Rationale for including the SDA in the proposal

Behaviour change is an important element in strategies for the prevention of sexual transmission of HIV. There is widespread recognition of the essential role that behaviour change can and must play in turning the tide of the pandemic. The challenges are great, but we are increasingly equipped with both evidence to inform action and recognition of the enormous potential of our shared efforts.

Elements to be considered in the situation analysis

There is a need to focus HIV prevention efforts on the diverse sources of new infections in different epidemic contexts. HIV epidemics are dynamic and vigilance about how they evolve is at the heart of effective HIV prevention programming. The injunction to “know your epidemic” has to be rolled out from the epidemiological centres (national capitals and research institutes) to districts and communities, and from epidemiologists to policy-makers, programme managers, and civil society advocates.

Knowing your epidemic means knowing where the epidemic exists (regionally and in terms of the populations most affected) and also what are its main drivers. In-depth understanding of the social and behavioural context is thus central to knowing your epidemic.

New biological understanding of fluctuating HIV infectivity, combined with accumulating data on concurrency and sexual networking, provides a new angle on the risks of multiple sexual partners where HIV is prevalent; an issue that needs to be further researched and applied in HIV prevention programmes.


Target populations

Behaviour change measures should be increasingly tailored and provided for the populations and settings with highest rates and highest risks of HIV. Programmes targeting populations at especially
high risk are among the most cost-effective prevention interventions available and represent a core component of any national HIV prevention programme. Programmes need to be reviewed and rethought in terms of up-to-date understanding of HIV epidemics at the subnational level. Behaviour change measures need to be planned in terms of the traditions and methods of community participation, including the participation of vulnerable populations, people living with HIV, women, and young people. Although the programmes for vulnerable populations are indispensable in all national responses, broader-based programmes are also essential in generalized epidemics or in settings where the epidemic is likely to spread from discrete high-prevalence groups into the broader population. Public education and awareness programmes that reach the general population are essential to any sound HIV response.

**Suggested main activities**

Effective prevention involves reducing risk, vulnerability, and impact. Behaviour change messages and models that focus on individual knowledge, skills, and choices are not enough, particularly in generalized epidemic contexts. Projects need to move from an intervention or service paradigm to one of engagement grounded in the right to HIV prevention. Behaviour change programmes need to support and empower individuals to understand and minimize their infection risks through the adoption of prevention behaviours.

The message content of behaviour change programmes may include sexuality education including promotion of correct and consistent condom use (relates also to SDA on condoms), delayed sexual debut, abstinence and partner limitation, and disclosure of status to sexual partners if known (relates also to SDA on testing and counselling), and safer injecting practices. Community outreach behaviour change programmes can use various channels of communication, including popular media, schools, workplaces, peer outreach, counselling, interpersonal education and persuasion and self help and solidarity groups and faith-based organizations, in informing and empowering the population to participate in HIV prevention and care.

Continued focus, investment, and leadership at the community, national, and global levels are needed to ensure there is locally relevant, high-impact behaviour change programming in national HIV strategic plans and monitoring and evaluation systems.

Specific guidance on programming for behaviour change communication in schools is available on publications of the UNAIDS Interagency Task Team on Education from the link: http://portal.unesco.org/ev.php-URL_ID=33743&URL_DO=DO_TOPIC&URL_SECTION=201.html.

Young people
Young people make up a segment of the population that is particularly vulnerable to HIV. Altogether, 50% of HIV transmission takes place among those aged 15–24, and 5 000–6 000 young people become infected every day. The second decade of life is a period of experimentation and risk, and many factors increase young people’s vulnerability to HIV during these years of rapid physical and psychosocial development. These factors include a lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, sexual coercion and violence, trafficking and growing up without parents or other forms of protection from exploitation and abuse.

A clear understanding of the situation of young people and their needs is required to design and successfully implement interventions to stem the tide of infections among young people. Without this information, the scale of the response required and the focus and relative urgency of the interventions remain unknown. Countries must strategically target their resources to interventions that respond to the specific situation in each individual country.

Young People Most at Risk. Many young people are particularly at risk of becoming infected with HIV because of the situations in which they live, learn and earn; as a result of the behaviours they adopt, or are forced to adopt because of social, cultural or economic factors. Young people most at risk of becoming infected with HIV include: young sex workers, young injecting drug users and young men who have sex with men. Many of these young people live on the fringes of society, and are unlikely to be reached by interventions implemented through schools, health services or the media.

These young people should be provided with information, skills and services through facilities and through outreach strategies. Their specific needs should be given increased attention. Careful evaluation of the impact and processes of interventions is essential to increase knowledge of what is effective among this group of young people.

Geographically Defined Communities. Interventions delivered to young people in geographically-defined communities (for example, rural villages, urban settlements or neighbourhoods) have the possibility to reach young people where they live regardless of whether they are in school or out of school, married or unmarried, employed or not. Initiatives should largely focus on working with existing youth-service organizations, where careful attention should be paid to selecting, training and specifying culturally appropriate interventions and tasks for programme staff. Staff should benefit from ongoing supervision. Organization leaders need to be vigilant in maintaining overall community support and resource mobilization.

Schools. In many respects, schools are uniquely well placed to contribute to decreasing HIV prevalence among young people. Of those young people who attend school, most enrol in school before they begin having sexual intercourse. Schools can provide fundamental information related to HIV prevention. However, sex education and HIV education interventions in schools vary widely. Programmes should be curriculum-based and designed and implemented using the characteristics shown to be associated with effectiveness.
**Health Services.** Health services complement interventions in other sectors but are often not used by young people. The most significant services for the prevention of HIV in young people are those that strengthen the ability of young people to avoid infection, including information and counselling; reduce risks, notably, by providing condoms and harm reduction interventions; and provide diagnosis and treatment for STI and HIV. In order to increase young people’s use of services it is necessary to train service providers and other clinic staff in how to provide high quality health services for young people. Facilities should be made more accessible and acceptable to young people. Work also needs to be done in the community to generate demand and support for the services targeting young people. Other sectors, in particular schools and the media, can assist in creating demand by improving young people’s overall knowledge about HIV/AIDS and encouraging health-seeking behaviours.

- **Sex workers**

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

- **Provision of the full range of HIV services such as**
  - Promote consistent and proper use of condoms to achieve >90% use at last sex with a non-regular partner; ensure consistent availability of quality male and female condoms.
  - Ensure availability of comprehensive health-care services with special emphasis to quality sexually transmitted infection treatment.
  - Integrate violence reduction [both social and structural] in the sex work settings and engage sex workers in enforcing child protection policies and regulations.
  - Work with sex workers to ensure participation in the development, implementation and monitoring of prevention services.
  - Address structural barriers including policies, legislation and customary practices that prevent access and utilization of appropriate HIV prevention, treatment and care services.
  - Review laws to ensure sex workers’ ability to protect themselves and to ensure safer sex practices by their clients.
  - Provide access to HIV counselling and testing and AIDS care, including antiretroviral treatment and prevention services.
  - Ensure availability of sexual and reproductive health services, including access to prevention of mother-to-child transmission services.
  - Link HIV prevention programmes with all relevant welfare services including establishment of social support mechanism for sex workers and their families.
- Assist women to leave sex work and provide a range of legal, economic and social services for those in sex work.
- Peer support programmes run by serving or ex-sex workers.
- Capacity building/training of implementing partners.
- Advocacy to donors, humanitarian organizations and national governments.
- Social mobilization to address sexual norms, reduction of sexual partners, increased condom use in humanitarian settings.

  o **Men who have sex with men**

  Potential for rapid spread within the population, if rate of unprotected anal intercourse is high.

  • High potential HIV prevention benefit. Evidence of programme effectiveness from numerous countries in 80s and 90s. Potential increase in risk behaviours due to prevention fatigue and AIDS complacency.

  Outreach activities for prisoners would include the following:

  • Provision of the full range of HIV services such as
    - Consistent and proper use of condoms, including consistent access to condoms and water-based lubricants.
    - Availability of quality treatment for sexually transmitted infections and referral for HIV services.
    - Availability of high quality HIV-related services (voluntary counselling and testing, specialized clinics, etc.).
    - Availability of safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for men who have sex with men to seek information and referrals for care and support.
    - Access to medical and legal assistance for boys and men who experience sexual coercion or violence.
    - Availability of specific and targeted information on prevention and risk reduction strategies designed to appeal to and meet the needs of men who have sex with men.
    - Access to information and prevention and care services for female partners of men who have sex with men.
  • Empowerment of gay, lesbian, bisexual and transgendered communities to participate equally in social and political life.
  • Training and sensitization of health-care providers to avoid discriminating against men who have sex with men.
  • Guarantee of human rights; removal of legal barriers to access prevention and care, such as laws that criminalize sex between males.
Injecting drug users

HIV spread through use of contaminated needles among injecting drug users is among the most explosive (rates have been seen to expand from 5% to 50% in one year in many injecting drug users) to populations. Injecting drug users often have multiple risks, such as sex work and drug use and often face incarceration for possession of drugs, which again increases their risk of contracting and transmitting HIV. There is evidence that injecting drug users are willing to protect themselves, their sexual partners and the society at large.

Outreach activities for injecting drug users would include the following:

- Harm reduction measures (13) such as access to sterile injection equipment; drug dependence treatment such as methadone and buprenorphine; community-based outreach; and providing HIV prevention information are among the most effective and cost-effective measures to prevent, the epidemic among injecting drug users. The earlier the implementation of HIV prevention programmes, the more effective and cheaper the specific measure will be. Unmet challenges/issues related to illegality of injecting drug use and of harm reduction programmes can drive injecting drug users away from services and/or into prisons and fuel the spread of the epidemic.
- Access to sterile injection equipment—to meet actual patterns of drug use.
- Access to quality, noncoercive drug treatment programmes especially drug substitution treatment such as methadone and buprenorphine.
- Removal of stigmatizing and coercive measures such as mandatory registration and forced HIV testing.
- Increase access of injecting drug users to service providers offering treatment for drug dependence, sexually transmitted infections, AIDS and tuberculosis.
- Training of health providers to increase familiarity with and effective work with injecting drug users and sex workers and training law enforcements and particularly to diminish harassment at prevention and treatment sites serving injecting drug users and sex workers.
- Promote the consistent and proper use of male and female condoms and ensure their availability, affordability and consistent supply.
- Access to HIV prevention, antiretroviral treatment and care services, including post-exposure prophylaxis, for sexual partners of injecting drug users.
- Create safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for injecting drug users to seek information and referrals for care and support.
- Removal of legal barriers to access prevention and care, such as laws and policies that prevent the provision of sterile injecting equipment and/or access to drug substitution treatment such as methadone and buprenorphine and meaningful involvement of drug users at all levels of planning and policy and financial support for their organizations.
- Availability and active promotion of hepatitis immunization for injecting drug users and their sexual partners.
• Targeted reproductive health and prevention of mother-to-child transmission services focused on appealing to the needs of women injecting drug users and women partners of injecting drug users.
• Promote community based and peer-led outreach programmes.

  o **Women and girls**

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

  Outreach activities for women and girls would include the following:

  • Comprehensive reproductive health services, accessible to all girls and women, regardless of marital status.
  • Safe physical and virtual spaces (for example drop-in centres or telephone hotlines, respectively) where women and girls can seek information and referrals for voluntary counselling and testing, treatment, care and support.
  • Legal and policy prohibitions against violence against women, including sexual coercion and rape and provision of legal and financial support for enforcement.
  • Gender equality in education, employment, credit and law (including inheritance and property rights).
  • Programmes to promote access to female and male condoms, voluntary HIV counselling and testing, couples counselling, support for voluntary disclosure and prevention of parent-to-child transmission.
  • Involvement of men and boys in HIV prevention and reduction of gender inequality.
  • Peer support programmes run by women and girls.
  • Capacity building/training of implementing partners.
  • In all sectors, establish specific programmes and allocate resources to work with women and girls; include AIDS information and referral in all programmes for girls and women.
  • Strengthen, introduce and enforce laws against sexual coercion, violence against women and discrimination on the basis of sex; eliminate existing discriminatory laws and practices.
  • Establish and regularly utilize a consultative mechanism representative of women of different backgrounds and ensure women’s participation in all civil society consultative mechanisms.

  o **Prisoners**

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

Outreach activities for prisoners would include the following:

- Provision of the full range of HIV services such as
  - Availability of condoms, sterile syringe and needles and skin piercing equipment and promotion of consistent and proper use of condoms.
  - Access to drug treatment programmes, especially drug substitution treatment, with adequate protection of confidentiality.
  - Access to HIV counselling and testing, antiretrovirals and TB treatment and care and quality sexually transmitted infection treatment.
  - Review of drug control laws; provision of alternatives to imprisonment for minor drug-related offences; offer treatment for drug users instead of imprisonment.
  - Structural interventions to reduce overcrowding, pre-trial detention period and speedy trial and sentencing reform.
  - Separate accommodation and facilities for young prisoners.
  - After release programmes—establish links with prevention and care programmes in the community.

- Peer support programmes run by long-term prisoners/ex-prisoners.
- Capacity building/training of implementing partners.
- Advocacy to donors, humanitarian organizations and national governments.
- Social mobilization to address sexual norms, reduction of sexual partners, increased condom use in humanitarian settings.
- Removal of legal barriers and reform of prison procedures/rules to enable access to HIV prevention and care services by prisoners.

  - **Mobile populations**

Populations such as transport workers and commercial drivers, mobile populations, uniformed services personnel and clients/non-regular partners of sex workers, can increase transmission within the risk settings and spread into the general population.

Outreach activities for prisoners would include the following:

- Focus on female spouses, male and female partners of sex workers, male and female sexual partners of injecting drug users.
- Consistent and proper use of condoms.
- Availability of quality sexually transmitted infection treatment and other reproductive health services, including HIV information, counselling and testing.
• Removal of legal barriers to access prevention and care.
• Workplace policies and programmes that normalize HIV prevention, guarantee confidential HIV prevention and services and prevent spousal separation and other risk factors.
• Develop multisectoral links—home, social welfare, labour and industry, workers unions, private sector and civil society.
• Political and social mobilization to address sexual norms, reduction of number of sexual partners, increased condom use.
• Peer support programmes.
• Capacity building/training of implementing partners.

- Populations of humanitarian concern

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

- Information-education-communication and media campaigns to address specific HIV risks and vulnerabilities.
- Consistent and increased availability and proper use of male and female condoms.
- Availability and provision of emergency contraception and post-exposure prophylaxis, especially to women who have been victimized by war and to humanitarian workers.
- Consistent and increased availability and proper use of male and female condoms.
- Capacity building/training of implementing partners.

Linkages with other SDAs/programmes

Behaviour change communication using community outreach is also linked to service delivery area of behaviour change communication using mass media, which may be delivered through television, radio or public events, and is typically targeted for large segments of population, but the content can be targeted to sub-populations. It also relates to some other service delivery areas under prevention and supportive environment.

Community outreach can facilitate community dialogue and action to shift norms and policy. Measures to reduce the behaviours that put people at immediate risk of HIV infection—such as unprotected sex and using non-sterile injecting equipment—should be combined with appropriate measures and efforts to define and mitigate the drivers of the epidemic such as gender inequality and human rights violations.

In a rights-based, engagement paradigm, segmented and tailored information and skills-building for individuals is coupled with mass media attention, social mobilization, advocacy, and leadership to change policies and social norms, and to invest in reducing the vulnerability of disadvantaged and
marginalized populations Especially in settings with high HIV prevalence, effective HIV prevention often requires changes to deep-seated traditions and social norms regarding human sexuality. The guidance note on social change communication caters for some of these issues.

An important part of the effectiveness gap and implementation gap in behaviour change is due to political rather than technical barriers. Having strong, local and up-to-date epidemiological data is invaluable for policy dialogue. Engaging and building leadership and a clear constituency for HIV prevention is also critical. There is a need to conduct and disseminate policy research, to inform diagnosis of political barriers and policy options (e.g. changes in legislation or taxes), and to share examples of the 12 policy actions that are featured in the 2005 UNAIDS Policy Position Paper on Intensifying HIV Prevention (http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf).

**Addressing gender, human rights and equity**

Behaviour change programming should be grounded in a human rights perspective. HIV-related stigma and denial are barriers to behaviour change, and need to be addressed. Partnering broader gender-based violence programmes with HIV prevention programmes is of paramount importance as the goals of both types of programmes are mutually reinforcing. All communication programmes need to be alerted to find the appropriate language and local images that show the benefits of gender equality and respect for human rights.

**Key implementing partners to be considered**

To keep up with this dynamic virus, national HIV programmes need to plan for continuous dialogue with and engagement of communities and groups that are affected by the epidemic and engaged in the response. Communities need to be given more resources, and allowed to act rather than engaging others to act for them. This applies especially to vulnerable populations, including people living with HIV. Communities are unlikely to question their own assumptions, for example, on gender norms, unless prompted to do so, but community-based programmes have succeeded in catalysing change by assisting communities to reflect on traditions, norms, and values (e.g. on widow inheritance) that jeopardize health and survival.

Other key partners will include youth and women’s organizations, trade unions and employer associations, and religious organizations.