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Moving Beyond of The Alphabet Soup of HIV Prevention

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Abstract

It is time to scrap the “ABCs” and elevate the debate on HIV prevention beyond the incessant controversies over individual interventions. The ABCs are a woefully incomplete list of necessary prevention interventions, but the goal should not be to just add more letters to the prevention alphabet. Instead, advancing global HIV prevention means holding national governments, donors and global agencies accountable for prevention efforts that are tailored to national epidemics, bring quality interventions to a scale, and address environmental factors in vulnerability. The debate is not so much about one intervention or another, but whether countries have a comprehensive prevention effort in place that responds to their own unique situations.

Infantilizing prevention

Today’s most commonly cited acronym for HIV prevention – “ABC” – falls severely short of describing the global effort needed to reduce HIV transmission. First, the ABCs mix up different prevention strategies. “A” (for abstinence) and “B” (for be faithful) are behaviors. “C” (for condoms) is a commodity. The implication of this string of concepts is that anyone can achieve protection if he or she chooses one or more options from the short menu. “A” is an important and preferred choice for many individuals, particularly many young people, and delaying sexual debut is an effective strategy in reducing infection rates. But abstinence is not realistic for much of humanity, and “A”-focused programming should not be delivered without other interventions, though it often is. “B” is not protective unless a couple knows the infection status of both partners, and both honor their commitment. For millions of women whose husbands are not monogamous, B is insufficient since the female partner may be ignorant of her risk or powerless to insist upon protection.

Absent from the ABCs is an acknowledgement of the limitations of self determination in this epidemic and the powerful impact of social factors like stigma, the unequal social status of women and girls, poverty, laws criminalizing drug use, and anti-gay bias. If HIV prevention comprises only the ABCs, the social reality of millions of women means they will simply not be able to choose A or C, and B will bring little protection – and perhaps even greater risk. The “alphabet soup” approach overlooks interventions needed to protect people in risk-filled environments such as prisons or refugee camps.

The ABCs infantilize prevention, oversimplifying what should be an ongoing, strategic approach to reducing incidence. True, the simplicity of the ABC slogan has probably helped some people better appreciate that they can take basic steps to protect themselves from HIV infection. But that advantage must be weighed against the dangerously misleading messages the ABCs send to both individuals and to policy makers. “ABC” gives the incorrect impression that all HIV transmission is sexual and that effective prevention is simply a matter of changing the individual choices of millions of people with a few, tried and true interventions. Reciting

the “ABCs” invites distracting and useless arguments, such as whether abstinence is better than partner reduction or both are better than condom use.

What is missing from the ABCs

The alphabet soup approach ignores core components of a comprehensive prevention response and the critical importance of adapting programming to distinct epidemics. Key aspects of prevention programming are invisible in the ABCs. In Eastern Europe nearly two thirds (62%) of new HIV infections reported in 2006 were due to non-sterile injection drug use.ⁱ Yet the ABC model focuses exclusively on sexual transmission, leaving out proven-effective interventions for IDUs such as drug abuse treatment and harm reduction approaches, including needle and syringe exchange. Most of the hundreds of thousands of cases of mother-to-child HIV transmission that occurred last year could have been avoided if PMTCT+ services reached more than the current 11% of HIV-positive pregnant women in less developed countries. Yet there is no PMTCT+ in the ABCs.

HIV testing is essential to expanding the reach of AIDS treatment and a crucial opportunity for delivering prevention messages to both HIV positive and HIV negative individuals. The majority of people who learn they are HIV positive try to avoid exposing others to infection.^{ii iii iv} Reducing the infectiousness of people living with HIV, and helping them change their risk taking behaviors, are themselves important strategies in prevention. But the ABCs disregard the importance of integrating HIV testing, prevention and treatment and fail to acknowledge the potential impact of treatment on HIV transmissibility.

We need to start including high quality, non-stigmatizing “prevention for positives” in the standard of care for people living with HIV/AIDS. Clinical and community-based treatment settings need to be used as opportunities to deliver HIV prevention information, as well as condoms and other prevention tools.^v In many high prevalence countries, a large portion of HIV incidence occurs in discordant couples where neither partner has been tested for HIV. The availability of high quality couples counseling and HIV testing can greatly reduce this transmission while keeping families together.

The context of risk and vulnerability

Addressing the context of risk, in addition to individual behavior, is essential to bringing HIV incidence down. Many researchers have detailed the multiple levels of causation that are significant in the spread of HIV. Over a decade ago, Sweat and Denison identified super-structural, structural, environmental and individual levels as important to understanding personal behavior related to HIV risk.^{vi} More recently there has been increasing recognition of the need to impact social norms around sexual behavior, anti-HIV stigma, and other issues. As Elaine Murphy and colleagues have observed, while an ABC approach is often credited with reducing HIV incidence in Uganda, success in that country depended on nation-wide social mobilization and steps towards gender equity under the political leadership of President Museveni.^{vii}

The Thai “100% condom campaign” is perhaps the most renowned example of a structural intervention that had dramatic, measurable impact.^{viii} Environmental interventions with female sex workers in the Dominican Republic are a related example.^{ix} The efficacy of syringe exchange programs in reducing HIV seroconversion among injection drug users is long established.^x Project Accept^{xi} is testing the community level impact of community mobilization, mobile voluntary counseling and testing, and post-test support services on prevalence and risk behavior in several countries in Africa and South-East Asia. Specific interventions like these, designed to address structural factors in risk, need to be tested and then brought to scale rapidly.

Limiting PEPFAR's impact

The dangerous limitations of the ABC approach are documented in the 2007 Institute of Medicine progress report^{xii} on the President's Emergency Plan for AIDS Relief (PEPFAR) – the biggest single funder of HIV prevention programming in the global AIDS response. The IOM report notes that “PEPFAR's primary approach to preventing sexual transmission of HIV is aimed at changing ABC behaviors.” The IOM observed that PEPFAR is missing critical prevention opportunities, including fuller integration of prevention and treatment services.

The IOM panel wrote that PEPFAR “cannot afford to conceptualize prevention narrowly or as distinct from treatment and care.” The report calls for supporting countries in delivering prevention, “throughout people's lives and regardless of their HIV status, and across the full spectrum of health and social services; and in all settings...”

The IOM also determined that PEPFAR's country teams need greater flexibility in tailoring prevention programming to fit their epidemics. PEPFAR's HIV prevention funding includes specific spending requirements, forcing those who design programs to align their approach with alphabetic earmarks rather than national priorities or scientifically proven approaches. A 2006 study from the US General Accountability Office that found the requirement that a third of PEPFAR prevention funds be spent on the “ABCs” of the ABCs makes it difficult for program planners to allocate prevention resources appropriately based on available data.^{xiii} (At this writing, the US Congress is poised to ease the abstinence-only spending requirement through the program.)

In some cases the implementation of PEPFAR ABC programming has raised deeper concerns, such as an emphasis on abstinence and incorrect information about condoms, as reported by Gordon and Mwale in Zambia.^{xiv} As Singh and colleagues observed in Uganda, prevention successes in that country were accompanied by significant increases in condom use along with other changes in sexual behavior.^{xv}

It's not just about more letters

Some have suggested adding letters to make the ABCs a more complete representation of current and future prevention approaches (for example, “M” for microbicides, “P” for pre-exposure prophylaxis, and “V” for vaccines). But we need more than a lengthier acronym. An effective national HIV prevention program is not a set of discrete interventions, but a planned and comprehensive approach with multiple tailored components, guided by data on the domestic epidemic.

A top priority for prevention programming is to “fit” the response to the national epidemic. The 2007 UNAIDS report, *Practical Guidelines for Intensifying HIV Prevention*,^{xvi} calls on all responders at the national level to “know your epidemic” by monitoring the dynamics and social context of HIV incidence, understand the key drivers of infection, and critically assess and then refine the domestic HIV prevention response. The Guidelines build on earlier work outlining the importance of tailored responses in different epidemic scenarios.^{xvii}

The UNAIDS Guidelines identify four basic epidemic scenarios and suggest countries “match and prioritize” a set of HIV prevention interventions appropriate for their setting. For example, in a country where HIV infection is spread predominately between sex workers and their clients, the prevention response should not focus exclusively on education in secondary schools. National health budgets should reflect prevention priorities by committing funds where they can have the greatest sustained impact on incidence. A shortfall of many national responses is their failure to dedicate resources to the prevention needs of groups at highest risk,

including populations like sex workers, injection drug users, men who have sex with men, and HIV discordant couples. A variety of resources are available to help planners determine how to use prevention resources most effectively to address their particular epidemics. xviii

Defining a comprehensive national response

The ABCs need to be retired as the short descriptor of HIV prevention, but a basic set of principles defining an adequate national prevention response is still needed. Such a list would help national policy makers assess their policies and resource allocations; it would provide a framework to help donors support nationally developed prevention plans; and it would aid advocates in evaluating whether their governments are making strategic investments in reducing HIV incidence. AIDS activist Zackie Achmat has noted that, “You cannot reduce prevention of HIV to a simple slogan.” Mounting effective, widescale national prevention campaigns requires an appreciation for the complexity of different epidemics, the unknowns of prevention research, and the need for continual assessment and revision of tactics.

Still, our understanding of HIV prevention need not be so complex that we fail to identify some basic standards by which to evaluate national governments, global agencies and donors engaged in AIDS prevention and treatment. A UNAIDS review^{xix} of prevention programming in three countries that successfully brought down HIV incidence revealed great diversity in the particular programs used, but several consistent themes in overall approach. The early prevention success stories in Senegal, Thailand, and Uganda were distinguished by:

- strong political commitment
- multi-sectoral and multilevel approaches
- interventions aimed at both the general population and groups at elevated risk
- integrated approaches to prevention and care, and
- wide-scale program delivery

Accountability is the critical factor

Reviews like this do not produce an easy checklist for evaluating national prevention programs. They reaffirm, however, that mounting an effective national HIV prevention campaign is not just a matter of learning the ABCs. It is an ongoing process of governments, affected communities, people living with HIV, and others working collaboratively to scale up quality, evidence-based approaches that “fit” the national epidemic, and then continually measuring outcomes and refining strategies. Examples of comprehensive prevention brought to scale are detailed in a 2007 report from the Global HIV Prevention Working Group.^{xx}

National accountability is critical to successful prevention (and treatment) programs. At the 2006 International AIDS Conference, AIDS activist Gregg Gonsalves warned of the “...the largely unaccountable, self-justifying infrastructure [which has come about in response to AIDS]” that emphasizes “generalized, international responsibility instead of specific local political accountability...” The public must hold governments accountable for well planned and executed approaches to prevention and treatment. Every government’s HIV prevention response, and its national HIV/AIDS prevention budget, can be assessed by looking at whether programming is tailored to the dynamics of the epidemic, is adequately scaled to have population-level impact, is integrated with treatment services, and addresses the context of vulnerability. Donors, global agencies and advocates should ask: does adequate prevention funding flow to evidence-based interventions tailored to the particular nature of the national epidemic?

Over a quarter century and 65 million infections into the AIDS pandemic, the time for slogans is long past. All those engaged in the response to AIDS must demand that governments and global institutions deliver on their promise of universal access to HIV prevention and treatment, investing increased resources in evidence-based, strategic approaches that can demonstrate concrete results through reduced HIV incidence and greatly expanded access to lifesaving treatment and care.

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