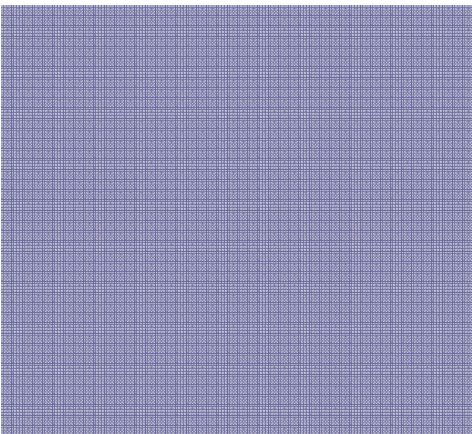
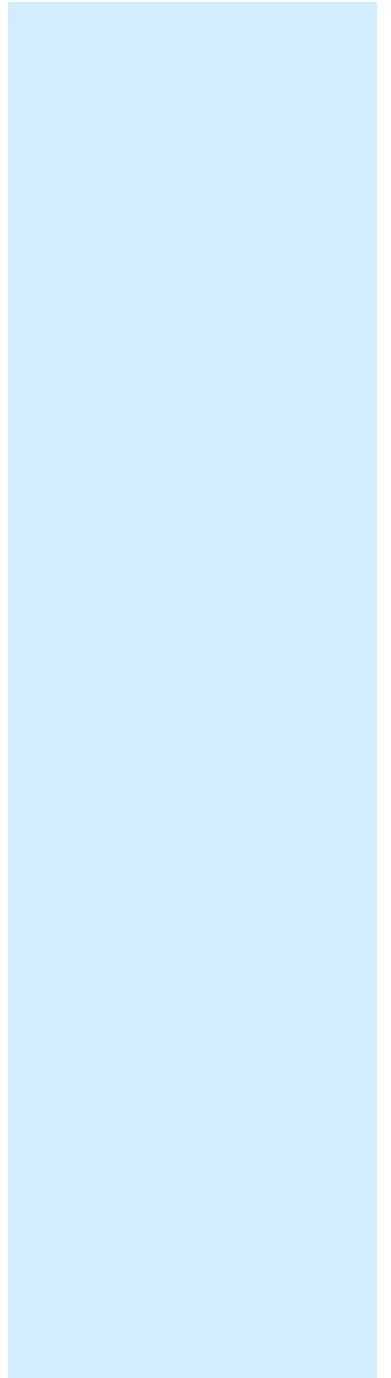
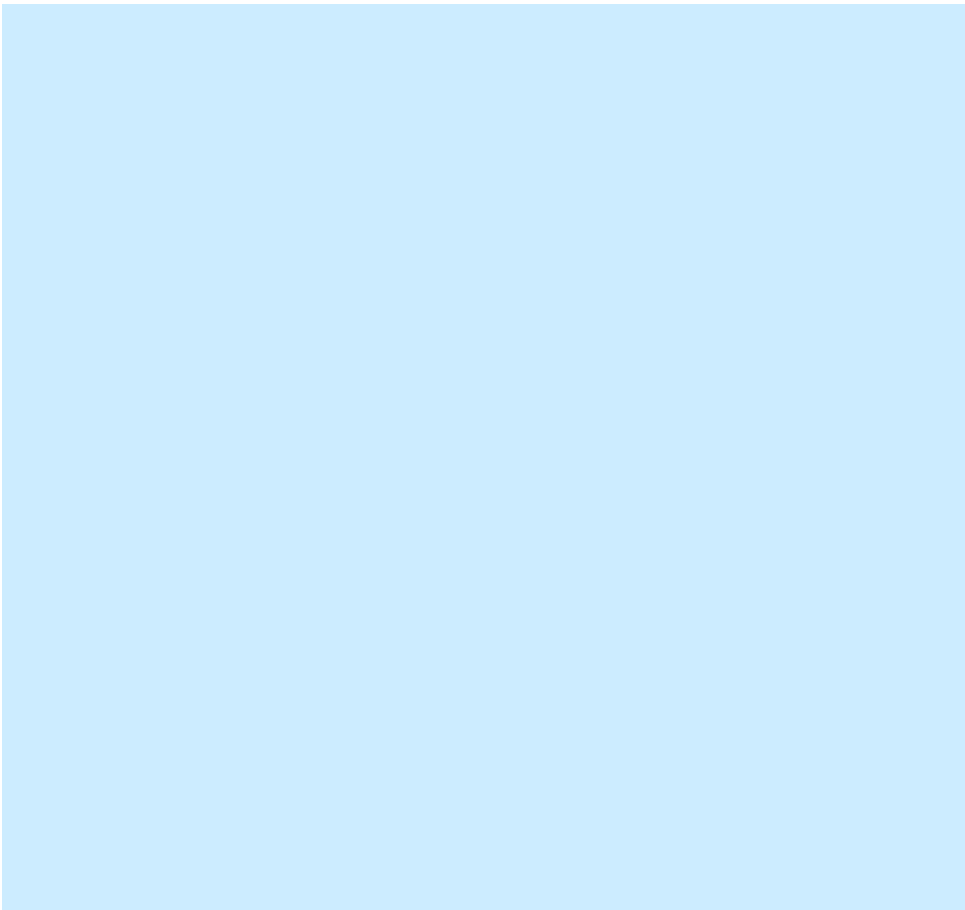




# Report of the UNAIDS HIV Prevention Reference Group Meeting



The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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

Glion, Switzerland

2–4 March 2009

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## Report of the UNAIDS HIV Prevention Reference Group Meeting Glion, Switzerland 2–4 March 2009

### Executive summary

A UNAIDS HIV Prevention Reference Group meeting was held in Glion, Switzerland, from 2 to 4 March 2009. The meeting was attended by specialists from 24 countries, including 34 external experts, five representatives of UNAIDS Cosponsors, a representative of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and six staff of the UNAIDS Secretariat. The chairperson of the meeting was Professor Peter Figueroa of the University of the West Indies, Kingston, Jamaica.

This was the third meeting of the UNAIDS Prevention Reference Group (previous meetings were held in 2005 and 2007). Four key objectives were set for the meeting by UNAIDS:

1. To advise UNAIDS on the next steps in the development of a taxonomy for HIV prevention activities;
2. To advise UNAIDS on ways forward in developing quality standards in relation to HIV prevention activities;
3. To advise UNAIDS on country-level efforts in HIV prevention reorientation;
4. To discuss combination prevention approaches to HIV prevention.

The first two objectives were direct follow-ups to the decisions taken by the Prevention Reference Group at its 2007 meeting, item 3 was in general a follow-up to the UNAIDS prevention policy position paper and prevention practical guidelines discussed at the 2005 and 2007 Prevention Reference Group meetings and item 4 was a follow-up to an ad hoc meeting in January 2008 to review the *Lancet* special issue on HIV prevention.

Prior to arrival at the meeting, UNAIDS had provided the Prevention Reference Group meeting participants with relevant background documents outlining progress by UNAIDS in each thematic area. The meeting itself consisted of plenary discussions and small breakout groups, each tasked with developing workable recommendations to UNAIDS.

The Reference Group concluded the meeting by making the following recommendations:

1. **Taxonomy of HIV prevention activities:** the Reference Group agreed that UNAIDS should finalize a taxonomy (with definitions) of HIV prevention activities, in order to establish a common language and definitions for HIV prevention. The taxonomy should be comprehensive and applicable at the global level, but should not be positioned as providing normative programming guidance or a ‘shopping list of activities’ to which countries should aspire.

It was agreed a small working group of Reference Group members will be convened by the UNAIDS Secretariat to advise on the revision of the draft document presented at the meeting, field-testing of the revised document, finalization and publication. After field-testing, the taxonomy and strategy for promoting its use should be submitted to the Reference Group for input, feedback and endorsement.

The small group would start its work at the beginning of April, should revise the taxonomy by the end of May and will conduct a field test. After field-testing, the taxonomy should be submitted to the Reference Group for endorsement and should be published before the end of June.

2. **Quality standards for HIV prevention:** the Prevention Reference Group agreed that UNAIDS should contribute to improving the quality of HIV prevention by developing a discussion paper on the topic, with inputs from several quality assurance and improvement fields within and outside the AIDS field. The paper should be developed within the next three to four months and should include documentation of quality standards in all areas of the HIV prevention taxonomy, where such standards exist, and should propose the establishment of quality standards for those areas of HIV prevention where such standards do not exist or have no consensus. UNAIDS should also develop strategies to support countries to address quality assurance and improvement in HIV prevention, including tools and technical assistance.
3. **Prevention reorientation and modes of transmission studies:** UNAIDS should be an advocate for the refinement and improvement of modes of transmission methodology and studies, in particular in order to use these studies to provide guidance on aligning HIV responses to the epidemic at the national and subnational levels, and for addressing optimum budget allocations for HIV prevention. UNAIDS should further support countries to tailor and prioritize their prevention responses, including through operational guidance on the integration of prevention, human rights, gender, stigma and care and treatment efforts.
4. **Combination prevention:** UNAIDS should lead the process of defining what combination prevention means. With increasing attention to the population-level impacts of treatment on transmission, UNAIDS should also offer practical guidance on how to develop models that include treatment and prevention, with clear outcomes from both, in different epidemic contexts. UNAIDS should offer specific operational guidance on the integration of programming in relation to stigma, discrimination, gender and human rights with HIV prevention programming, including attention to the relevant evidence bases. UNAIDS should encourage operations research to guide areas still needing clarification or consensus.
5. **Administrative issues:** The UNAIDS Prevention Reference Group was initially established to meet on an ad hoc basis with a changing membership on an issue-specific basis. At the meeting, the views of the participants were canvassed informally on whether there was a need for a continuing group that could provide ongoing advice to UNAIDS and that could be a link between one Reference Group meeting and the next. The UNAIDS Secretariat reported at the end of the meeting that a consensus view of participants was that it would be useful to establish more continuity in Reference Group meetings. UNAIDS will reflect these proposed structural changes in convening the next meeting of the Prevention Reference Group.

# Report of the UNAIDS HIV Prevention Reference Group Meeting Glion, Switzerland 2–4 March 2009

## Session I. Introductions

The third UNAIDS HIV Prevention Reference Group meeting was held from 2 to 4 March 2009 in Glion, Switzerland. It was attended by prevention specialists from 24 countries, including 34 external experts, five participants from UNAIDS Cosponsors, a representative of the Global Fund and six staff of the UNAIDS Secretariat.

The meeting was chaired by Professor Peter Figueroa of the University of the West Indies, Kingston, Jamaica, and was opened by Dr Barbara de Zaluondo, Chief, Programmatic Priorities and Support Division, UNAIDS.

The opening remarks noted that the meeting was being held in the context of a challenge to UNAIDS from Executive Director Michel Sidibé to mobilize and assist countries to achieve universal access to prevention, treatment, care and support by 2010. UNAIDS remains concerned that while significant progress has been made on HIV prevention since the 2007 Prevention Reference Group meeting, many countries still lag behind in their response; indeed, only 10% of countries have prevention programmes that are well matched to their epidemics.<sup>1</sup> The principle of ‘know your epidemic and response’ is now well accepted globally, and the 2007 Prevention Reference Group meeting had agreed that countries were committed to the approach in principle, but a lack of stable definitions and standards in prevention was hampering understanding of their current responses and interfering with documentation and learning from programme experience. The participants agreed that in order to enable countries to align prevention responses with the epidemic scenario, it was important to:

- Develop consensus on what comprised prevention activities (i.e. agree on the building blocks of prevention);
- Harmonize prevention terminology;
- Establish stable and common definitions of HIV activities.

It would also be important to establish quality standards to guide implementation of the prevention activities. These agreements set in motion the UNAIDS initiative to develop a taxonomy and quality standards of HIV prevention activities. The 2009 Prevention Reference Group meeting was convened to review the progress thus far and to offer advice to UNAIDS on the next steps in intensifying HIV prevention.

### *Objectives of the 2009 Prevention Reference Group meeting*

The objectives of the 2009 Prevention Reference Group meeting were:

1. To advise UNAIDS on the next steps in the development of a taxonomy for HIV prevention activities. More specifically:
  - To review, comment and endorse the taxonomy of HIV prevention activities;
  - To recommend a methodology for field validation, dissemination and utilization of the agreed-upon taxonomy.

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<sup>1</sup> UNAIDS analysis. UNAIDS Country Coordinator 2007 country reports.

2. To agree on a method for advancing quality standards in agreed clusters of HIV prevention activities.
3. To review country-level efforts in prevention reorientation and to recommend methods for systematic advancement.
4. To establish a working framework that suits the challenges of combination prevention.

## **Session II. Taxonomy and classification of HIV prevention activities**

### *Update on the development of the taxonomy*

Dr Barbara de Zalduondo provided further background to the genesis of the 2009 Prevention Reference Group. The interest of UNAIDS in establishing HIV prevention taxonomy and quality standards had evolved based on requests by country programmes for tools and guidance for scaling up more effective prevention programmes. The UNAIDS Prevention Policy Position Paper (2005) and the UNAIDS Practical Guidelines for Intensifying HIV Prevention Activities (2007) laid out the framework for HIV prevention, but users also made it clear that more detailed tools were needed. HIV prevention programme planners recognized the need for standard, comparable tools to track and compare their prevention efforts. Development of tools requires standardizing prevention language, due to large variations in the terminologies countries use. For example, the existing lists of prevention activities are not mutually exclusive, but rather focus on various dimensions (principally the activity, audience, setting and/or the objective) or different levels of detail. Consultations<sup>2</sup> had led to the development of two foundational papers whose contents were discussed at the 2007 Prevention Reference Group and which were finalized thereafter, namely:

- Sweat, M. *A Framework for Classifying HIV Prevention Interventions. A Report to the Joint United Nations Programme on HIV/AIDS*. Geneva, UNAIDS, 2008.
- Medlin, C., Balkus, J., Padian, N. *Developing Minimum Quality Standards for HIV Prevention Interventions. A Report to the Joint United Nations Programme on HIV/AIDS*. Geneva, UNAIDS, 2008.

Dr de Zalduondo outlined the subsequent progress of UNAIDS in developing the taxonomy as an exhaustive list of the building blocks that are used, in various combinations, to reduce HIV transmission in national and subnational HIV programmes. She outlined the consultations held to date with implementers, national programme managers, funders and Cosponsors and thanked the many contributors who had brought the work to its current state.<sup>3</sup>

### *How taxonomy relates to funding streams*

Dr Daniel Low-Ber, Director, Performance, Effectiveness and Impact Unit of the Global Fund, discussed the relevance of the taxonomy in relation to the service delivery areas used by the Global Fund in its funding programmes in the scaling up of prevention. As a performance-based grants manager, the Global Fund places a premium on the quality of programmes, as well as on the quality of community engagement. Prevention is a core part of Global Fund support, and countries need better guidance on how to achieve a greater prevention impact. The Global Fund is also focused on shifting to a more programmatic focus; that is, shifting from funding specific services to providing programme support for the

<sup>2</sup> Including consultations with the HIV Monitoring and Evaluation Reference Group.

<sup>3</sup> This progress is further outlined below and summarized in detail in the background papers for the meeting.



response to the three diseases, including implementation to scale and having an impact on the drivers of the disease.

The Global Fund builds on country and partner taxonomies and relies on the countries' own approach on the definition of activities. The UNAIDS taxonomy could potentially improve clarity on service delivery areas. Also, evidence could be measured against the taxonomy. Measuring programme outcomes is central when scaling up to achieve impact, even though there is also a need for information about inputs and outputs, for example on the number of people reached by services and capacity-building. The Global Fund is moving to longer-term financing, which will enable the gathering of better information on the impact of programmes. The Global Fund does not have its own indicators, but works with partner frameworks across diseases and on country proposed indicators and targets.

Besides scaling up, 'scaling down' to communities is also needed in order to improve the impact of programmes. The Global Fund's programmes on malaria have provided good examples of this by showing how getting to the communities and working through the communities may be very effective.

#### *UNAIDS taxonomy*

Michael Bartos, Team Leader of the Prevention, Care and Support Team at UNAIDS, introduced the working group session on the proposed UNAIDS taxonomy (see Annex 3 for the list of activities),<sup>4</sup> noting that it is intended to be a comprehensive and stable list of activities or services that would cover all programmatic and policy activities being implemented for HIV prevention globally.

The steps that UNAIDS had taken to develop the taxonomy were presented. It was noted that the list of activities was initially derived from the UNAIDS Practical Guidelines for Intensifying HIV Prevention and further elaborated in the UNAIDS discussion paper by Michael Sweat. This list was reviewed by various experts and key informants over a six-month period as well as by respondents to the UK National AIDS Manual international survey of HIV service providers. It was also checked against the UNAIDS National Spending Assessment and Resource Needs Model. Finally, it was compared with the national AIDS programmes of five countries (Guyana, India, Mozambique, Peru and Ukraine) in order to identify any missing HIV prevention activities and to see how well the activities identified in the draft taxonomy matched the activity descriptions of these national programmes.<sup>5</sup> Based on these processes, a total of 31 activities were identified, which comprise the current UNAIDS taxonomy list.

Michael Bartos emphasized the difference between the taxonomy and the practical guidelines programming guidance, stressing that in HIV prevention programme design each activity or service would be designed for a particular population, delivered in a particular setting and intended to achieve particular outcomes, alone or in combination with other activities. The draft UNAIDS taxonomy document illustrated this, providing lists of populations and settings

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<sup>4</sup> UNAIDS. *UNAIDS Taxonomy of HIV Prevention Activities*. Discussion draft for UNAIDS HIV Prevention Reference Group meeting, 2–4 March 2009. Available at: <http://ews.unaids.org/public/PRG/Documents/>.

<sup>5</sup> UNAIDS. *Background Note on Development and Application of UNAIDS Taxonomy for HIV Prevention for the UNAIDS HIV Prevention Reference Group Meeting*, 2–4 March 2009. Available at: <http://ews.unaids.org/public/PRG/Documents/>.

where activities are delivered, together with some example of outcomes to which activities are directed, using examples drawn from the strategy or design documents of the five national HIV programmes.

#### *Discussion*

During the discussion, participants noted that consensus on intensifying HIV prevention had been hampered by its complexity and multidimensional nature and agreed that a common language about HIV prevention was essential. Participants acknowledged that the taxonomy may never be perfect, but that it was an important start. They also noted that the taxonomy is not intended to provide normative guidance on what to programme in HIV prevention responses, but rather to facilitate programme planning so that planners and implementers would 'talk the same language'.

#### *Working groups*

In order to review various aspects of the taxonomy, participants were assigned into five working groups, as outlined in Table 1.

Table 1  
**UNAIDS taxonomy: questions for the breakout groups**

Group	Guiding questions
Group 1. Audience and settings	<ol style="list-style-type: none"> <li>1. Are the generic activities in the UNAIDS taxonomy the ones you are familiar with?</li> <li>2. Are there any gaps in the UNAIDS taxonomy? In other words, are the activities listed necessary and sufficient to cover the audiences and settings? Do they adequately cover the biomedical, behavioural and structural activities?</li> <li>3. Is the language used to describe the generic activities one that people are familiar with? Are the terms non-technical enough?</li> <li>4. What could be done to make the taxonomy more useful?</li> <li>5. Do you have any other comments? What was the issue and what is the resolution?</li> </ol>
Group II. Outcomes: enabling environment	Same as the above
Group III. Outcomes: individual, biomedical and behavioural	Same as the above
Group IV. Utilization: national programmes	<ol style="list-style-type: none"> <li>1. Is the UNAIDS taxonomy comprehensive enough for national programmes? If not, what are the gaps?</li> <li>2. Who are the stakeholders for the taxonomy for national programmes? Why are these the stakeholders and how would they use the taxonomy at the national level?</li> <li>3. What is the appropriate strategy to reach these stakeholders? What should UNAIDS do to get the taxonomy into their hands? What should be the role of UNAIDS in relation to disseminating the taxonomy for maximal use by these stakeholders (e.g. UNAIDS country coordinators hold seminars, raise money, work with technical support faculties, country coordinating mechanisms and national AIDS commissions)?</li> </ol>
Group V. Utilization: other consumers	<p>Same as the above with the omission of question 1 and the addition of the following question:</p> <ol style="list-style-type: none"> <li>1. Is the UNAIDS taxonomy comprehensive enough for these consumers? If not, what are the gaps?</li> </ol>

*Plenary feedback from the working groups*

After debate and detailed discussion about the taxonomy in the breakout groups, the participants presented the following points:

1. The purpose of the taxonomy needs to be clarified; especially to ensure that it does not exceed its mandate (i.e. carry more weight than it can) and in particular that it not be taken as a programming tool, which it is not its intention. The taxonomy is not a programme guide, but its tables on outcomes, audiences and settings appeared to move it towards it. The participants felt that the taxonomy should not only be clear on its purpose, but be just as clear on what it does not intend to do.

2. The taxonomy also needs to be structured and shortened by grouping linked activities together. Some proposed ways included to:
  - Distinguish between the various tools (e.g. prevention tools, promotion tools, etc.) and how we disseminate or use them (e.g. through the mass media).
  - Distinguish between whether the focus is on individuals or groups (mass media, education) or on creating an enabling environment.
  - Have activities grouped based on how proximal or distal they are to HIV outcomes.
  - Combine some of the activities in related areas (e.g. pre- and post-exposure prophylaxis, blood safety and screening of sperm donations as biomedical interventions).
  - Use risk factors and drivers as the basis of the classification.

Group IV presented a possible structure for the participants to discuss, as follows:

- Public health activities:
    - Biomedical, for example male circumcision, condoms, testing and counselling, etc.;
    - Education, for example sex, life, HIV;
    - Communication—mass, small group, interpersonal.
  - Community activities:
    - Mobilization;
    - Traditional and folk media.
  - Structural activities:
    - Income generation;
    - Economic support;
    - Legal reform and support;
    - Policy reform;
    - Gender;
    - Stigma and discrimination.
  - Cross-cutting activities:
    - Programme design—know your epidemic and response;
    - Monitoring and evaluation;
    - Quality improvement;
    - Programme management;
    - Research to practice.
3. The taxonomy should also be made more user-friendly (e.g. include electronic presentation with drop-down lists of subcategories, ensure it is clearly linked to, or lodged within, the programming guides that inform national prevention strategies).
  4. There is need for clear definitions for the activities. The definitions need to be generic enough to accommodate appropriate cultural and regional differences.
  5. There is need to include in-country discussions in the development of the taxonomy and the formulation of the definitions.
  6. There is a need to be clear about the audience for the taxonomy—who are its intended users?
  7. Use of the term ‘taxonomy’ itself was queried, as taxonomies include some hierarchy, and there was some suggestion that the list would be more appropriately called a ‘glossary’, or prevention activities.

8. A few activities were found missing: nurturing and support, building social capital and some promising but still experimental services (viz. HIV microbicides, vaccines).
9. The development of the taxonomy was seen as a good idea and it brought added value because it:
  - Standardizes prevention language at the international, national and community levels;
  - Can be used to improve documentation and comparison of best practices;
  - Helps in the role definition of players;
  - Could be used as a basis for identifying evidence gaps.

The following concerns were raised:

- a. The evidence base for the inclusion of specific activities was not provided, for example the evidence for sexually transmitted infection diagnosis and treatment as an HIV prevention strategy. The absence of evidence (as opposed to evidence of ineffectiveness) could be grounds for advocating for evaluation and research.
- b. The taxonomy is inappropriate as a stand-alone document; there is a need to cross-reference with other UNAIDS and related guidelines. One suggestion was to publish it as an annex to the Practical Guidelines for Intensifying HIV Prevention. As a stand-alone guide, participants felt it could potentially do harm because:
  - It could be seen by stakeholders as a shopping list of endorsed HIV prevention programmes;
  - Branding it as a UNAIDS publication will give the document gravitas and it will be perceived as normative, as the UNAIDS brand carries weight and authority (members felt that it was written as an ‘endorsement’ of each of the listed activities).
- b. The listing of illustrative outcomes—intended to illustrate the diverse potential uses of each activity—needs to be revisited and perhaps taken out of the document. The listed outcomes, which were drawn from the five country strategies, are at various levels, for example ‘reducing HIV incidence’ is on the same level as ‘overcoming denial’. Several outcomes overlap, making monitoring and evaluation of the resulting programmes challenging. If this table is to be included with the taxonomy, spelling out the causal chain could offer some clarity on how the outcomes link to activities.

### *Discussion*

There was vigorous debate on the nature and use of the taxonomy, although in conclusion participants agreed that the taxonomy was a good idea. They found its language simple and easy to understand. They recommended that UNAIDS refine and strengthen the list in consultation with key players and develop specific definitions of the activities (a detailed glossary). UNAIDS should also pilot-test it, develop a marketing plan for it and evaluate its implementation over time.

### *Conclusions*

Michael Bartos summarized the discussion and the next steps as follows:

1. There is a need for a common language to advance prevention, including gathering knowledge/data about prevention.
2. The activity/service list is useful as a glossary.
3. A set of short definitions of each activity/service needs to be added to the list.
4. The product should not be a stand-alone document, but a component of existing ‘know your epidemic and response’ programming guidance (e.g. the Practical

- Guidelines) that advises countries to focus on their epidemic, drivers and the people most vulnerable and at risk.
5. In the programming guidance package, the list of activities and definitions needs to be related to other documents: for example, monitoring and evaluation and indicator guides, programming guides (e.g. electronic toolkit).
  6. It may be useful to add higher-level clustering or ordering of the list, if that clustering helps resolve conceptual problems (e.g. tools versus delivery modes).
  7. Its use in relation to its primary stakeholders needs to be clarified.
  8. The UNAIDS Secretariat will conduct a structured discussion with key stakeholders, namely:
    - a. Affected communities;
    - b. Major funders;
    - c. Country programme implementers;
    - d. Normative guiders.
  9. On the basis of this structured discussion, the taxonomy/glossary will be issued as a field-test draft, with feedback gathered by users over an 18-month period.
  10. There is a further task in relating programme activities and their evidence base to outcomes. This is not a task for the taxonomy, but is a task for the Reference Group and its partners.

### **Special dinner guest speaker: Roger Staub, Swiss AIDS programme**

The 2009 Prevention Reference Group meeting was addressed by a dinner speaker, Roger Staub, Director of the AIDS Unit of the Swiss Federal Office of Public Health and National HIV/AIDS Programme Manager for Switzerland. He discussed the evolution of the HIV epidemic among different population groups in Switzerland and presented the Federal Government's HIV prevention response targeted at the general population, at the three most affected populations and at stable serodiscordant couples. He also discussed specific Swiss behaviour campaigns, including their successes and failures. He discussed the 2008 communication by the Swiss national AIDS commission on the non-infectiousness of people living with HIV with a fully suppressed viral load, adherent to treatment and in the absence of any sexually transmitted infection.

The presentation was discussed by Susan Kippax, Professorial Research Fellow at the National Centre in HIV Social Research, University of New South Wales, Australia. She reflected that Australia had been facing rather similar epidemics to that of the Swiss and had developed a similar response. Characteristics of the response had included acting quickly on rolling out prevention programmes for specific populations and having a strong bottom-up approach.

During the discussion session, participants sought to know more about the Swiss statement on non-infectiousness, HIV testing and prevention for people living with HIV, as well as adaptability of lessons learned to other regions of the world and the caution needed in doing so. It was noted that even context-specific policies such as the Swiss statement can spread widely and trigger strong and sometimes unexpected reactions in countries and communities. Examples included varied reactions around non-infectiousness among individuals with an undetectable viral load, and comparisons were drawn with communication around the

UNAIDS/WHO male circumcision guidance, which had presented considerable challenges in Brazil.

Participants warmly thanked Roger Staub for his stimulating presentation.

### **Session III. Quality standards for HIV prevention**

The second objective of the 2009 Prevention Reference Group was to give UNAIDS advice on how to approach the process of developing the quality standards associated with each HIV prevention activity and on the level of detail at which UNAIDS should promote attention to quality. This session was chaired by Professor David Serwadda, Dean of the School of Public Health, Makerere University, Uganda.

#### *Background*

Michael Bartos started the session with a brief overview of the progress UNAIDS had made since the 2007 Reference Group meeting. UNAIDS had commissioned a background paper on *Developing Minimum Quality Standards for HIV Prevention Interventions* for the 2007 meeting. This paper was finalized and published in 2008. The next stage was to issue an expression of interest on the establishment of expert groups for the development of quality standards on various areas of HIV prevention. This call for expressions of interest resulted in only one funded activity, in which the Asia–Pacific Institute for Broadcasting Development developed quality standards on mass media. A pre-publication draft of the results was made available to the meeting participants.<sup>6</sup> More generally, UNAIDS commissioned a desk review of quality standards for HIV prevention, identification of some helpful material in the literature and interviews with key informant practitioners on quality standards, including what types of quality standards they have and whether they use them. The result of this process was summarized in the third background document for the meeting.<sup>7</sup> Michael Bartos noted the large range of current approaches in quality standards for HIV prevention, with some clinical HIV prevention services (e.g. blood safety) having comprehensive and detailed guidelines, while others, in particular social and behavioural prevention activities (e.g. community mobilization), have virtually none. UNAIDS was seeking guidance from the Reference Group on how elaborate the UNAIDS quality standards ought to be, and on what aspects they should concentrate on.

A series of presentations was made to share different experiences and approaches to programming quality that UNAIDS could draw on.

#### *Presentation 1: Nancy Padian*

The first presentation was by Professor Nancy Padian, who was one of the co-authors of the papers commissioned for the 2007 Reference Group meeting (cited above). Professor Padian noted that to assess the quality of HIV prevention, expected outcomes have to be very clear.

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<sup>6</sup> *Minimum Quality Standards for HIV Communication Activities Undertaken by Media: Requirements for Radio, TV Broadcasters, Internet Content Producers and the Press*. Pre-publication document.

<sup>7</sup> *Developing Minimum Quality Standards for HIV Prevention. A Background Discussion Paper for the UNAIDS Prevention Reference Group Meeting, Glion, Switzerland, March 2009*. Available at: <http://ews.unaids.org/public/PRG/Documents/>.

“Quality is defined by outcomes”, she said. For the previous meeting of the Reference Group she had developed a framework for planning and evaluating behavioural interventions, including pre-implementation and implementation phases and measuring impact and outcomes. Quality is relevant in all aspects and levels of the framework and comparability across programme settings is critical. Real-time feedback loops are essential to ensure that quality can be improved in a timely manner.

Levels of evidence vary between different HIV prevention activities (Figure 1). There is a moral imperative to collect data on the effects of what is being done and to use evaluation feedback for quality improvements. As there is no perfect evidence, however, there is a need for ways to work in the absence of perfect data.

Levels of outcome or impact vary, and they may be environmental, cognitive, attitudinal or affective, or behavioural or biological.

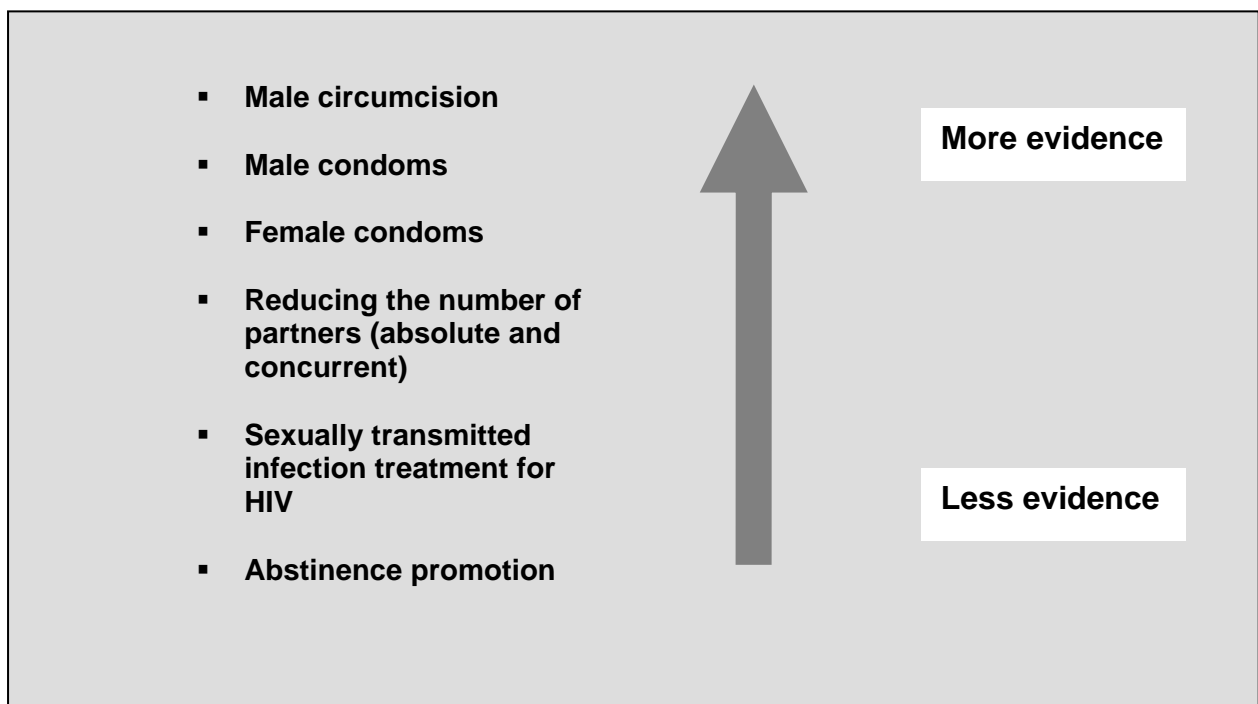
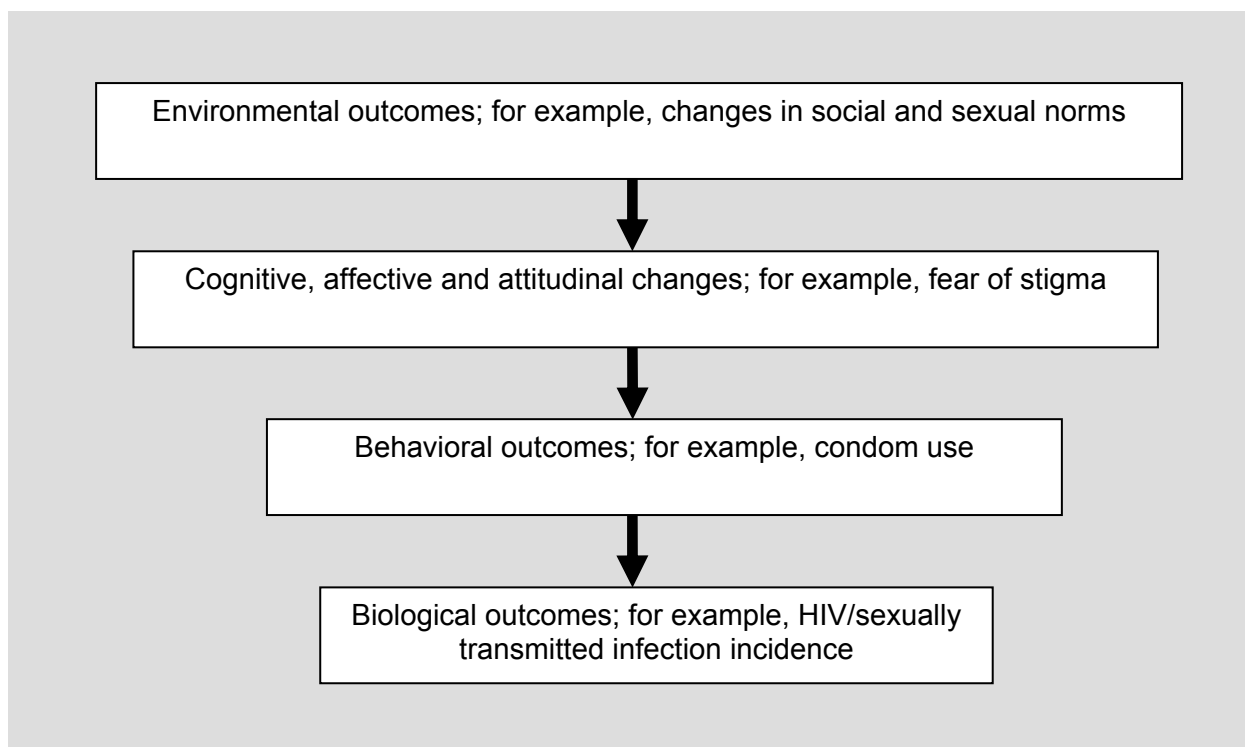


Figure 1. Levels of evidence for HIV prevention.

Professor Padian noted that the levels of outcomes can be viewed in a causal cascade that can provide entry points for assessing quality; for example:





It is widely accepted that there is no single magic bullet to eliminate the need for HIV prevention, but there is a need for combination packages that address the different linked levels in the chain, and these need to be evaluated. The paper that she wrote with C. Medlin and J. Balkus confirmed there is a big difference on what researchers and programme implementers look for in ‘quality’: the former focusing on effectiveness and retaining a sceptical position on interventions that demonstrate only behaviour outcomes. Implementers tend to focus on standard operating procedures and often assume that if the guidelines are followed, the outcomes will be achieved. Even when effectiveness data are available, political and social considerations have important effects on decision-making, and these can make some cost-effective interventions hard to promote.

*Presentation 2: contemporary issues in quality standards*

Dr Bruno Bouchet from Family Health International spoke about quality standards from the standpoint of quality improvement in clinical services. He distinguished between programme standards and service standards. Programme standards can help an HIV prevention programme determine which interventions should be implemented and put in place the conditions of its implementation. Service standards describe how a service should be delivered to optimize results. Some of the main issues with quality standards that Family Health International had encountered were that there is no common understanding of what standards are. Standards do not exist a priori: they have to be developed. Good standards are: realistic, reliable, valid, clear and measurable. He also noted that practitioners often overestimate their capacity to judge their own standards. In general, standards may vary in their level of detail, as this depends on their purpose and on their users. Once standards are established, job aids are needed to enable the staff to perform to standards. These are some of the reasons why there is a wide variation in how standards are applied.

The quality improvement model used by Family Health International is intended to create a dynamic of improvement in a system, rather than to focus on static standards. By testing changes in a system, it allows teams of service providers and their clients to identify best

practices. It generates knowledge about the behaviour of systems and people. The positive results of quality improvement changes induced in a system were presented in relation to a tuberculosis pilot project in Senegal. Dr Bouchet acknowledged that the challenges in behavioural interventions are greater, as the links between process and outcomes may be varied, weak and inconsistent—and a behavioural intervention can work well in one setting but not in another that is apparently similar. Nevertheless, the experience from HIV and tuberculosis treatment indicates that quality improvement methods should be able to provide considerable improvements in service coverage and efficiency for HIV prevention programmes.

*Presentation 3: quality in prevention. Examples from Germany*

Dr Christine Winkelmann from the Federal Centre for Health Education introduced some examples from Germany related to the quality of HIV prevention. She emphasized the need for systematic quality assurance and improvement to ensure effective prevention and the importance of sharing experiences. Her office is presently in the process of developing minimum standards for sexuality education, in order to respond to challenges such as the high rates of sexually transmitted infections and the termination of pregnancies in many European countries. This is being done in collaboration with WHO/EURO. The standards will include central topics, principles and aims and will be transferred to other countries from those where they were initially developed. In addition, the Federal Centre for Health Education and the Eppendorf University Medical Centre in Hamburg have developed a quality improvement project that is currently used in prevention and health promotion projects but is also planned to be piloted for HIV prevention in 2009. Dr Christine Winkelmann's office is also involved in a participatory quality development, which is being used in many HIV facilities. Like Family Health International's approach, this approach is designed to support performance improvement, tailored to the local situations, with strong participation of target groups and front-line workers and building on practice-based evidence.

*Presentation 4: health promotion competencies, standards and accreditation*

Barbara Battel-Kirk of the International Union of Health Promotion and Education concentrated her presentation on the relationship between competencies and standards in health promotion, including the differences between competencies and skill standards, their uses, processes of development and domains of core competencies. Quality standards are part of a system that includes the development of staff competencies, in order to perform at the expected standards, and accreditation—a system to evaluate competencies, confirm them and award recognition based on some agreed-upon criteria. The pros and cons of competency frameworks were stated to be:

Pros:

- Useful as a shared/agreed language for defining the tasks, skills and knowledge required for adequate practice and the boundaries of professions;
- Helpful in developing programmes and projects, curriculum development and recruitment and selection;
- Can contribute to defining and defending a discipline.

Cons:

- Can be restrictive, reductionist or mechanistic, and therefore will not allow for the dynamic nature of health promotion practice;
- Can limit innovation, advocacy and political aspects;

- Can undervalue professional judgement and experience;
- Can undervalue or disregard ethic values and principles.

Ms Battel-Kirk proposed for UNAIDS a model to link competencies and standards to the components of the prevention taxonomy. She also proposed for UNAIDS to work with and build on what already exist in relation to the quality of prevention. She finished her presentation by raising several questions that emerge from the development of quality standards, questions that UNAIDS would need to address as its quality standards work evolves. These include:

- Whether competencies and/or standards improve practice or impose limitations on creativity and advocacy.
- Who can/has the right/mandate to develop competencies and/or standards?
- Who evaluates, or what control is there over, those who do not comply.
- How to develop shared competencies for diverse groups—contexts, cultures, levels of engagement, availability of resources/education, etc.
- Where is the ‘user’ or ‘client’ voice?
- Who is going to resource these developments?

*Presentation 5: the Global Fund to Fight AIDS, Tuberculosis and Malaria*

Dr Daniel Low-Beer spoke about the importance to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) of quality standards. The Global Fund has eight to nine quality categories for its grants, but they are in the very early stages of development. They focus on three areas where quality needs to be built: quality of services; quality of engagement; and monitoring and evaluation.

Global Fund grants do not prescribe quality standards to countries, but support countries to ensure that their priorities are built on knowing their epidemic and on country ownership. Countries determine their own programmes. Therefore, for example, the full list of taxonomy activities presented at the Reference Group meeting need not be included in all country programmes, but the right combination, depending on the country realities, should be included.

The Global Fund believes that it is essential to strengthen community engagement. Quality of community engagement relates to a number of issues, including: (a) vertical political communication on HIV; (b) horizontal community mobilization and networks; (c) care networks; and (d) networks of people living with HIV. This engagement is as important as local surveillance and analysis for ‘knowing your epidemic and response’. By strengthening the quality and quantity of community engagement, support and ownership of HIV prevention would be more likely to grow, and therefore lead to the programmes having a greater impact.

*Presentation 6: UNAIDS*

Dr Barbara de Zaluondo from UNAIDS cited a theme from the UNAIDS 2008 *Report on the Global AIDS Epidemic*, noting that the discussion of quality includes two dimensions: whether we are ‘doing the right things’ and whether we are ‘doing things right’. A third issue involves ‘doing things to the right scale’ (i.e. enough to make a difference). Quality standards on prevention also apply to the cross-cutting principles of human rights, gender and involvement of affected communities. These principles are core quality criteria for all programming that UNAIDS endorses, and mainstreaming them into programmes provides

important criteria for assessing the quality of HIV prevention services and policies. If these principles are not well reflected, then a programme's standards can be considered to be deficient. UNAIDS promotes inclusion of these cross-cutting disciplines into HIV prevention responses.

UNAIDS considers gender to include women, men, men who have sex with men and other sexual minorities. UNAIDS also considers that a human-rights-based response should include the following core elements:

1. Participation, inclusiveness, transparency and accountability;
2. Content that gets to the heart of the issue—enabling people to access all the information that is pertinent to their situation, whether it is politically comfortable or not;
3. Reaching out to ensure the engagement of people who are most vulnerable.

The quality of engagement is crucial, but is at present not adequate or adequately funded. Yet, often the constraints on effectively designed and implemented prevention responses are not technical, but political or structural. This varies from country to country and therefore the responses need to be tailored, but UNAIDS stresses that gender equality, human rights and participation of affected communities are not just principles: national programmes can and should fund HIV programmes that promote gender equality, access to justice and the end of HIV-related stigma and discrimination.

#### *Presentation 7: Swaziland*

Mr Khanya Mabuza from the National Emergency Response Council on HIV/AIDS, Swaziland, discussed how his country applies quality standards to HIV prevention. Swaziland has completed a modes of transmission study in order to understand its epidemic. The country has defined a national approach to ensure quality standards are established, but this is in its early stages. The road map for the establishment of quality standards will include a regional strategy, regional monitoring and evaluation indicators, development of a results-based national strategic framework and a prevention strategy and guidelines. The process was initiated due to the finding that HIV prevention scale-up was lagging behind and realization that there is a need to re-examine their epidemic in order to respond appropriately. In addition, recent years have seen considerable interest in HIV prevention, and this has led to recognition that programmes lacked tools to measure quality. Swaziland is placing special attention on the importance of coordination, standardization and harmonization of prevention programmes and has recognized that these need to be strengthened and be evidence informed.

#### *Discussion*

During the plenary discussion, Reference Group participants noted that HIV prevention includes a complex set of actors (people, programmers) and activities (biomedical, behavioural, structural) and that what needs to be done is complex. Programmes have sometimes approached prevention in a unidimensional, simplistic way, yet a combination of strategies is needed. The discussion covered a number of additional points, including:

- Affirming that essential criteria of quality include respect for human rights, gender and engagement of affected communities.
- Having a clear picture of capacities and competencies is central to quality issues, especially when scaling up.
- Quality of design and quality of implementation are both important contributors to effectiveness.

- There is insufficient evaluation information and a wider range of research models exists than is typically considered.
- There are some quality standards that exist but are not being used: why?
- There are existing methods that allow real-time feedback to influence what is being done.
- Many donors are interested in monitoring and evaluation, but quality aspects of prevention have been invisible. Measures of quality should be built into funding proposals.
- The framework for standards needs to make clear the chain:  
Taxonomy → definitions → protocols → evaluation agenda of package
- Both the effectiveness and the implementation fidelity aspects of quality relate to the causal chain between interventions and outcomes.
- There is a need for quality standards for community engagement and for services.
- UNAIDS could learn more about quality standards from other disciplines. For example, the Roll Back Malaria Partnership or the Stop TB Partnership could provide examples of what could be reached through the development of clear guidelines.

### *Conclusion*

Following a wide-ranging discussion, the participants sought to determine a practical way forward in advancing a quality agenda, given the very different perspectives and approaches that emerged on the issues. It was proposed that a small expert group, drawing on the presenters and participants at the Reference Group, could be engaged to write a discussion paper for UNAIDS to circulate in order to develop a common language and understanding around issues of quality in HIV prevention. This expert group, and the recommendations in the paper, could be used to advance quality improvement processes with a wide range of partners.

### *Recommendations*

The following recommendations emerged:

1. The quality of HIV prevention should be further addressed through UNAIDS convening an expert working group on this topic to discuss the subject in sufficient depth.
2. The quality of HIV prevention incorporates multiple dimensions. Therefore it may be prudent for UNAIDS to select a few dimensions and start with those, rather than attempt to develop quality standards for all dimensions of all activities in the taxonomy. This is particularly important, since the development of quality standards then necessitates the development of indicators for these standards, adding to an already complex data collection process at the service delivery level.
3. UNAIDS should define principles for quality standards for HIV prevention that:
  - Are adaptable to different countries;
  - Make distinction between quality standards, quality assurance and quality improvement;
  - Include quality processes for community engagement and services;
  - Utilize lessons from other fields such as the Stop TB Partnership, the Roll Back Malaria Partnership, sexuality education and health promotion;
  - Do not compete with existing evaluation tools but rather coordinate with what is being overseen by the UNAIDS Monitoring and Evaluation Reference Group;
  - Build on what already exists, including what was presented during the meeting.

## Session IV. Modes of transmission

### *Introduction*

The session was introduced by Dr Karusa Kiragu, Senior Prevention Adviser, UNAIDS, Geneva. She noted that many countries did not yet have sufficient and evidence-informed alignment between their epidemic and their response. In particular, few countries have incidence data and therefore are not adequately aware of the changing nature of their epidemic. The modes of transmission studies were designed to contribute to HIV prevention planning in countries. They began in June 2007 and are now in various stages of finalization. Thus far they have been implemented with broadly similar methodologies in Bangladesh, China, Kenya, Lesotho, Mozambique, Nigeria, Swaziland, Thailand, Uganda and Viet Nam. They have received technical support from various partners, including national governments, UNAIDS, the World Bank, the Centers for Disease Control and Prevention, the United Nations Children's Fund, the United Nations Population Fund and international nongovernmental organizations.

Three modes of transmission studies were presented at the 2009 Prevention Reference Group meeting as an illustration of the kind of information that can be generated to guide HIV prevention programme assessment and reorientation.

### *Country presentation: Lesotho*

Motlalepula Khobotlo informed the participants how Lesotho's modes of transmission study had been conducted and summarized the findings and recommendations derived from the study. The study included epidemiological review, incidence modelling, review of prevention policies, response and strategic information and review of prevention resources. Risk factors for new infections were examined at the individual, community and structural levels. Key drivers of the epidemic were identified as low male circumcision, multiple and concurrent partnerships and poor targeting of key population groups. Funding assessment showed that only 11% of funding was spent on prevention, even though prevention was considered as a priority. Key recommendations from the study included the urgency of promoting partner reduction in the context of multiple and concurrent partnerships, scaling-up adult voluntary male circumcision, addressing social norms that fuel the epidemic and generating the necessary data to fill in the gaps identified in the modes of transmission study, such as men who have sex with men.

### *Country presentation: Nigeria*

Dr Joseph Nnorom presented the preliminary findings of Nigeria's modes of transmission study. Nigeria is a big country that has epidemics of different stages in various parts of the country, thereby necessitating varying regional responses. Previous behavioural surveillance data informed the current modes of transmission study, and validation of the results of the study and the earlier data show similar trends, providing credence to the study's findings. One significant finding of the study was that 3% of the population contributes to 25% of new infections in Nigeria. Almost 35% of new infections occur among individuals with low-risk behaviours, where their condom use is only 3%. Emerging recommendations include targeting high-risk groups and their partners with high-impact prevention interventions, including HIV counselling and testing. However, the data also demonstrate the need to sustain prevention efforts among low-risk groups, including promoting condom use and strengthening couple counselling and testing. Nigeria also identified the need to urgently implement surveys that can quantify populations at risk, in order to assess the magnitude of the challenge.

### *Country presentation: Thailand and the Asian Epidemic Model*

Dr Wiwat Peerapatanapokin discussed the epidemics in Thailand and Asia using integrated analysis and advocacy and the Asian Epidemic Model. This is a mathematical process model that replicates the transmission dynamics and calculates infections among different populations and routes of transmission over time. As the most effective components of the response vary by epidemic stage, the analysis provides essential information to inform programme planning and advocacy efforts. Integrated analysis also looks at what is driving the epidemic, where prevention should be focused, what are the impacts of the epidemic and what needs to be done to mitigate those impacts. The Asian epidemic remains focused in high-risk populations and their partners. Focused prevention efforts can avert or reverse the epidemics, and Asian epidemics can be controlled, but it takes courage to make the right choices.

### *Discussion*

The chairperson of the session, Dr Peter Lamptey, led the discussion and noted the value of these studies. For example, he noted the benefit of the Lesotho study, which had tried to confront some weaknesses of the HIV response, mentioning the small amount of funding allotted to prevention. The analysis provided a credible basis on which the Lesotho programme could then advocate for further funding. Participants for the most part agreed and felt that UNAIDS should continue its support and advocacy for the modes of transmission studies.

Participants noted that the modes of transmission studies were useful because they increased understanding of where the infections come from now, by providing evidence on where to shift attention and by confirming or discrediting assumptions and thereby providing facts for advocacy. The studies had also identified data gaps and highlighted the need to collect further information for fully evidence-informed responses. Two of the presentations had very little information about the nature of the prevention activities that were under way (what activities, where, for whom). The modes of transmission study from Thailand demonstrated the dynamic nature over time of the HIV epidemics and the need to shift and tailor these responses to the evolving epidemics.

Participants discussed how results would vary where different definitions applied; for example, whether transactional sex was included as commercial sex or casual sex, or if transgendered persons were counted as men who have sex with men. Concerns were also raised about the adaptability of the epidemiological model to different epidemics, and it was also stated that the model is being improved to be adaptable to different country situations.

Participants appreciated that the modes of transmission models' results depend entirely on the data inputs and on their quality. Some countries have become aware from the modes of transmission analysis that there is a need to generate those missing data, for example on the number of men who have sex with men in some southern African countries. Where some data have been missing there is a need for extra caution on using the results; for example, policy briefs need to be nuanced so that results would not be misused to stigmatize or blame already vulnerable groups. When developing models it must be kept in mind that the models are not only about a virus but also about people, and that the results might have negative impacts, such as blaming or increasing stigma towards certain populations.

Besides missing information, it was mentioned that there has been some conflicting evidence, for example on how women have been reporting multiple concurrent partners in different surveys in Kenya and Lesotho. In the countries where risk is biggest in monogamous couples, it would add value to know where the infection came from and to know for sure which infections are really new.

It was also observed that the modes of transmission studies demonstrated the utility of the taxonomy, as when it is in use it will be possible to define prevention programmes in a uniform and consistent manner. Having consistent descriptions and terminologies could enable better comparisons between countries, as well as examining trends within countries over time. It would also provide a stronger foundation for advocacy and funding requests, since they would be based on an accepted and established language not only on the epidemiological situation but also on what to do for those most at risk to reduce further transmission. In addition, having established quality standards would enable future modes of transmission studies to know whether interventions were administered in a quality fashion; that is, 'whether the right things were done right'.

## **Session V. Combination prevention**

The purpose of this session was to discuss a functional framework that suits the challenges of combination prevention. Five brief presentations were made examining different aspects of the concept of combination prevention and drawing out implications for HIV prevention intensification.

Professor Alan Whiteside presented the issue of combination prevention using an economics lens. He noted that HIV infectivity varies depending on the viral load and that the highest load is immediately after infection and immediately preceding death. He noted that in countries like Swaziland hard decisions will need to be made about treatment as more and more people become infected. A population-based campaign promoting a three-month abstinence period nationwide could choke off acute-phase transmission, reducing transmission considerably. This could be an important approach in light of the present economic climate and the likelihood that it could affect the government's ability to afford treatment.

Michaela Clayton of the AIDS and Rights Alliance for Southern Africa in Namibia discussed the essential role of human rights in combination prevention. She recommended greater interaction with the Human Rights Reference Group, while noting that HIV responses should address human rights concerns in three ways:

- a. Participation, inclusion, non-discrimination and accountability, incorporating these in the planning and implementation of all HIV programmes.
- b. Emphasis on ensuring that the most vulnerable and at-risk benefit.
- c. Specific programmes to support human rights:
  - i. Legal support;
  - ii. Legal audits/law reform;
  - iii. Know your rights;
  - iv. Training of law service providers;
  - v. Stigma reduction;
  - vi. Gender inequality.



Dr Mariangela Simao gave an overview of Brazil's HIV epidemic and of how combination prevention had been implemented and worked in the country. Brazil is the largest country in South America and has drastic regional differences, which influence the trends of the epidemic. There have been a number of achievements over the past several years, for example very high levels of HIV knowledge, condom use and testing coverage. However, there have been some setbacks, such as an increased HIV incidence among young men who have sex with men. Brazil's approach is a mixture of prioritizing and universalizing the prevention response and using a combination of prevention strategies. It is also based on integrating treatment and prevention. Dr Simao emphasised that knowing your epidemic is not enough: there is also a need to act on it and build strong political will. She gave some insight into the "daily struggle" that is required to sustain the Brazil success story and warned that there is never any room for complacency.

Professor Marie Laga spoke about the importance of prevention and about what it takes to strengthen it. She argued that HIV prevention requires radical, not subtle, behaviour change. To achieve that radical change, combination prevention is essential. Prevention programmes can do better if comprehensive programmes are implemented in scale and if there is a strong demand for an ongoing strategic approach to reducing incidence. Prevention science needs to do better by aligning with programmatic needs and contributing more programme evaluations to the evidence base. In the absence of perfect evidence other arguments can be used to prioritize interventions, including the potential impact, other health benefits and common sense. Buy-in and involvement of communities as well as leadership from all levels is also required.

### *Discussion*

During the following discussion the meeting was reminded that the message to the outside world should not be only about prevention failures but should be balanced to discuss successes as well, as there are very clear examples of where and how prevention has worked. Prevention programmers must not yield but must keep forging ahead. Participants also discussed the pressure for instant results, which are often requested by donors, and often seeking results that may not be achievable by isolated or distal activities ("leaflets don't lower incidence"). Another factor discussed was impact evaluation: some results may suggest that prevention efforts were not successful, when in fact the evaluation was not conducted adequately. Evaluating a non-event, for example infections averted, is always a challenge; therefore many evaluations may require mathematical modelling, and these models sometimes resort to using questionable assumptions rather than obtaining the needed data.

Participants also noted that it is not just low coverage that has led to poor results in many contexts, but also a lack of enthusiasm and a failure to invest in communities. Advocacy is therefore important, as lessons from South Africa's Treatment Action Campaign have shown.

Combination prevention requires addressing the drivers of the epidemic. However, in addition to working with more sensitive and complex issues, there are also some very basic things that could and should be done but have not been done, for example the adequate provision of condoms as part of the prevention package. Combination prevention is needed, and this should reflect strategic prioritization. The best combinations can be gleaned from programme data on which combinations really worked on the ground. However, gathering comparable evidence on what works is complicated by a lack of uniform terminology and specificity. Thus progress on the refinement and use of the UNAIDS taxonomy should improve the foundations for combination prevention.

## Session VI. Recommendations and the process forward

The chairperson of the 2009 Prevention Reference Group meeting, Professor Peter Figueroa, chaired the final session of the meeting. The objective of this session was to review the recommendations of the Reference Group thus far and to finalize them for consideration by UNAIDS.

Participants volunteered themselves into four groups to examine the objectives of the meeting. Following the group sessions, each group presented its conclusions to the meeting in plenary and their recommendations were discussed.

Following the discussion, the following final recommendations were agreed upon.

*Objective 1. To advise UNAIDS on the next steps regarding the development of a taxonomy for HIV prevention activities*

The Prevention Reference Group agreed that UNAIDS should issue a taxonomy of HIV prevention activities in order to establish a common language and definitions for HIV prevention. They agreed that the taxonomy would add value to HIV prevention discourse because it:

- Standardizes prevention language at the international, national and community levels;
- Provides a ‘big picture’ and unified approaches to prevention programming;
- Improves documentation and comparison in order to improve prevention practices;
- Helps in defining the role of players;
- Contributes to prevention advocacy efforts at the country level.

The Prevention Reference Group specifically recommended that:

- The taxonomy should be developed to enable common language to advance prevention, including gathering knowledge and data about prevention programmes.
- The present taxonomy list should be reordered more logically.
- A section on how to use the taxonomy should be added.
- The taxonomy list should include brief definitions of each activity and/or service.
- UNAIDS should lead a structured discussion with key stakeholders to finalize the taxonomy:
  - A small task team from the Reference Group, led by UNAIDS, should finalize the taxonomy;
  - UNAIDS should share the revised taxonomy with Reference Group members, who will share it with their constituencies over a two-week period (suggested) and make revision suggestions as appropriate;
  - The task team should formulate a dissemination and utilization plan and UNAIDS should share this plan with the Reference Group.
- The taxonomy should be field-tested within three months of the Glion meeting. The field-testing process should assess the utility of the taxonomy for a national strategic planning process, as part of a national prevention assessment, and by programme implementers. The results of the field test and the final taxonomy should be circulated to the Reference Group for endorsement.
- During earlier discussions, the Reference Group had noted that the publication of the taxonomy should eventually include the evidence base for each activity, in relation to

the outcomes cited. The Reference Group, however, agreed that relating programme activities and their evidence base to outcomes is not a task for the present taxonomy exercise, but is a task for a future Reference Group and its partners. Therefore UNAIDS should organize such a Reference Group discussion at a later date. UNAIDS should prepare the relevant background materials for this process.

UNAIDS agreed to several immediate next steps, to be completed following the meeting:

- Send to the Reference Group a timeline for finalization of the taxonomy the week following the meeting.
- Convene a task team consisting of members of the Reference Group to further advise UNAIDS on the details of the process outlined by the larger group. The task team would:
  - Agree on changes to the taxonomy, including inclusion of the definitions;
  - Define how other stakeholders would be consulted in that process;
  - Define how the taxonomy would be field-tested.
- The task team would start its work in the beginning of April and the draft revised taxonomy should be ready by the end of May. It would be sent at that stage to all the Reference Group meeting participants for their inputs and for them to consult with relevant stakeholders. The taxonomy revised based on the received feedback from stakeholders would be ready by the end of June.
- The taxonomy will be taken for endorsement by the Reference Group once it has been finalized.

*Objective 2. To agree on a method for advancing quality standards in agreed clusters of HIV prevention activities*

The Reference Group agreed that UNAIDS should contribute to improving the quality of HIV prevention by developing a discussion paper on this topic, with inputs from the quality assurance and improvement fields, within and outside the AIDS field. UNAIDS should establish quality standards in those areas of HIV prevention where such standards do not exist or where there is no consensus on them. The paper should be developed within the next three to four months.

More detailed recommendations related to the process included:

- UNAIDS should publish a paper on quality issues of HIV prevention programmes. The paper should include the main issues and constraints and make the case for what needs to be addressed.
- UNAIDS should document quality standards in all areas of the HIV prevention taxonomy where such standards exist and propose the establishment of quality standards for those areas of HIV prevention where such standards do not exist or have no consensus. Where standards do not exist, UNAIDS should secure the appropriate expertise to advise on the next steps.
- UNAIDS should support countries to enable them to implement quality standards. Therefore UNAIDS should develop appropriate tools and make technical assistance available on their use.
- Coordination at different levels is important:
  - At the global level, the process needs to be coordinated across UN organizations and major partners;

- At the country level, UNAIDS should ensure that inputs of all sectors are taken into consideration, and therefore close work with the national AIDS authorities is critical;
- It is important to ensure that a gender-equitable and rights-based response is a fundamental principle of a quality approach and that the voices of the beneficiaries are heard in the process.

In relation to these recommendations, the UNAIDS Secretariat noted that the resource implications of extensive quality standards and related work would have to be considered, but committed to conduct some immediate activities within the next month with partners, including in relation to the proposed expert group and discussion paper, as well as working on resource implications and timelines for a wider quality improvement response.

*Objective 3. To review country level efforts in prevention reorientation and recommend methods for systematic advancement*

The Prevention Reference Group recommended that UNAIDS should advocate for and support the next step beyond ‘knowing your epidemic and response’ by guiding responses to realign to epidemics, including by reallocating budgets if required.

The Reference Group noted that:

- Modes of transmission studies are useful in that they attempt to generate incidence data, thus helping to understand a country’s epidemic:
  - By bringing attention to some neglected key populations;
  - By putting on the front line the issue of ‘know your epidemic and response’;
  - By providing a platform for people to come together around the data;
  - By quantifying the epidemic.
- Modes of transmission studies have identified existing analytical weaknesses, as well as data deficiencies.
- However, modes of transmission studies provide an opportunity for evidence-informed advocacy, as is already the case in Thailand. They can be used for:
  - Policy, planning;
  - Resource mobilization;
  - Garnering political commitment.
- There is a need to convene a discussion to learn lessons from all continents that have implemented modes of transmission analysis.
- Data gaps in the modes of transmission studies should be addressed, including gaps in prevention response data.
- There are variations in terminology within the modes of transmission studies, for example regarding risk factors and vulnerabilities. There are also variations regarding programme activities and the substantive focus (e.g. casual sex, transactional sex). These variations hamper the comparability of modes of transmission studies across and within countries, limiting an important utility of the studies.

The Reference Group made the following recommendations:

1. UNAIDS should be an advocate for the refinement and improvement of modes of transmission methodology and studies, which should:
  - a. Use the HIV prevention taxonomy of activities;

- b. Show adequate standardization, allowing for comparability while ensuring context-specific utility allowing room for context-specific adaptation;
  - c. Establish an inclusive national process looking at knowing your response;
  - d. Provide guidance on aligning responses to the epidemic context and addressing optimum budget allocations for HIV prevention.
2. UNAIDS should strengthen the part of modes of transmission studies that assesses the programmatic response.
3. UNAIDS should consider changing the name to include ‘response and reorientation’.
4. UNAIDS should further support countries to tailor and prioritize their prevention responses, including through operational guidance on the integration of prevention, human rights, gender, stigma and care/treatment efforts.

*Objective 4. To establish a working framework that suits the challenges of combination prevention*

The Reference Group made the following recommendations:

1. UNAIDS should lead a group to define and articulate what combination prevention means.
2. UNAIDS should look beyond prevention to include care and treatment. With increasing attention to the population-level impacts of treatment on transmission, UNAIDS should also offer practical guidance on how to develop models that include treatment and prevention and outcomes from both, in different epidemic contexts.
3. The discourse around combination prevention should include risk, social drivers and vulnerabilities, and synergistic effects. It should also discuss prioritizing and tailoring activities. The discourse should provide specific guidance on how to include the cross-cutting issues of stigma, discrimination and gender and human rights as part of programmes.
4. UNAIDS should support the development of an operational research agenda to further combination prevention approaches, including in areas of capturing synergies between different programme elements, and issues in scaling up, in order to generate improved evidence and guidance.

#### *Establishment of an ongoing Prevention Reference Group*

The Prevention Reference Group was initially established to meet on an ad hoc basis with a changing membership on an issue-specific basis. At the meeting, the views of participants were canvassed informally on whether participants felt the need for a continuing group that could provide ongoing advice to UNAIDS and be a link between one Reference Group meeting and the next. The UNAIDS Secretariat reported at the end of the meeting that a consensus view of participants was that it would be useful to establish more continuity in Reference Group meetings. UNAIDS will reflect these proposed structural changes in convening the next meeting of the Prevention Reference Group.

#### *Meeting report and feedback*

In addition to the recommendations noted above, the following immediate next steps will be undertaken:

- UNAIDS will produce and circulate the meeting report by the end of March 2009;
- UNAIDS will make the feedback evaluation form available on the Internet.

# Annex 1

## Agenda 2009 Prevention Reference Group Meeting 2–4 March 2009 Glion, Switzerland

### **Session I: Introduction**

13:30–14:00 Arrival and registration

14:00–14.10 Welcoming and opening remarks

- *Barbara de Zaldondo, Chief, Programmatic Priorities and Support Division, UNAIDS*
- *Peter Figueroa: Chair, 2009 UNAIDS HIV Prevention Reference Group*

14:10–14:30 Participant introductions, housekeeping, logistics

### **Session II: Taxonomy and classification of HIV prevention activities**

Chairperson: Peter Figueroa

14:30–14:45 Update on development of a taxonomy *Barbara de Zaldondo, UNAIDS*

14:45–15:15 How taxonomy relates to funding streams *Daniel Low-Beer, Global Fund*

15:15–15.45 UNAIDS taxonomy *Michael Bartos, UNAIDS*

15:45–16.00 Questions

16:00–16.15 *Tea/coffee break*

16:15–16:30 Introduction to breakout groups

16.30–17:30 Breakout group to review the UNAIDS taxonomy and to make recommendations

- Group I: Audience and settings
- Group II: Outcomes (enabling environments)
- Group III: Outcomes (individual, biomedical and behavioural)
- Group IV: Utilization by national programmes
- Group V: Utilization by other consumers

17:30–17.45 Discussion, wrap-up

18:30–19:30 *Cocktails*

19:30–21:30 *Dinner*

Special speaker:

Roger Staub, Director, AIDS Unit of the Swiss Federal Office of Public Health and National HIV/AIDS Programme Manager for Switzerland

Discussant:

Susan Kippax, Fellow, Academy of the Social Sciences of Australia and Professorial Research Fellow at the National Centre in HIV Social Research, University of New South Wales

## **Day 2: Tuesday, 3 March 2009**

Chairperson: Sunil Mehra

08:30–09:20 Report-back of the group work

09:20–10:15 Plenary discussion and responses to working groups  
Final agreement and endorsement of the taxonomy  
Agreements on dissemination, utilization and next steps

10:15–10:30 *Tea/coffee break*

## **Session III: Quality standards for HIV prevention**

Chairperson: David Serwadda

10:30–12:00 Panel presentation

10:30–11:10 Panel 1

- UNAIDS quality standards *Michael Bartos, UNAIDS*
- Background to quality standards *Nancy Padian, RTI and UCSF, USA*
- Contemporary issues in quality standards *Bruno Bouchet, FHI, USA*
- Quality standards for sexuality education *Christine Winkelmann, Federal Centre for Health Education, Germany*

11:10–12:00 Panel 2

- Quality standards for health promotion *Barbara Battel-Kirk, IUHPE*
- Global Fund quality standards project *Daniel Low-Beer, Global Fund*
- Human rights, gender and affected communities *Barbara de Zaldondo, UNAIDS*
- Quality standards: country realities *Khanya Mabuza, NERCHA, Swaziland*

12:00–12:45 Plenary discussion

12:45–13:00 Next steps *Barbara de Zaldondo, UNAIDS*

13:00–14:30 *Lunch*

## **Session IV: Re-orienting HIV prevention programmes**

Chairperson: Peter Lamptey

14:30–14.45 Modes of transmission project: aligning programmes to findings *Karusa Kiragu, UNAIDS*

14.45–15.45 Country presentations  
Lesotho *Motlalepula Khobotlo*  
Nigeria *Joseph Nhorom*  
Thailand *Wiwat Peerapatanapokin*

15.45–16.00 *Coffee/tea break*

16.00–17.25 Plenary discussion of country presentations and next steps for UNAIDS

17:25–17:30 Wrap-up *UNAIDS*

## **Day 3: Wednesday, 4 March 2009**

### **Session V: Combination prevention**

Chairperson: Peter Figueroa

08:30–08:45 Review and expectations for the final day

08:45–09:30 Combination prevention: implications for the future

- Panel discussion *Marie Laga, Alan Whiteside, Michaela Clayton, Mariangela Simao*

09:30–10:00 Plenary discussion

10:30–10:45 *Tea/coffee break*

### **Session VI: Conclusions and next steps**

Chairperson: Peter Figueroa

10.00–11.30 Group discussion to make recommendations around meeting objectives

11:30–13:00 Wrap-up discussion, action points and next steps

Discussion of next steps

- Concluding remarks
  - Peter Figueroa, Chair, UNAIDS HIV Prevention Reference Group
  - UNAIDS

13.00 Lunch and departure



## Annex 2

### List of participants

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2–4 March 2009

Glion, Switzerland

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## Annex 3

### **Draft UNAIDS taxonomy of HIV prevention activities as presented to the HIV Prevention Reference Group meeting, 2–4 March 2009**

All HIV prevention activities can be classified as one of the following broad activities:

1. Mass media campaigns:
  - 1.1. Radio, television, newspaper
  - 1.2. Internet
  - 1.3. Small media materials
2. Traditional and folk media
3. Community mobilization:
  - 3.1. Community activities and large group events
  - 3.2. Self-help, empowerment and solidarity activities
4. Interpersonal communication, interactive dialogue, peer education
5. Education:
  - 5.1. Sex education
  - 5.2. Life skills education
  - 5.3. HIV education
6. Training:
  - 6.1. Pre-service training for professionals
  - 6.2. In-service training for professionals
  - 6.3. Training/skills building of adult learners
7. Voluntary counselling and testing (note: provider-initiated testing falls under treatment and care)
8. Psychosocial support services
9. Advocacy and lobbying
10. Female and/or male condom programming
11. Needle and syringe programming
12. Drug treatment, including drug substitution therapy
13. Providing safe virtual or physical spaces for vulnerable populations (e.g. telephone hotlines, drop-in centres or women's refuges)
14. Diagnosis and treatment of sexually transmitted infections
15. Post-exposure prophylaxis
16. Pre-exposure prophylaxis (still experimental)
17. Family planning services

18. Antiretroviral prophylaxis to prevent mother-to-child-transmission
19. Male circumcision
20. Counselling and services related to infant feeding options
21. Antiretroviral therapy for prevention
22. Blood safety:
  - 22.1. Blood donor recruitment
  - 22.2. Collection of blood from voluntary unpaid blood donors at low risk of acquiring transfusion-transmissible infections, and stringent blood donor selection criteria
  - 22,3. Testing of all donated blood for transfusion-transmissible infections, blood groups and compatibility
  - 22.4. Appropriate clinical use of blood and the use of alternatives, where possible, to minimize unnecessary transfusions
23. Screening sperm donations for HIV
24. Universal precautions:
  - 24.1. Universal precautions equipment
  - 24.2. Universal precautions procedures
  - 24.3. Safe medical injections
25. Separate accommodation to protect at-risk incarcerated populations
26. Income generation activities
27. Financial and in-kind sustenance support
28. Provision of legal services
29. Legal reform
30. Policy and institutional reform
31. Research and analysis of research and programme data