



Maximizing HIV Prevention: Building the Case for Social and Economic Vaccines



The XVII International AIDS Conference in Mexico City sheds a global spotlight on both the progress in combating HIV and AIDS and the failure of our current prevention efforts to stem the epidemic. Despite increased funding for and access to HIV and AIDS treatment around the world, the imperative to vastly increase HIV prevention remains urgent: for every two people put on treatment, five more are newly infected.¹ In the absence of a medical vaccine, the course of the epidemic will depend on how the global community rises to the challenge of prevention.

CARE's global work on HIV and AIDS in over 40 countries demonstrates that making a real difference in the AIDS epidemic requires more comprehensive, multisectoral approaches to prevention that address the broader context and the factors that are fueling the epidemic. We need strategies that link HIV prevention with development approaches that attack the underlying causes of vulnerability to HIV – such as economic and food security, community empowerment, reproductive health and education – that can build economic and social “vaccines.” A comprehensive approach of this nature means going beyond traditional prevention programming focusing on individual behavior change to also address the social, economic and cultural factors that shape people's risk of contracting HIV and impede their access to prevention programs.

Effective prevention strategies must be based on a “know your epidemic” approach and informed by the latest evidence, since the extent of the epidemic (concentrated v. generalized), the target populations, the social and economic drivers of vulnerability, and thus, the appropriate responses will vary from country to country. The appallingly low availability of and access to prevention services² compels us to place a vastly greater emphasis on prevention programs that are designed and implemented with sufficient duration, intensity and quality to affect the AIDS epidemic.³ The sobering reality is that most AIDS responses are not focusing the necessary strategies and resources on prevention, few countries have established prevention targets and virtually none are scaling up prevention programs to the level necessary to have a major impact.

“Every day, almost 7,000 people are needlessly infected with HIV because they do not have access to proven prevention interventions to prevent transmission. It is time to act.”

Dr. Peter Piot
Executive Director, UNAIDS⁴

Drawing on examples from our programming, CARE presents this paper as a clarion call to make effective HIV prevention an urgent global priority. This will require transcending traditional public health/biomedical interventions in the quest for prevention programming that addresses the social and economic factors affecting vulnerability to HIV. CARE's call for a heightened global focus on HIV prevention will demand new levels of energy, commitment to communities and marginalized groups, and human and financial resources, similar to that which helped secure the strides made in access to treatment. There is no alternative.

KEY ISSUES IN PREVENTION

New Infections Outpace Treatment

The global roll-out of ARV treatment has been a remarkable achievement that has transformed the landscape of the AIDS response. With some 3 million people now on treatment in low and middle income countries, it is now clear that HIV treatment is viable in resource limited settings. Yet as critical as increased access to treatment is and will continue to be, it alone will not end this epidemic. The number of HIV-infected individuals needing treatment continues to grow and to outpace our response. Even now only 30 percent of those in need of treatment are being reached.⁵ In addition, treatment involves a lifetime commitment to each individual and cannot be subject to the vagaries of funding. Given the escalating costs of treatment that are projected based on ever-increasing numbers of people needing treatment who are now living longer lives, that commitment could come under threat.

To be sure, treatment is exceptionally compelling, with tangible results in people's lives that would have been unimaginable a few years ago. Treatment is easy to measure since numbers of individuals accessing these services can be counted, while prevention is far harder to quantify, given that it is by definition enabling something not to happen. Governments and donors are often keen to have the clear data that treatment programs provide, which they can use to justify their investments. There are also prevention benefits linked to treatment, including the potential reduction in HIV transmissibility and the opportunity to incorporate prevention messages and services through treatment and other health services.

Prevention is challenging since it involves human behavior and prevailing social norms, which are never easy to change, and changes are often difficult to sustain. The complexity of HIV prevention is compounded by the fact that it requires confronting subjects that make



many people uncomfortable, including sex and sexual networks, sex workers, injecting drug use (IDU), prisoners, men who have sex with men (MSM) and transgender populations, as well as cultural and gender norms that perpetuate gender inequities and gender-based violence. Too often, those most at risk are among those most socially marginalized, whose voices and concerns are not heeded. CARE experience around the world has shown that these challenges can and must be addressed,

At this stage of the epidemic, we know that both treatment and prevention are essential and are mutually reinforcing strategies. We also know that insufficient attention and resources have been committed to prevention, and that addressing this imbalance constitutes a moral and financial imperative.

Revised UNAIDS Estimates – No Grounds for Complacency

In 2007, UNAIDS published changes in its global estimates of numbers of people living with HIV, revising the number downward by 16 percent from 2006, to 33.2 million. UNAIDS attributed this change largely to the revised figures of people living with HIV in India, as well as to revisions of estimates in sub-Saharan Africa.⁶ Some of these changes are attributable to evidence of behavior changes and a reduction in risky behaviors that have led to a decrease in new HIV infections, but UNAIDS contends that most of the revisions results from a refinement in methodology rather than in new trends in the AIDS epidemic.

These new figures cannot be used as grounds for complacency. While it's true that UNAIDS has concluded that the epidemic is slowing down globally, not all countries are experiencing a decline in new HIV infections, and the actual number of people infected with HIV continues to grow. If anything, the downward trends in new infections related to successful HIV prevention in some countries should spur greater emphasis on expanding these services. Moreover, in the generalized epidemics of southern Africa – including South Africa, Swaziland and Lesotho – the number of new infections has not fallen. With 68 percent of those living with HIV in sub-Saharan Africa, 61 percent of whom are female, the prevention imperative remains especially critical.⁷

MAKING THE LINK BETWEEN DEVELOPMENT AND HIV

HIV is more than a devastating disease; it involves complex social, economic, cultural and political challenges that require longer-term solutions. CARE has long seen how HIV and AIDS are inextricably linked to the larger context of poverty, gender inequality, poor governance and social marginalization. Recent evidence has revealed, for example, the complex interplay between poverty and risky sexual behavior, especially for women, which affects age at first sex, condom use and multiple sexual partnerships.⁸ This complexity is a challenge for traditional prevention approaches, which have focused largely on promoting individual behavior change (abstinence, being faithful and condoms – ABC), voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT). Effective prevention strategies must work to transform the context of people's lives in sustainable ways, forming a combination of economic and social vaccines.

This comprehensive approach also represents a promising strategy to tackle known drivers of the AIDS epidemic that require longer-term behavior change, including gender inequities and multiple concurrent sexual partnerships. By addressing the factors that influence women and men to engage in multiple partnerships, which often relate to food and economic insecurity as well as to material gain, and by working to change the social norms that perpetuate these practices, the possibilities for longer-term behavior change may be enhanced. Similarly, when women in marginalized communities, including sex workers, are empowered to collectively demand respect for their human rights, they are better able to protect themselves from HIV transmission, from sexual violence, and ultimately from being forced into dangerous, sexually exploitative situations.

There is broad consensus that gender inequity is a driver of the AIDS epidemic, especially in sub-Saharan Africa. While numerous HIV prevention interventions target women and girls, many programs fail to address the broader social forces that shape women's vulnerability.

The U.S. Institute of Medicine's report on the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) stressed that countries cannot rely on narrow prevention strategies, and that PEPFAR must "support countries in seizing the abundant opportunities for prevention throughout people's lives and regardless of their HIV status; across the full spectrum of health and social services; and in all settings, from the street to the school to the home to the clinic."⁹

Where women have low social status and limited financial autonomy, and where they face high levels of physical and sexual violence, abstaining from sex, insisting on monogamy or negotiating condom use are not always realistic options. Yet these have been the focus of HIV prevention messages.¹⁰ Systematic efforts to increase women's economic and social empowerment, including their legal status, must be part of comprehensive HIV prevention. The involvement of men and boys and reshaping of male norms are also a vital part of reducing women's vulnerability to HIV.

Recently, prevention strategies have come under new scrutiny, notably from those asserting that approaches linking HIV and poverty, gender inequities, condom promotion and HIV testing are unproven. This has led to increasing calls to expand prevention strategies to include male circumcision and the reduction of multiple concurrent sexual partners.¹¹ Clearly, these are critical prevention strategies that must be addressed and scaled up, especially in east and southern Africa. However, male circumcision is not the magic bullet, and targeting multiple concurrent sexual partnerships inevitably requires addressing the underlying social factors, and in some cases, the economic motivations, that influence why women and men engage in these relationships.¹²

Food and Economic Insecurity

There is a strong bidirectional link between food and economic insecurity and HIV risk. Low levels of assets, income and savings combined with food insecurity can lead to risky activities, like transactional sexual relationships, in order to survive or enhance livelihoods.¹³

HIV and Education: Educating Girls and Keeping Schools Safe

CARE has long recognized that formal and non formal education are vital to stem the spread of HIV. Getting children, particularly girls, into safe schools and helping them to complete their education benefits not only households and communities through better health and economic development, but also instills knowledge to help prevent the further spread of HIV. CARE supports increased access to quality education taught in safe environments which are sensitive to HIV and AIDS.



Similarly, food insecure households are often less able to access health services and HIV prevention information. Economic and food insecurity also increases reliance on benefactors, which heighten powerlessness to negotiate safe sex.¹⁴ Recent studies have shown that targeted food assistance and income generation programs that also work to enhance women's legal and social rights may decrease women's risk of HIV.¹⁵

In Malawi, CARE has developed a project called Supporting and Mitigating the Impact of HIV/AIDS for Livelihood Enhancement Program (SMIHLE), aiming to strengthen food and income security within the context of HIV and AIDS, with women as the primary beneficiaries. Working with community-based organizations, SMIHLE expects to reach 30,000 vulnerable households – 420,000 people¹⁶ – and has adapted interventions to meet the nutritional needs, income and labor constraints of these households. The main activities focus on improving livelihoods and mitigating the impact of HIV and AIDS through agriculture support, village savings and loans and natural resource management interventions, as well as building the capacity of village-based coordinating structures. Voluntary savings and loan groups have been key in enabling participants to access agricultural inputs and credit through microfinance institutions, while also enabling them to pay for school fees and medical services. The SMIHLE project has been successful in improving food and income security for these rural communities as well as their standard of living,¹⁷ and CARE believes that it has contributed to reducing women's risk to HIV.

Empowering Vulnerable Populations to Protect Themselves

CARE believes that investment in empowerment and community mobilization can reduce the risk of HIV. When working with sex workers, CARE has shown that these strategies make them less vulnerable to HIV and better able to access health services. The success of this approach has been confirmed by other analyses: The World Bank's David Wilson, for example, claimed that many prevention strategies are unproven or disproven, but that the evidence from the three sexually initiated epidemics in Asia (Thailand, Cambodia, and South and West India) shows that education, condoms, sexual health, rights, solidarity and empowerment have curbed HIV.¹⁸

To prevent the spread of HIV among sex workers and their clients in India, CARE's SAKSHAM project addresses the social and economic forces – such as gender inequality, rights violations, discrimination and stigma – that prevent sex workers from protecting themselves from HIV. The project is based on the premise that providing condoms and HIV information alone cannot be effective if women have little power to use these tools. For example, the fear of violence is a barrier that keeps sex workers from insisting that clients use condoms. Accordingly, SAKSHAM aims to address the need for collective strength, solidarity and negotiating power to confront the social and economic barriers that increase HIV risks for sex workers.¹⁹ SAKSHAM is beginning to show results in addressing underlying drivers of vulnerability and HIV risk: Initial data indicates increased rates of condom use, increased willingness to seek medical care and decreased levels of violence. A 2007 survey showed that more than 90 percent of sex workers had used condoms in their last sexual encounter with an occasional client, and more than 86 percent did so with a regular client.

Expand Access to PMTCT and Link with Reproductive Health

Most HIV infections are either sexually transmitted or associated with pregnancy, childbirth and breastfeeding, all falling within the realm of sexual and reproductive health. In addition, poor reproductive health and HIV share important root causes, including poverty, gender inequality and social marginalization of the most vulnerable populations.²⁰ Links between reproductive health and HIV services could expand women's access to both services and are especially relevant to PMTCT programs. For example, a woman may be tested for HIV in an antenatal clinic or a VCT site and learn that she is HIV-positive, but she may not have access to information about how to reduce the risk of transmitting HIV to her baby if she chooses to become pregnant, or to contraceptives to avoid pregnancy, if that is what she chooses. Some women may prefer to access information about HIV and AIDS through family planning or maternal and child health services, due to the stigma often associated with AIDS services.²¹

Working with Vulnerable Populations in Bangladesh: IDU, Sex Workers, MSM and Transgender

In Bangladesh, HIV is still largely confined to vulnerable populations, such as injecting drug users, male and female sex workers, MSM and transgender. CARE's program works with these vulnerable populations to develop support networks focused on community and social empowerment. The project also engages policymakers to influence HIV and AIDS programs at the local and national level with the aim of creating national-level support for effective prevention approaches and to discourage local resistance to working with marginalized populations.²²

PMTCT is an effective intervention to prevent HIV transmission to infants.²³ There have been recent improvements in the number of HIV-infected pregnant women in low and middle income countries accessing PMTCT services, increasing from 10 percent in 2005 to 23 percent currently, and as high as 31 percent in East and Southern Africa.²⁴ Yet some 70 percent of pregnant women in sub-Saharan Africa still do not access PMTCT services, in part due to barriers created by fear of violence, stigma and economic abandonment.

To address this reality in Kenya's Nyanza province, which has the country's highest HIV prevalence rate, CARE works to both increase the availability of PMTCT services and address the barriers that prevent women from accessing those services. CARE's PMTCT+ approach expands the range of services around the mother to keep her and her baby healthy. This includes ensuring that the HIV-positive mother has access to ART herself, and that she and her family have access to safe water, increased food and economic security, access to health services and psychosocial support. CARE collaborates with government health facilities to assure quality PMTCT services and to strengthen linkages between health and support services, including family planning, immunizations and treatment of tuberculosis and other opportunistic illnesses. CARE has helped create community support groups to combat stigma and gender-based violence. In a three-year period, uptake of PMTCT services in this program increased from 30 percent to over 90 percent.²⁵

Getting to Comprehensive Prevention

CARE's work on HIV and AIDS over the past 20 years has highlighted that the multi-faceted realities of the epidemic require a multi-faceted response that links HIV prevention programs with development initiatives to achieve sustainable results. Preventing HIV requires going beyond traditional strategies that focus on individual behavior. We need comprehensive approaches that address the social and economic factors that affect HIV risk. These include gender inequities, food and economic insecurity, reproductive health, education and empowering communities to protect themselves. By addressing the drivers of the epidemic and not just the symptoms, these interventions form the basis of comprehensive prevention strategies.

The success of treatment roll out has been and will continue to be a critical dimension of the AIDS response. But to reverse the global AIDS epidemic, treatment must be coupled with significantly increased resources for and commitment to scaling up effective prevention programming. To build the necessary momentum for prevention will require a concerted effort by the global community – national governments, international donors, civil society organizations, non-governmental organizations and local communities – to identify promising prevention approaches, address the resource requirements to scale up targeted prevention programs, and develop appropriate indicators and evaluation processes to measure these impacts.

CARE is committed to ensuring that our projects contribute to this evidence base and has invested in research to look at the impact of comprehensive

A Global Commitment to Prevention

CARE believes the time has come for a global commitment to prevention, similar to the historic movement that led to the roll out of life-prolonging treatment. The global community must come together to:

- Promote sustained, high-level political leadership to galvanize national and international prevention programs based on a “know your epidemic” approach.
- Increase funding specifically focused on comprehensive, evidence-based prevention strategies.
- Build the capacity of communities, civil society organizations, networks of people living with HIV and AIDS and national governments to develop and implement targeted prevention programs.
- Ensure that networks of people living with HIV and AIDS are partners in prevention programming on the national and international levels.
- Engage with marginalized groups – including male and female sex workers, MSM, IDU and transgender populations – to ensure that HIV prevention programs reach them and address their risks.
- Increase programmatic focus on the link between HIV risk and gender inequality, including the social and economic factors that impede access to prevention services.
- Increase investment in the operational research and the monitoring and evaluation necessary to validate innovative, comprehensive prevention approaches and bring successful interventions to scale.

prevention interventions on HIV outcomes. For example, CARE is currently conducting a multi-country, comparative research study in Africa, Asia and Latin America that is exploring the relationship between women's empowerment and HIV vulnerability.

At this stage in the global AIDS crisis, we know there is no single magic bullet. We must move toward comprehensive prevention approaches that address HIV risk and vulnerability. We must work to empower communities to protect themselves and to ensure that the responses improve the lives of people affected by HIV and AIDS. And, ultimately, we must recognize that individual behaviors are shaped by their social and economic context, and that to be effective in fighting the AIDS epidemic, HIV and AIDS programs must transform that context in sustainable ways.

**CARE would like to acknowledge the primary author
Janet Fleischman, Senior Consultant to CARE.**

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- ² According to the Global HIV Prevention Working Group, only 9% of risky sex acts worldwide are undertaken with a condom; only 12% of men and 10% of women in heavily affected countries know their HIV status; only 11% of HIV-infected pregnant women in low and middle-income countries received ARV; and prevention services only reach 9% of men who have sex with men, 8% of IDUs, and under 20% of sex workers. See "Bringing HIV Prevention to Scale: An Urgent Global Priority," Global HIV Prevention Working Group, 2007, <http://www.globalhivprevention.org/pdfs/PWG-Scaling-Up-ExecSumm.pdf>.
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- ²³ The United Nations promotes a comprehensive, four-pronged approach to prevent HIV infection in infants focused on: (1) primary prevention of HIV infection in women; (2) prevention of unintended pregnancies in women living with HIV; (3) prevention of transmission from HIV-positive mothers to their infants; and (4) provision of care, treatment and support for women living with HIV and their families. While most programs seeking to prevent HIV infection in infants focus on ARV drugs, research indicates that preventing HIV infection among women of reproductive age and avoiding unintended pregnancies can be more cost-effective than administering ARV drugs to mothers and infants. See Sweat M.D. et al, "Cost-effectiveness of nevirapine to prevent mother-to-child transmission in eight African countries", *AIDS*, 2004, 18: 1661-1671.
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