

2007

**Report of the  
UNAIDS HIV Prevention Reference  
Group Meeting**

Geneva  
4–5 April, 2007

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## Executive Summary

After years of working to expand access to lifesaving treatment for people living with HIV, there is a growing consensus by the international community, governments, treatment activists, people living with HIV and civil society that scaling up HIV prevention is critical to ensure universal access to care and treatment in the longer term.

UNAIDS' focus on promoting national and global commitment to HIV prevention is reflected in several key documents: *Intensifying HIV Prevention: A UNAIDS Policy Position Paper*<sup>1</sup>, which outlines principles and essential actions for HIV prevention; and the *Practical Guidelines for Intensifying HIV Prevention*<sup>2</sup> to assist countries and stakeholders at the country level to intensify prevention.

UNAIDS is now undertaking a process to clearly define behavioural interventions for HIV prevention by building consensus on key terms and concepts and developing measures for each activity to assess quality, intensity and coverage. The prevention field has a great deal of experience and some important successes and needs now to capitalize on them by being consistent and structured in its analysis. Clear and common definitions of the range of key prevention activities and their core components need to be developed to strengthen HIV prevention programmes and to ensure political and financial commitment to prevention. National and subnational AIDS programmes need to be able to plan, monitor and compare effectiveness of prevention activities, and this requires clarity on the inputs and their results. There is also a need for clarity on what should be costed as the basis for resource need estimates at country, regional and global level in order to provide universal access to quality prevention services.

To advise on and initiate this process, UNAIDS convened a meeting of the HIV Prevention Reference Group on 4–5 April, 2007. Participants included representatives from governments, nongovernmental organizations working in programmes and service delivery, advocacy groups, academics and partner organizations working in international, regional and national settings. They were charged with providing operational guidance on issues relating to the quality, intensity and coverage of behaviour change interventions to improve implementation of HIV prevention programmes.

The meeting participants affirmed the importance of greatly expanded delivery of HIV prevention as central to achieving universal access to prevention, treatment, care and support. They reiterated the need for a comprehensive approach to HIV prevention and urged UNAIDS to further promote the use of Practical Guidelines for Intensifying HIV Prevention. They also recognized that countries need additional assistance and guidance to make intensifying HIV prevention more practical and to translate UNAIDS' recommendations into action.

As in *Intensifying HIV Prevention: A UNAIDS Policy Position Paper*, the HIV Prevention Reference Group meeting strongly affirmed that behavioural interventions

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<sup>1</sup> UNAIDS (2005). *Intensifying HIV Prevention: A UNAIDS Policy Position Paper*. Joint United Nations Programme on HIV/AIDS, Geneva.

<sup>2</sup> UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Joint United Nations Programme on HIV/AIDS, Geneva.

should not only address individual behaviour but also recognize and have an impact on the broader social and cultural context. They noted that in particular, efforts were needed to address the key drivers of the epidemic such as poverty, gender inequality and human rights violations. UNAIDS' guidance recognizes that comprehensive programmes are needed to address HIV and that efforts to scale up effective HIV prevention interventions must address a range of factors beyond interventions aimed at individual behaviour.

Pressure to achieve ambitious HIV prevention targets without clear standards for high quality prevention services can be counter-productive. The HIV Prevention Reference Group recognized the need for setting standards to ensure access to comprehensive and effective HIV prevention services for people in many different settings. They affirmed the approach proposed by UNAIDS to develop a taxonomy of social and behavioural prevention activities and a framework for assessing quality so that these measures could be planned, costed and monitored with the same level of clarity that is routine in clinical services. They agreed that the taxonomy and framework should fit within the range of activities in a comprehensive prevention response; support and facilitate tailoring to regional, country and local situations; and encourage innovation.

### ***Taxonomy of Social and Behavioural HIV Prevention Activities***

Meeting participants reviewed a taxonomy presented by Dr Michael Sweat and developed by the Synthesis Project, which is conducting systematic reviews and meta-analysis of HIV behavioural interventions in developing countries. This effort underscores some of the potential benefits and challenges of standardization. The Synthesis Project's analysis considers a range of intervention topics that are defined variously as: mode of delivery; target population and/or setting; commodity involved; outcome or goal; and mechanism. The overlapping concepts and categories make it difficult to develop a taxonomy that reflects how programmes are designed and implemented on the ground. It was noted that defining programmes by just one feature could be "reductionist" and so it might be appropriate to define multi-dimensional programmes as a cluster of discrete activities.

Meeting participants expressed some concern and confusion about the term taxonomy and strongly recommended that it be defined and a new term and explanation used in subsequent discussions and documents. UNAIDS' Executive Director used "nomenclature" in the closing session, which may be a preferable term.

Participants agreed that reaching consensus on clear, explicit definitions for the activities included in HIV prevention programmes was critical in order to effectively plan, evaluate and cost these activities. The establishment of a taxonomy or list of key prevention activities (covering all the activities recommended in Practical Guidelines for Intensifying HIV Prevention) and quality standards for each area would ensure that players in different roles could:

- Speak in a common language about prevention programmes;
- Plan, budget and evaluate their prevention programmes more consistently;
- Learn from each others' experience through comparison;
- Replicate and adapt successful programmes to other settings; and
- Provide a robust evidence base for resource mobilization for HIV prevention.

## **Framework for Defining Quality in HIV Prevention Interventions**

Meeting participants also reviewed and commented on a framework for defining quality as presented by Dr Nancy Padian (University of California at San Francisco Medical School). This framework underscored that quality standards were needed to monitor and evaluate both the design and implementation of programmes, verify that programmes were being implemented as planned and allow for ongoing adaptation. The framework, structured in three main phases (pre-implementation, implementation and delivery), was an effort to systematize the analysis of quality by defining coverage, fidelity and intensity and to measure the impact on key outcomes. Dr Padian submitted that given that it was very difficult with many HIV prevention activities to measure impact on the epidemic – for example in infections averted – programmes needed to identify intervention-specific outcomes that could provide a sufficient measure of their useful effects.

Meeting participants agreed that it was important to define quality in relation to core elements of different interventions and that such analysis should be based on both research and programmatic experience. A framework could specify different dimensions of quality to facilitate a systematic approach to developing criteria and measures of quality, such as coverage, intensity and fidelity. The framework should be simple and practical and reflect programmatic realities, and it should emphasize a results-based approach. It should draw on and reflect existing planning and assessment approaches rather than developing another approach. The framework should also address several levels of quality:

- appropriateness to the context;
- adherence to principles, including gender equality, human rights and leadership by affected communities;
- design of activities and components (e.g. intensity);
- coverage, including analysis of who was – and was not – being reached, with special attention to marginalized and hard-to-reach populations;
- how well the implementation of activities adhered to its plans (e.g. fidelity); and
- effectiveness in achieving the specified objectives.

This framework would be applied to each of the HIV prevention activities to develop quality standards. These standards must balance consistency with flexibility to reflect and respond to diverse contexts. The framework should incorporate lessons from other quality assurance initiatives.<sup>3</sup> It should also reflect lessons from implementation and action, including the identification of bottlenecks, barriers and challenges in developing and implementing interventions.

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<sup>3</sup> For example: Center for Global Development (2004). "Millions Saved: Proven Successes in Global Health". *CGD Brief*. October 2004, 3:3. Washington, DC; Kelly, JA et al. (2000). "Transfer of Research-based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation". *AIDS Education and Prevention* 12, Supplement A, 87-98; Youth Peer Education Network (2006). *Assessing the Quality of Youth Peer Education Programmes*. Family Health International. <http://www.fhi.org/NR/rdonlyres/e6tz746qad3w44cmjqx57mi5sdq6hictb5ex7cy3bi2fvtkxhfgw6kdpfszgnktqumqydpl5sjko/peeredassessmententent1.pdf>; and Wegbreit, J et al. (2006). "Effectiveness of HIV prevention strategies in resource-poor countries: tailoring the intervention to the context". *AIDS* 2006, 20:1217–1235. Lippincott Williams & Wilkins.

## ***Recommendations and the Process Moving Forward***

There is a justified sense of urgency for HIV prevention which was featured at the General Assembly's 2006 High Level Meeting on AIDS; the HIV Prevention Reference Group recommended that UNAIDS build on this sense of urgency in its follow-up to the meeting. The secretariat agreed to several immediate next steps:

- Produce and circulate the meeting report;
- Produce draft documents incorporating input from the HIV Prevention Reference Group meeting:
  - a taxonomy paper (including the proposed list of prevention activities and their definitions, including their core components); and
  - a paper on the proposed framework for quality.

The HIV Prevention Reference Group recommended that UNAIDS take the following steps to engage in a consultative but efficient process to develop the tools defined in this meeting that will improve and simplify prevention planning, quality implementation, target setting and evaluation:

- convene a task team comprising participants from the HIV Prevention Reference Group meeting and other nominated representatives from nongovernmental organizations, civil society, governments, researchers, program managers and international collaborating partners to provide input on the further development of the taxonomy and the quality framework;
- apply the quality framework to each of the HIV prevention activities to clarify quality standards for each, with consultation and technical advice from experts and implementers for each activity area; and
- develop tools to support and actively promote the use of Practical Guidelines for Intensifying HIV Prevention.

The meeting participants also recommended that UNAIDS take the following additional steps as part of the process for finalizing the needed taxonomy and quality framework:

- circulate the draft taxonomy and quality framework papers to the task team for review and comment, including identifying and addressing gaps;
- prioritize activity areas for initial development of quality standards; these should emphasize areas where common quality standards are not available but sufficient data and experience exist to ensure that the process continues to move forward;
- consult with programme experts in different activity areas to identify existing tools and documentation that define or outline core elements, specify issues relating to quality, intensity and coverage, and/or include tools and indicators for evaluation; this will allow the process to build on experience and identify gaps and areas for updating and refinement;
- use the taxonomy and quality framework to structure the planned Electronic Compendium of Tools for HIV Prevention, which is gathering existing guidelines and tools and indexing them by geographic region, activity, target audience and other factors; and
- recommend development and field testing of new or updated technical guidelines and tools that measure quality, intensity and coverage for different programme areas in different epidemic settings.

Once these products have been developed, important additional steps should include:

- development of mechanisms—initiated by and appropriate for each country setting—to promote adherence to the standards developed;
- engagement and advocacy so the taxonomy and quality framework are adopted at regional and country level to guide HIV prevention interventions. This process remains to be defined.

The process outlined in these recommendations should lead to better definitions of activities providing for improved programme planning and implementation, more accurate costing and resource needs estimates of HIV prevention interventions and more effective advocacy for resource mobilization for HIV prevention. Ultimately, it was agreed, establishing quality standards was critical for holding the HIV prevention field accountable and to ensure that people in communities around the world benefited from access to high quality, effective prevention activities.

## Overview of the UNAIDS HIV Prevention Reference Group Meeting

After years of working to expand access to lifesaving treatment for people living with HIV, there is a growing consensus by the international community, governments, treatment activists, people living with HIV and civil society that scaling up HIV prevention is critical to ensure universal access to care and treatment in the longer term.

Sobering statistics underscore the importance of intensifying and scaling up prevention efforts. UNAIDS estimates that there were some 4.3 million new HIV infections in 2006.<sup>4</sup> In 2005, only about 20% of the people most at risk and most in need of HIV prevention services worldwide received them.<sup>5</sup> Vulnerable communities are generally far less able to access services; for example, it is estimated that only 9% of men who have sex with men worldwide have access to HIV prevention information and services.<sup>6</sup> At the same time, results of existing HIV prevention activities have not always had sufficient impact. For example, in Botswana, where AIDS education and messages are pervasive, only about one in three young people aged 15–24 both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.<sup>7</sup>

Urgent policy considerations are also driving this process. Countries and regions are grappling with how to move HIV prevention to the next level. The diversity of prevention activities and inconsistencies in how they are defined and evaluated has made it difficult for countries to systematically assess their HIV prevention programmes. In the global policy and donor arena, resource allocation is increasingly determined by outcomes and the ability of programmes to be measured, monitored and evaluated. UNAIDS is currently estimating the resources needed to turn the epidemic around by 2015 to meet the Millennium Development Goals. Following the General Assembly's 2006 High Level Meeting on AIDS, UNAIDS is gathering cost and expenditure data to estimate global resource needs to address AIDS. For HIV prevention, this process uses a list of prevention activities—a mix of different and potentially overlapping areas because interventions are described by target population, setting, outcome or method. While this nomenclature has been used for decades, many actors in the field have recognized a need to improve it.

The AIDS field has agreed that a wide range of programmatic and policy actions are required for a comprehensive response.<sup>8</sup> HIV prevention efforts range from discrete biomedical regimens to programmes aimed at transforming complex social and behavioural norms. While there have been many successes, there is a need for more clarity and consensus on common definitions and core components to describe these efforts and the minimum quality standards required for effective activities and combinations of services. Further, the field needs to carefully consider how concepts such

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<sup>4</sup> UNAIDS and WHO (2006). *2006 AIDS Epidemic Update*. Joint United Nations Programme on HIV/AIDS, Geneva.

<sup>5</sup> UNAIDS (2006). *2006 Report on the Global AIDS Epidemic*. Joint United Nations Programme on HIV/AIDS, Geneva.

<sup>6</sup> Stover, J. & M. Fahnestock (2006). *Coverage of Selected Services for HIV/AIDS Prevention, Care, and Treatment in Low- and Middle-income Countries in 2005*. Constella Futures.  
<http://www.futuresgroup.com/Documents/3482HIVCoverage2005.pdf>

<sup>7</sup> UNAIDS and WHO (2006). *2006 AIDS Epidemic Update*. Joint United Nations Programme on HIV/AIDS, Geneva.

<sup>8</sup> UNAIDS (2005). *Intensifying HIV Prevention: A UNAIDS Policy Position Paper*. Joint United Nations Programme on HIV/AIDS, Geneva.

as quality and effectiveness are defined. For example, a programme may be determined to be effective at meeting its objectives even if those objectives are not appropriate. Such definitions and standards are critical for ensuring quality programmes, as well as for replication and scale-up. While it can be difficult to reflect complex social, structural and behavioural issues in discrete definitions and measurable variables, there are now the opportunity and imperative to make significant improvements.

To respond, UNAIDS convened a meeting of the HIV Prevention Reference Group on 4–5 April, 2007. This group is called at the discretion of the UNAIDS Executive Director to advise on particular issues, and its membership shifts according to the technical area being addressed. This was the second meeting of the group. Participants included representatives from governments, nongovernmental organizations working in programmes and service delivery, advocacy groups, academics and international partner organizations working in international, regional and national settings. They were charged with providing operational guidance on issues relating to the quality, intensity and coverage of behaviour change interventions to improve implementation of HIV prevention programmes.

The meeting started what will be an ongoing process of developing and refining a taxonomy of behaviour change strategies or interventions<sup>9</sup> that provides standard definitions and outlines the core elements of each strategy. A related process is the development of a framework that proposes the main dimensions of the quality, intensity and coverage required for behaviour change measures to be effective in achieving their specified objectives. Experts in each defined area will be invited to use the framework to develop specific measures of quality. The overall framework will define key implementation standards for behaviour change measures and can be used to plan, cost, monitor and improve HIV prevention programmes.

The meeting organizers recognized that it would not be possible to define the taxonomy across all HIV prevention interventions and identify the approach to a framework on quality standards in a short meeting. Instead, participants were tasked with establishing a common understanding of the need for such a definition; raising questions and issues to be elaborated in more focused, technical discussions on specific topics; and advising UNAIDS on the process to complete the improved taxonomy and clarify or develop the related quality standards.

This report summarizes the background issues, technical presentations and key themes that emerged during the meeting's rich and lively discussions. It begins with summaries of background presentations outlining the technical and political context for the meeting and UNAIDS' perspectives on HIV prevention. The next two sections summarize presentations commissioned for the meeting on taxonomy and a framework for quality. The following sections highlight a number of key themes that emerged throughout the discussions and debates: structural and contextual issues; standardization; comprehensive programmes and scale-up; research and programme perspectives; and the role of key constituent groups. Finally, the report concludes with the recommendations and next steps proposed by meeting participants.

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<sup>9</sup> In noting that the term *intervention* "conveys doing something to someone or something and as such undermines the concept of participatory responses, UNAIDS Editors Notes for Authors (May 2006) suggests instead preferred terms such as programming, programme, activities or initiatives. During the HIV Prevention Reference Group meeting, participants acknowledged that the technical literature on HIV prevention widely uses *intervention*. This report uses the term in the same sense that it was used in the meeting, which reflected the literature.

## Welcome and Background to the Meeting

Dr Purnima Mane, Director of Policy, Evidence and Partnerships, UNAIDS, welcomed participants and noted that the meeting was part of UNAIDS' broader efforts to scale up HIV prevention. She observed that HIV prevention has been a central priority for UNAIDS and that it had become a particular focus in 2004–2005 with the development of *Intensifying HIV Prevention: A UNAIDS Policy Position Paper* to outline principles and essential actions for HIV prevention. This document provided a strong statement to contextualize action but more was needed to assist countries and stakeholders at the country level to intensify HIV prevention. Dr Mane stated that this had led to the development and recent publication of the *Practical Guidelines for Intensifying HIV Prevention*. She stated that the central message of this publication was that "countries need to know their epidemics so that policies and actions can be tailored to the specific audiences and settings where risks and rates are highest and address the drivers of the epidemic in each place". She noted that such responses required strong leadership for HIV prevention, setting ambitious but realistic and measurable prevention targets, and utilizing strategic information to shape the prevention response.

Dr Mane explained that to further the process of intensifying HIV prevention in the context of universal access, UNAIDS was also working with countries regionally and globally to provide technical leadership to expand access to HIV prevention, recognizing that universal access to AIDS treatment and HIV prevention must go hand in hand. She observed that while UNAIDS encouraged countries to develop their own standards and initiatives for prevention, countries often turned to UNAIDS for guidance. The Reference Group meeting was launching a process to clearly define HIV behavioural interventions through building consensus on key terms and concepts. She explained that this process was both technical and political and that it was critical to balance the urgent need for guidance in this area with taking the time to ensure that the agreed on definitions and tools were technically sound and reflected programmatic realities.

Dr Michael Merson, Director of the Duke Global Health Institute and chair of the HIV Prevention Reference Group meeting, welcomed participants and situated the meeting and the topic of HIV prevention within the context of other related initiatives. He explained that UNAIDS convened HIV Prevention Reference Group meetings on key issues and worked collaboratively with the Global Prevention Working Group convened by the Bill and Melinda Gates and Kaiser Family Foundations. He noted that the Global Prevention Working Group generally worked at a global, normative level and focused on policy-makers. In contrast, UNAIDS HIV Prevention Reference Group meetings (also supported by the Bill and Melinda Gates Foundation) were designed to advise on more operational issues. In reviewing the ambitious meeting agenda, Dr Merson reminded the participants that this was the first step in a longer, ongoing process to improve the taxonomy and quality framework for planning and evaluating HIV prevention interventions. He underscored both the urgency and opportunity for expanding prevention efforts and reminded the group of its important role in moving this agenda forward.

Dr Barbara de Zalduondo, Associate Director: Epidemic Monitoring and Prevention, UNAIDS, expanded on many of the points raised by the previous speakers and provided a technical perspective on UNAIDS' interests and expectations for the meeting. In order to make the renewed global commitment to HIV prevention meaningful, she explained, it was critical to translate the global policy framework and commitments into terms that were used and understood by a range of practitioners: researchers, programme managers, evaluators and communities.

Dr de Zalduondo noted that following universal access consultations, countries were reviewing and refining their national AIDS strategies and developing costed plans for scale-up. However, HIV prevention planning was far behind, since some basic building blocks of planning were not available. These included a clear list of activities required in the national prevention response and the unit cost of delivering each required item effectively in the relevant setting. Each country must go through the planning processes to define the populations and settings most in need of HIV prevention and the specific policies, information, services and support that would help them most. She noted that countries were asking for normative guidance on the details of the critical requirements that must be in place and how the recommended elements should be implemented. For example, an intervention aimed at young people could mean very different things: young people of different ages, in or out of school, women or men or both, married or unmarried, sexually active or not, and so forth.

Dr de Zalduondo stated that this lack of clear definitions was compounded by the diversity of HIV prevention activities and further complicated by the fact that many programmes on the ground combined a host of different activities. For example, the UNAIDS Resource Needs Model<sup>10</sup> identified 19 types of HIV prevention activities that encompassed a comprehensive prevention intervention, any combination of which might be included in an actual programme.<sup>11</sup> She observed that more specific guidance was needed to support operational planning and costing and that furthermore, implementation monitoring was required at a more detailed level to ensure that programmes were delivered as planned.

Dr de Zalduondo explained that the HIV prevention field had a wealth of experience to draw on and that the wide range of prevention efforts already underway constituted a vast array of natural experiments of different activities and approaches. However, the loose and varied definitions of programmes and strategies were standing in the way of learning. She stated that rigorous analysis to learn from this experience must be built on a common understanding of what had been done and achieved. This would require reaching consensus on defining prevention interventions and consistent quality standards for assessing them. Dr de Zalduondo stated that such an analysis could help determine how best to improve the impact of prevention services by adding more core components to the design; more effort and investment; better defined prevention activities that more closely matched a community's epidemic and needs; better adherence to quality standards in implementation of existing activities; or some combination of these.

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<sup>10</sup> UNAIDS (2005). *Resource needs for an expanded response to AIDS in low and middle income countries*. Joint United Nations Programme on HIV/AIDS, Geneva.

<sup>11</sup> For example, sex worker interventions can be defined so broadly that they can cost from 19 yuan to 1476 yuan per person served (Yuan, Jianhua. Personal communication, February 25, 2007).

Dr de Zalduondo reported that quality tools and standards were available and routinely used across many health and development initiatives; in biomedical interventions, for example, quality was monitored through protocols, standard operating procedures, good clinical practice guidelines and a range of other tools. Quality standards must become as common in the field of behavioural interventions, she stated. Many programmes in the behavioural arena had quality standards and excellent monitoring and evaluation systems. The problem, she declared, was that there was no common set of standards for most behavioural HIV prevention interventions. Establishing such quality standards would require building technical consensus on terms and definitions; specifying the critical elements of each activity; agreeing on the criteria or dimensions of quality; and establishing a methodology and approach to quality that could be costed. This meeting was a first step in that process.

## **Taxonomy and Terminology: Presentation**

To initiate and frame the discussion of a taxonomy, Dr Michael Sweat of Johns Hopkins University, Bloomberg School of Public Health drew on his work in the Synthesis Project, a collaborative project with WHO supported by the U.S. National Institutes of Mental Health. Dr Sweat explained that the project was conducting systematic reviews and a meta-analysis of HIV-related behavioural interventions in developing countries. He stated that the project's main goal was to carefully establish the strength of evidence for the impact of a range of HIV behavioural interventions targeted to reducing risk of exposure to HIV. He noted that this work highlighted some of the potential benefits and challenges of standardization.

Dr Sweat reported that the Synthesis Project analysis considered a range of intervention topics (see box below) and that the list underscored some of the challenges in categorizing and analyzing behavioural interventions. These interventions were defined variously by the:

- mode of delivery (e.g. mass media, peer education) or activity;
- target population and/or setting (e.g. men who have sex with men, injecting drug users, school-based);
- commodity involved (e.g. condom social marketing, needle exchange);
- outcome or goal (e.g. abstinence or empowerment); or
- mechanism (e.g. structural and policy interventions).

Dr Sweat noted that these existing definitions were not very satisfactory for integrated national planning and costing or for comparative evaluation: while they did reflect the way actual programmes were conceptualized or conducted in the field, there were numerous overlapping concepts and categories.

### **Synthesis Project Intervention Topics**

The Synthesis Project has searched, catalogued and analysed peer-reviewed scientific literature on a range of topics and plans to continue this work in other areas as follows:

#### ***Completed Reviews***

- Voluntary counselling and testing
- Condom social marketing
- Partner notification
- Family planning for HIV-infected women
- Mass media
- Abstinence and abstinence-only
- Peer education
- Needle exchange
- Psychosocial support
- Treatment

#### ***Reviews in Process or Upcoming***

- Comprehensive sex education
- Free condom distribution
- Behavioural counselling
- Income generation
- Diffusion interventions
- Built environment interventions
- Interpersonal skills training
- Policy interventions

Dr Sweat explained that while programmes often involved elements of these different categories, they tended to be identified only by the most prominent dimension, e.g. sex worker interventions or workplace programmes. Most programmes included more than one intervention, making analysis and assessment of actions and effects even more dynamic and complex. He observed that most HIV prevention work was rich, dynamic and multidimensional and that reducing interventions to one dimension did not reflect many factors that were well established determinants of successful prevention. Evaluating such interventions was challenging, he agreed, and a real understanding of interventions should include examining the synergy among multiple components.

Interventions could also be categorized by their underlying theory, according to Dr Sweat. Different theoretical models incorporated or emphasized interactions among a range of factors to achieve a health outcome; factors included, for example, the intervention itself, psychological factors, the environment and the actual behaviours (see Figure 1). The way in which interventions were constructed often reflected the theory they were based on, either implicitly or explicitly. Given the multiple elements of many projects, they might contain all of these factors, making it difficult to determine where to focus analysis of what inputs caused which results.

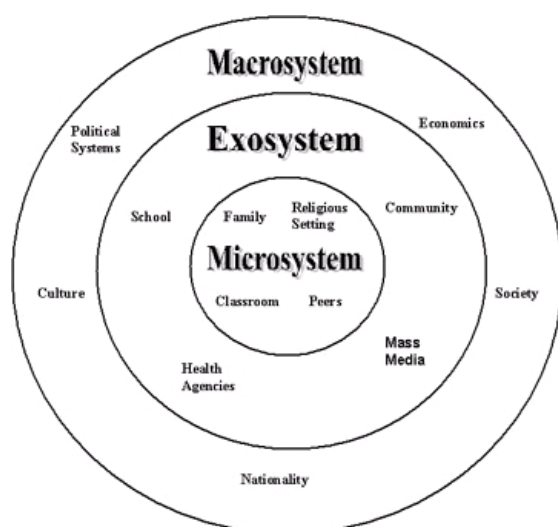


Figure 1. Bronfenbrenner's Ecological Model.

Dr Sweat reported that efforts aimed at definition and standardization were often met with criticism that they were “reductionist” and could not reflect the complex reality of actual programmes and the environments in which they operated. One approach to addressing this very real concern, he suggested, was to consider such multidimensional programmes as a cluster or bundling of discrete, well-defined activities. This would allow for interventions to be defined more holistically, recognizing that real behavioural HIV prevention programmes included multiple components. Indeed, he noted, different sets of well-defined activities and participants would be expected in different settings; there were many models for this kind of standardization in public health and other fields, all of which involved a systematic reflection and review process.<sup>12</sup> For the HIV prevention field, he stated, it was critical to explore ways to effectively communicate and convey practical ways to maintain analytical rigour while respecting the complex, dynamic and multidimensional nature of many interventions and their settings.

Finally, Dr Sweat explained, determining an appropriate timeframe for analysis was also key. If programmes sought to measure change, especially complex social and behaviour change, over too brief a timeframe, they could inadvertently suggest that a programme was not working even when the cumulative effect of such change over time could be significant.<sup>13</sup>

Following the discussion (summarized below), Dr Sweat proposed several modifications to the taxonomy to respond to concerns raised by meeting participants. He reminded participants that the overall process would entail:

<sup>12</sup> Kelley, Jeffrey A et al. (2000). Transfer of Research-Based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation *AIDS Education and Prevention* 2000:12, Supplement A:87–98, 2000; Wegbreit, Jeny et al. (2006). Effectiveness of HIV prevention strategies in resource-poor countries: tailoring the intervention to the context *AIDS* 2006:20(9):1217–1235; Global Health Policy Research Network, Millions Saved: Proven Successes in Global Health, *CGD Brief* October 2004 Volume 3, Issue 3. Center for Global Development; Maria Elena Figueroa et al. (2002). *Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcome*. Communication for Social Change Working Paper Series. <http://www.comminit.com/stcfscindicators/sld-5997.html>.

<sup>13</sup> Cleland, John, Mohamed M Ali and Iqbal Shah (2006). Trends in Protective Behaviour among Single vs. Married Young Women in Sub-Saharan Africa: The Big Picture. *Reproductive Health Matters* 2006:14(28):17-22.

- developing a list of intervention components;
- establishing a clear definition of each intervention component;
- specifying the core elements of that intervention component;
- determining quality standards through a consensus process; and
- costing the intervention component.

Providing guidelines for actual programmes would continue to involve defining priority behaviours, drivers, populations and settings where change was needed and then deciding which intervention components fitted together in a way that would work best in a given setting.

Dr Sweat suggested defining the intervention components primarily by mode of delivery or activity, perhaps in combination with the audience or beneficiary populations, for example, peer education (activity) with street children (audience) or sexual and reproductive health services (compound activity) for female, male and transgender sex workers and their clients (audiences). For programmes that were known to require multiple intervention components, these would be bundled for costing and quality assessment.

Finally, in response to concerns about whether HIV prevention programmes should emphasize interventions that focused on individual behaviour change or broader social change, Dr Sweat acknowledged the complexity of behaviour change and its important link to social change. The outcome of social change was also built up from multiple interventions and activities, he noted. Given the broad recognition of the multiple levels of cause and constraint in reducing HIV vulnerability, risk and impact,<sup>14</sup> the HIV Prevention Reference Group's taxonomy of definitions and intervention components should address those that promoted positive social change, Dr Sweat concluded.

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<sup>14</sup> UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Joint United Nations Programme on HIV/AIDS, Geneva; UNAIDS (2005). Intensifying HIV Prevention: A UNAIDS Policy Position Paper. Joint United Nations Programme on HIV/AIDS, Geneva.

## Taxonomy and Terminology: Discussion

Overall, the HIV Prevention Reference Group agreed with the proposed concept of a taxonomy to develop a common understanding about terminology and definitions for HIV prevention efforts. Some participants struggled with issues of standardization and addressing structural and contextual issues (described in more detail below).

Ultimately, however, most agreed that developing the taxonomy and identifying core components of the main programmatic and policy actions would enable the HIV prevention field to take a systematic approach to developing, evaluating, costing and advocating for behavioural HIV prevention work. Several participants working at the country level noted that with the emphasis on treatment, it could be a challenge to engage donors, policymakers and activists to bring the same sense of urgency and commitment to prevention in the absence of such a clear roadmap.

There was some debate among participants about whether the activity or the target population would be the most appropriate basis for the taxonomy and approach to defining quality. The meeting organizers proposed that it was important to distinguish between the work of developing a taxonomy and the programme design and management process for which models and guidelines existed<sup>15</sup> and did not need to be reinvented. The missing building blocks were the definitions of the tools that were selected and combined in the programme design process to achieve a range of objectives with and in varied populations and settings. UNAIDS agreed that programme design and management hinged on the populations and settings where rates and risks of HIV were higher. However, the present taxonomy process involved working to build consensus on the “tools in the tool box” that were used in many different programmes, populations and settings; for example, such tools could include treatment of sexually transmitted infections, peer education, condom distribution and policy reform—all of which were relevant in different ways to different populations and settings. While ultimately no clear consensus was reached, UNAIDS indicated that using activities or mode of delivery would best match the overall objectives of improving the comparability, evaluation and costing of scaled up HIV prevention programmes.

A number of meeting participants maintained that the term taxonomy was too academic and would not be clear or relevant to many of the people with an interest in this work. This challenge of terminology echoed some of the broader concerns about public health and development paradigms and meanings across diverse stakeholders.

The group acknowledged that some of the existing terminology describing HIV prevention was not precise and not used by all in the same ways, and that this could hinder efforts to arrive at greater clarity and comparability. There was some debate

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<sup>15</sup> For example: Family Health International and USAID (2001). Strategies for an Expanded and Comprehensive Response to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing. <http://www.fhi.org/NR/rdonlyres/elwuuussewhozpizshiomzjg6sh33t57krclhuil5mudazpqfxrhbsxhwbogfquvsgmtvlfxrel5pkn/ECRenglish1.pdf>; UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Joint United Nations Programme on HIV/AIDS, Geneva; UNAIDS, USAID and IMPACT (1998). Meeting the Behavioural Data Collection Needs of National HIV/AIDS and STD Programmes. A Joint IMPACT/FHI/UNAIDS Workshop: Report and Conclusions. [http://data.unaids.org/Publications/IRC-pub03/MeetingBehavData\\_en.pdf](http://data.unaids.org/Publications/IRC-pub03/MeetingBehavData_en.pdf); World Bank (2006). Gender Equality as Smart Economics: A World Bank Group Gender Action Plan (Fiscal years 2007–10) <http://siteresources.worldbank.org/INTGENDER/Resources/GAPNov2.pdf>; UNICEF. Life Skills: UNICEF Programming Cycle. [http://ux641a12.unicef.org/lifeskills/index\\_12074.html](http://ux641a12.unicef.org/lifeskills/index_12074.html).

about the degree to which the field should continue to use existing, familiar terminology, even if many of the terms were not well defined and did not effectively describe real activities. A number of participants maintained that the field should continue to use terms that were commonly understood, and that developing and adopting new terminology would likely confuse things further. Others suggested that a lack of precision in the field of behavioural interventions was behind the lack of programme data and sometimes contradictory evaluation results, which could undermine confidence in funding HIV prevention. New terms might help people approach the work with more precision and fewer assumptions. It was agreed that this issue would probably best be considered again when the proposed taxonomy was available. Expert groups would need to weigh whether or not new terms were likely to increase clarity and a common understanding.

## **Framework for Planning and Evaluating Behavioural Interventions: Presentation**

Dr Nancy Padian from the University of California at San Francisco presented a framework for planning and evaluating behavioural HIV prevention interventions for the group to consider and adapt (see Figure 2). The framework highlighted that quality standards were required to monitor and evaluate both the design (pre-implementation) and the implementation of programmes to verify that programmes were being implemented as planned and to allow for ongoing adaptation. She explained that the framework was an effort to systematize the analysis of quality by looking at coverage, fidelity and intensity, and that it was structured in three main phases:

- Pre-implementation referred to planning to achieve specific objectives or outcomes based on the context. The context would have multiple dimensions that needed to be considered and that affected the feasibility of outcomes:
  - health and development (e.g. epidemiological profile and health, education and other social welfare systems);
  - political and economic (e.g. levels of development, labour markets, regulatory infrastructure and media); and
  - sociocultural (e.g. religion, gender inequities and attitudes about individual, family and state responsibility).
- Implementation and delivery included issues and processes such as:
  - adaptation: identifying core components and causal mechanisms, consulting with stakeholders and tailoring the work to the context;
  - integration with delivery systems: considering how the programme activities fitted together and with other existing systems, and identifying available capacity and requirements available in that setting;
  - roll-out and delivery: bundling of activities activity-specific features such as coverage, fidelity and intensity, operational issues and ongoing political support.
- Measuring the impact on key outcomes required identifying intermediate measures in areas relevant to the programme, for example:
  - environmental (e.g. change in social and sexual norms);
  - cognitive, attitudinal or affective (e.g. fear of stigma);
  - behavioural (e.g. condom use); and
  - biological (HIV or sexually transmitted infections).

Pre-Implementation	Ensure Quality Implementation and Delivery			Impact and Outcomes
<b>Assessing the Macro- and Micro-Context</b>	<b>Adaptation</b>	<b>Integration with Delivery Systems</b>	<b>Rollout and Delivery</b>	<b>Environmental</b> e.g. Changes in social and sexual norms  <b>Behavioral</b> e.g. Condom use  <b>Biological</b> HIV/STI Pregnancy
Health and development Context <i>Epidemiological (prevalence, incidence, distribution of risk)</i> <i>Health Systems</i> <i>Education system</i> <i>Social welfare system</i>	Identify Core Components/ Causal Mechanism	Consider “bundled” interventions	Intervention-specific features:  <i>Coverage/Access</i>  <i>Fidelity</i>  <i>Intensity</i>	
Political/Economic Context <i>Level of development</i>  <i>Labor markets</i> <i>Regulatory</i>  <i>Democracy/free media</i>	Consult with Stakeholders  Tailor to context  Conduct pilots whenever possible	Identify human resource and training requirements	Operational Issues <i>-Effective management</i> <i>-Predictable funding</i>  Strong political support	
Socio-cultural Context  <i>Religion</i> <i>Gender</i>				

Figure 2. Proposed framework for planning and evaluating behavioural HIV prevention interventions.

Dr Padian explained that identifying appropriate quality measures for specific programmes was critical. Such measures could include: coverage, or number of people reached; fidelity, or how well the programme adhered to the guidelines that defined the core components and procedures of the intervention; and intensity, or the frequency, duration and depth of the information and services provided by each core component. Measuring fidelity for a complex programme could be based on the core elements, for example, information provision rather than the specific delivery mode. This could potentially allow for adaptation to local realities; for example, a programme designed to provide information might do so using a standard approach but define the most appropriate setting for that specific context. She added that the coverage of the programme was another key dimension in the proportion of the target audience that was served or reached by the programme.

Dr Padian acknowledged that it was very difficult with many HIV prevention activities to measure impact on the epidemic – for example, number of infections averted. She suggested that programmes needed to consider and experiment with identifying intervention-specific intermediate outcomes that could provide a sufficient measure of the programme’s effects. She gave the example of antiretroviral treatment programmes, which generally measured impact by the number of people on treatment, rather than the clinical outcomes associated with that treatment. She explained that measuring outcomes and impact usually required comparison research rather than being considered part of routine programme design. As information from programme data were improved (by better and more consistent use and publication of definitions and quality standards), it would become possible to use these programme data to assess effectiveness.

### **Developing Quality Standards: Communication**

Comprehensive communication—while not an activity per se—is a cross-cutting area where quality standards would be helpful. Effective communication is critical to many prevention interventions, and there are few agreed standards for either communication approaches or content. Vast resources are invested in communication programmes to convey information, encourage behaviour change, address stigma and a whole host of other outcomes. However, without standards, messages can be unclear, ineffective, misleading and contradictory. Ideally, communication standards need to go beyond mass media and address interpersonal communication through peer education, counselling and so forth.

Rather than constraining conceptual approaches to HIV prevention, defining quality standards and measures might in fact contribute to broadening these definitions and help the field experiment with new approaches to prevention. For example, Dr Padian explained, consciously bundling interventions or outcomes could increase programme efficiencies as well as better meet real peoples' needs. In many settings, implementing a comprehensive programme that responded to multiple needs through bundling interventions would best be done by partnering with other groups that brought additional expertise in other technical areas. Cost effectiveness and programme effectiveness could be enhanced by, for example, integrating programmes for prevention, care and treatment. A new approach to prevention focused on quality could result not just in better access to and improved quality of what already existed but new strategies and approaches that could improve the work overall.

### **Framework for Planning and Evaluating Behavioural Interventions: Discussion**

There was general agreement on the need for a framework that allowed for the definition of quality standards of HIV prevention interventions. Most participants found the framework useful overall, saying it provided a good way to systematize a number of complex concepts and levels of analysis. However, many felt that it was too academic, and there was a general sense that it would need to be simplified for use in programmes. It was noted that the need to have a framework that was more simple and general (to be relevant across a range of diverse behavioural activities) would need to be balanced with the need to account for major differences in complex programmes and environments. Several participants noted that the three main phases of the draft quality framework were important elements of most existing programming frameworks even if they were not always adhered to.

Implicit in moving from the taxonomy of activities to the development of quality standards was the identification of those core elements that needed to be in place for each activity to be considered “implemented”. Core elements of interventions needed to be identified and established as standards to permit comparisons and generalizability. Identifying these core elements could ensure continuity while also facilitating adaptation to particular regional, country and community contexts. This process could make a significant contribution by also identifying which core elements needed to be maintained in a systematic way to ensure quality implementation and impact. While most people agreed with this approach, some

questioned the underlying premise of identifying common core elements, asserting that “the strength lies in the diversity rather than in the commonality”.

Several issues were identified that needed to be incorporated into the framework for measuring quality:

- quality should be defined in relation to the core elements of different interventions, drawing on both programme experience and research;
- the framework should reflect quality standards not only for interventions and core elements, but also for the content of information that was part of those interventions; and
- coverage and intensity should go beyond numbers to consider more specifically who was—and was not—being reached, with special attention to vulnerable or difficult-to-reach populations.

Interestingly, the rich discussions throughout the meeting gravitated toward definitions, integration and impact; there was relatively little discussion of quality. Identifying and even discussing quality measures was quite difficult at a general level. It appeared that quality measures would likely need to be addressed as part of the technical discussions among experts from each area. Among other issues, they would need to consider how best to balance assessing quality based on outcome measures (i.e. did the implemented activities succeed in producing the intended results) with devising and incorporating process indicators (e.g. the proportion of the activities implemented as planned).

There were several interesting debates about what an appropriate evidence base would be for assessing quality, coverage and intensity. Participants acknowledged that when it came to measuring the effectiveness of behavioural and social change interventions, there was nothing comparable to the randomized controlled trial that demonstrated whether a biomedical intervention was sufficiently efficacious to roll out. They agreed that it was important to develop processes and measures that were both rigorous and practical to use and that provided information that was useful internally for adapting and improving programmes as well as for reporting to donors, governments or other external constituents.

Finally, the process will need to consider which HIV prevention activities to prioritize for developing quality measures. The organisers had emphasized that some areas—such as voluntary counselling and testing—have already established guidance and quality standards. The focus of this process should be on developing quality standards for interventions and activities where standards do not already exist but which have a strong evidence base to build on. These can get underway and into use quickly. Participants noted that all standards must be based on empirical research, refined and reinforced through a process of consensus-building, dissemination and ongoing use. Such standards do not have to be static—they can and indeed must be flexible enough to be adapted for use in a wide range of settings and must also be updated and modified based on new evidence or the changing nature of the AIDS epidemic.

## Applying the Taxonomy and Framework: Lessons and Challenges

Following the presentations and discussion of the taxonomy and framework, participants broke into small groups to test the process of developing definitions and using the framework. Each group considered one of four HIV prevention interventions: peer education, condom social marketing, social mobilization and structural initiatives to reduce gender-based violence. The four examples were selected by the organizers for discussion because they illustrated diverse types of prevention activities and were generally areas where international guidelines had not been developed or widely disseminated. This small group work was designed to test the overall concept rather than to arrive at precise technical definitions or indicators.

The small groups' deliberations highlighted some of the complexities of deriving definitions and quality measures for diverse activities. The groups considering the relatively discrete concepts of peer education and condom social marketing could define the intervention and apply the framework relatively easily. For example, the peer education group enjoyed a rich discussion about the varied approaches and nuances of these programmes and proposed ways that this diversity could be reflected within the framework. The group felt that it would be relatively straightforward to develop a checklist or similar tool which would indicate the core essential components of peer education and assess a minimum level of quality while also capturing the unique elements of diverse programmes. The group considering condom social marketing saw similar potential for developing tools to assess quality using the quality framework. They found that such tools would need to go beyond the usual social marketing indicators focused on numbers sold to incorporate contextual factors such as legal or structural barriers, supply and the role of the private sector. They recommended that a technical expert group be convened to carry this process further and develop actual quality standards.

In contrast, the groups looking at the broader concepts of social mobilization and structural interventions to address gender-based violence struggled somewhat with applying the framework and identifying quality standards. It was noted that social mobilization processes could be organic, community-based efforts or externally driven. They often involved a wide range of actions and activities and the framework's comprehensiveness reflected this complexity. However, the group felt that meaningful quality measures for social mobilization would by definition need to be developed with stakeholders, and it was not clear that such a process would lend itself to standardization. The group considering structural interventions to reduce gender-based violence described their efforts to arrive at a definition as "like an accordion" that kept expanding and contracting. They noted that reducing gender-based violence was an important outcome in its own right—defined with or without reference to reducing risk of HIV. A key question was how to include and balance process indicators with outcome measures. Since the outcome desired was reducing violent behaviours, process indicators could be defined as contextual changes such as changes in laws, policies or norms concerning gender-based violence that condition the behaviours of gender-based violence—all of which might or might not have an impact on HIV infections.

The small group work highlighted several themes that surfaced throughout the meeting:

- developing definitions and quality standards seemed to work best for discrete interventions and activities;
- getting to definitions of quality was challenging—suggesting that they may need to be linked to components or core elements of the intervention rather than the broad issue of the intervention;
- it was important—and challenging—to develop both process indicators and outcome indicators, and balance both when working to develop quality standards for diverse interventions.

## **Key Areas of Discussion and Debate**

This section summarizes and synthesizes some of the major issues that were discussed and debated throughout the meeting.

### ***Structural and Contextual Issues***

A number of participants argued forcefully that any meaningful analysis must consider structural elements of the context within which programmes were being implemented. For example, contextual factors concerning gender, economic power and sexual negotiation might more powerfully influence a woman's ability to internalize or act on information on sexual risk reduction than the quality or intensity of the behavioural intervention. They maintained that any definitional exercise such as the one being proposed would be challenged to incorporate adequate attention to these structural and contextual factors in order to be meaningful.

While it is important for analytical purposes to clearly define interventions and core elements, it is also critical to consider the impact of structural and contextual factors. This perspective was reinforced and taken further by some participants who felt that the potential of “mechanistic” behavioural interventions were reaching their limit and that it would be difficult to have more impact on HIV prevention without fostering structural changes around underlying issues such as stigma, discrimination, gender and religion. Some asserted that these contextual factors should be dominant and the emphasis should be on social change with behavioural outcomes rather than the current paradigm, which focused more on the behavioural outcomes while sometimes acknowledging the need for, or halo effects involving, social change.

### ***Standardization***

Standardization has clear advantages—and pitfalls. Standardization can allow for consistency, facilitate a common understanding of what a programme is and is not doing, and enhance the ability to evaluate and replicate interventions. Standardization may also help in defining the critical elements and features based on programme experience and technical areas where complementary efforts can work together for greater synergy. However, some participants expressed concern that standardization was inherently rigid or “reductionist”, did not allow for adaptation and could not reflect the complex dynamics of actual HIV prevention programmes and the contexts they operated in. Several participants proposed that developing common principles rather than standards or guidelines would allow for an appropriate balance between

standardization and diversity. Others, however, felt that principles were too vague and that more standardization was critical to allow comparability, monitoring, learning, costing and planning for scale and quality of programmes.

Several participants suggested that standardization could play an important political role as well as a programmatic one in that defining technical standards could help in holding governments, donors and other actors accountable for delivering on and implementing international agreements. Ideological debates on issues such as sex education could be ameliorated by an accepted set of standards, which then could be adapted to a given setting. In this way standardization could provide a technical and neutral approach to holding countries accountable for implementing a range of programmes in areas that might be controversial or politically unpopular, such as working with marginalized populations (for example, sex workers or men who have sex with men).

While some participants continued to express reluctance to standardize, many others felt that it would be very useful in their work. There was a clear sense that whatever the limitations of standardization, it was critically important in the current climate of resource mobilization and evaluation, and that failure to do so would undermine the ability of HIV prevention efforts to garner critically needed political and financial support.

### ***Comprehensive Programmes and Scale-up***

An ongoing concern during the meeting about the process of developing standardized definitions and identifying core elements was that it would not reflect the comprehensive nature of many HIV prevention initiatives in the field. Some participants expressed concern that the rich experience and important lessons about comprehensive responses gained over decades of work on HIV prevention would be lost in this process. At several points in the discussion, participants raised concerns that the process outlined during the reference group meeting might lead donors or countries to think in terms of identifying individual “magic bullet” behavioural interventions for HIV prevention. They underscored that even if it were not possible to measure the complexity of comprehensive programmes or to reflect it in the quality measures that were developed, it would be important for UNAIDS to make statements that publicly supported the principle of comprehensive approaches to HIV prevention.

There was also some concern that there would be pressure to scale up discrete programmes in ways that might not be feasible or appropriate. Some participants noted that while organizations in many settings had implemented effective behavioural interventions at a small scale, scaling up those interventions had often proven to be a real challenge. They stated that it was not necessarily the case that initiatives that worked well on a small scale were appropriate or feasible in a larger context. These participants cautioned that a process of identifying excellent, high quality programmes would not always translate into scale-up; such a process needed to be approached analytically and critically, recognizing that in some cases projects that worked well in particular settings or at a small scale simply could not be effectively scaled up.

## ***Research and Programme Perspectives***

A number of participants expressed concern about balancing the needs of the research enterprise with more practical concerns of programme planning and evaluation. Some felt that the taxonomy and quality framework presented at the meeting overemphasized the academic and research perspective. For example, it was noted that in limiting its analysis to information from peer-reviewed journals, the Synthesis Project would likely miss important programmatic experience since many programmatic efforts—including many that were implemented and evaluated rigorously—were not published in the formal literature. The participants felt that it was critical that this process bring in additional expertise, experience, assessment tools and programme evaluation data from programmes in the field. Clearly academics and researchers could make an important contribution as experts and resources in defining the specific areas and developing the quality assessment criteria. However, ultimately this was a process for programmes and policies, it was agreed, and as such must be driven by programmatic rather than academic considerations.

## ***Role of Key Constituent Groups***

The process of defining HIV prevention interventions and quality can benefit from incorporating the perspectives and expertise of key constituent groups. Their input is also critical for ensuring that the process reflects and is responsive to diverse interests as it moves forward. Meeting participants suggested several approaches to incorporating these different interests. They proposed that after the definitions and core components were developed, the document should be circulated for comment to ensure that it reflected the realities of programmes in diverse settings. Members of the HIV Prevention Reference Group, international partners, national AIDS authorities from countries with a range of different epidemic profiles, academics and researchers, and civil society groups should all be invited to contribute to this review process.

International partners at the meeting welcomed the process as an opportunity to enhance work on HIV prevention. They offered to recommend good programmes and tools to be included in the process and to engage other key partners, especially the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank. Greater clarity on programme components and outcomes could play an important role in dispelling notions that prevention does not work. Consistent approaches to costing could help international partners and donors assess what was reasonable to expect from different types and levels of investment in prevention.

Clearly it would not be feasible or necessary to evaluate every intervention with the equivalent of a randomized controlled trial. However, greater consensus on the level and type of evidence for assessing quality and effectiveness of behavioural interventions would strengthen the case for working and investing in HIV prevention. Researchers could contribute expertise in developing tools and measuring impact as well as identifying key questions for prevention in the context of different types of epidemics. Drawing in diverse social science expertise could also help to determine innovative ways to assess broader social change as part of HIV prevention work.

Nongovernmental organizations involved in programme implementation could lend valuable technical expertise in defining the core elements, approaches to assessing

quality and cost. They could play an important role in identifying existing evaluation components and tools, and helping to prioritize which core elements the process should address first. While there was a clear sense of urgency to produce these definitions and tools, it was also recognized as important to ensure that they would be useful to programmes and organizations working in the field. A “virtual task force” of nongovernmental organizations working in HIV prevention could provide a mechanism for this process to benefit from their rich experience. Such a group could also help UNAIDS identify channels through which information and tools developed through this process could be distributed to ensure that they were both useful and used.

## **Recommendations and Process Forward**

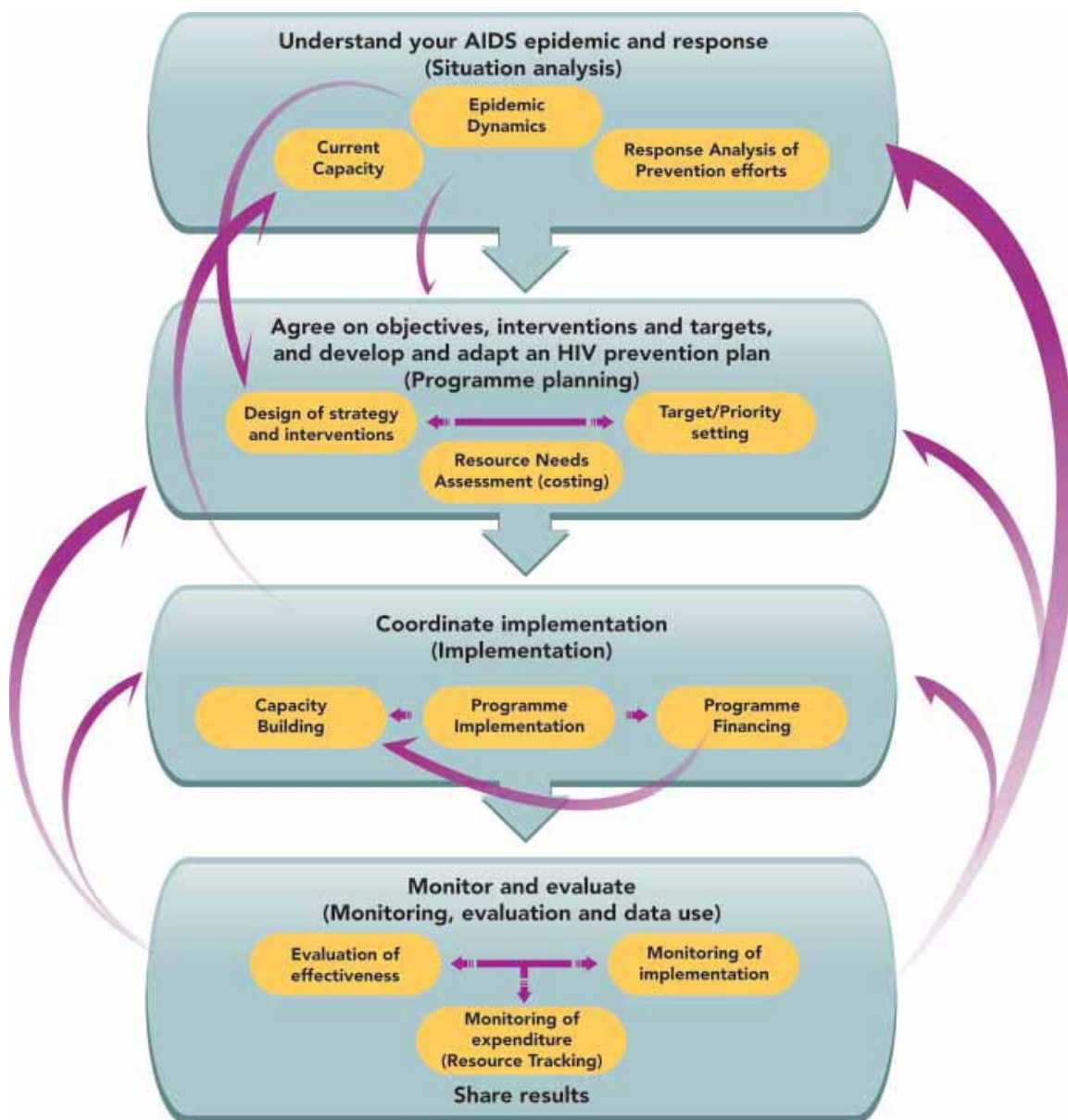
The HIV Prevention Reference Group recognized the need for setting standards to ensure access to comprehensive and effective HIV prevention services for people in many different settings. It affirmed the approach proposed by UNAIDS: developing a taxonomy of social and behavioural prevention activities and a framework for assessing quality so that these measures could be planned, costed and monitored with the same level of clarity that was routine in clinical services. It was agreed that this taxonomy and framework should fit with the range of activities in a comprehensive prevention response, support and facilitate tailoring to regional, country and local situations, and encourage innovation. It should also involve dialogue with other key groups working on similar initiatives such as the Monitoring and Evaluation Research Group (MERG) and the working groups establishing performance standards for the US President’s Emergency Plan for AIDS Relief to ensure complementarity and sharing of experience.

### ***Taxonomy of Social and Behavioural HIV Prevention Activities***

The meeting agreed that reaching consensus on clear, explicit definitions for the activities included in HIV prevention programmes was critical for effectively planning, evaluating and costing these activities. It agreed that the establishment of a taxonomy of key prevention activities (covering all the activities recommended in Practical Guidelines for Intensifying HIV Prevention) and quality standards for each area would ensure that different players in different roles could:

- speak in a common language about prevention programmes;
- plan, budget and evaluate their prevention programmes more consistently;
- learn from each others’ experience through comparison;
- replicate and adapt successful programmes to other settings; and
- provide a robust evidence base for resource mobilization for HIV prevention.

Given some of the concerns and confusion about the term taxonomy, the meeting strongly recommended that taxonomy be defined and a new term and explanation be used in subsequent discussions and documents. UNAIDS’ Executive Director used “nomenclature” in the closing session, which may be a preferable term.



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

Source: UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access.

Figure 3. HIV Integrated Programming Cycle.

### **Framework for Defining Quality in HIV Prevention Interventions**

Meeting participants agreed that it was important to define quality in relation to core elements of different interventions and that such analysis should be based on both research and programmatic experience. It was agreed that a framework could specify different dimensions of quality to facilitate a systematic approach to developing criteria and measures of quality, such as coverage, intensity and fidelity, and that such a framework should be simple, practical, reflect programmatic realities and emphasize a results-based approach. It should draw on and reflect existing planning and assessment approaches rather than develop another approach. For example, the programming cycle outlined in the diagram above (see Figure 3) is one of many that

charts an analytic process for deciding what a program should include. In addition, the framework should address several levels of quality:

- appropriateness to the context;
- adherence to principles, including gender equality, human rights and leadership by affected communities;
- design of activities and components (e.g. intensity);
- coverage, including analysis of who was – and was not – being reached with special attention to marginalized and hard-to-reach populations;
- how well the activities' implementation adhered to its plans (i.e. fidelity); and
- effectiveness in achieving the specified objectives.

This framework would be applied to each of the HIV prevention activities to develop quality standards. Quality standards should balance being consistent with being flexible enough to reflect and respond to diverse contexts. The framework should incorporate lessons from other quality assurance initiatives.<sup>16</sup> It should also reflect lessons from implementation and action, including the identification of bottlenecks, barriers and challenges in developing and implementing interventions.

### ***The Process Moving Forward***

The secretariat agreed to several immediate next steps, to be completed within several weeks following the meeting:

- Produce and circulate the meeting report;
- Produce draft documents incorporating input from the HIV Prevention Reference Group meeting:
  - a taxonomy paper (including the proposed list of prevention activities and their definitions, including their core components);
  - a paper on the proposed framework for quality.

The HIV Prevention Reference Group recommended that UNAIDS engage in a consultative but efficient process to develop the tools defined in this meeting that would improve and simplify prevention planning, quality implementation, target setting and evaluation. The UNAIDS secretariat will draft a specific work plan through the end of 2007 and beyond to implement these recommendations:

- convene a task team comprising participants from this HIV Prevention Reference Group Meeting and other nominated representatives from nongovernmental organizations, civil society, governments, researchers, program managers and international collaborating partners to provide input on the further development of the taxonomy and the quality framework;
- apply the quality framework to each of the HIV prevention activities in order to clarify quality standards for each and include consultation and technical advice from experts and implementers for each activity area; and

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<sup>16</sup> Center for Global Development (2004). Millions Saved: Proven Successes in Global Health. *CGD Brief*. October 2004, 3:3. Washington, D.C.; Kelly, J. A. et al. (2000). Transfer of Research-Based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation. *AIDS Education and Prevention*, 12, Supplement A, 87-98, 2000. The Guilford Press.; Youth Peer Education Network (2006). *Assessing the Quality of Youth Peer Education Programmes*. Family Health International. <http://www.fhi.org/NR/rdonlyres/e6tz746qad3w44cmjqux57mi5sdg6hictb5ex7cy3bi2fvtkhxfgw6kdpfszgnktgqumqydpl5sjko/peeredassessmentent1.pdf>; Wegbreit, J et al. (2006). Effectiveness of HIV prevention strategies in resource-poor countries: tailoring the intervention to the context. *AIDS 2006*, 20:1217–1235. Lippincott Williams & Wilkins.

- develop tools to support and actively promote use of the *Practical Guidelines for Intensifying HIV Prevention*.

The meeting participants also recommended that UNAIDS take the following additional steps as part of the process for finalizing the taxonomy and quality framework:

- circulate the draft taxonomy and quality framework papers to the task team for review and comment, including identifying and addressing gaps;
- prioritize activity areas for initial development of quality standards; these should emphasize areas where common quality standards are not available, but sufficient data and experience exist to ensure that the process continues to move forward;
- consult with programme experts in different activity areas to identify existing tools and documentation that define or outline core elements; specify issues relating to quality, intensity and coverage; and/or include tools and indicators for evaluation. This will allow the process to build on experience and identify gaps and areas for updating and refinement;
- use the taxonomy and quality framework to structure the planned Electronic Compendium of Tools for HIV Prevention, which is gathering existing guidelines and tools and indexing them by geographic region, activity, target audience and other factors; and
- recommend development and field testing of new or updated technical guidelines and tools that measure quality, intensity and coverage for different programme areas in different epidemic settings.

Once these products have been developed, important additional steps should include:

- the development of mechanisms—initiated by and appropriate for each country setting – to promote adherence to the standards developed; and
- engagement and advocacy so the taxonomy and quality framework are adopted at regional and country level to guide HIV prevention interventions. This process remains to be defined.

The process outlined in these recommendations should lead to better definitions of activities providing for improved programme planning and implementation, more accurate costing and resource needs estimates of HIV prevention interventions and more effective advocacy for resource mobilization for HIV prevention. Ultimately, establishing quality standards is critical to holding the HIV prevention field accountable, and to ensure that people in communities around the world benefit from access to high quality, effective prevention activities.

## Annexes

### Annex 1: Participant's Agenda

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#### Meeting Agenda

Revised 4 April 2007  
UNAIDS HIV Prevention Reference Group  
Kofi A. Annan Conference Room  
UNAIDS/WHO Building  
4 – 5 April 2007

#### Day 1: Wednesday, 4 April 2007

##### Morning Session:

**Chairperson:** *Mike Merson, Chairperson: UNAIDS HIV Prevention Reference Group*

**Co-Chairperson:** *Purnima Mane: Director: Policy, Evidence and Partnerships Department, UNAIDS*

**Rapporteur:** *Richard Delate, UNAIDS*

**08:00 – 08:30**      **Arrival and registration**  
*Tea/coffee/juices and croissants will be available.*

**08:30 – 08:45**      **Welcoming and opening remarks**  
*Purnima Mane, Director: Policy, Evidence and Partnerships Department, UNAIDS*  
*Mike Merson, Chairperson: UNAIDS HIV Prevention Reference Group*

**08:45 – 09:00**      **Participant introductions, expectations and logistics**

**09:00 – 09:45**      **Stating the problem: why develop a taxonomy of prevention interventions and a framework that specifies issues relating to quality, intensity and coverage**  
*Barbara de Zaluondo, Associate Director: Epidemic Monitoring and Prevention, UNAIDS*

##### **Discussants:**

*Kieran Daly, International Council of AIDS Service Organizations, Canada*  
*Peter Mwarogo, Family Health International, Kenya*

##### **General discussion**

**09:45 – 10:00**      **Tea/coffee**

**10:00 – 11:00**      **Defining behavioural interventions and components of: condom social marketing, social change, peer education, structural interventions to reduce gender-based violence and micro-finance.**  
*Michael Sweat, Johns Hopkins University*

**Discussants:**

*Basma Khraisat, Family Health International, Jordan*

*Gina Dallabetta, Avahan, India*

**General Discussion**

**11:00 – 12:00**

**Towards a framework for planning and evaluating behavioural change interventions**

*Nancy Padian, University of California, San Francisco*

**Discussants:**

*Souleymane Barry, Social and Scientific Systems, Uganda*

*Wu Zunyou, Chinese Centre for Disease Control, China*

**General discussion**

**12:00 – 13:15**

**Lunch**

Venue: UNAIDS Cafeteria

**Afternoon Session**

**Co-chairperson:**

*Peter Figueroa, National AIDS Programme, Jamaica*

**Rapporteur:**

*Terhi Aaltonen, UNAIDS*

**13:15 – 13:35**

**Introduction to group work**

*Richard Delate, UNAIDS*

**13:35 – 15:45**

**Group work: refining the framework for assessing quality, intensity and coverage of prevention interventions**

1. Social marketing of condoms; venue: Suman Mehta Conference Room (34046)
2. Social mobilization for social change; venue: Video Conference Room
3. Micro-finance; venue: Kofi Annan Room
4. Peer education; venue: Kofi Annan Room
5. Structural interventions to reduce gender-based violence; venue: Kofi Annan Room

**15:45 – 16:00**

**Tea/coffee**

**16:00 – 18:00**

**Plenary: reporting back from the group discussions**

*Moderator: Peter Figueroa, National AIDS Programme, Jamaica*

1. Social marketing of condoms  
*C Y Gopinath, PATH, Thailand*
2. Social mobilization for social change  
*Sue Goldstein, Soul City, South Africa*
3. Micro-finance  
*Ellen Weiss, Horizons Program, USA*
4. Peer education  
*Olaronke Ladipo, Society for Family Health, Nigeria*
5. Structural interventions to reduce gender-based violence  
*Lennarth Hjelmåker, Swedish AIDS Ambassador*

**18:00 – 18:30**      **Summary of key points raised and to be taken into consideration in refining the taxonomy and framework**  
*Mike Merson, Chairperson, UNAIDS HIV Prevention Reference Group.*

**18:30 – 19:45**      **Reception: ILO gardens**

## **Day 2: Thursday, 5 April 2007**

### ***Morning Session***

**Co-chairperson:**      *Khanya Mabuza, NERCHA, Swaziland*

**Rapporteur:**          *Jyothi Raja, UNAIDS*

**08:30 – 09:00**      **Re-entry - summary of key recommendations and observations from Day 1**  
*Christopher Armstrong, CIDA, Canada*

**09:00 – 09:45**      **Towards a taxonomy: reflections on the definitions and core components of behavioural interventions**  
*Michael Sweat, Johns Hopkins University*

**09:45 – 10:30**      **Discussion**  
**Simplifying the framework for planning and evaluating behavioural change interventions**  
*Nancy Padian, University of California, San Francisco*

**10:30 – 10:45**      **Discussion**  
**Tea/coffee**

**10:45 – 11:30**      **Group discussions on the next steps and what each stakeholder group contributes towards them**  
Group 1: National AIDS Authorities; venue: Kofi A Annan Room  
Group 2: Nongovernmental organizations and civil society; venue: Conference Room 1  
Group 3: Research; venue: Rudick Adamyan Conference Room (34047)  
Group 4: International Partners; venue: Video Conference Room

**11:30 – 12:30**      **Reporting back from the group discussions: next steps and what each stakeholder group contributes towards them**  
*Moderator: Khanya Mabuza, NERCHA, Swaziland*

1. National AIDS councils  
*Sahu Supriya, Tamil Nadu State AIDS Control Society, India*
2. Nongovernmental organizations and civil society  
*Anuar Luna, Red Mexicana de Personas que Viven con VIH-SIDA, Mexico*
3. Research  
*Marie Laga, Institute of Tropical Medicine, Belgium*
4. International collaborating partners  
*Caroline Ryan, President's Emergency Plan for AIDS Relief*

- 12:30 – 13:30**            **Lunch**
- Chairperson:**            *Mike Merson, Chairperson of the UNAIDS HIV Prevention Reference Group*
- Co-chairperson:**        *Purnima Mane, Director: Policy, Evidence and Partnerships Department, UNAIDS*
- Rapporteur:**            *Richard Delate, UNAIDS*
- 13:30 – 15:00**            **Review and finalization of the recommendations of the UNAIDS HIV Prevention Reference Group**  
*Barbara de Zalduondo, UNAIDS*
- 15:00 – 15:30**            **Tea/coffee**
- 15:30 – 16:30**            **Summary and recommendations from the meeting and UNAIDS Executive Director’s feedback.**  
*Mike Merson, Chairperson of the UNAIDS HIV Prevention Reference Group*  
*Peter Piot, Executive Director: UNAIDS*
- 16:30 – 16:50**            **Observations from the meeting, wrap-up discussion and next steps**  
*Mike Merson, Chairperson: UNAIDS HIV Prevention Reference Group*
- 16.50 – 17:00**            **Closing remarks**  
*Purnima Mane, Director: Policy, Evidence and Partnerships Department, UNAIDS*

## Annex 2: List of Participant

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### **Christopher Armstrong**

Team Leader HIV/AIDS  
Canadian International Development Agency  
Promenade du Portage Gatineau  
Québec, Canada K1A 0G4  
Tel: 1 819 934 4245  
Email: [christopher\\_armstrong@acdi-cida.gc.ca](mailto:christopher_armstrong@acdi-cida.gc.ca)

### **Souleymane Barry**

Senior Technical Adviser and SSS Associate  
Director  
Social & Scientific Systems, Inc.  
51 Mackenzie Vale, Kololo  
Kampala, Uganda  
Tel: 256 41 2230 307  
Cell: 256 77 2221 323 or 240 475 3887  
Fax: 256 41 2230 306  
Email: [sbarry@s-3.com](mailto:sbarry@s-3.com)

### **Michaela Clayton**

Director  
AIDS and Rights Alliance for Southern Africa  
(ARASA)  
53 Mont Blanc St  
Windhoek  
P.O. Box 604  
Namibia  
Tel. 264 61 300381  
Fax: 264 61 227675  
Email: [michaela@arasa.org.na](mailto:michaela@arasa.org.na)

### **Chris Collins**

Health Policy and Communications Consultant  
Global HIV Prevention Working Group  
112 N 2<sup>nd</sup> Street 2D  
Philadelphia PA  
USA  
Tel: 1 845 482 9033  
Fax:  
Email: [Chris.Collins@gatesfoundation.org](mailto:Chris.Collins@gatesfoundation.org) or  
[chriscsf@aol.com](mailto:chriscsf@aol.com)

### **Gina Dallabetta**

Senior Program Officer  
Avahan, The Foundation's HIV Prevention  
Initiative  
Sanskrit Bhawan A-10 Qutab  
Institutional Area Aruna Asaf Ali Marg  
110067 New Delhi, India  
Tel: 91 11 4100 31 00  
Fax: 91 11 4100 31 01  
Email:  
[Gina.Dallabetta@india.gatesfoundation.org](mailto:Gina.Dallabetta@india.gatesfoundation.org)

### **Kieran Daly**

Director, Policy & Communications  
International Council of AIDS Service  
Organisations  
International Secretariat  
65 Wellesley Street E., Suite 403  
Toronto, Ontario  
Canada M4Y 1G7  
Tel: 1 416 921 0018 ext. 21  
Fax: 1 416 921 9979

Work mobile: +1 416 275 8413

Email: [kierand@icaso.org](mailto:kierand@icaso.org)

### **Peter Figueroa**

Director  
National AIDS Programme  
Ministry of Health  
2 King St. Ocean  
Complex 4th Floor  
Kingston, Jamaica  
Tel: 1 876 948 1628  
Fax: 1 876 967 1324/1280  
Email: [figueroap@moh.gov.jm](mailto:figueroap@moh.gov.jm)

### **Sue Goldstein**

Senior Manager  
Research and Special Projects  
Soul City: Institute of Health and Development  
Communication  
2nd Floor Park Terrace 33 Princess of Wales  
Terrace, Parktown 2193 Johannesburg  
South Africa  
Tel: 27 11 6435852  
Fax: 27 11 6436253  
Email: [suegold@soulcity.org.za](mailto:suegold@soulcity.org.za)

### **CY Gopinath**

Creative Director  
PATH  
37/1 Petchburi Soi 15, Petchburi Rd  
Bangkok 10400, Thailand  
Tel: 66 2 653 7563  
Fax: 66 2 563 7568  
Email: [cygopi@gmail.com](mailto:cygopi@gmail.com)

### **Kátia Guimarães**

Technical Advisor for Gender Issues  
Brazil National STD/AIDS Programme  
SEPN 511, Bloco C, 2Andar  
70760-543 Brasilia DF  
Brazil  
Tel: 55 61 3448 8061/8012  
Fax: 55 61 3448 8224  
Email: [katia.guimaraes@aims.gov.br](mailto:katia.guimaraes@aims.gov.br)

### **Lennarth Hjelmåker**

Sweden's Special Ambassador on HIV/AIDS  
Gustav Adolfs Torg 1  
103 39 Stockholm  
Sweden  
Tel: +46 8 4051701  
Fax: +46 8 7231176  
Email: [lennarth.hjelmaker@foreign.ministry.se](mailto:lennarth.hjelmaker@foreign.ministry.se)

### **Basma Khraisat**

Country Director  
Family Health International  
Jordan  
Tel: 962 6 462 8088  
Fax: 962 6 4628077  
Email: [basmakh@go.com.jo](mailto:basmakh@go.com.jo)

**Christine Kopp**

Deputy Head  
Swiss National HIV/AIDS Programme  
Swiss Federal Office of Public Health AIDS  
Section  
Bundesamt für Gesundheit, Sektion AIDS  
CH 3003 Bern  
Tel: 41 31 322 9636  
Fax: 41 31 324 4648  
Email: [Christine.Kopp@bag.admin.ch](mailto:Christine.Kopp@bag.admin.ch)

**Olaronke Ladipo**

General Manager, HIV Division  
Society for Family Health  
8 Port Harcourt Crescent  
Area 11 Garki  
PMB 5116 Wuse  
Abuja, FCT Nigeria  
Tel: 234 8055227212  
Fax: 234 94618830  
Email: [Oladipo@sfnigeria.org](mailto:Oladipo@sfnigeria.org)

**Marie Laga**

Professor and Head of HIV/STI Research and  
Intervention Unit  
Institute of Tropical Medicine  
Nationalestraat 155  
2000 Antwerp  
Belgium  
Tel: 32 3 2476316  
Fax: 225 2 212544  
Email: [mlaga@itg.be](mailto:mlaga@itg.be); [mlaga@pandora.be](mailto:mlaga@pandora.be)

**Carol Larivee**

Chief of Party  
Ghana Sustainable Change Project  
29 Mango Tree Ave  
Accra, Ghana  
Tel: 233 244330197  
Fax:  
Email: [lariveeca@aol.com](mailto:lariveeca@aol.com)

**Anuar Luna**

Red Mexicana de Personans que Viven con  
VIH  
Astronomos 38-4 Col Escandon  
11800 Mexico DF  
Mexico  
Tel: 52 55 52737308  
Fax: 52 55 55155583  
Email: [anuar\\_luna@hotmail.com](mailto:anuar_luna@hotmail.com)

**Khanya Mabuza**

Assistant Director  
NERCHA  
P.O. Box 1937  
Mbabane, Swaziland  
Tel: 268 404 1703/404 1726  
Fax: 268 404 1692  
Email: [kmabuza@nercha.org.sz](mailto:kmabuza@nercha.org.sz) or  
[khanya65@yahoo.com](mailto:khanya65@yahoo.com)

**Michael Merson** (Chair of the HIV Prevention  
Reference Group meeting)

Director, Professor  
Global Health Institute, Duke University  
Durham, NC 27708  
USA  
Tel: 1 919 6817760  
Fax: 1 919 6817748  
Email: [michael.merson@duke.edu](mailto:michael.merson@duke.edu) or  
[tammy.sorrell@duke.edu](mailto:tammy.sorrell@duke.edu)

**Peter Mwarogo**

Country Director  
Family Health International  
Chancery Building, Valley Road  
P.O. Box 38835-00623  
Kenya  
Tel: 254-020-2713913  
Fax: 254-020-2726130  
Email: [Pmwarogo@fhi.or.ke](mailto:Pmwarogo@fhi.or.ke)

**Nancy Padian**

University of California, San Francisco  
School of Medicine  
74 New Montgomery, Box 0886  
San Francisco, CA 94105-3444  
USA  
Phone: 1 415 597 4968  
Fax: 1 415 597 9300  
Email: [npadian@globalhealth.ucsf.edu](mailto:npadian@globalhealth.ucsf.edu)

**David Plummer**

Commonwealth/UNESCO Regional Professor  
in HIV Education for the Caribbean  
University of the West Indies  
Trinidad and Tobago  
Tel: 1868 662 2002 ext 3800/3802  
Fax : 1868 662 6616  
Email: [dplummer@fhe.uwi.tt](mailto:dplummer@fhe.uwi.tt)

**Caroline Ryan**

Senior Advisor, HIV Prevention  
Office of the Global AIDS Coordinator  
US Department of State SA-29  
2201 C Street  
20522-2920 Washington D.C.  
USA  
Tel: 1 202 6632684  
Fax: 1 202 6632702  
Email: [cryan@cdc.gov](mailto:cryan@cdc.gov); [cgr8@cdc.gov](mailto:cgr8@cdc.gov)

**Supriya Sahu**

Project Director  
Tamil Nadu State AIDS Control Society  
No. 417, Pantheon Road  
Egmore, Chennai- 8  
India  
Tel: 91 44 28190261  
Fax: 91 44 281 90465  
Email: [supriyasahu@yahoo.com](mailto:supriyasahu@yahoo.com)

**Pavlo Smyrnov**

Director, Field Programmes  
International HIV/AIDS Alliance  
9th Floor, Building 10A  
5 Dymytrova str.  
Kyiv 03680 Ukraine  
Tel: 38044 490 5485  
Fax: 38044 490 5489  
Email: [smyrnov@aidsalliance.org.ua](mailto:smyrnov@aidsalliance.org.ua)

**Michael Sweat**

Associate Professor  
Johns Hopkins Bloomberg School of Public Health  
615 North Wolfe Street Bldg. E5533  
Baltimore, MD 21205-2179  
USA  
Tel: 1 410 614 4536  
Fax: 1 703 995-0615  
Email: [msweat@jhsph.edu](mailto:msweat@jhsph.edu)

**Ellen Weiss**

Research Utilization Director  
Horizons Program  
4301 Connecticut Avenue, NW  
Suite 280  
Washington, DC 20008  
USA  
Tel: 1 202 237 9400  
Email: [eweiss@pcdc.org](mailto:eweiss@pcdc.org)

**Wu Zunyou**

Director, National Center for AIDS/STD Control and Prevention  
Chinese Center for Disease Control and Prevention  
601 NCAIDS, China CDC, No. 27 Nanwei Road  
Xuanwu District  
Beijing 100050 China  
Tel: 86 10 6316 5758  
Fax: 86 10 6317 9516  
Email: [wuzunyou@gmail.com](mailto:wuzunyou@gmail.com) or  
[wuzy@263.net](mailto:wuzy@263.net)

**UNAIDS PROGRAMME**

**Ian Macleod**

Senior Adviser - HIV and AIDS  
UNICEF Regional Office for South Asia (ROSA)  
Kathmandu, Nepal  
Tel: 977-1 441 7082 ext 224  
Mobile: 977 98510 82718  
E-mail: [imacleod@unicef.org](mailto:imacleod@unicef.org)

**Purnima Mane**

Director  
Policy, Evidence and Partnerships  
UNAIDS  
Tel: 41 22 7914446  
Fax: 41 22 7914647  
Email: [manep@unaids.org](mailto:manep@unaids.org)

**Joseph Hubert Perriens**

Acting Coordinator  
Prevention in the Health Sector  
HIV/AIDS Department  
World Health Organization  
Tel: 41 22 791 4456  
Fax: 41 22 791 4834  
Email: [perriensj@who.int](mailto:perriensj@who.int)

**Peter Piot**

Executive Director  
UNAIDS  
Tel: 41 22 7914510  
Fax: 41 22 7914179  
Email: [piotp@unaids.org](mailto:piotp@unaids.org)

**Oussama Tawil**

Director, RST, Middle East and North Africa (MENA)  
c/o WHO Regional Office for the Eastern Mediterranean  
Abdul Razzak Al Sanhoury Street  
Nasr City, Cairo 11371  
Egypt  
Tel: 20 2 276 5257  
Fax: 20 2 276 5427  
Email: [tawilo@unaids.org](mailto:tawilo@unaids.org)

**Content Team:**

**Anindya Chatterjee**

Senior Adviser, Prevention and Public Policy  
Prevention, Care and Impact Mitigation  
UNAIDS  
Tel: 41 22 7911468  
Fax: 41 22 7914746  
Email: [chatterjeea@unaids.org](mailto:chatterjeea@unaids.org)

**Richard Delate**

Adviser, Vulnerability and Prevention  
Prevention, Care and Impact Mitigation  
UNAIDS  
Tel: 41 22 7913620  
Fax: 41 22 7914746  
Email: [delater@unaids.org](mailto:delater@unaids.org)

**Barbara de Zaldoondo**

Associate Director  
Epidemic Monitoring and Prevention  
UNAIDS  
Tel: 41 22 7911557  
Fax: 41 22 7914746  
Email: [dezaldoondob@unaids.org](mailto:dezaldoondob@unaids.org)

**Kevin O'Reilly**

Prevention in the Health Sector  
HIV/AIDS Department  
World Health Organization  
Tel: +41 22 791 4507  
Fax: +41 22 791 4834  
Email: [oreillyk@who.int](mailto:oreillyk@who.int)

**Deborah Rugg**

Team Leader, Evaluation

UNAIDS

Tel: 41 22 79 14694

Fax: 41 22 7914746

Email: [ruggd@unaid.com](mailto:ruggd@unaid.com)

**Meeting Rapporteur:**

**Elizabeth McGrory**

24 Second Avenue

Nyack, NY 10960

USA

Tel/Fax: 1 845 353 3973

E-mail: [emcgrory@gmail.com](mailto:emcgrory@gmail.com)



UNAIDS  
20 AVENUE APPIA  
CH-1211 GENEVA 27  
SWITZERLAND

Tel.: (+41) 22 791 36 66  
Fax: (+41) 22 791 48 35

[www.unaids.org](http://www.unaids.org)

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