

# UNAIDS Practical Guidelines for Intensifying HIV Prevention

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# UN General Assembly Special Session on HIV/AIDS

# 2001

Consensus on:

- Specific time bound targets ALL prevention-focussed
- A scaled-up response

NO consensus on:

- Naming specific vulnerable groups
- Treatment targets

# UNAIDS Prevention Policy Position Paper

# 2005

Adopted by the Programme Coordinating  
Body viz. member states and civil society

- Specifies vulnerable groups
- Agrees comprehensive prevention
- Manages political differences



## Purpose of the Practical Guidelines

- To guide the national planners defining and addressing local vulnerabilities
- To prompt review of existing HIV strategies, resource allocation, tracking
- To emphasize the opportunity and need to *do more, and do better*

## Prioritize your response; tailor to the epidemic

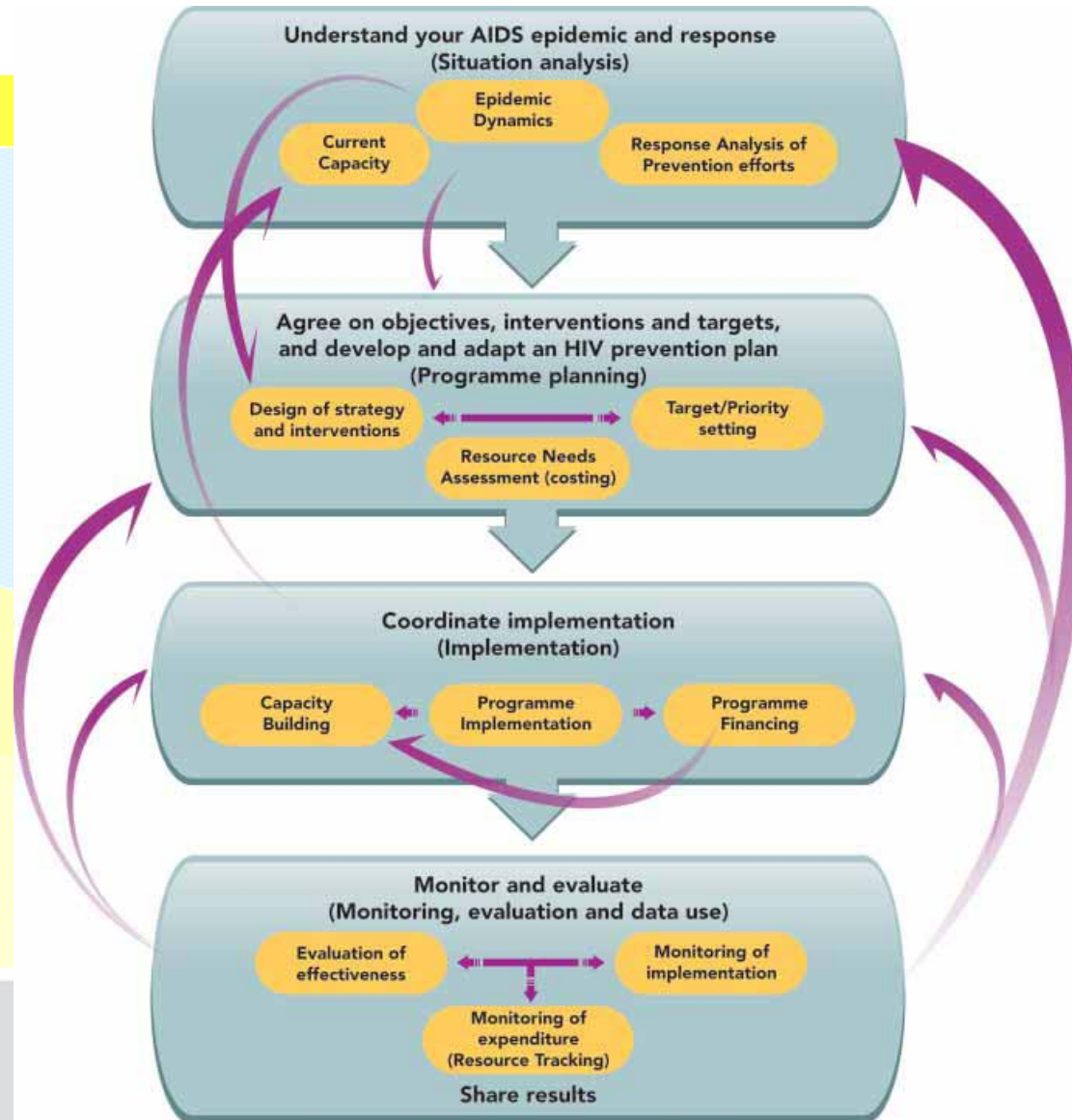
- “Gap analysis” of location, scale and needs of the priority populations
- Prioritize programmes to appropriate populations, behaviours & locations
  - Where, among whom, and why are the HIV infections happening?
  - How fast are infections moving?
  - What are the drivers of the epidemic?
- Not all prevention measures can be achieved in the short-term, but must be sustained and converging.
- Prevention and treatment should be mutually reinforcing.

## Reinforcing strategies of risk, vulnerability and impact reduction

"...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."

Source: UNAIDS (2006). Page 17 of *Intensifying HIV Prevention*. Geneva.

# HIV Integrated Programming Cycle



## Different epidemiological scenarios

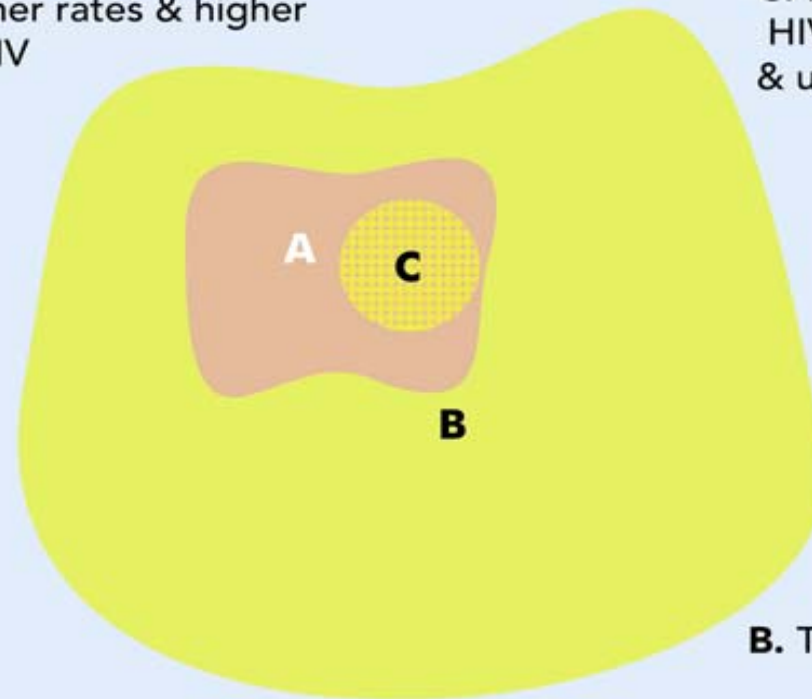
- **Scenarios defined by epidemic dynamics, not just “cut-off points”**
- **Most countries have multiple scenarios:**
- **New category of generalized epidemic, distinguished by prevalence:**
  - **Hyperendemic scenarios:** HIV prevalence exceeds 15% of population

## Low-level scenarios

are those with HIV prevalence levels of below 1% and where HIV has not spread to significant levels within any subpopulation group.

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

**C.** People living with HIV both diagnosed & undiagnosed



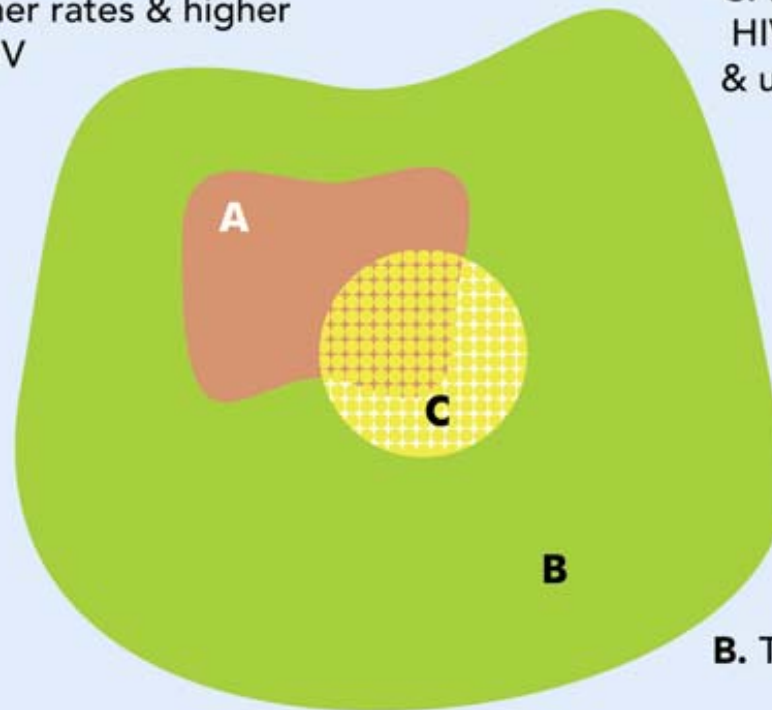
**B.** Total population

## Concentrated scenarios

are those with HIV prevalence levels of below 1% and where HIV has not spread to significant levels within any subpopulation group who have sex with men, injecting drug users or sex workers and their clients, but the virus is not circulating in the general population.

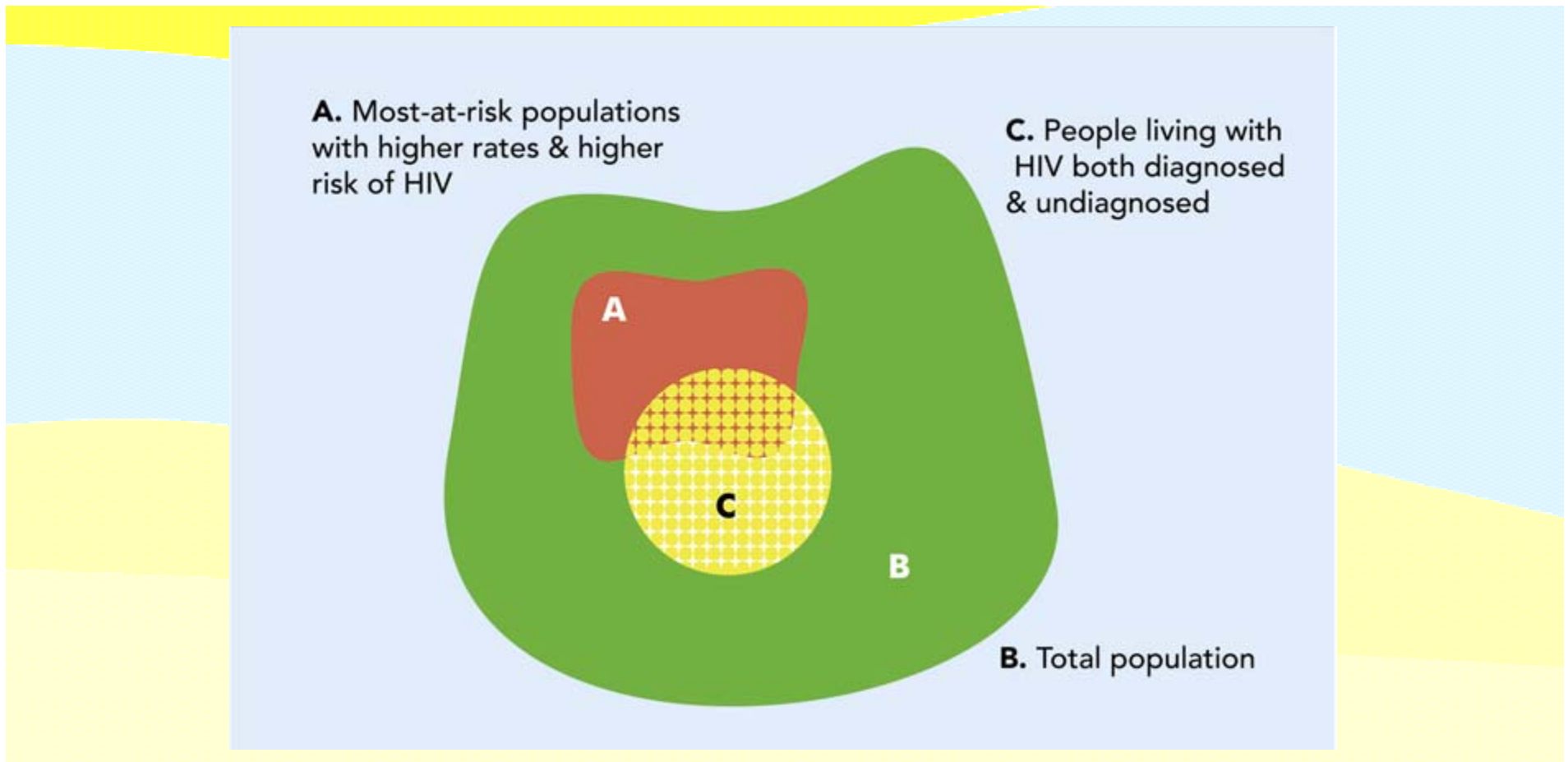
**A.** Most-at-risk populations with higher rates & higher risk of HIV

**C.** People living with HIV both diagnosed & undiagnosed



## Generalized scenarios

are those where HIV prevalence is between 1–15% in pregnant women attending antenatal clinics, indicating that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic.

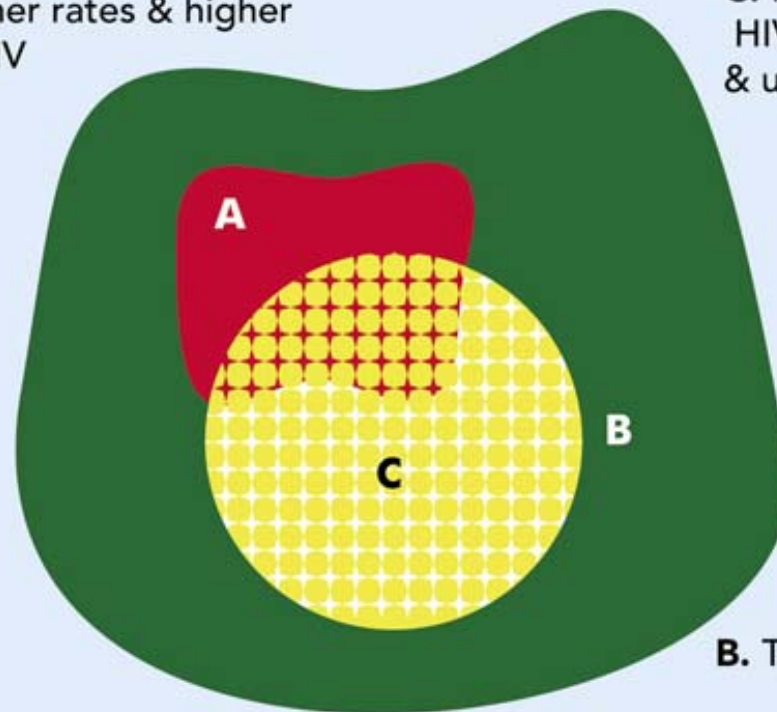


# Hyperendemic scenarios

refer to those areas where HIV prevalence exceeds 15% in the adult population driven through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use.

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

**C.** People living with HIV both diagnosed & undiagnosed



## Prioritize your response – Key in low level scenarios

- **Collect and analyze reliable data on HIV, risk behaviours and drivers to support policy dialog;**
  - Build knowledge of and implement programs for most-at-risk populations;
- **Universal Access to comprehensive prevention, treatment, care and support is truly affordable**
- **Prioritize actions to promote combat stigma and discrimination and promote human rights and gender equality.**

## Prioritize your response – Additional in hyperendemic scenarios

- **All sexually active adults should consider themselves at risk;**
- **Universal access to provider-initiated HIV counselling and testing;**
- **Highlight “positive prevention”.**
- **Social movements to address social, cultural & economic practices;**
- **Full engagement of government sectors, civil society & people living with HIV**

## Consulted constituencies to define essential services for 14 Key Audiences

1. General population
2. Injecting drug users
3. Health-care workers
4. Men
5. Men who have sex with men
6. People living with HIV
7. Populations of humanitarian concern
8. Pregnant women
9. Prisoners
10. Recipients of blood or blood products
11. Sex workers
12. Transport workers and commercial drivers, mobile populations, uniformed services personnel and clients/non-regular partners of sex workers
13. Women and girls
14. Young people

**TABLE 2.1 GENERAL POPULATION**

**Why?**

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

**What?**

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

**How?**

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

**Difference in epidemic scenarios**

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

**TABLE 2.9 PRISONERS****Why?**

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

**What?**

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

**How?**

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

**Differences in epidemic scenarios**

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

## Conclusion

- Practical Guidelines don't stand alone – but simplify and explain integrated programming cycle for prevention in context of Universal Access
- Universal Access – A new paradigm for prevention
  - Prevention and treatment – mutually reinforcing: NOT prevention “*versus*” treatment, but intensified, accelerated prevention *in order to achieve Universal Access to Treatment, Care and Support*
- Practical guidelines summarize the building blocks for strong national prevention programmes, grounded in policies agreed by national governments