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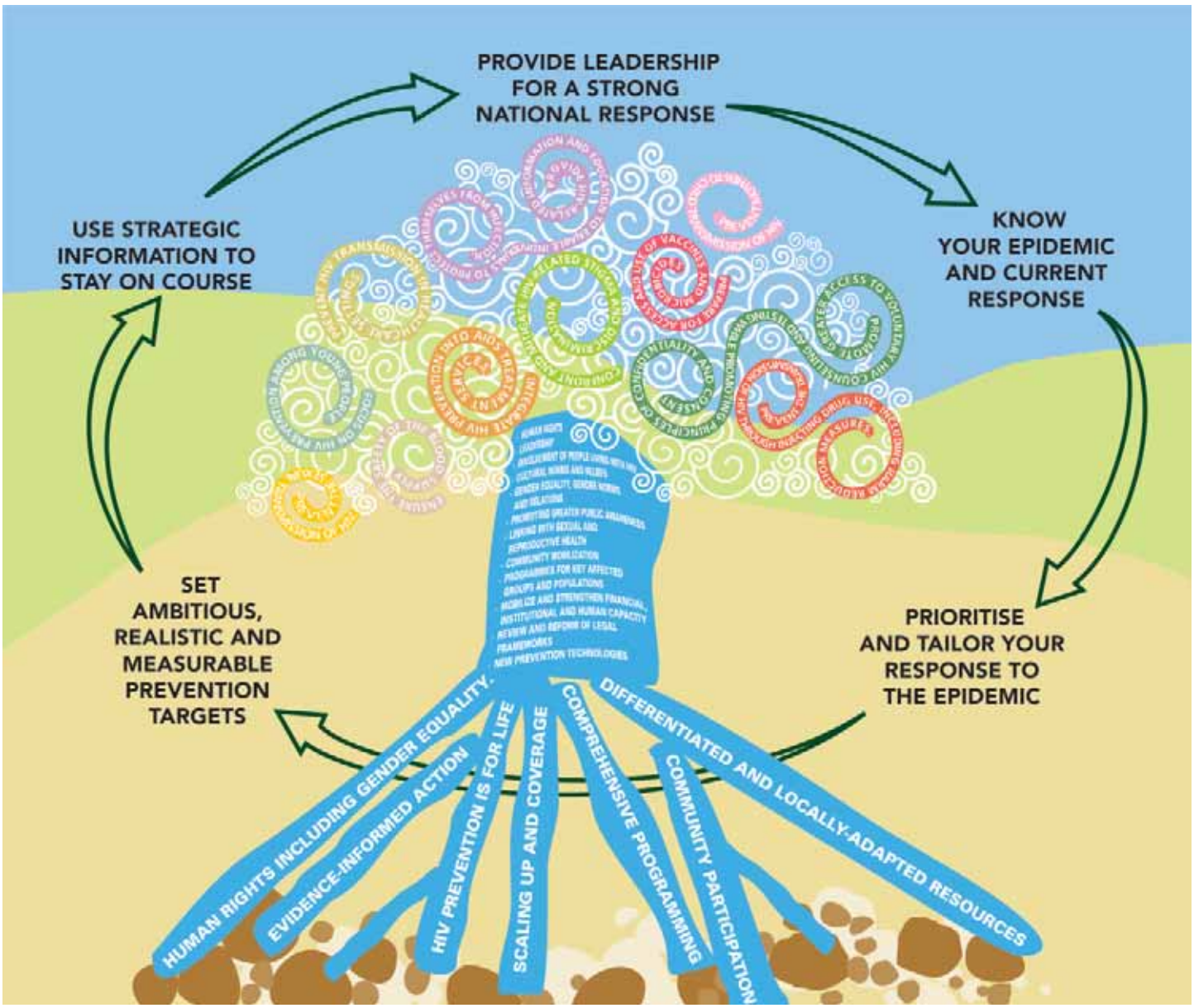
Practical Guidelines for Intensifying HIV Prevention

TOWARDS UNIVERSAL ACCESS



Uniting the world against **AIDS**

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UNAIDS, 20 avenue Appia
1211 Geneva 27, Switzerland
Telephone: (+41) 22 791 36 66
Fax: (+41) 22 791 4835
E-mail: distribution@unaids.org
Internet: http://www.unaids.org

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UNAIDS Practical Guidelines for Intensifying HIV Prevention

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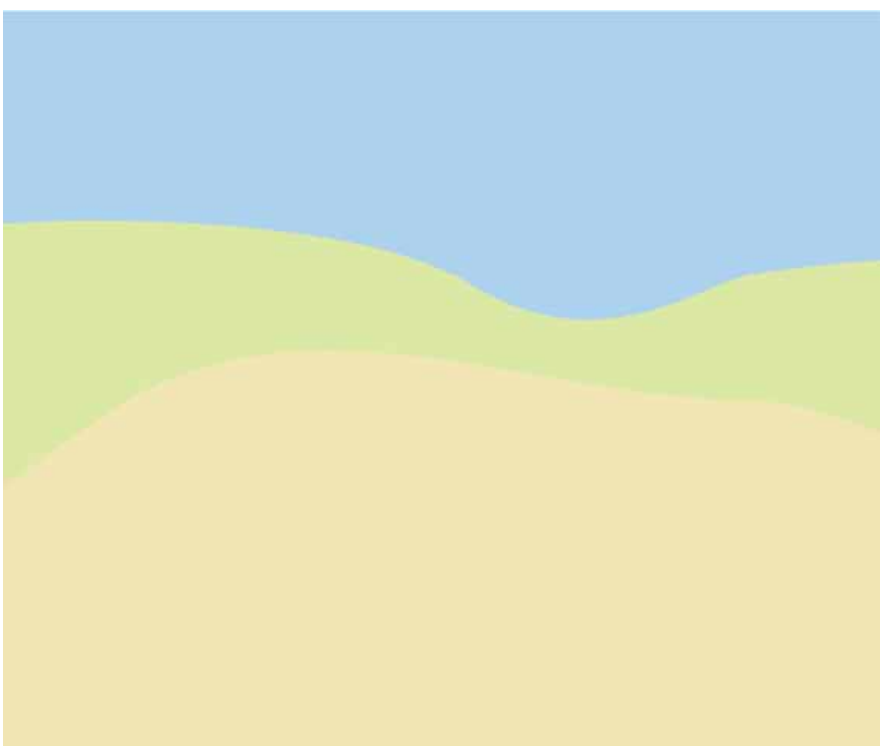

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EXECUTIVE SUMMARY

These *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access* are designed to provide policy makers and planners with practical guidance to tailor their national HIV prevention response so that they respond to the epidemic dynamics and social context of the country and populations who remain most vulnerable to and at risk of HIV infection. They have been developed in consultation with the UNAIDS cosponsors, international collaborating partners, government, civil society leaders and other experts. They build on *Intensifying HIV Prevention: UNAIDS Policy Position Paper and the UNAIDS Action Plan on Intensifying HIV Prevention.*

In 2006, governments committed themselves to scaling up HIV prevention and treatment responses to ensure universal access by 2010. While in the past five years treatment access has expanded rapidly, the number of new HIV infections has not decreased — estimated at 4.3 (3.6–6.6) million in 2006 — with many people unable to access prevention services to prevent HIV infection. These Guidelines recognize that to sustain the advances in antiretroviral treatment and to ensure true universal access requires that prevention services be scaled up simultaneously with treatment.

UNAIDS and WHO categorize HIV epidemics as low level, concentrated or generalized scenarios. For planning purposes these Guidelines propose an additional scenario—the hyperendemic scenario.

- **Low-level scenarios** are those with HIV prevalence levels of below 1% and where HIV has not spread to significant levels within any sub-population group.
- **Concentrated scenarios** are those where HIV prevalence is high in one or more sub-populations such as men who have sex with men, injecting drug users or sex workers and their clients, but the virus is not circulating in the general population.
- **Generalized scenarios** are those where HIV prevalence is between 1–15% in pregnant women attending antenatal clinics, indicating that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic.
- **Hyperendemic scenarios** refer to those areas where HIV prevalence exceeds 15% in the adult population driven through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use.

These *Guidelines* recognize that within countries and regions different epidemic scenarios may exist. They also recognize that an epidemic can evolve over time from a low-level scenario – to a concentrated scenario – to a generalized scenario and a hyperendemic scenario, or remain relatively stable or decline depending on the response and the underlying dynamics and drivers of the epidemic. Gender inequality and human rights violations are examples of two drivers that impede participation by vulnerable populations in sound and timely HIV prevention planning and access to prevention information and services and thus shape the course of the epidemic.

To ensure a more effective national HIV prevention response requires **strong, informed and committed leadership, coordination and accountability.** The National AIDS Authority — in line with the 'Three Ones Principles"— should lead the way in strengthening the national HIV prevention response ensuring that those most vulnerable to HIV infection and those living with HIV are meaningfully involved in this response. The level of involvement of specific

Kicosehp NGO, Kibera Community Self Help programme, Kenya. The largest slum area in Afica with over 1 million people. HIV incidence is very high, Kenya.Support group for people living with HIV. A social worker counselling on nutrition and how to balance a diet.

ministries, sectors, civil society and stakeholders will differ from epidemic scenario to epidemic scenario.

These *Guidelines* encourage countries to **"know your epidemic and your current response"**. To *know your epidemic* requires that countries identify the key drivers of the epidemic focusing on the relationship between the epidemiology of HIV infection and the behaviours and social conditions that impede their ability to access and use HIV information and services. Knowing your epidemic is the basis for *knowing your response* which provides countries with an opportunity to critically assess who is and who should be participating in HIV prevention.

Knowing your epidemic and response enables countries to **"match and prioritize your response"** by identifying, selecting and funding those HIV prevention measures that are most appropriate and effective for the country in relation to its specific epidemic scenario(s) and settings. Matching and prioritizing the response entails identifying those populations most-at-risk and vulnerable, gauging the extent to which new HIV infections are occurring within these populations and the extent to which they are consulted and engaged in tailoring the response for their communities. Engaging vulnerable populations is critical to an effective response, so too is ongoing analysis of what works, the costs and benefits of the different HIV prevention measures and their feasibility given the available human and financial resources.

Matching and prioritizing the response enables countries to **"set ambitious, realistic and measurable prevention targets"** in relation to their epidemic scenario. This entails defining the goals, outcomes, outputs and processes for HIV prevention services to be delivered to the peoples and places where they are most needed and to constantly measure and track whether they are achieving their objectives.

These *Guidelines* provide a synthesis of essential prevention measures required for countries to **"tailor your prevention plans"** in relation to the epidemic scenarios. Some measures are repeated in all scenarios whereas others are additional or modified from one scenario to another. They include a synthesis of the essential measures to meet the HIV prevention needs of specific populations or key audiences.

Strengthening the national response requires that countries **"utilize and analyse strategic information"** including epidemiological data, new evidence relating to the epidemic, policy and programmatic guidelines, tools, training materials and best practices. To be effective, programmes need to continually gather and use strategic information to track and report on progress and to ensure accountability through verifying the allocation, use and impact of AIDS spending.

These *Guidelines* provide building blocks aimed at supporting countries to prioritize, and sequence their investments to effectively scale up their national HIV prevention response. The fundamental recommendations underlying these guidelines are for countries to engage their leaders and communities to know their HIV epidemics, to match the prevention response to meet their priority needs, and to ensure a sustained and coordinated national response that scales-up towards universal access to prevention, treatment, care and support for all those in need.

INTRODUCTION

These *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access* are designed to provide policy makers and planners with practical guidance for improving HIV prevention programming and results. They have been developed through broad consultation with UNAIDS cosponsoring agencies, donors, government and civil society leaders and other experts. They build on *Intensifying HIV Prevention: UNAIDS Policy Position Paper*.

Recent improvements in providing access to antiretroviral treatment reinforce the importance of HIV prevention. In 2005, the number of people on antiretroviral treatment in low- and middle-income countries almost doubled, from 720 000 to 1.3 million *(47)*. In 2006, however, 4.3 (3.6 – 6.6) million additional people became infected with HIV. Universal access to treatment can only be achieved and sustained if the number of new HIV infections is significantly reduced through intensified HIV prevention.

Understanding what HIV prevention measures are likely to be effective and cost-effective in each setting is fundamental to this effort. Funding for HIV programmes in low- and middle-income countries has increased, but is still far short of what is required *(29)*. Prioritizing the HIV prevention measures that are likely to produce the greatest impact in each setting is essential to the overall effort to promote universal access to HIV prevention, treatment, care and support by 2010.

The UNAIDS *Policy Position Paper on Intensifying HIV Prevention* provides the basis for renewed emphasis on HIV prevention worldwide *(30)*. That paper recognizes that bold leadership actions are necessary to increase coverage[a] and bridge the prevention gap, through efforts to build on the synergies between prevention and treatment and to address barriers to scaling up. A comprehensive agenda of policy and programmatic actions defined in that paper stresses the need to address not only immediate risk, but also deep-rooted causes of vulnerability to HIV infection. Scaling up national HIV prevention efforts must emphasize both full access to proven and effective strategies for populations at higher risk *(26)* for investments to reduce vulnerability, impact and promote broader social change to reduce HIV

City centre open Mall, Gaborone, Botswana. Social workers doing prevention on the streets. They belong to COCEPWA (Coping Centre for people living with HIV/AIDS).

a) Coverage is sometimes defined as the percentage of the population needing a service that has access to the service. Access may depend on many things such as the proximity of the nearest service point, the schedule during the week when the service is available, the cost of the service and eligibility criteria that may be established by national guidelines or service providers. As a practical matter, it is often better to measure coverage in terms of utilization: the percentage of the population in need that actually uses the service. USAID/UNAIDS/WHO/UNICEF (2004). Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003. The POLICY Project, Washington, DC http://www.futuresgroup.com/Documents/CoverageSurveyReport.pdf

Box 1: Risk and vulnerability

Risk is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown; multiple unprotected sexual partnerships; injecting drug use with contaminated needles and syringes. **Vulnerability** results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include: (i) personal factors such as the lack of knowledge and skills required to protect oneself and others; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost and other factors (iii) societal factors such as social and cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations, and act as barriers to essential HIV prevention messages. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV.

Source: Adapted from UNAIDS (1998). Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathways. Geneva.

Boys and girls selling food to travellers at a bus stop, Accra, Ghana.

AUDIENCE AND APPLICATION

These *Guidelines* do not provide a "blueprint" for HIV prevention efforts in every country. Instead, they are designed to guide national planners through an ongoing process of defining local vulnerabilities and needs and channelling resources and efforts through the development and implementation of evidence-informed HIV prevention programming, at national, state, provincial or district levels (See Box 2). These *Guidelines* can also be useful in reviews of existing HIV strategies, including strategies for resource allocation, mobilization and tracking, to ensure that essential HIV prevention measures are funded and implemented where they are most needed.

Given the scale of the HIV epidemic and its interrelationships with vulnerability (See Box 1). Both are essential to producing a lasting and meaningful impact.

Improving the effectiveness of efforts to contain and reverse the spread of HIV requires that planners:

- identify populations at higher risk of HIV infection;
- define what prevention measures are essential for these populations;
- ensure adequate delivery of essential prevention measures to the identified populations; and
- act on the drivers of the epidemic, including harmful social norms and laws, gender inequality and neglect of human rights.

other human development problems *(26)*, planning for intensifying prevention must be coordinated and integrated not only within a comprehensive AIDS action framework, but also within other national development processes and frameworks.

Whenever possible, HIV prevention efforts should be planned and integrated with treatment, care and support as part of a comprehensive approach to provide a coordinated mutually reinforcing information and services.

Box 2: Resources for designing and managing national HIV strategic plans

UNAIDS and other partners have developed a range of guidelines, tools and strategies to assist countries in designing and managing a prioritized, costed and funded, national HIV strategic plan (see Annex 2). These include guidelines to help countries in:

- engaging partners, including civil society;
- strategic planning, including planning for increased human and institutional capacity;
- setting strategic and operational targets;
- costing national strategic plans or annual work plans;
- tracking and analysing expenditures;
- monitoring programme implementation and results;
- evaluating project and programme effectiveness;
- communicating and sharing results with stakeholders; and
- using the results to improve programme coverage, equity and effectiveness.

RATIONALE FOR PRIORITIZATION

In every national and sub-national situation, there are prevention investments that will be more effective at reducing HIV infection than others. "Knowing your epidemic" in a particular region or country is the first, essential step in identifying, selecting and funding the most appropriate and effective HIV prevention measures for that country or region. Some prevention investments can be implemented relatively quickly and can have a rapid impact on the epidemic. Others, including those that address cultural, structural and institutional determinants of vulnerability, are equally important but may require more time to achieve change. Those longer-term investments are essential, however. Without them, the HIV epidemic cannot be successfully contained and reversed, as factors that drive vulnerability will remain in place.

Migrants, Beijing, China.

The programme for HIV prevention in Kiev, Ukraine. Some IDUs having exchanged a syringe for a new one, use it and return in an hour for another one.

No single prevention measure or approach will effectively serve the varied populations in need in any country. As resources are limited, it is essential that strategic information (See Box 3) be used to guide assistance towards populations and settings where HIV transmission occurs and which contribute most to the epidemic. Government services should prioritize those in need who are also least able to control their own risk or to secure information and services for themselves *(28, 38)*—such as those made most vulnerable through social marginalization, poverty, gender, age and other locally relevant factors.

Measures to reduce the behaviours that put people at immediate risk of HIV infection—such as unprotected sex and using non-sterile injecting equipment— should be combined with appropriate measures and efforts to define and mitigate the drivers of the epidemic (see Box 7). Mitigating the drivers of the epidemic requires action that addresses gender inequality and ensures that the human rights of all people—in particular women and children —are respected *(9)*. Failure to invest in measures that mitigate the drivers of the epidemic can undermine the use of prevention services and result in lost opportunities to prevent new HIV infections.

Box 3: Strategic information

Strategic information is information on the epidemic and its drivers which can inform and support sound programmatic and policy decision-making to achieve programme goals. Sources of strategic information include:

- **surveillance and research** to define the epidemiological, behavioural situation and context, the populations, geographic locations, and risk settings most in need of HIV services;
- **policy and programme documents** that describe and analyse the national political context and response and the response capacity of communities, the private and public sectors;
- **analysis of existing research and programmatic data**;
- **stakeholder consultations** such as meetings with people living with HIV and with members of marginalized groups; and
- **monitoring and evaluation** reports from existing programmes and services.

In collaboration with countries UNAIDS has developed a number of tools and guidelines to assist countries in strengthening their HIV strategic information systems, and to establish standard indicators to measure the impact of essential measures for HIV prevention, AIDS treatment, care and support (See page 38 and Annex 2).

PREVENTION: A VITAL COMPONENT OF UNIVERSAL ACCESS

GLOBAL COMMITMENT TO UNIVERSAL ACCESS

Governments have made a series of international commitments to improve the AIDS response, with the ultimate objective of moving towards universal access to comprehensive prevention, treatment, care and support by 2010 *(43)*. These include the Millennium Development Goal 6 to halt and reverse the spread of the epidemic by 2015, the 2001 United Nations General Assembly Declaration of Commitment on HIV/AIDS, the 2005 Gleneagles G8 Universal Access Targets, and the African Union's 2006 Abuja Call for Accelerated Action and, most recently, the 2006 United Nations Political Declaration on HIV/AIDS.

Box 4: 2006 Political Declaration on HIV/AIDS

Therefore, we:
"Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most-affected communities, civil society and the private sector, **towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010."**

PLANNING FOR HIV PREVENTION WITHIN THE NATIONAL COMPREHENSIVE RESPONSE

Intensifying HIV prevention requires adequate attention and allocation of resources within the scaled-up and comprehensive AIDS response, as well as the identification of opportunities for integrating efforts in the activities of multiple sectors. Integration can, for example, include:

- expanding access to HIV testing and risk reduction counselling;
- HIV prevention, including prevention of mother-to-child transmission, in more health-care settings;
- HIV prevention as part of a package of sexual and reproductive health services for women and men;
- expanding access to legal and social support;
- ensuring implementation of human rights programmes including policies of zero tolerance for sexual violence, and legal reform that protects the rights of people living with HIV and vulnerable populations.
- sensitizing legislators, the judiciary and other key influencing bodies on HIV-related vulnerability and gender concerns;

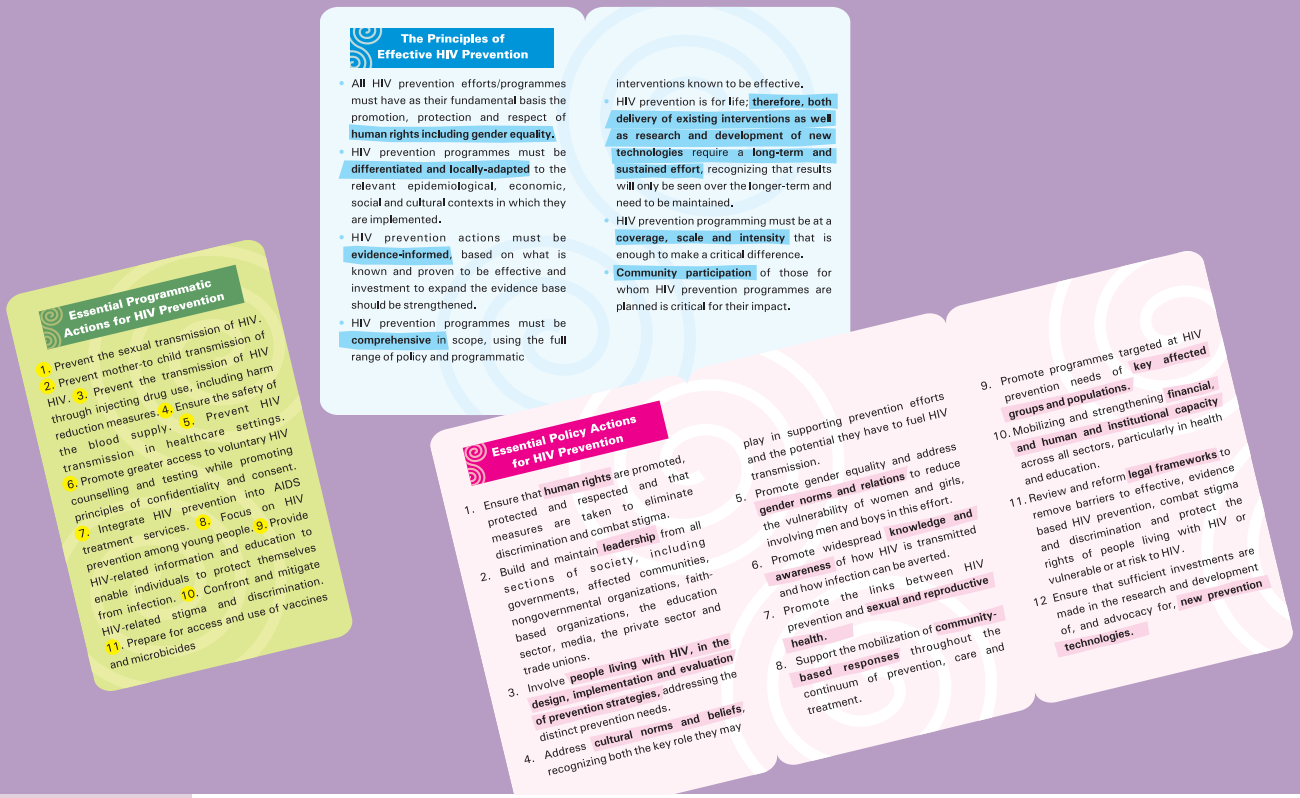
HIV test in a Vaccination and HIV testing center. Government of Vietnam, Hanoi.

- campaigns against stigma and discrimination, harmful gender norms, violence against women and intergenerational sex;
- ensuring access to education for all children, through the elimination of school fees or other means; and
- requiring industry and commerce to implement HIV workplace-based policies and programmes.

GUIDING PRINCIPLES FOR INTENSIFYING PREVENTION

The UNAIDS *Policy Position Paper: Intensifying HIV Prevention*, provides specific recommendations for intensifying prevention within the comprehensive national response to AIDS (Box 5). It was unanimously endorsed by the UNAIDS Programme Coordinating Board in 2005. The Policy Paper and its endorsement by the Board reaffirmed the global commitment to locally owned and adapted, comprehensive and evidence based HIV prevention strategies founded on respect for human rights.

Box 5: Key recommendations from the UNAIDS Policy Position Paper on Intensifying HIV Prevention



The Principles of Effective HIV Prevention

- All HIV prevention efforts/programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality.
- HIV prevention programmes must be differentiated and locally-adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented.
- HIV prevention actions must be evidence-informed, based on what is known and proven to be effective and investment to expand the evidence base should be strengthened.
- HIV prevention programmes must be comprehensive in scope, using the full range of policy and programmatic interventions known to be effective.
- HIV prevention is for life; therefore, both delivery of existing interventions as well as research and development of new technologies require a long-term and sustained effort, recognizing that results will only be seen over the longer-term and need to be maintained.
- HIV prevention programming must be at a coverage, scale and intensity that is enough to make a critical difference.
- Community participation of those for whom HIV prevention programmes are planned is critical for their impact.

Essential Programmatic Actions for HIV Prevention

1. Prevent the sexual transmission of HIV.
2. Prevent mother-to child transmission of HIV.
3. Prevent the transmission of HIV through injecting drug use, including harm reduction measures.
4. Ensure the safety of the blood supply.
5. Prevent HIV transmission in healthcare settings.
6. Promote greater access to voluntary HIV counselling and testing while promoting principles of confidentiality and consent.
7. Integrate HIV prevention into AIDS treatment services.
8. Focus on HIV prevention among young people.
9. Provide HIV-related information and education to enable individuals to protect themselves from infection.
10. Confront and mitigate HIV-related stigma and discrimination.
11. Prepare for access and use of vaccines and microbicides

Essential Policy Actions for HIV Prevention

1. Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate discrimination and combat stigma.
2. Build and maintain leadership from all sections of society, including governments, affected communities, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions.
3. Involve people living with HIV, in the design, implementation and evaluation of prevention strategies, addressing the distinct prevention needs.
4. Address cultural norms and beliefs, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission.
5. Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls, involving men and boys in this effort.
6. Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted.
7. Promote the links between HIV prevention and sexual and reproductive health.
8. Support the mobilization of community-based responses throughout the continuum of prevention, care and treatment.
9. Promote programmes targeted at HIV prevention needs of key affected groups and populations.
10. Mobilizing and strengthening financial, and human and institutional capacity across all sectors, particularly in health and education.
11. Review and reform legal frameworks to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV.
12. Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies.

LEADERSHIP FOR A STRONGER NATIONAL HIV PREVENTION RESPONSE

The National AIDS Authority — guided by the principles of "The Three Ones[b]"—should ensure that there is active leadership, coordination and accountability for effective HIV prevention across the many partners and sectors of the national AIDS response. This may be done, for example, through the establishment of a national HIV prevention task force or other coordinating entity under the umbrella of the National AIDS Authority. Such a coordinating entity, however, should always include the participation of the government departments and civil society partners that are critical to ensuring health, human rights and social protection.

The critical ministries and partners to involve will vary according to the epidemic and context. In countries with low-level or concentrated epidemics, such as in North Africa and Eastern Europe, ministries of justice and prisons could play an important role in prevention efforts. In regions with generalized HIV epidemics, such as those in East Africa and the Caribbean, ministries of tourism, justice and gender may have greater relevance. In the high prevalence countries of southern Africa, education, social welfare, local government and defence must be at the centre of the response. In all cases, the active involvement and participation of communities and people living with HIV are essential *(38)*.

Box 6: Possible roles and responsibilities of the National AIDS Authority for HIV prevention leadership

- Provide overall leadership and advocacy for HIV prevention;
- Coordinate various actions on HIV prevention and integrate with treatment, care and support elements of the national AIDS strategy;
- Create platforms for policy debate on HIV prevention;
- Build a vocal constituency for HIV prevention;
- Monitor and evaluate HIV prevention programmes within the overall AIDS response;
- Support resource mobilization and capacity building of the National AIDS Authority to scale up HIV prevention;
- Coordinate inputs around HIV prevention for national AIDS and development planning;
- Assess response capacity within each ministry and civil society sector and identify measures to strengthen capacity;
- Analyse human resource, legal and social protection needs and identify measures to build human resources and scale up legal and social protection services; and
- Analyse the extent to which each sector contributes to reducing HIV vulnerability and identify measures of vulnerability reduction.

b) The "Three Ones" principles are:
- *One agreed AIDS action framework that provides the basis for coordinating the work of all partners;*
- *One national AIDS coordinating authority, with a broad-based multisectoral mandate; and*
- *One agreed country-level monitoring and evaluation system.*

KNOW YOUR EPIDEMIC AND YOUR CURRENT RESPONSE

THE DRIVERS OF THE HIV EPIDEMIC

Risk behaviours and vulnerabilities are enmeshed in complex webs of economic, legal, political, cultural and psychosocial determinants[c] that must be analysed and addressed at the policy and programme levels. Effective HIV prevention programming focuses on the critical relationships between the epidemiology of HIV infection, the risk behaviours that transmit HIV and the cultural, institutional and structural factors that aid or impede peoples' abilities to access and use HIV information and services, and can thus make them more or less vulnerable to HIV infection (Box 7).

Box 7: Drivers and risk factors

The term *driver* relates to the structural and social factors, such as poverty, gender inequality and human rights violations that are not easily measured that increase people's vulnerability to HIV infection. Risk factors are defined by the Dictionary of Epidemiology, 3rd edition as "an aspect of personal behaviour or life-style, an environmental exposure, or an inborn or inherited characteristic, which on the basis of epidemiologic evidence is known to be associated with health-related condition(s) considered important to prevent". These include behaviours such as injecting drug use, unprotected casual sex, and multiple concurrent long term partners with low and inconsistent condom use[d].

Source: Last J (ed). (1995). A dictionary of epidemiology, 3rd edition. Oxford University Press.

VULNERABLE POPULATIONS MOST IN NEED

An effective national response provides adequate HIV prevention information, services, and support to those populations most vulnerable and likely to be exposed to and critical to the dynamics of the epidemic and the response *(2, 14, 20)*.

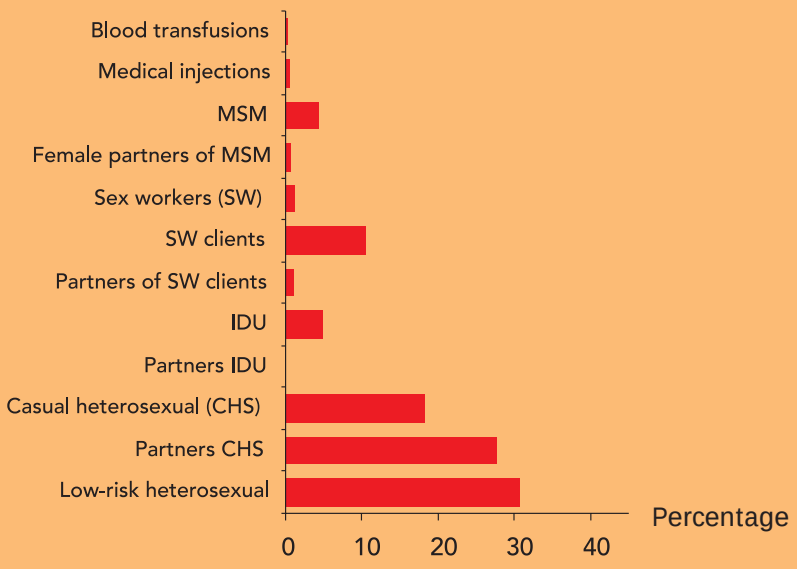
Epidemiologically as well as socioculturally important settings are locations where risk behaviours are frequent and/or promoted (for example, urban districts or roadside truck stops associated with adult entertainment and sex work, "shooting galleries" for injecting drug users, or bath houses that cater to casual sex between men) and where people most-at-risk can be reached.

A grocery store. Beijing, China.

c) See, for example, Sweat MD, Denison JA (1995). Reducing HIV incidence in developing countries with structural and environmental interventions. AIDS, 9 (Suppl A):S251–S257; Barnett T, Whiteside A (2002). AIDS in the 21st Century: disease and globalisation. Palgrave Global Publishing, Houndsmill, UK; Pisani E et al. (2003). Back to basics in HIV prevention: focus on exposure. BMJ 326:1384-1387, doi:10.1136/bmj.326.7403.1384 http://bmj.bmjjournals.com/cgi/content/full/326/7403/1384.
d) Recently the term driver is also used to describe those risk factors which are so widespread as to account for the increase and maintenance of an HIV epidemic at the population level.

Knowing the extent of HIV in various populations is key, as risk behaviours can only transmit HIV if the virus is present in the first place *(21)*. These populations can be identified through "second generation surveillance" *(53)* including national and subnational surveys, rapid assessments *(24)*, participatory mapping of the HIV response to date and consultation with vulnerable populations and service providers[e]. These studies assist in determining new HIV infection rates, modes of transmission and the socio-economic and cultural contexts that increase people's vulnerability to HIV infection.

Box 8: Studying the source of new infections in Kenya to improve the focus of prevention



Kenya's prevention programme has long defined its epidemic as generalized, based on previous 2nd generation HIV surveillance, which demonstrated that since the late 1980s, Kenya has had more than 1% HIV prevalence in the general population in most parts of the country. A recent analysis, however, identified some data that could significantly improve the focusing of the prevention effort. This study showed that most new infections occur in populations usually defined as 'low risk', such as cohabitating couples, pointing to the specific need to address prevention resources to serodiscordant couples. The data showed that programmes that result in reducing the number of partners (for example, HIV counselling and testing, promotion of abstinence, fidelity and avoidance of concurrent sexual partnerships) and in making casual sex safer (condom use) should be a priority. The data also showed that, although Kenya's epidemic is 'generalized', sex workers and their clients remain an important group on which to focus prevention, as well as treatment, care and support services. The study identified that injecting drug users and men who have sex with men should receive attention in Kenya, populations not previously recognized. In addition, the analysis indicated the importance of focusing on the sexually active population as expected in a generalized epidemic.

Source: Gouws E et al. (2006). Short term estimates of adult HIV incidence by mode of transmission: Kenya and Thailand as examples. Sexually Transmitted Infections, 82 (Suppl. 3): iii51 – iii55. doi:10.1136/sti.2006.020164

e) One methodology is the Priorities for Local AIDS Control Efforts, or PLACE method. see Measure Evaluation (2005) PLACE, priorities for local AIDS control efforts: a manual for implementing the PLACE method. Carolina Population Center, Chapel Hill, and see http://www.cpc.unc.edu/measure/leadership/place.html

In most situations, a combination of social vulnerabilities, biological and behavioural factors place the following groups at differentially higher risk of acquiring and/or transmitting HIV:

- sex workers and their clients;
- injecting drug users;
- men who have sex with men; and
- incarcerated people (prisoners).

Other populations, such as people with sexually transmitted infections, mobile or migrant workers who endure long periods of spousal or partner separation, uniformed services personnel and ethnic or cultural minorities may also be exposed to HIV at a significant level, depending on the local situation[f]. Broad social norms are equally important to consider, particularly in hyperendemic scenarios (described later) and make young people and women and girls particularly vulnerable due to factors such as gender inequality, restricted access to information and services and lack of decision-making skills and power. In many settings with long-standing epidemics, married women and girls are at elevated risk *(39)*.

Effective HIV prevention programmes prioritize those most affected by and those most vulnerable to HIV infection. This is not only the right thing to do in terms of protecting the human rights of all members of society: it is also the best way to prevent HIV.

The coercive approach to HIV prevention has been rejected as ineffective and abusive. Such approaches include mandatory HIV testing, restriction of movement and criminalization of harm reduction measures and HIV prevention modalities. These tend to drive individuals away from health information and services, have an adverse effect on prevention goals, and violate human rights. Effective HIV prevention measures are those that emphasize human dignity, responsibility, agency, and empowerment through access to health information, services and community support and participation *(30)*.

Effective programmes create an enabling environment through the adoption and implementation of non-discriminatory and vulnerability reducing-laws and policies. This also ensures that HIV prevention efforts do not characterize any group as “vectors of the disease”, do not single out populations for blame and persecution and do not marginalize or stigmatize them. Instead, people living with HIV should be seen as vital partners in HIV prevention efforts *(36)*.

A typical urban brothel behind the Intercontinental Hotel, Phnom Penh. Cambodia.

f) For a detailed discussion of vulnerability and the settings that intensify and mitigate risk, see UNAIDS (2006), Chapter 5. At risk and neglected: four key populations in Report on the global AIDS epidemic. Joint United Nations Programme on HIV/AIDS, Geneva.

EPIDEMIOLOGICAL SCENARIOS

For the purpose of epidemiological surveillance, UNAIDS and WHO have categorized the HIV epidemics in different countries broadly as **"low level", "concentrated," or "generalized"**. The typology is based on the extent to which HIV infection is present and spreading in the population as a whole (the "general population") and on the level of HIV in sub-populations that are most vulnerable and at risk of exposure to — and transmission of — the virus.

For HIV programme planning purposes, an additional scenario — **"hyperendemic"** — is required. This term describes a situation in which HIV is established in the general population, yet differences in both the *level* (the prevalence) and the *drivers and risk factors* of the epidemic (the behavioural patterns that account for epidemic spread and the social, cultural, economic and policy conditions that support those behavioural patterns) require additional strategies for effective HIV prevention.

Beyond national HIV prevalence

It is important to note that epidemic levels within a particular country or region may vary by population or geography. In some settings—including a few provinces of China and some states in India and in Moldova, Myanmar, Thailand and Ukraine—prevalence of more than 5% is found in most-at-risk populations and prevalence is between 1% and 5% in pregnant women in antenatal clinics. In concentrated epidemic scenarios such as these, most vulnerable populations still contribute an important proportion of new infections, but there are also varying and sometimes considerable levels of HIV spread in the larger population through sexual networking *(19)*. Knowledge of these variations is essential to planning the right mix of prevention measures to effectively address HIV spread among different populations and/or in different parts of the country.

Most countries have geographical and regional variations in their HIV epidemics and experience a mix of epidemic scenarios across the country, often with higher prevalence and more new infections in urban areas and settings such as around transport junctions, mines, migrant labour camps and barracks of uniformed services. Epidemics can also evolve from low-level to concentrated and

A meeting with the youth at one of the Red Crescent Society in a suburb of Cairo. On the board drawings show what transmits HIV and what does not.

from mixed to generalized and hyperendemic over time, or they may decline or remain stable with relatively low prevalence levels, depending on the prevention response and on the underlying dynamics of transmission *(2)*. Ongoing collection and analysis of strategic information (see Box 3 page 6) to assess the epidemic situation and the local response is crucial to understand the current and evolving realities of the local epidemic and adjust appropriate HIV prevention strategies and programmes accordingly. While data from national estimates of HIV prevalence in the general and most-at-risk populations are valuable for both scaling up and analysing prevention needs, planners should not overlook the need for careful analysis of local patterns that underlie the dynamics and social conditions that shape the current epidemiology, as these will help planners understand where the epidemic is going next and what needs to be done in response.

Low-level scenarios

In low-level scenarios, HIV has not spread to significant levels in any sub-population. The low-level epidemic suggests either that networks of risk are diffuse (with low levels of partner exchange or use of non-sterile injecting equipment), or that the virus has been introduced only very recently. Fiji at 0.1 [0.0–0.4]%, and Turkey at [<0.2%] are examples of countries that currently have low-level scenarios *(29)*. In low-level epidemic situations, basic information about the most vulnerable and at-risk populations is needed and must be collected in an ethically sound manner *(31)*. Empirical study of risk behaviours, networks and other factors indicating the potential for HIV spread, such as rates of other sexually transmitted infections is essential for prevention planning. Knowing your epidemic entails knowing why HIV is spreading, or why it is not.

Health promotion. Women's group during meetings. Upper Egypt.

Concentrated scenarios

In concentrated scenarios, HIV prevalence is high enough in one or more sub-populations, such as men who have sex with men, injecting drug users or sex workers and their clients to maintain the epidemic in that sub-population *(2)*, but the virus is not circulating in the general population. Buenos Aires, Argentina, provides an example of a concentrated epidemic where the prevalence in men who have sex with men is more than 15% and in sex workers is more than 5%, but the national prevalence in the adult population aged 15–49 years remains low at 0.6 [0.3-1.9]%. The future course of an epidemic of this type will be determined by the size of the vulnerable sub-population[s] and the frequency and nature of links between sub-populations and the general population and the degree of responding to the needs of the affected and most vulnerable populations. Spread of HIV can be explosive in settings with injecting drug use *(15)*. Knowing your epidemic requires understanding the dynamics of HIV transmission within affected populations and how those groups interact with other groups and the population as a whole. This is a high priority so that countries can prevent the expansion of the epidemic into the general population.

Generalized scenarios

A number of countries now consistently report an HIV prevalence of between 1–5% in pregnant women attending antenatal clinics, indicating that the presence of HIV among the general population is sufficient for sexual networking to drive the epidemic. In these epidemic scenarios, HIV transmission in serodiscordant couples and multiple partner relationships that give rise to sexual networks in the general population — account for the majority of new infections. Most-at-risk populations such as sex workers and their clients are still at risk of HIV infection. However, the behaviours of very large sub-populations, with relatively low risk (such as unmarried young people, and married women and men who do not regularly visit sex workers or have multiple partners) contribute to the larger proportion of new infections. In a generalized epidemic with more than 5% adult prevalence, no sexually active person is “low risk”.

In some parts of Africa, there is research evidence on sexual networks which shows that longer-term multiple concurrent partnerships intensify the epidemic *(19)*. Broad social norms that lead to multiple sexual partner relations and/or norms and policies that prevent individuals or populations from protecting themselves (for example gender norms that lessen girls’ access to education and information), are directly implicated in the epidemic dynamics.

With adult prevalence over 5% in countries such as Cameroon 5.4% [4.9–5.9%] and Uganda 6.7% [5.7–7.6%] *(29)* the majority of sexually active people may be at elevated risk. As more women are living with HIV, a significant number of new infections are from mother-to-child transmission *(54)*.

Hyperendemic scenarios

An exceptional epidemiological situation exists in the southern African Region, where very large numbers of people — over half of them women and girls—are living with HIV. HIV has spread to a level above 15% in the adult population, through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use. All sexually active persons have an elevated risk of HIV infection. The drivers and risk factors of this predominantly heterosexual epidemic are complex and diverse, but may include behaviours such as early sexual debut, high levels of longer-term multiple concurrent sexual partnerships—especially for men, intergenerational sex, gaps in consistent condom use with casual and longer-term partners, low acceptability of condom use in cohabiting couples and biological co-factors such as low levels of male circumcision and the presence of sexually transmitted infections especially viral infections which are difficult to treat *(23)*. High levels of HIV-related stigma, gender based violence, including sexual coercion and violence in marriage, gender inequality and geographic mobility result in rapid and continuing spread of HIV in the general population, leading to and maintaining very high prevalence. Stigma may also lead many individuals to avoid risk reduction behaviours (e.g. abstinence, partner limitation, disclosure of status to sexual partners if known, correct condom use) because of the association of these behaviours with being HIV positive.

HIV prevalence in Swaziland is 33.4% [21.2–45.3%]; Botswana, 24.1% [23.0–32%]; South Africa, 18.1% [16.8–20.7%]; Zimbabwe, 20.1% [13.3–27.6%] *(29)* and other adjacent countries in southern Africa have hyperendemic epidemics that require exceptional effort and resources to mobilize entire communities to change sexual behaviours as well as social norms. It is important to remember that there is still significant geographic variation in HIV prevalence within these countries.

FOCUS ON NEW INFECTIONS

The collection and analysis of data, to assess the epidemic situation and the local response should be ongoing. More important than the "type of scenario" is keeping up to date on the sources of new infections, as this can change in ways that should be reflected in the national and subnational prevention programme. For example, modelling incidence data from Cambodia showed that—in addition to a dramatic decline in the level of new infections in the late 1990s—infections in married couples replaced infections due to unprotected sex with sex workers as the largest source of new infections *(5)*. Box 8 (see page 11) provides another example from Kenya, illustrating changing prevention needs with changing scenarios.

MATCH YOUR RESPONSE TO THE EPIDEMIC

Priorities for HIV prevention planning should be set by analysing and identifying the actual gaps between the locations, scale and needs of the priority populations and the efforts that are currently under way to address these. This kind of information is increasingly gathered and held by the National AIDS Authority in databases that reflect who is doing what where[g]. Delivering an effective, comprehensive response requires collaboration and coordination among many partners – government, non-governmental organizations (NGOs), civil society, community groups, faith-based organizations, the private sector, labour unions and others. Neither governmental nor non-governmental entity is equally capable of providing all the needed HIV measures to all key audiences. All stakeholder efforts are needed and still need to be coordinated to align their efforts to accomplish the national HIV plan, and shortages of trained HIV prevention personnel are nearly universal. Capacity building to fill these gaps, within a 1–5 year time frame, is a crucial part of HIV prevention planning.

CRITERIA FOR PRIORITIZING OR PHASING-IN HIV PREVENTION ELEMENTS

Intensifying HIV prevention requires planning that considers both the scope of the HIV prevention measures (the number of different elements delivered) and the scale (intensity[h] and coverage) that can be achieved with the available resources. Choices should be justified by objective criteria based on equality and need, and have broad-based consensus and support from government, civil society and affected communities. The following illustrate criteria that can assist in this crucial step of planning.

Epidemiology

To have an impact on HIV incidence and prevalence, *programme efforts must be directed to the appropriate populations and behaviours, in the appropriate locations or settings.* There are three critical considerations.

Ponlue Chivit's (light of life) HIV-positive support group meeting. There are a total of 75 members, 24 women and 51 men. Since the club started, there hasn't been a month they didn't lose at least one member. Phnom Penh. Cambodia

g) The Country Response Information System version 2.1.2 contains indicator, project, and research modules. The project modules provide basic functionality to track who is doing what where in a country. Version 3.0, expected in the summer of 2007, will be even more project/programme-orientated to better support country M&E needs and donor reporting requirements reflecting an increasing sophistication in the analyses being done. For example, it will be possible to define multiple programme indicators in addition to tracking financial information.

h) Intensity refers to optimal duration and dose (quantity) of programmes. In biomedical interventions the notion is clearly defined, such as the dosages required in effective prevention of mother–to-child transmission or in methadone substitution treatment. In behavioural interventions, examples of intensity include regularity of outreach contact or attendance in a drop-in centre, in numbers and duration of counselling or peer education sessions.

- **Where, among whom and why are HIV infections happening now?** What are the populations with high HIV prevalence, where are those populations being exposed to HIV, what are the risk behaviours, what are the high-risk situations and what factors limit the ability of those who are vulnerable to reduce their risk behaviours?

- **How fast are infections moving?** HIV may move through a "network" of exposures (For example, from client to sex worker, who may then infect other clients, who transmit the virus to their regular partners). In hyperendemic situations, recent studies indicate that exceptionally rapid and extensive spread can occur through heterosexual networks when many adults have long term, concurrent (versus sequential) sexual partnerships *(23)*. In Malawi, for example, a recent study found that among some 1000 adult villagers whose sexual relationships were mapped over a two year period, some 65% were connected in the same sexual network *(10)*.

- **What are the drivers of the epidemic?** Apart from risk behaviours, what are the sociocultural and policy factors which act as drivers of the epidemic? Factors such as gender inequality, low access to information and services, or lack of sexual autonomy and power of decision-making contribute to higher rates of HIV among women, girls and young people. Discrimination against men who have sex with men is likely to impede scaling-up of programmes for men who have sex with men. The interaction of socioeconomic, behavioural and epidemiological factors and community responses can both accelerate the spread of the epidemic and slow it down. These factors need to be understood in terms of the direction and extent of their impact.

A street market in northern Cambodia.

Evidence of effectiveness, cost effectiveness and cost benefit

Evidence *(22,15)* of the effectiveness of HIV prevention measures is an important criterion that should inform and guide prioritization and HIV prevention planning. Evidence from scientific research can help planners establish priorities for action on HIV prevention by:

- demonstrating how the HIV prevention measure under consideration has achieved the required results in similar epidemics;
- providing conceptual models of how and why a service is supposed to

work, which can then be evaluated in light of the setting for which the HIV prevention measure is being considered;
- providing estimates of the results (outcomes) that can be expected for a given level of investment (inputs). Some measures (such as correct and consistent condom use) have a direct impact on HIV transmission and very high efficacy if practised. The effects of other actions, such as campaigns against sexual violence and coercion go beyond HIV and may require time, but are equally essential since they create the conditions necessary for achieving prevention results; and
- providing models for monitoring, to ensure that proven HIV prevention measures are implemented according to design (with adequate quality, scope and scale) and deliver the intended results.

Investing in and planning for HIV prevention often occurs as part of a political decision-making process in which resources are allocated among competing demands. Decision makers may need to address prejudice and denial to win political acceptance for proven HIV prevention strategies. Policies that will have an adverse impact, worsening the epidemic, such as limiting engagement of vulnerable communities or criminalizing non-marital sex or the possession of needles, should be resisted.

Effectiveness also involves estimating the impact that the HIV prevention measure is likely to have on the target audience and beyond. Some transmission networks, or chains of infection are “short” (an individual is infected, but does not pass that infection on to anyone else), while others are “long” and have many pathways (for example, an injecting drug user infected by using contaminated injecting equipment, transmits HIV to other injecting drug users and to sexual partners including sex workers, who transmit HIV to their other clients). Logically, any measure that prevents the first infection in a long pathway will have a larger impact at the population level than those that interrupt shorter pathways of infection.

When considering costs, planners should remember that a costly measure that provides acceptable effectiveness and substantial benefits should take precedence over measures that are less expensive but have less impact on the epidemic. The responsibility of HIV programme planners is to provide realistic estimates of what it will cost to achieve the prevention targets.

Street children and children living in the poor neighborhood of Phnom Penh receiving non-formal education at Friends Education Centre. Cambodia.

Feasibility, sustainability and response capacity

National planning processes for scaling up HIV prevention programmes must also address the issues of needed human resources and commodity security. Planners should work with the human and organizational resources available to them today, while they plan and invest to increase that capacity to be able to expand services in the future. Many effective programmes invest in building the capacity of affected communities that have previously been marginalized.

Risk analysis

When dealing with HIV, taking no action is a high-risk strategy. For example, failure to provide programmes for injecting drug users may permit the rapid spread of HIV into the general population. Failure to provide health-care workers with access to universal precautions may lead to loss of confidence in the health-care system, and among health-care personnel, and subsequent denial of treating HIV positive individuals. Even when effective HIV prevention efforts require high levels of expenditure, failure to implement critical services will lead to much higher costs.

Mobilizing communities to address HIV related stigma and discrimination *(36, 16)* helps in increasing the uptake of services. On the other hand, forced HIV testing of most-at-risk populations will hamper HIV prevention efforts, as people will avoid testing and other HIV prevention or treatment services. Planners should carefully assess the potential impact of each HIV prevention measure and consult with potential beneficiaries about their likely reception. In all cases, a human rights-based approach should be followed to avoid increasing stigma or infringement of human rights of individuals or communities.

Additional or "auxiliary" benefits and other overriding considerations

Many HIV prevention measures have health and social benefits beyond the intended HIV benefits. For example, implementing intensified HIV prevention measures can strengthen health-care systems, augment social capital, reduce family dissolution and promote community development, prevent unwanted pregnancies or other sexually transmitted infections and reduce gender violence. Institutions that address the vulnerabilities of populations at greatest risk for HIV can be used to address other needs such as poverty reduction and control of other communicable diseases.

PRIORITIZING ACCORDING TO EPIDEMIOLOGICAL SCENARIO

While prioritizing for effective HIV prevention requires matching the HIV response to a specific epidemic and setting, certain measures are essential in all epidemic scenarios. For example, HIV prevention responses will not be effective in any type of epidemic unless steps are taken to reduce HIV related stigma and discrimination[i]. HIV prevention for people living with HIV ("positive prevention") is important in all settings, even more so in generalized and hyperendemic scenarios. Similarly certain measures such as ensuring blood safety and promoting universal precautions in health-care settings are also vital in all settings. Addressing the drivers of the epidemic is equally vital to ensure progress in the response.

Women and girls require special attention in all epidemic scenarios, due to their reduced access to information, resources, lower power and autonomy — as compared to their male counterparts — in nearly all settings. The needs of young people who are part of most-at-risk populations, or residing in high prevalence settings should be prioritized.

Timing is a critical factor in all epidemic settings. Some programmes—such as sexually transmitted infection treatment and meeting the prevention needs of injecting drug users—are more effective in reducing HIV spread if implemented in recent epidemics *(46)*.

When prioritizing HIV prevention measures, various elements must be considered, according to scenario (low-level, concentrated, generalized and hyperendemic). They are presented here.

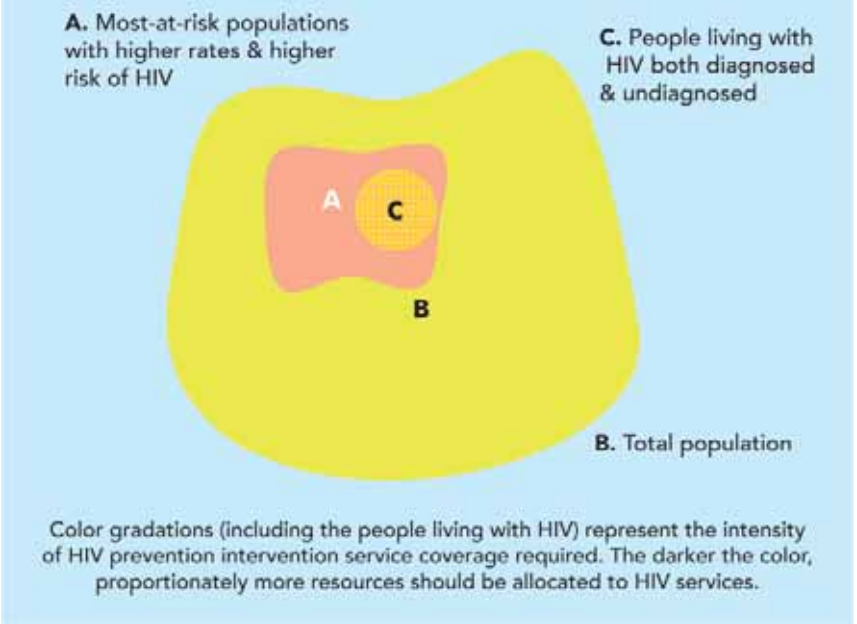
A village school. Hargeisa, Somalia.

i) Concrete and immediate measures that can be undertaken are: public information and social mobilization campaigns against stigma and discrimination; laws and policies against such discrimination; working with traditional and religious leaders; training and codes of conduct for health care workers, police and the judiciary; and providing legal aid to those that are victims of such stigma and discrimination [See Kidd R and S Clay (2003). Understanding and Challenging HIV Stigma: Toolkit for Action. Trainers Guide. The Change Project and ICRW.] Legal reform may be required to establish the rights of people living with HIV to full access to public services and to freedom from discrimination.

Prioritization in low-level scenarios

- Regularly collect and analyse reliable data on HIV prevalence, risk behaviours and drivers.
- Build the knowledge and capacity of the most-at-risk population[s], as successful prevention with this population will reduce the spread of HIV within vulnerable groups.
- Prioritize action to combat stigma and coercive measures, which are significant barriers to the participation of those most-at-risk and people living with HIV in prevention efforts.
- Implement programmes with and for most-at-risk populations at sufficient scale and intensity.

Figure 1. Low-level scenarios

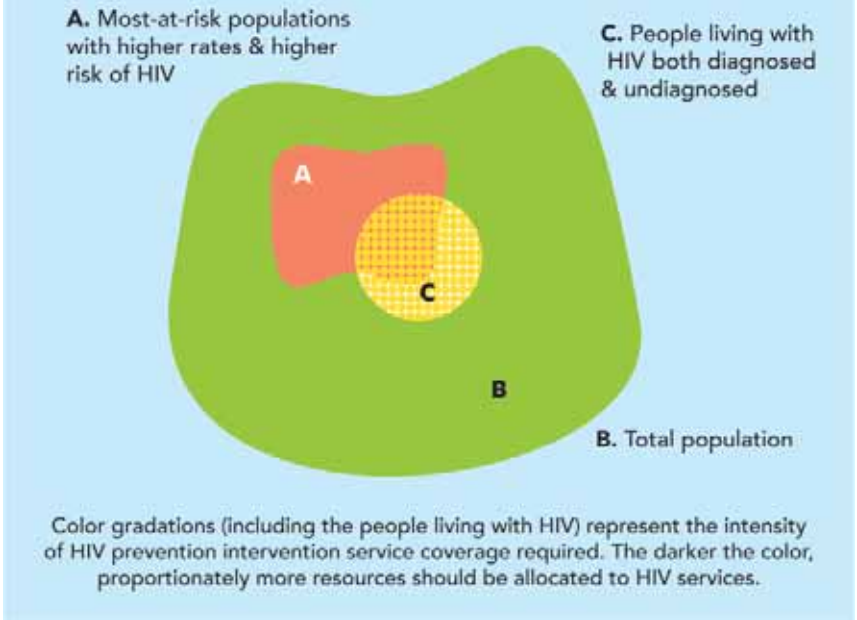


Color gradations (including the people living with HIV) represent the intensity of HIV prevention intervention service coverage required. The darker the color, proportionately more resources should be allocated to HIV services.

Prioritization in concentrated scenarios

- Programmes with and for most-at-risk populations retain their priority and are funded and implemented with sufficient scale and intensity. Resources must be kept focused where the rates and risks are highest and where the epidemic is moving.
- Attention is paid to "bridge populations" and particular sub-populations and sufficient measures are undertaken to inform the wider population.
- Stigma and discrimination must be continually addressed as a necessary condition for successful prevention and treatment.

Figure 2. Concentrated scenarios

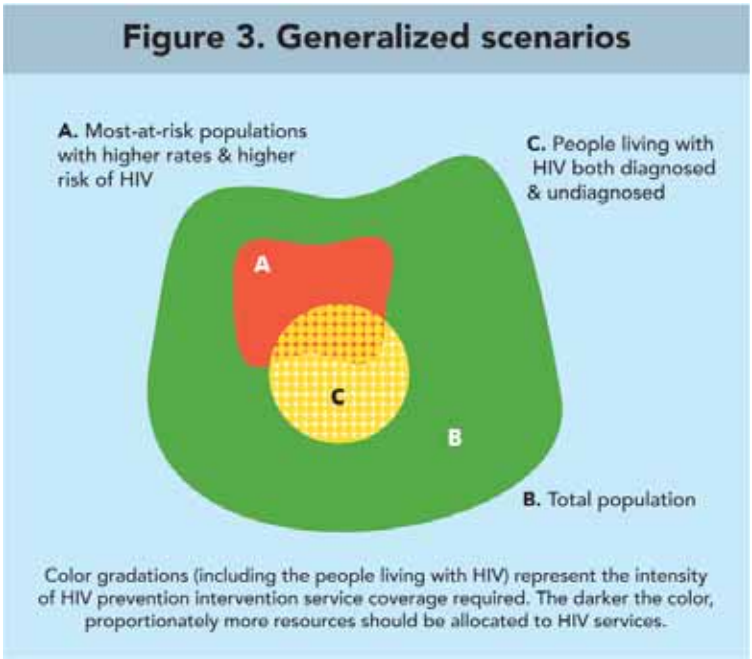


Color gradations (including the people living with HIV) represent the intensity of HIV prevention intervention service coverage required. The darker the color, proportionately more resources should be allocated to HIV services.

Prioritization in generalized scenarios

- Programmes for most-at-risk populations remain important, but prevention efforts must also extend to those in the general population with increased vulnerability to HIV.
- Nationwide promotion of behaviour change, including condom use, delayed sexual debut, abstinence and partner limitation are necessary along with programmes on stigma and discrimination, gender equality, etc.
- Reaching young people, adult men and women with appropriate programmes becomes a top priority.
- Prevention programmes should include public information and social mobilization campaigns that instigate social debate and change around gender norms that condone or encourage multiple sexual partner relations or sexual violence. They should provide social and legal assistance to girls and women who suffer from sexual and other forms of violence.
- Laws and policies that prevent migrant workers from bringing spouses or returning home frequently should be modified and there should be widespread provision of condoms and programmes and services for migrant populations.
- Expanded access to HIV counselling and testing, including free or subsidised client-initiated and routine provider-initiated testing and counselling, is necessary.
- Efforts of people living with HIV to act as spokespersons on HIV prevention should be encouraged and HIV prevention efforts should address their needs; because of the large numbers of people living with HIV at this stage of the epidemic, "positive prevention" (including living positively, how to remain well and how to reduce onward transmission of HIV) is critical.
- Every channel of communication, including popular media, schools, workplaces and faith-based organizations, should play a role in informing and empowering the population to participate in HIV prevention and care.

Figure 3. Generalized scenarios

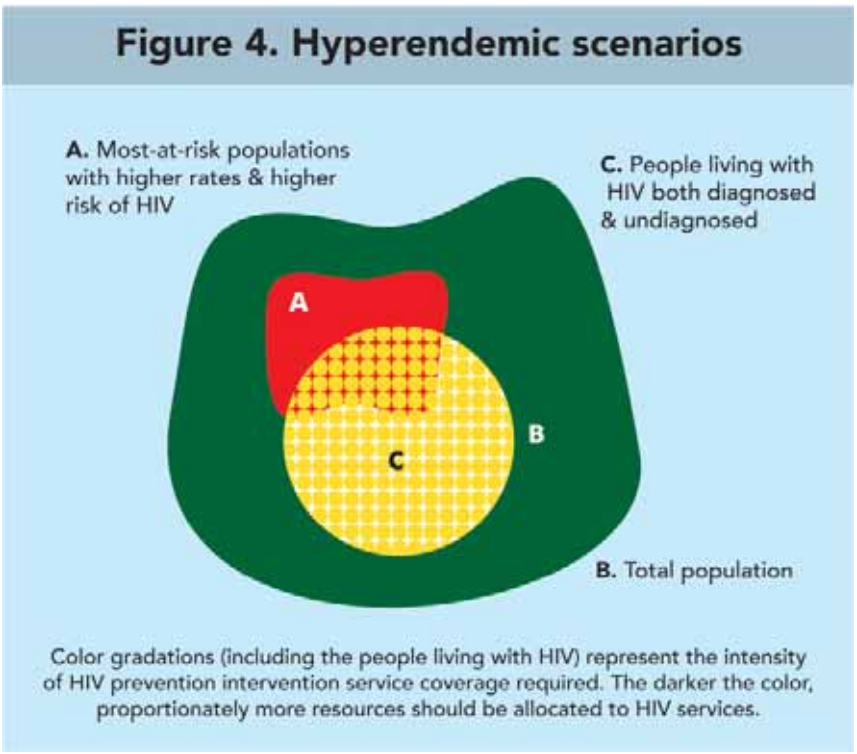


Color gradations (including the people living with HIV) represent the intensity of HIV prevention intervention service coverage required. The darker the color, proportionately more resources should be allocated to HIV services.

Prioritization in hyperendemic scenarios

- All sexually active adults should consider themselves as being at risk of contracting HIV. Extraordinary efforts that mobilize the whole community are required *(23)*.
- Broad social movements to address every sociocultural and economic practice that contributes to unsafe sex are necessary; these include:
  - — campaigns and laws targeting men to renounce multiple, concurrent partnerships, sexual coercion, gender-based violence and intergenerational sex; and
  - — concerted efforts to ensure the protection of young people, especially young women and girls, from all forms of sexual exploitation.
- Universal access to provider-initiated HIV counselling and testing is needed in health-care settings, complementing free or subsidized client initiated counselling and testing services.
- All relevant government sectors and civil society including people living with HIV, business, non-governmental organizations, faith-based organizations and the mass media must be fully engaged.
- "Positive prevention" including living positively, how to remain well and how to reduce onward transmission of HIV is critical to address the needs of the large numbers of people living with HIV at this stage of the epidemic.
- Full national engagement involving all relevant government sectors, organisations of people living with HIV, civil society (e.g. the private business sector, non-governmental organizations, faith organizations, the mass media, and organizations serving populations not reached by national media, and education systems, such as indigenous populations, refugees and displaced persons) must be engaged in the response.

Figure 4. Hyperendemic scenarios



‘HIV PREVENTION IS FOR LIFE’

Not all prevention objectives can be achieved in the short term. Even the short-term measures must be repeated again and again, to reach new cohorts and to sustain prevention. Long-term prevention outcomes require sustained and cumulative efforts—including a series and even several converging avenues of action, including activities to build up human and institutional capacity and to generate resources.

Box 9: Reinforcing strategies of risk, vulnerability and impact reduction

“Most importantly, a comprehensive approach to HIV prevention must address not only risk but also deep-seated causes of vulnerability which reduce the ability of individuals and communities to protect themselves and others against infection. This necessitates providing for instance, more opportunities and greater equality in education and employment for women, young people and marginalized populations…enabling families to maintain their homes when disability or death occurs; food security programmes especially for vulnerable young people and women; and specific protection measures for refugees and people in conflict and displaced situations.”

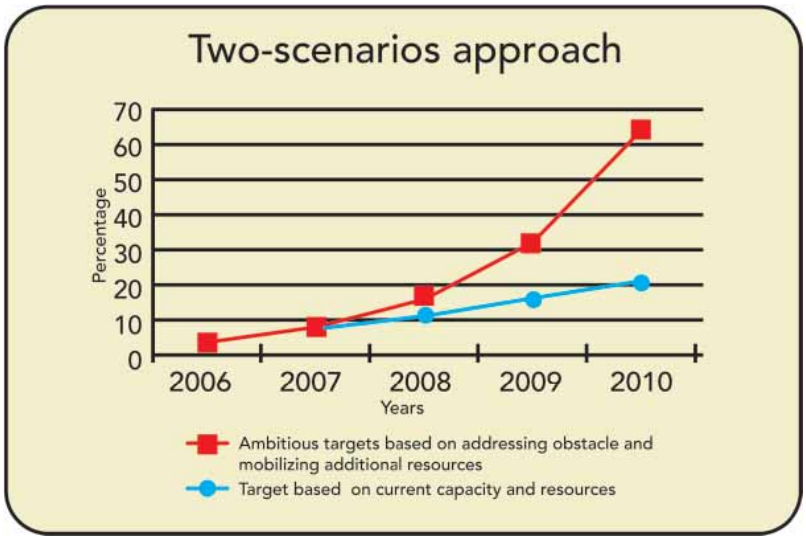
Source: UNAIDS (2006). Page 16 of *Intensifying HIV Prevention*. Geneva.

Currently there are several promising new HIV prevention technologies that are the subject of randomized controlled trials. These include microbicides, vaginal diaphragm, pre-exposure prophylaxis with antiretroviral drugs, herpes suppression and herpes treatment and vaccines *(7)*. The partial protective effect of male circumcision in preventing female-to-male HIV transmission has been confirmed in three randomized controlled studies undertaken in Africa involving more than 11 000 men. These studies have confirmed that male circumcision reduces the risk of HIV acquisition in men by more than half. Male circumcision should only be offered under conditions of informed consent and in appropriate sanitary settings by adequately trained and equipped professionals, with standard pre- and post-surgical counselling, including the need to adopt or maintain safer sex practices, including correct and consistent condom use.

Containing and reversing the HIV epidemic requires balancing the need to achieve short-term results with efforts towards the longer term goal of creating an environment that reduces HIV risk, promotes innovation, and supports sustained and universal access to HIV prevention, treatment, care and support.

SET AMBITIOUS, REALISTIC AND MEASURABLE PREVENTION TARGETS

Figure 5.



Source: UNAIDS (2006). Setting National Targets for Moving Towards Universal Access by 2010: Operational Guidance. Geneva

Establishing ambitious and realistic targets sharpens the focus of the national prevention response. Targets can assist in mobilizing political and community support for universal access to HIV prevention, and are tools for advocacy and resource mobilization. Targets will vary according to where a country is in the epidemic trajectory, increasing in complexity and scale as HIV prevalence increases.

Target setting, is an important step in results-based planning. It involves a logical hierarchy as illustrated in figure 6. **National targets** provide a yardstick to measure action and results. Ambitious, but realistic national targets define the strategic priorities to be addressed in relation to the population in need and the coverage required to meet these needs. **Operational targets** define the inputs, processes

Figure 6: The Hierarchy of Targets

and outputs required for the national target to be met which in turn are the summation of programme targets. **Programme targets** are set and used by managers to ensure that their activities are on track. Targets are expressed in terms of concrete outcomes that include objective and verifiable measures of "what success will look like," so that implementers, beneficiaries and other stakeholders are clear that they are talking about the same thing. The UNAIDS document, *Setting National Targets for Moving Towards Universal Access* *(34)* provides detailed operational guidance on target-setting.

In 2006, countries embarked on the process of target-setting to scale up their national response towards universal access to HIV prevention, treatment, care and support by 2010. By the end of December 2006, 90 countries had provided target data and 84 countries had set outcome targets for at least one prevention measure. At least one quarter of the 90 countries that had set targets have proceeded with costing the HIV strategic or action plans to achieve their targets *(42)*.

TARGET-SETTING IN DIFFERENT EPIDEMIC SCENARIOS

In low-level and concentrated scenarios, national targets can focus on providing essential HIV prevention services to vulnerable and most-at-risk populations. Specific targets may include the rate of coverage of HIV prevention programmes for most-at-risk populations; the percentage of adults who know the sexual mode of transmission of HIV and three methods of preventing it; and the percentage that report use of condoms in the last episode of casual or transactional sex.

Box 10: Steps for setting ambitious targets

- Review the status and transmission dynamics of the HIV epidemic.
- Define and prioritize the measures to be included in the national response.
- Estimate the size of populations in need.
- Review the current coverage rates and historic rate of scaling up, and project the potential achievements by 2010.
- Determine the resources available, the current coverage capacity and what would be required to overcome identified obstacles.
- Estimate the impact on rate of scale-up that would result from investments in overcoming specific obstacles to implementation.
- Set ambitious targets and mobilize resources accordingly.

Source: UNAIDS (2006). Setting National Targets for Moving Towards Universal Access by 2010: Operational Guidance. Geneva.

Operational targets may be set for programme activities, such as mapping and estimating the number of injecting drug users, men who have sex with men, and sex workers; investigating HIV in prisons in all major locations in the country; identifying and engaging representatives from priority population groups in planning services; verifying that the majority of most-at-risk populations have access to tailored HIV information, voluntary counselling and testing and support for positive living; and ensuring that systems are in place to monitor changes in HIV prevalence and risk behaviour at regular intervals.

Targets for concentrated scenarios

Setting targets in a concentrated epidemic scenario includes and builds upon that of low-level epidemics, with a commensurate increase in the scale and intensity of HIV prevention measures and targets.

Additional, operational targets could include the percentage of all mobile populations having equitable access to essential HIV prevention measures for most-at-risk populations; the percentage of antenatal care services in high-risk settings that provide prevention of mother-to-child transmission services, including primary prevention for women, family planning and referral for antiretroviral therapy for pregnant women living with HIV, their partners and children; and the percentage of secondary health facilities that provide sexually transmitted infection services, voluntary HIV counselling and testing and diagnosis and treatment of tuberculosis and other opportunistic infections.

Targets for generalized scenarios

In addition to the targets that are appropriate for low and concentrated scenarios, countries with generalized epidemics should establish operational targets for various programmes that are designed to prevent further growth of the epidemic especially in the general population. Targets could address the percentage of adults and young people with accepting attitudes towards people living with HIV; increases in the age of sexual debut of young adults; the percentage of persons attending voluntary counselling and testing that accept test results with post-test counselling and referral; and the percentage of government departments that accept HIV prevention as a line item in their budgets.

Target-setting in a hyperendemic scenario

In a hyperendemic scenario, all modes of unsafe behaviour must be addressed regardless of the social sensitivities or political difficulties involved. Beyond the types of operational targets established in a generalized epidemic scenario, hyperendemic countries may establish short- and medium-term targets addressing the:

- percentage of budget expended by all identified government departments on HIV prevention and treatment-related activities;
- percentage of community gatherings (e.g. local government, tribal, faith-based) that provide the opportunity for dialogue and planning on the prevention and management of HIV;
- percentage of orphans and children made vulnerable by AIDS that are covered by child protection measures.

TAILOR YOUR PREVENTION PLANS

Table 1 synthesizes the recommended prioritization of prevention measures for the various epidemic scenarios discussed.

Some measures are repeated in all scenarios, whereas others are additional, or modified from one scenario to another. All are indicated briefly in this overview document; more detailed specifications, however, need to be developed in the context of local planning processes. These tables serve as checklists for both planning and evaluating existing programmes. The strategic information, programmatic and policy actions highlighted in green should be addressed first, to move most quickly to prevention goals. Those highlighted in white are necessary supportive actions that will support scaling up of prevention.

TABLE 1.1 WHAT TO DO IN LOW-LEVEL SCENARIOS?

Strategic information

- Gather and analyse strategic information to define most-at-risk populations and risk settings *(31)* and on the HIV response, response capacity and resource needs in the public and private sector. Provide the data and analyses to the National AIDS Authority and other stakeholders on a regular basis.
- Initiate and/or maintain/adapt second generation surveillance system and establish a national HIV monitoring and evaluation system to include surveys of behaviour in sub-populations, surveillance of sexually transmitted infections and other biological markers of risk, HIV surveillance in sub-populations, HIV case reporting, and tracking of HIV in donated blood.
- Gather information on the HIV response and response capacity in the public and private sector, beginning in high-risk settings.
- Monitor HIV programme coverage, disaggregated by population sub-group, sex, age, marital status and geographic area; analyse information with stakeholders; identify implementation gaps; and coordinate partners and adjust programmes to meet demand and improve programme performance.

Programmatic actions

- Ensure high coverage of most-at-risk populations with acceptable and high quality HIV prevention, treatment and care services. See Tables 2.1–2.14 for descriptions of essential HIV prevention measures for various at-risk groups.
- Build the capacity of the most-at-risk populations to organize, advocate and deliver peer prevention; secure the active participation of these populations in designing, delivering and evaluating prevention services.
- Promote and provide access to comprehensive prevention, treatment and care services, including prevention of mother-to-child transmission, for people living with HIV.

- Provide training to law enforcement personnel to reduce harassment at prevention and treatment sites serving most-at-risk populations.
- Integrate HIV prevention issues, including the adverse effects of stigma and discrimination, sexual violence, gender inequality, homophobia and human rights violations in broader public health and development campaigns.
- Promote programmes aimed at promoting livelihood alternatives to transactional sex.
- Provide training of service providers (e.g. community, social and health-care workers) for working effectively with most-at-risk populations.
- Provide sexuality and reproductive health education, including HIV prevention information and education on issues such as dealing with stigma and discrimination, sexual violence and abuse as well as gender sensitivity and equality to young people through the school curriculum and to teachers through teacher education curriculum.
- Ensure adherence to blood safety standards *(49, 50, 51, 52)* (all blood and blood products tested for HIV before transfusion; all health care settings observe universal precautions).

Policy actions

- Provide a clear mandate for leadership, resource mobilization, coordination and reporting to the National AIDS Authority and define a costed plan for effective HIV prevention, in the context of the "Three Ones" and with reporting annually to government and to civil society on planning, development and implementation.
- Mobilize and commit resources to HIV prevention sufficient to meet the needs of the essential HIV prevention plan; track and analyse expenditures to improve future planning cycles.
- Review and amend legislation and policies that create or enforce barriers to HIV prevention (e.g. laws that discriminate against women and girls, criminalize sex work or sex between males, or restrict access to male and female condoms, sterile needles and syringes and harm reduction measures such as substitution treatment).
- Promote full enforcement of laws against child marriage, sexual abuse and gender-based violence.
- Review imposition of user fees or taxes on key commodities such as HIV test kits, male and female condoms, treatments for sexually transmitted infections and antiretroviral drugs.
- Review every sector to establish that current practices do not facilitate risk behaviour (e.g. promoting sex tourism, requiring overnight stays at border crossings) or hamper access to HIV prevention services.
- Review, amend and enact appropriate laws and policies and enforce anti-discrimination legislation.

TABLE 1.2 WHAT TO DO IN CONCENTRATED SCENARIOS?
Strategic information
• All actions outlined in low-level scenarios. • Include plans and budgets for second generation surveillance[j], in the national HIV monitoring and evaluation system *(27)* that includes all of the elements recommended for a low-level epidemic, along with additional elements that focus on the intersection of groups with differing risk (e.g. behavioural surveillance in sub-populations with risk behaviour and in bridging groups). • Conduct additional research on sexual networking patterns to better understand the potential HIV transmission flow from most-at-risk populations to the general populations.
Programmatic actions
• All actions outlined in low-level scenarios. • Provide and promote voluntary HIV counselling and testing with referral to services; begin in high-risk settings where HIV rates are high and expand within the public and private health sector as rapidly as possible. • Provide prevention and care programmes focused on vulnerable and 'bridge' populations such as mobile populations, uniformed forces, clients of sex workers and most-at-risk young people (see Tables 2.11 and 2.14).
Policy actions
• All actions outlined in low-level scenarios. • Train and support leaders (political, networks of people living with HIV and vulnerable communities, private sector, faith-based) to speak out against HIV-related stigma and discrimination and in favour of human rights, including gender equality and universal access.

j) Second generation surveillance involves monitoring high-risk behavioural and HIV serological trends over time among populations at risk of HIV.

TABLE 1.3 WHAT TO DO IN GENERALIZED SCENARIOS?

Strategic information

- All actions outlined in low-level and concentrated scenarios.
- Include plans and budgets for second generation surveillance in the national HIV monitoring and evaluation system[k] *(27)*, according to guidelines for generalized epidemics, including: sentinel HIV surveillance among pregnant women, urban and rural; cross-sectional surveys of attitudes and behaviour and HIV infection in the general population; cross-sectional surveys of attitudes behaviour among young people; HIV and behavioural surveillance in sub-populations with high-risk behaviour; and data on morbidity and mortality.
- Conduct periodic, participatory national assessments of the HIV response and response capacity and resource needs in the public and private sector and from the central government to the community levels. Provide this information to the National AIDS Authority and other stakeholders using, high profile processes and events on a regular basis to motivate participation and coordination across the many partners.
- Gather and use strategic information to understand the contexts and drivers of predominant risk behaviours and to guide investment and action towards achieving objectives such as human capacity development and system strengthening and universal support for human rights including gender equality.
- Gather and analyse data from additional sources to estimate HIV incidence in key audiences, in order to refresh HIV prevention planning and keep it aligned with the epidemic.

Programmatic actions

- All actions outlined in low-level and concentrated scenarios.
- Promote and provide quality HIV prevention, treatment, care and support for most-at-risk populations and people living with HIV. (See Tables 2.1–2.14 for descriptions of the essential measures for various at-risk groups.)
- Build capacity for HIV prevention planning and implementation in government, non-governmental organizations and civil society, including the capacity of most-at-risk populations and people living with HIV to organize and advocate; to deliver peer prevention and to lead "positive prevention programmes." Secure the active participation of communities in designing, delivering and evaluating prevention services.
- Plan and implement a long-term (for example, 5 years) national HIV communication programme to mobilize society and to create an enabling environment for prevention, treatment, care and support. Relevant themes include:

k) Good M&E requires both internal self-assessment and external verification. UNAIDS/The World Bank (2002). National AIDS Councils: Monitoring and Evaluation Operations Manual. Geneva. http://data.unaids.org/Publications/IRC-pub02/JC808-MonEval_en.pdf

  - — support for HIV counselling and testing and disclosure, delay of sexual debut, partner limitation, couples counselling and testing and safer sex and normalising condom use;
  - — expectations of bold and radical leadership by politicians and other opinion leaders;
  - — promotion of principles and local action for human rights, gender equality and zero tolerance for gender-based violence; and
  - — promotion of solidarity and support for affected families and young people, including children affected by HIV.
- Provide evidence-based sexuality and reproductive health education through the school curriculum; ensure inclusion of sexuality education in teacher training curriculum and for out-of-school youth in high-risk and high prevalence areas through peer education.
- Ensure universal access to HIV counselling and testing, including provider-initiated voluntary HIV counselling and testing according to national guidelines, beginning in areas of high concentration of HIV.
- Ensure universal and uninterrupted condom availability and integrate condom promotion into reproductive and primary health-care services in the public and private sector.
- Prioritize programmes for women and men that address risk behaviours and gender related vulnerability.
- Promote and provide full range of prevention of mother-to-child transmission services, beginning in urban areas and other areas with high concentration of HIV.
- Identify priority geographic settings where male circumcision is likely to have the greatest impact on the HIV epidemic and progressively expand access to safe male circumcision services within the context of ensuring universal access to comprehensive HIV prevention, treatment, care and support.
- Promote joint HIV/TB services and positive prevention services available at all hospitals.
- Provide prevention and care programmes focused on vulnerable populations (e.g. mobile populations, uniformed forces, clients of sex workers and most-at-risk young people such as street children and in- and out- of- school youth), on a national and regional basis.
- Partner with Ministry of Labour, employer associations and trade unions to promote the availability of HIV prevention and treatment services or referrals at the workplace.
- Ensure health-care, law enforcement and social services employees are trained on HIV issues, including gender and human rights.

Policy actions

- All actions outlined in low-level and concentrated scenarios.
- Advocate and promote removal of user fees or taxes that reduce access and use of key commodities, such as HIV test kits, male and female condoms, treatments for sexually transmitted infections and antiretroviral drugs.
- Train and support leaders (e.g. political leaders and leaders from within networks of people living with HIV, vulnerable communities, the private sector, faith-based organizations and traditional healers) to speak out against HIV-related stigma and discrimination and to demonstrate solidarity and support for universal access to HIV prevention, treatment, care and support.
- Identify government departments or sectors that can reduce risk situations and provide services for most vulnerable populations (e.g. by reducing spousal separation; enforcing laws and regulations governing treatment of prisoners) and engage them in improving AIDS responses.
- Promote and energize multisectoral linkages with government ministries that are or should be involved in the AIDS response (e.g. local development; social welfare; health; education; agriculture; youth and sports; women; human resources; uniformed services) and establish clear sectoral responsibilities for risk reduction, vulnerability reduction and impact reduction for each.
- Promote male circumcision as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men as part of a comprehensive HIV prevention package which includes: promoting delay in the onset of sexual relations, abstinence from penetrative sex, and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV counselling and testing services; and treating sexually transmitted infections.
- Conduct a high profile, national review of every sector to evaluate whether current practices promote risk behaviour or hamper access to HIV prevention services.

TABLE 1.4 WHAT TO DO IN HYPERENDEMIC SCENARIOS?

Strategic information

- All actions outlined in low-level, concentrated and generalized scenarios.
- Conduct additional behavioural and ethnographic studies (e.g. young people, girls, married men) to map and define sexual networks, communication networks and opportunities to promote social change.

Programmatic actions

- All actions outlined in low-level, concentrated and generalized scenarios.
- Ensure well informed, active and visible participation of leaders in HIV prevention and AIDS response.
- Develop and implement diversified programmes for young people, reaching both boys and girls that include gender equality and respect, access to comprehensive sexual and reproductive health services including access to treatment, ensuring access to information, sexuality education, life skills.
- Ensure special programmes for orphans, street children and others at high risk, balancing needs for risk, vulnerability and impact reduction.
- Promote and ensure male involvement in sexual and reproductive health programmes including HIV prevention, STI treatment, HIV counselling and testing, prevention of mother-to-child transmission services,
- Ensure health care and other social services employees are trained on HIV issues, including stigma, human rights and gender issues.
- Identify priority geographic settings where male circumcision is likely to have the greatest impact on the HIV epidemic and progressively expand access to safe male circumcision services within the context of ensuring universal access to comprehensive HIV prevention, treatment, care and support.

Policy actions

- All actions outlined in low-level, concentrated and generalized scenarios.
- Build public awareness and demand to amend legislation and policies that create barriers to HIV prevention, such as laws that discriminate against women and girls.
- Conduct a high profile, national review of every sector to establish that current practices do not promote risk behaviour or hamper access to HIV prevention services.
- Promote male circumcision as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men as part of a comprehensive HIV prevention package which includes: promoting delay in the onset of sexual relations, abstinence from penetrative sex, and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV counselling and testing services; and treating sexually transmitted infections.

USE STRATEGIC INFORMATION TO STAY ON COURSE

As noted in Box 3 (see page 6), there are many sources of strategic information which can be used to inform and support sound decision-making, to enhance achievement of the programme goals.

The importance of transparency

The tracking and reporting of progress made by prevention, treatment, care and support programmes towards attaining operational targets should be inclusive and transparent, through a participatory planning process. This is best undertaken in collaboration with stakeholders including key audiences. Accountability can be further enhanced through public financial management and expenditure tracking that verifies the allocation, use and impact of AIDS spending *(29)*.

If progress is not observed

At the operational level, monitoring progress against milestones and targets helps managers know when it is necessary to fine tune their programmes. If progress is not observed, the programme managers, stakeholders and communities need to ask and answer the following questions.

- What was the cause of low uptake of services?
- Was the HIV prevention programme developed and pre-tested with the beneficiary audience?
- Are the planned coverage, intensity and quality standards for the measures appropriately phased, realistic and adequate?
- Are the prevention programmes being implemented as planned, to the necessary quality standards and scale and to the intended populations? Good monitoring is needed to identify implementation gaps so that they can be remedied.
- Is the current mix of HIV prevention measures meeting the changing needs?
- Are inclusive planning, monitoring and evaluation methodologies used to ensure the involvement of most-at-risk populations to ensure a “reality check” and serve beneficiaries according to their needs?

Continual gathering and use of strategic information

To be effective, programmes need to include the tracking and assessing of the epidemic and the impact of measures; listening to and involving stakeholders; and fine-tuning the programme according to

Peer Education Programme Toco, Trinidad. Leroy Serapio is in charge of this programme. He and several peer assistants lead a session on communication skills for High School students outside Toco community center.

the evidence from monitoring and evaluation, including feedback from those being served.

There are costs to HIV prevention programmes, but these costs must be analysed in comparison with the costs:

- of not preventing the spread and expansion of the HIV epidemic;
- of treatment for people who become infected;
- in loss of social capital with rising HIV infections;
- to the families and communities in terms of personal/individual, familial, social and economic loss; and
- of dealing with a larger epidemic later due to current inaction and inertia.

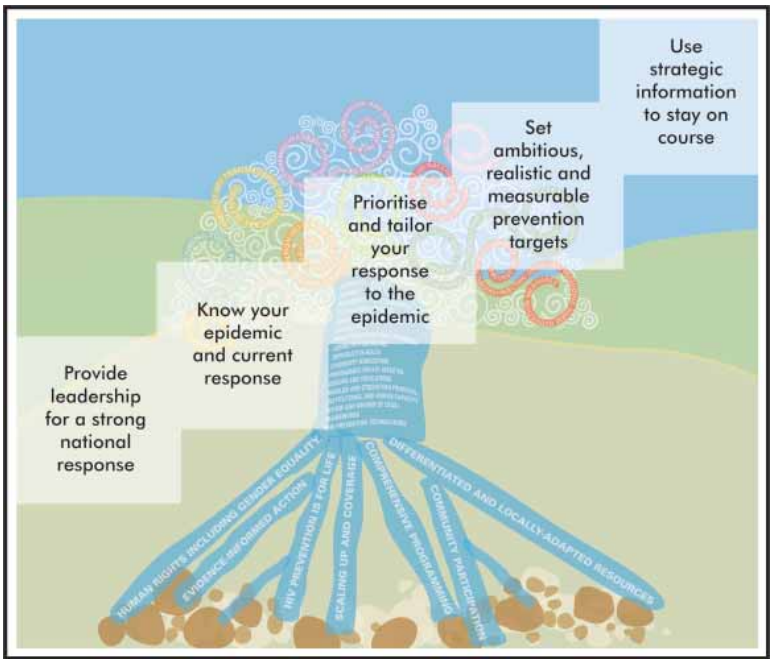
Credible data on the current course of the epidemic, likely future development and on the outcomes and impact of prevention services are powerful tools for getting the attention of policy makers who have many competing imperatives and constituencies. It is vital to present convincing evidence and estimates to ensure policy decisions in favour of the adequate mobilization of resources for HIV prevention, including areas of legal reform and sound economic and social policy frameworks.

CONCLUSION

A renewed emphasis on HIV prevention is critically needed. The more than four million new HIV infections each year place an untenable burden on families and communities and on HIV treatment efforts that are struggling to reach all those in need today. The success of the movement towards universal access will largely depend on whether leaders maintain a strong focus on the goal of delivering essential prevention services to the populations most in need.

These *Practical Guidelines* summarize the building blocks of strong national HIV prevention programmes and aim to support national policy makers and planners in the public and non-governmental sectors to prioritize and sequence their investments, to effectively scale up their prevention efforts. The steady growth of the HIV epidemic does not arise primarily from deficiencies in scientific knowledge ("evidence"), or in available prevention strategies. Continued increasing transmission of HIV results largely from failure to use the highly effective tools that are available to slow the spread of HIV and to deliver them in sufficient intensity and coverage to the populations most in need.

Box 11: Summary of requisites for intensifying effective prevention



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ANNEX I. PRIORITIZED HIV PREVENTION MEASURES FOR KEY AUDIENCES

A woman from northern Thailand with her baby. Worldwide, about three-quarters of HIV infections have been acquired through unprotected sexual intercourse.

The body of these guidelines recommend that HIV programme planners use strategic information to define the most-at-risk populations and risk settings, and then match prevention measures to those people and settings, according to their epidemic scenario and the capacity of the HIV response (Table 1.1 – 1.4). Tables 2.1-2-14 summarize the specific HIV prevention requirements needs of 14 key audiences. Planners must consider that different epidemic scenarios, and different key audiences, may be found in different geographical areas within their country, or within their region/ province.

The key audience tables are arranged alphabetically, for easy reference. The tables that pertain to a country's most-at-risk and most vulnerable populations, are essential components of the recommended prevention measures for each epidemic scenario, as indicated in Table 1.1-1.4 They can help planners to ensure that the variety of needed components are included in HIV prevention programmes designed for and with each of their key audiences, or to evaluate existing programmes for gaps in essential services. Depending on the human and other resources available, prevention measures may have to be phased in – first to hot spots or settings with greatest need and then to other geographic areas.

While these tables list the critical prevention measures and summarize the rationale for investing in prevention in different audiences, the scale and intensity of the prevention measure within the national AIDS programme must be determined by formative research in the local situation, and by the current response and response capacity.

Table 2.1 General population

Why?

- Everyone has a right to health information and services to promote health and avoid acquiring or transmitting HIV infection.
- In generalized epidemics, no section of society remains unaffected and the need for HIV prevention is universal.
- Addressing the general population creates a framework/environment for more targeted HIV prevention measures to promote behaviour change and stigma reduction.

What?

- Coordinated mass media campaigns segmented by audience to raise awareness, promote public debate increase support for needed programmes and reduce stigma towards persons living with HIV and in vulnerable groups.
- Campaigns to address social and gender inequalities and sexual norms (e.g. intergenerational sex) and to reduce stigma around sexual diversity.
- Widely available, accessible, comprehensive prevention services to support delay of sexual debut, mutual fidelity, reduction of number of partners, use of male and female condoms and access to reproductive health, family planning and sexually transmitted infection services.
- Legal reform to remove barriers to access prevention services.
- Antidiscrimination legislation for persons living with HIV and those in vulnerable groups.
- Comprehensive evidence-based sexuality education in schools.

How?

- Ensure the National AIDS Authority estiablishes and contributes to a coordinated national health communication strategy.
- Establish agreements with the educational authorities to establish comprehensive sexuality education in the school system.
- Messages should be tested to guarantee effectiveness.

Difference in epidemic scenarios

- Low: focus on raising awareness, including life skills education reducing stigma.
- Concentrated: all above actions with focus on all populations and in particular young people, women and men.
- Generalized: focus on all populations.

Table 2.2 Injecting drug users

Why?

- HIV spread through use of contaminated needles among injecting drug users is among the most explosive (rates have been seen to expand from 5% to 50% in one year in many injecting drug user) to populations).
- Injecting drug users often have multiple risks, such as sex work and drug use and often face incarceration for possession of drugs, which again increases their risk of contracting and transmitting HIV.
- There is evidence that injecting drug users are willing to protect themselves, their sexual partners and the society at large.
- Harm reduction measures *(13)* such as access to sterile injection equipment; drug dependence treatment such as methadone and buprenorphine; community-based outreach; and providing HIV prevention information are among the most effective and cost-effective measures to prevent, the epidemic among injecting drug users. The earlier the implementation of HIV prevention programmes, the more effective and cheaper the specific measure will be *(48)*.
- Unmet challenges/issues related to illegality of injecting drug use and of harm reduction programmes can drive injecting drug users away from services and/or into prisons and fuel the spread of the epidemic.

What?

- Adequate coverage and low threshold access—including in correctional settings, to sterile injection equipment—to meet actual patterns of drug use.
- Access to quality, noncoercive drug treatment programmes especially drug substitution treatment such as methadone and buprenorphine.
- Removal of stigmatizing and coercive measures such as mandatory registration and forced HIV testing.
- Increase access of injecting drug users to service providers offering treatment for drug dependence, sexually transmitted infections, AIDS and tuberculosis.
- Training of health providers to increase familiarity with and effective work with injecting drug users and sex workers and training law enforcements and particularly to diminish harassment at prevention and treatment sites serving injecting drug users and sex workers.
- Promote the consistent and proper use of male and female condoms and ensure their availability, affordability and consistent supply.
- Access to HIV prevention, antiretroviral treatment and care services, including post-exposure prophylaxis, for sexual partners of injecting drug users.
- Create safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for injecting drug users to seek information and referrals for care and support.
- Removal of legal barriers to access prevention and care, such as laws and policies that prevent the provision of sterile injecting equipment and/or access to drug substitution treatment such as methadone and buprenorphine and meaningful involvement of drug users at all levels of planning and policy and financial support for their organizations.
- Availability and active promotion of hepatitis immunization for injecting drug users and their sexual partners.
- Targeted reproductive health and prevention of mother-to-child transmission services focused on appealing to the needs of women injecting drug users and women partners of injecting drug users.

How?

- Promote community based and peer-led outreach programmes.
- Promote adequate coverage of the full range of harm reduction measures – particularly sterile syringe and needle access and drug substitution treatment.
- Ensure the involvement and commitment of narcotics control authorities.

Differences in epidemic scenarios

- HIV prevention measures remain the same irrespective of the stage of the epidemic.

Table 2.3 Health-care workers

Why?

- Health-care workers and their clients need to be protected from acquiring infections in health-care settings.
- Adherence to universal precautions protect against HIV and other blood-borne infections.
- Health-care workers need to be confident that performing their duties will not endanger their lives or the lives of people with whom they interact.

What?

- Adherence to universal precautions in all health-care settings.
- Training and sensitization of health-care workers to avoid stigma and discrimination against clients and patients.
- Availability and promotion of hepatitis immunizations for health-care workers.
- Availability of post-exposure prophylaxis to health workers.
- Confidential HIV counselling and testing services.
- Access to antiretroviral treatment and care for health-care workers.

How?

- Reliable availability of universal precautions commodities and contaminated waste disposal.
- Workplace policy for health-care workers and laboratory staff.
- Continual training and coaching of health-care workers.

Differences in epidemic scenarios

- Same package in all stages of the epidemic.

Table 2.4 Men

Why?

- Male behaviour is a key determinant of the pandemic and men have a key role to play in ending it. Strategies on how to get male involvement/ engagement and achieve those behaviour changes are less clear and "evidence for effectiveness" is difficult to obtain.
- Social definitions of masculinity and the behaviours boys and men learn often include behaviours that put both them and their sexual partners at risk of HIV.
- Men can practice safer sex, be faithful, limit partners, refrain from sexual coercion and violence and promote and practice gender equality; as political and social leaders men can promote similar measures by allocating resources and passing and enforcing laws.
- Work with men to change risky behaviours should be a top priority and many other health and social benefits accrue (such as reductions in sexual coercion and violence, or unwanted pregnancies).

What?

- Massive political and social mobilization to address sexual norms, gender equality, fidelity, mutual respect and consent in sexual relations and marriage, reduction of sexual partners and increased male and female condom use.
- Integrate gender into all HIV programmes and involve men in prevention and wider sexual and reproductive health programmes.
- Communication to challenge risk behaviour and social norms.
- Utilize country wide and/or targeted social marketing programmes to increase condom use and to promote HIV counselling and testing, disclosure of HIV status to sexual partners and condom use by discordant couples.

How?

- Outreach to men through workplace, health sector and high-risk settings.
- Coordinated mass media campaigns, segmented by audience, that address high-risk sexual norms, promote gender equality and family and community accountabilities and reduce multiple and concurrent partnerships.
- Strengthen health sector services, including encouraging women to bring their partners to reproductive health services and augmenting public, private and traditional sexually transmitted infection services where these are commonly used by men.

Differences in epidemic scenarios

- Low: Prevention programmes should ensure that men have a general awareness of prevention measures but should focus on addressing gender inequality, stigma and discrimination.
- Concentrated and above: measures listed above.

Table 2.5 Men who have sex with men

Why?

- Potential for rapid spread within the population, if rate of unprotected anal intercourse is high.
- High potential HIV prevention benefit. Evidence of programme effectiveness from numerous countries in 80s and 90s *(11).*
- Potential increase in risk behaviours due to prevention fatigue and AIDS complacency.

What?

- Guarantee of human rights; removal of legal barriers to access prevention and care, such as laws that criminalize sex between males.
- Consistent and proper use of condoms, including consistent access to condoms and water-based lubricants.
- Availability of quality treatment for sexually transmitted infections and referral for HIV services.
- Availability of high quality HIV-related services (voluntary counselling and testing, specialized clinics, etc.).
- Empowerment of gay, lesbian, bisexual and transgendered communities to participate equally in social and political life.
- Availability of safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for men who have sex with men to seek information and referrals for care and support.
- Training and sensitization of health-care providers to avoid discriminating against men who have sex with men.
- Access to medical and legal assistance for boys and men who experience sexual coercion or violence.
- Availability of specific and targeted information on prevention and risk reduction strategies designed to appeal to and meet the needs of men who have sex with men.
- Access to information and prevention and care services for female partners of men who have sex with men.
- Availability and promotion of hepatitis immunization.
- A specific effort should be made to meet the prevention information and service needs of transgendered persons, who may not identify themselves as MSM.

How?

- Local assessments of the size and characteristics of men who have sex with men communities.
- Community/peer-led measures within the community of men who have sex with men; peer outreach at places (and internet sites) where men who have sex with men socialize.
- Ensuring participation of men who have sex with men in the prevention response—planning, outreach, condom promotion, etc.
- Public awareness campaigns to promote inclusion of alternative sexual communities and decrease acceptability of homophobia.
- Strengthening referrals between prevention, care and treatment.
- Multisectoral links between home ministry, social welfare, justice and police.

Differences in epidemic scenarios

- Low: Ensure availability of the essential package of services in at least all major urban areas and advertise its availability through safe spaces.
- Concentrated and above: high coverage of men who have sex with men.
- Essential HIV prevention measures remain the same in all the stages of the epidemic.

Table 2.6 People living with HIV

Why?

- The fact that increasing numbers of people living with HIV are aware of their status and surviving because of antiretroviral treatment provides an enormous prevention opportunity.
- Newly diagnosed people are the greatest source of qualitative information about why prevention programmes have failed them and what can be done to improve them.
- Within antiretroviral therapy roll-out, many opportunities are currently missed to address prevention in the context of treatment and care and the multiple points of contact between people living with HIV and health-care services.
- People living with HIV who speak out have been the most powerful resources in breaking the silence on HIV, creating awareness and supporting the importance of prevention *(12)*.

What?

- Provide pre- and post-test risk reduction counselling and access to affordable and confidential treatment, care and support for all people living with HIV, including quality sexually transmitted infection treatment.
- Provide support for self-help groups and networks of people living with HIV.
- Create safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for people living with HIV, or who believe they may have HIV, to seek information and referrals.
- Include preventive counselling within roll-out of antiretroviral therapy programmes.
- Provide assistance in fully understanding disclosure issues in relation to future sexual partners and support in negotiating safer and healthy sex lives. Provide support for couples and family based counselling, testing and referral.
- Ensure adequate supplies of male and female condoms and promote their consistent and proper use.
- Promote campaigns to reduce stigma and discrimination.
- Promote availability and use of post-exposure prophylaxis.

How?

- Ensure legal protection and social support is available to people living with HIV.
- Ensure post-test counselling at voluntary HIV counselling and testing centres and health facilities.
- Facilitate the formation of support networks and self-help groups (recognizing the diversity in populations and needs of people living with HIV).
- Support initiatives to encourage the greater involvement of people living with HIV.

Differences in epidemic scenarios

- Low and concentrated: coordinated, mass media campaigns segmented by audience to raise awareness, promote public debate, reduce stigma and discrimination.
- Medium and high generalized: massive political and social mobilization to address sexual norms, encourage counselling and testing and encourage solidarity of infected and affected.
- Essential HIV prevention measures remain the same in all the stages of the epidemic.

Table 2.7 Populations of humanitarian concern

Why?

- Populations of humanitarian concern (displaced populations, populations affected by conflicts, disasters and other emergencies and sometimes humanitarian workers) can be at risk of HIV infection due to their mobility, infrastructure destruction, sexual violence, rape as a weapon of war, break in social norms and other factors associated with displacement and conflicts.

What?

- Adherence to universal precautions in health-care settings and access to safe blood.
- Consistent and increased availability and proper use of male and female condoms.
- Availability and provision of emergency contraception and post-exposure prophylaxis, especially to women who have been victimized by war and to humanitarian workers.
- Information-education-communication and media campaigns to address specific HIV risks and vulnerabilities.
- Consistent and increased availability and proper use of male and female condoms.

How?

- Advocacy to donors, humanitarian organizations and national governments.
- Insistence that humanitarian organizations implement guidelines on HIV prevention measures in emergency settings from the early phases of emergencies.
- Social mobilization to address sexual norms, reduction of sexual partners, increased condom use in humanitarian settings.
- Availability of universal precautions and ensuring adherence to universal precautions.
- Capacity building/training of implementing partners.
- Combining humanitarian and development funding.

Differences in epidemic scenarios

- Low: raise awareness and promote HIV prevention through sexual and reproductive health services and through partnership with general health and development programmes.
- Concentrated: focus on specific highly vulnerable populations.
- Generalized and above: massive mobilization.

Table 2.8 Pregnant Women

Why?

- HIV transmission from parent-to-child accounts for the majority of all infections in children. Available strategies can reduce mother to child transmission from 30% to less than 1%. In countries and areas of countries with high HIV prevalence, coverage is extremely low (e.g. <10% in sub-Saharan Africa). While the programme should address pregnant women, it is important that both parents understand their roles and responsibilities in HIV prevention.

What?

- Prevention of HIV in women and girls (see Table 2.13).
- Voluntary HIV counselling and testing in pregnancy, with treatment, care and support, or referral to treatment, care and support, for women.
- Antiretroviral drugs antenatally and at time of delivery for pregnant women with HIV.
- Safe delivery practices and counselling and support for strategies to reduce the risk of HIV transmission via breastfeeding.
- Programmes to meet food and nutritional needs of pregnant and lactating women.
- Care and support for the mother, her partner, the infant and others in the household.
- Universal access to reproductive health services, including family planning.

How?

- Strengthen and make accessible to all comprehensive reproductive health services.
- Community mobilization around prevention of mother-to-child transmission, with support for antiretroviral drugs at home for home deliveries and support for strategies to reduce the risk of HIV transmission via breastfeeding and reduction of stigma related to exclusive breastfeeding.

Differences in epidemic scenarios

- All epidemic stages: HIV capabilities in all reproductive health services; public education on prevention of mother-to-child transmission.

Table 2.9 Prisoners

Why?

- Significantly higher rates of HIV infection among prisoners than in the general population have been observed in many countries. Sex between males and drug use are prevalent in many prisons. Most prisoners do not have access to HIV prevention services.
- Injecting drug users, men who have sex with men and sex workers are at increased probability of imprisonment because their behaviours are illegal in many countries.
- Prisons can be used as an opportunity to promote HIV prevention services. Good prisons health is good public health.
- Prison presents a focused opportunity to influence the behaviour of individuals at risk before they return to society.

What?

- Removal of legal barriers and reform of prison procedures/rules to enable access to HIV prevention and care services by prisoners.
- Availability of condoms, sterile syringe and needles and skin piercing equipment and promotion of consistent and proper use of condoms.
- Access to drug treatment programmes, especially drug substitution treatment, with adequate protection of confidentiality.
- Access to HIV counselling and testing, antiretrovirals and TB treatment and care and quality sexually transmitted infection treatment.
- Review of drug control laws; provision of alternatives to imprisonment for minor drug-related offences; offer treatment for drug users instead of imprisonment.
- Structural interventions to reduce overcrowding, pre-trial detention period and speedy trial and sentencing reform.
- Separate accommodation and facilities for young prisoners.

How?

- Provision of the full range of HIV services as part of prisons health services.
- Peer support programmes run by long-term prisoners/ex-prisoners.
- After release programmes—establish links with prevention and care programmes in the community.

Differences in epidemic scenarios

- HIV prevention measures remain the same in all the stages of the epidemic.

Table 2.10 Recipients of blood or blood products

Why?

- The efficiency of HIV transmission through blood or blood products is high and hence testing for HIV is imperative.

What?

- Build broad recognition of the ethical and legal obligation to protect recipients of blood and blood products.
- Ensure HIV testing of all blood and blood products intended for transfusion.
- Promote safe blood donation.
- Ensure availability of HIV counselling and testing services for recipients of blood and blood products.

How?

- Mandatory HIV testing of all blood and blood products.

Differences in epidemic scenarios

- No difference between different stages of the epidemic.

Table 2.11 Sex workers

Why?

- Sex workers have a large number of sexual partners; protecting them from HIV infection benefits them and has a large potential prevention benefit for the general population.
- HIV prevention programmes with sex workers are highly cost-effective. Evidence shows that keeping HIV levels low among sex workers slows the spread of the epidemic.
- There is strong evidence of the effectiveness of prevention programmes for sex workers.

What?

- Promote consistent and proper use of condoms to achieve >90 % use at last sex with a non-regular partner; ensure consistent availability of quality male and female condoms.
- Ensure availability of comprehensive health-care services with special emphasis to quality sexually transmitted infection treatment.
- Integrate violence reduction [both social and structural] in the sex work settings and engage sex workers in enforcing child protection policies and regulations.
- Work with sex workers to ensure participation in the development, implementation and monitoring of prevention services.
- Address structural barriers including policies, legislation and customary practices that prevent access and utilization of appropriate HIV prevention, treatment and care services.
- Review laws to ensure sex workers' ability to protect themselves and to ensure safer sex practices by their clients.
- Provide access to HIV counselling and testing and AIDS care, including anti-retroviral treatment and prevention services.
- Ensure availability of sexual and reproductive health services, including access to prevention of mother-to-child transmission services.
- Link HIV prevention programmes with all relevant welfare services including establishment of social support mechanism for sex workers and their families.
- Assist women to leave sex work and provide a range of legal, economic and social services for those in sex work.

How?

- Setting based outreach (non-governmental organization-led)
- Develop multisectoral links–home, social welfare, labour and industry, workers unions, private sector and civil society.
- Political and social mobilization to address sexual norms, reduction of number of sexual partners, increased condom use.

Difference in epidemic scenarios

- Low and concentrated: setting based outreach.
- Generalized epidemic and above: focus on all adult males in the country.

Table 2.12 Transport workers and commercial drivers, mobile populations, uniformed services personnel and clients/non-regular partners of sex workers

Why?

- Populations such as sexual partners of injecting drug users, clients of sex workers, (including: truck drivers, uniformed services, mobile populations and workers away from home) regular sex partners of sex workers, female sex partners of men who have sex with men and women, can increase transmission within the risk settings and spread into the general population.

What?

- Focus on female spouses, male and female partners of sex workers, male and female sexual partners of injecting drug users.
- Consistent and proper use of condoms.
- Availability of quality sexually transmitted infection treatment and other reproductive health services, including HIV information, counselling and testing.
- Removal of legal barriers to access prevention and care.
- Workplace policies and programmes that normalize HIV prevention, guarantee confidential HIV prevention and services and prevent spousal separation and other risk factors.
- Mass media and health education to inform populations, including most-at-risk and bridge populations, about HIV and increased condom use.
- Communication for social change to convey complexities and promote dialogue.
- Mass media campaigns to address social and gender inequalities, sexual norms (for example intergenerational sex), transactional sex and to promote dialogue about sexual rights, human rights and to reduce stigma.

How?

- Setting based outreach (non-governmental organization-led)
- Develop multisectoral links–home, social welfare, labour and industry, workers unions, private sector and civil society.
- Political and social mobilization to address sexual norms, reduction of number of sexual partners, increased condom use.

Differences in stages of the epidemic

- Low and concentrated: setting based outreach.
- Generalized epidemic and above: focus on all adult males in the country.

Table 2.13 Women and girls

Why?

- Women and girls are particularly vulnerable to HIV infection. Young women aged 15–24 are three to four times more likely to become infected than young men and rates of infection in women are rising in every region and most countries.
- Practices such as child marriage, sexual coercion and violence; women's lack of power to negotiate safe sex. Other gender power imbalances and inequalities and poverty make adoption of abstinence, being faithful or using condoms impossible for most vulnerable girls and women.
- Too few girls and women have access to information, sexuality education and reproductive health services that would empower them against HIV.

What?

- Comprehensive reproductive health services, accessible to all girls and women, regardless of marital status.
- Safe physical and virtual spaces (for example drop-in centres or telephone hotlines, respectively) where women and girls can seek information and referrals for voluntary counselling and testing, treatment, care and support.
- Sustained mass media campaigns addressing social and gender inequalities, harmful sexual norms, transactional sex, stigma, women's rights, including engagement and leadership by men.
- Legal and policy prohibitions against violence against women, including sexual coercion and rape and provision of legal and financial support for enforcement.
- Gender equality in education, employment, credit and law (including inheritance and property rights).
- Programmes to promote access to female and male condoms, voluntary HIV counselling and testing, couples counselling, support for voluntary disclosure and prevention of parent-to-child transmission.
- Involvement of men and boys in HIV prevention and reduction of gender inequality.

How?

- Set and meet targets to make HIV prevention, female condoms, voluntary HIV counselling and testing, prevention of mother-to-child transmission and treatment or referral accessible to all girls and women.
- In all sectors, set programmatic gender equality objectives and hold ministries accountable annually.
- In all sectors, establish specific programmes and allocate resources to work with women and girls; include AIDS information and referral in all programmes for girls and women
- Strengthen, introduce and enforce laws against sexual coercion, violence against women and discrimination on the basis of sex; eliminate existing discriminatory laws and practices.
- Establish and regularly utilize a consultative mechanism representative of women of different backgrounds and ensure women's participation in all civil society consultative mechanisms.

Differences in epidemic scenarios

- Low: raise awareness and promote HIV prevention through sexual and reproductive health services; comprehensive sexuality education for girls and women in and out of the education system; public education; and through partnership with general health and development programmes.
- Concentrated and above: in addition to actions in low-level scenarios, with intensive outreach to engage women in all walks of life in their social and leadership roles.

Table 2.14 Young people

Why?

- Youth in schools are easy to reach and accessible in large numbers.
- Youth are a powerful prevention resource.
- Adopting safe behaviour and attitudes is easier if started before patterns are formed.
- Young people make up an important part of most-at-risk populations, including sex workers and their clients, men who have sex with men and injecting drug users.
- Young people who have lost one or both parents, who are poor and otherwise disadvantaged are especially vulnerable.
- In addition, in generalized epidemics, 40% of all new HIV infections occur among young people aged 15–24, with girls and young women disproportionately affected—making them another top priority for HIV prevention.

What?

- Peer education and outreach to young people out-of-school, children and adolescents involved in sex work, street youth.
- HIV, gender, sexual and reproductive health and drug use issues included in school curriculum; gender inequalities addressed through life skills building for boys and girls.
- Address intergenerational and transactional sex through campaigns for social change.
- Ensure access to comprehensive sex education.
- Ensure access to youth friendly health services and HIV counselling and testing.
- Remove legal barriers to access prevention and care services including condoms.
- Involve parents and adults in community in school-based HIV awareness and prevention activities.
- Promote mass media campaigns to raise awareness, promote public debate, reduce stigma and promote gender equality.

How?

- Using mass media accessed by youth and social mobilization of young people.
- School-based programmes that provide sexuality education.
- Access to out-of-school youth through existing youth services and organizations such as youth clubs, workplace programmes, tailor-made programmes/services for most-at-risk young people.

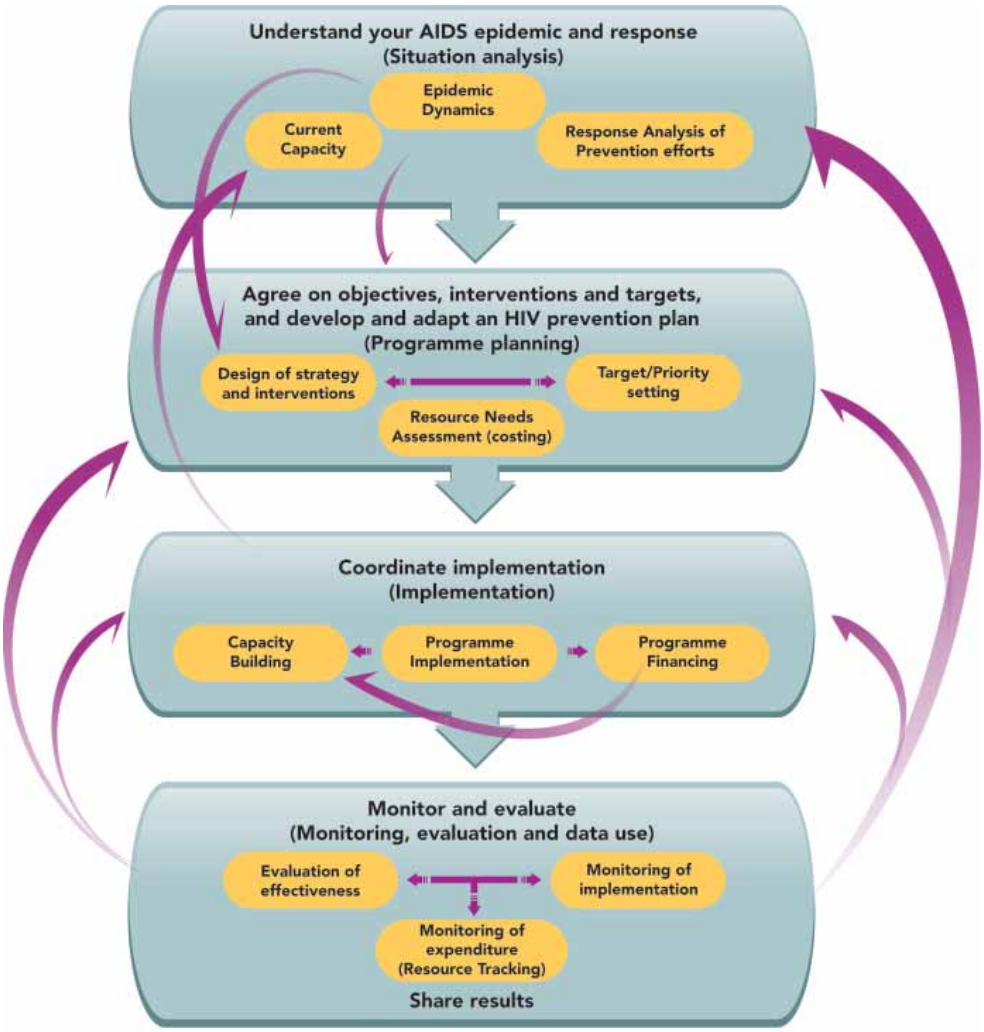
Differences in epidemic scenarios

- Low: focus on most-at-risk adolescents and young people—geographical focus, linked to multiple risk behaviours and risk environments, include sexual, reproductive and substance abuse health education and gender issues into school and teacher training curricula.
- Concentrated: focus on most-at-risk young people with measures that meet the needs of young people.
- Generalized and above: comprehensive life skills programme for all young people out-of- and in-school; focus on delay of sexual debut, condom use, HIV testing, reduction of concurrent and number of partners, gender inequality and risks arising from drug use.
- Mass media campaign to raise HIV awareness including vulnerability of girls and risks of intergenerational sex and programmes focused on the segmented needs of and that appeal to, young people out-of-school, reduce stigma and school-based programmes in all epidemic stages.

ANNEX 2: RESOURCES FOR HIV PREVENTION PLANNING

Programme design, including setting strategy and HIV prevention measures on the basis of your epidemic situation analysis, is only one part of the integrated programming cycle.

HIV Integrated Programming Cycle



Adapted from the National HIV Prevention Planning Cycle of the UNAIDS policy position paper on Intensifying HIV prevention, 2005

A number of tools and resources are available to assist communities, governments and other stakeholders to plan and implement the HIV integrated programming cycle. Most focus on the full comprehensive response, including prevention, treatment, care and support, or on specific areas or audiences.

Tools for HIV Prevention Planning

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"We encourage countries to know their epidemic because we have learnt over the last twenty-five years that the epidemic keeps evolving. It is important for countries to take stock of where, among whom and why new HIV infections are occurring. Understanding this enables countries to review, plan, match and prioritise their national responses to meet these needs".

Dr Peter Piot
Executive Director, UNAIDS

Joint United Nations Programme on HIV/AIDS (UNAIDS)
20 avenue Appia, 1211 Geneva 27, Switzerland
Telephone: (41) 22 791 36 66; Fax: (41) 22 791 4835
Email: distribution@unaids.org
Internet: http://www.unaids.org

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