Backed by extensive research, Hanley and de Irala explore "risk reduction" and "risk avoidance" approaches to the prevention of AIDS in Africa. They succinctly identify the philosophies and agendas underpinning these approaches, question Western assumptions, and challenge the AIDS Establishment to give due acknowledgment to the effectiveness of abstinence and fidelity in AIDS prevention. The authors understand that faithful human love is the most effective promoter of health and wholeness.

Sister Miriam Duggan, F.M.S.A., F.R.C.O.G.
Founder, Miriam Duggan Home
Kampala, Uganda

Deep respect for life and responsible sexuality are essential for integral human development. When Pope Benedict XVI calls for the humanization of sexuality, he has in mind the kind of arguments that Hanley and de Irala present in this book with such clarity, coherence, and conviction.

Rev. Michael Czerny, S.J.
Founder and Director
African Jesuit AIDS Network
Nairobi, Kenya

The ruthless promotion of condoms by Western governments and international organizations is responsible for millions of deaths in Africa from AIDS-related diseases. Those in the Western world who want to overcome the tremendous crisis of HIV/AIDS that is devastating sub-Saharan Africa should ponder and take to heart the powerful message of Hanley and de Irala.

Bishop Hugh Slattery, M.S.C.
Diocese of Tzaneen
South Africa

Affirming Love,
Avoiding AIDS

Phillip, a father of three and volunteer community health worker, brings bread, comfort, and company to a man with AIDS in his home near Lake Victoria in western Kenya, where close to a third of the population is HIV positive.

Affirming Love, Avoiding AIDS

What Africa Can Teach the West

Matthew Hanley
Jokin de Irala

with a foreword by Edward C. Green

The National Catholic Bioethics Center
Philadelphia

Cover design by Nicholas Furton
Photograph on page iv by Matthew Hanley
ISBN 978-0-935372-56-4

An earlier version of this book was published in Spanish as *Propontelo, proponselo: evitar el SIDA* by Ediciones Internacionales Universitarias, 2006.

Unless otherwise noted, quotations from Church documents are from the Vatican English translation, published online at www.vatican.va.

Library of Congress Cataloging-in-Publication Data

Hanley, Matthew.

Affirming love, avoiding AIDS : what Africa can teach the West / Matthew Hanley, Jokin De Irala ; with a foreword by Edward C. Green.

p. ; cm.

An earlier version of this book was published in Spanish as Propontelo, proponselo: evitar el SIDA, by Ediciones Internacionales Universitarias, 2006.A

Includes bibliographical references and index.

ISBN 978-0-935372-56-4

1. AIDS (Disease)--Africa. 2. AIDS (Disease)--Religious aspects--Catholic Church. I. Irala, Jokin de. II. Hanley, Matthew. Propontelo, proponselo : evitar el SIDA. III. National Catholic Bioethics Center. IV. Title.

[DNLM: 1. Acquired Immunodeficiency Syndrome--prevention & control. 2. Christianity. 3. Sexual Behavior. WC 503.6 H241a 2010]

RA643.86.A25H36 2010

362.196'97920096--dc22

2010002609

This book is dedicated to all who suffer anguish
from the HIV/AIDS epidemic
and to those who care for them and remain for them
a compassionate human presence.

Contents

Foreword

Future historians of the AIDS era will puzzle over and debate the reasons why spending ten billion dollars annually by 2007 seemed to have so little effect on global HIV infection rates. Specifically, when dealing with a disease that can be so easily prevented, why did efforts not go toward changing the behaviors that drive HIV epidemics, namely, having many sexual partners (especially those that are concurrent), the injection of mood-altering drugs, prostitution, and intercourse among homosexual men? Future historians will rightly conclude that special-interest groups presided over the rise of a vast multi-billion-dollar enterprise and focused it almost exclusively on the distribution of medical devices and drugs.

Serious efforts to change high-risk behaviors have been conspicuously missing in the effort to control AIDS. Put another way, there has been little or no primary prevention in HIV/AIDS, even though public and private sectors have poured more money and resources into this single

disease than into any other in history. Efforts to include primary prevention are often rejected, surprisingly, in the name of achieving a so-called comprehensive approach to reducing the spread of HIV. Moreover, the heavy emphasis on "risk reduction," greatly facilitated by invoking the name of human rights, has also been regularly cast as the "scientific" course of action, thus requiring a monopoly of resource allocation. That drum has been beaten with great urgency, as though the inclusion of primary prevention messages would cause the comprehensive preventive paradigm to crumble and lead to an even greater pandemic.

How did the world's great experts in HIV/AIDS and allied fields get so far off course? How did they manage to convince themselves, the rest of the scientific and international development establishments, liberal churches, the mass media, and indeed most of the world that they were doing the right thing?

Let me mention one basic reason.[1] The global response to AIDS was developed by Americans (with some European input) for the type of "concentrated" HIV epidemics found in America and Europe. We then attempted to apply Euro-American solutions to problems in Africa, Asia, the Caribbean, and indeed the rest of the world. The great majority of HIV epidemics are concentrated among high-risk groups, usually among the universal risk groups of homosexual men, injecting drug users, and prostitutes. Yet a majority of the world's HIV infections are found in Africa among general populations, that is,

not in these high-risk groups. In 2007, Africa accounted for 67 percent of all people living with AIDS and 75 percent of all AIDS deaths.

The Euro-American approach has its own flaws. First of all, prevention tools, aimed at reducing risk or harm among homosexual men and injecting drug users, have not been very successful even in concentrated epidemics. For example, HIV incidence appears to be rising again in the United States, and it has certainly risen in recent years among homosexual men, the risk group that contributes the highest proportion of HIV infections to the U.S. epidemic. But however effective risk reduction has been in concentrated epidemics, it should have occurred to AIDS experts that we need different approaches when most HIV infections are found in general populations. An approach that may be effective for a drug addict or a prostitute—which is based on the ultimately self-defeating premise that the risk behavior cannot (or even should not) be changed—will probably not be the best approach for married couples or most teenagers. After all, the majority of unmarried teenagers in less-developed countries are not sexually active, to go by our best behavioral surveys.[2]

There are several other reasons why global AIDS prevention got started on the wrong track, but let us look at what has worked. We probably now know the answer to this for at least the "hyper-epidemics" of Africa. These have been reduced by behavior change of a more fundamental sort than adoption of condoms or other technologies, or testing. In every African country

where HIV infections have declined, this decline has been associated with a decrease in the proportion of men and women reporting more than one sex partner over the course of a year—which is exactly what fidelity programs promote.[3] The same association with HIV decline cannot be said for condom use, coverage of HIV testing, treatment for curable sexually transmitted infections, provision of antiretroviral drugs, or any other intervention or behavior.

The other behavior that has often been associated with a decline in HIV prevalence is a decrease in premarital sex among young people, but the evidence for this is not as strong as the evidence for partner reduction, nor does abstinence or delay of sexual debut involve as great a proportion of those between the ages of fifteen and forty-nine (where we track HIV infections and behavioral trends) who are sexually active.

It is quite possible that condom use also contributes to declines in HIV infection rates, but it is hard to know for certain. We might learn that condom use "in last high-risk encounter" or with last "nonregular partner" rose from, say, 40 to 60 percent, but the great majority of that condom use is irregular, and a growing body of research findings show that irregular condom use does not help overall.[4] In fact, it might actually contribute to higher levels of infection because of the phenomenon of risk compensation, whereby people take greater sexual risks because they feel safer than they really ought to because they are using condoms at least some of the time.[5] This is a complex and controversial issue

that has generally been underappreciated, but Hanley and de Irala fairly and concisely pull together the evidence and profitably discuss its implications.

In fact, the only type of condom use that is really associated with risk reduction is *consistent* condom use. One of my criticisms of the AIDS Establishment in 2003 was that the major surveys we were relying on to inform and guide our AIDS prevention programs, such as the Demographic and Health Survey funded by the U.S. government, did not ask about consistent condom use, even though the word condom was used in questions twenty-nine times.[6] Perhaps because of criticism like my own, along with the landmark study of condom effectiveness by Norman Hearst and Sanny Chen,[7] the Demographic and Health Survey began asking a question about consistent condom use in 2005. Yet to date, the findings have not been published, analyzed, or discussed.

My guess is that when the data on consistent condom use are finally made available, levels of consistent use will prove to be so low as to make the billions of dollars poured into condom promotion look ill spent as well as ill monitored. And we will see that consistent condom use is especially rare in general populations, where most infections in Africa are found, in spite of all the efforts that have gone into promoting condoms to married couples, teenagers, and others in the general population. Even among discordant couples (where one partner is HIV positive and one is uninfected) who know their HIV status and have access to condoms, consistent condom use is rare.[8]

Under optimal conditions, condoms reduce risk of HIV infection by about 85 percent, but of course conditions are not usually optimal.

Hanley and de Irala also point out other facts that are not well known or publicized by the popular media. For example, even in countries like Thailand and Cambodia, where HIV infections are concentrated among prostitutes and their clients, declines in HIV infection rates, typically depicted as resulting exclusively from condom use, have also been attributed to declines in the proportion of men having contact with sex workers and to declines in the proportion of men having more than a single sex partner.

Those Catholics who are agonizing over a perceived disconnect between Church teaching on condom use and effective AIDS prevention will benefit from reading Hanley and de Irala's book. Firmly planted on solid epidemiological ground, their work stands in sharp relief to many others in the faith-based community who have curiously adopted a politically correct and unsubstantiated viewpoint that is virtually indistinguishable from what one might expect to find at thoroughly secularized institutions. If anything, we should have learned from the evidence alone that to make a constructive contribution to global AIDS control, one does not need to jettison core beliefs related to sexual restraint or imply (as some Church-affiliated entities have done) that the epidemic stems primarily from outdated moral teachings which principally serve to foster stigma and discrimination.

Yet the Church, and in fact all religious groups and leaders, can be as misled by the experts as everyone else. It is not surprising that compassionate and well-meaning people of faith sometimes end up supporting ineffective types of AIDS prevention when they are assured by scientists and the mass media that condoms are the best weapon we have in the war against AIDS, that abstinence and fidelity or monogamy are not feasible and may even be "impossible" and, even more remarkably, that marriage is in fact a dangerous enterprise for women in the developing world. For example, Nicholas Kristof wrote in the *New York Times* that "just about the deadliest thing a woman in South Africa can do is get married."[9] In 2009, the chairman of the Uganda AIDS Commission testified before UNAIDS that marriage has somehow emerged as a major risk factor for AIDS.[10] I am afraid he has been led astray by foreign donors who want to keep the focus on condoms. The truth is that married people in Africa are always found to have lower HIV infection rates than people who are single, divorced, or widowed, when comparing the same age groups (except for the comparison between married teenage females and unmarried teens, most of whom are abstaining). Allison Herling and I discussed this issue in some detail in an article published by *First Things*, in which we identify "the central fact that has emerged from all the recent studies of the HIV epidemic: What the churches are called to do by their theology turns out to be what works best in AIDS prevention."[11] We are referring of course to the promotion of marital fidelity and premarital abstinence.

Hanley and de Irala cover the evidence that has been debated bitterly in recent years, and they show how fidelity and abstinence are in fact not faith-based motivational programs but evidence-based AIDS prevention. They cover in some detail the evidence for what brought down HIV infection rates in Uganda so dramatically. In my own research I have found that the Catholic Church has played a significant role not only in caring for the sick and dying, but also in AIDS prevention. An Irish medical missionary, Sister Dr. Miriam Duggan, F.M.S.A., was a key figure in the development and shaping of Uganda's distinctive prevention program that put primary emphasis on marital fidelity and delay of sexual debut.

One of the notable Catholic AIDS prevention programs is Youth Alive, which has had to struggle financially because most of the major donors have refused to fund an AIDS program that does not promote and distribute condoms. As I reported in a study I conducted for the U.S. Agency for International Development,

> Youth Alive emphasizes "the spiritual approach to life" as well as to AIDS. "We are dealing with such great problems as stigma, shame, depression and loss of loved ones that come with this disease. You cannot take care of this with a condom. You need spiritual and social support." The program director explained, "When I say A, B, C, to us as a church, the C is for character formation for the youth, and not condom."
>
> One informant put it this way. "If you elevate the condom to the highest good, then you are saying or implying that people are only animals who cannot

> reason and who cannot control their biological urges." "We teach that people are more than that, that they are intelligent, worthy, valuable, loved by God." Another comment was "We have a belief that each and every individual has the capacity to change."[12]

It is seldom mentioned, but the major HIV/AIDS organizations do not really agree with this last statement. Every reason is given to argue that poor people in particular do not have the freedom, the "agency," the power, or the opportunity to fundamentally change sexual behavior—except for adopting certain technologies that we on the donor side can provide. This attitude quite naturally serves selfish financial interests, even as it also reflects often passionate ideological commitments to the sexual freedom and license enshrined by the Western sexual revolution.

But Hanley and de Irala convincingly point out that this position is fundamentally one born of despair, and one which inevitably shortchanges the very people our prevention programs strive to protect. In fact, after discussing the scientific questions on their own empirical terms, Hanley and de Irala present and contrast the Christian perspective on these matters with the prevailing secular perspective, discussing in some detail the competing visions of the person and of human sexuality, and the role of holding out hope for a better future. Here they make their most creative contribution to the global AIDS debates by providing a glimpse of what, beneath all the rhetoric, ultimately drives much of AIDS prevention

policy, and contrasting it with a positive, rational articulation of the unpopular Catholic teachings that are frequently misunderstood or misrepresented.

If I may be permitted to end on a personal note, I went through a very difficult period after coming to Harvard in 2001 and speaking out from that bully pulpit about how and why our AIDS prevention approach was not working well. Especially during the years 2002 to 2005, I was making many presentations to audiences at the U.S. Agency for International Development, at reproductive health and family planning associations and conventions, in the House of Representatives and the U.S. Senate, and elsewhere. Matt Hanley would often be in the audience, at times possibly the only person present who really supported my viewpoint. He would usually come up to me after I had received a chilly reception and say a few words of encouragement. This was important for me, because I had been raised to think that if I thought one way about some issue and everyone else thought the opposite way, both common sense and a modicum of humility would suggest that it was I who was wrong. Matt's presence reminded me that sometimes the majority of experts can be wrong.

Edward C. Green

Edward Green is the director of the AIDS Prevention Research Project at the Harvard Center for Population and Development Studies in Cambridge, Massachusetts.

Notes

1. I address this question in my forthcoming book, *AIDS and Ideology* (Sausilito, CA: PoliPoint Press, 2010).
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9. Nicholas D. Kristof, "When Marriage Kills," *New York Times*, March 30, 2005, http://www.nytimes.com/2005/03/30/opinion/30kristof.html.
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11. Edward C. Green and Allison Herling Ruark, "AIDS and the Churches: Getting the Story Straight," *First Things* 182 (April 2008): 22–26.
12. Edward C. Green, *Case Studies of ABC: Models for the Implementation of Abstinence and 'Faithfulness' Behavior Change Programs* (Cambridge, MA: USAID and Harvard School of Public Health, 2003), especially p. 25. This unpublished study is available at http://www.ccih.org/resources/ABCplus/research/abc/case-studies-of-ABC.pdf.