Step 3: Prioritize and tailor your response: generalized scenarios

In **generalized scenarios*** HIV prevalence is between 1%–15% amongst pregnant women attending antenatal clinics, indicating sufficient levels among the general population for heterosexual sexual networking to fuel the epidemic.

A. Most-at-risk populations with higher rates & higher risk of HIV

B. Total population

C. People living with HIV both diagnosed & undiagnosed

Strategic information

- All actions outlined in low-level and concentrated scenarios.
- Gather and use strategic information to understand the contexts and drivers of predominant risk behaviours and to guide investment and action towards achieving objectives.
- Gather and analyse data from additional sources to estimate the incidence from key groups in order to refresh prevention plans.

Programmatic actions

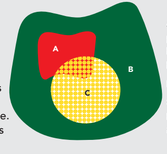
- All actions outlined in low-level and concentrated scenarios.
- Provide and promote high quality HIV prevention, treatment, care for all key audiences and people living with HIV.
- Build capacity for HIV prevention planning and implementation in governmental and nongovernmental organizations, and civil society.
- Plan and implement a long-term (e.g. five years) national HIV communication programme to mobilize society and to create an enabling environment for prevention, treatment, care and support.
- Intensify diverse and evidence-informed sexuality and reproductive health education for both in- and for out-of-school youth.
- Ensure universal access to confidential HIV counselling and testing including provider-initiated counselling and testing.
- Ensure universal and uninterrupted availability of male and female condoms.
- Prioritize programmes for women and men that address risk behaviours and gender related vulnerability.
- Promote the full range of prevention of mother to child transmission services.
- Identify priority geographic settings where male circumcision is likely to have the greatest impact; progressively expand access to safe male circumcision services.
- Promote joint HIV/TB services and positive prevention.
- Partner with employers, employees and unions to promote HIV prevention and treatment at the workplace.
- Ensure health care, law enforcement and social services employees are trained on HIV issues including gender and human rights.

Policy actions

- All actions outlined in low-level and concentrated scenarios.
- Conduct a high-profile review of every sector to establish that current practices do not hamper access to HIV prevention services.
- Advocate for elimination of fees or taxes that increase cost of commodities or services.
- Promote and energize multisectoral linkages with government ministries that need to be involved in the AIDS response (e.g. local development, human resources, and uniformed services) and establish clear sectoral responsibilities for risk reduction.
- Promote male circumcision as part of comprehensive HIV prevention programming.
- Identify government departments or sectors that can reduce risk situations (e.g. reduce spousal separation, improve prisoner welfare etc.).

Step 3: Prioritize and tailor your response: hyperendemic scenarios

In **hyperendemic scenarios*** HIV prevalence exceeds 15% in the adult population, driven in particular through heterosexual multiple concurrent partnerships as well as low and inconsistent condom use. All sexually active adults are at elevated risk of HIV infection.



A. Most-at-risk populations with higher rates & higher risk of HIV

B. Total population

C. People living with HIV both diagnosed & undiagnosed

Strategic information

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

Programmatic actions

- All actions outlined in low level, concentrated and generalized scenarios.
- Ensure well-informed, active and visible participation of leaders.
- Strengthen pediatric prevention and treatment.
- Ensure special programmes for orphans, street children and others at high risk, balancing needs for risk, vulnerability and impact reduction.
- Promote male involvement in sexual and reproductive health programmes including HIV prevention, treatment of sexually transmitted infections, HIV counselling and testing, prevention of mother-to-child transmission services.

Policy actions

- All actions outlined in low-level, concentrated and generalized scenarios.
- Build public awareness and demand for changes in legislation that hinder prevention, such as laws that discriminate against women and girls.

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

Dr Peter Piot
Executive Director, UNAIDS

UNAIDS, 20 avenue Appia
1211 Geneva 27
Switzerland
Telephone: (41) 22 791 36 66
Fax: (41) 22 791 48 35
Email: distribution@unaids.org
Internet: http://www.unaids.org

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Uniting the world against AIDS

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Practical Guidelines for Intensifying HIV Prevention

TOWARDS UNIVERSAL ACCESS

Five steps to HIV prevention planning and implementation

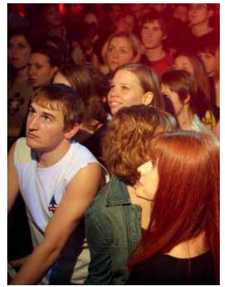
1. Provide leadership for a strong national response
2. Know your epidemic and current response
3. Prioritize and tailor your response to the epidemic
4. Set ambitious, realistic and measurable prevention targets
5. Use strategic information to stay on course

Uniting the world against AIDS

Step 1

Provide leadership for a strong, informed, committed and accountable national response

The National AIDS Authority — in line with the "Three Ones Principles"— should provide active leadership, coordinate the involvement of different partners and sectors, and ensure accountability for an effective national HIV prevention response.



Step 2

Know your epidemic and your response

Key to planning an effective HIV prevention response is knowing who is most affected by HIV, the extent to which HIV is prevalent amongst the population and different subgroups, and the risk behaviours, laws, policies, and settings that may facilitate the transmission of HIV.

Key questions in planning an effective national HIV prevention response include:

- What is the epidemic scenario? Is it low, concentrated, generalized or hyperendemic?
- Where, among whom and why are new HIV infections happening?
- Where and how fast are infections moving?
- What are the legal, human rights, gender, socioeconomic and cultural drivers of epidemic?
- Have the most effective and feasible strategies been prioritized for the local context?
- Have the risks of the current strategy been analysed?
- Have the human and financial resources for an effective response been assessed?
- Have the wider benefits of prevention programmes been assessed?

Step 3

Prioritize and tailor your response

Effective HIV prevention requires prioritizing and matching the response according to the epidemic in each country. Not all prevention objectives can be achieved in the short term. And even in the short term, programmes must be repeated again and again to reach new cohorts and to sustain prevention. HIV prevention is for life.

PRIORITIZED HIV PREVENTION MEASURES FOR KEY AUDIENCES

The UNAIDS Practical Guidelines for Intensifying HIV Prevention recommend that HIV programme planners use strategic information to define the most-at-risk populations and risk settings, and then match prevention measures to those people and settings, according to their epidemic scenario and the capacity of the HIV response. The tables in this pocket insert summarize the specific HIV prevention priorities for 14 key audiences. Planners must consider that different epidemic scenarios, and different key audiences, may exist in different geographical areas within their country, or within specific region.

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

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

Step 4

Set ambitious, realistic and measurable prevention targets

Setting ambitious and realistic targets sharpens the focus of national prevention responses, assists in obtaining political and community support and mobilizing resources. In setting targets, national AIDS authorities should:

- Review the status and transmission dynamics of the HIV epidemic.
- Define and prioritize measures to be included in the national response.
- Estimate the sizes of populations in need.
- Review current coverage rates and historic rate of scaling up, and project potential achievements by 2010.
- Determine resources available, current coverage capacity, and requirements to overcome obstacles.
- Mobilize resources to meet targets.

Step 5

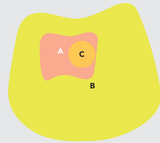
Use strategic information to stay on course

Sources of strategic information include:

- Surveillance and research to define the epidemiological and behavioural contexts, and the populations and risk settings of most concern.
- Policy and programme documents that analyse the national political context and the response capacity of communities, the private and public sectors.
- Analysis of existing research and programmatic data.
- Stakeholder consultations such as meetings with people living with HIV and with members of marginalized groups.
- Monitoring and evaluation reports from existing programmes and services.

Step 3: Prioritize and tailor your response: low-level scenarios

In **low-level scenarios*** HIV prevalence is below 1% and has not spread to significant levels within any sub-population group.



A. Most-at-risk populations with higher rates & higher risk of HIV

B. Total population

C. People living with HIV both diagnosed & undiagnosed

Strategic Information

- Gather information that defines the most-at-risk populations, risk settings,the response capacity and the resource needs in the public and private sector.
- Include budgets and plans for second generation surveillance.
- Monitor HIV programme coverage, disaggregated by population subgroup, sex, age, marital status and geographic area; and adjust programmes to meet demand and improve performance.

Programmatic Actions

- Ensure high-quality coverage of HIV prevention, treatment and care services for most-at-risk populations.
- Build capacity of the most-at-risk populations to organize, advocate and deliver prevention.
- Strengthen services for prevention of mother-to-child transmission, and for people living with HIV.
- Provide training to law enforcement personnel to reduce harassment of most-at-risk populations.
- Deal with stigma and discrimination, sexual violence, gender inequality, homophobia and human rights violations in broader public health campaigns.
- Implement programmes with and for most-at-risk populations at sufficient scale and intensity.
- Promote livelihood alternatives to transactional sex.
- Train service providers to work effectively with most-at-risk populations.
- Provide diverse and evidence-informed sexuality and reproductive health education through the school curriculum.
- Ensure adherence to blood safety standards.

Policy actions

- Provide a clear mandate for leadership, resource mobilization, coordination and reporting to the National AIDS Authority.
- Develop a costed plan for effective HIV prevention.
- Commit sufficient resources to HIV prevention, track and analyse expenditures, and build in accountability procedures.
- Amend legislation and policies that create or enforce barriers to HIV prevention.
- Enforce laws against child marriage, sexual abuse and gender-based violence.
- Review user fees or taxes on key commodities such as condoms.
- Review every sector for practices that facilitate risk behaviour.
- Review, amend and enact appropriate laws and policies and enforce anti-discrimination legislation.

Step 3: Prioritize and tailor your response: concentrated scenarios

In **concentrated scenarios*** HIV prevalence is high in one or more population sub-group such (e.g. men who have sex with men, or sex workers and their clients) but is not at high levels in the general population.

A. Most-at-risk populations with higher rates & higher risk of HIV

B. Total population

C. People living with HIV both diagnosed & undiagnosed

Strategic information

- All actions outlined in low-level scenarios.
- Conduct periodic national assessment of the national response.
- Analyse the context and drivers of the predominant risk behaviors.

Conduct additional research on sexual networking patterns to better understand the potential HIV transmission flow from most-at-risk populations to the general populations.

Programmatic actions

- All actions outlined in low-level scenarios.
- Provide and promote confidential voluntary HIV counselling and testing with referral to services; begin in high-risk settings.
- Provide prevention and care programmes focused on mobile populations such as uniformed forces, clients of sex workers and most-at-risk young people.

Policy actions

- All actions outlined in low-level scenarios.
- Train and support leaders (political, networks of people living with HIV and vulnerable communities, private sector, faith-based) to support prevention, speak out against HIV-related stigma and discrimination, and to support human rights, including gender equality and universal access.

Colour gradations across these four diagrams represent the intensity of the HIV prevention intervention required. The darker the colour, proportionately more resources should be allocated. The larger the circle (denoting people living with HIV), the greater their proportion in the population. The greater the overlap into the green areas (total population), the greater the extent to which HIV has spread into the general population.

Women and Girls

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

Young People

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

Injecting Drug Users

Why?

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

What?

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

Meaningful involvement of drug users at all levels of planning and policy, and financial support for their organizations.

- Availability and active promotion of hepatitis immunization for injecting drug users and their sexual partners.
- Targeted reproductive health and prevention of mother-to-child transmission services focused on appealing to the needs of women injecting drug users and women partners of injecting drug users.

How?

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

Differences in epidemic scenarios

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

Men who have Sex with Men

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

Sex Workers

Why?

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

What?

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

How?

- Setting-based outreach.
- Develop multisectoral links - home, social welfare, labour and industry, workers unions, private sector and civil society.

- Political and social mobilization to address sexual norms, reduction of number of sexual partners, increased condom use.

Differences in epidemic scenarios

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

Men

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

People Living with HIV

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

Prisoners

Why?

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

What?

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

How?

- Provision of the full range of HIV services as part of prisons health services.

- Peer support programmes run by long-term prisoners/ex-prisoners.
- After-release programmes—establish links with prevention and care programmes in the community.

Differences in epidemic scenarios

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

Transport Workers and Commercial Drivers, Mobile Populations, Uniformed Services Personnel and Clients/non-regular Partners of Sex Workers

Why?

- A number of populations by virtue of their mobility, occupational settings, or partners, are at heightened risk of exposure to HIV and can increase the spread of HIV, including populations such as sexual partners of injecting drug users, clients of sex workers (including: truck drivers, uniformed services, mobile populations and workers away from home) regular sex partners of sex workers, female sex partners of men who have sex with men and women.

What?

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

How?

- Setting-based outreach.
- Develop multisectoral links - home, social welfare, labour and industry, workers unions, private sector and civil society.

- Political and social mobilization to address sexual norms, reduction of number of sexual partners, increased condom use.

Differences in epidemic scenarios

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

Pregnant Women

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

Populations of Humanitarian Concern

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

General Population

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

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

Health-Care Workers

Why?

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

What?

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

How?

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

Differences in epidemic scenarios

- Same package in all stages of the epidemic.

Recipients of Blood or Blood Products

Why?

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

What?

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

How?

- Mandatory HIV testing of all blood and blood products.

Differences in epidemic scenarios

- No difference between different stages of the epidemic.