HIV prevention conundrum: Did the Pope have a case?

We consider the statements Pope Benedict XVI made on the AIDS scourge[1] at the press conference granted to journalists during the papal flight en route to Yaoundé, Cameroon, realistic, reasonable and scientifically sound.

> *"I would say that this problem of AIDS can't be overcome only with publicity slogans. If there is not the soul, if the Africans are not helped, the scourge can't be resolved with the distribution of condoms: on the contrary, there is a risk of increasing the problem. The solution can only be found in a double commitment: first, a humanization of sexuality, that is, a spiritual and human renewal that brings with it a new way of behaving with one another; and second, a true friendship, also and above all for those who suffer, the willingness -- even with sacrifice and self-denial -- to be with the suffering. And these are the factors that help and that lead to visible progress.*
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> *Because of this, I would say that this, our double effort to renew man interiorly, to give spiritual and human strength for correct behavior with regard to one's body and that of another, and this capacity to suffer with those who suffer, to remain present in situations of trial. It seems to me that this is the correct answer, and the Church does this and thus offers a very great and important contribution. We thank all those who do this."*

As Benedict XVI affirmed, there is evidence in Uganda and in most African countries that *"the most efficient reality, the most present at the front of the struggle against AIDS, is precisely the Catholic Church, with her movements, with her various organizations"*. There is no need of documenting the extraordinary contribution of Sr Miriam Duggan, Nsambya hospital, Kitovu hospital, Youth Alive, Meeting Point groups, Lacor hospital, Reach Out Mbuya, and many other realities of the Catholic Church to the successful response Uganda made to the epidemic.

It is equally true that as the Pope reiterated *"this problem of AIDS can't be overcome only with publicity slogans"*. Uganda with the leadership of President Museveni and the brave participation of the people at all levels including religious and cultural leaders, did not indulge in asking for help. Ugandans acted with a clear and determined strategy based on abstinence (delay of sexual debut) and fidelity (zero grazing). Moreover it is not even a matter of level of funding: in the crucial years when prevalence declined from 15% in 1992 to 6% in 2004, the Uganda AIDS Control Programme cost was 23 cents of dollar per person.[2]
Indeed the *"the scourge* (of AIDS) *can't be resolved with the distribution of condoms: on the contrary, there is a risk of increasing the problem."*

Our experience demonstrates that the Church's position on condom and AIDS is the most reasonable and scientifically sound for the prevention of AIDS epidemics. Uganda has a record of success in the fight against HIV/AIDS.[3] [4]. Some went to the extent of labelling the Ugandan experience as "social vaccine"[5]. The comprehensive approach to prevention that would later be defined "ABC", though initially a truly indigenous and locally developed response to the pandemic has become an inclusive evidence-based approach to prevent sexual transmission of HIV. For many years we have been part of the struggle against the disease,

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[1] Press conference on route to Cameroon "Our Faith is Hope by definition" http://www.zenit.org/article-25405?l=english
[2] Low-Beer, Daniel, *'This is a routinely avoidable disease." Financial Times (*Nov 28, 2003)
[3] Edward C. Green, Daniel T. Halperin, Vinand Nantulya, and Janice A. Hogle. Uganda's HIV Prevention Success: The Role of Sexual Behavior Change and the National Response. AIDS and Behavior 2006; Volume 10, Number 4: 347-350.
[4] USAID. What happened in Uganda? – Declining HIV Prevalence, Behavior Change and National Response <http://www.synergyaids.com/Documents/WhatHappenedUganda.pdf>.
[5] Stoneburner RL, Low-Beer D. Population-level HIV declines and behavioral risk avoidance in Uganda. Science 2004; 304: 714–18.

and we acknowledge that the Church and religion at large have had a strong impact in slowing down the spread of the epidemic, through a work of education of the youth and of the population to a responsible use of their sexuality. We know how important condoms can be in focal epidemics among high-risk-groups; there is limited or no direct evidence, however, that the common and popular prevention measures (including condom social marketing, VCT, syndromic or mass treatment of STIs) have contributed to the reduction or slowing down of HIV in generalised epidemics.[6] [7] [8] [9].

Leading scientific journals published studies showing that the major factors for the decline of prevalence of HIV in Uganda was the reduction in casual, multi-partners sex (the B of ABC). Since then, evidence for a pivotal role for partner reduction, complemented by decline in premarital sex, has emerged for more recent HIV declines in Kenya, Zimbabwe, Ethiopia and Malawi. In Uganda, Kenya, and Zambia, increases in abstinence behaviours have been associated with declines in HIV prevalence[10]. In Uganda the percent of youth 15 to 24 years reporting pre-marital sex in the past year declined from 53% to 16% for females and 60% to 23% for males between 1989 and 1995. [11] In Kenya, similar declines in pre-marital sexual activity in the past year were seen, from 56% to 41% for males and from 32% to 21% for females 15 to 24 years, between 1998 and 1993. [12] All successful stories in Africa have been preceded by declines in casual sex and in premarital sex, in general registered over 5-6 years before the evidence of decline.[13]
Again in Uganda, prevalence of HIV was lower (6.4%) among people who had never used condoms compared to 9.3% among those who had ever used condom[14]. Use of condom was associated with higher prevalence among both men and women. The same survey showed that the West Nile and North-eastern regions of Uganda that had the lowest prevalence of HIV (2.3% and 3.5% respectively) had some of the lowest levels of knowledge about condom in the country, some of the lowest sexual activity in the past 4 weeks (41.5% and 50.4% respectively), some of the lowest number of lifetime sexual partners (mean of 1.7 and 1.8 respectively for women and 5.2 and 4.0 respectively for men). The percent of people aged 15 to 59 engaging in "higher-risk" sex was also among the lowest in these two regions. For

[6] Gregson S; Adamson S; Papaya S; Mundondo J; Nyamukapa CA; Mason PR; Garnett GP; Chandiwana SK; Foster G; Anderson RM. (2007) Impact and process evaluation of integrated community and clinic-based HIV-1 control: A cluster-randomised trial in eastern Zimbabwe PLOS MED. 4: 545-555; UNAIDS (1999) Trends in HIV incidence and prevalence: Natural course of the epidemic or results of behaviour change?. Geneva: UNAIDS. 36 p.; Stephenson JM, Obasi A (2004) HIV risk reduction in adolescents. Lancet 363: 1177–1178; Kamali A, Quigley M, Nakiyingi JS, Kinsman J, Kengeya-Kayondo J, et al. (2003) Syndromic management of STIs and behaviour change interventions on transmission of HIV-1 in rural Uganda: A community randomised trial. Lancet 361: 645–652; Quigley M, Kamali A, Kinsman J, Kamulegeya I, Nakiyingi JS, et al. (2004) The impact of attending a behavioural intervention on HIV incidence in Masaka, Uganda. AIDS 18: 2055–2063; Sherr L et al. Voluntary HIV testing in rural Zimbabwe - what is the uptake, impact on sexual behaviour and HIV incidence 3 years later? Third South African AIDS Conference, Durban, abstract 46, 2007; Matovu JKB et al. Voluntary HIV counselling and testing acceptance, sexual risk behaviour and HIV incidence in Rakai, Uganda. AIDS 2005, 19: 503-511; Padian NS et al. Diaphragm and lubricant gel for prevention of HIV acquisition in southern African women: a randomised controlled trial. The Lancet (online edition), July 13th, 2007; Gray RH et al. Randomised trials for HIV prevention. The Lancet (online edition), July 13th, 2007.
[7] Shelton, James D. Ten myths and one truth about generalised HIV epidemics. *The Lancet* 2007; 370: 1809-1811
[8] David Wilson. Partner reduction and the prevention of HIV/AIDS: the most effective strategies come from communities. British Medical Journal 2004; 328: 848-49.
[9] Shelton, James D. Confessions of a condom lover. The Lancet 2006; 368: 1947-1949.
[10] Bessinger R, Akwara P, Halperin D. Sexual Behavior, HIV and Fertility Trends: A Comparative Analysis of Six Countries; phase I of the ABC Study. Chapel Hill, NC: Measure Evaluation, 2003.
Cheluget B, Baltazar G, et al. Evidence for population level declines in adult HIV prevalence in Kenya. *Sexually Transmitted Infections* 2006 82; Suppl 1: i21-6.
[11] Bessinger et al, 2003.
[12] Kenya DHS. Available at www.measuredhs.com.
[13] DHS. Available at www.measuredhs.com.
[14] Uganda MoH. Uganda HIV/AIDS Sero-behavioural Survey 2004-05

women it was 5.5% (the lowest) in West Nile and 8.6% in the North-east while for men it was 29.4% and 18.5% respectively. The percentage of youth aged 15-24 years who had had sex before age 15 was also among the lowest, being 9.6% and 5.2% respectively for women and 12.0% and 7.1% respectively for men. Moreover, and interestingly, HIV prevalence was lower (1.6%) among uncircumcised men than the circumcised ones (2.4%) contrary to the general picture in the country. The West Nile region is not isolated from the rest of the country, with heavy movement of people by buses and aeroplanes to and from Kampala everyday. Many people travel from the Democratic Republic of Congo and the Southern Sudan through West Nile to Kampala daily. In addition, the West Nile is one of those in a post-conflict period, having seen long post-Amin era conflict. All these point to the fact that high use of condom was not the real factor that kept prevalence of HIV low in those two regions. Rather it was behavioural.

The drivers of the changes happening in several African countries are behaviours so clearly in line with the Catholic teaching, behaviours that scientists, sociologists and cultural leaders should be working on to identify and help to preserve to help avoid HIV.

Moreover the recent levelling trends of HIV prevalence in Uganda can be attributed to the 'moving *away'* from the original and verified indigenous Ugandan strategy. There is indeed an unacceptable pressure by western experts and organisations to change the focus from the effective A and (especially) B to the debatable C. This is mainly due to the western taboo about the impossibility of changing sexual behaviour and interfering with personal behaviours. This is simply hypocrisy as in the case of smoking, alcohol and drug addiction, different approaches are implemented.

The Pope's message should, instead of being criticised, be a wake up call to the proven realities regarding the dynamics of HIV transmission not only in Uganda but in sub Saharan Africa. After all, it is universally acknowledged that the principal driver of the epidemic in the sub region is people having multiple and concurrent sexual relationships. Any solution that does not embrace this reality and the necessary risk avoidance strategies is certainly bound to fail. We caution against an interpretation of Catholic religion and of the Pope's teaching as prejudicially against science, because this is simply against evidence.

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