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UNAIDS Expert Consultation on Behaviour Change

in the Prevention of Sexual Transmission of HIV:

highlights and recommendations

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Foreword

A quarter of a century of global experience in responding to HIV has produced some promising innovations—and underscored some persistent challenges. Despite recent advances in the expansion of access to prevention, treatment, care and support services, the fundamental role of human behaviour in the continued spread of HIV is increasingly clear. Remarkable local and regional differences in the intensity and scope of the pandemic serve as powerful reminders that social and cultural factors ultimately shape the impact of HIV on both individuals and communities. Now more than ever, our capacity to manage a growing and unsustainable demand for HIV-related care and treatment seems contingent on our ability to facilitate the adoption of key prevention behaviours.

Although we continue to place great hope in opportunities to employ male circumcision, microbicides, vaccines and other new and potential approaches to prevent the spread of HIV, we also recognize that failure to sustain a focus on behaviour change threatens to undermine the benefits of such advances. Unfortunately, fostering behaviour change is not an easy task. It demands a persistent commitment to meeting the diverse and changing needs of individuals, and to addressing the characteristics of their social, cultural and physical environments that place them at risk. It is both a collaborative process and an urgent imperative.

Nevertheless, we can now derive considerable strength and inspiration to meet this challenge from a growing number of settings in which substantial changes in behaviour have occurred and have been accompanied by significant declines in HIV infection rates. In Cambodia, Thailand, and parts of southern India, a focus on programmes to meet the needs of specific populations at elevated risk appears to have contributed to dramatic declines in infection rates in these populations, as well as in the general population. In places such as Kenya and Zimbabwe, in which HIV has spread rapidly through the general population, changes in behaviour norms appear to have disrupted some of the sexual networks that allowed HIV to pass from person to person, contributing to lower infection rates.

These and other examples underscore some critical elements of success: the need to focus HIV prevention efforts on the diverse sources of new infections in different epidemic contexts; the need to support and empower individuals to understand and minimize their infection risks through the adoption of prevention behaviours; and the need to engage communities and available social capital to take action against stigma and support sustained change.

This report seeks to reflect and advance what we hope will be part of a continuing global dialogue about the role of behaviour change in intensifying HIV prevention. To a certain extent, the meeting it documents had its origins in a series of our own personal conversations and reflections about the enormous opportunities that exist to pool both resources and expertise to save lives. But it is our conviction that the richness of the consultation itself testifies to a widespread recognition of the essential role that behaviour change can and must play in turning the tide of the pandemic. The challenges are indeed great, but we are increasingly equipped with both

evidence to inform action and a recognition of the enormous potential of our shared efforts.

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Meeting summary

On 25–26 September 2006, 26 experts from 17 countries were joined by UNAIDS for an expert consultation to reconsider the state of knowledge about behaviour change measures for the prevention of sexual transmission of HIV.

This meeting fulfilled a commitment to the UNAIDS Programme Coordinating Board in June 2005, to consider in depth the current state of the art in behaviour change. The objective of the meeting was to create a forum for dialogue about the evidence and priorities to prevent sexual transmission, to pinpoint a few specific barriers to behaviour change that can be overcome, and to seek a practical way forward to innovate and test or expand some promising new approaches to behaviour change. The meeting was co-chaired by Peter Piot, Executive Director of UNAIDS and Kent Hill, Assistant Administrator for Global Health of the United States Agency for International Development (USAID). It was planned collaboratively by staff of UNAIDS and the United States Office of the Global AIDS Coordinator. The agenda and participants are listed in Annexes 1 and 2.

Background papers were commissioned to summarize relevant epidemiological data and prevention strategies, and to analyse some of the major drivers of high-risk behaviour (Annexes 3 and 4 provide links to the papers and meeting presentations).

Many of the key principles of HIV programmes to promote healthy behaviour have been known for 20 years, but have still not been sufficiently scaled up. The opening session established a framework for identifying and analysing behaviour and behaviour change needs in specific epidemiological contexts (low-level, concentrated, generalized, and hyperendemic), as recommended in the UNAIDS *Practical Guidelines for Intensifying HIV Prevention*[1]. The session included provocative presentations on gender inequality and household wealth (or poverty) as two frequently cited drivers of risk behaviour, on new thinking about behaviour change in highly generalized (or hyperendemic) settings and about the challenges of measurement to document progress in comprehensive HIV prevention programmes.

Moving from plenary sessions into small groups and back into plenary over the two days, participants identified and analysed four priority issues in behaviour change to reduce sexual transmission of HIV:

- prevention measures that are effective in concentrated epidemics;
- analysis of and responses to 'concurrency' (sexual behaviour involving multiple concurrent partners) and other potential drivers of the extraordinary, hyperendemic scenarios of southern Africa;
- gender inequality, intergenerational sex, and gender-based violence, as major sources of vulnerability for women and girls in all epidemic scenarios; and
- HIV-related stigma and denial as barriers to behaviour change.

[1] Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, Joint United Nations Programme on HIV/AIDS, 2007.

Summary of working group findings

Group A (policy and programmatic actions to improve behaviour change outcomes in concentrated epidemic scenarios) agreed that the core problems in concentrated epidemics are securing adequate information about "where the next 1000 infections will come from" and building the political will and foster the engagement of communities to ensure that high-quality services and enabling policies are in place and a sufficient level to respond to the specific needs of those settings and people.

The key issue in concentrated epidemics is to "know your epidemic"—including the drivers of risk behaviour—and to match the prevention response to the specific populations, locations, and drivers.

Gender inequality and human rights are critical issues in concentrated epidemics, as the most at risk are often socially marginalized and thus unable to freely seek information and services, or to control their risks.

Group B (concurrent, multiple partner relationships in generalized epidemics) echoed the call for better surveillance and programme evaluation data to define what works and determine where the next 1000 infections will come from. They emphasized that gender and sexual norms that subordinate women, accept intergenerational sex, and allow high levels of sexual violence are pervasive and undermine HIV prevention (this pertains to all epidemic scenarios).

The group stressed that prevention measures focused on individual knowledge and choices will never suffice. Rather, these must be complemented by a social movement, in which people are encouraged to know their HIV status and adult men are held responsible for behaviour change.

The group called for development, testing and evaluation of mass media and community mobilization strategies to convey the special risks of concurrent sexual partner relations, to know if they are worth scaling up and replicating in other places.

Group C (policy and programmatic actions to reduce gender inequality, gender-based violence, and intergenerational sex) posited that gender is at the heart of effective HIV prevention. A central puzzle for the meeting participants was why are we still dealing with so many of the same gender issues over 20 years of responding to HIV? Like Group B, they noted that gender norms that tolerate male behaviours such as multipartner sex, sexual violence and coercion, and intergenerational sex, while they prescribe sexual naivety, early marriage, and high fertility for girls, make it hard for women and girls to benefit from 'ABC' programmes that promote abstinence (A), faithfulness to one partner (B), and/or condom use (C). The working group emphasized that these observations are now backed up by experience and research, and they endorsed Dr Geeta Rao Gupta's model of the four levels of programmatic response to reduce gender inequality: "do no harm"; compensate for inequalities; trigger transformation; and empower women. They proposed that HIV prevention programmes need: a systematic process to review the gender-responsiveness of HIV programmes, using checklists to

ensure clarity and focus on the desired outcomes; to include measurable indicators of progress; to ensure that all the necessary audiences and organizations are leveraged; and to ensure that information and mobilization approaches are culturally relevant and sustainable.

Group D (HIV-related stigma and denial) addressed the origins or causes of stigma, its different applications and effects among women and men and among young people, and what specific steps can be taken to reduce them in and through HIV-related programmes. As in other working groups, the participants confirmed that individual measures need to be complemented with efforts to promote social change. They recommended differentiating between measures of success (stigma reduction) in the popular environment, in institutions and services, in the agendas and behaviours of leaders, and in HIV programmes themselves. Noting that changing attitudes and social norms takes time, they recommended moving from short turnaround, 'project mode' to a more sustained and sustainable model through: incorporating HIV programme goals such as stigma reduction into continuing reproductive and sexual health services; building the capacity of vulnerable populations and communities to plan and run their own programmes; and long-term commitment to institutionalizing behaviour change programming, including stigma reduction.

Highlights of issues discussed

In the plenary discussions, as well as in the working groups, a wealth of experiences and insights were shared and developed during the two-day meeting. The diverse experience of the participants contributed to this richness, and participants expanded each others' views, while recalling the task to focus on practical steps to improve prevention results. The following highlights are developed in more detail in the body of the report.

Know your epidemic is not just for epidemiologists and disease surveillance experts: it needs to become the approach to HIV prevention programming. Too often programmes are undertaken without clear diagnosis of current needs and without prioritizing to ensure that those needs are met. Knowing your epidemic means knowing where it exists (regionally and in terms of the populations most affected) and also what are its main drivers and where it is moving. In-depth understanding of the social and behavioural context is thus central to knowing your epidemic.

Behaviour change programmes need to be reviewed, renewed and differentiated in light of current knowledge. Too many behaviour change measures are neither tailored nor provided for the populations and settings with highest rates and highest risks of HIV. They need to be reviewed and rethought in terms of up-to-date understanding of HIV epidemics at the subnational level, and in terms of the traditions and methods of community participation, including the participation of vulnerable populations including people living with HIV, women, and young people.

Behaviour change messages and models that focus on individual knowledge, skills, and choices are not enough, particularly in generalized epidemic contexts. As indicated in the UNAIDS policy position paper on

intensifying HIV prevention[2], effective prevention involves reducing risk, vulnerability, and impact. Projects need to move from an intervention or service paradigm to one of engagement, and from a paradigm of options to one of human rights. In a rights-based, engagement paradigm, segmented and tailored information and skills-building for individuals is coupled with mass media attention, social mobilization, advocacy, and leadership to change policies and social norms, and to invest in reducing the vulnerability of disadvantaged and marginalized populations.

Messages that just encourage gender equality and male responsibility are too weak and diffuse. There needs to be more explicit programming to help move towards transformative and empowering approaches to gender relations to help men take charge of their sexuality, and to create an updated social consensus on what constitute the rights and duties of men with regard to sex and social privilege. Current gender norms in many social contexts appear to legitimate or excuse male exploitation of women and children and intolerance of men who have sex with men. Programme examples from various regions show that these norms can be changed.

Plan better for sustainability. Evidence from Thailand, Uganda, and much of western Europe and North America shows that prevention programmes must be continued, renewed, and updated, or risk behaviour will return and HIV incidence will increase again. HIV treatment is for life: the same realization is needed in behaviour change measures. The project paradigm has to be replaced by lodging prevention measures in a continuing, funded, institutional home, and by ensuring that the home has people with expertise and a mandate to plan, implement evaluation and report on behaviour change measures. HIV prevention programmes, including those designed to reduce risk behaviour, need to be institutionalized as critical components of public health and development, and embedded in longer, more consistent cycles of health promotion and social support for change.

Invest much more in evaluation. Evaluation research on behavioural measures to reduce sexual transmission in low- and middle-income countries has been grossly inadequate. Systematic and greatly expanded effort is needed to define the basic parameters of activities designed to reduce HIV risk and vulnerability (the objectives; the nature, quality, and intensity of inputs; the audiences; and the settings), to monitor fidelity of implementation, to measure success in reaching planned objectives, and to measure the cost of effective models. This is essential in order to support planning and resource allocation for behaviour change programmes within and across countries.

This meeting provided an opportunity to reflect on behaviour change as an important element in strategies for the prevention of sexual transmission of HIV. Presentations on the epidemiology of HIV drove home the point that HIV epidemics are dynamic and differentiated within countries and even within subnational units (districts, etc.). Vigilance about how they evolve and adapting the response to match are at the heart of effective HIV prevention

[2] Intensifying HIV prevention: a UNAIDS policy position paper. Geneva, Joint United Nations Programme on HIV/AIDS, 2005.

programming. Effective responses are local, and even at the local level, there is change from year to year. Yet in many places, the responses are 20 years old. To keep up with this dynamic virus, national HIV programmes need to plan for continuous dialogue with and engagement of communities and groups that are affected by the epidemic and engaged in the response. Furthermore, new biological understanding of fluctuating HIV infectivity, combined with accumulating data on concurrency and sexual networking, provides a new angle on the risks of having multiple sexual partners where HIV is prevalent. This issue needs to be further researched and applied in HIV prevention programmes.

As for HIV treatment, effective prevention is for life. It is therefore both necessary and practical to invest in combination, nuanced strategies that both support individual knowledge and behaviour change for most-at-risk and vulnerable populations, and that also address drivers of this epidemic, promoting gender equality and respect for human rights. These principles, highlighted in the 2005 UNAIDS policy position paper on intensifying HIV prevention, must be made operational according to the epidemiological and social context, but they apply in all epidemic scenarios.

This two-day meeting of experts was part of a larger concerted effort by UNAIDS to catalyse debate, provide practical guidance, and create a more unified and mobilized constituency for effective HIV prevention scale-up. While the meeting did not reach a consensus on many issues, it did identify solid common ground on what needs to be done to make established HIV prevention principles operational, so that countries can achieve their goals of moving towards universal access to HIV prevention, treatment, care, and support for those who need them and to control and reverse the AIDS epidemic by 2015.

Introduction

On 25–26 September 2006, 26 experts from 17 countries, joined by UNAIDS Secretariat and Cosponsor staff, met for an expert consultation to reconsider the state of knowledge on behaviour change measures for the prevention of sexual transmission of HIV.

In June 2005, the UNAIDS Programme Coordinating Board unanimously endorsed the UNAIDS policy position paper on intensifying HIV prevention. The paper summarized the principles and the policy and programmatic actions that together comprise effective HIV prevention programmes. The first of the programmatic actions featured in the paper is to prevent sexual transmission. While the paper indicated key programmatic and policy actions that are used to prevent sexual transmission, it did not go into detail about what is effective in behaviour change efforts for varied populations and in diverse national, cultural, and epidemiological settings. Therefore, UNAIDS convened a small group of experts with diverse regional, technical, and institutional backgrounds to consider these issues. The meeting was co-chaired by Peter Piot, Executive Director of UNAIDS, and Kent Hill, Assistant Administrator for Global Health of the United States Agency for International Development. It was planned collaboratively by staff of UNAIDS and the United States Office of the Global AIDS Coordinator and was organized by UNAIDS.

Background papers were commissioned to summarize relevant epidemiological data and prevention strategies, and to analyse some of the major drivers of high-risk behaviour. Many of the key principles of HIV programmes to promote healthy behaviour have been known for 20 years, but still are not being sufficiently scaled up. The opening session included provocative presentations on gender inequality and household wealth (or poverty) as two frequently cited drivers of risk behaviour, on new thinking about behaviour change in highly generalized (or hyperendemic) settings and about the challenges of measurement to document progress in comprehensive HIV prevention programmes.

The co-chairs opened the meeting with calls for an open exchange, a dispassionate examination of evidence, and creative thinking to reinvigorate behaviour change programming to reduce sexual transmission of HIV. They noted that evidence from a few countries in sub-Saharan Africa, South Asia, South-East Asia and the Caribbean demonstrates that whole societies can change behaviour enough to turn the tide of the HIV epidemic—a fact that inspires both hope and some impatience, as there are so many countries where such success is not yet in view. The intention of this meeting was to consider the current state of the art in behaviour change, to pinpoint a few concrete barriers to change that can be overcome, and to come up with a practical way forward to be innovative and test or expand some promising new approaches to change. The meeting stimulated dialogue about research evidence and participants' programme experience, and a range of recommendations were brought forward for HIV programme managers, researchers and policy-makers, regarding what they can do more of, and what they can do differently to intensify HIV prevention efforts aimed at reducing HIV risk behaviour in specific epidemiological and social contexts. The participants acknowledged that changes in approach are critical to making HIV prevention a more effective component of AIDS programmes in

the context of broad, multistakeholder agreement on the need to move towards universal access to comprehensive HIV prevention programmes, treatment, care, and support to those who need them, by 2010[3].

Six presentations established a framework for addressing behaviour and behaviour change needs in specific epidemiological contexts, as many factors are different in low, concentrated, generalized, and hyperendemic scenarios. The bulk of the meeting involved dialogue and debate among participants, in small groups and in plenary sessions. On day 1, small working groups considered the evidence summarized in the presentations, defining key challenges, gaps and needs. Participants identified four priority issues that were then debated in depth in working groups on day 2. The priority issues were:

- prevention measures that are effective in concentrated epidemics;
- analysis and responses to 'concurrency' (sexual behaviour involving multiple concurrent partners) and other potential drivers of the extraordinary, hyperendemic scenarios of southern Africa;
- gender inequality, intergenerational sex, and gender-based violence as major sources of vulnerability for women and girls in all epidemic scenarios; and
- HIV-related stigma and denial as barriers to behaviour change.

This report outlines the presentations which framed the meeting, describes the key points shared from the small group discussions, summarizes highlights from the plenary sessions, and synthesizes the main recommendations brought forward from the meeting. The agenda, participants list, and links to the presentations and background papers are annexed to this report (Annexes 1–4).

Presentations

Epidemiological trends and their implications for HIV prevention

An overview of the global HIV epidemic was presented by Dr Peter Ghys (UNAIDS). He reminded participants that HIV has historically defied many epidemiological projections—including the expectation that levels of prevalence would peak and then rapidly fall off in African countries. UNAIDS' 2006 review of the evidence identified countries where behaviour change has contributed significantly to halting HIV spread—including Cambodia, Kenya, Thailand, Uganda and Zimbabwe, four states in India, and in urban areas of Burkina Faso and Haiti, where the epidemic has actually been reversed. However, there are still eight countries with adult HIV prevalence greater than 15%, all of them in sub-Saharan Africa (Figure 1), where behaviour change to reduce HIV transmission does not appear to have taken hold extensively. There will be countries in which HIV prevalence will be reduced in one part of the country, while in other parts, the prevalence will increase. They will pose a stark challenge for HIV prevention programming.

[3] United Nations General Assembly. Scaling up HIV Prevention, Treatment, Care and Support, 24 March 2006. A/60/737. http://data.unaids.org/pub/InformationNote/2006/20060324_HLM_GA_A60737_en.pdf
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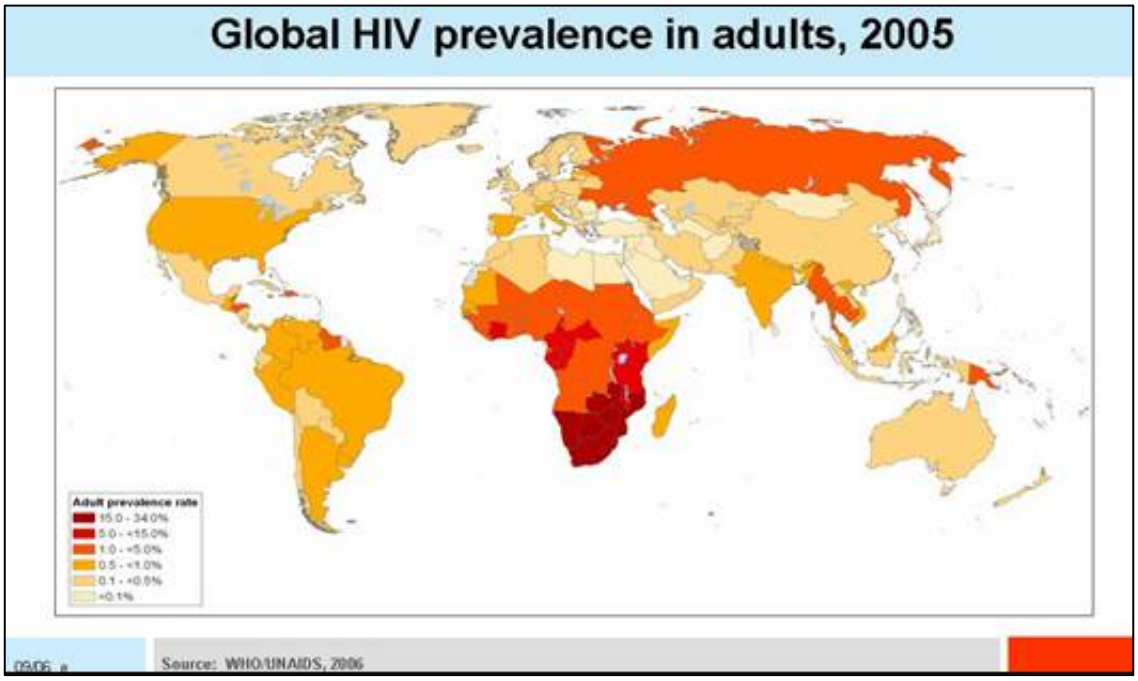
Figure 1 Global HIV prevalence in adults, 2005



Dr Ghys portrayed the diversity of HIV epidemics, regionally and within countries. He emphasized that with 20 countries having commissioned representative national biological and behavioural surveys (Demographic Health Surveys with HIV testing (DHS-Plus)), in addition to sentinel surveillance in antenatal care clinics, and with populations with higher rates and risks of HIV[4], there is much more detailed information available today on the distribution of infections within national populations. This information helps policy-makers identify the right issues and refocus prevention efforts in the right direction. Dr Ghys emphasized that policy-makers need to know their epidemic and stressed that the important thing to know is the source of new infections: who is at risk and what risk behaviours and settings contribute to those new infections. He highlighted diverse behavioural risks in different regions and illustrated that HIV epidemics are dynamic. Successful past responses should not lead to complacency. HIV epidemics are changing and can change very rapidly. For example, Thailand's epidemic began with an explosion of infections among injecting drug users in the late 1980s; by the 1990s, the epidemic had spilled over into the general population due to the extensive crossover between risk arising from injecting drug use and sexual risk. Only constant vigilance and involvement of the affected communities can produce the information required to keep HIV responses efficiently on course. In Thailand and Uganda, surveillance indicates a resurgence of HIV, as HIV prevention programmes have lagged behind after more than a decade of success.

Dr Ghys alerted the participants to the need to consider the epidemiology and prevention issues that are raised by care and treatment. Increasing access to antiretroviral therapy increases HIV prevalence due to more people

[4] World Health Organization and Joint United Nations Programme on HIV/AIDS. Second generation surveillance for HIV: compilation of basic materials [CD-ROM]. Geneva, World Health Organization, 2002 (WHO/HIV/2002.07).

with HIV living longer. This underscored the importance of shifting from a focus on national HIV prevalence to seeking information on new infections (incidence), on variations in HIV prevalence within countries, and on measuring rates of behaviours that increase the risk of exposure to HIV.

Gender, sexuality and HIV

Dr Geeta Rao Gupta (International Center for Research on Women) presented the background paper she co-authored with Ellen Weiss, entitled *Gender and Sexuality: Implications for HIV Prevention for Women*. This paper takes a fresh look at what is known about creating the conditions that will enable women and girls to adopt behaviours that prevent the heterosexual transmission of HIV. Gender inequality is a critical barrier to HIV prevention: it has often been viewed as too abstract or too deeply ingrained to be altered by HIV programmes. Dr Gupta unequivocally concluded that this can be done. Gender roles and expectations are cultural and therefore learnt, and are complex, but they can be changed through specific programmes that are within the time frame of public health programmes. She cited concrete examples from the paper that illustrated four strategies to reduce gender inequality.

- ***Do no harm***—i.e. programmes should not seek to reach short-term gains (such as increased condom use in casual sexual relations) by referring to or implicitly reinforcing gender stereotypes that enhance or legitimize risk behaviour, or that oppose the dignity and rights of young people, women and girls, men who have sex with men, or transgender populations.
- ***Address or compensate for gender differences*** in power and knowledge. Dr Gupta gave the example of microbicides and female condoms as prevention technologies that do or will help women protect themselves in the current inequitable climate, but are unlikely to change that climate. These are essentially harm reduction approaches in an unequal world.
- ***Trigger transformation*** in gender norms: HIV programmes can model and facilitate experiences of equitable gender relations, and policies and services can require and enforce gender equality in the programme setting by ensuring equal access and by engaging men in sexual health activities. Disallowing gender-based violence and prosecuting infractions are other examples. In such cases, health and social development programmes use various strategies to change the climate for women and girls, by demonstrating equitable social and gender norms.
- ***Empower women***. As a desired goal, this involves changing the background circumstances to unleash women's potential, by ensuring fair and equal access to information and resources, and by recognizing women's contributions on a par with those of men. Policy changes to ensure women's inheritance rights and to outlaw gender-based violence including marital rape are two examples of changes in the environment that would support women's dignity and autonomy as people and reduce their vulnerability to HIV risks and impacts.

The role of poverty and wealth in driving HIV transmission

Dr Stuart Gillespie (International Food Policy Research Institute) and Dr Robert Greener (UNAIDS) presented their background paper entitled *Is Poverty or Wealth Driving HIV Transmission?* They reported a number of observations based on recent national household surveys that conflict with

the widespread belief that poverty causes HIV risk. They cited studies that found a positive correlation between national wealth and HIV prevalence in sub-Saharan Africa, and analyses that have noted a higher HIV prevalence in urban areas where average household wealth is higher. They also drew attention to studies showing the potential impact of urban–rural circulation and high professional mobility, including labour migration. Recent analyses of data from representative national DHS-Plus by Mishra et al.[5] have taken these analyses to the individual household level. DHS studies with individually linked HIV serostatus results in eight countries (Burkina Faso, Cameroon, Ghana, Kenya, Lesotho, Malawi, Uganda, and the United Republic of Tanzania) found that relative wealth is associated with higher HIV rates in men and to a lesser extent in women. They also noted that Mishra's multivariate analyses indicate that "the effect of wealth status appears to operate through its association primarily with urban residence, the number of reported sexual partners, and age". In the studies by Mishra and Kongnyuy et al.[6], richer men more often reported having at least two concurrent sexual partners and having had more than five sexual partners in their lifetime than men in less wealthy households. This fits the gender stereotypes that had been cited by Dr Gupta and conflicts with the common perception that poverty leads to risk behaviour and thus to HIV.

Dr Gillespie and Dr Greener noted, however, that the available studies have examined associations between measures of wealth and HIV prevalence, whereas prospective studies are needed to establish how relative wealth or poverty relates to vulnerability and risk. Such studies also need to rule out the possibility that the association is explained by longer survival with HIV among wealthier people. They observed that the effect pathways linking HIV risk and wealth are complex and involve balancing positive factors (such as increased knowledge of prevention and increased condom access) and negative factors (such as increased numbers of partners, earlier sexual debut, and greater alcohol consumption). Citing the *Transitions to Adulthood study* by Hallman[7], and a cross-sectional study in Botswana and Swaziland by Weiser et al.[8], they acknowledged that poverty and food insufficiency can provide impetus for unprotected transactional sex, especially for women and girls. They observed that food insufficiency and malnutrition may also have a biological effect on increasing vulnerability to HIV infection, although this requires further research. In addition to affirming the importance of gender inequality as a barrier to HIV prevention, they pointed to a need for more nuanced mapping of the effects of economic development on HIV programmes. Increased disposable income for men is associated with increased risk behaviour (especially alcohol consumption and transactional sex). They signalled the need for attention to the gendered effects of economic inputs and for HIV prevention strategies to make pathways out of poverty less risky.

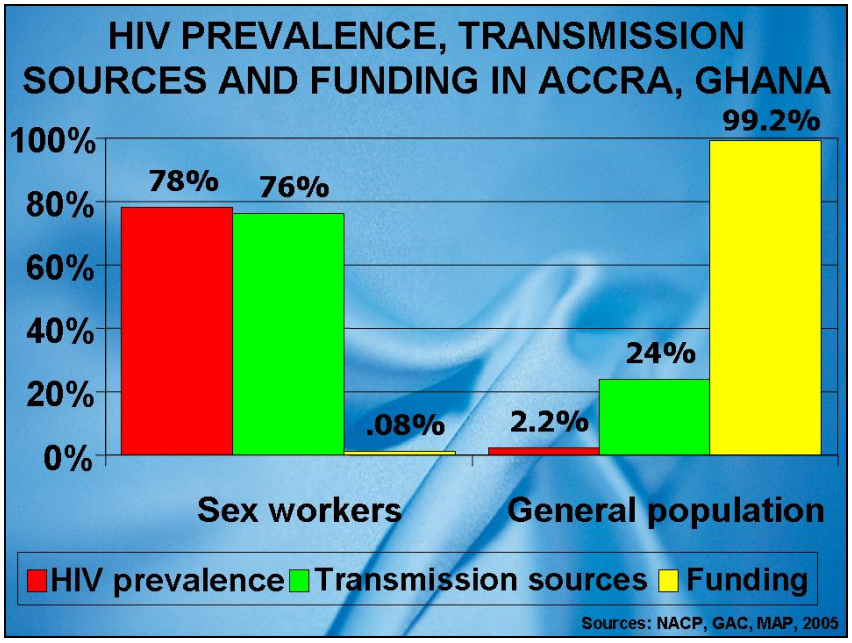
[5] Mishra V et al. Are poor more affected by HIV/AIDS in sub-Saharan Africa? The 2006 HIV/AIDS Implementers' Meeting of the United States President's Emergency Plan for AIDS Relief, Durban, South Africa, 2006:abstract 49.
6 Kongnyuy EJ et al. Wealth and sexual behaviour among men in Cameroon. BMC International Health and Human Rights 2006, 6:11.
7 Hallman K. Socioeconomic disadvantage and unsafe sexual behaviours among young women and men in South Africa. Policy Research Division Working Paper No. 190. New York, Population Council, 2004.
8 Weiser S et al. Food insufficiency is associated with high risk sexual behaviour among women in Southern Africa. Paper presented at the XVI International AIDS Conference, Toronto, Canada, 2006. University of California, draft.

Current thinking about behaviour change and prevention of sexual transmission of HIV

Dr David Wilson (World Bank) presented his background paper, *HIV Epidemiology: a Review of Recent Trends*. He echoed Dr Ghys' emphasis on the diversity among countries and regions in the nature of the HIV challenge, and on the importance of knowing your epidemic and matching HIV prevention measures to the behavioural and epidemiological needs of today. He presented summary data from Asia and Pacific regions showing that behaviour change, and most importantly, a reduction in multiple sexual partner relations has occurred in countries where HIV incidence has decreased. Using a framework of the distinction between concentrated and generalized epidemics, he presented a range of examples from World Bank studies that showed stark contrasts between the distribution of new infections and the consequent prevention needs in these different scenarios. In Ghana in 2005, for example, a World Bank study found that 76% of HIV infections are attributable to sex work (Figure 2). This contrasts with Zambia, in which there is a generalized epidemic, where more than 90% of sexually transmitted infections occur through heterosexual contacts in the general population and less than 10% among sex workers and their clients.

Dr Wilson presented examples of disconnections between such epidemiological and behavioural patterns and the design of national HIV programmes. In the Ghana example, 0.08% of World Bank resources for HIV prevention in Ghana were devoted to sex work projects; instead, the focus was on the general population, which accounted for less than a quarter of new infections (Figure 2).

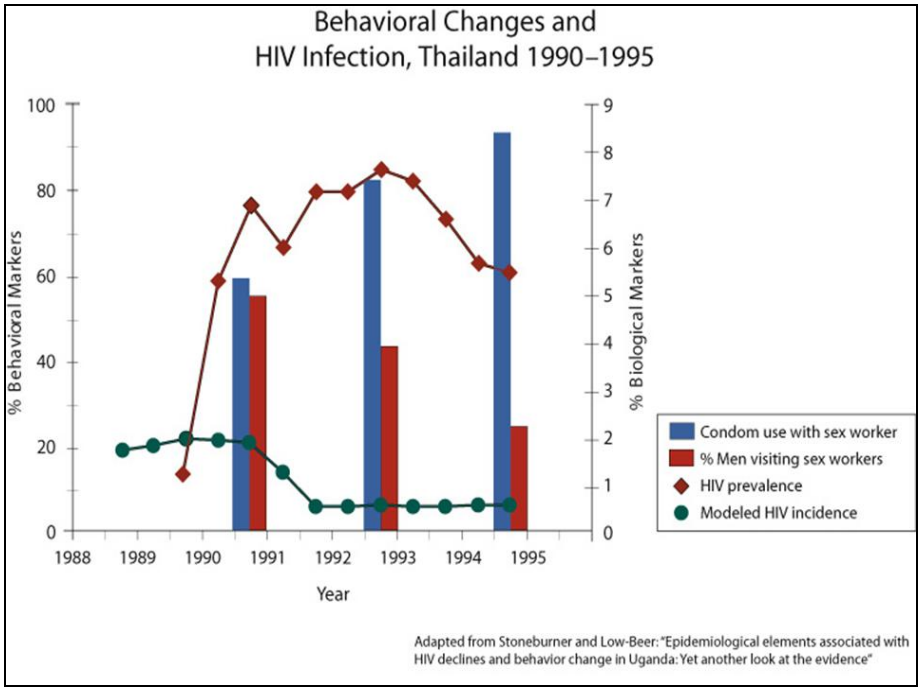
Figure 2 HIV prevalence, transmission sources and funding in Accra, Ghana



He argued that HIV prevention programmes need to be adjusted to keep up with changing sexual cultures, population movements, and economic and social conditions. Societies are dynamic in all world regions, with new

cohorts emerging, which bring changing communication and service needs. Uganda and Thailand, countries with generalized and concentrated epidemics, respectively, led the world in controlling HIV spread in the 1990s. Changes in sexual norms and practices, including not only increased condom use in sex work settings, but also a steep reduction in the proportion of men who visited sex workers, played a key role in both countries—the latter factor being even more significant than increased condom use. In the language of the current debate, according to Dr Wilson, the data indicate that 'B' (faithfulness to one partner) was as important as 'C' (condom use), if not more so, in turning these epidemics around (Figure 3).

Figure 3 Behavioural changes and HIV infection, Thailand, 1990–1995



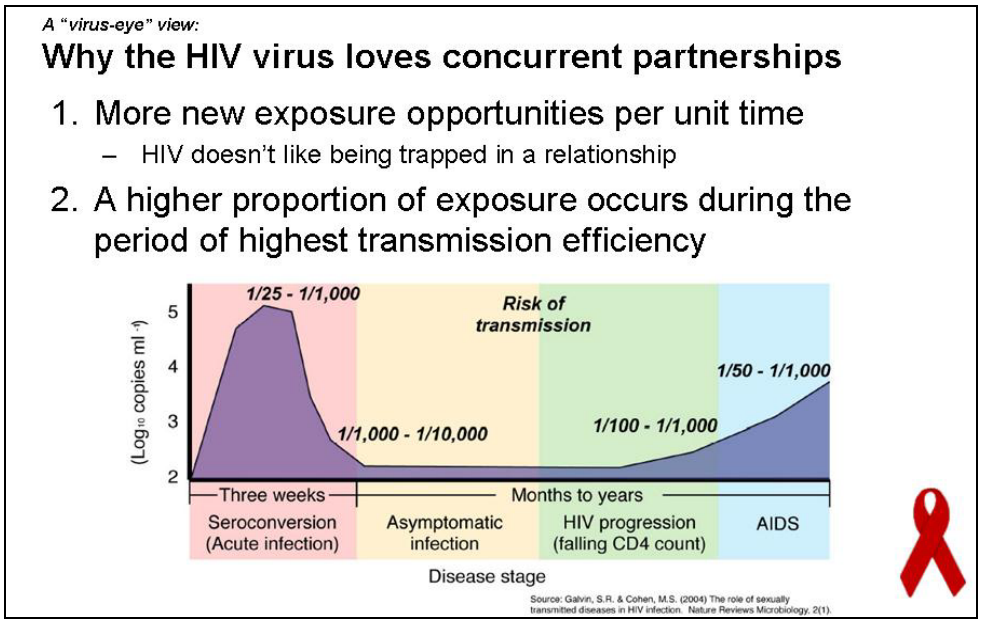
The rate of new HIV infections is, however, on the rise again. In concentrated epidemics, Dr Wilson argued that this is due partly to neglect: effective strategies are available, but they are not being implemented to scale. In Dr Wilson's view, in generalized epidemics, especially in the hyperendemic countries of southern Africa, more knowledge and more radical responses are required in the face of a lethal cocktail of concurrent sexual partnerships, and lack of male circumcision in most countries of the region. More focus on behaviour change measures dealing with male responsibility, reducing alcohol abuse, sexual coercion and violence, and "de-norming" intergenerational sex, is needed to turn these hyperendemic scenarios around. He argued for a dual strategy to change social norms while also supporting individual behaviour change through measures that build knowledge, motivation, skills, and self-efficacy for change.

So much risk, so little time: concurrent partnerships and a paradigm shift in understanding and addressing the highest prevalence HIV epidemics

Building on the premise that there are different strategic priorities in different epidemic settings, Dr Michael Cassell (USAID) stated that a lot is known about the kinds of targeted programming that are effective in concentrated epidemics, and that we must continue to emphasize the application of resources in these settings to scale up programming for most at-risk and vulnerable populations. Conversely, Dr Cassell noted that each year, most new infections continue to occur in sub-Saharan Africa, where despite some evidence of national-level decreases in HIV prevalence associated with behaviour change, we still face divergent perspectives on behaviour change priorities and effective programmatic approaches. He proposed that developing more effective behaviour change strategies for these highly generalized epidemic settings ranks among the most important current priorities for HIV prevention.

More effective strategies need to make use of the new science that indicates that concurrent sexual partnerships are potent vehicles for sexual transmission—while they do not engender commensurate perceptions of personal risk. Galvin and Cohen's work[9] on changes in infectiousness across the life-cycle of HIV infection (Figure 4) and other research indicate that the per-act likelihood of HIV transmission via general heterosexual activity during the acute infection stage (within three to four weeks of infection) may be as high as that of transmitting HIV via contaminated injecting equipment. Few if any HIV programmes explicitly communicate this. A high prevalence of concurrent, or overlapping, sexual partnerships in a population would allow for substantially more exposure of uninfected individuals to recently infected individuals during this period of acute infection.

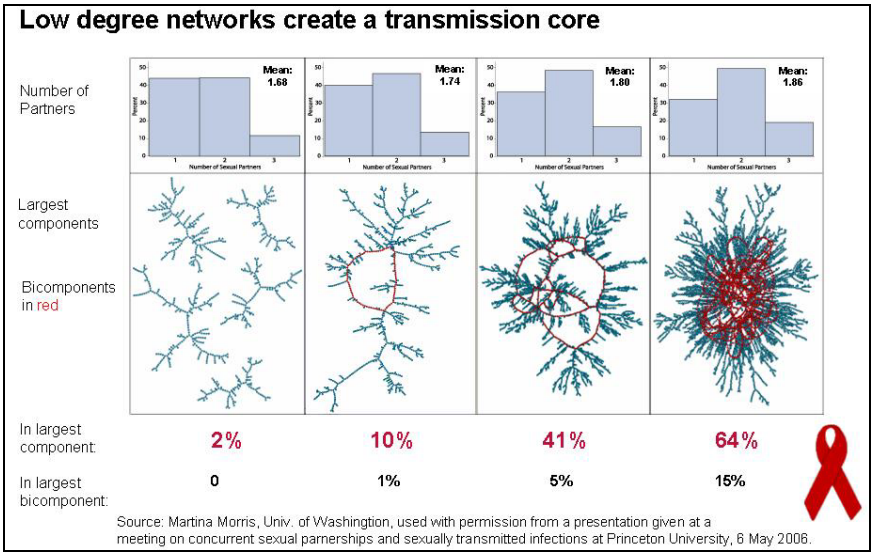
Figure 4 A 'virus-eye' view: why the HIV virus loves concurrent partnerships



[9] Galvin SR, Cohen MS. The role of sexually transmitted diseases in HIV transmission. Nat Rev Microbiol. 2004 Jan; 2(1):33-42.

In addition, he cited Martina Morris' data on sexual networks, illustrating how seemingly small differences in the mean number of sexual partners in a community could have a dramatic effect on sexual transmission of HIV. Figure 5 shows the extraordinary increase in connectedness when the proportion of the population that has two or three partners increases only slightly. Paradoxically, a high prevalence of concurrent sexual partnerships can allow the rapid transmission from person to person to person in a population in the relative absence of individuals who have many contacts (such as sex workers and frequent clients of sex workers) and without any one individual perceiving himself or herself to be at elevated levels of risk.

Figure 5 Low-degree networks create a transmission core



Like Dr Wilson, Dr Cassell concluded that decreasing incidence in generalized epidemics may therefore require changing individual perceptions and social norms—dramatically increasing the perceptions of risk and social undesirability of multiple sexual partner behaviours that at present are considered normal. He challenged the group to think about how these insights could be translated into HIV programmes, to communicate more specifically about the risks associated with concurrent sexual partnerships, and to think beyond strategies that attempt to reverse the most severe epidemics by reaching any one risk population or through any one programmatic approach.

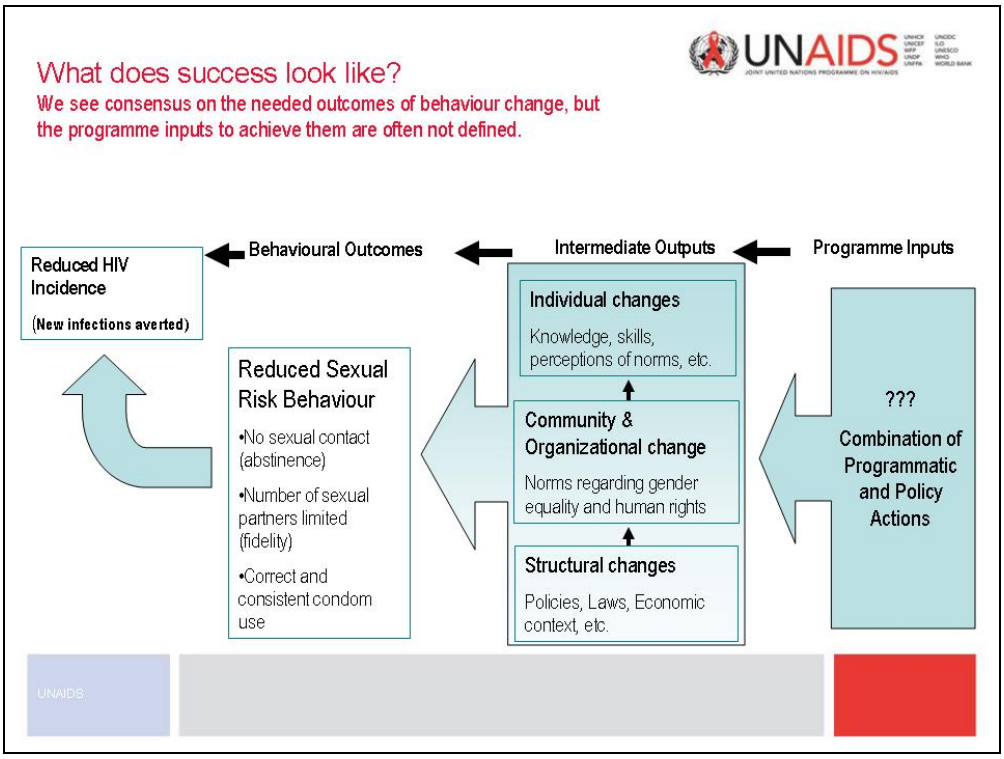
How do we measure success? (Beyond counting condoms)

Dr Barbara de Zalduondo (UNAIDS) concluded the morning session with a short presentation on the importance and challenges of monitoring and evaluation in behaviour change programmes. While the three behavioural outcomes to reduce exposure to HIV through sex—abstaining from sex, partner limitation, and correct and consistent condom use—have been advocated for over 20 years, only the third outcome area (condom use) offered objective indicators that are easily tracked through routine service statistics (number of condoms distributed or sold). Sophisticated models of behaviour change exist, which detail the importance of individual knowledge, perceptions, attitudes, and skills, and of the effects of peers, access to

information and services, and community norms and values. However, there has been a lack of global consensus on the specific programmatic and policy actions required to modify the many individual, community, and structural elements of these models so as to bring about the desired results in different regional and risk settings (Figure 6). Operational guidelines and quality standards for effective implementation of individual and combination behaviour change measures also rarely exist and are even more rarely used to ensure faithful implementation of clear protocols—in contrast to the norm for clinical services.

This gap has been particularly noticeable since 2001, when the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators were agreed upon by the global HIV community. In the areas of HIV treatment and care and support, the UNGASS indicators are at the programme output level (numbers of people served, etc.), and thus are easy to relate to programme planning and improvement. In contrast, the behaviour change indicators are outcome indicators (age of sexual debut, number of sexual partners in the past 12 months, etc.). They identify important results, but do not provide the kind of obvious road map for planners and managers on what to do more of and what to improve, in order to achieve those outcomes.

Figure 6 What does success look like?



The 2005 UNAIDS policy position paper on intensifying HIV prevention, pointed out that a range of behaviour change measures and policy changes are needed to overcome the individual, community, and structural barriers to behaviour change. The previous speakers had challenged the participants to define steps to overcome gender inequality, to make routes out of poverty less risky, and to change social norms around concurrent sexual

partnerships, male sexual responsibility, sexual and gender-based violence, and intergenerational sex. Dr de Zalduondo emphasized that since "indicators drive public health programming", we need to provide programme managers with two things in relation to these new programmatic and policy approaches:

- behaviour change models and protocols that provide concrete definitions of success in terms of observable programme outputs, (e.g. training of adult and young men and women in crisis counselling for sexually abused women and girls);
- reliable and practical output indicators that behaviour change programmes can use to document, analyse, and improve their progress annually (e.g. number of districts with one or more shelters that provide confidential crisis counselling for abused women and girls).

The definition of programme outputs is critical to annual monitoring and measurement, and the ability to convincingly report progress each year is critical to building confidence in new programme and policy measures, and to keeping the funding flowing.

Working group findings

With the background material in place, participants were assigned to small groups to brainstorm on and prioritize the critical issues and needs for enhancing behaviour change to reduce sexual transmission of HIV. The presentations had emphasized that after over 20 years of responding to HIV, there are some concerns and measures that are firmly established (e.g. the negative impact of gender inequities on HIV prevention), whereas other concerns are not sufficiently understood (e.g. the relationship between poverty and HIV risk).

The array of issues in behaviour change is vast and multifaceted, so through a series of small group and plenary discussions, the participants identified and prioritized four important issues to focus on in the meeting. Two of the selected issues centred on improving the fit of the prevention response to the epidemic and to the drivers of HIV transmission in concentrated epidemics around the world. In such settings, there is two decades of experience, with documented success stories of reducing HIV spread. However, in the hyperendemic settings of southern Africa, which have only recently been recognized, behaviour change strategies have failed to limit sexual transmission. The other two issues selected by the group—HIV-related stigma and denial, and gender inequality and inequality in sexual relationships—are barriers to behaviour change in all epidemic scenarios. They share the challenges of being rooted in social history and regulated by social and cultural norms. Thus they challenge HIV prevention programmes to move beyond the individual behaviour change paradigms of the 1990s to elicit community- or societal-level responses.

In the four working groups, participants shared their experience and worked together to discuss what is new after two decades of responding to AIDS, and what actions we can recommend to policy-makers and HIV programme planners at the end of this meeting. The groups were encouraged to clearly define the desired outcomes to be achieved by resolving their critical issue (i.e. what success looks like) and to consider how success should be

measured. The working groups took different paths to answer these questions: their main observations and recommendations were as follows.

Group A: policy and programmatic actions to improve behaviour change outcomes in concentrated epidemics

Effective prevention programmes in concentrated epidemic scenarios focus effort on defining the populations and settings with highest rates and highest risks of HIV infection, and on engaging people in those populations and settings to define and meet their specific needs for information, health, and other services, and support. After 2 decades, a great deal is known about how to do this. However, often this knowledge is not put into practice or not with sufficient intensity, quality, and coverage. Therefore, the most important recommendation for concentrated epidemics is to focus on and scale up proven strategies to meet the needs of key populations.

To support this goal, the group recognized a number of actions that are needed in greater frequency or with greater consistency.

- Collect adequate and timely data on the key populations—those with highest rates of HIV—and bridging populations.
- Catalytic activities to advocate with and engage leaders at all levels in recognizing the realities of HIV and of vulnerability.
- Policies that establish HIV prevention and treatment as rights.
- Ensure behaviour change programmes not only build knowledge but also address individual attitudes and skills and the group values and norms that support changes in behaviour.
- Address the social context that can impede providers' access to vulnerable populations and impede the participation and leadership of vulnerable populations in improving their own health. Specifically, reduce gender inequality, HIV-related stigma and discrimination or harassment of vulnerable populations.
- Create opportunities for reflection, sharing, and reviewing experiences of government and civil society.
- Intensify political advocacy for effective HIV and human rights policies and programmes.
- Ensure there are long-term resource mobilization plans, to sustain programmes over time.
- Invest in building the capacity of civil society as well as government to respond to the epidemic.

The group also identified a number of pitfalls to be avoided. These included:

- mechanization of the response—i.e. automatic repetition of programmes without review and evaluation of their effectiveness;
- piecemeal, low-coverage or short-term activities rather than a sustained and sufficient response;
- failing to reach out and involve partners in other sectors—e.g. police or justice—who can make or break a programme that aims to serve marginalized populations.

It was agreed that the core problems in concentrated epidemics are securing adequate information about where the next 1000 infections will come from and building the political will and engagement of communities to ensure that high-quality services and enabling policies are in place to respond to the specific needs of those specific settings and people.

Group B: concurrent, multiple partner relationships in generalized epidemics

The second working group picked up the challenge of behaviour change programming in countries and settings where the HIV epidemic is driven by sexual transmission in the general population—i.e. in settings and sexual partnerships that have not been emphasized or labelled as high risk. Transmission within married couples or other stable sexual relationships, and to or among young people who are not exposed to other risks (e.g. injecting drug use, sex work, or sex between men) are classic examples. The group decided to focus on the hyperendemic settings of southern Africa and on concurrent multiple sexual partnerships. Their strategy was to follow through from defining the problem, to listing principal barriers to change, to identifying critical policy and programme actions to overcome the barriers.

Definition of the problem

- Recent analyses of the combined effects of infectiousness and sexual networking indicate that existing ways of measuring and communicating about multiple partnerships are inadequate. We need to better understand, measure, and communicate the heightened risks of concurrency.
- Technical categories for sexual partnerships (concurrent, multiple, casual, regular, commercial, etc.) are complex and often cannot be translated into different languages.
- Local categories are also very diverse and are rarely elicited and studied. This is a huge challenge both for communication and measurement.
- People are highly creative in interpreting the available labels and categories for sexual relations to maintain a positive self-image and to achieve their relationship goals (e.g. “serial monogamy with dovetailing” and “spicing my life” were two culturally specific labels mentioned).
- Gender and sexual norms, including norms around intergenerational sex, are critical components that have to be addressed.
- There is a need to unpack the emerging knowledge about concurrency and translate it into clear simple facts that health programmes should communicate.
- The issues overlap with other social issues beyond HIV, such as alcohol use and vulnerability.

Barriers to change

- Insufficient epidemiological information—where are the new infections?
- Inadequate HIV counselling and testing programmes (lack of motivation for testing and lack of programmes specifically for couples).
- Pervasive gender inequities.
- Underlying taboos that silence or complicate public debate on sex.
- Broader social and political forces that threaten institutions such as the family and marriage.
- Lack of historical perspective.
- Adversarial (zero-sum) framing of gender issues, whereas both men and women would benefit from greater gender equality.

Critical policy and programme actions and outcomes to overcome the barriers

- Promote leadership at all levels.
- Encourage people to know their HIV status and create a safer environment for testing and disclosure of serostatus.
- Use the full range of mass media and advocacy approaches to support a social movement and social change that will:
  - "de-norm" intergenerational sex, multiple partners, and unprotected sex with people of different or unknown HIV status;
  - support marriage and fidelity, and protection of girl children;
  - enable young people to abstain from sex;
  - work through locally appropriate messengers and role models.
- Support social change to reject gender-based violence and sexual coercion.
- Increase awareness of and response to the contributions of alcohol and drug abuse on sexual risk behaviour.
- Communicate the spectrum and risks of transactional sex.

While these issues, barriers, actions, and stakeholders are common across generalized epidemics, the group stressed that effective solutions are local. HIV prevention programmes need more emphasis on providing technical support for local solutions. High-coverage, mass approaches such as popular radio or television dramas are very effective in sparking local dialogue and that dialogue is critical to social change. However, the mass media alone or lack of investment in understanding local perceptions can remove important community and cultural differences (e.g. in history, language, and values) and can overlook people and institutions that can contribute to positive behaviour change. Respecting communities and working locally, however, should not be confused with romanticized notions of tradition and culture that may include outdated legacies of colonialism and patriarchy. The group stressed that behaviour change measures that convey the special risks of concurrent sexual partner relations need to be developed, tested, and evaluated, to know if they are worth scaling up and replicating in other places.

Group C: policy and programmatic actions to reduce gender inequality, gender-based violence, and intergenerational sex

Gender is at the heart of effective HIV prevention. This has been recognized for decades, so a central puzzle for the meeting participants was why are we still dealing with so many of the same issues, after 2 decades of responding to HIV?

The background paper on gender, sexuality and HIV had outlined key lessons learnt and provided a framework for defining what programmes can do today to reduce the impact of HIV on women and girls, and to reduce the impact of gender cultures on the HIV risks of all people. This working group focused on defining concrete outcomes that would reduce sexual transmission of HIV, and on the barriers, programmatic actions, and key stakeholders involved. They also provided specific recommendations for measurement of improved gender equality. They recognized that many of their issues arose also in other groups.

Definition of the problem or outcomes sought

- Decreased gender-based violence and coercion.
- Decrease in early marriage.
- Decreased intergenerational sex.
- Decreased numbers of sexual partners or partner change.
- Decreased unprotected sex.
- More equitable and respectful sexual and social relationships.

Barriers

- Gender norms that tolerate:
  - multipartner sex (for men and sometimes for women and men);
  - sexual violence and coercion;
  - early marriage for girls;
  - sexual ignorance and passivity for women and girls but sexual experience for men and boys;
  - sexual relationships between (older) men and (younger) girls.
- Norms of masculinity and femininity that entwine individual identity and self-evaluation with the above risk-enhancing gender norms.
- HIV-related stigma, which can be more intense for women than men and intensifies disincentives to HIV testing and disclosure of serostatus.
- Lack of education and of economic and social power and autonomy among women and girls, which constrain their actions and choices regarding HIV prevention, and often put abstinence, faithfulness, and condom use beyond their control.

Policy and programmatic actions

The actions available today to reduce these barriers include the following.

- Sexuality and life-skills education tailored to address the barriers listed above.
- Reviewing and reforming legislation and legal frameworks, and oversight to ensure that reforms are enforced.
- Community-based programmes to promote norms of masculinity that reject sexual violence and promote sexual responsibility.
- More gender-responsive HIV programmes (e.g. ensuring the availability and promotion of HIV testing and counselling for couples).
- More gender-responsive policies (e.g. primary schooling free of charge and subsidies for girls' education).
- Collaboration and action beyond the health sector to reduce women's vulnerability:
  - keeping girls in school;
  - ensuring property rights and inheritance rights for women and girls;
  - ensuring women's access to credit;
  - political leadership by and for women;
  - laws and services to protect women's rights in case of violence.
- Measures of success—existing indicators:
  - age at marriage;
  - age of sexual partner(s) (individual);
  - age of first sex;
  - rate and consistency of condom use (partner specific);
  - Gender Empowerment Measure score[10].

[10] The Gender Empowerment Measure seeks to measure relative female representation in economic and political power. It thus considers gender gaps in political representation, in professional and management positions in the

- Measures of success—new indicators needed in HIV programmes:
  - prevalence of violence against women;
  - age differentials among sexual partners;
  - frequency of communication with partner about sex;
  - perception of equality in decision-making;
  - percentage of women in a community or unit who own land or a dwelling.

The working group emphasized that these observations are now backed up by experience and research, and they need to be put into practice. They proposed that HIV prevention programmes need a systematic process to review the gender-responsiveness of HIV programmes, using checklists such as the above to ensure clarity and focus on the desired outcomes, to ensure that all the necessary audiences and organizations are leveraged, and to ensure that information and mobilization approaches are culturally relevant and sustainable.

Group D: HIV-related stigma and denial

This working group addressed the origins or causes of HIV-related stigma, its different applications and effects among women and men and among young people, and what concrete steps can be taken to reduce them in and through HIV-related programmes

Some group members saw denial as the principle challenge among young people. Stigma and denial are related, but are not the same, and the distinction needs further exploration. Social judgments that disrespect and devalue people and lead to ill-treatment and discrimination are the foundations of stigma. Internalized judgments (self-stigma) are also critical. These perceptions may be based on experience of ill-treatment, the expectation of ill-treatment, or both. The group considered the programme outcomes, barriers, programmatic approaches, and key stakeholders that can reduce HIV-related stigma and denial and suggested that these should be incorporated in practical guidance for programmes.

Defining success—outcomes sought

- Reduced sexual transmission of HIV.
- Reduced denial of HIV.
- Reduced HIV-related stigma—both observed (enacted) and internal (self-stigma).

Barriers to programmatic success in reducing HIV-related stigma and denial

- Insufficient knowledge about vulnerable populations. Populations that are vulnerable in one setting may be different to those in another, and the behaviours or conditions that lead to social judgements (stigma) in one place will have different implications in another.
- Labels and categories used by programmes that intentionally or inadvertently cause or increase stigma.
- Sensationalism in media and programmes that intensify stigma.
- Barriers to leadership by people living with HIV.

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economy, and in earned incomes. Human development report 2002. New York, United Nations Development Programme, 2002.

- Fear and efforts to scare people into adopting protective behaviour, which often cause us and them attitudes and discriminatory behaviour.
- Psychological processes that lead people to deny (opt out of) perceived risk.
- Gender differences in the application and impact of stigma.

Programmatic and policy approaches to reduce stigma and denial

- Ensure informed leadership at all levels, including active leadership of vulnerable populations.
- Implement policy changes to guarantee human rights and to protect the dignity of all people.
- Reduce self-stigma and empower people living with HIV by demonstrating or modelling acceptance and respectful interaction with HIV-positive people.
- Utilize existing HIV prevention programmes and infrastructure to decrease stigma (ensure stigma-reduction actions are planned and implemented), e.g. through expanding roles for HIV-positive people.
- Apply methods of communication for social change, including two-way dialogue and listening to people, to expand impact and keep messages up to date.
- Institutionalize stigma-reducing prevention programmes, to ensure sustainability.
- Advocate and plan long-term programmes, with longer funding cycles (five years).
- Move away from project mode and instead make stigma reduction part of pre-service training and the core business of health and development institutions.
- Link or incorporate HIV prevention programmes that take action against stigma into existing services, such as reproductive health services.
- Empower and resource vulnerable populations to run their own programmes and to engage with others in the general population.
- Support and extend community-based measures.
- Hold leaders accountable for commitments at all levels (from local values and promises to Millennium Development Goal 6).

This working group recognized that better and more routine measurement of stigma and denial is critical to establishing baselines and assessing the effectiveness of stigma-reduction activities. They recognized the progress achieved in the past five years in developing international standards and indicators for HIV-related stigma and discrimination, but felt these innovations are not yet widely known or used. They also noted additional challenges, as measures are needed to bring about effects at the individual as well as community level, and to have an effect on perceptions (e.g. self-stigma) as well as for observed behaviour (experiences of shaming or discrimination).

Measuring denial poses even greater difficulties, because by definition, it is intangible and requires either clinical assessment or a great deal of knowledge about individuals in order to distinguish denial from, for example, ignorance or lack of interest.

The group recommended that systematic qualitative methods could be used to develop indicators of HIV-related stigma; they are needed in and for:

- the popular environment (e.g. news coverage and entertainment);
- HIV programmes;
- institutions and services;
- the agendas and behaviour of leaders.

Rates of disclosure of HIV serostatus and frequency of exclusion from workplaces or from home and family also could be measured to describe the aggregate levels of stigma and their change over time.

Roles and strengths of key stakeholders

The meeting co-chairs proposed from the outset that there is a need for diverse and re-energized participation of a wide range of actors to stimulate and sustain behaviour change to prevent sexual transmission of HIV. The knowledge and energy of individuals and the social capital they can draw upon through their social networks and institutions are essential to scaling up effective behaviour change programmes. Coherence is important but this does not mean everyone has to do and think the same things. Different stakeholders have different strengths and contributions to make, and to be practical, these should be recognized and leveraged in programme planning. Thus all the working groups were asked to define the critical stakeholders that needed to be involved in implementing their recommendations and their specific strengths in reducing sexual transmission. Many commonalities emerged when considering the four working group themes, so the key ideas are presented together.

Stakeholders who carry influence as individuals as well as social capital through their roles and networks

- Local leaders are audiences for accurate information about HIV and are key actors in promoting behaviour change. They can use their varied roles both to advocate behaviour change and to model it in their own lives.
- Political leaders are usually local leaders. They also can include policy and programmatic reforms into political platforms and legislative agendas that can have a wide impact.
- People living with HIV are both the ultimate experts on HIV risks and prevention needs and are convincing communicators to their peers and communities—when their rights and dignity are protected so that they can disclose their serostatus.
- Parents are prime audiences for accurate information about sexual and reproductive health, including HIV, and they play crucial direct and indirect roles in guiding their children and as models for behaviour.
- Teachers, like parents, are prime role models as well as channels for information and education.
- Celebrities of the media, sports and popular culture can have a huge impact as role models and spokespeople (e.g. Philly Lutaya[11], Magic Johnson[12]). They can take action against the sexualization and mixed

[11] A prominent Ugandan musician and the first African to declare publicly that he had AIDS. He put up a strong crusade against AIDS through his words and music.

12 An American basketball star who retired when he was found HIV positive in 1991. Among other things, he continues to act as a spokesperson in the response to HIV.

messages often conveyed by mass media and offer positive models for social and behaviour change.

Organizational stakeholders

- Faith-based organizations often have charismatic leaders and have consistent, continuing access to massive audiences. They have standing to monitor the application and misapplication of social judgements within their membership.
- Schools and colleges also have regular access to large populations; their mission is education and they can provide repeated and reinforcing messages. They must be required to provide safe environments for young people.
- Political parties can feature good models, and have infrastructure for social mobilization and for monitoring government policies and actions (e.g. report cards).
- Health systems and providers, including traditional healers, are essential for promoting prevention in the context of care and treatment—for people living with HIV (positive prevention), prevention in couples, and for defining or communicating prevention needs expressed by their clients.
- Women's groups in many places already have generated a women's movement or movements of men and women to increase gender equality and opportunities for women and girls. These groups can put HIV issues on the agenda and provide leadership to other women who may be defending the status quo.
- Trade unions and other associations. In generalized epidemics they need to recognize HIV issues, advocate positive workplace policies, and mainstream HIV prevention, as well as treatment, care and support, into their activities.
- Civil society organizations, including networks of people living with HIV, research organizations, and nongovernmental organizations, reflect and represent diverse and vulnerable subpopulations and often have credibility in affected communities that the government cannot easily reach.
- Uniformed services (e.g. the army and police) can introduce dramatic positive changes when the command leadership is involved (e.g. in Rwanda, Thailand and Uganda). The uniformed services may have higher or lower prevalence of HIV than their communities: either way, their powers make it crucial to engage them in HIV prevention.

International partners

- Donors make major contributions through funding national and local efforts, through requiring monitoring and reporting for accountability, through policy dialogue with the host country government and civil society, and by modelling good collaborative practice. The challenge for donors is to assist and catalyse action in a supportive manner while supporting the leadership and responsibility of the host country.
- UNAIDS can communicate the recommendations of this meeting to country and regional staff, and can broker or provide technical assistance to countries to improve their behaviour change programming accordingly. Working through the Joint United Nations Teams on AIDS,

according to the Action Plan for Intensifying HIV Prevention[13], the UNAIDS Secretariat and the 10 Cosponsors have a special role in helping countries to reflect these recommendations in their behaviour change strategies.

- International nongovernmental organizations, researchers, and other nongovernmental partners can provide additive technical experience and human resources to support and extend national responses, to share lessons learnt elsewhere, and to build capacity in new areas.

Participation of all key stakeholder groups—government, civil society, private sector, multilateral organizations, and international partners—and a commitment to greater participation of people living with HIV are traditional in HIV work. Different groups can contribute differently to the response. If coordinated and harmonized, their many distinct contributions can produce a stronger overall response.

[13] Action plan for intensifying HIV prevention. Geneva, Joint United Nations Programme on HIV/AIDS, 2006.

Highlights from plenary reports and discussions

The 2005 UNAIDS policy position paper on intensifying HIV prevention presented the global consensus framework on the elements of an effective HIV prevention response—one that provides an integrated set of policy and programmatic actions to reduce risk, vulnerability, and impact of HIV as these occur in each particular locale. To guide this process of planning in relation to the evidence of local needs, prevention programme planners should be strong advocates for better surveillance and monitoring data, so that everyone can "know your epidemic" and design or refine evidence-based responses accordingly.

In areas with concentrated epidemics, a great deal of progress can be expected from increasing the coverage of proven measures for high-risk populations and settings. Models for reducing risk and vulnerability of sex workers and their clients, men who have sex with men, migrant populations, prisoners, and injecting drug users exist and need to be scaled up.

Key issues

Balance treatment and prevention

The universal access movement and the charge to governments and to UNAIDS in June 2006[14] have changed the paradigm for HIV responses, emphasizing that both treatment and prevention are necessary and mutually supporting, rather than contrasting goals. Making this new paradigm operational requires special effort, since different people are often involved in prevention and treatment and often draw from different resource pools. The need for a unified, prevention, treatment, care, and support response holds in all epidemiological scenarios, not just in generalized, high-prevalence epidemics. However, treatment cannot be allowed to use all the resources, for if prevention fails, universal access to treatment will never be achieved.

The three main components (ABC) used to describe balanced behaviour change programming are programme outcomes, not strategies[15]. There is universal agreement on the scientific merit of these outcomes: the controversies are around what specific measures effectively promote them.

Programmes to achieve ABC outcomes are necessary but not sufficient

Existing strategies are often unavailable or inappropriate for women and girls. In particular, social change and policy change activities are required to change and reduce the cultural, economic, and political barriers that prevent women and girls from choosing behaviours that can save their lives. Strategies exist to change gender norms, reduce tolerance of sexual violence, and increase women's access to information and resources. It is no longer appropriate to relegate these to the margins, because they are essential and there is enough knowledge on how to implement them.

[14] Ibid (2006).

15 Technical consultation on behaviour change communication. Meeting report. Washington, DC, Horizons, 2001.

Importance of perceptions, as well as behaviour

While public health measurement prefers to focus on concrete, observable items such as overt behaviours, internal, psychological phenomena (perceptions, attitudes, etc.) affect and even cause those concrete actions. For example, fear of violence can constrain women's choices as effectively as actual violence. Young people do not listen to life-saving information, when they perceive HIV as a disease of older people. While public health science requires a focus on objective results, intangible social and individual perceptions can determine those results and they need to be analysed and addressed on many fronts. For example, men's resistance to improving women's status may be based on the perception that gender equality is a zero-sum game—i.e., men may fear that they will lose out if women's rights are respected—which is not the case. Young people need to be given the facts: in many countries, young people (especially girls) are at twice or three times the adult risk of HIV infection.

The relationship between health and wealth in HIV infection is different from that for many infectious diseases

(though diseases of affluence are well known). Analyses of DHS data show that the typical predications that poverty causes sexual risk behaviour have been oversimplified. Poverty is certainly relevant to HIV risk and vulnerability, as it is inversely related to education and access to health information and services, but the causal pathways are more complex and not well understood or well integrated into programme planning. The mechanisms and the balance of factors relating wealth, or poverty, and HIV risk appear to differ both regionally and by gender.

In the hyperendemic settings of Southern Africa, nothing less than massive social mobilization is required to reverse the epidemic

The whole intervention paradigm needs to be replaced by one of societal engagement and social mobilization in countries where HIV levels are so high. This will be new terrain. There is no proven formula for success in these epidemics, so a combination of bold action, research, monitoring, and evaluation will be needed to define what works.

New behaviour change measures will require measurable milestones and indicators

The challenges of defining and measuring sexual behaviour and decision-making have been a core problem in HIV research, communication, and evaluation for 20 years. The lack of consistency in definitions of programmes and difficulties of measurement have led national programmes to rely on standardized, population-level surveys to measure reported behavioural outcomes; these are invaluable but they require special projects (e.g. DHS), are expensive, and are done only every three to five years. These need to be complemented by clear and measurable outputs, outcomes, and indicators that managers can monitor for quality control and programme improvement. The new social change approaches proposed in this meeting are promising, but if they are not evaluated and monitored, they will probably not be adequately supported over time.

Have we oversimplified stigma?

Stigma is a prime mechanism of informal social control and can have a positive impact (e.g. stigma associated with theft, rape, etc.) as well as a

negative social impact. Social judgement is fundamental to the maintenance of society, but is not the traditional domain of health specialists. In the cases of tobacco smoking and use of seat belts in industrialized countries, the relationship between objective health, economic facts, and individual rights has been worked through over the past 20 years, yielding a social consensus that endorses government regulation in domains that were previously considered private.

The debate is in progress regarding what public health specialists and governments should do and fund to support the prevention of sexual transmission of HIV, as the domain of sexual behaviour among consenting adults is widely considered private today. Indeed, participants cited references to the debate around ABC policies in the United States of America as “culture wars”.

It is not yet clear how behaviour change programmes should reconcile needs for simplicity and diversity

Almost decades of experience in intensive programme development and evaluation in the United States have proved that what works in health and sexuality education is a clear, simple message. In contrast, the many factors affecting HIV transmission risk are complex (Figures 4 and 5). Linguistic and cultural diversity in low- and middle-income countries is often much greater than in industrialized, high-income countries. Participants noted that different audiences need and respond to different messages and measures and have different sensitivities and ideals within countries (by gender, age, marital status, cultural heritage, risk profile, education, residence, etc.) and even within communities. Nevertheless, the dominant behaviour change approaches, such as the mass media and school-based education, strive to reach vast audiences with the same content. These rarely invest enough in qualitative research on language and culture, to engage with the dual challenge of retaining simplicity while adapting to local diversity.

General recommendations

Behaviour change measures need to be reviewed, renewed and differentiated in light of current knowledge

Too many behaviour change activities are neither tailored nor provided for the populations and settings with highest rates and highest risks of HIV. They need to be reviewed and rethought in terms of up-to-date understanding of HIV epidemics at the subnational level and in terms of the traditions and methods of community participation, including the participation of vulnerable populations, people living with HIV, women, and young people.

Ground behaviour change programming in a human rights perspective

There is a global consensus, conveyed in the 2005 UNAIDS policy position paper on intensifying HIV prevention and numerous human rights policy documents, to which most governments have agreed. These policy instruments are powerful advocacy tools and they have not been adequately used to promote HIV prevention measures that address drivers of the epidemic.

The new prevention technologies are promising

The results from the randomized controlled trials of male circumcision will be released soon, and if the South African study findings are confirmed, male circumcision will be an important addition to combination prevention measures[16]. However, when new prevention measures become available, e.g. male circumcision, microbicides, and eventually vaccines, they must be implemented in a way that adds to, rather than distracts from, behaviour change programmes. None of the new technologies is likely to provide 100% protection, and if this is misunderstood, negative effects of risk compensation (increases in risk behaviour) could outweigh their protective benefits.

Make space for the sociology of sexuality and pleasure

Scientists are problem-solvers, but there is too much focus on sexuality as a problem and not enough on the positive, healthy aspects of sexuality such as pleasure, desire, commitment, intimacy, and love. The role of pleasure and commitment needs to be understood for women and girls as well as for men and boys, and within the cultural context of each community.

Programmatic recommendations: what to do more of and what to do differently

Know your epidemic

Knowing your epidemic is not just for epidemiologists and disease surveillance experts: it needs to become the new approach to HIV prevention programming. It means knowing where the epidemic exists (regionally and in terms of the populations most affected) and also what are its main drivers. In-depth understanding of the social and behavioural context is thus central to knowing your epidemic.

Better and more collaboration is needed among partners working towards ABC outcomes

Such collaboration will promote more consistent and coherent support for behaviour change and will extend the impact of all programmes.

Communities need to be given more resources, and allowed to act rather than engaging others to act for them

This applies especially to vulnerable populations, including people living with HIV. Support for communities should be “not to give the answer, but to help them pose the right questions” and then to answer their questions

[16] This meeting took place before the second two randomized controlled trials of male circumcision were stopped by their data safety boards in December 2006 due to evidence of a positive effect on reducing the risk of sexual transmission of HIV from women to men. Had the meeting been held later, the behaviour change aspects of this new prevention technology would have been considered during the meeting. The World Health Organization (WHO) and the UNAIDS Secretariat convened a consultation on 6–8 March 2007 to examine the findings of the three randomized controlled trials that examined the impact of male circumcision on HIV acquisition in men, and their implications for countries, particularly those in sub-Saharan Africa and elsewhere with high HIV prevalence and low levels of male circumcision, with a view to offering definitive guidance. The United Nations and its partners emphasize that male circumcision does not provide complete protection from HIV and should therefore never replace other known effective preventive methods, such as delay in onset of sexual activity, correct and consistent use of condoms, and reduction in the number of sexual partners. For further information, see the statement on Kenyan and Ugandan trial findings regarding male circumcision and HIV developed by WHO, the United Nations Population Fund, the United Nations Children’s Fund, the World Bank, and the UNAIDS Secretariat, 13 December 2006 (http://www.who.int/mediacentre/news/statements/2006/s18/en/index.html).

themselves.) Communities are unlikely to question their own assumptions, for example, on gender norms, unless prompted to do so, but community-based programmes have succeeded in catalysing change by assisting communities to reflect on traditions, norms, and values (e.g. on widow inheritance) that jeopardize health and survival.

Review and recommend improved responses to geographical mobility
In both concentrated and generalized epidemic scenarios, long-distance travel, migration, and internal displacement due to conflict or natural disasters all complicate HIV prevention programming, and monitoring and evaluation of programme effectiveness and results. These issues are too often ignored. To respond effectively requires policy analysis in multiple sectors (e.g. labour market policies, housing and social welfare programmes, and disaster relief policies) and funding and implementation practices that permit and encourage cross-programme and cross-border collaboration.

All communication programmes need to be alerted to find the appropriate language and local images that show the positive benefits of gender equality and respect for human rights. Gender equality and complementarity is not a zero-sum situation. Abundant data show that enhancing women's education, knowledge, and economic skills and participation is good for the family, e.g. for child health. The positive impact on marriages and other adult partnerships needs more research.

Clear communication is needed about the facts that make concurrency dangerous
Public health specialists should communicate clearly about the facts that make concurrency and other patterns of sexual or other risk behaviour dangerous to individuals or public health. In contrast, social judgements and moral claims about behaviours, such as values of fidelity to one marital partner or of male privileges to seek multiple sexual partner relations, are the purview of families and communities of shared belief.

More nuanced thinking about risk needs to be prompted and promoted
Young people, for example, may be miscalculating their risks because they do not have accurate local information as well as because of denial and fear of stigma. Most behaviour change focuses on individual risks, but people can also be altruistic if inspired and given the chance. They can be encouraged to think about not only what they personally are risking by, for example, taking an unpopular stand or exposing themselves to stigma by resisting social pressure to be sexually active or by disclosing their HIV status. Programmes should encourage people to think more broadly about risk, asking themselves, for example, what their community has to gain, as well as what they have to lose.

Partner broader gender-based violence programmes with HIV prevention programmes
The goals of both types of programmes are mutually reinforcing.

Work with the media
It is imperative to work with the media to ensure they are well informed and are held accountable.

Monitoring and evaluation should receive much more prominence in behaviour change programming

In each of the prevention programme areas, there needs to be more attention to establishing and communicating a clear causal model or framework, so that implementing staff understand how their day-to-day activities are expected to lead to or support the behaviour change outcomes, and so that monitoring can track both the results and mediating variables that are expected to affect the results. Without data on expected outputs and mediating variables, unexpected results cannot be explained and successes cannot easily be replicated elsewhere.

Research needs

Investigate the relationship between economics and HIV

In order to design HIV programmes that contribute to national development agendas, we need to better understand the links and countervailing effects linking relative wealth, access to information and resources, HIV risk behaviour, and risk reduction. These links are likely to differ from place to place and between men and women. The gendered nature of the links is critical. Gender should be integral to studies of economics and HIV, and knowing your epidemic and response should include local research and analysis of the effects of poverty and wealth as potential drivers of risk and protective behaviour.

Conduct operations research on social mobilization for prevention of sexual transmission of HIV

The causes of social movements and the tactics of social mobilization in other fields (e.g. political organizing) should be more widely understood and integrated into HIV prevention planning.

Phased-start models should be used to test and evaluate strategies for promoting behaviour change at the population level in hyperendemic settings. To respond to the needs for both urgent action and urgent learning, evaluation designs using phased starts, and comparing different mixes and intensities of information and services, need to be prioritized.

Explore the opportunities for and limits of constructive uses of social stigma

Can public health programmes invoke and leverage community values to attach social judgements to behaviours that are dangerous to public health, in a way that is ethically sound? Who has the authority and standing to invoke what kinds of value judgments, over whom? How can a social consensus on this be clarified and developed? More thinking is needed in these areas.

Expand research on policy environments and policy change

An important part of the effectiveness gap and implementation gap in behaviour change is due to political rather than technical barriers. Having strong, local and up-to-date epidemiological data is invaluable for policy dialogue. Engaging and building leadership and a clear constituency for HIV prevention is also critical. There is a need to conduct and disseminate policy

research, to inform diagnosis of political barriers and policy options (e.g. changes in legislation or taxes), and to share examples of the 12 policy actions that are featured in the 2005 UNAIDS policy position paper on intensifying HIV prevention.

Review and refine measurement strategies for tracking the effectiveness of behaviour change programmes

New indicators have been developed for anti-stigma programmes, for gender equality outcomes, and others, but these need to be adapted to local settings, and to be more widely known. New efforts to explain concurrency in communications and to reduce it through programmes will require formative and evaluation research.

Conclusion

This meeting provided an opportunity to reflect on behaviour change as an important element in strategies for the prevention of sexual transmission of HIV. The UNAIDS, World Bank, and USAID presentations on the epidemiology of HIV drove home the point that HIV epidemics are dynamic and differentiated within countries, and even within subnational units (districts, etc.). Vigilance about how they evolve is at the heart of effective HIV prevention programming. Effective responses are local, but even at the local level, there is change from year to year. The injunction to know your epidemic has to be rolled out from the epidemiological centres (national capitals and research institutes) to districts and communities, and from epidemiologists to policy-makers, programme managers, and civil society advocates. Furthermore, new biological understanding of fluctuating HIV infectivity, combined with accumulating data on concurrency and sexual networking, provides a new angle on the risks of multiple sexual partners where HIV is prevalent. This issue needs to be further researched and applied in HIV prevention programmes.

Many challenges exist in behaviour change programming to reduce sexual transmission of HIV: how to communicate consistent, clear, simple messages, while also recognizing the complexity of the HIV epidemic, taking account of the rich diversity of social and behavioural contexts that make women's experience different from men's, and young people's different from that of adults. New blood and innovation are needed to revitalize our thinking and our responses. In the face of this diversity, diverse responses are required. Everyone's efforts are needed. A "big tent" approach enables us to unite for HIV prevention.

Finally, improving behaviour change measures and ensuring that prevention funds are spent wisely require a renewed commitment to programme evaluation and evaluation research. As important as any of the technical recommendations gleaned from the meeting was a comment from a participant on the afternoon of day 2. He recounted that in his 27 years' experience designing and evaluating sexual health education programmes for young people, three rounds of programme design, implementation, and evaluation (each building on the knowledge gained in the previous rounds) failed to show any impact on behaviour. In the fourth round, the measures succeeded. His message: keep questioning, implementing, evaluating, and learning, and do not give up.

Continued focus, investment, and leadership at the community, national, and global levels are needed now, and for the foreseeable future, to ensure there is locally relevant, high-impact behaviour change programming in national HIV strategic plans and monitoring and evaluation systems. This two-day expert meeting was one part of a large, concerted effort by UNAIDS to catalyse debate, provide practical guidance, and create a more unified and mobilized constituency for effective HIV prevention scale-up, so that countries can achieve their goals of providing universal access to HIV prevention, treatment, care, and support for those who need them, and to control and reverse the AIDS epidemic.

Annexes

Annex 1 Participant's agenda

Day 1, 25 September 2006		
Session 1.		
08:30–09:00	Welcome and opening remarks by meeting co-chairs	Peter Piot (UNAIDS) and Kent Hill (USAID)
09:00–09:30	Participant introductions and expectations; meeting logistics	Judith Morrain-Webb (Meeting Facilitator)
09:30–09:45	Overview of the consultation; agenda; confirmation of and thanks to rapporteurs	Purnima Mane (UNAIDS)
09:45–10:10	*Setting the Scene: Epidemiological Trends and their Implications for HIV Prevention—a Global Perspective*	Peter Ghys (UNAIDS)
10:10–10:30	*Gender, Sexuality and HIV: 25 Years of Lessons Learned*	Geeta Rao Gupta (International Center for Research on Women)
10:30–10:50	*Is Poverty or Wealth Driving the HIV Epidemic?*	Stuart Gillespie (International Food Policy Research Institute) and Robert Greener (UNAIDS)
10:50–11:10	*Break*	
11:10–12:30	Behaviour change interventions: what's new?	
	• *Current Thinking about Behaviour Change and Prevention of Sexual Transmission of HIV*	David Wilson (World Bank)
	• *So Much Risk, So Little Time: Concurrent Partnerships and a Paradigm Shift in Understanding and Addressing the Highest Prevalence HIV Epidemics*	Michael Cassell (USAID)
	• *How Do We Measure Success? (Beyond Counting Condoms)*	Barbara de Zalduondo (UNAIDS)
	Discussion	
12:30–13:30	*Lunch*	
Session 2.		
13:30–15:00	Report from Session 1 Rapporteur (5 minutes) Moderated discussion • Major drivers of the epidemic and behaviour change interventions—what is needed to influence incidence and drivers, in different epidemic scenarios • Emerging issues for discussion and resolution in the meeting	

15:00–16:15	Lessons learned from HIV programmes—what NEW ideas should we develop here? Part 1 Small groups. Gaps or missing links in behaviour change programmes for and with key audiences in low, concentrated and generalized epidemics[17] Young people (Doug Kirby; Winnie Kivenyo Beuttah) • Sex workers and their clients (Werasit Sittitrai) • Heterosexual adults (Ana Luisa Ligouri, Robert Ochai) • Men who have sex with men (Robert Carr, Cheikh Ibrahima Niang) • Prisoners and others with multiple risks (Maia Rusakova, Dabesaki Mac-Ikemenjima) *Speedway* report back	
16:15–16:30	*Break*	
16:30-17:30	Lessons learned in country programmes—what NEW ideas should we develop here? Part 2 "Pair and share" on roles of different agents, institutions, and agencies in behaviour change: • Faith-Based Organizations (Sam Ruteikara); • Government and provincial authorities (Derek von Wissel, Rob Moodie); • Nongovernmental organizations working with young people (Dabesaki, Werasit); • Community-based agencies (Robert Carr, Geeta Rao Gupta); • Health-care settings (King Holmes, Tim Flanigan) • Universities (Suzanne Leclerk Madlala, Cheikh Niang); • Reproductive health settings (Steve Kraus); • Donors (Robin Gorna, Kent Hill).	
17:30–18:00	Summing up and defining the key challenges for tomorrow	Purnima Mane and Session 1 and Session 2 rapporteurs
18:00–19:30	*Reception*	

17 The focus of this discussion should be on what is feasible, credible and effective in low, concentrated, mixed and general population epidemic scenarios. What has not been tried, and why not? What are the existing opportunities we are missing, especially in the era of commitment to universal access? How can we use resources strategically to achieve behaviour change, in behaviour change programmes and through the larger range of HIV, and other health and development services?

Day 2, 26 September 2006

Session 3

09.00–09:30	Checking in: reactions to the discussions and outcomes of day 1
09:30–11:30	Our best thinking on solving the key challenges for intensifying prevention of sexual transmission Small groups map out: • the issues and outcomes needed; • programmatic strategies to achieve those outcomes; • research needs, in relation to their key challenges (agreed at the end of day 1)[18] . Topics could include: • gender power and social change; • community mobilization and integration with HIV services; • supporting leadership and effective action of opinion-leaders, faith-based communities, workplaces and people living with HIV, in the context of universal access and positive prevention); • constructive social control of sexual behaviour—roles of parents, faith-based organizations, and public health services in culturally diverse communities; • policy actions to promote human rights, gender equity, zero tolerance for violence, etc.; • impacting structural factors: making real links to the development agenda—realistic time scale for action and results? Accountability and demonstrating impact?
11.15–11:30	*Break*
11:30–12:30	Moderated report back. A bold vision of each key challenge and draft recommendations for solutions • What can programs do more of, less of and differently to have a greater impact? • What has not been tried? And why not? • What role for institutions? National government? Local government? Groups of people living with HIV? Schools? Parents? Media? Faith-based organizations? Employers? Health service providers (traditional and biomedical)? Donors?

[18] Each small group will be asked to address the following:
What can programs do more of, less of and differently to have a greater impact?
What has not been tried? And why not?
What role for institutions? National government? Local government? Groups of people living with HIV? Schools? Parents? Media? Faith-based organizations? Employers? Health service providers (traditional and biomedical)? Donors?
What are the knowledge gaps? What is the priority research agenda?
What are the resource needs and how should they be addressed, including training?

	• What are the research gaps? What is the priority research agenda? • What are the resource needs and how should they be addressed, including training? • What should different constituencies be doing in particular to strengthen this agenda e.g. UNAIDS as a family, governments, people living with HIV, civil society with groups of affected populations in particular, faith-based organizations, researchers, etc.	
12.30–13.00	Focused discussion—clarification of the draft recommendations	
13.00–14.00	*Lunch and posting of draft recommendations*	
Session 4.		
14:00–14:20	Participants individually review and comment on posted recommendations	
14:20–15:30	Development of consensus on recommendations from the consultation Small groups: • Top ideas and insights for dissemination • Top priorities for country-level action to intensify prevention of sexual transmission. What should stakeholders advocate and donors fund? • Top priorities for international partners to assist in moving this agenda in the context of universal access • Top priorities for research Report back and discussion	
15:30–15:45	*Break*	
15:45–16:30	Moderated discussion on strategic dissemination of key recommendations from this meeting What should different constituencies be doing in particular to strengthen this agenda e.g. faith-based organizations, researchers, UNAIDS as a family, governments, people living with HIV, civil society with groups of affected populations, etc.	
15:45–16:45	Wrap-up • Round-robin (all participants): what I heard, and what I plan to do • Summary of meeting outcomes	
16:45–17:00	Closing session: thanks and follow-up planned	Purnima Mane and Kent Hill

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Annex 3 Links to presentations

- *Setting the Scene: Epidemiological Trends and their Implications for HIV Prevention—a Global Perspective*
  http://data.unaids.org/pub/Presentation/2007/ghysstanecki20060921_en.pdf
  Peter Ghys, UNAIDS

- *Gender, Sexuality and HIV: 25 Years of Lessons Learned*
  http://data.unaids.org/pub/Presentation/2007/grgupta_en.pdf
  Geeta Rao Gupta, International Center for Research on Women

- *Is Poverty or Wealth Driving the HIV Epidemic?*
  http://data.unaids.org/pub/Presentation/2007/gillespiegreener20060922_en.pdf
  Stuart Gillespie, International Food Policy Research Institute

  Current Thinking about Behaviour Change and Prevention of Sexual Transmission of HIV http://data.unaids.org/pub/Presentation/2007/wilson_%20un-usg_en.pdf
  David Wilson, World Bank

- *So Much Risk, So Little Time: Concurrent Partnerships and a Paradigm Shift in Understanding and Addressing the Highest Prevalence HIV Epidemics*
  http://data.unaids.org/pub/Presentation/2007/cassell_en.pdf
  Michael Cassell, USAID

- *How Do We Measure Success? (Beyond Counting Condoms)*
  http://data.unaids.org/pub/Presentation/2007/bdez_en.pdf
  Barbara de Zalduondo, UNAIDS

Annex 4 Links to background papers

- *Gender and Sexuality: Implications for HIV Prevention for Women*
  Contact: geeta@icrw.org
  Geeta Rao Gupta and Ellen Weiss, International Center for Research on Women

- *Is Poverty or Wealth Driving HIV Transmission?*
  Contact: gillespies@unaids.org ; greenerr@unaids.org
  Stuart Gillespie International Food Policy Research Institute, and Robert Greener, UNAIDS

- *HIV Epidemiology: a Review of Recent Trends and Lessons*
  http://data.unaids.org/pub/ExternalDocument/2007/20060913wilson_en.pdf
  David Wilson, World Bank