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Why HIV prevention programmes fail.

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Why do many well-intentioned HIV-prevention programmes have disappointing results? How do the beliefs and practices of medical doctors and researchers contribute to the success or failure of prevention efforts? In seeking to explain the obstacles to effective HIV/AIDS management, attention is usually given to factors internal to affected communities (e.g. exotic aspects of local cultures; or individuals' health, attitudes or behaviours). The spotlight also often falls on technical aspects of STI control regimes or the content of health educational messages. Less attention has been given to the way in which prevention efforts are conceptualised and managed, and to the challenges that face those trying to build partnerships between medical doctors/ researchers and the non-traditional partners they need to work with if the epidemic is to be effectively managed in the marginalized communities in which it often flourishes.

These factors are showcased in a case study of a state-of-the-art prevention programme in a South African mining community¹. This programme was well-funded and backed by an impressive array of local and international experts. On paper it seemed ideal. Its impetus came from a group of township residents concerned about rocketing levels of HIV². The programme was managed by a representative group of 'stakeholders' living or working in the local community – grassroots groupings, mining industry doctors and human resources personnel, private GPs, traditional healers, trade unionists, representatives of local and national health departments, biomedical and social scientists and foreign donor agencies.

Launched on a wave of optimism and good will, the project's impact was disappointing. Not only was there no reduction of STIs in the three-year study period, but STI levels actually rose amongst mineworkers, one of the key target groups. Part of the explanation for the project's results lie in social, economic and cultural obstacles which hindered the

¹ Campbell, C (2003) *Letting them die: why HIV prevention programmes fail*. Oxford: James Currey. Bloomington: Indiana University Press.

² Baseline research suggested that levels of HIV were 25% amongst mineworkers, 68% amongst sex workers and 50% amongst young people.

likelihood that project beneficiaries (in particular mineworkers, commercial sex workers and young people) would derive maximum benefit from state-of-the-art STI control efforts and peer education. These factors are discussed in great detail in the study, and space precludes discussing them here.

The other part of the explanation lies in the various ways in which differences between project stakeholders undermined its effective implementation. The rationale underlying 'multi-stakeholder partnerships' is that epidemics are extraordinary events, arising because existing medical systems and practices are inadequate for addressing them. Furthermore, HIV, with its complex mix of biomedical, behavioural and social roots, is too complex for any one group to deal with, requiring the collaboration of biomedical and social scientists and practitioners; actors and agencies from the public sector, the private sector and civil society; and players at the local, national and international levels.

The stakeholder team showed various forms of resistance to developing new ways of thinking and acting in collaboration with non-traditional partners. There was an over-representation of medical experts on the team. Committed to biomedical rather than social understandings of disease transmission and prevention, their primary commitment was to implement STI control and distribute free condoms. There was little acknowledgement of the need to supplement these approaches with efforts to create social environments that would support increased condom use and uptake of STI services.

The project also suffered from variable levels of commitment by key stakeholders. Deprived township residents appeared locked into a cycle of fatalism and denial about HIV. Adult denial of the problem hindered prevention amongst young people. Potentially influential stakeholders ranging from mine medical officers to mineworkers' trade unions chose not to follow through their initial commitment to implementing all the strategies laid out in the project proposal. In the three-year study period most miners were not exposed to peer education, nor were miner representatives mobilised to participate in project activities and decision-making – although these had initially been highlighted as key project goals.

Given the narrow biomedical framework which informed many key stakeholders' participation, it is not surprising that the project suffered from poor capacity in areas such as organisational development, project management and social science. The project co-ordinator was a senior scientist with no management training or experience, for example. Despite his strong commitment to a 'social change' approach to public health, he and other stakeholders lacked the skills needed to implement such an approach. Although around three-quarters of the project's intended beneficiaries consult traditional healers, virtually no effort was made to facilitate the traditional healers' participation.

The project suffered greatly from lack of conflict mediation skills. This was a key shortcoming in the face of the personal and political conflicts and controversies, and the frequent lack of inter-group trust, that will inevitably arise when such a diverse group of partners seek to address a problem as fraught and stigmatised as HIV/AIDS. There was also a lack of appropriate health systems infrastructure to facilitate the collaboration of this group of non-traditional stakeholder partners with their very different skills, abilities and motivations.

What of the broader context of HIV prevention beyond this community? With poor government leadership, ground has been left open for international development agencies and externally funded NGOs. The discourses of HIV prevention are often the discourses of western science and policy, regardless of the extent to which these are appropriate for local conditions. Projects are often designed by 'overseas experts', with only minimal and tokenistic consultation of local people, who may have little sense of 'ownership' of project proposals and lack the conceptual understandings, technical skills, or trained staff to implement them properly.

The potential impact of the project was also hampered by the assumption by more educated, affluent and powerful stakeholders that it was 'others' (such as miners, sex workers and young township residents) that needed to change in order for HIV prevention to succeed. Their unwillingness to accept that they too would need to change was at the root of their lack of effort in working towards genuinely collaborative relationships with non-traditional partners in the interests of create social conditions that were supportive of improved sexual health.

More attention needs to be given to the way in which biomedical frameworks of understanding of health and disease have the potential to hinder attempts to develop holistic approaches to HIV/AIDS management. The roots of the HIV epidemic lie in a complex mix of biomedical, behavioural and social factors. Medical interventions – such as STI control and more recently anti-retroviral drugs – are clearly vital. But these need to be supported by efforts to create social environments that enable vulnerable individuals and communities to derive maximum benefit from drugs and treatments.

A call to medical doctors and researchers to adopt more holistic and multi-disciplinary approaches runs counter to the current tide of increasing specialisation and compartmentalisation. Yet the nature of the HIV/AIDS epidemic challenges this culture of specialisation. This is particularly the case for those who seek to rise to the challenge of slowing the rate of HIV transmission, supporting those lay people who often have to carry the burden of AIDS-care and enhancing the abilities of deprived communities to respond to future health threats.