

HIV Prevention strategies:



How do we do?

A comparison

Darija Kupers-Oving
Christa Jacobs-van den Berg
Henk Jochemsen

Prisma

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1. Background

1.1 Introduction

The enormous impact of the HIV pandemic requires a joined effort from many different players to respond effectively. Church and faith-based organisations (FBO's) also play their role in the response towards HIV and AIDS. However, a lot of criticism has been heard that the church and FBO's have been lacking in effective prevention strategies, mainly due to their moral stances on sexuality.

However, one should realize that HIV prevention is not necessarily a natural role for the church. In the early stages of the HIV pandemic, the churches were mainly concerned with care, which is a natural role of churches, based on their biblical and moral beliefs. More and more churches also started discussing prevention of HIV, with regards to sexual behaviour. The main focus being on abstinence (until marriage) and faithfulness. Along with (international) secular prevention messages of ABC, this teaching however could feed stigma and discrimination of those infected and affected by HIV, as the message clearly addressed one's own responsibility and behaviour.

The churches have also endured criticism regarding their stance on condoms. The Catholic church may have been most outspoken against condoms, as it is also related to their position on procreation. But many other churches and FBO's also felt uncomfortable to discuss condoms. This again relates to their moral stances on sexuality and the fear of encouraging infidelity.

Now, we see more and more churches and FBO's involved with HIV and AIDS on different levels including prevention, care and destigmatization. We see the changes in knowledge, in attitudes, in teachings, in activities and in policies. Many churches and FBO's have reached beyond their comfort zone in reaching those in need and at risk. The criticism may be justified at times, but unfortunately the recognition of the work that is being done, the changes that have taken place, and the progress that has been made, is often lacking.

Prisma and her members work with and support their southern partners on their approach to HIV and AIDS. Together we have developed a vision paper on HIV and AIDS. This report deals with the question whether what we actually do in HIV prevention is corresponding with our vision in HIV prevention. Furthermore we investigate how the work of Prisma in this field relates to the general consensus and research on effective prevention strategies. This in order to learn and improve our work in the field, for those affected by the pandemic.

1.2 Background

This paper has a longer than intended history. The initial research started in 2009. Data of approximately 80 projects was analysed. The projects were approved HIV/AIDS project proposals submitted by Prisma members.¹ That initial study was needed to gain insight into

¹ The projects were funded by MFS1 funds in 2008. This could give rise to a picture which may not entirely correspond with the current situation.

the prevention strategies used by Prisma members. The findings of this initial research are presented in Chapter 2.

Following the analysis of Prisma² HIV prevention strategies, a comparison was made with strategies used by other players (Chapter 3). The results of the analysis and the comparison were presented to Prisma members in May 2010.

The members agreed that more research regarding prevention strategies would be welcomed. At the end of 2010 the researcher continued where she left off. A literature review was done, and this served as a framework in which to discuss Prisma prevention strategies in policy and practice.

The results of this long trajectory can be read in this document.

1.3 Aim of the research

- a) Insight into the state of the art with respect to (knowledge of) effectiveness of prevention strategies
- b) Inventory of prevention strategies used by Prisma members/partners
- c) Comparison of these two results
- d) Recommendations for policies regarding the work of Prisma

1.4 Methodology

For this research, an analysis³ was made first of 80 Prisma funded HIV/AIDS project proposals of Prisma members. Christa van den Berg studied the project proposals and identified the prevention categories. The HIV prevention activities were categorised accordingly. This resulted in an overview of activities, which was analysed. The results of this analysis are summarized and presented in chapter 2.

Secondly, a desk study was done into the prevention strategies of large players and relevant FBO's.⁴ The desk study was a qualitative study based on online information available of those parties. The information on prevention strategies was gathered and summarized per organisation, and finally comparisons could be made between the organisations and Prisma based on those summaries.

In addition, a selective literature study was done, of which the series of six articles on prevention published in the Lancet formed the core. A review of these articles can be found in chapter 5.

² In this document when referring to Prisma, Prisma members and their partners are included.

³ See annex 1

⁴ 030403.preventie alg werkdoc.03052010 (unpublished document, for internal Prisma use)

2. Prevention strategies used by Prisma

2.1 Introduction

This chapter provides a summary of the process and outcomes of the initial research into the Prisma prevention strategies. This preliminary research was conducted in 2009, using data of 80 projects funded by Prisma in 2008.

2.2 Categorisation

For the preliminary research into Prisma prevention strategies, the prevention categories were defined first. These categories were based on a quick scan of the data, as presented in Table 1 below:

Prevention Categories	Including:
• Awareness/ education community	IEC = Information, Education and Communication BCC = Behaviour Change Communication
• Education youth	Sexuality education Peer education
• Prevention mother-to-child transmission	
• Voluntary Counselling & Testing (VCT)	
• Capacity Building (Strengthening own organization)	Work place policy
• Building networks with local and national actors to influence policy	Networking, Lobby and Advocacy
• Improving the life of PLWHA & OVC	Life skills training & psychosocial support
• Gender mainstreaming	Including gender mainstreaming, SRHR, and family approach
• Destigmatization & sensitization	
• Other	

Table 1: overview prevention categories

2.3 Analysis

The analysis demonstrates that the main categories Prisma invests in, are Awareness/Community Education, followed by Education of Youth, and Support. A presentation of the analysis was made and presented to Prisma members in May 2010.

The method used for and results of the preliminary research were presented to the Prisma members in May of 2010.⁵ In table 2 a summary is given of the results of the analysis.

2.4 Conclusions

Prisma has a strong focus on Awareness and behaviour change, and on the education of youth. Prisma also invest in providing the support and conditions for people to be able to sustain

⁵ 030403.preventie alg werkdok.03052010

(intended) behaviour change through support and skills building to reduce risks/risky behaviour that make people more vulnerable to HIV.

The 4th largest category is destigmatization and sensitization, often aimed at churches. This is followed by gender mainstreaming, including SRHR and family approach, which focuses mostly at gender (in)equality and healthy relationships.

Category	Results	Remarks
Awareness/Community Education	65	
Education of Youth	53	Including sexuality education and peer education
Support & Skills building	51	
Destigmatization and sensitization	35	
Gender	28	Including gender mainstreaming, SRHR, and family approach
Voluntary Counselling and Testing (VCT)	26	
Networking/Lobby/Advocacy	25	
Capacity Building	20	Including Work Place Policies
Vertical Transmission/ Prevention of Mother to Child Transmission (PMTCT)	7	
Other	2	Both refer to use or promotion of natural remedies

Table 2: summary of results analysis

VCT is the main technical/medical strategy that Prisma invests in. More specialised (bio)medical or technical strategies are not carried out by most Prisma members. Only seven activities were aimed at reducing vertical transmission.

In the following chapter, prevention strategies as used by major players in the field of HIV and AIDS will be discussed. This will allow us to compare the Prisma strategies to those used by other major players. That comparison will be discussed at the end of chapter 3.

3. Prevention Strategies used by major players

3.1 Introduction

In the previous chapter, the Prisma prevention strategies were discussed. In this chapter, the findings of the desk research on prevention strategies of major players with regards to HIV and AIDS will be presented. This desk study consisted of online publications or websites of the organisations included, both secular and Christian. The findings presented in paragraph 3.2 are a summary of that study.⁶ In paragraph 3.3 a comparison is made between Prisma and the major players with respect to the HIV prevention strategies they use. This should provide insight into the general view of what would be considered effective prevention strategies and could bring to light possible blind spots in the Prisma strategies.

3.2 Major Players

The selection of organisations considered to be main players is based on their 'authority' and (international) relevance. However, some possible key organisations that we wanted to include, do not have policies or other specific information online on prevention strategies. Unfortunately, more Anglo-Saxon organisations are represented than Southern organisations. However, all organisations selected have an international (including 'Southern') focus and/or expertise.

The first category of organisations are so-called secular organisations. They include both development organisations and research centres, namely UNAIDS, UNFPA, The Center for AIDS Prevention Studies University of California (CAPS), Centers for disease control (CDC), and more locally: the Dutch Ministry of Foreign Affairs.

The second category are Christian organisations. They include the World Council of Churches, and Inerela+ as prominent players. Also Tear Fund and World Vision are included in this category.

Secular organisations

The above-mentioned secular organisations are quite diverse and could therefore be expected to have different approaches or focuses. However, we will see there is also overlap on certain issues.

Education, especially on schools, with regards to sexuality and SRHR (Sexual and Reproductive Health and Rights) is a priority for most organisations. Most of the organisations also have a focus on key populations and/or marginalised groups. Awareness and information in general remains important.

Gender inequality is a concern, and receives specific attention in prevention strategies. There is also specific attention for SRHR - and linking of HIV/AIDS and SRHR - and PMTCT (Prevention of mother to child transmission). The GIPA principle⁷ is upheld by many organisations and several organisations specifically stress the need of the participation of all target groups.

⁶ More elaborate information can be found in the work document referred to (0304030.preventie alg werkdoc.03052010)

⁷ Greater Involvement of People with HIV & AIDS

Behaviour change and risk/ harm reduction strategies are employed. This also refers to sexual practices, including condom use and harm reduction for Intravenous Drug Users (IDU's).

Christian organisations

The Christian organisations studied also have several strategies in common. There is a strong focus on young people and (sexual) education and on fighting stigma and discrimination, especially in the church. PMTCT is also an important strategy, as are furthering access to treatment and (community) care, and promotion of VCT(voluntary counselling and testing). Awareness, (sexual) behaviour change and safer practices are also areas of their activities.

Common ground and differences

As could be expected, there are differences between the secular and the Christian organisations regarding their HIV prevention strategies, but there are also several common approaches. Education, a focus on young people, and PMTCT are among the common approaches. Awareness and information, sexual behaviour (change) and safer practices are also strategies used by both secular and Christian organisations.

Differences can be found in the focus on key populations (i.e. groups of people running a relatively high risk of HIV infection) and harm reduction strategies, which are given a higher priority by secular organisations. Harm reduction and behaviour change are, however, also key strategies for the Christian organisations, but those are mostly described in general terms and not explicitly as 'condoms' or 'needle exchange'.

Obviously, these are generalisations. On some issues a Christian organisation may seem to have more in common with a secular organisation. For example, both Tear Fund and CAPS emphasize the importance for prevention interventions of differences between communities in nature and status of the pandemic. WCC and UNAIDS both want to invest in 'new technologies'. However, the above does provide a general picture on most accepted, and agreed upon strategies for HIV prevention.

3.3 Comparison Prisma and major players

The strategies used by the major players we reviewed and those used by Prisma partners show quite some overlap. Notable are the focus on awareness and community education (information), and the education of youth as common strategies for both the main players in general and for Prisma. The fight against stigma and discrimination, especially among churches and church members is a shared focus with other Christian organisations. The attention for gender and SRHR is shared with the secular organisations.

Prisma considers support & skills building and networking, lobby & advocacy as prevention strategies, but both are not specifically mentioned by other organisations. This also applies to capacity building of organisations, including work place policies development. These differences could be explained by the idea that those strategies are not considered to be direct prevention strategies, but strategies that address structures that reduce the effectiveness of prevention strategies, or otherwise create conditions to allow for prevention strategies (e.g. behaviour change) to last.

Capacity building of organisations, including (the development of) workplace policies is another category found to be included in Prisma prevention strategies, but not for other organisations. Assuming that Prisma and her partners are aware of their own needs and development, this could be considered a prevention strategy aimed at the partner organisations themselves. Especially with regards to the Workplace Policy, which often also addresses risk situations (e.g. long term travel) in work settings for staff members.

Voluntary counselling and testing is regarded as a separate category for Prisma; although in itself it is not a prevention strategy, some of the Christian organisations include it in the strategy 'access to treatment and care'.

In comparison with the major players, harm reduction does not seem to be a favoured prevention strategy for Prisma. However, harm reduction and safer practices are mentioned as part of behaviour change which is an important strategy for Prisma. Behaviour change often focuses on making responsible and informed decisions with regards to sexuality and risk behaviour, but also on attitudes towards PLWHA. This is pursued mostly through awareness raising, education, information and skills (tools for change). There is particular attention for youth.

A remarkable difference is the fact that there is little Prisma focus on PMTCT in comparison with the other organisations in general, including the Christian organisations. Apart from PMTCT, Prisma in general has little or no attention for medical technical strategies, like vaccination, Post Exposure Prophylaxis (PEP), male circumcision, blood safety, male/female condoms, screening of HIV and/or other STI's, etc). This probably relates to the fact that Prisma works with Christian NGO's and churches that have good access to the population, but are not well-connected to care-giving organisations that are working in care settings where the more medical technical interventions are available.

Prisma prevention strategies do not seem to have specific attention for key populations. However, since attention for key populations was not explicitly defined as a specific prevention category, there may have been some activity in this respect that remained unidentified.

3.4 Conclusion

Between the prevention strategies of Prisma and those of the major players in general there is considerable overlap, especially with regards to, educations and awareness, and the focus on youth. Destigmatization and sensitization of churches are a shared focus of both Prisma and the Christian organisations included in this study.

The main differences are that Prisma, in contrast to other organisations considers secondary prevention approaches that address structural issues as prevention strategies, Prisma strategies do not include technical/bio-medical prevention strategies, and have a limited focus on vertical transmission (PMTCT) and on key populations in comparison with the other organisations. Also the other Christian organisations included in this study do have a stronger (explicit) inclusion of PMTCT and gender in their strategies.

4. Literature Review

4.1 Introduction

A few years ago the renowned medical journal The Lancet published a series on HIV prevention, consisting of six articles.⁸ They conclude that a 'new movement of HIV prevention is needed that supports a combination of behavioural, structural and biomedical approaches, and is based on scientifically derived evidence and the wisdom and ownership of communities'. This is considered to be a comprehensive approach, that can prove to be more effective. Although the series focussed on advising the decision makers on national and international level, (I)NGO's - including FBO's – certainly have a role to play as well.

In this chapter, the articles will be described briefly. These series are used as a basis to further discuss a comprehensive approach towards HIV prevention.

4.2 The history and challenge of HIV prevention

Although information on how HIV is transmitted was known early in the pandemic, the spread of the virus progressed essentially unabated. Prevention efforts fell short. The response was for the most part delayed, insufficient, fragmented and inconsistent. This had everything to do with the sensitivity of transmission, which is mainly sexually.

Also for FBO's, HIV and AIDS were sensitive issues. And while many of them cared compassionately for patients suffering from AIDS, most of them refused to promote condoms or provide sexual education for youth because of fear to encourage or condone promiscuity.

Currently (2008) it is estimated that key prevention services reach less than 10% of individuals at risk worldwide. Expansion of those services could avert more than half the HIV infections projected to occur by 2015, and save \$24 billion in treatment costs.

Combination prevention offers the best hope for success in prevention. Combination prevention is described as 'a combination of behavioural, structural, and biomedical prevention approaches, adapted and prioritised to specific contexts and based on scientifically evidence and bottom-up wisdom and ownership of local communities'. To achieve this it will be required to build synergies between prevention, care and treatment.

Competing understandings of evidence and differences in prevention paradigms have sometimes undermined rather than contributed to an effective prevention response. We need innovative means to obtain, understand and weigh evidence on the outcome of prevention programmes.

There is an urgent need for reliable evidence based research to better guide the selection of available behavioural and structural interventions in specific areas or populations.

4.3 Biomedical interventions to prevent HIV infection

It is not likely that a HIV vaccine or topical prophylaxis will be available in the near future. The only biomedical interventions that are effective in prevention include use of condoms, male

⁸ See appendix 3 for literature references of the Lancet prevention series

circumcision, prophylactic use of antiretroviral drugs or contraception to prevent unwanted pregnancies to reduce vertical transmission (MTCT). Effectiveness of pre-exposure prophylaxis is still being researched. The prophylactic use of antiretroviral drugs in sexual transmission is promising.

It is advised that biomedical models should be integrated with other modes of prevention. These combination prevention strategies are needed for example to maintain adherence to ARV's and to avoid risk compensation (false sense of safety).

4.4 Behavioural strategies to reduce HIV transmission

Behavioural change has been responsible for the prevention successes to date. Strategies to modify risk behaviours need to remain a main priority for HIV prevention. These include the delay of first sexual intercourse, decrease number of sexual partners, safer (protected) sexual practices, provide counselling and testing for HIV, encourage adherence to biomedical strategies, decrease sharing of needles and syringes, and decrease substance abuse.

Advances in scaling up antiretroviral treatment in resource-poor settings, the benefits of male circumcision, and the hoped for promise of pre-exposure prophylaxis and microbicides do not render behavioural strategies obsolete. Sexual behaviours and the sharing of injection equipment that cause the most HIV infections worldwide, occur for many motivations, e.g. procreation, desire, peer pressure, pleasure, physical or psychological dependence, self-esteem, love, access to material goods, obligation, coercion and force, habit, gender roles, custom, and culture.

Radical behaviour changes are needed, both between individuals and across large groups of people at risk, to reduce incidence. Modest changes in behaviour are helpful, but changes in transmission require that large numbers of people change their behaviour substantially, and maintain these changes for a long time. *Sustaining those changes is essential.*

A mix of communication channels disseminating simple and clear messages about several risk reduction and health seeking options. One risk reduction option should not be emphasized over another, as people want to make their own choice, and the mix of strategies is essential.

The local involvement in message design, production and dissemination is important. Using the creativity and energy of people who are most affected by the epidemic to develop messages and strategies to motivate behaviour change is crucial.

Behaviour strategies, though not sufficient to reduce HIV transmission, are essential in a comprehensive HIV prevention strategy. Furthermore, behavioural strategies need to be combinations of approaches at multiple levels of influence. HIV prevention is neither simple nor simplistic.

4.5 Structural approaches

Social, economic, political and environmental factors directly affect HIV risk and vulnerability. HIV prevention efforts cannot succeed in the long term without addressing the underlying drivers of HIV risk and vulnerability in different settings. Structural factors include the physical, social, cultural, organisational, community, economic, legal or policy features of the

environment that affect HIV infection. These factors operate at different societal levels and different distances to influence

individual risk and to shape social vulnerability to infection.

Structural approaches to HIV prevention seek to change social, economic, political or environmental factors

determining HIV risk and vulnerability. They should be implemented in a contextually sensitive way, in recognition of both the need for situational relevance and the interaction between different levels of influence.

Behaviour strategies aim at increasing knowledge, stigma reduction, access to services, delay of onset of first intercourse, decrease in number of partners, increases in condom use, and decreases in sharing of contaminated injection equipment, and achieved by use of multilevel approaches (e.g. individuals, couples, families, social networks, institutions and communities).
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Like all features of HIV prevention, structural approaches can be challenging to assess. They are not always amenable to assessment with comparative experimental designs because of their situational specificity and the need to address multiple interacting elements. Alternative methods for rigorous assessment do exist, but further developments are needed.

4.6 Making programmes work - recommendations on country level

Although this article strongly focuses on national level programme managers, the recommendations are also relevant for more local, or international organisations. Especially with regards to working evidence based.

Four areas are identified to refocus HIV prevention efforts: improvement of targeting, selection and delivery of prevention interventions, and optimisation of funding. One main challenge is the lack of available information and the limited capacity to apply what information is available. The global community has unwittingly contributed to this uncertainty. By pretending sufficient evidence is available to design evidence based (national) strategic plans for HIV prevention, implicitly evidence has been redefined as ‘anything that any self-proclaimed HIV/AIDS expert believes is likely to be effective’.

Also, because the response to the epidemic has been short-term, using an emergency approach to the epidemic, there has been too little investment in development of new methods or in generating data about the effectiveness of current data.

The effectiveness of any prevention programme depends on the extent to which effective interventions reach people at high risk of contracting the virus. Improvement of the prevention response through better targeting requires understanding of the epidemiology of the virus, of human behaviours, and their drivers. As captured by UNAIDS recommendations: understand your epidemic. The most important data to collect is trends in HIV incidence in different populations, so that a country’s epidemic can be understood, as well as for assessment of the effect of prevention programmes. We must strive to generating better and more useful data, and making better use of existing data for decision making.

Prevention interventions must include a complex set of interventions and approaches – biomedical, behavioural, community – tailored to the specific context. Choosing the mix is difficult, as evidence is often lacking. There is a need for more information about effectiveness

and the cost of different prevention activities and packages, and effect assessment in programme activities.

Very little data exist about the current level of implementation of HIV prevention strategies. However, the limited available literature suggests that below optimum efficiency of implementation is very common. Volumes, costs and quality of prevention services delivered should be monitored. Sound management systems are required.

4.7 Coming to terms with complexity

During the course of the epidemic and the response, a huge body of knowledge has been created about HIV transmission and how to prevent it. Yet, everyday around the world nearly 7000 people become newly infected with the virus. Evidence has been collected about what works, but for many reasons these successful approaches have not yet been fully applied. Action and funding have not necessarily been directed to where the epidemic is or to what drives it. Few programmes address vulnerability to HIV and structural determinants of the epidemic. We need to use the existing body of evidence and the lessons from our successes and failures in HIV prevention.

A combination of knowledge of the epidemic and of the context is what makes information strategic and the basis for action. Only when the knowledge is applied in a comprehensive AIDS programming cycle, can it create an effective feedback loop between information, programming, assessment of programme effectiveness, and back to improved information and programming.

“HIV prevention responses must be informed by an analysis of where the next 1000 HIV infections are likely to come from in any given context.”

HIV/AIDS is highly dynamic. Initial HIV outbreaks in highly vulnerable populations might be followed by a slower spread which could nevertheless affect large numbers of people. History shows we have failed to heed early warning signs of these changing dynamics.

Expanded HIV prevention grounded in a strategic analysis of the epidemic’s dynamics in local contexts is essential of getting ahead of the epidemic. There are no short cuts or magic bullets. No one-dimensional HIV prevention solution has ever become available. ‘Combination prevention’ is absolutely necessary when it comes to stopping the epidemic. There is a global consensus that effective HIV prevention requires locally contextualised approaches that address both individuals and social norms and structures, and are grounded in human rights.

But despite the broad consensus of what needs to be done and the evidence base, we have only partial understanding of what facilitates systematic implementation of prevention programmes, what bottlenecks hinder progress, and what strength of effort will be necessary.

Four core challenges are further discussed which stand in the way of fully comprehensive combination prevention: inadequacy of attempts to tackle sexual transmission, unwillingness to be frank with young people, difficulties of dealing rationally with drug use, and the failure to yet eliminate the mother to child transmission.

4.8 Comparison of the Lancet articles with the work of Green⁹

In this section we compare the content of the Lancet articles with some major points for a recent publication of the scientist Edward Green who did a lot of research in this field.

In his book Edward Green is very critical toward what he calls 'AIDS world'. According to Green too much money is spent on technical prevention, such as condoms, ARV's and VCT. He describes his struggle to get more attention for the role the ABC model has played in Uganda to turn around the epidemic. The book discusses why the Ugandan approach against HIV/AIDS was initially successful, and why it later failed as the public health message changed under increasing western influence.

Based on research, he finds that - besides male circumcision - fidelity and delay of sexual debut are the only evidence based strategies to prevent transmission of HIV. Not only are these much cheaper strategies, they also more in line with local cultures and traditions. These strategies emerged locally, and were not influenced by donors.

Green further attacks the biased, stereotyping and even racist assumption that Africans are overly promiscuous. It is believed that most Africans begin sex at an early age, and then are highly sexually active, with many sexual partners. However, empirical data demonstrate this assumption is incorrect. Africans do not have more sexual partners in their lifetime than 'westerners'. The problem lies with multiple concurrent sexual partners. Green suggests that US and global strategies should be based on these assumptions.

The overall message of the book is that evidence shows that concurrent sexual partnerships (MCP) is driving the HIV/AIDS epidemic in many African countries. Hence behaviour change is crucial for HIV prevention, and should not be overlooked due to increased attention for technical or biomedical strategies. Fidelity, and partner reduction, should be promoted more strongly.

ABC and behaviour change

Green describes the recent positive changes within 'AIDS world' to include behaviour change. In this context he also refers to the Lancet articles described above.

Both the authors of the Lancet series and Edward Green recognize the important role of behaviour change, even though the Lancet series holds a broader approach towards HIV prevention. This latter approach supports a comprehensive prevention approach including structural, biomedical, and behavioural strategies.

The authors of the Lancet and Green differ, however, on the so-called ABC approach. Green uses it because, even though the term is not preferred in the West/by donors, it is used (and preferred) in Africa. ABC addresses sexual behaviour change: Abstinence, or delay of sexual debut, being faithful (fidelity) or at least reduction of partners, and use of condoms.

⁹ Edward C. Green. 'Broken Promises, how the AIDS establishment has betrayed the developing world'. Sausalito, CA: Polipoint Press 2010.

The Lancet authors are critical of the ABC approach, which seems to have 'led to an inappropriate and ineffective focus on abstinence only, while the evidence is clear that several behavioural changes are essential for epidemic control'. They further quote Collins and colleagues who think ABC falls severely short of what is needed to reduce HIV transmission. ABC infantilizes prevention, oversimplifying what should be an ongoing, strategic approach to reducing incidence.

Green on the other hand claims that the ABC approach is a successful prevention approach, which has clearly contributed towards the prevention success in Uganda. Green argues that the ABC debate focuses mostly on A(bstinence) vs C(ondoms), which could be regarded as an ideology inspired debate, causing a lot of hostility. However, B for being faithful (fidelity, or partner reduction) seemed to have lost focus due to this debate. While fidelity seems to be the sexual behaviour change with the most impact on prevalence rates (p192).

Green further argues that prevention messages have changed. From 'fear messages' to 'positive sex messages' and abstract/macro messages. Green states that Uganda demonstrated that AIDS prevention messages can make people feel personally vulnerable and afraid of getting AIDS, and therefore allow them to take certain simple, commonsense steps to not become infected, by not having more than one sex partner, delaying the age of first sex, or use condoms as a back-up. Behaviour change messages address behaviour that individuals can change. It makes them feel empowered to protect themselves and their loved ones. Messages on macro level (e.g. poverty, gender imbalance) can overwhelm people, and make them feel less empowered to do something about the epidemic and to protect themselves. Also, messages that have positive sex messages do not have the same impact as messages with a fear factor. Those fear messages address risk behaviour, but do not and should not stigmatize people.

Another related point of critique of Green is that 'African AIDS', which is a generalized hyper epidemic, is approached in the same way as concentrated epidemics. Strategies that are successful in concentrated epidemics are implemented to target the generalized AIDS epidemics. As a consequence the focus is on harm reduction, instead of targeting sexual behaviour itself. For this generalised epidemic, risk avoidance should be promoted over risk reduction.

Condoms

The Lancet gives more credit to the use of condoms than Green does. Green actually challenges the effectiveness of condoms – as condoms have only proven to be effective if used consistently. Several studies have confirmed that condoms have not worked as a primary intervention in the population-wide epidemics of Africa.

Condom promotion has worked in countries such as Thailand and Cambodia, where most HIV is transmitted through commercial sex and where a 100 percent condom use policy in brothels (but not outside of them).

Other strategies

According to Green some strategies that are currently promoted as HIV prevention strategies, such as VCT and ARV's, are important strategies for treatment, but they do not actually impact HIV prevalence. Therefore, they should not be considered or used as prevention strategies. Condoms do play a role in prevention, but never as a stand-alone strategy.

Other issues he addresses in his book are the relationship of HIV prevalence with poverty, and gender inequality. However important these issues are, they are not driving the epidemic, and therefore should not be in the core of HIV prevention. If anything, it is found that higher income and higher education actually increases HIV infections. This certainly should not be a reason to ignore low levels of income and education, but they are not key in HIV prevention.

In short

Green states in his book that HIV prevention strategies should be behavioural, rather than primarily technological or biomedical in nature. They should be appropriate to the type of HIV epidemic (i.e. generalized or concentrated), and in general seek to avoid risk, rather than solely to reduce the risk of inherently risky behaviours. Strategies need to be compatible with local cultures to be effective, and be cost-effective and feasible.

Conclusions

The renewed attention for the role of Behaviour Change in HIV prevention is considered a positive change. This also applies to Prisma (members and partners), as this report shows that Prisma was found to focus mostly on behaviour change. Behaviour change clearly plays a crucial role in HIV prevention, and FBO's can make an important contribution.

FBO's have played an important role in promoting behaviour change, especially fidelity and abstinence, and are still most comfortable in using these strategies. Local FBO's have a history, and have gained experience using behaviour change strategies. Therefore, FBO's could share their gained expertise and share best practices. It is also important that FBO's carefully monitor their work, to provide evidence of what works and doesn't work.

A focus on behaviour change should not prevent FBO's from regarding other strategies to address prevention of HIV. Sustaining behaviour change is of utmost importance, and working or linking with or referring to organisations that provide technical or structural approaches could be beneficial both ways.

5. Prisma: where are we at?

5.1 Introduction

In this chapter we will do two things. First we will compare Prisma practice, which means the actual strategies used by Prisma partners as identified by the preliminary research described in chapter 2 and 3, with the policy as describe in the Prisma vision paper on Hiv&Aids. Secondly we will compare the Prisma reality with the findings from the literature discussed in chapter 4.

5.2 Practice and Policy

Practice

Prisma is active mostly in the behavioural strategies through grassroots organisations, but not active in the technical health care domain.

Prisma has a strong focus on Awareness and behaviour change, and on the education of youth. Prisma also invest in providing the support and conditions for people to be able to sustain (intended) behaviour change through support and skills building to reduce risks/risky behaviour that make people more vulnerable to HIV.

The 4th largest category is destigmatization and sensitization, often aimed at churches. This is followed by gender mainstreaming, including SRHR and family approach, which focuses mostly at gender (in)equality and healthy relationships.

VCT is the main technical/medical strategy that Prisma invests in. Other specialised (bio)medical or technical strategies are generally not included in the strategies of Prisma members. Reducing vertical transmission (mainly mother to child) has limited attention.

Policy

In 2010 a Prisma Vision Paper¹⁰ was published. In this paper the general Prisma approach is presented, including HIV prevention. Prisma considers HIV prevention to be part of a comprehensive approach towards HIV and AIDS. To avoid confusion in this paper from now on the term 'comprehensive approach' will be used to refer to the general approach towards HIV and AIDS, which includes HIV prevention, and the term 'combination approach' will be used with regards to HIV prevention specifically.

In the vision paper, the Christian principles are described first. Based on these principles Prisma has formulated several 'organizational principles' or 'policy strategies' which will guide the practical approaches. Nine approaches are presented, of which three refer to prevention and/or behaviour (change). These are:

- family values are promoted that encourage positive living and are aimed at couples staying together and fidelity in relationships
- we seek to enable people to make responsible and informed choices regarding sexuality, risk taking/-avoiding behaviour, relationships, and family life,

¹⁰ Response to HIV and AIDS, Prisma Vision Paper, 2010
http://www.prismaweb.org/media/43481/20100115_final_prisma_vision_paper_hiv_aids_response.pdf

- comprehensive sexual education for children and youth is encouraged through programs that offer values-based sex education, family life and life-skills training, as well as reproductive healthcare.

A fourth could be the recommendation for a Work Place Policy. As discussed in chapter 3 (par 3.3), this is considered a practical Prisma prevention strategy.

In addition to the policy strategies, Prisma has also defined core responses. Those core responses towards HIV and AIDS include a Comprehensive Approach – including prevention, care & support, impact mitigation, destigmatization, advocacy, and a greater involvement of PLWHA (GIEPA) -, a solid AIDS analysis, Partnerships with Churches and Faith Communities, Addressing Underlying Vulnerability and finally Monitoring and Evaluation.

To highlight the specific core response on Prevention, the following is stated:

*“Prisma promotes sexual abstinence outside of marriage and fidelity within marriage. Recognizing that not all people can or will choose to be abstinent - and that even within marriages one or both spouses may be HIV positive and/or may have sexually transmitted infections, and/or may be unaware of their exposure risk - partner programs also include appropriate information and encourage reflection on condom use as a means to reduce risks and save lives. Prisma supports the ‘ABC approach’ but as part of the additional, broader SAVE prevention model”.*¹¹

Other prevention activities mentioned include: life skills promotion, peer education, comprehensive information, prevention of vertical (mother to child) transmission, promotion of safe injections and safe blood transfusions, and helping most-at-risk-populations in a transition to healthy lifestyles.

Regarding HIV and Injecting Drug Users (IDUs), Prisma supports harm reduction initiatives, such as needle exchange programmes, but urges to combine these with drug counselling and rehabilitation.

Comparison Practice and Policy

Looking at the actual prevention interventions as compared to the Prisma Vision Paper, it could be concluded that the Prisma Policy has a broader approach towards HIV prevention than the actual activities that were funded by Prisma.

This conclusion does not necessarily mean that Prisma members do not ‘practice what they preach’. First of all because the HIV prevention activities funded by Prisma, are merely a selection of HIV activities of Prisma members and –partners. Other activities that Prisma members support could be financed in other ways. Furthermore, the vision paper describes what activities correspond with the vision of Prisma, the practice also depends on the possibilities of the partners of Prisma members.

¹¹ SAVE is a response that was originally formulated by the leaders of the African Network ANERELA+ as a reaction to the shortcomings of the existing ABC method. In SAVE, S refers to safer practices (covering all the different modes of HIV transmission), A refers to available medications, V refers to voluntary counselling and testing, E refers to empowerment through education (www.anerela.org).

Notable gaps between Practice and Policy are especially found in the attention that is paid in the Vision Paper to the structural component of HIV prevention, and for biomedical strategies, especially regarding ARV's, which are not found or are limited in the actual strategies in practice. Also the attention for PMTCT is very limited in practice according to the analysis, as compared to the policy.

More overlap and differences will surface when discussing policy and practice in light of the literature in the following paragraph.

5.3 Discussion of Policy and Practice in light of the Literature

It appears that the Prisma vision has a lot in common with the activities and recommendations in the literature regarding HIV prevention, whereas the practice is limited in certain areas.

A summary or conclusion of the literature we discussed in chapter 4 would be the following as stated in paragraph 4.1: *A comprehensive, or combination approach towards HIV prevention entails a combination of behavioural, structural, and biomedical prevention approaches, adapted and prioritised to specific contexts and based on scientifically evidence and bottom up wisdom and ownership of local communities.*

This summary is used to discuss the Prisma practice and policy in light of the literature, by breaking this statement down in segments.

1) A combination of behavioural, structural and biomedical prevention approaches

As based on the preliminary research, we find that Prisma prevention interventions (practice) focus mainly on behavioural approaches. In the Prisma vision paper (policy) we recognise this focus on behavioural strategies, but there is also attention for structural and biomedical interventions.

As found in the literature, it is advised that prevention messages should make use of a mix of communication channels, and aim at multiple levels of influence. Prisma practice and policy both show that awareness, education and behaviour change are aimed mainly at individuals. Prisma policy states that it wants "people to be able to make responsible and informed decisions regarding sexuality, risk behaviour, relationships and family life", and encourages "comprehensive sexual education for children and youth through programs that offer values-based sex education, family life and life-skills training, as well as reproductive healthcare". The literature adds that to do so "*people need to overcome their unwillingness to be frank with young people, and promote an open and safe environment for them*".

In addition to the individual level, Prisma also promotes family oriented interventions aiming at all members of the family, including men, women and children. Different communication channels are also found in the cooperation and involvement of churches and church leaders, to share the prevention messages. These levels are limited, but natural and/or comfortable for Prisma partners.

A structural approach addresses not only the cultural setting, but also the political, economic and environmental settings. Prisma encourages an advocacy role for Prisma partners and wants to address underlying vulnerability. Prisma acknowledges that to a large extent the spread of HIV is determined by the social, economic, political and cultural context and wants to address underlying causes of vulnerability to contracting HIV, including poverty, gender disparities, disability, repression, violence and food insecurity. In fact a substantial part of the work of Prisma members and their partners is aiming at alleviating and overcoming those underlying causes of vulnerability. The activities of Prisma aiming at the underlying economic and political power structures are limited. Mainly Lobby & Advocacy aim at changes at that level. Furthermore, economic interventions in the sense of income generating activities targeting small groups or individuals and aiming to reduce poverty, are gaining importance among Prisma members.

Prisma is not a medical organisation, and there is limited attention for bio-medical interventions. Forming alliances or other forms of collaboration between Prisma partners and health care organisations are not found in practice with regards to VCT, PMTCT and ARV's. However, the following statement in the Prisma vision paper suggests there are opportunities to do so: *"Prisma participates in coalitions that may include groups that do not adhere to the Christian values and practices to which Prisma subscribes. Prisma enters into these coalitions when such collective efforts can substantially contribute to the reduction of HIV transmission and the impacts of AIDS."*

2) *adapted and prioritised to specific contexts*

The contextualisation of the intervention is very important. Prisma recognizes the cultural setting in which the partners work, and acknowledges both the positive and the negative influence thereof on vulnerability and HIV. Moreover, Prisma in its vision paper strongly recommends a solid AIDS analysis to 'know your epidemic' and to have a baseline for further monitoring.

3) *based on scientific evidence*

Working 'evidence based' is often easier said (and claimed) than done. The literature states that *"One main challenge is the lack of available information, and the limited capacity to apply what information is available. The global community has unwittingly contributed to this uncertainty. By pretending sufficient evidence is available to design evidence based (national) strategic plans for HIV prevention, we have implicitly redefined evidence as 'anything that any self-proclaimed HIV/AIDS expert believes is likely to be effective. Also, because the response to the epidemic has been short-term, using an emergency approach to the epidemic, there has been too little investment in development of new methods or in generating data about the effectiveness of current data".*¹²

The need for evidence based research is not specifically addressed in those words by Prisma in its policy. But Prisma does address the need for an analysis regarding HIV & AIDS in the working area where a programme is implemented (in addition to an actor and gender analysis)

¹² Stefano M Bertozzi, Marie Laga, Sergio Bautista-Arredondo, Alex Coutinho, Making HIV prevention programmes work, The Lancet, [Volume 372, Issue 9641](#), Pages 831 - 844, 6 September 2008

in order for a programme to be effective. Prisma further recognises that implementation of the response to HIV & AIDS must be accompanied by sound monitoring and evaluation. Prisma, through its member organisations and partner organisations, will encourage that best practices are documented, disseminated and (contextually) replicated. Lessons could be learned and shared from our successes and failures in HIV prevention. The exchange of experience and information is crucial, to improve targeting, selection and delivery of prevention interventions and the most effective use of funds. This could be further promoted. Sound monitoring and evaluation should generate more and more useful data.

This is in correspondence to the literature which states that *“During the course of the epidemic and the response, a huge body of knowledge has been created about HIV transmission and how to prevent it. Yet, everyday around the world nearly 7000 people become newly infected with the virus. Evidence has been collected about what works, but for many reasons these successful approaches have not yet been fully applied. [...] Few programmes address vulnerability to HIV and structural determinants of the epidemic. We need to use the existing body of evidence and the lessons from our successes and failures in HIV prevention”*.¹³

4) *and bottom up wisdom and ownership of local communities*

Prisma is aware of local ownership of communities and the involvement of people most affected by HIV and AIDS in programmes, including people living with HIV. Although this could arguably be stated more explicitly in the policy, this is actually a strong point of Prisma partners. Prisma partners are mainly grassroots organisations, rooted locally, and close to the local people, including specific risk groups.

Furthermore, the literature suggests that to achieve the above (a combination approach) it involves building synergies between prevention, care and treatment. This corresponds with the comprehensive approach as described in the Prisma vision paper. Looking at the actual strategies used (Prisma practice) the results of this comprehensive approach become clear, considering that support of people infected and affected by HIV and skills education and training are regarded as (secondary) prevention strategies.

¹³ Peter Piot, Michael Bartos, Heidi Larson, Debrework Zewdie, Purnima Mane, Coming to terms with complexity: a call to action for HIV prevention, *The Lancet*, [Volume 372, Issue 9641](#), Pages 845 - 859, 6 September 2008

6. Recommendations

With regards to the aims of this study, the following has been found:

- a. The review of literature and of the strategies used by major players has provided insight into the state of the art with respect to (knowledge of) effectiveness of prevention strategies (Ch 3 & 4).
- b. The inventory of prevention strategies used by Prisma(partners) made on the basis of preliminary research, has provided insight into the strategies mostly, and possibly most comfortably, used by Prisma partners (Ch 2).
- c. The comparison of key literature with Prisma practice and policy, has provided insight in overlap and missing gaps for Prisma (Ch 5).

This results in the following *recommendations* for Prisma.

- 1) Even though the Prisma vision on prevention is broader, Prisma in practice focuses most on behaviour change and awareness. However, behaviour change is difficult to measure and to attribute. Further research¹⁴ into effective behaviour change strategies is recommended.
- 2) The literature recommends a mix of communication channels disseminating simple and clear messages about several risk reduction and health seeking options.¹⁵ These authors also suggest that one risk reduction option should not be emphasized over another, as people want to make their own choice, and the mix of strategies is essential. A task for Prisma partners is to find out if their message is being heard and if not, to make it heard, without attacking other prevention messages.
- 3) In light of the need to use a mix of communication channels aimed at multiple levels of influence, Prisma partners should take advantage of opportunities to form alliances or other forms of cooperation to improve on communication and expand levels of influence (individual, family, peer groups, communities, institutions, policymakers, etc). Again, forming alliances would be recommended.
- 4) Sustainable behaviour change in individual sexual norms and practices requires structural changes as well. Although structural strategies are mentioned in the Prisma vision paper, there is a lack of operational guidance which should be addressed.
- 5) Prisma partners have attention for young people and sexuality education. A lack of openness is one of the challenges for effective combination prevention.¹⁶ Prisma can also improve by being frank with young people, providing information and guidance in a non-directive, yet normative way.

¹⁴ E.g. educaids research: 030403.educaids final report –role of school hiv aids clubs.01032011

¹⁵ T. J. Coates, Richter, L., Caceres, C. Behavioural strategies to reduce HIV transmission: how to make them work better. The Lancet, [Volume 372, Issue 9639](#), Pages 669 - 684, 23 August 2008

¹⁶ P. Piot, Bartos, M., Larson, H., Zewdie, D., Mane, P., Coming to terms with complexity: a call to action for HIV prevention, The Lancet, [Volume 372, Issue 9641](#), Pages 845 - 859, 6 September 2008

- 6) The shared focus on destigmatization and sensitization of churches (church leaders and members) invites us to share best practices. There are strategies that show positive results, such as Channels of Hope (by World Vision/CABSA). Prisma partners should utilise these available strategies. Prisma could play a role in organising such workshops for partners. Prisma partners should also make a habit of sharing their best practices. The CABSA/CARIS website is a suitable and available platform.
- 7) The Prisma focus is limited regarding structural and bio-medical strategies. Prisma could expand their focus in practice according to their vision, and also form alliances and other means of cooperation with other organisations or institutions in the field of health care. With regards to bio-medical strategies, VCT, PMTCT and ARV's are such areas where cooperation is needed. Also attention for drug adherence could be a topic that FBO's can address to strengthen medical interventions.
- 8) It is recommended that bio-medical prevention strategies are integrated in the MFS 2 Alliance Health group, in order to gain more expertise and opportunities for cooperation.
- 9) Prisma has a broad vision on HIV prevention. The comprehensive approach, as presented in their vision document, influences or adds towards Prisma prevention strategies. Prisma could utilize and highlight this in its external communication. Strategies such as Lobby & Advocacy and Capacity Building & workplace policies are such examples.
- 10) Prisma does not seem to have a focus on key high-risk populations. Prisma is aware of local ownership of communities and the involvement of people most affected by HIV and AIDS in programmes, including people living with HIV. This could be stated more pronouncedly in the policy. Prisma partners are mainly grassroots organisations, operating locally, and close to the local people, including specific risk groups, which provides strategic advances of reaching people. However, it is important to realize one cannot reach everyone with one strategy and there is a need to focus with each strategy. It is important to appreciate each organisation's own place and role in HIV prevention, to form alliances where possible, and resist public denouncement of other organisations and their work with other key populations.
- 11) Prisma in its vision paper strongly recommends a solid AIDS analysis, to 'know your epidemic', and to have a baseline for further monitoring. This should be included in Prisma practice.

Appendices

Appendix 1:

Outcomes and update as presented to Prisma members May 2010
(Selection only)

1. Introduction

As planned, Prisma would write a paper on prevention strategies, as part of the HIV programme of the ICCO Alliance. Further discussion led to the decision to gain more insight into the prevention strategies used by Prisma members first.

The prevention categories were defined first, followed by the actual exploration phase (analysis) of the HIV prevention programmes and projects that were funded by Prisma in 2008. In this document, the results of the analysis are presented.

After the analysis, Prisma prevention strategies are compared to international prevention guidelines.

Finally, the results will be discussed with Prisma members to determine further steps towards a final prevention policy.

Goal of the paper is to analyse Prisma prevention strategies used, and how these compare to other (international) prevention guidelines and strategies.

2. Categories

The following categories in prevention strategies have been made, based on a quick scan of most common strategies used by Prisma partners:

- Awareness/ education community (IEC/BCC)
 - IEC = Information, Education and Communication
 - BCC = Behaviour Change Communication
- Education youth (including peer education)
- Prevention mother-to-child transmission
- Voluntary Counselling & Testing (VCT)
- Capacity Building (Strengthening own organization), incl Work place policy
- Building networks with local and national actors to influence policy (networking & advocacy)
- Improving the life of PLWHA & OVC (life skills training & psychosocial support)
- Gender mainstreaming
- Destigmatization
- Other

The categories include direct prevention strategies (e.g. awareness/ education) and indirect prevention strategies (e.g. destigmatization).

3. Results of analysis

All the hiv projects in 2008 that received Prisma funding have been scanned, and all prevention related activities have been noted in their category in a database. After completion, an analysis was done. Also the results per category were ordered into different subcategories. In this section the results of the analysis per category will be presented. First an overview of the results will be presented by numbers (counts). In the subchapters it will be explained what activities are included in the category.

Category	Results	Remarks
Awareness/Community Education	65	
Education of Youth	53	Including sexuality education and peer education
Support & Skills building	51	
Destigmatisation and sensitisation	35	
Gender	28	Including gender mainstreaming, SRHR, and family approach
Voluntary Counselling and Testing (VCT)	26	
Networking/Lobby/Advocacy	25	
Capacity Building	20	Including Work Place Policies
Vertical Transmission/ Prevention of Mother to Child Transmission (PMTCT)	7	
Other	2	Both refer to use or promotion of natural remedies

For further information I refer to the full document (030403.preventie alg werkdoc.05032010) as presented to the Prisma members in May 2010.

Appendix 2:

The Lancet prevention series

Michael H Merson, Jeffrey O'Malley, David Serwadda, Chantawipa Apisuk. *The history and challenge of HIV prevention*. The Lancet, [Volume 372, Issue 9637](#), Pages 475 - 488,

Nancy S Padian, Anne Buvé, Jennifer Balkus, David Serwadda, Ward Cates. *Biomedical interventions to prevent HIV infection: evidence, challenges, and way forward*. The Lancet, [Volume 372, Issue 9638](#), Pages 585 - 599, 16 August 2008

Thomas J Coates, Linda Richter, Carlos Caceres. *Behavioural strategies to reduce HIV transmission: how to make them work better*. The Lancet, [Volume 372, Issue 9639](#), Pages 669 - 684, 23 August 2008

Geeta Rao Gupta, Justin O Parkhurst, Jessica A Ogden, Peter Aggleton, Ajay Mahal. *Structural approaches to HIV prevention*. The Lancet, [Volume 372, Issue 9640](#), Pages 764 - 775, 30 August 2008

Stefano M Bertozzi, Marie Laga, Sergio Bautista-Arredondo, Alex Coutinho. *Making HIV prevention programmes work*. The Lancet, [Volume 372, Issue 9641](#), Pages 831 - 844, 6 September 2008

Peter Piot, Michael Bartos, Heidi Larson, Debrework Zewdie, Purnima Mane. *Coming to terms with complexity: a call to action for HIV prevention*. The Lancet, [Volume 372, Issue 9641](#), Pages 845 - 859, 6 September 2008

Appendix 3:

Abbreviations

ABC: Abstinence, Being faithful, Condoms

ARV's: Antiretroviral drugs

FBO: Faith-based organisation

GIPA principle: greater involvement of people living with HIV&AIDS

IDU: Intravenous/Injecting Drug User

MFS: Medefinancieringsstelsel (funding)

NGO: Non-governmental organisation

OVC: Orphans and other vulnerable children

PMTCT: Prevention of mother to child transfer

PLWHA: People living with HIV & AIDS

SRHR: Sexual and reproductive health and rights

STI: Sexually transmitted infection

VCT: Voluntary counselling and testing

