries where this is the case a trend is emerging where people are resisting going forward to be tested for HIV, in the knowledge that they cannot be held responsible for transmission if they do not know their HIV status.

5. At best 15 per cent of people living with HIV know it

The single largest contributory factor to challenging HIV transmission is that about 85 per cent of people living with HIV don't know it. This means that they continue their lives as normal, believing themselves

to be immune from the HIV that is all around them. The majority of people only go to test for HIV when they are already seriously sick. In most cases this means that they would have been living with HIV for some eight to ten years already. In that time there are a number of people who could have been put at risk of HIV infection simply because they did not know. One of the commitments which people living positively with HIV are always ready to make is: 'HIV stops here!' This is positive prevention in action – but it is impossible to enact when you don't know your HIV status, or if you do not have access to the medication, nutrition, care and support which helps you to live positively.

Some of the factors preventing people from being tested are:

- *Gender inequality:* a wife is afraid either to go and get tested or to ask her husband to get tested because she might get kicked out of the home if found to be HIV positive even though it is likely that it is her husband who infected her.

- *Stigma, discrimination and criminalization:* one example is that in prisons people are fearful of going to be tested. They are afraid that the 'authorities' will get to know, other inmates will find out, and they will either be isolated or even in danger of their lives.

- *Lack of access to treatment, care and support:* where these are not available there may seem little incentive to know your HIV status because the only thing you will receive is rejection.

- *Travel restrictions:* it is better not to test for HIV because then you don't have to lie about your HIV status to get a visa.

You can see quite clearly that one of the main reasons for people not going to find out their HIV status is the fear of rejection, isolation, discrimination and all that goes with this. If we are truly to overcome this

hurdle to HIV prevention we will have to work harder at levelling the playing fields.

6. The complex challenges of behavior change

One of the biggest challenges to our prevention messages is the all too human belief: 'I'm immune, it can't happen to me!'. For example, I may believe that I need not worry about testing before I get married because it could not happen to me; or that HIV only affects young people so I need not worry because I am older; or that HIV only affects black people, so I need not worry because I am white; or that HIV only affects gay men, so I need not worry because I am heterosexual. In each of these examples, a sense of invulnerability has become our individual barrier to making the right decisions. One of the biggest challenges of HIV prevention is to help people understand that they are vulnerable to HIV *simply because they are human*. (It is, after all, the *human* immunodeficiency virus we are talking about.)

I think it was Antony de Mello, amongst others, who said that the most futile thing we as humans could try to do was change settled patterns of behavior. As human beings, we should seek – rather - to enter deeper into the heart of God, deepen our relationship with God, and then it would be God who changed within us that which God wanted changed. From a spiritual perspective I have always found this helpful. If I were able to change myself, or to save myself, there would have been no need for Jesus to come and save me.

This may also help explain why behavior change is so difficult for people. I believe that the answer to this challenge is to help people into adopting the right behaviors from the start: which would mean engaging more in teaching about HIV and AIDS, sex, sexuality and so on, not just in Sunday schools and confirmation classes, but also in Bible studies, sermons and any and all forums of teaching open to us.

The pressure to encourage young people to develop desirable patterns of behavior from the start does not absolve us from working harder towards helping not only ourselves but other people to alter existing

patterns of behavior. The key to challenging behavior, though, is not to be judgemental but rather compassionate and accepting, helping people to see their immeasurable value in the sight of God. It is not truly possible for me to love myself until I can fully accept God's unconditional love for me; it is not truly possible to show love to our neighbour - with all that that would entail in HIV prevention and positive living – without first accepting and living the 'love of self' which an acceptance of God's love would mean.

In conclusion, I hope that, if I have done nothing else, I have been able to highlight for you the reality that there is no magic bullet. Rather, HIV is a complex issue that demands of us comprehensive and multifaceted interventions. One of the participants in the Open Space Meeting described civil society thus: 'We are a tropical forest, not a formal, planted garden'. For me, from my place within the faith community's response to HIV, this means that we don't all have to do everything, but we do all have to do something.

It is also more useful if our interventions complement each other. If I believe in a tree with a bird in it, but you prefer a tree without a bird, that does not mean you should chop down my tree or that I should chop down yours – there is not only room but also a necessity for both trees in this tropical forest of ours. For me this remains one of the main strengths of a prevention message like SAVE. Within safer practices there may be some interventions that from your particular faith perspective you cannot endorse, but you can still teach about the safer practices you believe in, and so together we can speak about SAVE rather than attacking each other on our different approaches. Dr Peter Piot of UNAIDS has said: 'We will not overcome HIV without the support of faith communities'. Our contribution as faith communities to overcoming the effects of HIV on people's lives is not only valuable but it is crucial to the eventual success. And, as we further develop and refine our individual and collective responses to HIV prevention, it would be useful for us to bear in mind one very important thing:

HIV is a virus, not a moral condition.