

Bringing Prevention Back to the Forefront

Summary of a consultation among civil society
organisations in relation to the development of the UNAIDS
Global Prevention Strategy

as facilitated by



October 2004



CONTENT

Introduction	1
1. What works?	3
2. Responding to a changing, global environment	6
3. Working within national environments.....	9
4. Scaling up action on prevention	10
5. Prevention thinking: A help or hindrance to reducing vulnerability?	13
Supporting documents:	16

INTRODUCTION

The following report summarises the feedback gained from a consultation carried out among civil society organisations in relation to the development of a Global Prevention Strategy of the United Nations Joint and Cosponsored Programme on AIDS (UNAIDS). The consultation was facilitated and resourced by the International HIV/AIDS Alliance under its role as a UNAIDS Collaborating Centre from its secretariat office in Brighton, UK. The consultation took place over a period of 10 days in October 2004. It was carried out electronically among Alliance organisations, partners and associates involved in local, national and international responses to HIV/AIDS.

The Alliance disseminated its request for input to roughly 59 organisations, with 23 responses received. These were from: NELA – (Nigeria Network on Ethics, Law, HIV/AIDS Prevention, Support and Care); African Services Committee; Alliance Zambia; Catholic Agency for Overseas Development (CAFOD); Centre for Health and Gender Equity (headquarters and partner in Peru); Christian Aid; Harm Reduction Development Programme, Open Society Institute (OSI); Health Communications Project, John Hopkins Bloomberg School of Public Health; International AIDS Vaccine Initiative; International Community of Women Living With HIV/AIDS (ICW); International Council of AIDS Service Organisations (ICASO); Kimirina, Ecuador; Mozambique Red Cross; NAZ Foundation; Palmyrah Workers Development Society, (PWDS), India; Southern African AIDS Trust (SAT); Stop AIDS Alliance; UK Consortium on AIDS and Development; Umzingwane Aids Network, Zimbabwe; Student Partnership Worldwide (SPW); and Vasavya Mahila Mandali (VMM), India.

Many respondents expressed considerable concern and frustration about both the method and timeframe of the consultation. They stated that they would have preferred to comment on an existing draft document from UNAIDS and to have had more input time. Several organisations noted that, given the tight deadline, they

could either not reply at all or could only provide brief, “off the cuff” feedback rather than a considered response. Overall, it was felt that this was very unsatisfactory, especially considering the vital importance of the strategy in question. A request was made that organisations would be allowed to review and comment on the policy once it has been drafted and UNAIDS needs to give sufficient time to this.

In terms of the framework for the consultation, the Alliance asked participants to respond to five key questions:

1. What prevention strategies have been shown to be effective in your area?
Over what period of time?
2. How is the external environment affecting your work, both positively (in terms of new opportunities and challenges) and negatively? Areas to consider – civil society capacity/involvement, funding, economic conditions.
3. How much does the current legal and policy environment underpin effective prevention work in your country?
4. What would be necessary to take effective prevention strategies to scale?
5. Does current thinking in prevention work contribute to reducing vulnerability, tackle human rights issues and reduce stigma and discrimination?

Points to consider were also shared in the discussion paper, they were as follows:

- Ensure that a solid policy framework is based on effective practice on the ground. We must not be tempted to provide a technical / interventions shopping list of our projects but rather consider how the lessons learnt can ensure policy and direction that can influence right across the UN agencies – not just UNAIDS.
- Is there anything missing from current prevention thinking / statements at a national, regional and global level? What needs greater attention / emphasis and why?
- Vulnerability reduction. UNAIDS will remain committed to the reinforcing strategies of *Risk, Vulnerability* and *Impact* reduction. Does the increasing level of vulnerability and the direct link to human rights, stigma and discrimination mean that we need to reinforce efforts towards reducing vulnerability and bring this to the centre of our efforts?
- Does the current prevention strategy reinforce the diversity of those affected by the epidemic and allow for / ensure that responses are contextual, country / regionally specific and aimed at having the most long term sustainable impact?
- What do we feel is the current success of the Global Strategy framework on HIV/AIDS in ensuring that HIV is seen as an integral operational priority for all UN Agencies – eg. WFP, UNHCR, UNICEF, UNFPA, WB. How have we seen this reflected in their work and our opportunities for joint programming in countries etc.

The feedback to the questions is grouped under similar themes in the following pages.

1. WHAT WORKS?

Based on their extensive, practical experience, the respondents to the consultation reported that a wide range of HIV prevention strategies have been shown to be effective in their areas. These include:

- Reducing parent to child transmission (PTCT), including provision of drugs to both the parent(s) and the child.
- Information, education and communication (IEC), including through the media and drama.
- Communication for social change addressing socio-economic issues, such as child sexual abuse.
- Community dialogue and participatory approaches (e.g. using Stepping Stones).
- Specific initiatives with young people, both in and out of school.
- Preventive counselling.
- Behaviour change communication, especially with vulnerable groups, such as sex workers (SWs) and men who have sex with men (MSM).
- Ensuring strategies and activities are specific for the needs of rural and urban populations
- Voluntary counselling and testing (VCT) in a variety of settings and for a variety of community members.
- Prevention and treatment, including syndromic management, of sexually transmitted infections (STIs).
- Peer education among particular age groups and types of community members.
- Education, social marketing and distribution of male and female condoms.
- Harm reduction for injecting drug users (IDUs).
- Improving the safety of blood supply.
- Addressing the specific needs of young people.
- Addressing the cultural and social norms and gender roles of community groups.

Several respondents noted that, in turn, each of these strategies can be enhanced through specific approaches, such as the involvement of people living with HIV/AIDS (PLHA) and the use of participatory and inclusive methodologies.

Against the context of this broad “menu”, organisations identified a number of **key strategies** that they felt to be particularly vital at this stage in the pandemic. While some of these (e.g. the building of life skills) are well established components of prevention work and need renewed energy and attention, others (e.g. the large-scale provision of VCT) have only gained prominence more recently and require further investigation and intensive scaling up.

The key strategies include:

- **VCT:** VCT not only provides a vital in-road to treatment, but is a key prevention strategy in and of itself. For example, Alliance Zambia has seen that, with effective counselling, individuals and couples who test HIV negative are motivated to employ strategies to remain so. The African Services Committee also notes that over the past 4 years legislating mandatory HIV counselling for pregnant women in a number of settings while maintaining the voluntary testing option has made vital inroads. However, as experience and needs increase, several respondents noted the need for VCT services to move beyond simple, generalised services towards more specific, higher quality and more strategic

services rooted in comprehensive prevention programmes. VCT services must be incorporated into all levels of primary health care with a strong emphasis on sexual and reproductive health services. For example, VMM in India identified the need for mobile VCT services for rural communities and youth-friendly VCT services for young adult and children. VCT services must reach out to pregnant women and be incorporated into maternal health care at all levels of delivery. They also emphasised that the “C” should not be tokenistic, with counselling not only always present, but also unrushed and of high quality. Meanwhile, the Mozambique Red Cross emphasised that there should be referral systems that, for example, link prevention programmes in schools and workplaces with appropriate VCT services in the community.

- **Harm reduction for Intravenous Drug Users (IDUs):** Respondents with extensive experience of harm reduction work reported on the overwhelming evidence for the validity and importance of this strategy, as the OSI has learned from the foundation of over 200 syringe exchange programmes in Eastern Europe and the Former Soviet Union during 1998-2004. Research and evaluation by donors, national research agencies and academic institutions has shown these programmes to be highly effective in reducing HIV transmission. Again, however, there is a need for programmes to be more strategic and focused, for example addressing the specific needs of sub-sets of IDUs, such as SWs, street children, prisoners and migrant labourers.
- **Secondary prevention for PLHA:** In the context of increased access to treatment and, potentially, more people knowing their HIV status, there is a need to address the specific prevention needs of PLHA, both in terms of avoiding re-infection and protecting others from infection. For example, the African Services Committee recommended that secondary prevention work should be fully integrated into publicly funded programmes for HIV prevention.
- **Life skills training and empowerment:** Although life skills have been on the HIV/AIDS agenda for over two decades, they are often not adequately or appropriately addressed within prevention efforts. For example, the Health Communication Project cites the need for programmes with young people to more proactively include attention to self-esteem and negotiation skills – to better equip them for life before, during and after their first sexual activity and building healthy relationships. Meanwhile VMM, India, notes that focusing on life skills can provide a “safe” and strategic starting point in contexts where explicit attention to sex and sexuality is still taboo in many societies.
- **Peer-led peer education programmes:** Peer education has been another “mainstay” of prevention work for many years. However, it is increasingly important that such programmes are not only implemented by peers, but designed, monitored and evaluated by them. For example, SPW has found that sustained, full time peer – peer education, in which young people are recognized and valued as members of the workforce against HIV/AIDS, has been highly effective. From experience they have noted that complementing national education strategies through long-term peer education programmes focused on ASRH (adolescent sexual and reproductive health) and HIV/AIDS massively increases the impact of HIV/AIDS prevention programmes. The NAZ

Foundation has found that involving MSMs in developing, leading and running projects in South Asia not only improves the appropriateness of the initiatives, but makes them more likely to be accessed by other community members. Meanwhile, Umzingwane in Zimbabwe argues that young people need to be given opportunities both to run their own activities and to participate in the decision-making structures that monitor and supervise overall community action on HIV prevention.

- **Gender mainstreaming into all HIV prevention activities:** Again, the subject of gender has been on the HIV/AIDS agenda for many years. However, there is a shared sense that prevention initiatives need to address this area with both renewed energy and a more systematic approach, in terms of ensuring that it is incorporated into all activities, regardless of the community targeted or the nature or location of the work. Greater time and resources need to be given to conducting a gender analysis and to mapping out gender roles within the context of social and cultural norms at the start of programming and must feed into impact assessments and monitoring and evaluations.

While identifying the above key strategies, the civil society groups responding to the consultation overwhelmingly reported that, overall what works, or could potentially work, in their areas is **comprehensive / combination prevention** [see box]. These are programmes that provide a “menu” of options that can be selected, combined and adapted to individuals lives and needs. The menu should focus on “moving beyond awareness raising”, in terms of not only providing information, but enabling people to assess their individual level of risk and build the tools and skills to respond. In particular, as the Health Communications Project emphasises, the range of options should focus less on “don’t” and more on “do”, in terms of empowering people to take positive action. Meanwhile, one of the core components of prevention work, such as communication messages targeted at addressing behaviour, should, as IAVI outline, be combined with access to new technologies, such as microbicides and vaccines, as and when they become available.

“No single drug or medical approach is effective in treating a person with HIV. Similarly, a combination approach and an enabling environment are needed to help people prevent HIV transmission. Strategies must offer real choices for people including people with HIV, which meet their different and changing needs and that address the contexts in which decisions can be made and acted upon.”

IAVI

“Prevention-only and awareness raising projects are a thing of the past”.

VMM, India

“Reducing the risk of infection is not about choosing one or other option randomly or as dictated by social or religious pressures. It is preferable to think of it in terms of a continuum running from high risk activities to those carrying low or even no risk. Reducing risk is a process, an education, in which people see what risks their behaviour entails and in which they take steps to reduce that level of risk in their circumstances.”

CAFOD

As noted by organisations such as CAFOD, it is crucial that prevention strategies are not too simplistic and, instead, respond to the specific and complex realities of people’s lives, for example in terms of religious, cultural and economic factors. Likewise, the infrastructure behind prevention work should be multi-dimensional, in terms of providing a web of support and services, for example with referrals between

NGOs, government and the private sector. For example, the Lovelife programme in South Africa showed us that prevention work in young people's centres needs to be linked to establishing adolescent-friendly services in government clinics.

Overall, however, despite consensus on the importance of comprehensive/combo prevention, several respondents questioned whether such programmes were going from rhetoric to reality – in terms of actually materialising, particularly on a large-scale. It was felt that, in practice, there were multiple barriers to programmes becoming a reality, including a lack of resources and the limited remit of some organisations that, for example, focus on abstinence to the exclusion of other options. These barriers contribute to what the Centre for Health and Gender Equity describes as fragmented, rather than inclusive, strategies – where civil society groups end up focusing on their own area of work or speciality, pulling against each other rather than developing shared goals and presenting a united front.

In terms of the **targets for prevention work**, there was a degree of disagreement among respondents, often reflecting the stage of the epidemic in the country in question. For example, in Ecuador, Kimirina emphasised the importance of working with key populations, while in India VMM and PWDS felt that strategies should now be broadening out from “high risk” groups to the generalised population. Overall, however, there was a sense that prevention efforts should focus where and with whom they are most needed in a given country, based both on the dynamics of the epidemic and on evidence of what communities need.

There was universal agreement about the inextricable **link between prevention and care, support and treatment**. It was felt that this was not only sound good practice for HIV/AIDS programmes, but a political necessity in terms of ensuring adequate attention to prevention within a policy environment currently orientated towards treatment. In terms of practical examples, the Mozambique Red Cross highlighted how, with the presence of treatment, VCT can now be a more effective prevention strategy, as people receiving a positive diagnosis can be offered hope. Meanwhile several organizations including CAFOD and Christian Aid emphasised that keeping PLHA well reduces the impact on children lessening their years as orphans, reduces the risk of families declining into further poverty and becoming more vulnerable to HIV.

Finally, several of the respondents emphasised that prevention strategies do not “just happen”, but, instead require **extensive and intensive capacity building** to enable local individuals, organisations and sectors to develop, manage and implement them. This is a process that takes place over time and requires a wide range of resources, not just financial support and technical skills, but also energy, creativity and political will.

2. RESPONDING TO A CHANGING, GLOBAL ENVIRONMENT

Among the respondents to the consultation, there was a strong sense of a sea change occurring in the global HIV/AIDS arena, with civil society and HIV prevention

experiencing both positive and negative impacts. On the one hand, organisations welcome concrete progress, for example in terms of the overall increased availability of funding for HIV/AIDS and the growing commitment to multi-sectoral approaches. On the other hand, however, they fear that both resources and attention will predominantly be channelled into treatment work, while prevention will be forced to take a financial and political back seat.

To address some of the challenges of the current environment, respondents suggested that regional and international policy makers and donors should:

- **Act as the guardians and advocates for prevention:** This involves ensuring that, at all levels, prevention receives adequate political, financial and technical support in its own right, as well as in terms of its intrinsic link to treatment. There is a sense that, while many policy makers appreciate the basic logic behind increasing prevention in parallel to access to treatment, for this to become a reality it will take forceful, proactive advocacy. As Christian Aid comments treatment, and the power of treatment advocates, must not crowd out prevention. Otherwise, not only will the human consequences be severe, but the increase in numbers of people needing treatment will diminish any hope of reaching a stage of universal access.
- **Treat civil society as valid, equal partners in HIV prevention policy and programme development:** Policy makers should recognise the validity of the experiences amassed by civil society in relation to HIV prevention and give them a “place at the table”, for example in forums where decisions are made about the allocation of resources.
- **Critically assess the impact of focusing resources on a limited number of priority countries:** For example, the Centre for Health and Gender Equity argues that the current concentration of US funding in a few countries has limited the resources available for programmes elsewhere, where the epidemic is taking hold and prevention efforts could forestall the rapid spread of HIV.
- **Address the global economic and structural factors that limit the potential for local HIV prevention efforts to succeed:** Policy-makers should recognise and address the external, environmental factors that restrict HIV/AIDS prevention as much, if not more, than issues directly related to HIV/AIDS. For example, Kimirina cites the need for Ecuador to be freed from the international debts and economic crisis that inflict severe limitations on community-based HIV/AIDS efforts.
- **Address head-on the politicisation of HIV prevention and refocus on the legitimacy and efficacy of evidence-based successes:** For example, several respondents argued passionately that the international community, including UN bodies, has a role to play in addressing how the politics of the current US Administration – with, for example, its focus on abstinence, prioritisation of certain faith based groups and opposition to organisations advocating for the legalisation of sex work - fails to respect the evidence of years of community-based work. In addition, they were concerned about the financial restrictions placed upon US-funded projects, including that no more than 20% of funds spent on HIV can be allocated to prevention and that at least 33% of prevention

funds must be spent on abstinence-until-marriage programmes. There is a sense that the dominance of the religious and political right means that the Administration is failing to recognise and supportively address the reality of issues relating to HIV/AIDS – such as diverse social and cultural norms that drive and inform sexual relationships, sexual orientations – and that, in turn, this is taking safer sex education and sound adolescent sexual and reproductive health education many steps backwards.

- **Use international influence and funding vehicles to ensure programmes for the “invisible” populations that governments are unable and/or unwilling to support:** For example, the NAZ Foundation and Centre for Health and Gender Equity suggest that international and intergovernmental organisations can play a key role by setting a good example with policy frameworks that are unapologetic about issues of sexuality, power and sexual diversity. In turn, they can use these to mobilise national governments to address highly taboo behaviours (e.g. female cleansing, anal sex, pre-marital sex) and support the most stigmatised and marginalised populations (e.g. Street Children, IDU, MSMs, SWs). Meanwhile, the OSI cites how, although vast gaps still remain, grants from the World Bank and Global Fund on AIDS, TB and Malaria and other donors have enabled the expansion of harm reduction programmes with IDUs in Eastern Europe and the former Soviet Union.
- **Use international standards to enable the improvement and/or enactment of relevant national standards.** For example, ICASO emphasises how policy-makers and donors can play a vital role in terms of ensuring that regional and international standards for human rights are actually put into action on the ground.
- **Develop tailor-made strategies for individual countries rather than a “one size fits all” approach:** For example, several respondents noted that, while escalated epidemics may require prevention initiatives to be generalised in some contexts, specific initiatives targeting highly vulnerable populations, such as IDUs and SWs, are still extremely vital.
- **Have realistic expectations and timeframes for prevention interventions.** While an emergency response to HIV/AIDS may help to galvanise action, it is vital to recognise that prevention work takes time to produce a measurable impact and should not be judged against the same type of quantitative indicators used for some elements of treatment work. For example, PWDS in India is concerned that the project frameworks of international donors tend to be orientated towards short-term outputs. In turn, this forces NGOs and community groups to focus on simple, project-related activities with near-immediate results, rather than to develop longer-term, more strategic approaches to the more complex issues that really shape HIV/AIDS epidemics, such as examining vulnerability through a gender analysis. It also means that organisations tend to become more introspective – a situation that limits collaboration and risks duplication.

- **Ensure a greater connection between the prevention-related policies of different international, regional and national agencies.** For example, OSI cites the need for a greater continuity in terms of supportive, rather than repressive, policies in relation to drug users among UNODC, World Health Organisation (WHO) and UNAIDS, as well as national governments, such as those in the Former Soviet Union.
- **Be one step ahead of emerging prevention needs.** Many civil society organisations feel that, as they benefit from a unique overview of emerging trends and needs, regional and international policy makers are crucial to alerting national governments to the need for forward planning. For example, Alliance Zambia highlights how the scaling up of treatment will bring more emphasis to VCT, while, in turn, increased awareness of VCT will create greater demands for services. To meet such challenges, national policy-makers need more than financial and practical resources, such as test kits. They also need to be encouraged to plan, budget and strategise in relation to capacity building within public, private and nongovernmental sectors, and to develop increased human resources (for example, in the case of VCT, in terms of counsellors, laboratory technicians, post-test club leaders, etc).

3. WORKING WITHIN NATIONAL ENVIRONMENTS

Against the context of the rapidly changing global HIV/AIDS arena, civil society organisations also face challenges in relation to the legal and policy environments of their own countries and the extent to which these do, or do not, underpin effective prevention work.

It is recognised that effective prevention efforts require positive, supportive, enabling environments where people and organisations feel empowered on both strategic and practical levels. Respondents to the consultation reported that, in many countries, concrete progress is being made towards creating such environments, in terms of, for example, increasing policy measures relating to human rights. In India, the National and State governments have listened to the arguments and evidence from groups such as the NAZ Foundation that supporting vulnerable MSMs is a key strategy in preventing HIV transmission and accordingly increased their funding to relevant initiatives. NAZ also reports that MSMs are now at least mentioned in the National AIDS Plans of many other South Asian countries, even if the support of governments still tends to be more passive than active.

However, many organisations reported that antiquated laws and gaps in legislation are still posing immense barriers to promoting and increasing prevention programmes and services, particularly for marginalised and vulnerable groups. Indeed, according to respondents, the legal and policy environments for HIV prevention work in many countries are characterised by failure to:

- **Enact existing supportive policies and legislation.** For example, in Nigeria, NELA is concerned that, while the government has issued a policy statement on HIV/AIDS, the document is non-committal and non-binding.

- **Fill strategic gaps in policies and legislation.** For example, while feeling that the country's legislation is generally supportive of HIV prevention work, the Mozambique Red Cross cites the lack of laws on domestic violence, rape and sexual abuse as a significant barrier.
- **Update antiquated policies and legislation.** For example, in the light of the need for increasing the scale-up of testing and for appropriate, confidential counselling, Alliance Zambia is concerned about legislation which states that only laboratory technicians can draw blood from people. In the face of the devastating impact HIV/AIDS has had on the public sector work force there is a real need for government to be more innovative and learn from civil society in terms of human capacity and training.
- **Address constrictive policies and legislation.** For example, OSI finds that drug policies and legislation in Eastern Europe and the Former Soviet Union overwhelmingly emphasise punitive law enforcement at the expense of public health – a situation that increases human rights abuses, fuels discrimination and drives drug users away from services. Meanwhile, in Peru, a partner of the Centre for Health and Gender Equity, is concerned that a recent amendment to the 1995 Anti-AIDS Bill makes HIV testing mandatory among pregnant women.

In addition, HIV prevention efforts in many countries are inevitably severely affected, and often acutely restricted, by the specific dynamics of the national political environment. For example, Zimbabwean NGO's working on Human Rights and/or linked to international agencies are currently facing legal opposition. Meanwhile, groups in Peru are still experiencing the aftermath of the 2001-2003 period when the Ministry of Health was run by fundamentalist Ministers who replaced technical staff with people with the same religious conviction and prohibited the use of terms such as gender, sexual education and human rights.

4. SCALING UP ACTION ON PREVENTION

The civil society organisations responding to the consultation recognised that it is vital to not simply maintain, but dramatically increase, HIV prevention initiatives. However, the majority also noted that scaling up is not simply a question of numbers, in terms of doing more projects and reaching more people. It is much more a matter of re-strategising overall responses and re-emphasising specific interventions.

Respondents noted that scaling up effective HIV prevention requires a “jigsaw” of components. These include:

- **Political will – to support HIV prevention, alongside treatment – and a supportive legal and structural environment.** If prevention work lacks political clout – and, in turn financial and practical resources – organisations will struggle to maintain their existing level of activity, let alone to take it to scale. Overall, a context is needed that provides protection of human rights (including for women, girls, sexual minorities and other marginalised groups) and fosters dialogue and action on social, economic and political barriers, such as gender inequalities.

- **Analysis and promotion of what works:** In some cases, there is a need to look more strategically at which exact prevention strategies work in which exact contexts and with which exact populations. The results need to be documented, with the key components developed as tools to facilitate their replication. On the other hand, however, where evidence already exists, there is no need for constant re-invention. Instead, attention should be focused on how to put strategies into action as quickly and cost-effectively as possible and at the maximum scale that is feasible.
- **Adequate resources:** While this crucially refers to funding, it also includes services and technologies such as supplies of testing equipment and commodities for specific programmes, e.g. methadone and other substitutes for use in harm reduction programmes with IDUs.
- **Concrete efforts to address stigma and discrimination:** If fear and stigma continue to dominate the HIV/AIDS environment, prevention efforts will only ever have limited impacts and limited potential for scale up - as people will fail to make the links between the epidemic and their own lives and to take appropriate action.
- **Increased availability and marketing of VCT and, in turn, increased knowledge of HIV status:** VCT services need to be not only increased, but better advertised, with community members actively mobilised to use them. The public at large, as well as specific vulnerable groups, need to know what VCT is, what its benefits are and where appropriate services can be accessed.
- **Increased production and distribution of condoms:** Bigger investment is required in the production and distribution of condoms at a lower price, making them available to everybody, especially young people. They also need to be made more widely accessible in a broader variety of settings, such as schools, colleges, workplaces and public offices.
- **Increased multi-sectoral co-ordination, collaboration and referral services:** A broad variety of stakeholders, ranging from businesses to traditional leaders and religious groups, still need to be mobilised to take a full role in scaled up HIV prevention work. Also, proactive efforts need to be made to enhance collaboration and reduce duplication. For example, CAFOD highlights how it is necessary for different stakeholders to dismantle their mutual prejudices and identify their unique strengths – in order to develop a more shared understanding and reduce duplication. In particular, it is vital to ensure workable, “joined up” referral systems whereby, for example, if a community member is mobilised to take an HIV test by a peer educator, they can have a test at a government clinic and then, if positive, be referred to an NGO for care and support.
- **Increased mainstreaming of HIV prevention by development agencies:** There is a sense that there is still immense untapped potential among development organisations - that are established in communities and have decades of experience – to integrate HIV/AIDS into their on-going work and,

hence, reach many, many more regions and people. For example PWDS in India argues that prevention strategies still need to be more development-based than health-based and to focus on the causes of vulnerability, such as low literacy and the disempowering role of women, rather than people's resulting behaviour. As such, it believes that it is better to scale up HIV prevention by integrating it into on-going programmes - for example of organisations working with children or on human rights - than start new, isolated interventions with a new set of organisations and projects.

- **Increased involvement in HIV prevention by faith based organisations:** As Christian Aid argues, religious groups, with their far-reaching community networks, have great potential for being involved in HIV prevention work, but, despite their long term successful efforts in care and support work, some have not felt confident to move into prevention work. Their role needs to be actively encouraged, by presenting relevant evidence that, for example, sex education and HIV/AIDS projects for young people reduce rather than increase promiscuity.
- **Increased efforts to identify and reach “invisible” and marginalised communities:** For example, to scale up overall responses to HIV prevention, it will be necessary to scale up specific interventions for priority populations, such as needle exchange programmes for IDUs.
- **Re-vitalised prevention communication methods and messages:** There is a sense that, in many contexts, IEC work has become stale and has not been adapted to changing times and levels of knowledge. It has often lacked a “local” feel, failing to acknowledge social and cultural norms. While emphasis should be placed on behaviour change communication, solid and empowering information messages still have a crucial place within expanded HIV prevention work.
- **Simplified administrative systems and procedures.** For example, donors need to ensure that the scaling up of prevention initiatives, for example by NGOs and community groups, does not entail a scaling up of the complexity of funding proposals, reporting formats, etc. Instead, administrative procedures should be streamlined, with, where possible, the same, or at least complementary, requirements for different donors.
- **Enhanced meaningful involvement of PLHA:** PLHA have a key role to play in terms of a scaled up response, not simply as the face of HIV/AIDS, but in terms of the unique strategic insight that they can provide to the design, implementation and evaluation of interventions, and as being powerful advocates for prevention as well as treatment.
- **Increased involvement of different stakeholders in different roles.** As responses scale up, there is increased potential and necessity for the creative use of skills and interests. For example, counselling does not necessarily have to be carried out by an adult counsellor within a counselling organisation. Instead, it could, for example, be carried out by community health workers who

already have a gained trust within communities or by a trained student within a school-based peer education programme.

- **Core prevention methods to become “routine”.** For example, where appropriate and following the necessary training, health workers should discuss HIV/AIDS and offer HIV testing as a routine, everyday aspect of good quality health care.
- **Collaborative development of and, in turn, access to new prevention technologies:** As IAVI highlights, the development of technologies such as vaccines and microbicides needs be based upon meaningful partnerships between different sectors (scientists, governments, policy makers, communities, etc) and between developing and industrialised countries. Research needs to be done with communities, not to or for them, and an enabling environment needs to be developed, characterised by trust and open discussion.
- **Increased human and institutional capacity building at all levels:** For example, at the national level, scaled up prevention work will require increased human resources for key positions, such as strategists within National AIDS Councils and managers of NGOs, with efforts made to address the “brain drain” resulting from people dying or moving to better employment opportunities elsewhere. Meanwhile, at the community level, as emphasised by organisations such as SAT and the Alliance Madagascar, there needs to be extensive investment in local institutions to both implement effective prevention work and ensure that organisations continue to run efficiently and sustainably.

Lastly, but crucially within the current climate, many respondents noted that the **scale up of treatment** is now a complementary component or, some argue, pre-requisite, to scaling up prevention. With the increased hope represented by ARVs, it is expected that many more people will want to learn more about HIV/AIDS, be tested and to know if they too can be treated.

5. PREVENTION THINKING: A HELP OR HINDRANCE TO REDUCING VULNERABILITY?

Respondents to the consultation expressed a number of different opinions about whether the current framework for prevention approaches – particularly the focus on risk, vulnerability and impact reduction – actually facilitates or compounds the reduction of vulnerability, tackling of human rights issues and reduction of stigma and discrimination.

Some organisations felt that the current **emphasis on rights** – which has gained particular prominence in campaigns around access to treatment - is both fundamental and vital to HIV prevention work. For example, organisations such as Alliance Zambia have included rights-based concepts in their support to concrete initiatives, such as the work of an organisation of university graduates that intervenes in cases of employers trying to impose mandatory testing.

Several respondents also indicated that **reducing risk** is a key foundation stone for their prevention efforts, for example by providing people with better STI information and treatment and, in turn, making them less likely to become infected if exposed to HIV. Of particular note, some organisations described the ever-changing complexity of trying to address risk in practice. For example, the Stop AIDS Alliance highlighted how the arrival of treatment in countries such as the Netherlands has made some gay men “overly optimistic”, in terms of encouraging them to either take more risks or become more calculating in their risks.

Overall, however, many respondents expressed that, despite the “worthiness” of remits to emphasise rights and reduce risk, in practice many initiatives struggle in terms of concretely addressing **vulnerability** and achieving **impact**. This is fundamentally because, in practice, they fall fowl of prevailing socio-cultural inequalities and political circumstances, as well as stigma and discrimination. Indeed, some organisations argue that specific client and behaviour-driven interventions (e.g. safer sex, condom use and harm reduction) will only ever have limited effect and longevity if they fail to address some of the underlying, contextual causes of vulnerability (e.g. poverty, gender inequalities and religious objections to barrier methods), as well as the practical limitations faced by countries, such as poor health care infrastructure.

“Without fighting prejudices, nothing seems possible.”

Stop AIDS Alliance

As CAFOD advocates, in reality, discriminatory or unjust economic, social, cultural, legal, political, gender and religion-related factors, significantly curtail the behaviour choices of those who are vulnerable. Even when the influence of these factors is recognised, HIV prevention strategies are still too often concerned solely with risk reduction layers. As a result, issues related to vulnerability and risk are consigned to completely separate response strategies by governments, NGOs and other institutions. The result is a disjointed approach that fails to make the connection in practical terms between immediate risks of infection and underlying vulnerability.

Respondents shared many examples of what this means in practice. For example, several organisations feel strongly that there is still a severe lack of attention to – and, consequently, progress on – gender issues, with the Health Communications Project arguing for greater efforts to explore the power dynamics between men and women, with particular emphasis on domestic violence. Meanwhile, other organisations, such as the African Services Committee believe that there is still much work to be done with health care workers - whose own fears and prejudices prevent them from both routinely offering HIV tests to all patients and taking a test themselves. Finally, the OSI cites how punitive legislation in many Eastern European countries, combined with oppressive practices of bodies such as the police, mean that groups such as IDUs and SWs remain criminalised – a situation where human rights can seem little more than a pipe dream and prevention efforts are extremely limited.

Meanwhile, Christian Aid advocates for vulnerability to be examined – and, in turn, linked to – economic frameworks. For example, it cites how, if a community is impoverished through an economic policy decision (e.g. the privatisation of an industry and resulting unemployment), the policy architects may argue that this

impact will be short-term. But, if HIV vulnerability increases, the impact will be permanent and potentially devastating. For this reason the likely impact on HIV must be assessed before economic policy decisions are taken, by governments, donors or international institutions, such as the IMF or World Bank.

Furthermore, concrete changes to structural and contextual barriers are necessary not only for the continuation and scaling up of present prevention initiatives, but the development of future technologies. For example, IAVI emphasises how the introduction of microbicides or vaccines would not obviate the need for continued social mobilisation, the realisation of human rights commitments, improved gender equity and behaviour change activities. Instead, their successful introduction would actually depend on success in each of these.

Overall, respondents felt that, while recognising the challenges of putting principles into action, future thinking about HIV prevention should continue and, indeed, increase its focus on human rights. For example, African Services Committee feels that greater attention should be paid to the definition of “vulnerable”, taking on board human rights as well as economic factors – as vulnerable people are not necessarily from poor countries, but may be strategically vital to reach and in acute need of resources and support. Meanwhile, the Centre for Health and Gender Equity argues that, irrespective of their level and nature, all HIV prevention strategies should be based on an integrated health and rights framework. This includes ensuring the right to access to information, the right to hold governments accountable and the right of make choices free of violence or coercion of any kind.

As a final point, it was felt that the scale and urgency of the global pandemic brings an unprecedented opportunity to foster constructive dialogue and address the far-ranging social, policy and legal impediments to HIV prevention. However, some respondents felt that attention to such areas is immaterial when a large proportion of power – to both fund and shape prevention programmes – lies in the hand of donors, such as the US Administration, that do not support, let alone promote, people’s full range of rights, for example the right to sexual expression or to explicit information about modes of HIV transmission.

SUPPORTING DOCUMENTS:

The following documents were submitted to support the feedback of some of the responding organisations:

- *“Developing Country Roles and Leadership in Microbicide and Vaccine Research and Access. New Preventative Technologies: Providing New Options to Help Stop the Spread of HIV/AIDS”*, International AIDS Vaccine Initiative, www.eu2004.ie (under The Presidency, Meetings and Events, Presidency documents)
- *“A Comprehensive Response Today: Ending the Epidemic Tomorrow,”* International AIDS Vaccine Initiative, www.eu2004.ie (under The Presidency, Meetings and Events, Presidency documents)
- *“Downward Spiral: The Absence of HIV from Economic Policy-Making”*, Christian Aid, 2004, www.christianaid.org.uk (under in-depth, HIV/AIDS)
- *“Dying to Learn: HIV, Young People and Churches,”* Christian Aid, 2003, www.christianaid.org.uk (under in-depth, HIV/AIDS)
- *“HIV Debate: No Simple Solutions”*, CAFOD, www.cafod.org.uk (under Policy/Analysis, Comment/Editorial)