The deepening problem of prevention

Introduction

Many research and intervention programmes have come to the startling discovery that preventing the transmission of HIV is a very complex phenomenon. It varies from one culture to the other, from one age group to the other, from male to female, from one socio-economic group to the other and from one sexual orientation to the other.

During the past XVII World AIDS Conference held at Mexico, two very interesting studies were presented to illustrate the various ways in which HIV-positive people acted upon the prevention of HIV-transmission[1].

HIV-positive men and women in KwaZulu Natal - Umyungundlovu

The first study was one of HIV-positive men and women in Umyungundlovu[2]. This region has the highest local HIV prevalence in the world: 44,4% of the adult population. The study was conducted by the University of Toronto which administered 101 questionnaires to men and 101 questionnaires to women. All of the participants were HIV-positive and on antiretroviral therapy[3].

The study found the following[4]:

- One in three patients had had unprotected sex in the last four weeks;
- Of these, one in six patients had had sex with a possibly serodiscordant[5] partner;
- HIV-positive women were less sexually active-38%-as opposed to HIV-positive men--52%;
- There was a striking relationship between having unprotected sex and women's vulnerability;
    - The vulnerability of the women was further highlighted when they also found that the majority of these women were unemployed--85%;
    - Every single women that reported to have unprotected sex was unemployed;
    - There was a huge correlation between unprotected sex and physical abuse within the relationship, feeling lonely and marginalised, low perceived power to negotiate condom use;
- One of the biggest predictors of unprotected sex was alcohol use before sex-83%-drank before unprotected sex compared with 48% before protected sex and,
- The study also highlighted the problems concerning condom use that still prevail: 40% of the participants was of the opinion that condoms can break easily and one in five people were convinced that free condoms supplied by the government contained HIV.

Viewing these results is distressing since it focuses again on the prevailing ignorance and how a lack of knowledge can lead to HIV transmission. The weak position of women in sub-Saharan Africa is still a source of great concern, because of their vulnerability.

HIV-positive men and women in Europe[6]

A second study was done in Europe amongst HIV-positive men and women. Eurosupport 5[7] sent out 3000 questionnaires, but only 1212 replied, a response rate of only 39%. They have found that:

- Gay men were more likely to report having had unprotected sex with possibly serodiscordant partners;
- Unprotected sex was associated with having an HIV-positive partner;
- Women using cannabis[8] and wanting a child were associated with unprotected sex;
- Young gay men reported the use of recreational and erectile-dysfunction drugs to be associated with unprotected sex;

- Socio-economic status was positively correlated with unprotected sex in gay men (employment), but negatively in straight men (poorer education) and,
- Gay men who were taking antiretroviral medication tended not to engage in unprotected sex and men who knew their viral load[9] were half as likely to have unprotected sex as those who did not know it.

It is interesting to note that despite the obvious differences between the participants in the two studies, there are some similarities too. Both these groups experienced a lack of knowledge which caused them unknowingly to take health risks. Both groups showed an unwillingness (or ignorance) to change their unhealthy sexual behaviour.

Are there any solutions?
There are, in fact, some general aspects that should be taken into account when one designs an intervention:

- The simple ABC[10] method of prevention is an over-simplified approach. Although it should form the core of the health risk message, the message should be disseminated within a certain perspective. Aspects such as age, gender, socio-economic status and culture should all be taken into account;
- We all agree that a simplified intervention of ‘dumping’ information on people does not work any more. People now need personal tailored risk reduction messages, it is not a case of ‘one size fits all’ any more;
- Dissemination of knowledge should preferably be done by peers. The top-down approach has been accepted as too paternalistic. Many positive results have come from peer-to-peer training in the past and it is accepted as the way to go;
- It is also widely accepted that if we do not change the individual’s circumstances we will not be effective with an intervention. Programmes that should receive attention too include those that:[11]:
  - focus on inequality and poverty;
  - promote equality for women and girls;
  - recognise cultural and other forms of diversity;
  - promote personal responsibility and,
  - build human capacity: the target group should take ownership of the programme.
- Lastly, the health care systems should be strengthened to provide what the community needs.

Conclusion
The main message should always be: There is hope. Today HIV-positive people can live relatively healthily with the help of antiretroviral medication. However, it is much better to get the message of prevention before infection takes place. This is not so easy. Disseminating health risk messages in such a way that they will lead to human behaviour change is unfortunately not easy. More research on this topic is needed.