Intensifying HIV prevention

UNAIDS policy position paper

Joint United Nations Programme on HIV/AIDS

UNAIDS

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Executive Summary

At the 15th Meeting of the Programme Coordinating Board (PCB) in June 2004, UNAIDS was requested to develop a global strategy to intensify HIV prevention. A Strategy Framework for Intensifying HIV Prevention was discussed at the 16th Meeting of the PCB in December 2004. At this same meeting, UNAIDS was asked to develop a global strategy for intensifying HIV prevention for presentation to the 17th Meeting of the PCB to be held in Geneva in June 2005. Since December 2004, extensive consultation has taken place with PCB members and all stakeholders. These discussions have led to the development of this policy position paper.

The primary goal of this paper is to energize and mobilize an intensification of HIV prevention with an ultimate aim of universal access to HIV prevention and treatment. The paper defines the central actions that must be taken to arrest the spread of new HIV infections and to turn the tide against AIDS. It identifies what needs to be done to speedily and effectively bridge the HIV prevention gap, building on synergies between HIV prevention and care, and to ensure the sustainability of HIV treatment scale-up in the present context. It highlights the role of UNAIDS, in relation to intensifying HIV prevention and points to ways in which jointly supportive action can be achieved.

This paper is directed towards all those who have a leadership role in HIV prevention, treatment and care. Its foundations lie in the *Declaration of Commitment on HIV/AIDS* endorsed by all member states of the United Nations in June 2001 and the Global Strategy Framework on HIV/AIDS endorsed by the 10th meeting of the UNAIDS Programme Coordinating Board in Rio de Janeiro in December 2000. The paper also builds upon commitments expressed in the International Conference on Population and Development (ICPD) Programme of Action and the Beijing Platform for Action, together with their follow-up reviews. It highlights significant opportunities for a strengthening of HIV prevention in the context of antiretroviral programmes such as the "3 by 5" Initiative to expand HIV antiretroviral treatment in developing countries.

This paper consists of four main sections. Section 1 explains why HIV prevention must be significantly strengthened to meet the present challenges and harness the opportunities available. Section 2 identifies key actions that must be central to the HIV prevention response and core principles underlying these actions. Section 3 identifies what national partners must do to scale up HIV prevention at country level. Finally, Section 4 describes the support that UNAIDS will provide towards this process.

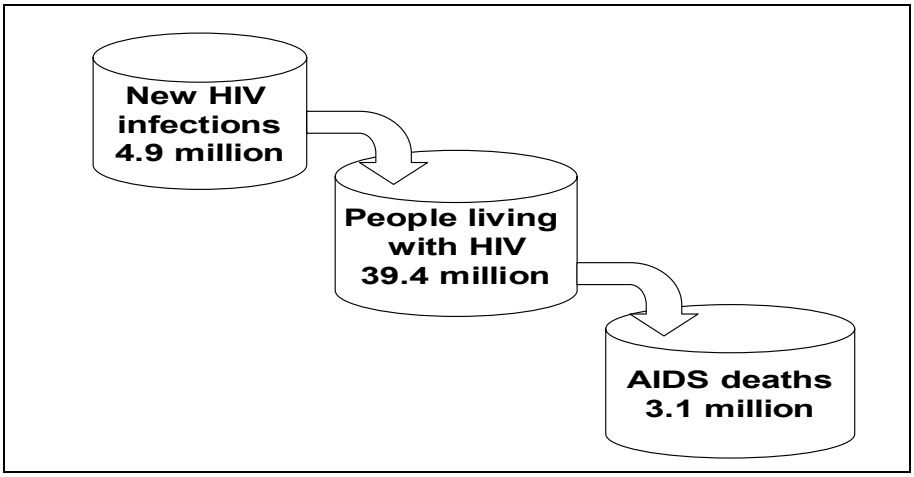
Section 1: Why Intensify HIV Prevention?

AIDS remains a complex and incurable disease devastating individuals, communities and nations. Since the start of the epidemic, an estimated 60 million people have been infected with HIV, of whom some 20 million have died.

The rate of new HIV infections continues to climb every year, with an estimated 4.9 million people having been infected in the twelve months ending December 2004[1]. Globally, the total number of people living with the virus also continues to grow, reaching 40 million at the end of 2004 and trends indicate that left unchecked the epidemic will continue to increase[2].

Despite a noticeable improvement in AIDS-related morbidity and mortality as a result of availability of antiretroviral treatment in North America, Western Europe, Australia, New Zealand and Brazil, the underlying dynamics of the epidemic remain determined by the rate at which new infections are taking place in relation to the number of AIDS deaths (Figure 1). In other words, at this stage of the global AIDS epidemic, there are more HIV infections every year than AIDS-related deaths.

Figure 1: Global HIV dynamics, 2004



The trends in increasing numbers of people being infected with HIV year after year are of major concern, posing a major threat to the whole AIDS response. Furthermore, a series of complex interactions are holding back efforts to scale up HIV prevention resulting in a major gap between the need and availability of HIV prevention services.

Based on UNAIDS data[3], a 2003 report from the Global HIV Prevention Working Group[4] reviewed the most recent evidence on HIV prevention needs and current resources. The

[1] *AIDS epidemic update*. Geneva, UNAIDS, 2004.

[2] *AIDS in Africa. Three Scenarios to 2025*. Geneva, UNAIDS, 2005.

[3] *Progress Report on the Global Response to the HIV/AIDS Epidemic 2003.* Geneva, UNAIDS, 2003.

[4] The Global HIV Prevention Working Group is an international panel of nearly 40 leading public health experts, clinicians, biomedical and behavioural researchers, and people affected by HIV/AIDS. The Working Group seeks to inform global

report revealed that less than one person in five at risk of HIV had access to basic HIV prevention services globally[5]. It also revealed that only one in ten people living with HIV has even been tested for the virus.

More recent data paint a similar picture, revealing evidence of wide regional variations in access to HIV prevention options[6] for instance:

- in Southeast Asia only 0.1% of people 15-49 years old have received counselling or have been tested;
- in sub-Saharan Africa only 5% of pregnant women living with HIV have access to services which would prevent the virus from infecting their children;
- in Eastern Europe only 7.6% of injecting drug users have access to programmes which could protect them from HIV infection;
- in Latin America and the Caribbean only 14% of risky sexual acts are protected by condoms; and
- in the Eastern Mediterranean, only 0.5% of sex workers are covered by any HIV prevention programme.

Even where HIV prevention programmes exist, there is often little information on their quality. The HIV prevention gap has contributed to rising numbers of people living with HIV and particularly mounting rates of infection among women—who currently constitute just under half of all people living with HIV. Young people too are disproportionately affected—constituting over one-half of the estimated new infections occurring in the year 2004.

Rapidly growing epidemics in newly-affected regions and populations, such as among injecting drug users in Eastern Europe, and uncontrolled 'mature' epidemics combined with population growth, have contributed to the net overall increase in HIV incidence worldwide. In all contexts men continue to be key drivers of the epidemic.

No area of the world is untouched by AIDS. At the country level, the epidemic is manifested in very different ways influenced by a host of complex factors including culture, gender norms, poverty and levels of investment in HIV prevention and the broader AIDS response.

It has been estimated that the implementation of a comprehensive HIV prevention package could avert 29 million (or 63%) of the 45 million new infections expected to occur between 2002 and 2010[7]. The cost of the necessary HIV prevention measures is estimated to reach US$ 4.2 billion annually by 2007[8] but will increase for every year that action is delayed[9].

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policy making, program planning, and donor decisions on HIV prevention, and advocate for a comprehensive response to HIV/AIDS that integrates prevention and care. The Working Group was convened in 2002 by the Bill & Melinda Gates Foundation and the Henry J. Kaiser Family Foundation.

5 Global HIV Prevention Working Group (2003) Access to HIV Prevention, Closing the Gap. http://www.kff.org/hivaids/200305-index.cfm

6 Source: USAID, UNAIDS, WHO, UNICEF and the Policy Project. Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low and Middle Income Countries in 2003. Washington, DC, Policy Project, 2004.

7 Stover J, Walker N, Garnett GP, et al. (2002) Can we reverse the HIV/AIDS pandemic with an expanded response? Lancet, 360 (9326): 73-77

8 Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries- "Making the Money Work" The Three Ones in Action. Geneva, UNAIDS, discussion paper – 9 March 2005

9 Schwartlander B, Stover J, Walker N, Bollinger L, Gutierrez JP, et al. (2001) Resource needs for HIV/AIDS. Science, 292:2434–2436.

❖ More opportunities for HIV prevention than ever before

Much has been learned in how best to control the spread of HIV since the start of the epidemic. HIV prevention has led to decreases in the incidence of HIV infection in numerous populations such as among men who have sex with men in many Western countries, among young women in Uganda, among young men in Thailand and among injecting drug users in Spain and Brazil[10]. However these initiatives have not been taken to the kind of scale needed to make a significant impact on the global incidence of HIV. The AIDS epidemic can only be reversed if effective HIV prevention measures are intensified in scale and scope.

The commitment to tackling AIDS is unprecedented. A secure and growing knowledge base, high levels of political commitment and civil society engagement have been accompanied by increased funding by governments of both high- and lower-income countries, as well as through the creation of new funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank initiatives including the Multicountry AIDS Program and the US President's Emergency Plan for AIDS Relief.

The targets for HIV prevention established by governments in the 2001 United Nations General Assembly Special Session *Declaration of Commitment on HIV/AIDS*[11] have laid the foundations on which to build global momentum to intensifying HIV prevention, both for the delivery of existing interventions and the research and development of new prevention technologies, such as microbicides and vaccines.

HIV prevention, if properly resourced, can also have a major impact on other national priority areas including controlling the spread of sexually transmitted infections and

10 AIDS Epidemic Update. Geneva, UNAIDS, 2004

11 Para 47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

Para 52. By 2005, ensure: that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

Para 54. By 2005, reduce the proportion of infants infected by HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary counselling and testing, access to treatment, especially anti-retroviral therapy, and, where appropriate, breast-milk substitutes and the provision of a continuum of care.

Para 58. By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

Para 65. By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance; *Declaration of Commitment on HIV/AIDS—United Nations General Assembly Special Session on HIV/AIDS*. New York, United Nations, 2001.

tuberculosis, addressing gender inequality, promoting education, tackling drug and alcohol use, improving health services and mitigating the impact on children made orphans and vulnerable by AIDS.

Important additional opportunities for an intensification of HIV prevention also arise from forging links with other programmes and services, for example through workplace programmes, trade unions, faith-based organizations, community groups, women's and young people's organizations and groups of people living with HIV.

HIV and AIDS, and sexual and reproductive ill-health are driven by many common root causes, including gender inequality, poverty and the social marginalization of the most vulnerable populations and groups. Strong linkages between HIV and AIDS, and sexual and reproductive health programmes and services, and special effort to reach those excluded from access to health and other services, will result in more relevant and cost-effective programmes with greater impact.

The protection, promotion and respect of human rights are essential pre-requisites to effective planning, programming and implementation of HIV prevention. The Commission on Human Rights has endorsed several relevant resolutions that can help enable individuals to exercise their rights and give states the basis on which to strengthen their legislation, policies and action to empower people to protect themselves from HIV and to combat stigma and discrimination.

❖ Learning from the sustainability of HIV treatment efforts

The extraordinary mobilization of efforts stimulated by the "3 by 5" Initiative, and greatly increased funding, has resulted in an estimated 700 000 people in low- and middle-income countries receiving treatment at the end of 2004[12]. Increased coverage with antiretroviral treatment is expected to reduce mortality and morbidity to AIDS world wide and will simultaneously provide countless new HIV prevention opportunities through client-initiated and provider-initiated routine offer of voluntary, confidential and good quality HIV counselling, testing, and referral.

Despite considerable success, the 700 000 on treatment represent only 12 % of those in need of treatment now. Challenges persist in providing life-long antiretroviral treatment and care to many more millions of people every year in low-income countries. The number of new infections—five million a year—must be dramatically reduced in the next few years to ensure that antiretroviral treatment scale up remains economically and socially sustainable.

Increased antiretroviral treatment access provides opportunities for involving many new players in HIV prevention, including people living with HIV, treatment activists and health workers. Partnerships between such players have been a driving force in pushing forward the HIV treatment agenda, and their strength and passion needs to be built upon in future work.

Greater access to HIV antiretroviral treatment reinforces HIV prevention through increased HIV testing. An increased uptake of HIV testing can contribute to a reduction in stigma and denial— key barriers to a successful response. The lifelong care of millions of people receiving antiretroviral medication also allows health care workers to deliver

[12] "*3 by 5" Progress Report*. (December) 2004. Geneva, World Health Organization, 2004

and reinforce HIV prevention in ways hitherto not possible through HIV prevention strategies involving people living with HIV, for example, and other strategies[13].

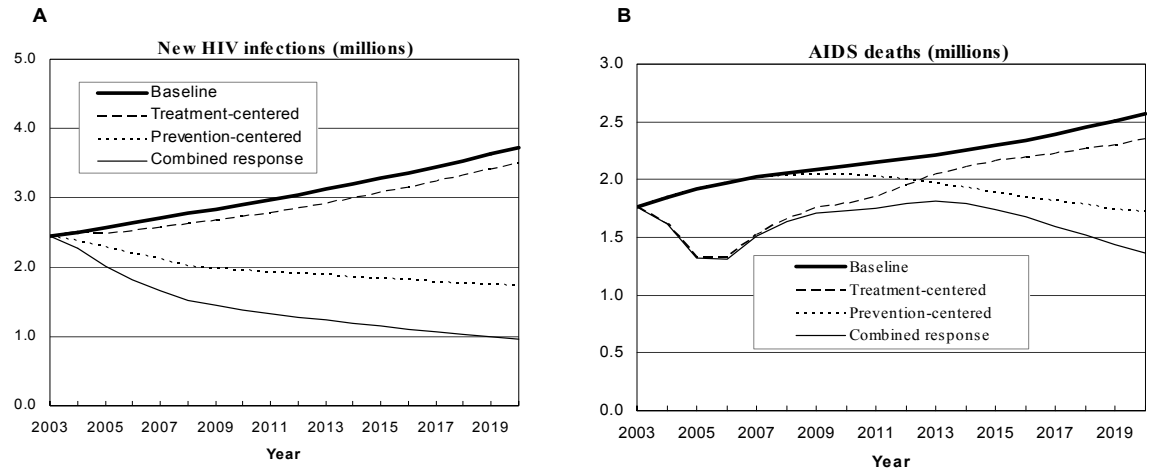
For key populations experiencing rapidly rising or high HIV infection rates (for example, injecting drug users, sex workers, economic migrants, prisoners and men who have sex with men), HIV treatment access provides significant new opportunities for HIV prevention as a result of the increased accessibility of these hitherto hard-to-reach groups. These opportunities must not be lost if a significant impact on the HIV epidemic is to be made. Simultaneously, one must acknowledge that the global attention to AIDS treatment has caused some neglect of HIV prevention recently, a problem which can be addressed best if HIV treatment and prevention are recognized as equally important and supportive of each other and their synergies are harnessed programmatically, in policy as well as in advocacy.

Mathematical modelling by Salomon, et. al. comparing a range of scenarios shows that in the scenario in which effective HIV prevention and treatment are scaled up jointly, the benefits, both in terms of new HIV infections and deaths averted are greatest (Figure 2)[14].

The conclusions from this study are clear:

- successful HIV treatment can enable more effective HIV prevention;
- intensified HIV prevention is needed to make HIV treatment affordable and sustainable; and
- sustained progress in the response against AIDS will only be attained by intensifying HIV prevention and treatment simultaneously.

Figure 2: Projected new adult infections and total adult deaths in sub-Saharan Africa, in millions, by the year 2020: Impact of three scenarios compared to baseline



❖ Barriers to scaling up HIV prevention

HIV prevention can be controversial and uncomfortable for individuals, societies and governments to confront. It forces discussion of difficult issues such as sex, sexuality and drug use. There can be an unwillingness and inability to provide access to the full range

[13] Global HIV Prevention Working Group (2004). *HIV Prevention in the Era of Expanded Treatment Access*. Available at http://www.kff.org/hivaids/hiv061004pkg.cfm.

[14] Salomon JA, Hogan DR, Stover J, Stanecki KA, Walker N, et al. (2005) Integrating HIV prevention and treatment: From slogans to impact. *PLoS Med* 2: e16.

of options that are known to be successful in HIV prevention. In many places, there is strong cultural resistance to addressing the needs of vulnerable populations and a reluctance to recognize and act on societal and structural factors which fuel the epidemic. Many countries have legal restrictions, which, when coupled with stigma and discrimination, can drive vulnerable populations underground and thereby make them inaccessible to HIV prevention efforts. HIV prevention interventions should proactively address culture. While culture can function as a vehicle for promoting HIV prevention, it must be recognised that it can also constitute a barrier against HIV prevention.

In addition, HIV prevention has been subject to diverse levels of scepticism and an associated lack of commitment, investment and emphasis in recent years. This has not been an issue for HIV prevention exclusively. The trend relates to "prevention" efforts across a broad range of public health fields, where it can be difficult to demonstrate the impact of interventions when the end goal is to ensure that something does not happen.

Not to be forgotten are personal barriers to behaviour change and adoption of safer behaviour. These are often rooted in economic and social factors such as poverty, gender and cultural norms.

In order for HIV prevention to be taken to scale, strategies are needed to overcome the barriers to HIV prevention.

Operational Barriers to Scaling Up Effective HIV Prevention.

- Poor planning, inappropriate prioritization, and low capacity to track and show results of HIV prevention programmes.
- Limited human and institutional capacity to manage and deliver HIV prevention programmes.
- Lack of access to commodities.
- Lack of effective and efficient coordination mechanisms among stakeholders working at country level.

Section 2: Working for Success

Success in HIV prevention requires a series of sustained, specific, concrete and robust actions. Experience and best practice built up over more than 20 years of the AIDS response have shown that some essential policy and programmatic actions based on a few key principles have to be undertaken irrespective of the level of the epidemic. These are outlined in this section.

❖ The principles of effective HIV prevention programmes

Crucial to the success of any effective HIV prevention effort are a number of over-arching principles in which programmes should be grounded.

The Principles of Effective HIV Prevention

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

Human Rights Including Gender Equality

It is of fundamental importance that human rights including gender equality be at the foundation of our policies and programmes with respect to HIV prevention. HIV disproportionately affects those groups and individuals already marginalized and /or least able to realize their human rights. Prevention efforts will not be successful unless the underlying determinants of vulnerability to infection are addressed and the rights of all people are respected, promoted and protected.

Differentiated and Locally-Adapted Response

There is no single AIDS epidemic but many. The UNAIDS Secretariat and WHO have characterized different AIDS epidemic states as low level, concentrated and generalized[15]. Countries can move across these categories, given the dynamic nature of the epidemic. Within the country, there are often a series of multiple, changing and overlapping micro-epidemics, each with its own nature (the populations most affected), dynamics (patterns of change over time) and characteristics (severity of impact).

[15] UNAIDS/WHO Working Group on global HIV/AIDS and STI surveillance. *Guidelines for Second Generation HIV Surveillance.* Geneva, UNAIDS, 2000.

The Three AIDS Epidemic States

Low-level

- *Principle*: although HIV infection may have existed for many years, it has not spread to significant levels in any sub-population. Recorded infection is largely confined to individuals with higher risk behaviour: e.g., sex workers, injecting drug users, men having sex with men. The epidemic state suggests that networks of risk are rather diffuse (with low levels of partner exchange or sharing of drug injecting equipment), or that the virus has been introduced only very recently.
- *Numerical proxy*: HIV prevalence has not consistently exceeded 5% in any defined sub-population.

Concentrated

- *Principle*: HIV has spread rapidly in a defined sub-population, but is not well established in the general population. The epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population.
- *Numerical proxy*: HIV prevalence consistently over 5% in at least one defined sub-population. HIV prevalence below 1% in pregnant women in urban areas.

Generalized

- *Principle*: in generalized epidemics, HIV is firmly established in the general population. Although sub-populations at high risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection. In some countries with generalized epidemics, prevalence levels have decreased (e.g., Uganda) where as in others, HIV prevalence continues to increase (e.g., Swaziland).[16]
- *Numerical proxy*: HIV prevalence consistently over one percent in pregnant women.

Adapted from *Guidelines for Second Generation HIV Surveillance.* Geneva, WHO and UNAIDS, 2000.

An understanding of the nature, dynamics and characteristics of local epidemics is needed to ensure that HIV prevention strategies can be reviewed and adapted to fit local conditions. In low and concentrated HIV prevalence settings where the epidemic is nascent, attention needs to be given to prioritising HIV prevention among those at highest risk, identified after epidemiological and social mapping. In generalized HIV epidemics, strategies for such populations combined with broader strategies to reach all segments of society at sufficient scale are needed.

In all settings, it is critical to undertake the policy and prevention actions mentioned later, though their intensity, priority and scale in each context will depend on the epidemiological and social situation.

Evidence-Informed Action

Various programme evaluations, intervention research and country-level experiences have already provided the evidence of effective HIV prevention approaches, and crucially, the setting and contexts in which they can be applied. This evidence, complemented with local data from HIV surveillance, behavioural and epidemiological studies, community-based research and monitoring and evaluation data should inform policy makers in scaling up HIV prevention.

[16] 2004 Report on the global AIDS epidemic. Geneva, UNAIDS, 2004

In addition, agreed and quality standards must be adhered to and developed where needed across a range of disciplines for clinical, operational and evaluation studies. These standards, in turn, will provide policy makers with greater reassurance that if reviews of evidence call for changes in programming approaches, such changes can be made. Continued investment is needed in research that expands the evidence base for HIV prevention, particularly on the determinants of HIV-related vulnerability, including gender relations, culture, poverty and under-development, and how these might be addressed.

Comprehensive Programming

To be successful, HIV prevention must utilize all approaches known to be effective, not implementing exclusively one or a few select actions in isolation. Comprehensive HIV prevention programmes benefit from the full range of up-to-date scientific information concerning transmission and the measures that can be adopted to protect against infection. These should be offered to individuals and communities in a frank, non-discriminatory and open manner. Comprehensive programming should also be multisectoral in approach, recognizing the importance and value added of effectively engaging all relevant sectors. This programming should link with poverty reduction strategies. It also includes a broader focus on sexual and reproductive health, comprehensive and appropriate sexual education, life skills, drug-related education, work-place education, school-based education, and linkages with existing programmes in all sectors.

Most importantly, a comprehensive approach to HIV prevention must address not only risk but also deep-seated causes of vulnerability which reduce the ability of individuals and communities to protect themselves and others against infection (Figure 3). This necessitates providing for instance, more opportunities and greater equity in education and employment for women, young people and marginalized populations, who are particularly vulnerable to HIV; enabling families to maintain their homes and property when disability or death occurs; food security programmes especially for vulnerable young people and women; and specific protection measures for refugees and people in conflict and displaced situations.

Figure 3: Reinforcing strategies of risk, vulnerability and impact reduction [17]

HIV Prevention Is for Life

HIV prevention needs long-term investment and sustained engagement in order to have maximum impact. There are no easy solutions or "quick fixes" to promoting and sustaining safer forms of sexual and drug-related behaviour over time, or to changing contextual factors

[17] Global Strategy Framework on HIV/AIDS. Geneva, UNAIDS, 2001

that drive the HIV epidemic. In addition, HIV prevention programmes have to be continuously reinforced to meet the needs of new generations.

The need for a long-term investment in AIDS, and HIV prevention in particular, has major implications for national governments and donors, in terms of resources, in maintaining and extending the necessary human and institutional capacity required, and in funding research into new prevention technologies, primarily HIV vaccines and microbicides.

Scaling Up and Coverage

HIV prevention programmes currently being implemented are at a scale insufficient to arrest and turn back the AIDS epidemic. Scaling up is essential to any meaningful intensification of HIV prevention in the context of moves to ensure universal access to treatment and care as part of the comprehensive response to HIV and AIDS. Where HIV prevalence is high—either in a geographic area (for example sub-Saharan Africa) or concentrated in particular populations (such as drug users in the Russian Federation)—maximum coverage will be needed in order to slow the epidemic. Equally essential is the need for optimal coverage and intensity[18] of HIV prevention programmes in all settings in order to have an impact.

Community Participation

HIV prevention programmes should be planned **with** and not just **for** whom they are meant. The importance of supporting the genuine involvement of key affected communities is referred to later in this section (HIV Prevention Policy Action 7). However, as an underpinning principle, it is key to ensure the participation and ownership of communities in the scaling up of any developmental programme.

❖ The essential HIV prevention policy and programmatic actions

Two decades of experience demonstrate the value of a comprehensive and sustained approach to HIV prevention, informed by country-level experience and evidence. These have been summarised in two boxes below: Policy Actions (which address societal factors that create and exacerbate vulnerability to HIV or create a supportive climate for HIV prevention programmes to take root) and Programmatic Actions (which directly address the risk of HIV transmission). These actions are by no means "exclusive" and their application should be based on the needs of local situations. Nonetheless, they reflect the primary elements of any effective HIV prevention strategy, and form the cornerstone of any national HIV prevention response, as part of a broader comprehensive national AIDS strategy. It bears repeating that any one action on its own will not suffice. Gaps in existing HIV prevention actions, including the lack of focus and limited coverage, must be identified and urgently addressed.

[18] Intensity of a programme is defined as levels of contact with prevention services and quality and range of specific actions undertaken.

Essential Policy Actions for HIV Prevention

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

1. Human rights. All over the world, AIDS has thrived on stigma, shame and discrimination and has given rise to the abuse of human rights. Protecting and promoting human rights are therefore an essential part of any comprehensive AIDS prevention strategy, as is promoting the dignity of people living with HIV/AIDS. The *Declaration of Commitment on HIV/AIDS* and all relevant resolutions of the UN Commission on Human Rights, stress the importance of human rights in HIV prevention. The Guidelines on HIV/AIDS and Human Rights, a document developed by an international consultation of human rights experts, provides states and other actors with guidance on how to effectively promote and protect human rights within the context of AIDS.

2. Leadership. National governments have the mandate to direct policy, provide resources, and offer leadership at a scale that will arrest and turn back the HIV epidemic. Often, they have shied away from undertaking comprehensive HIV prevention because of competing economic and political priorities and the association of HIV with issues such as sex, sex work, sex between men, and drug use. There is no doubt that these can be difficult and sensitive issues, but they must be addressed transparently, informed by evidence, if an effective response to HIV prevention is to be mounted.

Numerous opportunities exist for the display of leadership and a significant scaling up of the national response. Politicians and leaders in all sectors including religious, business and community must use every opportunity available to speak out openly about AIDS and its growing impact on individuals, families, communities and societies.

3. Involvement of people living with HIV. Since the beginning of the epidemic prevention strategies have been more effective when they have meaningfully involved people living with HIV in their design, implementation and evaluation. The principle of the Greater Involvement of People Living with HIV/AIDS (GIPA) [19] in the AIDS effort was formally recognized at the 1994 Paris AIDS Summit, when 42 countries agreed that, ensuring their full involvement at national regional and global levels will stimulate the creation of supportive political, legal and social environments. HIV prevention strategies have, however, often failed to address the distinct prevention needs of people diagnosed with HIV and/or to build capacity for their meaningful participation. Their involvement has often been relegated to little more than tokenism. An effective response requires that this change.

The aim of prevention for people living with HIV is to empower them to avoid acquiring new sexually transmitted infections, delay HIV disease progression and avoid passing their infection to others. Prevention counselling strategies increase knowledge of HIV transmission and improve safer sex negotiation skills. Other HIV prevention strategies , also include scaling up, focusing and improving services and commodity delivery; services for serodiscordant couples; protecting human rights; strengthening community capacity for mobilization; and supporting advocacy, policy change and community awareness[20]. These strategies do not stand alone, but work in combination with one another.

4. Cultural norms and beliefs. HIV transmission is fuelled by a variety of factors, including most importantly, the local context created by local norms, myths, practices, and beliefs, as well as social, economic and human security realities. HIV prevention efforts must be tailored to respond to those norms, practices and beliefs that hamper HIV prevention. Simultaneously, those norms, practices and beliefs that potentially can support HIV prevention need to be fully harnessed.

5. Gender equality, gender norms and relations. Gender inequalities as well as gender norms and relations, including practices around sexuality, marriage and reproduction; harmful traditional practices; barriers to women's and girls' education; lack of access for women to health information and care; and inadequate access to economic, social, legal and political empowerment are major contextual barriers to effective HIV prevention.

Worldwide, women and girls have been rendered vulnerable to infection by widespread inequalities and economic, political, social, cultural and human security factors. The UNAIDS-led Global Coalition on Women and AIDS has identified seven action areas to address women's vulnerability to HIV, namely:

1. Preventing HIV infection among young women and girls, focusing on improved reproductive health care;
2. Reducing violence against women;
3. Protecting the property and inheritance rights of women and girls;
4. Ensuring equal access by women and girls to care and treatment;
5. Supporting improved community-based care with a special focus on women and girls;
6. Promoting access to existing prevention options including the female condom, and research into new prevention technologies such as microbicides;
7. Supporting ongoing efforts towards universal education for girls.

[19] From Principle to Practice, Greater Involvement of People Living with or affected HIV/AIDS. (UNAIDS Best Practice Collection). Geneva, UNAIDS, 1999.

[20] Positive Prevention: Prevention strategies for people living with HIV/AIDS. Brighton, International HIV/AIDS Alliance, 2003.

Action in each of these areas and towards the broader goal of gender equality is necessary to turn back the increasing feminization of the epidemic globally.

In addition, it is important to engage men and boys in these efforts for a long-standing impact on gender inequalities. Involving men is important not only because they often control women and girl's vulnerability to HIV. Societal norms about masculinity and gender also heighten men's vulnerability to HIV since they encourage men to engage in behaviours that put their health at risk and deny them needed protective information and services. Men, like women, are influenced by gender norms and constrained by traditional beliefs and expectations. These need to be challenged and changed if both men and women are to be protected from HIV infection and if men are to be encouraged to play a more responsible role in HIV prevention. Special attention needs to be paid to boys in terms of their socialization towards gender norms[21].

6. Promoting greater public awareness. AIDS is an epidemic of the information age. Yet it is precisely those tools of the information age that are our strongest weapons to fight the AIDS epidemic—to fight denial, inaction, ignorance, stigma and discrimination: the key forces that allow this epidemic to spread.

Public understanding of how AIDS is prevented and treated continues to be limited in many parts of the world. Communication, utilizing all forms of media, has a pivotal role to play in the fight against AIDS. With its wide-reaching, global infrastructure and communications expertise, the media's ability to change the course of this epidemic is virtually unparalleled[22]. The media can convey information efficiently and achieve wide coverage. The media is critical in stimulating public debate and dialogue, and in challenging long established social norms that inhibit HIV prevention[23].

Communication is central to HIV prevention strategies aimed at influencing individual and social behaviour. Media and interpersonal communication complement each other in supporting HIV prevention, both among societies and individuals. Interpersonal communication (face to face) is most efficient to reach key populations at risk and personalise the discussion around their life contexts.

Since there are many variations in the contexts that determine behaviour, communication approaches to promoting HIV prevention need to be specific to be relevant to local situations. Government policy and an understanding of social and economic context, culture, and gender relations must inform the development of communication strategies for HIV prevention[24].

7. Linking with sexual and reproductive health. The overwhelming majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Sexual and reproductive health initiatives and HIV prevention initiatives should be mutually reinforcing. Both HIV and sexual and reproductive health are driven by many common root causes and stronger linkages between them will result in more relevant and cost effective programmes with greater impact. Over the last three decades,

[21] *Men and AIDS - A gendered approach* (World AIDS Campaign). Geneva, UNAIDS, 2000.

[22] *Media and HIV/AIDS- making a difference.* Geneva, UNAIDS, 2004.

[23] *Missing the Message 20 years of learning from HIV/AIDS.* London, PANOS, 2003

[24] *Communication Framework for HIV/AIDS*. Geneva, UNAIDS, 1999.

donors and governments have invested heavily in reproductive health services reaching millions. Integrating HIV prevention in existing reproductive and sexual health programmes can rapidly scale up coverage of HIV prevention programmes. While sexual and reproductive health may not cover the entire gamut of HIV prevention, linkages between the two are vital[25].

8. Community mobilization. Communities have been at the forefront of the response to AIDS since the emergence of the epidemic. Mobilizing communities to act collectively ensures that the AIDS epidemic is owned and responded to by all levels of society. Not only is this in keeping with the rights of communities but it also ensures that the response is sustainable, reaches the necessary populations, and achieves impact. Community mobilization is therefore, central to effective HIV prevention and the AIDS response, as a whole. It requires investment and support and cannot be taken for granted.

9. Promote programmes targeted at HIV prevention needs of key affected groups and populations. Although comprehensive prevention programmes must be made available to the general population, actions must be taken to identify key populations based particularly on epidemiological data – both those most at risk of HIV infection and those living with HIV – and to address their specific prevention needs and that of their sexual partners, where applicable. These key populations include:

- Women and girls;
- Youth;
- Men who have sex with men;
- Injecting and other drug users;
- Sex workers;
- People living in poverty;
- Prisoners;
- Migrant labourers;
- People in conflict and post conflict situations;
- Refugees and internally displaced persons.

In the framework of the strategy of prevention of the HIV/AIDS, it is necessary to bear in mind the need to apply a precise and coherent approach towards migrants, indigenous peoples and other vulnerable populations. In the context of increasing human mobility, it is important to recall the commitment to develop and begin implementing national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.

Indigenous peoples should enjoy, without discrimination and stigmatisation, the highest attainable standard of physical and mental health. To prevent, halt and reverse the epidemic among these groups requires interventions that increase their access to prevention, treatment and care information and services, taking into account their special vulnerability.

10. Mobilizing and strengthening financial, institutional and human capacity. There are a range of resources needed to mount and sustain an effective HIV prevention response as

[25] The Role of Reproductive Health Providers in Preventing HIV. Geneva, Allan Guttmacher Institute and UNAIDS, 2004

part of a comprehensive AIDS programme. These include expanding and making more effective use of existing finances, and strengthening institutional and human capacity.

Exponentially increasing financial needs is a fundamental characteristic of AIDS epidemics, particularly when they reach a generalised stage. National governments must therefore take a serious lead in increasing the domestic resources available for HIV prevention. Key actions include real-term increases in funding for HIV prevention, public-private sector ventures, workplace programmes, and recognition that investment in HIV prevention should be understood as a capital investment for the future and not an item of expenditure. AIDS must be addressed in development planning in sector wide approaches (SWAps), Poverty Reduction Strategy Papers (PRSPs) and Public-Private partnerships (PPPs) for example, as well as in arena such as the "Education for All- Fast Track Initiative".

Strengthening the capacity of key institutions in several sectors is critical to ensuring adequate HIV prevention. Multisectoral and inter-sectoral collaboration are not new concepts but there has to be some breakthrough in ensuring that health systems are strengthened to ensure rapid and adequate HIV prevention (particularly in a context where access to treatment is increasing), that the education sector fully play its role especially in the area of comprehensive and appropriate sexual education, and that social services (particularly those concerned with the care of orphans and vulnerable children, including girls) and the private sector and civil society organisations are fully engaged in this inter-sectoral effort.

Measures are also needed to maintain and build capacity in the other key sectors, maintaining good nutrition and food security, and understanding HIV prevention, treatment and care in situations of conflict, instability and displacement.

Urgent steps are needed to protect and build human capacity in both high prevalence countries as well as those where the epidemic has not advanced so far. These include:

- Taking action to prevent new cases of HIV infection;
- Protecting human life by increasing the availability of anti-retroviral drugs and other forms of treatment when workforce attrition is largely influenced by high rates of infection;
- Adapting and/or reinforcing existing or taking new measures including by developed countries to facilitate the retention of skilled workers in developing countries;
- Enabling skilled workers in international organisations, as well as international non-governmental organisations, to support national efforts when needed;
- Expanding the numbers and capacities of staff in key sectors; and
- Engaging actors from different walks of life.

Strengthening civil society capacity (and especially the capacity of organisations of people living with HIV) to raise resources, build institutions and undertake HIV prevention is crucial.

11. Review and reform of legal frameworks. Effective HIV prevention programming takes place within the existing legal framework of a country. However, review, and if necessary, reform of the existing legal frameworks is essential to ensure that people's ability to control their risk of infection through comprehensive programmes is protected. This would include the elimination of the gender based inequalities that fuel the epidemic through sexual exploitation and gender-based violence; access to health care and other services free from discrimination; the provision of opportunities for work and a safe work environment; removing barriers to effective evidence based HIV prevention, including among sex workers, injecting and other drug users, and men who have sex with men; and access to education. Criminal laws and correctional systems in particular need to be reviewed and reformed if necessary, to ensure that they do not result in misguided attempts to control HIV and that they respect, protect and fulfil the rights of all people including people living with HIV and vulnerable or at-risk populations.

The vulnerability of people in situations of enhanced possibility of HIV transmission such as during and after conflict, displacement or incarceration also needs to be recognised and the rights of people in such situations to information, services, and protection, need to be respected, protected and fulfilled. In particular, as stated earlier, existing national legislation should be reviewed, and reformed if necessary, to ensure that it is consistent with international human rights obligations.

12. New prevention technologies. New technologies, such as HIV preventive vaccines and microbicides, offer hope for sustained control of the HIV epidemic, particularly in the world's most vulnerable and marginalised populations, of which women constitute such large proportions. Policy makers and donors need to generate sufficient support for research and development in ways that promote efficiency and coordination and are based on ethical principles, as well as contributions of intellectual and financial capital by the private sector. Developing countries, in collaboration with those who can provide support where it is required, need to build capacity for clinical trials, social research, licensing and access.

Essential Programmatic Actions for HIV Prevention

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

1. Prevention of sexual transmission of HIV—Prevention of sexual transmission of HIV must have as its basis the promotion and protection of human rights, including the right to control one's own sexuality, free of coercion, discrimination and violence. Programmes should be comprehensive, high quality and evidence-based, and should include accurate and explicit information on safer sex, including correct and consistent male and female condom use, as well as abstinence, delay in onset of sexual debut, mutual fidelity, reduction of the number of sexual partners, comprehensive and appropriate sexual education, and early and effective treatment for sexually transmitted infections. Programmes should also include information and education services that explain in an open and frank manner how sexual transmission of HIV can be averted. Services should be particularly directed towards key populations most affected by HIV. The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections[26]. Along with the female condom, it is a key component of comprehensive prevention strategies to reduce risks to sexual exposure to HIV, and both should be made readily and consistently available to all those who need them.

In addition, once available, microbicides that are proven safe and effective will provide another prevention option that would help to reduce new HIV infections.

2. Prevention of mother-to-child transmission of HIV—involves a comprehensive package of services including preventing primary HIV infection in women, preventing unintended pregnancies in women with HIV infection, preventing transmission from HIV-infected pregnant women to their infants, and providing care, treatment and support for HIV-infected women and their families[27]. Closer integration with HIV treatment services to ensure that HIV positive mothers can access antiretroviral therapy and with maternal and child-health services can help improve the coverage of quality comprehensive services for the prevention of mother to child transmission of HIV.

3. Preventing transmission of HIV through injecting drug use—by developing a comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users.

4. Ensuring the safety of the blood supply—includes mandatory and rigorous HIV screening of donated blood, respecting the confidentiality of blood donors, and promoting appropriate clinical use of donated blood[28]. Transfusion with contaminated blood, being an extremely efficient form of HIV transmission, may account for 5% to 10% of cumulative HIV infections worldwide. HIV transmission through contaminated blood, however, has declined significantly in recent years. Some countries, however, have not fully implemented proven blood safety policies and risk HIV transmission due to inconsistent screening and using paid blood donors.

[26] Position Statement on Condoms and HIV Prevention, July 2004. Geneva, UNAIDS/UNFPA/WHO, 2004.

[27] *The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children 3-5 Ma.y* UNFPA, 2004,

[28] *Blood and Clinical Technology Progress 2000-2001.* (WHO/BCT/02.10). Geneva, World Health Organization, 2002.

5. Preventing HIV transmission in healthcare settings—including both formal and informal settings, through the consistent use of universal precautions and post-exposure prophylaxis for HIV infection. It is standard practice for health care workers to use universal precautions or routine protective measures—such as wearing gloves and other protective clothing. WHO recommends that all health-care workers take such precautions when they are likely to come in contact with a patient's blood or other body fluids. These precautions protect health-care workers and patients against many types of infections that are carried in blood and other body fluids including HIV[29]. UNICEF, WHO, UNFPA and Global Alliance for Vaccines and Immunizations partnership also recommend that all countries should use only auto-disposable syringes and safe disposal for immunization[30].

6. Promoting greater access to HIV counselling and testing—is imperative in any HIV prevention strategy. Efforts should be made to encourage people to know their HIV status through access to client-initiated voluntary and confidential counselling and testing, and routine offer of testing in the health sector, respecting the principles of confidentiality. In all types of HIV testing the principles of confidentiality and consent should be maintained and counselling should be provided.

7. Integrating HIV prevention into AIDS treatment services—to exploit the synergy between the two by training health sector personnel and community care providers in the provision of both HIV prevention and care, offering HIV preventive counselling in treatment settings, and ensuring the availability of HIV prevention commodities and services in all health care settings.

8. Focus on HIV prevention on young people—is imperative because young people between the ages of 15 and 24 years are both the most threatened by the AIDS epidemic— accounting for half of all new cases of HIV—and the greatest hope for turning the tide against AIDS[31]. Vulnerability to HIV, especially among young people, is compounded by a limited knowledge of how HIV is spread and how infection can be avoided. In addition, young women in many countries are far less knowledgeable about HIV than young men. Early sexual debut, transgenerational sex, and gender disparities highlight the fact that HIV education must be accompanied by access to life-skills education and necessary services, including for young girls in particular safeguards to protect them from sexual violence and exploitation, and protection of their rights. Keeping children in school also helps protect them against HIV infection[32]. Special attention should be given to children made orphans and vulnerable by AIDS and those in situations of conflict and displacement[33].

There is a need to provide young people with a full complement of tools to prevent HIV transmission including comprehensive, appropriate, evidence- and skills-based sexual education in schools; youth friendly health services offering core interventions for the

[29] http://www.who.int/hiv/topics/precautions/universal/en/

[30] *2004 Report on the global AIDS epidemic: 4th global report.* Geneva, UNAIDS, 2004

[31] *2004 Report on the global AIDS epidemic: 4th global report*. Geneva, UNAIDS, 2004.

[32] Global Initiative on HIV/AIDS and Education. UNESCO, 2004. The UNESCO led "Global Initiative on HIV/AIDS and Education" was launched in March 2004 to enhance national HIV prevention and mitigation by helping governments to implement comprehensive, nation-wide education programmes for young people. It will contribute to enhance HIV prevention in the "Education for All" framework.

[33] *Young People and HIV/AIDS: Opportunity in Crisis*. Geneva, UNAIDS, UNICEF and WHO, 2002; and *2004 Report on the global HIV/AIDS Epidemic: 4th global report*. Geneva UNAIDS, 2004

prevention, diagnosis and treatment of sexually transmitted infections and HIV; interventions to prevent transmission through unsafe drug injecting practices; services targeted to other vulnerable groups at high risk; mass media interventions; and consistent access to male and female condoms, readily available to all who need them. Programming, planning, implementation and monitoring of HIV prevention activities should include the meaningful involvement of youth. In this context, the appropriate role and responsibility of parents, families, legal guardians and caregivers should be recognized.

9. Provide HIV-related information and education—knowing the facts about how HIV is spread and can be prevented and learning skills for HIV prevention form an essential part of all HIV programmes. However, in 21 African countries, more than 60% of young women, for example, have either never heard of the virus or have at least one major misconception about how it is spread. Without this basic knowledge, people are unlikely to seek services or negotiate safer behaviour.

Lack of awareness also contributes to increasing stigma and discrimination. In many countries, despite high levels of awareness about the existence of AIDS, a large number of people feel that they are not at risk. For example, a quarter of adults in the United Kingdom—more than 10 million people—feel they do not know enough about how the risks of HIV could potentially relate to them[34]. Information about HIV prevention must be provided at all available opportunities. These include through inclusion in school curricula, non formal education, community outreach, workplace, prisons and mass media programmes. In addition gender specific interventions must also be provided.

10. Confronting and acting on HIV-related stigma and discrimination—stigma around HIV often leads to discrimination and this, in turn, leads to human rights violations for people living with HIV and their families. People can discriminate, both in their personal and professional capacities, while systems and institutions can discriminate through their practices and policies. Stigma and discrimination undermine HIV prevention efforts by making people afraid to find out whether or not they are infected, or may cause those who are infected to engage in unsafe behaviours for fear of raising suspicion about their HIV positive status.

In many countries, laws, policies and regulations have contributed towards the development of a supportive environment for HIV prevention, care and support. But even in places where supportive policies and legislation exist, nonexistent or weak enforcement of these laws may facilitate the perpetuation of stigma and discrimination; this is because there is often little accountability for discriminatory action or redress for those who have been stigmatized and discriminated against. A supportive environment for HIV prevention should be created through legal and policy action to reduce HIV-related stigma and discrimination, by promoting public awareness and openness about AIDS, and by ensuring the greater involvement of people living with HIV in all aspects of HIV prevention[35]. Specific programmes for addressing HIV-related stigma and discrimination are so central to ensuring the success of HIV prevention strategies that they must be prioritized in all settings such as work place[36], health care and education.

[34] Media and HIV/AIDS: making a difference. Geneva, UNAIDS, 2004.

[35] World AIDS Campaign, Live and Let Live, Strategy background note. Geneva, UNAIDS, 2002

[36] Code of Practice on HIV/AIDS and the world of work. Geneva, International Labour Organization, 2001.

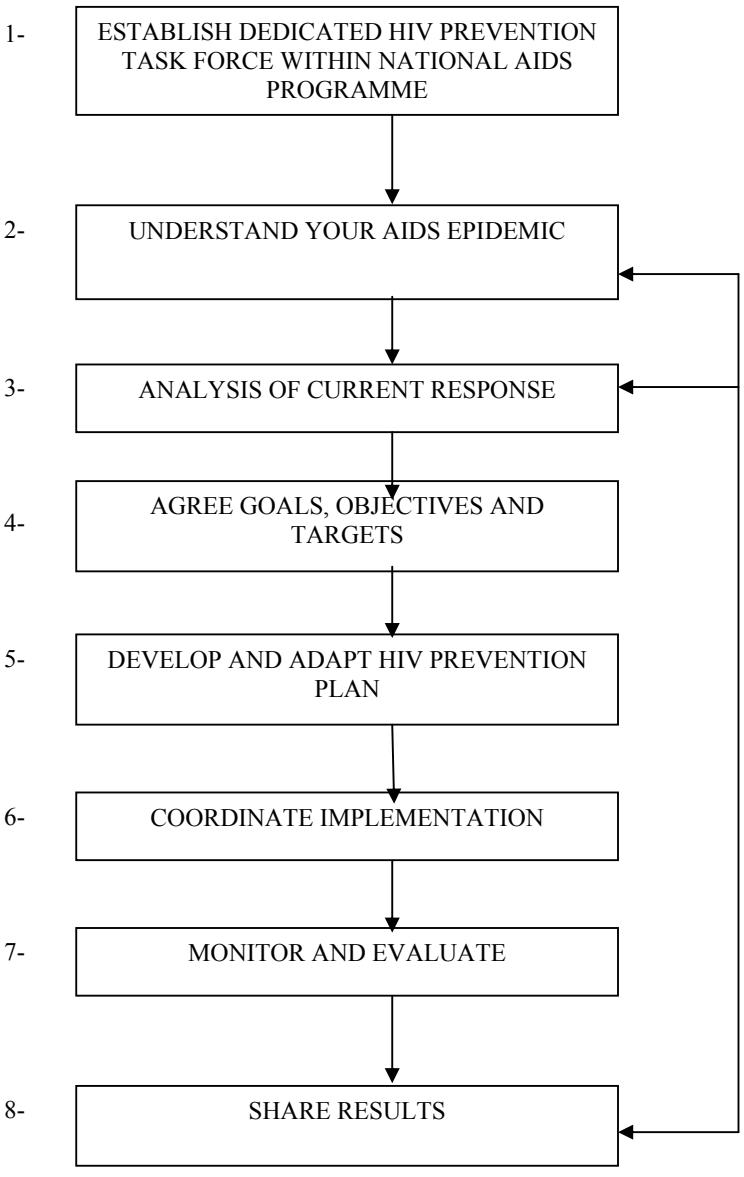
11. Preparing for access and use of vaccines and microbicides – It is crucial to ensure that men and women will have access to new prevention technologies once they have been tested, proven safe and effective, and approved for use. To assure such access and prepare for the introduction of such technologies, issues related to financing, intellectual property rights, manufacturing, procurement, logistics, delivery, and provider and consumer education must be addressed. For the distribution of safe and effective microbicides, as one example, we must design and engage in thoughtful preparedness studies, explore ways to use existing delivery or fulfilment systems for consumer products, and plan product attribute studies to determine women's preferences for a variety of products. Very importantly, mechanisms to finance the purchase and delivery of products must be established to ensure universal availability.

Ensuring availability of safe and effective vaccines and microbicides will also demand appropriate regulatory approval and licensing infrastructure, manufacturing capability, sufficient logistical capacity, and reasonably reliable in-country delivery networks. Even when these are in place, ensuring adoption will require end-user awareness about preventive products, effective pricing and financing mechanisms to ensure affordability, and a supportive social and policy environment.

Section 3: National Level Responses

National leadership, ownership and commitment to HIV prevention constitute the pre-requisites for implementation of a successful HIV prevention strategy. A number of national-level actions to developing and implementing an intensified HIV prevention response need to follow. These are outlined in Figure 4. This section goes on to discuss the development of and support for vocal HIV- prevention constituencies to advocate for effective national HIV prevention action.

Figure 4: National HIV Prevention Planning Cycle



❖ Planning for success

Establishing an HIV Prevention Task Force

While it is essential that HIV prevention is firmly grounded in the national AIDS control programme, the development, coordination of implementation and review of HIV prevention strategies needs to be assigned to a dedicated HIV prevention group, reporting to the national AIDS authority, to ensure appropriate oversight and follow up. It should not be a newly created structure, but rather a formalization of existing national coordination mechanisms focusing on HIV prevention. Ideally, it should consist of:

- a larger group of all key stakeholders including civil society and the private sector, to assume leadership and ownership of the strategy, and be responsible for coordination; and
- a smaller core group that drives the process, and which should be involved in all steps of planning and monitoring of the national HIV prevention response.

Understanding the National AIDS Epidemic

Existing and most recent information in the following areas should be gathered, synthesized and analysed:

- HIV epidemiological and behavioural surveillance;
- the social, economic and cultural context; and
- the barriers and opportunities for HIV prevention

In understanding the national AIDS epidemic, it may be helpful to ask where and why the most recent infections occurred. Many countries do not collect information on behaviours that are responsible for new infections. Using prevalence figures only for planning purposes has its limitations as patterns of transmission change over time. For example, in Thailand, only 5% of new infections were among spouses (cohabiting partnerships) through heterosexual transmission in 1991 while in 2002 this proportion was 50%. In Indonesia, injecting drug use and sex work accounted for roughly the same proportion of existing infections in 1997. A rapidly escalating number of injecting drug users since then has meant that unsafe injecting accounts for a much larger percentage of new infections today[37]. This shows clearly the need for studying incidence (new infections) and the dynamics of the epidemic to plan and implement appropriate HIV prevention interventions. The process of checking on recent infections will need to be repeated regularly, reflecting the changing dynamics of the AIDS epidemic.

A balance will need to be struck between:

- a detailed mapping of national HIV epidemiological data (which may be time consuming and which may call for additional studies); and
- a "rapid" assessment of the national situation to provide the basic key elements necessary to make decisions on how and what to prioritize in HIV prevention.

[37] 2004 Report on the global AIDS epidemic: 4th global report. Geneva, UNAIDS, 2004

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Assessing the Current HIV Prevention Response

This is intrinsically linked to the above step, but is separated here to emphasise its importance. The key issue to be addressed is whether the current HIV prevention response is adequate with regard to:

- addressing the relevant affected groups (scope);
- coverage of HIV prevention programmes (scale);
- quality and type of HIV prevention programmes (intensity);
- adaptation of HIV prevention programmes to fit the local culture and context;
- integration and synergies with other programmes; and
- coordination of different stakeholders.

Agreeing Goals, Targets and Objectives

The above steps will provide a strong platform for the development of an intensified national HIV prevention plan.

- **The overall HIV prevention goal** should be to reduce HIV incidence significantly, which in countries with generalized epidemics can be best measured by HIV prevalence in 15–24-year olds. Elsewhere, it can be measured by reduction in prevalence in key affected populations.
- **Specific objectives** should then be developed to contribute to this goal, defined in each country based on the results of the assessment done to understand the AIDS epidemic and the response, and informed by well-documented evidence on which programmes to prioritize, depending on the dynamics of the local epidemic.
- **National coverage targets** should then be developed by the country, to be reached with a specified time frame, and using internationally agreed indicators to measure progress[38]. Preliminary targets need to be aimed at high coverage with the ultimate aim of universal access to HIV prevention. Over the long term, most societies will have to accept that HIV will not disappear entirely and will need to focus on how to maintain it at lower levels of incidence, and have clear milestones to indicate progress.

Development and Adoption of a National HIV Prevention Plan

In developing this plan, attention needs to be paid to:

- filling the gaps in service provision (as identified in the review of the current HIV prevention response) and capacity building;
- bringing the HIV prevention response to scale to ensure higher coverage;
- providing a clear division of labour and responsibilities within stakeholders; and
- maximising synergies and avoiding overlaps in service provision.

For each objective, as agreed in the above step, a detailed implementation plan should be developed including:

- intermediate results;
- performance targets;
- specific strategies;
- suggested programmes including staff training;

[38] The Declaration of Commitment on HIV/AIDS, Guidelines on construction of Core Indicators. Geneva, UNAIDS, 2005

- responsible partners; and
- timetable for action.

In addition, it will be important to identify the resources (financial, human and technical) required to implement the plan.

Coordinating the Response: the "Three Ones"

National efforts must be harmonized with one another to maximize their effectiveness. Waste and inefficiency from duplicate efforts absorb scarce resources and are major barriers to effective action. Making the "Three Ones" a reality and ensuring full civil society and private sector involvement in HIV prevention at country level are urgent necessities, as is the need to ensure a substantially enhanced profile for such work. Key actions include ensuring:

- the country-level AIDS Action Framework has clear objectives related to prevention;
- the single agreed monitoring and evaluation system includes appropriate indicators to track and record the impact of HIV prevention efforts; and
- "Three Ones" principles are embedded in broader country-development strategies (e.g., poverty reduction strategies) as well as in HIV prevention.

Multilateral and bilateral organizations can assist national responses to AIDS by:

- reviewing development assistance being allocated to the AIDS epidemic, and in particular, to HIV prevention; and
- ensuring that HIV prevention is centrally placed in AIDS funding approaches and that these support nationally-led AIDS strategies in line with the "Three Ones" principles.

Monitoring and Evaluating Implementation

Regular monitoring and evaluation of the national HIV prevention plan (as part of the comprehensive AIDS strategy) is essential to track progress. The burden on staff who implement programmes should be kept to a minimum to ensure that they are not diverted from their core responsibilities. International guidance has been produced to support national monitoring and evaluation services[39]. UNAIDS has a key supportive role to play here, which is addressed in the next section.

Sharing Results

Just as the AIDS epidemic is changing constantly, so should the national AIDS strategy (including around HIV prevention) which must be responsive to and anticipate these changes. The lessons learned and results from the monitoring and evaluation identified in the previous step, should be fed into steps two (Understand Your Epidemic) and three (Analysis of the Current Response) to ensure that the HIV prevention plan can be adapted accordingly.

❖ Building a vocal constituency and leadership for HIV prevention

Activism, leadership and good governance have played an important role in supporting effective AIDS responses. In the case of HIV prevention, a vocal constituency for HIV prevention needs to be developed, building on current HIV vaccines and microbicides activism. In addition, the experiences of treatment activism and advocacy need to be learned from. In many instances, the organizations and individuals may be the same, and already provide articulate advocacy leadership platforms. However, it will also be

[39] The Declaration of Commitment on HIV/AIDS, Guidelines on construction of Core Indicators. Geneva, UNAIDS, 2005.

important to mobilize new actors to ensure as broad based a response as possible. Civil-society activism provides one of the most important ways of overcoming unwillingness to act promptly on AIDS, whether it be at the individual level or societal. However, leadership and activism must come from across the board—from national governments, from business and from the media, as well as from civil society. Steps must be taken at national level to fuel and resource such advocacy and to build demand for HIV prevention, including through work with young people's networks and women's organizations. To do this, every available opportunity, and leadership in different sectors, must be exploited for speaking up on HIV prevention and making HIV prevention messages and services known.

Section 4: The Role of UNAIDS in Supporting Efforts to Intensify HIV Prevention

The need to intensify HIV prevention requires that UNAIDS[40] strengthens its own response to support both global and national HIV prevention strategies, as part of a comprehensive response to AIDS. This section summarises an appraisal currently being made by UNAIDS on how best to maximize its own collective efforts on scaling up HIV prevention, building on the comparative advantages of the Cosponsors and Secretariat.

Endorsement by the Programme Coordination Board is being sought for the broad range of actions identified in this section which will then be further articulated and developed. In general terms, UNAIDS will:

- further harmonize and coordinate its own efforts with a clearer division of responsibilities with the UNAIDS Secretariat and Cosponsors, as well as with other national and global level stakeholders;
- strengthen its support for global and national HIV prevention efforts through specific areas of focus; and
- provide clearer accountability to results.

In order to ensure that efforts to intensify HIV prevention can be sustained, UNAIDS will continue to be guided by the centrality of national ownership and the need for a truly multisectoral response.

In line with its five core functions[41] UNAIDS will focus on the following areas:

- **advocacy** on HIV prevention;
- **policy development** in areas critical for HIV prevention;
- **technical support** and capacity building for implementation of scaled up HIV prevention programmes;
- **coordination and harmonization** of HIV prevention efforts; and
- **tracking, monitoring and evaluation** of HIV prevention programmes.

❖ Advocacy on HIV prevention

The goal of UNAIDS' advocacy in HIV prevention is to:

- generate increased and wide-ranging support for the key principles and essential actions set out in this policy paper; and
- to promote the scaling up of national, regional and global HIV prevention programmes by national governments with key partners, such as bilateral and multilateral donors, civil society and the private sector.

[40] UNAIDS refers to the ten Cosponsors and Secretariat of the Joint United Nations Programme on HIV/AIDS. The ten Cosponsors are: the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Populations Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

[41] The five core functions of UNAIDS as endorsed by the PCB in 2002 in Lisbon are, (i) leadership and advocacy for effective action on the epidemic; (ii) strategic information to guide efforts against AIDS worldwide; (iii) tracking, monitoring and evaluation of the epidemic and of responses to it; (iv) civil society engagement and partnership development; and (v) mobilization of resources to support an effective response.

In particular, UNAIDS will strengthen its own advocacy work in the following areas.

- UNAIDS will promote and support the development of strong HIV prevention constituencies at the global, regional and country levels, among civil society including community groups, policy makers, opinion leaders, religious leaders, women's groups, youth leaders, people living with HIV, and strengthen their capacity to advocate for effective HIV prevention.
- The UNAIDS Secretariat will support the UNAIDS family by engaging in specific initiatives to raise the profile of HIV prevention.

❖ Policy development in areas critical for HIV prevention

Based on the individual comparative advantages of the ten Cosponsors and the Secretariat, UNAIDS will provide coordinated policy guidance to scale up HIV prevention.

- The Secretariat will focus on policy coordination and best practice documentation.
- At the country level, policy guidance will be provided by the UN Technical Working Groups on HIV/AIDS[42] set up by the UN Theme Groups on HIV/AIDS.
- A review to identify policy gaps in HIV prevention will be conducted by UNAIDS with the involvement of key global, regional and national partners.
- Each convening Cosponsor agency for thematic issues[43] will lead on providing policy guidance on specific areas at the global level, coordinated by the Secretariat.
- The UNAIDS Reference Group on HIV Prevention[44] established in 2004 will continue to provide UNAIDS with advice on new developments and key issues in HIV prevention.

In addition, within the next year, UNAIDS will develop:

- operational guidance for implementing the essential HIV prevention actions;
- a compendium of evidence for the HIV prevention actions;
- an agenda for research needed to strengthen the evidence base; and
- an implementation plan for the recommendations of the UNAIDS Reference Group on HIV Prevention for HIV prevention in the context of treatment.

❖ Technical support and capacity building for implementation of scaled-up HIV prevention programmes

To scale up HIV prevention at a significant level, countries will need significantly increased technical support. HIV prevention technical assistance will be facilitated and

[42] In many countries, the Theme Groups have set up Technical Working Groups (comprising UN agency focal points and other national and international partners) to serve as their operational arms and oversee Theme Group activities.

[43] UNAIDS' Committee of Cosponsoring Organizations (CCO) conferred convening agency status in October 2001 on Cosponsors and the Secretariat for the following areas of work: ILO (World of work), UNODC (Injecting drug use), UNDP (Governance and development planning), UNESCO (Education sector), UNFPA (Condom programming for prevention of HIV, Young people) UNICEF (Orphans and vulnerable children), WHO (Care and support within the health sector, Prevention of HIV transmission to pregnant women, mothers and children), World Bank (Evaluation of HIV/AIDS programmes at country level, Economic impact) UNAIDS Secretariat (Men who have sex with men, Commercial sex work, Evaluation of HIV/AIDS programming at global level). Source: UNAIDS (2002) Convening Agencies: Roles and Responsibilities.

On joining UNAIDS, two Cosponsors took convening agency status for the following areas of work: WFP, Food Security and Nutrition (2003); UNHCR, Displaced populations and refugees (2004).

[44] The UNAIDS Reference Group on HIV Prevention, composed of leading international HIV prevention experts was established by UNAIDS in late 2004. Its objective is to advise UNAIDS on approaches for effectively strengthening and sustaining HIV prevention initiatives at a scale that matches the needs of the epidemic.

brokered by the lead UNAIDS Cosponsor responsible for specific thematic areas or specific population groups.

At the country level, the UN Theme Group on HIV/AIDS will review the implementation support needs of countries and the capacities available among UNAIDS Cosponsors, national partners including governments, civil society, private sector, multilateral and bilateral agencies. Where gaps are identified, the UN Theme Group on HIV/AIDS will advise countries on how implementation support can be accessed. The UNAIDS Secretariat Regional Support Teams will work with their Cosponsor counterparts to identify resources at the regional level to support countries in their technical support needs.

UNAIDS will also support national and international partners to develop nationally-led capacity building plans. This support will involve:

- advocating for capacity building as a sustainable response to ensure scaling up of HIV prevention; and
- brokering capacity building of country partners around the essential HIV prevention actions.

❖ Coordination and harmonization of HIV prevention efforts

UNAIDS is mandated to strengthen, coordinate and harmonize the UN system's response to AIDS, which includes HIV prevention. In doing so, UNAIDS' will follow the "Three Ones" principles, and will:

- assess how it is coordinating its efforts in HIV prevention through country, regional and global mechanisms;
- ensure that the respective roles of the UNAIDS Cosponsors and the UNAIDS Secretariat in intensifying HIV prevention are clarified and communicated clearly to all stakeholders;
- strengthen the HIV prevention component within the UN Implementation Support Plans (UN-ISP) developed each year by UN Country Teams;
- provide support to national coordination mechanisms such as the National HIV Prevention Task Force and the National HIV Prevention Plan (as set out in Section 3); and
- assist regional entities (such as the South Asian Association for Regional Cooperation, Pan Caribbean Partnership against AIDS, Economic Community of West African States, Economic Commission for Africa and Great Lakes Initiative on HIV/AIDS) in strengthening their own efforts to intensify HIV prevention.

Similar efforts will be made at the regional levels by the Secretariat's Regional Support Teams and the UN Regional Directors' Group.

❖ Tracking, monitoring and evaluation of HIV prevention programmes

To ensure that efforts around scaling up HIV prevention are moving in the right direction and achieving the desired results, UNAIDS will focus on the following activities.

- *Analysis of key national information* namely the trends in the epidemic, resource flows, coverage of HIV prevention programmes and monitoring and evaluation findings to create a sense of urgency around HIV prevention.

- Building national capacity for developing *local understanding* of the epidemic, undertaking vulnerability assessments, determining the mix of appropriate HIV prevention measures, and the gaps and barriers in their implementation.
- Supporting national efforts to develop national *goals and targets* around HIV prevention and measure progress towards them and increase their awareness among policy makers.
- Documentation of *good examples* and *best practices* of HIV prevention programmes particularly those targeting vulnerable populations to encourage learning and acknowledge successes for building a positive spirit and optimism around HIV prevention.
- Developing (with a broad group of stakeholders) specific indicators for *measuring global success* around HIV prevention to which all those engaged in the movement to intensify HIV prevention can be held jointly accountable so as to ensure greater commitment, more resources, joint accountability and clearer divisions of labour.

The UNAIDS Cosponsors and the UNAIDS Secretariat will work on developing an action plan over the next few months to ensure that there is clarity of results towards which UNAIDS will work.

Programme Coordinating Board, 27-29 June 2005
Decisions, Recommendations and Conclusions

Agenda item 3: UNAIDS Policy Position Paper: Intensifying HIV Prevention

8. Welcoming the action taken by UNAIDS on the decision of its 16th Programme Coordinating Board meeting in December 2004 for UNAIDS to engage in the development of a strategy for intensifying HIV prevention, the UNAIDS Programme Coordinating Board:

8.1 expresses satisfaction with the extent and range of consultations in which UNAIDS has engaged in the development of the UNAIDS Policy Position Paper: Intensifying HIV Prevention;

8.2 endorses the UNAIDS Policy Position Paper: Intensifying HIV Prevention, as amended;

8.3 urges UNAIDS to strengthen its leadership of, and support to, global, regional and national efforts to intensify HIV prevention as part of a comprehensive response to AIDS;

8.4 requests UNAIDS to take the lead in intensifying HIV prevention, through expediting the development of an action plan based on the Policy Position Paper and the recommendations of the Global Task Team, and to inform the Programme Coordinating Board of this action plan by December 2005; noting that this will entail further harmonizing and coordinating its efforts through a clear division of responsibilities between the UNAIDS Secretariat and Cosponsors, as well as by coordinating its efforts with national and global stakeholders;

8.5 requests UNAIDS to provide a progress report in June 2006 on UNAIDS' efforts to intensify HIV prevention; and

8.6 notes the United States statement that the United States could not fund needle and syringe programmes because such programmes are inconsistent with current United States law and policy, and notes that this external partner cannot be expected to fund activities inconsistent with its own national laws and policies.