This is an attempt to contribute in an area where too little has been written in proportion to the size and urgency of the issue facing Christian’s and Christian ministries around the world. Secondly it is an attempt to approach the subject from the perspective of practitioners working at the coalface of the current HIV/AIDS crisis. This document was first drafted following the 2002 Chiang Mai Micah Consultation on HIV/AIDS, as an attempt to reflect the views of Tear Fund partners working in this area (or at least those present at that conference). Therefore it speaks from the perspective of evangelical Christian workers ministering among poor and marginalised communities in 2/3rds world settings.

The goal here is to outline a theology of HIV/AIDS which is Biblical, Christ-centred and useful for guiding those involved in HIV/AIDS related ministry. As such, this brief paper will necessarily be an outline of significant issues and responses, rather than an in depth theological examination. It will however refer interested readers to publications that provide this background of greater depth and nuance. It also has to noted that no one position on an issue as complex as HIV/AIDS will please everyone. It is an issue that has heard strident and controversial views pronounced with great vitriol by Christians with conflicting perspectives on the issue.

The reasons for the heat and discomfort generated by this is issue is manifold: the discussion of HIV/AIDS requires us to also discuss human sexuality and sexual practice, traditionally areas Christians have not felt comfortable discussing; the practice of HIV/AIDS ministry requires involvement in the lives of people the Church has often avoided, feared or even loathed; while thinking through the conflicting theological and ethical issues is hard work, and this is something we are tempted to avoid. This document has not been written for those safely ensconced in theological colleges or churches where they have the luxury of arguing in favour of very abstract and ideal moral positions. Instead this paper hopes to move us beyond personal and theological comfort-zones by presenting Biblical and missiological perspectives that will be of practical use to Christian practitioners engaged with real people in tragically real situations on the frontline of the HIV/AIDS holocaust sweeping parts of Africa, Asia and Eastern Europe.

There are three parts to this paper:
1. towards a theology of HIV/AIDS;
2. towards a theology of HIV/AIDS responses.
3. towards an understanding of Behaviour Change and Harm Reduction strategies.

1. **Towards a theology of HIV/AIDS:**

HIV/AIDS first appeared in the early 1980’s, in the West largely among the North American homosexual community, and in other communities around the world amongst commercial sex workers and intravenous drug users. This helped reinforce the early opinion among many Christians that this disease was a judgement of God on promiscuous sexual behaviour. These were often lifestyles Christians saw as bizarre or wicked. These were embarrassing subjects; ones we felt uncomfortable to even discuss. This certainly wasn’t the only evangelical perspective on the subject, but the
one expressed most loudly and certainly the one the secular world heard. In large part, this was because of the evangelical churches pre-existing condemnation of homosexuality as a lifestyle, but possibly also reflected the flip-side of a *health and prosperity teaching* held (consciously and unconsciously) by many evangelicals. i.e., that God only blesses, protects andprospers those who please him. If we hold this to be true, a logical extension is also to believe that those whose lives are blighted, suffering and poor are outside God’s blessing (a worldview, by the way, in radical contradiction to Christ’s Sermon on the Mount). Actually, one sees this understanding of the mechanics of divine blessing present in the popular form of every major religion – animism, Hinduism, Buddhism and Christianity. It almost seems to be a theology buried deep in the human psyche. Furthermore, it is possible to garner evidence for this position from a superficial or selective reading of the Christian scriptures (e.g. Deuteronomy 30:9, Psalm 1:3, Galatians 6:7, Romans 1:27).

A further inadequacy of this “God’s judgement” theology is that it tends to further victimize the victim. Hundreds of thousands of women and children have contracted the AIDS virus despite living lives of moral fidelity. For example, in many cultures a woman’s highest risk factor is to be faithfully and submissively married to a husband.

It is required, therefore, that we as Christians have *an adequate Biblical theology* of suffering, of disease, of poverty and of judgement. In this regard we note that an orthodox evangelical reading of the Bible understands that:

**(i)** *Firstly* that *all humanity* (and all creation) is under the curse of the fall (Genesis 3) – which has resulted in the consequences named here (suffering, disease and poverty).

**(ii)** *Secondly*, *Jesus reversed the curse* of the fall for all those who would become his followers (Galatians 3:13, Ephesians 1:7), although *the full realisation* of that reverse (redemption) won’t be experienced until Christ returns and completes his Kingdom (Ephesians 1:10, 1:14).

**(iii)** *Thirdly*, we see that during his earthly ministry Jesus’ attitude to suffering, disease and poverty was one of *compassion rather than judgement*. He went out of his way to receive and fellowship with those so afflicted. Rather than pronounce God’s judgement on them, he instead taught that these ones were actually closer to God’s Kingdom than those the world considers rich, powerful or successful (eg Matthew 5:3-12; Luke 6:20-26). Jesus announced that he had come not to judge, but to save (John 3:17; 12:47). Particularly striking was Jesus laying on of hands to heal leprosy (Mark 1:40-45); a dreaded skin disease that in Old Testament terms was a curse marking the sufferer as being outside of God’s blessing (e.g. Leviticus 13:45-46).

**(iv)** *Fourthly*, Christ called his followers to emulate his concern and ministry to those who are suffering, poor, or diseased (Matthew 10:5-10; 25:31-46; Luke 10:25-37). Again he called his followers to acts of compassion rather than words of judgement. Indeed, Jesus specifically warned against judging events before the proper time (Luke 6:37; John 12:47; c.f. with Paul in 1 Corinthians 4:5), and especially against associating suffering with God’s judgement (e.g. Luke 13:1-5, his message here is that we are all equally “sinners”, and all equally in need of repentance and conversion). For the present time *mercy triumphs over judgement*, a
principle that must be evident in the lives and ministries of all of those who follow Christ. If not, we ourselves will fall under divine judgement (James 2:12-13). We see this ethic demonstrated graphically in the life of Jesus who reserved his harshest words not for those caught in moral transgressions (e.g. John 8:1-11; Luke 7:36-50; 18:9-14), but for the religious authorities who condemned and excluded “sinners” instead of offering them help (Matthew 23:1-3, 13-15, 23; John 9:39-41).

(v) **Fifthly**, that *God will indeed judge every human thought, intention and action at the end of time*, rewarding and punishing on the basis of the motivations hidden in each human heart. There is no hierarchy of sins, with sexual sins at the top (James 2:10, Romans 3:23). For these reasons we are warned against entering into judgement of others “before the appointed time” (1 Corinthians 4:5; Romans 14:10; James 4:12). We cannot know how God’s final judgement will work out in practice, but can be confident in His perfect justice and perfect love being fulfilled. That does not mean we should sit back and ignore sin (in any of its forms): *like Jesus we will do everything we can to free people from sin and to limit the damage that results from sin. However, we are to do this from a base of compassion, not condemnation* (Luke 9:51-56).

In summary, we believe that the Bible calls us to regard disease, suffering and poverty as consequences of the fall, and as curses on humanity that Christ came to deliver us from. He calls his followers to join him in working for the deliverance of the world from these curses, rather than pronouncing them as signs of God’s judgement upon individuals.

2. **Towards a Christ-Centred Theology of HIV/AIDS Responses:**

(i) **Jesus’ response to the sick:** as we have seen Jesus’ response to sickness and disease was consistently one of compassionate acts to alleviate suffering. Rather than enter into speculation on the theological ‘cause’ of the illness, he instead saw his own response as an opportunity to glorify God (John 9:1-3). Particularly striking was Jesus’ laying on of hands to heal leprosy; a dreaded skin disease that in Old Testament terms was a curse marking sufferer as being outside of God’s blessing (Leviticus 13).

1 Jesus does not ignore or ‘go easy’ on moral sins: his goal is to free us from them. His final words to the women caught in adultery are to “go, and leave your life of sin”. However, these are words that flow out of compassion for and acceptance of the women, rather than out of the spirit of judgement and condemnation which had possessed the woman’s accusers.

2 But obviously there is a hierarchy of consequences of sins, depending on how much pain is caused to God, others and ourselves. Though we wish to avoid all sin, we can see that (for example) telling our mother in law that we like her new outfit (when actually it’s hideous) may be a lie, but it will probably have fewer destructive repercussions than going out and killing someone. Killing someone will unleash a cascading torrent of grief, pain, anger, hate and desire for vengeance on an ever widening number of people. Having a one-off lustful thought may seem to cause little destruction… but then again, if repeated often it may well lead to the full act of adultery and marital betrayal, with all their hugely hurtful consequences (Matthew 5:27-32). 1 John 5:16-17 seems to imply this hierarchy of consequences. We can not stand in judgement (condemnation) on other peoples sins (Matthew 7:1-5), but we can certainly judge the consequences of various sins – and do all we can to prevent or limit those consequences ever happening in the first place.
Leprosy has rightly been described as the ancient-world’s equivalent of AIDS, in terms of the disgust and fear it evoked. Theologically, it was seen as a sign of being accursed; socially, it lead to complete ostracisation and isolation from the community, as it was thought to be highly contagious (much more contagious than it actually is – another parallel with the popular perception of HIV/AIDS). Jesus reached beyond the stigma and fear of this disease with his loving touch and compassionate prayer, in order to bring healing of the PLWLs’ physical, social and spiritual dis-ease. After encountering Jesus, the PLWL was restored to their religious community and wider society.

(ii) **Jesus’ response to the marginalised and despised:** Jesus’ encounters with the leprous are but one example of his response to the marginalised of his day. His interactions with Samaritans (John 4:7), gentiles (Luke 7:9), tax collectors (Luke 19:2), drunkards (Matthew 11:19), and women of ill repute (Luke 7:37), were all marked by responses of compassion and life-giving ministry. Indeed, Jesus reserved his harshest criticism for the most successful and exalted citizens of his day (Luke 6:24-26), while consistently acting with mercy towards those society had already judged and excluded.

(iii) **Jesus’ response to women:** Related to the above, and of special relevance is Jesus’ response to women. The disempowerment of women and their lack of status vis a vis men is one of the forces driving the HIV/AIDS epidemic in many places. In many places it is unacceptable for a woman to negotiate safe sex; to ask her husband to be sexually faithful; to insist he uses a condom if he isn’t faithful; to refuse sex if she suspects he is infected; or to leave him if she feels her life is at risk. Rape and sexual abuse are always more common in such cultures (and subcultures). The 1st century culture Jesus entered was similarly patriarchal and repressive of women. A pious Jew would not greet a woman in the street or even make eye contact. An infamous prayer was attributed to 1st century Pharisees that thanked God for ‘not having been born a woman, a gentile or a dog’. But Jesus broke radically with these cultural norms, greeting women and entering into public dialogue with them (John 4), ministering to their needs (Luke 8:43 - even when these needs defined them as religiously “unclean”, c.f. Leviticus15:19), defending them against culturally sanctioned violence (John 8:11): and including them in his community as followers and as patrons (Luke 8:1-3). When we set about challenging oppressive gender expectations that fuel the AIDS epidemic in many cultures, Jesus provides us with a radical role model.

(iv) **Jesus and sexuality.** Jesus reiterated that in the beginning God had created Man and Women to be one flesh (have physical and sexual union), and that this was “good” (Matthew 19:4). In saying this Jesus was explicitly speaking out against divorce and the oppression of women in marriage, and endorsing the sacredness of the sexual relationship between man and woman – where it is monogamous, committed and mutual. In other passages (Matthew 5:27-28), Jesus

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1 PLWL – People Living With Leprosy.
condemns *lust* – that is, the desire to sexually possess someone to whom we are not bound in committed, mutual monogamy. But within this covenanted, mutual relationship, the Bible speaks of sexual-love as something glorious to be celebrated and enjoyed by both men and women (e.g. The Song of Songs). The Bible exalts this holy intimacy and sacred sexuality: it is a vital, God-given aspect of our humanity that the Church should be leading the way in discussing and celebrating, rather than talking about it in embarrassed whispers. Biblically then, there is every mandate for the church to be a place of open discussion concerning issues of human sexuality.

**Summary:** from the Scriptures we learn that Jesus is more concerned about God-glorifying compassionate responses to dis-ease than to attributing ethical/theological cause or blame. This is particularly true of his responses to the most marginalised members of his society; those who were excluded and regarded as “sinners” or as being “unclean”. Jesus was particularly counter-cultural in his treatment of women: he refused to lord power over them or exploit them, but honoured them as worthy of respect, time and ministry. Jesus endorsed sexual union and faithfulness within committed, monogamous heterosexual relationship as “good”, as being part of God’s intention for humanity. Human sexuality is a gift from God for pleasure (as well as procreation). The Bible celebrates this gift (Song of Songs). But the Church in general has handled the subject of sex with embarrassment and discomfort. This lack of frank discussion fuels the AIDS crisis by failing to offer forum for discussion, clear guidelines, role models or accountability for those (particularly the young) exploring their sexuality.

In these preceding two sections, we have laid down principles for a theological response to the HIV/AIDS crisis. We now move on to a more detailed discussion of applying these principles to concrete responses: namely, behaviour change and harm reduction strategies.

### 3. Towards an Understanding of Behaviour Change and Harm Reduction Strategies:

**(i) Behaviour Change Strategies.** The World Health Organisation, and indeed most health agencies involved in the HIV/AIDS crisis, promotes the *A, B, C, D strategy*. A for Abstinence; B for Be faithful; C for Condom use, and D for Don’t share needles. The A and B emphases are more to do with behaviour change, and the C and D with harm reduction (or damage limitation). Behaviour change strategies focus on increasing commitment to and the practice of abstinence (before marriage) and faithfulness (when married). Clearly, this strategy is completely compatible with Biblical theology and so sits most comfortably with Christian agencies involved in HIV/AIDS work. The Bible, continually calls us to conversion and transformation (Luke 15:1-7; Romans 12:1-2; 1 Corinthians 5:17). The effectiveness of this moral behaviour change approach is frequently credited for bringing about declines in HIV infection rates in Uganda (although condom promotion has also played a part there).
The danger with this approach is its potential superficiality, i.e. that we attempt to change behaviour without speaking to the individual and cultural values, beliefs, motivations, expectations and world-views underpinning them. Such an approach usually proves ineffective in the long run, and ignores Jesus’ counsel to first clean the inside of the dish before addressing the outside (Matthew 23:25-26). But when done well, behaviour change strategies are clearly the most effective long term solutions to the HIV/AIDS crisis, both for individuals and societies. Without behaviour change occurring, there is no hope for increasing the respect with which women and children are treated, the respect with which the marriage relationship is held, and the respect with which individuals will treat their own bodies. Christian’s involved in HIV/AIDS work should be at the forefront of quality behaviour change strategies which offer the opportunity for deep and abiding personal, relational and societal transformation.

(ii) Harm Reduction Strategies: By harm reduction strategies we mean programmes or interventions designed to mitigate or lessen the damage done by the behaviour (e.g. pre or extra-marital sex) the target population is engaging in. Providing clean needles to intravenous drug users or condoms to commercial sex workers are both examples of harm reduction strategies. The rationale is that the target population will, even under optimum conditions, not easily or immediately abandon the behaviour that is causing danger to both themselves and others. Even if a certain percentage of the target population do abandon the behaviour, probably not all will. And of those who change behaviour, it is probable that less than 100% of them will avoid a single remission.

A harm reduction strategy argues that those unable or unwilling to change behaviour because of physical, economic or social enslavement should not simply be abandoned to their fate, but should still be assisted towards the better life God desires for them, even if they have not yet come to a point of conversion or complete behaviour change. This strategy acknowledges that behaviour change is very often a step-wise progression, not necessarily a sudden and completed conversion. Often behaviour change is the final goal of such a program, but pragmatically it recognises that this may be a long process and in the mean time the potentially lethal damage the target population is doing to itself (and to those it interacts most intimately with) must be reduced. Not all drug addicts will immediately give up intravenous drug use upon being presented with alternative lifestyle options: but both compassion and common sense suggest that they and their families should be protected from the diseases that would be spread among

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4 And indeed, there is evidence emerging from the United States that the faith based programmes emphasising only abstinence from sex until marriage have not been successful in the long run. Though successful in delaying the age of first sexual act (which is an important goal), in the long run the rate of premarital pregnancy is the same for teenagers having been through this programme as it is for the general teenage population, while the rate of STD’s among this ‘abstinence group’ is actually higher than for the general teenage population. It appears that because the programme asks the participant to make an intentional commitment to celibacy before marriage, it successfully delays the age of first sexual act. But because the programme gives little or no information on how to protect against pregnancy or STD’s when the temptation becomes to strong and the sexual act does occur, these teenagers are very vulnerable. Thus, here is a strong argument for programmes that combine teaching on abstinence and faithfulness with accurate, appropriate information on contraception (especially condoms) and STD prevention. See Appendix One.
them by dirty needles. Not all sex workers will be physically able to leave this industry even after hearing of other options: but they and their families should be protected from the diseases that would spread among them if they did not have access to condoms. This is really a lesser of two evils argument. While providing clean needles or condoms might not be the activity Christians would wish to pursue in an ideal world, it is greatly preferable to watching HIV/AIDS being passed from person to person, and then watching the results as large numbers of people (often secondary victims) suffer and die.

A “judgement of God” theology might argue that individuals should be allowed to reap what they sow, to suffer the consequences of their choices. But very often there has been little room for choice for those forced into prostitution (particularly in the 2/3rds world and Eastern Europe) by their own families, by brute force, or by desperate poverty. And as we have already argued, Jesus response was always one of compassionate action rather than judgement. In many cases harm reduction intervention can be seen as a strategy of protection for societies weakest and most victimised.

Actually, by analogy we can see that harm reduction strategies are already common place in our societies, and most citizens (including Christians) would be horrified to see the associated target populations abandoned to their fates. For example diet books and diet aids exist for those who over-eat. Filters are attached to cigarettes to mitigate the effects of nicotine on smokers. In fact the quality of tobacco is monitored at all stages of production to lessen the effects of nicotine poisoning. Some Christians regard alcohol consumption as social evil, and certainly alcohol over-consumption does enormous damage to most of our communities. But again, alcohol quality is monitored to mitigate this effect. In pubs, laws exist to make sure alcohol is served in clean glasses to reduce the possibilities of other diseases being ingested along with the alcohol.

**Very few Christians would argue that over eaters, smokers, and heavy drinkers (and those close to them) should be completely abandoned to the consequences of their behaviours without any mitigation.** And in fact, this makes for good public health policy. Harm reduction strategies save money that would otherwise have to be spent on treating the worst unmitigated consequences. This is even more the case when an agency promotes condom use as part of its HIV/AIDS strategy. By reducing the potential number of infections, it reduces the potentially enormous amount of health spending that otherwise must be used to nurse these people. By promoting condoms, it also helps to protect the “innocent” – e.g. the faithful wife who will be infected by an unfaithful husband and the newborn child who will be infected pre or peri-natally by that mother.

There is a further protection or mitigation argument for employing harm reduction strategies. Jesus was “the friend of sinners” (Matthew 11:19), and calls us to be likewise. Would it be possible to call ourselves the friend of an I.V drug user or sex worker, and refuse to countenance any harm reduction strategy on their behalf? Do we have to choose between encouraging a friend to embrace life

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5 And, conversely, by preventing new cases of sickness ‘adds’ to the productive labour force and so bolsters local and national economies.
transformation through Jesus and giving them the means to preserve their earthly life if they remain unwilling to embrace this, or if they struggle to remain constant even after embracing it? Are these two strategies incompatible?\(^6\)

A further reason Christians often argue against harm reduction strategies is that they don’t want to sanction or facilitate the particular behaviour being practiced by providing, for example, clean needles or condoms (though we need to ask: does the provision of filters increase cigarette consumption? Does the provision of clean glasses increase alcohol consumption in a pub?). However, there is no empirical evidence to link increased I.V. drug use with increased clean needle provision, or increased prostitution with condom provision, for example. And it can be argued that it is much better for needles and condoms to be distributed by Christians, along with a message of possible transformation and hope, than by a secular agency which has only that single strategy.

A further reason for Christians to be involved in Harm Reduction programmes is a purely empirical one: they work. Indeed, there is substantial evidence that the 'abstinence only' youth programmes heavily promoted by the Bush administration in the U.S. (and around the world) have not been very effective at preventing STI's or unwanted pregnancies, especially when compared with more comprehensive programmes that included comprehensive sexual health and contraceptive information\(^7\).

**Summary:** We have argued here that harm reduction is a legitimate, though not ultimate strategy for us as Christians. *We should try and mitigate the destructive effects of sin on the world,* even on those caught up in sin. This is in character with Jesus “the friend of sinners”, who calls us to follow in his footsteps. We should be concerned for those trapped into harmful lifestyles by powers greater than themselves – for example, many young women and children are coerced and sold into prostitution rather than entering voluntarily. We should also be intensely concerned for the well being of secondary victims – the faithful wife (and her unborn child) married to a promiscuous or drug abusing man.

This will also lead Christians and the Church into **advocacy** work on behalf of the poor, the marginalised, and the powerless. The Scriptures call us to be a voice for the voiceless and to seek justice for the oppressed (Proverbs 29:7, 31:8-9; Isaiah

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\(^7\) "Despite the US federal government's 20-year support for abstinence-only-until-marriage programmes for American adolescents, there is no peer-reviewed research proving that these have had a positive impact on behaviour. Those advocating a broad-based sexual health promotion approach argue that programmes delivering a clear, sustained message of abstinence as one option alongside the use of condoms and other forms of contraception are the most effective in reducing risky behaviour among young people" ([www.eldis.org/hivaids/abstinence.htm](http://www.eldis.org/hivaids/abstinence.htm)).


1:15-17, 10:1-3; Mark 12:38-40). We are to do all in our power to influence Governments and others who hold powerful positions to pass laws and carry out policies which lift up the poor, protect the vulnerable and make possible the rehabilitation of the outcast.

**However, though harm reduction strategies are necessary, our ultimate strategy should be that of transformation:** that is, promoting behaviour change through the power of Christ crucified and risen from the dead. As Christians we should be pursuing and promoting behavior change at the deepest and most profound levels, change that touches people at the core of their values, beliefs, hopes, motivation and understanding of reality. Our ultimate goal is new men and new women, becoming more and more like Jesus and working to see their whole society transformed by the power of his Compassionate Love and healing Word.

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Appendix 1: (from www.eldis.org/hivaids/abstinence.htm)

**Abstinence only**
The most thorough evaluations of abstinence only programmes have been done on those in the United States. Several studies have shown some evidence of behavioural and attitude change as a result of these programmes. However, a recent review of evaluations of abstinence only programmes that claimed success concludes that, with the exception of the mass communications programme 'Not Me, Not Now', none of the evaluations produced credible evidence of effectiveness, and evidence from the Not me, Not Now' was limited as well.

However, two studies comparing abstinence only programmes with safer sex programmes conclude that the latter have better long term results, including higher levels of abstinence as well as increased condom use. Evidence from surveys conducted in Zimbabwe also suggests that unless young people receive full factual information, serious misconceptions and misunderstandings about abstinence may result, increasing the chance of risky sexual behaviour.

The role of abstinence in reducing HIV rates in Uganda is disputed. Data suggests that a combination of factors is responsible for the decline, rather than one single intervention approach. These factors include increased condom use, faithfulness and abstinence. **Recommended reading...**

**Broad-based sexual health programmes**
In developing countries, studies have shown that the impact on young people's behaviour has been stronger from programmes which combine abstinence, monogamy and information about safer sex. Safer sex education has a positive influence on reproductive health knowledge and attitudes and evidence shows that it can also lead to greater abstinence and decreased sexual activity.

However, an assessment of the effectiveness of 21 broad-based school programmes covering youth reproductive health and HIV/AIDS prevention concluded that HIV/STI (sexually transmitted infections) programmes had a greater impact on behaviour change than the other broad-based programmes. Constraints on the effectiveness of broad-based programmes included: lack of funding, lack of teacher training, low level of involvement by youth and parents, and the fact that the primary focus of the programmes was on older youths who were already sexually active. **Recommended reading...**

**Peer education**
Evidence from peer education programmes indicates that giving young people access to accurate information, as well as the opportunity to discuss sexual and reproductive health issues, can bring about changes in behaviour which lead to risk reduction. Evaluations of various programmes show improvements in student attitudes and knowledge about abstinence and condom use, as well as behavioural changes including increased contraceptive use and decreased sexual activity.

However, evidence from the US suggests that peer educators had no greater influence on young people than adult educators. Wider evidence also indicates that peer education programmes have not been cost effective or sustainable, and that their main impact has been on the peer educators themselves. **Recommended...**
Mass media HIV awareness and behaviour change
Health promotion campaigns conducted through mass media, such as radio, television, video, posters and magazines, have been shown to raise awareness of HIV risk and the importance of abstinence, faithfulness and condom use. There is evidence that mass media and social marketing campaigns have been most effective when combined with educational materials, sexual and reproductive health services, and interpersonal interventions. **Recommended reading...**

Youth development programmes
Pioneered in the United States, youth development programmes focus on helping young people build on their strengths and assets. Those programmes that combine a variety of strategies, including abstinence and contraceptive use, have been assessed as most promising for HIV prevention and reduction of teenage pregnancy. Key components of youth development programmes include:
- Involving adults and members of the community
- Building relationships with adults who can act as mentors
- Providing opportunities for young people to pursue their interests
- Engaging youth as active leaders and partners in the community
- Providing sexual health education.