African Successes in HIV Prevention:
Considering the Power of Behavior-Based Approaches

Dec 17-20, 2006
Munyonyo, Uganda

From December 17-20, 2006, a unique group of scientific researchers, pioneers of the Uganda behavior-based approach, religious leaders, reproductive health specialists, historians, policymakers and government leaders met in Munyonyo, Uganda to bring together the latest research evidence from Africa that pertains to prevention of the sexual transmission of HIV, and related issues. This symposium was hosted by Harvard University's AIDS Prevention Research Project and the Anglican Church of Uganda with funding from the John Templeton Foundation.

This document provides a summary of the evidence and the group's commitment to promotion of evidence-based HIV prevention.

The African HIV Prevention Strategy

A behavior-based approach to HIV prevention has been successful in Uganda and in other generalized epidemics in Africa. ABC– Abstain, Be faithful, and Condom use – is a strategy whose components are complementary. All three elements of this approach are essential in reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population. Although the overall programmatic mix should include an appropriate balance of A, B, and C interventions, it is not essential that every organization promote all three elements. A, B and C should be promoted in ways that do not undercut any of the three interventions or behaviors.

Evidence from Africa must guide African programmes. This evidence can be summarized as follows.

Growing evidence suggests that having multiple sex partners, especially multiple concurrent partners, is the major driver of at least the generalized epidemics of Africa. When "B" behaviors improve, that is, when more men and women practice mutual fidelity, national prevalence rates tend to fall. In every example in Africa of prevalence rates falling (including Uganda, Kenya, and Zimbabwe), there have been significant declines in casual, multi-partner sex in the previous years. More needs to be done to increase our understanding of how best to promote the B message.

Abstinence works and can and should be promoted. It works best as part of a broader character formation effort that includes: teaching skills in forming friendships, understanding peer pressures, fostering self respect and respect for others, what it means to fall in love, what it means to take responsibility for one's own behavior, and how certain actions and decisions can have life-long consequences. Taking such a broad approach in fact engages the interest of young people, who are interested in discussing these topics and are looking for advice and guidance.

In fact, most Africans are already practicing B and A behaviors. Those who are not, have the capacity to change behavior. People are not animals or machines, and are capable of behavior

change. When behaviors change, HIV incidence and eventually prevalence decline. There is a critical need to conduct research, consolidate findings, and identify best practices for A, B, and C.

At the level of the individual or in high-risk groups, condoms are effective when used consistently and correctly. However, the effectiveness of condom *promotion* in HIV prevention in Uganda and in generalized epidemics elsewhere in sub-Saharan Africa at the population level is not clear. Two key problems have emerged in Ugandan and other African studies: 1) inconsistency of use and 2) potential for behavioral disinhibition, or acquiring a false sense of security that may result in more risky behavior. Despite extensive condom studies, there is an urgent need to learn how best to promote correct and consistent condom use, and do this in a way that does not lead to taking greater risks in sexual behavior and thereby potentially cancel out the protective effects of condom use.

Contributing Factors

Communities can be mobilized to fight AIDS, and Uganda was the first country to achieve widespread mobilization of virtually all sectors in fighting AIDS. Given the importance and ubiquity of faith-based organizations (FBOs) in Africa, and their roles in health care and education, it is necessary to form partnerships with FBOs in AIDS prevention. Collaboration with FBOs is enhanced by the fact that A and particularly B interventions have been found to be effective, and these are the interventions that FBOs are best positioned to promote. Other important groups include women's and men's associations, care groups, youth organizations, traditional healers, local media, and both traditional and governmental leadership. Through such involvement, new norms of sexual behavior can be fostered, as occurred with Uganda's successful zero-grazing strategy (fidelity and partner reduction).

Some aspects of African culture can be vehicles for positive changes and improved health. African cultures value religious faith, values, and community. Faith and values can be powerful agents of behavior change.

Prevention programmes can and should address issues such as stigma, gender inequality, sexual coercion, cross-generational relationships and transactional sex. They should directly involve people living with HIV/AIDS, in order to achieve maximum behavioral objectives and reduce stigma.

There is a need to balance individual rights with social responsibilities. African cultures value family and community. These values must be balanced with the needs and desires of the individual.

In mature epidemics, infections are found increasingly among discordant couples. This does not mean that that marriage is dangerous for women, as is sometimes asserted. Most data show that married women are at less risk than unmarried sexually active women. ABC interventions are still needed in mature epidemics. Men who stray from marriage or who have sex with young women must be targeted by campaigns to change community and social norms so that their behavior becomes unacceptable.

Evidence from Africa shows that poverty is often *not* associated with HIV infection in the way widely assumed. There are risk factors associated with wealth as well as with poverty. Wealth is associated with greater mobility, more disposable income for alcohol and recreation, and urban residence, which can lead to higher HIV prevalence rates among the wealthy than among poorer population segments. Uganda has demonstrated that HIV prevention is possible even in the presence of widespread poverty. While we strongly affirm that poverty reduction is critical to human health and well-being, poverty alleviation is not a panacea to the scourge of AIDS. Therefore general economic aid and poverty alleviation programmes, while critical, should not substitute for effective behavior change programmes.

Current trends in Uganda

Current data show worrying trends in Uganda. HIV prevalence has stagnated after years of decline. "Love faithfully" and "zero grazing" were the main messages for most Ugandans in the earlier national prevention programme of the late 1980's and early 1990's. This message is not as strong today. There is increased complacency and less fear of becoming HIV infected. Since the early or mid-1990s, there is less emphasis on B messages and interventions and more on condom promotion. While the abstinence message continues to be strongly promoted, critical components of the behavior of abstinence, such as formative character strategies, may have been diluted or lost. There is less emphasis in Uganda on prevention in general, and much emphasis and funding these days relates to treatment. The growing availability of ARVs may contribute to growing complacency in Uganda. This needs to be counteracted with a stronger overall prevention message.

AIDS in Uganda has increasingly become a donor-driven, medical service-focused, routine, unfeared, and non-fatal problem instead of a national emergency that all Ugandans as a matter of national pride want to address collectively and with a sense of urgency, as volunteers if necessary.

Behavior-based interventions have been successful, but more needs to be done. Therefore we commit ourselves to a renewed emphasis on African-derived, evidence-based HIV prevention programmes, policies, and resource commitments. We submit the following Resolutions and Recommendations.

Resolutions and Recommendations

General/Policy

1. We recommend a renewed emphasis on prevention and urge all actors in the African response to follow the African evidence for behavior-based programmes to guide programmes, policies and resource commitments.

2. We call upon Ugandans and the people of other countries affected by HIV/AIDS to not become complacent about the threat and to renew the government, NGO, and community-level action that once made HIV prevention in Uganda such a success.

Gender and Promotion of Mutual Faithfulness in Sexual Relationships

3. We call upon AIDS prevention programmes in Africa and directed at Africa to put primary emphasis on reducing the number of multiple and concurrent partnerships.

4. We urge development of innovative strategies, based upon existing knowledge of best practices, to protect women and girls from male behaviors that put them at risk of HIV infection or abuse. This should result in programmes that change male behavior and undercut prevailing norms that sanction or tolerate abusive behaviors by men.

5. In light of the increased vulnerability of women to HIV, we call upon governments to institute policies that increase the equality of women, such as through greater educational opportunities.

Abstinence

6. We urge development of innovative programmes for youth that encourage youth to abstain and delay sexual debut. These programmes should reach youth before they become sexually active, go beyond one-time pledges, be life skills- and values-based, and include character formation efforts that foster mutual respect between young men and women and an abiding sense of personal and social responsibility for one's own behavior.

7. We call upon researchers in the field of HIV/AIDS to produce research of abstinence and faithfulness behaviors, interventions, levers for change, and best practices in order to improve and guide interventions on the ground.

Condoms

8. We urge development of innovative strategies that increase consistent and correct condom use among those engaging in risky sexual behavior, in ways that do not inadvert-ently foster a false sense of security (disinhibition). This should not be the primary interv-ention for the general, not-at-current risk population, in line with African evidence to date.

Actors in HIV prevention

9. We call for a return to true ownership of AIDS prevention to Africans, to recapture volunteerism, passion, popular mobilization and sense of duty and to refocus on behavior, culture, and community rather than solely a delivery of a package of services.

10. We call upon international donors, governments, and health-based organizations to re-examine their funding priorities and commit HIV prevention funds according to proven successful evidence-based strategies in Africa.

11. We call for greater involvement of faith based organizations in AIDS prevention, recognizing their power and ubiquity in Africa, their long-established role in health care and education in Africa, even before governments provided these, and recognizing their comparative advantage in promoting marital faithfulness, abstinence and even targeted condom use if this does not conflict with doctrine.

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