



ELECTRICITY ACCESS ROLLOUT PROGRAMME (EARP)

SCALING -UP ENERGY ACCESS PROJECT (SEAP)



FINAL REPORT

HIV/AIDS PREVENTION BEHAVIORAL STRATEGY (HPBS)

"An awareness to reduce HIV/AIDS transmission at
construction sites & nearby communities"

(How to make them work better?)

Developed by:

ANGELIQUE INTERNATIONAL LIMITED (AIL)

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*An awareness Strategy to reduce HIV/AIDS transmission at
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Abbreviations

AIDS: Acquired Immune Deficiency Syndrome
AIM: AIDS Impact Module
ART: Anti-Retroviral Treatment
ARV: Anti-Retroviral (drugs)
BCC: Behavior Change Communication
BMI: Body Mass Index
BSS: Behavioral Surveillance Survey
CAMERWA: Centrale d'Achats des Médicaments Essentiels du Rwanda
CDC: Centers for Disease Control and Prevention
CDLS: Comité de District de Lutte contre le SIDA
CHW: Community Health Worker
CNLS: Commission Nationale de Lutte Contre le SIDA (National AIDS Control Commission)
DALYs: Disability Adjusted Life Years
DDP: District Development Plan
DHS: Demographic and Health Survey
EDPRS II: Economic Development and Poverty Reduction Strategy II
EMR: Electronic Medical Recording System
EMTCT: Elimination Mother-to-child Transmission of HIV
FOSA: Formation Sanitaire (Health Facility)
FSW: Female Sex Workers
GBV: Gender-Based Violence
GF: Global Fund
GIPA: Greater Involvement of People living with HIV and AIDS
HAART: Highly Active Antiretroviral Therapy
HBV: Hepatitis B Virus
HCC: Health Communication Center
HCV: Hepatitis C Virus
HF: Health Facility
HIV: Human Immunodeficiency Virus
HMIS: Health Management Information System
HSSP III: Health Sector Strategic Plan III
IDU: Injecting Drug Users/Intravenous Drug Users
IEC: Information, Education, Communication
IHDPC: Institute of HIV Disease Prevention and Control IV: Intravenous
IYCF: Infant and Young Children Feeding
MESST: Monitoring and Evaluation Systems Strengthening Tool
MC: Male Circumcision

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MDGs: Millennium Development Goals **M&E:** Monitoring and Evaluation
MIFOTRA: Ministère de la Fonction Publique et du Travail (Ministry of Public Service and Labor)
MINECOFIN: Ministry of Economy and Finances
MPPD: Medical Procurement and Production Division
MoH: Ministry of Health (Rwanda)
MOT: Mode of Transmission
MSM: Men who have Sex with Men
MSW: Male Sex Workers **MTR:** Mid Term Review
MUAC: Mid Upper Arm Circumference
NCBT: National Center for Blood Transfusion
NCC: National Commission for Children
NGO: Non-Government Organization
NRL: National Reference Laboratory
OAG: Office of Auditor General
OBBI: Other Blood Borne Infections
OI: Opportunistic Infection
OVC: Orphans and Vulnerable Children
PEP: Post-Exposure Prophylaxis
PEPFAR: US President's Emergency Plan For AIDS Relief
PICT: Provider-initiated Counseling and Testing
PIT: Provider-initiated Testing
PLHIV: People Living with HIV
PME: Planning, Monitoring and Evaluation
PMTCT: Prevention of Mother-to-Child Transmission of HIV
PSF: Private Sector Federation
PWD: People With Disability
QMS: Quality Management System
RBC: Rwanda Biomedical Center
RCA: Rwanda Cooperative Agency
RCLS: Confessions Religieuses pour La Lutte Contre Les SIDA (Rwanda Interfaith Network against HIV and AIDS)
RRP+ : Réseau Rwandais des Personnes Vivant avec le VIH (Network of PLHIV)
SDC: Sero-Discordant Couples **SRH:** Sexual and Reproductive Health
SDGs: Sustainable Development Goals
STI: Sexual Transmitted Infection
WG: Technical Working Group
TRAC Plus: Centre for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics
TB: Tuberculosis
UNAIDS: Joint United Nations Program on AIDS
UNGASS: United Nations General Assembly Special Session on HIV and AIDS

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UN: United Nations

UPHLS: Umbrella des Personnes Handicapées dans la Lutte contre le SIDA
(Umbrella of People with Disabilities in the Fight against HIV and AIDS)

US: United States

USG: United States Government

USPLS: Umbrella of Public Sector against HIV and AIDS

VCT: Voluntary Counseling and Testing

VPDD: Vaccine Preventable Diseases Division

WHO: World Health Organization

1. Introduction

No one thought, 25 years ago, that HIV prevention would be as difficult as it has proven to be. Despite efforts, UNAIDS now estimates that 33 million people are living with/, and 2·5 million new infections arise every year. So, we must do better and the question is how we have learned that no simplistic or even simple solutions exist for HIV prevention. We need to remain humble as we approach the issue of how to keep the virus from moving from one person to another.

Despite this, it has been difficult to develop and implement strategies and programmes that extend behaviorally-based HIV prevention to enough countries and people, and throughout a sufficient number of sectors of society to reverse or even stem the advance of HIV/AIDS. The 2007 UNAIDS report estimates that over 2 million new HIV infections occur every year.¹ Countries such as Mozambique, South Africa, and Zambia show no decrease in levels of HIV/AIDS infection. This strategy has been studied and drafted by Mr. Olivier RUKUNDO, the Public and Environmental health Specialist and associate to BESST Ltd on behalf of AIL Ltd.

1.1 The Aim

The strategy is aiming to:

- Reduce the rate of new HIV infections in our operations sector (Electrical industry)
- Ensure appropriate management of construction workers affected and infected by HIV/AIDS
- Facilitate access to Voluntary Counseling and Testing (VCT)
- Facilitate access to Sexually Transmitted Infection (STI) treatment
- Capacitate the our Sites with the necessary knowledge on treatment, self care and wellness as HIV infected
- Reduce the stigma and discrimination attached to construction workers suffering from HIV/AIDS
- Encourage safe working environments on our construction sites
- Position the our Sites to respond to the risks of direct and indirect costs incurred as a result of the disease
- Aim to reduce HIV/AIDS infection in the communities in which the industry works
- Monitor, evaluate and review the Strategy continuously to ensure relevancy and effectiveness

1.2 Know your epidemic

Rwanda continues to experience a mixed HIV epidemic, generalized in the adult population, with an adult HIV prevalence rate stabilized around 3 percent, and concentrated in some high risk groups such as FSW. The HIV prevalence in the population aged 15–49 as estimated through the Rwanda Demographic and Health Survey (DHS) remained the same in both 2005 and 2010 at approximately 3 percent (confidence intervals [2.6–3.5 percent] in 2005 (8); [2.78–3.36 percent] in 2010.

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HIV prevalence in 2010 remained higher among women (3.7 percent) than in men (2.2 percent) and higher in Kigali City (7.3 percent) than in the other provinces (average 2.4 percent), maintaining the same trend as reported in DHS 2005 data.

Though HIV prevalence has remained relatively stable in the general adult population, representing sexual HIV transmission, prevalence rates among HIV-exposed infants, representing vertical transmission, have drastically declined. The transmission of HIV from mother to child is down to 2.9 percent for HIV-exposed infants at 18 months of age from 6.9 percent in 2009(9). In an effort to understand the dynamics of the HIV epidemic across risk groups, the RBC commissioned an application of the UNAIDS Modes of Transmission (MOT) model in order to estimate the expected distribution of new HIV infections by exposure group (10). The model uses existing demographic, epidemiological and behavioral data for each risk group from national, regional and international sources. This exercise was led by the HIV and PME Divisions within RBC with close collaboration of partners including UNAIDS, Centers for Disease Control and Prevention (CDC) and MEASURE Evaluation. The modeling exercise is limited to sexual transmission and is applied to the adult population 15–49.

1.3 Strategy Model

- ❖ As warden of Site, the Service has a social responsibility towards the Site to address the current and future impact of HIV/AIDS. This responsibility together with the belief that the industry is faced with increased HIV prevalence numbers amongst its workforce, urged the Department to implement a Strategy in response. Interventions were designed to raise awareness levels on HIV/AIDS and to equip the Site with the necessary knowledge to change attitudes and behaviours that fuel/accelerate the spread of the disease.
- ❖ Strategy interventions in the model are outlined as:
 - The line items included in tender documentation enforcing HIV/AIDS programme implementation on projects of size
 - Training and awareness raising on construction sites
 - Implementation of HIV/AIDS preventative measures on site e.g. condom distribution(Male and Female types)

2. POLICY ENVIRONMENT

2.1 National policies

The strategies presented in the STRATEGY are aligned with Rwanda's Development strategic documents: Vision 2020, EDPRS2 (2013–2018)(1) and HSSP3 (2012–2018)(3).

The Vision 2020, which gives long-term objectives for the country's development progress, recently revised several of its key indicator targets because those that had been set initially have already been achieved. Among these is the target for HIV prevalence that has been **reduced from 8 to 3 percent (the current level)**. As Rwanda is striving to come close to the general objective of the global HIV response of 'No new HIV infections' and 'No HIV-related deaths', our goal for the medium term is to maintain the HIV prevalence at the current level (3 percent of adult population). The new EDPRS (2013–2018) considers HIV as one of its cross-cutting issues and acknowledges the extensive gains made in preventing HIV using five integrated components: VCT, prevention of mother-to-child transmission (PMTCT), male circumcision, behaviour change communication (BCC), and HIV treatment. HIV is also identified as an important program within the health sector strategy of EDPRS2 (2), as one of the foundational issues on which emerging economic priorities can be developed. The goal of the health sector in Rwanda within the EDPRS framework is to improve the quality, demand and accessibility of primary healthcare, of which HIV is an important component.

The HSSP 2012–2018 (3) also gives a general orientation on health sector priorities in the HIV response for the coming five years, identifying the key challenges to which the health sector needs to concentrate in order to achieve universal access for HIV prevention and treatment services. 3.1.2 International policies Apart from these guiding national documents, the STRATEGY is also aligned with the main international strategic documents, such as the MDGs and the new UNAIDS Investment Framework.

The spectacular progress achieved by Rwanda in the last five years, not only for the health indicators, but also for those measuring social and economic development shows that Rwanda is on track for achieving most 2015 MDG targets.

For MDG 6A specifically, the aim was to have halted and begun to reverse the spread of HIV and AIDS and to provide universal access to treatment of HIV and AIDS for all those who need it by 2015.

Comparing the stabilization of HIV prevalence between the current national HIV prevalence and past estimates, coupled with declining rates of HIV-related mortality, plausible evidence suggests that the spread of the infection is halting. Even though we do not have consistent and comparable measurements of HIV incidence for risk groups within the country over time to allow for the analysis of temporal trends, projections of new infections obtained by statistical models (EPP/Spectrum) suggest that HIV incidence is on a downward trend. In terms of access to ART for eligible HIV patients, the current coverage is estimated at over 90 percent of patients, well within the definition of universal access. All the key interventions identified by the UNAIDS Investment Framework (PMTCT, promotion of condom use and distribution, working with key populations, treatment, care and support to PLHIV, male circumcision and BCC programs) are programmatic priorities within the STRATEGY logical framework. The critical enablers and synergies with development sectors identified in this framework are also taken into account in our Strategy (described in the next chapter on overarching principles).

Furthermore, to adapt to the changing economic environment and prepare for possible financial constraints in the implementation of our STRATEGY, we have conducted an in-depth prioritization exercise that generated three scenarios with different levels of costing described in the costing chapter of this document.

2.2 Overarching principles

2.2.1 National mobilization and ownership

One of the main reasons behind Rwanda's success, not only in addressing HIV and AIDS, but in the health sector in general, and more widely in the country's social and economic development has been the strong commitment of decision makers and opinion leaders to join efforts to reach jointly set targets, and to hold donors and development partners accountable for a common nationally-led vision.

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HIV is a cross-cutting issue for EDPRS 2, which means that all economic development sectors are accountable for contributing to the national HIV response and all sectors of Rwandan society are aware of their responsibility in addressing the epidemic.

Of course, external support has been and continues to be a major contributor to the national HIV response, but the strategies adopted and the relationship between national and international actors all aim at strengthening the alignment of all stakeholders to national priorities and the sustainability of interventions. This continues to be a strong principle that will guide the implementation of this STRATEGY.

2.2.2 Equity and human rights

In spite of the strong results achieved by Rwanda in the last decade in addressing the HIV epidemic, issues of stigma and discrimination relating to the HIV epidemic are still persistent. Great strides have been taken to ensure geographic and financial accessibility to health and HIV services to all citizens, yet some marginalized groups still experience barriers to accessing appropriate and adapted services. Regarding the involvement of PLHIV in the planning and management of the HIV program, the Rwandan network of PLHIV (RRP+) plays an important role of advocacy and representation in all the decision-making bodies for the HIV response.

RRP+ is also involved in interventions for economic empowerment of PLHIV (through cooperative formation and strengthening) and in addressing stigma and discrimination related to HIV.

The RRP+ will continue to play a prominent and active role at the national and decentralized levels in the implementation of this plan. Gender equity, following the findings of the recent gender assessment of Rwanda's national HIV response, the promotion of gender equity remains a priority orientation of the HIV response. The principles outlined in the gender and HIV strategy adopted in 2010 and operationalized in the National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010–2014 are integrated in this STRATEGY of HIV integration. The integration of HIV services is achieved at various levels: – Complementarities of HIV services.

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The HIV response employs combinations of and achieves synergy between different HIV strategies and services in order to offer a comprehensive package of services adapted to different target groups. This includes linkages between preventive and curative services, and between community-based and facility-based interventions. – Integration of HIV services within broader health programs. As HIV progressively becomes a chronic disease, it needs to be better integrated into the general system of healthcare provision, particularly health programs with strong linkages to HIV interventions, including sexual and reproductive health, nutrition and mental healthcare. Integration of HIV services into the health system has always been a strong characteristic of the Rwandan HIV response, and this has benefited both the HIV program and the health system in general. In this STRATEGY, a large component of the overall planning of resources is linked to health infrastructures and equipment and to human resources for health, which cannot be managed separately for the HIV program, but on the contrary analyzed through a systemic approach, where HIV is contributing to, and benefiting from, the general health system's resources.

- HIV mainstreaming. The multi-sector integration of HIV in the wider national development agenda is ensured by the identification of HIV as a cross-cutting issue within EDPRS 2. Each sector within EDPRS has specific HIV mainstreaming strategies and targets.
- Regional integration of the HIV response. With the strengthening of the East African Community, citizens in each East African country entertain more socioeconomic opportunities across countries, leading to higher regional mobility. As such, it is becoming increasingly relevant and important to establish harmonized protocols and guidelines for HIV prevention and care interventions in all countries of the region.
Regular regional coordination meetings take place between the health sector and HIV decision makers to develop regional reference documents that will be uniformly applied.

2.2.3 Cost-effective and evidence-based planning and response

The planning process of this STRATEGY has been based on existing evidence, both at national and international levels, to assess progress made to date in the national HIV response and to select the best strategies for achieving national targets.

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The national M&E system has been central to obtaining up-to-date data through routine monitoring, surveillance and surveys and research and evaluation.

One area of improvement in our M&E system during the coming period will be to strengthen the evaluation component of the system, with the objective to gather data that will allow us to better assess the degree to which impact results are being achieved in terms of reduction of new HIV infections and HIV-related deaths.

Special emphasis will be placed on improving the quality of services. This will be achieved through the strengthening of the integrated supervision system that will identify areas of weakness within our interventions and the associated mentoring designed to address and correct these weaknesses. Finally, one of the most important trends that is taken into account in the strategic planning process is the declining trend of external funding for the HIV response.

This STRATEGY maintains ambitious national targets for the reduction of new HIV infections and of HIV-related deaths, but to take into account the difficult financial environment, different scenarios with varying levels of funding have been elaborated, with prioritization of the most cost-effective interventions in the scenarios with lower budgets. The methodology for the development of these scenarios and for prioritization of interventions is described in the Costing and Prioritization chapter at the end of this document. Another strategy adopted to maximize cost efficiency of HIV interventions is to increasingly call upon civil society and private actors for activities where they have expertise and bring comparative advantage for efficient implementation.

2.2.4 Capacity building

Strengthening the capacities of healthcare providers is a priority to improve quality of services and ensure optimal efficiency of interventions. Increasing resources are being allocated for the training and recruitment of specialized medical doctors to meet increasing demand for high quality care. Task shifting, with appropriate training of nurses to fulfill responsibilities previously reserved to physicians, allows for better coverage of services to the increasing number of patients receiving ART and freeing physicians for management of more complex medical problems.

Apart from improving knowledge and skills of healthcare providers and other health workforce members, capacity building activities also aim at organizational and

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institutional strengthening to ensure continuity of quality service provision in spite of the frequent problem of human resource instability and rapid turnover.

a. The purpose Of the capacity building

The purpose of the capacity building is to:

- ✓ To create a safe and non-discriminatory work environment
- ✓ To ensure confidentiality for those who disclose their HIV status
- ✓ To ensure and demonstrate commitment for the fight against HIV/AIDS
- ✓ To promote the rights and responsibilities of both management and employees

b. Training Modules and Planning

Section	Key Activities	Timing
Registration and Opening	<ul style="list-style-type: none"> • Pre-training HIV/AIDS questionnaire 	20Min
Module I: The Basic Facts and Myths about HIV/AIDS	<ul style="list-style-type: none"> • HIV and AIDS facts • Small group questionnaire and discussion • Large group debriefing • Lesson learnt presentation • Co-factors for HIV infection 	50Min
Break		30Min
Module II: The Impact of HIV/AIDS on Your Business	<ul style="list-style-type: none"> • The impact of HIV/AIDS on business • Case Study: Local Dispensary 	50Min
Lunch		30Min
Module III: Workplace Programs- Getting Started and the Essential Elements	<ul style="list-style-type: none"> • Introduction to workplace activities • What a business can do • A workplace program • Getting started and organized • Essential programmatic elements 	50Min
Break		60Min
Module IV:	Resources and support tools	50 Min

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Creating Your Program	<ul style="list-style-type: none"> • IFC's role • Partnerships/NGO presentation(s) • Creating the Roadmap for Action 	
Workshop Closing	<ul style="list-style-type: none"> • Follow-up process: Introduction <ul style="list-style-type: none"> • Wrap-up and evaluations 	

c. CHECKLIST FOR FOLLOW UP SESSION

Name of Company: _____ Site Name _____

Country: _____

Date of Session: _____ Facilitator: _____

Tel. Number: _____ Email Address: _____

Name of Participant: _____ Number of Employees: _____

Description of Action/Activity	No Action	Action in Progress	Action Completed
<p>Foundations of the HIV/AIDS program:</p> <ul style="list-style-type: none"> • The Management support • Coordinator selected and appointed • AIDS workers committee established • Training resolutions adopted at the operational level • Management endorsed the resolutions • resolutions and materials like posters promoted and circulated at all levels in the workplace • Budget allocated • Condoms are available and accessible to all employees 			

3. PRINCIPLES OF THE HIV/AIDS AWARENESS PROGRAMME

3.1 Awareness workshops with workers

Contractors will have to provide awareness workshops (To be facilitated by an oriented expert [To be hired]) to all of the workers that will work on our sites.

- The content of workshops should comply with a list of Specific Learning Outcomes (SLOs) that focus on HIV/AIDS;
- Workers should be exposed to workshops for a minimum of two and-a-half hours;
- Sessions should be interactive and not more than 25 people should attend a session;
- A video of HIV/AIDS in the construction industry, obtained from the Department of Public Works is to be screened to construction workers at workshops.

3.2 Awareness materials and condoms

Awareness material should be obtained from the National Department of Public Works and in National commission to fight against AIDS/HIV

3.3 Awareness Posters

Four awareness posters were developed for the programme containing key HIV/AIDS messages. – The information on the closest VCT facility and the closest clinic should be displayed on a poster on site.

- Posters should be displayed in highly trafficked areas on site. An HIV/AIDS information booklet was developed for the programme and should be distributed to all workers on site.
- Both male and female condoms should be readily available on site and kept in condom dispensers. And where applicable illustration pictures shall be in place to enhance the information dispensing.

4. STRATEGY SCENARIOS

4.1 Behavioral strategies (Key messages)

- **HIV prevention is neither simple nor simplistic.** We must achieve radical behavioral changes—both between individuals and across large groups of at-risk people—to reduce incidence. Once achieved, it is essential that such changes are sustained
- **Although cognitive-behavioral,** persuasive communications, peer education, and diffusion of innovation approaches to change are beneficial within a combination prevention framework, behavioral science can and must do better. Novel theoretical and programmatic approaches are needed to inform new approaches to motivate behavioral change
- **Goals for behavioral strategy involve knowledge,** stigma reduction, access to services, and delay of onset of first intercourse, decrease in number of partners, increases in condom sales or use, and decreases in sharing of contaminated injection equipment. A multilevel approach that encompasses behavioral strategies must be taken—behavioral HIV prevention needs to be integrated with biomedical and structural approaches, and treatment for HIV infection
 - **The fundamentals of HIV prevention need to be agreed upon,** funded, implemented, measured, and achieved in a comprehensive and sustained manner. Access to HIV prevention information, messages, skills, and technologies is essential and a fundamental human right

Advances in scaling up antiretroviral treatment in resource-poor countries, the benefits of male circumcision, and the hoped for promise of pre-exposure prophylaxis and microbicides do not render behavioral strategies obsolete. If anything, behavioral strategies need to become more sophisticated, combined with advances in the biomedical field, and scaled up.

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But that task is not easy. Sexual behaviours and the sharing of injection equipment that cause most HIV infections worldwide occur for many motivations (eg, reproduction, desire, peer pressure, pleasure, physical or psychological dependence, self-esteem, love, access to material goods, obligation, coercion and force, habit, gender roles, custom, and culture). The varieties of sexual expression are infinitely greater than is acknowledged or sanctioned by most societies' defined legal and moral systems.

Ironically, most societies—either openly or clandestinely—provide opportunities for varied sexual expression, often within the context of substance use, even if the defined legal and moral systems seem somewhat rigid. Sexual behaviour typically does not occur in public, making it difficult to motivate protection when potential transmission occurs, and making it almost impossible to verify reports of what people say they have or have not done. Substance use to the point of intoxication is not only allowed, but is central to many countries' economies, and attempts to control the distribution and sale of illegal substances—and especially drugs that are injected—have met with little success.

Behavioral change has been responsible for the prevention successes to date. Strategies to modify risk behaviours need to remain a main priority for HIV prevention. We define behavioral strategies as those that attempt to delay onset of first intercourse, decrease the number of sexual partners, increase the number of sexual acts that are protected, provide counselling and testing for HIV, encourage adherence to biomedical strategies preventing HIV transmission, decrease sharing of needles and syringes, and decrease substance use. Behavioral strategies to accomplish these goals can focus on individuals, couples, families, peer groups or networks, institutions, and entire communities.

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Whereas structural strategies seek to change the context that contributes to vulnerability and risk and biomedical interventions block infection or decrease infectiousness, behavioral strategies attempt to motivate behavioral change within individuals and social units by use of a range of educational, motivational, peer-group, skills-building approaches, and community normative approaches.

This series of documents on HIV prevention emphasizes that highly active HIV prevention inevitably must be combination prevention. Advances in biomedical HIV prevention, as in the case of male circumcision or the potential of antiretroviral therapies for prevention, provide substantial opportunities to re-invigorate behavioral approaches to HIV prevention and challenge us to advance structural approaches so that these advances can get to those who need them the most.

All these prevention approaches contribute to effective HIV prevention within communities, and thus behavioral strategies need to be used in combination with biomedical and structural approaches that are combined strategically to address local epidemics.

The first successful examples of behavioral change resulting in decreases in HIV incidence emerged from communities of men who have sex with men in many countries took the HIV epidemic seriously fairly early on and established measures to change transmission behaviours and reduce rates of HIV infection. Senegal averted an epidemic through behaviour change that was helped by cross-sectoral cooperation, the reach of the faith sector, and inclusion of marginalized and poor groups with high risk of HIV.

Some Approaches for harm reduction combining access to clean syringes and needles together with education, outreach, and access to drug treatment have been successful worldwide in reduction of HIV transmission acquired via sharing of

prevention and injection equipment. Heavy alcohol use and stimulants (this includes daily and weekly cash in-hand salaries) remain major drivers of HIV transmission in many places and in many groups of people.

4.2 What do some successes have in common?

To reduce major successes in HIV prevention to one or two elements (eg, reduction in the number of associates), or to one or two strategies, is always a temptation and analogous to immunotherapy for treatment of HIV disease. We reject that simplistic analysis and instead argue that reductions in HIV transmission in entire countries or regions or in specific risk groups inevitably result from a complex combination of strategies and several risk-reduction options with strong leadership and community engagement that is sustained over a long time. The effective mix will vary by transmission dynamics and several other factors.

Three important lessons emerge from other case studies.

- ❖ First, radical behavioral change is needed in a sufficiently large number of people who are potentially at risk to reduce HIV transmission. Rwanda's 70% decrease in HIV prevalence, for example, was linked to a 60% reduction in sex with non-primary allies, a 1-year delay in onset of first intercourse, and increases in condom use. One analysis of the Rwanda success surmised: "Our findings indicate that substantial HIV reductions in Rwanda resulted from public-health interventions that triggered a social process of risk avoidance manifested by **[fundamental]** changes in sexual behaviours.

First, Communications were clear and direct, and widespread involvement from various sectors of Rwandan society was achieved. Modest changes in behaviour are helpful, but changes in transmission require that large numbers of people change their behaviours substantially and maintain these changes for a long time.

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- ❖ Second, a mix of communication channels disseminated simple and clear messages about several risk reduction and health-seeking options (eg, delay of onset of first intercourse, reduction in number of buddies, condom use especially with non-primary buddies, HIV testing, and treatment for sexually transmitted infections). One risk reduction strategy (eg, abstinence or partner reduction) should not be emphasized over another (eg, condom use), since people like choice and the mix of strategies is essential if not be emphasized.

- ❖ Third, local involvement in message design, production, and dissemination was essential. In fact, one of the most energizing activities in many strategies and campaigns for HIV prevention involves using the creativity and energy of people who are most affected by the epidemic to develop messages and strategies to motivate behavioral change.

Sustaining reductions in high-risk behaviour and HIV incidence once they have occurred has happened rarely, if at all. The number of HIV infections in men who have sex with men is now increasing in the USA and many European countries. Rwanda has reported stable HIV prevalence in a rapidly growing population (which translates into a quite greater number of people living with HIV/AIDS) and increases in risky sexual behaviour [actual rate of 3% of seropositivity]. Despite Thailand's successes in reducing general population prevalence, HIV has remained high in injecting drug users, men who have sex with men, and informal sites and industrial sex workers in multicultural groups.

4.3 Behavioral intervention research

Experience with behavioral intervention research parallels programmatic experience. Several studies and meta-analyses have investigated individually targeted behavioral interventions to reduce HIV-related sexual risk behaviour. Historically, most approaches are based on:

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- cognitive-behavioral approaches,
- communications theory,
- peer education, or diffusion of innovation, and
- The benefits and restrictions of these approaches are now well known.

The behavioral changes effected are statistically significant in studies that are designed to assess the efficacy of such interventions, but rarely sufficient to reduce sexually transmitted or HIV infections. Project EXPLORING is the only intervention study for HIV behaviour with an HIV endpoint, and it draws attention to the benefits and restrictions of behavioral interventions for individuals. It used an intensive one-to-one training and counselling format over ten sessions to reduce HIV incidence in sex workers.

A multilevel approach to behavioral strategies for HIV prevention with HIV counseling and testing as an example

APPROACH	Examples	Applied to HIV counselling and testing
Individual	Education; drug-related or sexual risk reduction counselling; skills building; prevention case management	HIV testing and counselling for individuals
Couple	Couples counselling	HIV counselling and testing for couples
Family	Family-based counselling programmes	Home-based family HIV counselling and testing
Peer group/network	Peer education; diffusion of innovation; network-based strategies	Voluntary counselling and testing for all network members

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Institution (eg, school, workplace, prisons)	Institution-based programmes	Services for voluntary counselling and testing available within workplaces and other institutional settings
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The training and counseling was highly individualized. Similar to other behavioral approaches, the training and counseling attempted to increase knowledge, perceived risk of acquiring HIV, motivation, and skills to change. Training and Counselors and clients assessed circumstances and occasions in which an individual might engage in risky behaviour, and then established risk reduction plans to assist the individual in avoiding HIV acquisition.

Control participants [*in this case: site employees& Nearby communities*] received Training and/or counseling on the basis of Project RESPECT model, in which individuals were given brief risk reduction training along with HIV evaluation or testing periodically. A previous clinical examination would show the efficacy of the Project RESPECT model in reduction of incident sexually transmitted infections. Individuals in the intensive experimental intervention should also receive maintenance sessions every 4 months after the conclusion of the treatment sessions.

Average follow-up can be at least 1.5 years, which is longer compared to that occurred in any other intervention check-up of behavioral change.

The overall incidence should be ranged between 2.0-3.0 person-years, and the rate of HIV acquisition in the intervention group must be lower than that in the control group, thus the effect will be not significant after adjustment for baseline data and variables). Thus, intensive one-to-one analysis would be not more effective than was thrice-yearly HIV analysis, testing, and recommendation.

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This controlled prevention trial is a good indicator of what has happened in large-scale programmes—namely, that effects are often marginal and changes are difficult to sustain. The effects of the intervention on HIV incidence seemed to be substantial in the first 12 months, with a lower reduction in the first 6 months and a greater reduction in the first 12 months.

But the intervention and control groups did not differ significantly in HIV incidence at the end of the 3·5 years of follow-up. Had the study terminated when behavioral studies are usually stopped (i.e., at 12-months' follow-up), the intervention would have been declared effective. The Project EXPLORING intervention was effective in reduction of some HIV risk factors (eg, increasing *safer sexual norms, protective communication skills, and self-efficacy to practice safer sexual behaviours*). But important risk factors such as stimulant and other drug use, heavy alcohol use, and depressive symptoms will not be affected, and these were important predictors of sero-conversion in both the intervention and control groups.

4.4 Get the programmes right

Two solutions to limited efficacy and lack of sustainability in behavioral strategies for HIV prevention exist.

- First, we need to think differently about the goals of different levels of interventions. Behavioral strategies are necessary but not sufficient to reduce HIV transmission, but are essential in a comprehensive HIV prevention strategy.
- Second, behavioral strategies themselves need to be combinations of approaches at multiple levels of influence.

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Resume: Multiple (multicultural) behaviours jointly enhance risks, and they need to be targeted through many levels to achieve the best results. Behavioral strategy aims might involve increased knowledge and awareness about how to protect oneself from HIV infection; dishonor/stigma reduction; encouraging access to services (eg, HIV mentoring or counselling, diagnosis, testing, and treatment of sexually transmitted infections, use of antenatal and reproductive health services); reducing use of sex workers; improving attitudes toward safer sexual practices; delaying onset of intercourse; decreasing number of buddies; increasing condom sales at affordable place and means; recognition of early symptoms of sexually transmitted infections or HIV; recognition and appreciations/encouragement of the benefits and limitations of male circumcision for protection against HIV; disclosure of HIV sero-status; harm reduction strategies; how to access treatment for HIV+; the importance of adherence to antiretroviral drugs; and so on.

The right combination of strategies, of course, depends on the profile of the populations engaging in risky activities, among whom HIV is spreading. Adoption of a comprehensive framework—in terms of combination HIV prevention and the use of multilevel behavioral strategies—requires that each strategy be assessed only in terms of what it is trying to achieve.

Failure to show that a specific strategy reduces HIV infection does not render it useless in a comprehensive programme or a multilevel behavioral strategy for HIV prevention. The combination of strategies (*i.e. Occupational, Health and Safety strategy & measures*) might be relevant to the end result.

Emphasis on some behavioral goals (eg, abstinence) to the exclusion of others has hampered prevention efforts. A so-called ABC approach to prevention of sexual transmission (abstinence, be faithful, condoms) has led to an inappropriate and ineffective focus on abstinence only, when the evidence is clear that several

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behavioral changes are essential for epidemic control. It would be useful if the abstinence-only controversy could be laid to rest. Although some moral systems encourage abstinence for ethical or religious reasons (and that is their right), public health in a pluralistic world needs to follow scientific findings. There have also been discussions, which are not particularly useful, as to whether condom use, partner reduction, abstinence, or delay in onset of intercourse reduced HIV prevalence in Rwanda and regional Countries. A combination of all these approaches is essential for immediate and sustained reductions in HIV transmission.

Scenario 1:

Specific activities undertaken in a multilevel behavioral intervention to increase access to Primary mentorship and access to drug for users :

Individual level:

- Drug-related counselling sessions with injecting drug users
- Fitpacks distributed (syringe-disposal containers with harm reduction information)
- Risk reduction pamphlets

Peer group/network level:

- Harm/risk reduction group sessions for injection drug users

Institution level:

- Visits to and trainings for community-based organizations serving primary mentorship for users
- Training for community-based organizations
- Pharmacy visits
- Pharmacist forums and trainings
- Pharmacy guides
- Posters in pharmacies

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Community level:

- Trainings and awareness
- Health fairs
- Posters, pamphlets, and stickers

Along with the work of several advocacy groups, resulted in these provisions being removed from the 2008 PEPFAR authorizing legislation. Collins and colleagues summarized it well when they said: “It is time to scrap the ABCs and elevate the debate on HIV prevention beyond the incessant controversies over individual interventions. Small scale, isolated programs, however effective, will not bring the AIDS epidemic under control.

To lower HIV incidence, especially in high transmission areas, policy makers, donors, and advocates need to demand national prevention efforts that are tailored to their epidemics, bring quality interventions to scale, and address environmental factors in vulnerability. That is why today’s most commonly cited acronym for HIV prevention—ABC—falls severely short of what is needed to reduce HIV transmission. ABC infantilizes prevention, oversimplifying what should be an ongoing, strategic approach to reducing incidence.”

4.5Combination behavioral prevention

HIV transmission is a dyadic event that occurs in social contexts, and thus, behavioral strategies working with social units might have greater potential than might those working with individuals in isolation.

Strategies working across many levels of influence might be more likely to affect behaviour than might those working only at one level, as shown by the multilevel behavioral intervention to increase access to primary mentorship on HIV.

The goal aim was to develop a community-based participatory research programme to establish whether a multilevel intervention would increase the seronegativity.

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The intervention worked to change behaviour at the level of individuals (peer groups and networks, institutions, and the community. Positive opinion and attitudes toward pharmacy approaches sales to use drug for concerned users increased among pharmacists and community members in the intervention community.

A significant decrease in seropositivity and a significant increase in pharmacy use were recorded in African intervention communities. Behavioral change interventions at the individual level include educational, skills-building, counselling, prevention case management, and other strategies that are delivered either one-to-one or in small groups. School-based HIV prevention also falls into this category, although it is often implemented in a limited form, meaning that the number of sessions is truncated, the lessons are informational only and not skills-based, and the format addresses the biology of HIV without providing the students with practical lessons and strategies on how to avoid acquiring HIV.

Although individual-level interventions might be helpful, they are not sufficiently efficacious or lasting to be used alone to reduce HIV transmission.

5. SCENARIOS-BASED STRATEGIC ANALYSIS

Research and programme agendas need to move beyond intervention studies at the individual level, especially those using approaches based on cognitive theories, and explore other potentially more powerful approaches to the behavioral change.

Strategies for buddies and site workers attempt to motivate behavioral change within a primary relationship. These strategies recognize that HIV transmission is a social event that occurs between two people, both of whom need to participate in the change.

HIV testing and counselling for partners and sites workers represents one very effective approach. Some estimates suggest that 60–95% of new HIV infections in Rwanda occur between coupled groups or living together, Prostitutors and construction/industrial sites without efficient control.

This strategy is showing benefits including reduction of HIV transmission, sexually transmitted infections, and unintended pregnancies between community members. We need more experience with concordant negative workers to understand how to prevent infection outside—and thus, inside—of the relationship. Identification of concordant positive buddies has the advantage of referring them for care and treatment, and encouraging outside partners or other members of the conjugal unit to be hardened if they are in a polygamous union.

Families and teenagers are clearly important in HIV risk, in addition to HIV transmission between partners, parents to children worker to worker, and infections resulting from home-based care activities. A series of studies on problem behaviours in adolescents have documented the important role that families have in promotion of a variety of health-promoting and HIV-associated

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risk reduction strategies in adolescents. Specific strategies that focused on communication between parents and adolescents have shown efficacy in reduction of problem behaviours. Family-based interventions for parents with HIV infection have been efficacious in reducing emotional distress and problem behaviours in none school attending adolescents and groups of between 15-35 years old in such families.

Scenario 2:

Addressing the social dynamics of HIV transmission within buddies and sites and industrial employees in Rwanda

- *Basic trainings about and Voluntary HIV counselling and testing for these categories has shown efficacy in reducing risk behaviour and HIV transmission within married or cohabiting young people groups.*
- *Basic trainings about and Voluntary HIV counselling and testing can allow them to provide mutual support for accessing treatment and for reproductive decision making*
- *Adverse consequences do occur, especially if the woman is infected and the man is not. Adverse consequences can be predicted from a history of alcohol abuse and violence within the relationship, and these factors should be used to advise these groups about the potential negative effects of voluntary counselling and testing for HIV*
- *Basic trainings about and Voluntary HIV counselling and testing might be little because of the myth that monogamy is safe, gender inequality, concerns that individuals infected with HIV will have adverse consequences, and the inherent difficulties of groups confronting together the possibility of one or both of them being infected with HIV*
- *Demand, however, is flexible and can be increased through community outreach, media, and home/site-based testing*

One family-centric model of behavioral HIV prevention involves HIV Basic trainings about and Voluntary HIV counselling and testing, delivered in the home/site to the entire family.

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In this approach, site-based trainers, explain the danger and what to do to the entire group and community and obtain permission, and then provide fallout to all family and community members. The perceived advantages are easier access, reduced stigma, and the possibility that counseling and disclosure for partners might be eased, especially in sero-discordant partners.

There are at least three primary approaches to use peer groups and networks as agents of change. The first involves peer education, which is especially effective when there is participation and collaboration with exposed people to be affected and vulnerable groups who are often alienated from formal service providers and government structures.

The first approach implicates the peer education is especially effective in increasing condom use and reducing sexually transmitted infections in high-risk groups in Rwanda especially including female sex workers, female bar or hotel workers, *Construction and industrial development sites*, in truck stops, high-risk men, men in the military, or clients of female sex workers. Peer education programmes have also been successful in increasing condom use in secondary-school students (aged 13–18 years) and rural populations.

The **second approach** involves diffusion of innovation and the involvement of influential leaders in the community, “...trusted trendsetters whose actions, attitudes, and views influence those of other members through interactions in existing social relationships”.

Diffusion of innovation was first applied to HIV prevention in a series of community-level outcome trials. This approach to HIV prevention relies on nine core elements that are clustered under three main headings: developing momentum, exposure, and repetition; delivering effective, theory-based HIV prevention messages; and initiating and sustaining risk reduction conversations.

The **third approach** involves network-based interventions. Social networks are associated with HIV risk behaviours and with sero-status, especially in injecting drug users. Network-based interventions involve gaining access to social networks through key individuals; identifying members of the injection, sexual, or social networks; training network leaders as peer educators; asking leaders to

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disseminate HIV risk reduction messages throughout their networks; and then assessing effects. Social network interventions have been used successfully to reduce sharing of related first aid equipments between injecting drug users and to reduce unprotected intercourse in groups of sex practitioners and heterosexual. Interventions for HIV prevention have been delivered in several social institutions including workplaces, prison, the military, faith-based organizations, and schools.

These types of institutions not only offer the opportunity to reach a large number of sometimes high-risk individuals, but might also be able to take advantage of stare networks and leaders, channels for diffusion of innovation, and media and other educational or motivational approaches. Workplace peer education programmes for prevention of HIV, for example, are quite popular but rarely assessed.

The workplace is a favored setting for reaching general populations of men and women of reproductive age and are regarded as an efficient place to deliver Trainings, voluntary counselling and testing services and to promote partners and family-centered HIV services. Workplace programmes, however, require attention to issues of confidentiality and maintenance of quality. Large and multinational businesses have been able to implement these types of programmes, but they are beyond the resources of enterprises of small and medium size.

A participatory research programme undertaken with the military provides one successful example of an institution-delivered intervention. Entire companies were assigned to the intervention group, a diffusion group (residing in the same barracks but not receiving the intervention), and a control group. Incidence of new sexually transmitted infections was seven times lower and HIV incidence was 50% lower in the intervention group than in the diffusion and control groups.

The intervention included participatory planning by the squad members, and used several strategies to reduce alcohol use and brothel patronage and increase consistent condom use, sexual negotiation, and condom skills.

Strategies at the community level involve the use of mass media, social marketing, and community mobilization. The use of mass media and condom social marketing have been effective in increasing condom sales and distribution in a variety of populations in Rwanda including sites truckers, urban and peri-urban adults, male miners, adolescents, and men and women seeking services for sexually transmitted infections.

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Project Accept, an example of community mobilization, is the first international, multisite, community randomized controlled study to establish the efficacy of a multilevel structural intervention for HIV prevention, with HIV incidence and shame reduction as study endpoints.

The intervention uses three major strategies:

- I. Community mobilization to enhance the access to the danger, the uptake of voluntary counselling and testing, thus increasing the rate of HIV testing, knowledge of status, and frequency of discussions about HIV;
- II. Community-based Awareness programs, voluntary counselling and testing to increase access to such services beyond health-care facilities and make awareness of HIV status more normative in community settings; and
- III. Comprehensive post-test support services that aim to improve the psychosocial wellbeing of people infected with HIV and their social network, and assist HIV-negative people in maintaining their negative status. Outcomes are being assessed at the individual and social level, with community sampling methods and recent HIV infection as the biological endpoint.

5.1 Get the behavioral science right

Behavioral science needs to do better in supporting effective HIV prevention. Behavioral strategies need to be liberated from the structures of present theoretical and methodological thinking. The goal is radical behavioral change, which means progressing from small focused studies of individuals on one area of HIV prevention to more comprehensive strategies that record effects on varied inputs, levels, and outcomes.

We can do a better job of disseminating effective approaches and, at the same time, supporting effective strategies built from the ground up. Social and behavioral science capacity is needed to achieve this aim, especially in hyper-epidemic settings.

Footstep 1: expand theoretical and methodological approaches

The limited benefit of behavioral strategies derives both from the present dominance of some theoretical approaches to behavioral change, and the limitations to knowledge from randomized trials testing the efficacy of interventions in individuals and small groups. The theories guiding most interventions are

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essentially cognitive and individualistic, and assume that people have the motivation and freedom to adopt protective actions. These theories generally do not address the fact that, whether in sexual contact or injecting networks, HIV transmission is a social event and many factors other than perceived threat, knowledge, self-efficacy, behavioral intentions, and perceived social norms affect whether or not an individual is going to share needles or have sexual intercourse and then whether or not sexual intercourse will potentially involve transmission risk.

Intervention studies have focused almost exclusively on the individual or small group, and scale-up of these types of strategies to achieve an epidemic effect has never been tried and might be tenuous. Examination of the Compendium of Evidence-Based Interventions by the US Centers for Disease Control and Prevention (CDC) shows that these strategies are almost entirely delivered to individuals or small groups. Although such strategies are no doubt useful, no attempts have been made to show how they might produce region-wide or country-wide reductions in HIV incidence or prevalence.

Almost all the interventions in the Compendium are based on social-cognitive theory or variations thereof.

Although the development of the Compendium was motivated by the need to compile and disseminate scientifically validated interventions, the major concern is that reliance on specific scientific methods—especially the randomized controlled design—determines the type of interventions that are studied rather than considering which types are needed for epidemic effect and matching the design to the research question. “...John Tukey reminds us that the public health significance of the research question should be paramount in the design of research. Important questions should not be ignored if they cannot be fitted into the framework of an RCT [randomized controlled trial]. Rather, the strongest possible design that can feasibly be implemented should be chosen, whether an RCT or an alternative design.

The main restrictions are that behavioral changes, although statistically significant, were insufficient to reduce HIV acquisition and that the interventions did not change the major contributors to infection—namely, the use of alcohol, stimulants especially short-term cash workers, and other drugs. Clearly, enough is known

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about the benefits and limitations of cognitive-behavioral intervention approaches and we should move on from social-cognitive interventions that are delivered to individuals or small groups and assessed for their efficacy in randomized controlled designs. Efforts have to be made to study other approaches, especially those that can potentially lead to population-wide sustained changes in behaviour and that address the link between substances and HIV transmission. Inevitably, theoretical models and the practical implications derived from them will increase in complexity, but that might be inevitable and perhaps what is needed.

Community mobilization efforts, which are effective in the early stages of the HIV epidemic in communities in resource-rich countries might be difficult to engineers, especially as we enter the age of antiretroviral therapy in most parts of the world. New motivational models, beyond those based on various methods of persuasive communication, are needed.

One example involves the use of economic incentives, cash, or other benefits transferred to individuals or families on the completion of publicly observable behaviours that support prevention or treatment.

Financial incentive strategies might be quite successfully for this case to decrease stimulant addiction and to improve people, child health and education. Experiments are underway to establish the effect of conditional cash transfers on child and families wellbeing, and programmatic efforts are underway to assess the benefits of cash incentives for successful completion of high discipline. Barnett and Weston, postulate that these types of interventions, as well as microfinance and other economically-based approaches, work by increasing predictability and thus hope for the future, leading to decisions that enhance health.

These types of interventions are but one example of innovative thinking in behavioral change. Clearly, the field needs many more creative approaches in view of what we know about the difficulty of preventing HIV transmission and the limits of present strategies for behavioral change.

Step 2: understand and stimulate ground-up approaches

Behavioral strategy is needed to mobilize prevention activities and programmes. Such efforts inevitably should involve building social and behavioral science capacity, particularly in resource-poor and hyper-epidemic settings. We need individuals on the ground who are knowledgeable about behavioral and social science and capable of integrating that knowledge with creative thinking about prevention and appropriate assessment strategies.

Scenario 3:

Insights from sero-epidemiological and behavioral-epidemiological studies in African countries include Rwanda

- *The best predictor of condom use at last intercourse is condom use at first intercourse, suggesting that early and comprehensive sex education is essential*
- *Partners who were older increased risk for HIV acquisition in young people in Africa, (e.g.: South Africa). But the highest risk was for partners 1-4 years older than the young woman, suggesting that strategies with slightly older men might be important in reduction of HIV risk for young women,*
- *Living in urban areas and in townships increases risk for HIV,*
- *Women in the work force/manpower are less likely to be infected with HIV than are men, which is the reverse of what is true in Africa generally. This finding means that the young women most likely to get infected with HIV are the least likely to enter the formal workforce. Workplace programmes will not reach those at highest risk for HIV,*
- *The best predictor of whether or not a young woman will get infected is whether or not she is in the training. Doing whatever we can to maintain training attendance might have health and other benefits.*

The data make the point that young people in Rwanda and Africa are at very high risk of acquiring HIV infection. Programmatic insights are clear; action is needed.

An assessment of so-called reputationally strong programmes (ie, those that are perceived to be efficacious even in the absence of evaluation data) of HIV prevention in the USA by the US CDC noted that such programmes had many intervention goals and typically used multilevel intervention approaches. However, the analysis also showed that community-based programmes succeed only in the context of strong institutional support and capacity to implement and sustain the programme.

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Thus, inspiration of ground-up or reputationally strong programmes needs not only funding streams that allow creativity to come out and be exercised, but also capacity building and organizational stability for community-based organizations to be able to undertake such work.

Community mobilization is an essential component in HIV prevention, as shown by documented successful programmes. Investigations are needed to understand how such mobilization occurs and what sustains it, especially over the long period of time that is needed for initial and maintained HIV prevention. A crucial element in successful prevention programmes is committed and sustained leadership at all levels.

Use of data to mobilize communities, to assess successes, and to plan for the future is another key factor in several successful programmes. Agencies funding research to effect behavioral change should priorities assessments of locally developed programmes and behavioral epidemiological and observational studies ahead of small-scale intervention studies. Assessments of existing programmes are essential, especially if we are to use all available approaches to achieve the difficult aims in behavioral HIV prevention.

Footstep 3: integrate behavioral, biomedical, and structural HIV prevention strategies with HIV treatment

The recent report of the Institute of Medicine, draws attention to the practical issues in ensuring adherence and the methodological challenges in measuring it in the context of prevention trials. The scientific published work for adherence suffers from the same concerns as does that for behaviour change—ie, it focuses on individuals and small groups, does not have methodological rigor, and has been undertaken primarily in high-income countries with uncertain generalization to low-income and middle-income countries. *We know that factors at the provider or clinic level, or sociocultural levels can affect adherence, and yet most strategies do not address these factors.⁹³ Similar to prevention, adherence science needs to expand beyond individual boundaries and to think more broadly about motivational and structural strategies, especially how such strategies can be applied to large populations so that prevention technologies have a chance of working when implemented.*

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Footstep 4: prevention with positives

Treatment for HIV has extended life in resource-rich countries, and HIV prevention has yet to catch up.

The next challenge is how to undertake effective HIV prevention in the period of more generalized access to antiretroviral therapy in resource-poor parts of the world. Prevention with positives becomes more achievable as individuals living with HIV/AIDS are encouraged to learn their aerostats and access treatment. HIV prevention typically has referred to protecting individuals from becoming infected with HIV, but substantially more efforts are being directed at helping individuals with HIV to avoid spreading it to others. Most individuals will want to remain sexually active after they learn of their positive aerostats, and this desire is even more likely as antiretroviral drugs extend not only life but also quality of life for people living with HIV/AIDS.

People who are unaware of their aerostats are very likely to transmit a high proportion of infections, and evidence from all countries shows that individuals reduce risk and take precautions to protect their partners once they know their aerostats.

So, the early and previous clinical evaluation and existing data access should help at this sense to stop this transmission due to the highlighted unacquainted situation.

Outline#: Percentage of sites sex workers, injecting drug users, plus the possibilities to men having sex with men who are reached by HIV prevention programmes

One of the major tasks for HIV prevention in the developing world must involve increasing the number of people who know that they are infected with HIV. Several strategies have proven successful in this regard, including the use of community opinion leaders, home/Site-based family-delivered training, counselling and testing, provider-initiated counselling and testing, and community-level counselling and testing as in Project Accept. Assistance with disclosure and partner testing, or the advancement of counselling and testing for buddies, can help to identify partners who are infected and in need of treatment, or who are not infected and in need of protection.

Risk compensation also deserves more attention, since any advances in reduction of HIV infections could be undone by compensatory increases in risk behaviour; however, this possibility should never be an excuse for failing to implement effective HIV prevention. A frequent observation, which was noted in many places after the introduction of highly active antiretroviral therapy, would be an increase in HIV risk behaviour or incidence, or the incidence of sexually transmitted infections. By contrast, risk compensation was not observed in clinical trials of the diaphragm or of male circumcision. Well crafted and informative observational studies are essential for understanding the extent, nature, and determinants of risk compensation, especially as innovations in HIV prevention or treatment are extended to entire populations. This approach should be a high priority for funding agencies, and repeated surveys will be essential to identify trends over time, as well as the use of strategies to address the issue.

Establishment of prevention as a standard of care, especially in medical settings, for all people living with HIV/AIDS is a major priority. It is essential to operationalise what this means for various settings and secure the resources for implementation. At the least, it will be essential that clinical-care providers undertake continual risk assessments and provide ongoing information, counseling, services for sexually transmitted infections, and referral to harm reduction and drug treatment for their patients infected with HIV. People who continue to engage in risky practices might need specialized referrals for more intensive pro-grammes, or treatment for substance abuse or mental-health issues.

5.2 Get the simple things right

HIV prevention is hampered by unparalleled impediments. The goals of universal access should include HIV prevention technologies and devices (eg, condoms, clean gratuitous, and drug treatment at a minimum or free), information, skills, and services. But this has not been the case in worldwide HIV prevention. Prevention of HIV is more controversial than is treatment for HIV/AIDS. But what should not be controversial is the imperative to use scientifically established and evidence-based strategies to save human lives.

It is not rare for governments to object to evidence-based and proven approaches to reduce behavioral risk for HIV infection.

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UNAIDS reports that non-governmental informants in countries report, laws, regulations, or policies that present obstacles to effective HIV prevention, treatment, care, and support for populations most at risk of HIV.

The initial programmes in Rwanda de-emphasized condoms because of concerns that they might encourage promiscuity and similar concerns have been raised about male circumcision and widespread access to treatment; however, fear of disinhibition should never be used as an excuse not to implement effective HIV prevention strategies, and especially now that male circumcision has such potential and that treatment of HIV disease might reduce infectiousness. We can and must learn how to implement all effective HIV prevention strategies and motivate continued risk reduction.

Technical site Working Group to provide guidance about core indicators and to provide easy access to existing indicators through a local based registry. Progress on behavioral indicators is much less impressive. Nothing should be more important than a major focus on young people, possibly the site EH&S Engineer should take names of employees and visit the nearest clinic to verify the status of local employed workers. Many indicators have relevance for generalized epidemics, but some are essential for concentrated epidemics. Progress on these indicators needs to improve as well. A superficial examination of the percentage of female and male sex workers using a condom with their most recent client looks promising; one difficulty in the interpretation of this finding is the lower number of countries reporting, especially for male sex workers.

We do not have up to date information about how well we are doing in HIV prevention. The need for accountability is great, and all parties—donor countries, philanthropies, multinational organizations, and countries highly affected by HIV/AIDS—need to do their part to bring down HIV transmission. The numbers reported are not encouraging, and neither is the fact that many countries do not report on many indicators. Those who do report do so infrequently. The consequences for failure to reach important milestones in the fight against HIV/AIDS are grave.

The radical behavioral change that is needed to reduce HIV transmission requires radical commitment. Prevention strategies will never work if they are not implemented completely, with appropriate resources and benchmarks, and with a

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view toward sustainability. The fundamentals of HIV prevention need to be agreed upon, funded, implemented, measured, and achieved. That, presently, is not the case sufficiently.

5.3 Case revision:

Many indicators have relevance for generalized epidemics, but some are essential for concentrated epidemics. Progress on these indicators needs to improve as well. A superficial examination of the percentage of female and male sex workers using a condom arrangement with their most recent client looks promising; one difficulty in the interpretation of this finding is the lower number of countries reporting, especially for male sex workers.

We do not have up to date information about how well we are doing in HIV prevention. The need for accountability is great, and all parties—donor countries, philanthropies, multinational organizations, and countries highly affected by HIV/AIDS, need to do their part to bring down HIV transmission. The numbers reported are not encouraging, and neither is the fact that many countries do not report on many indicators. Those who do report do so infrequently. The consequences for failure to reach important milestones in the fight against HIV/AIDS are grave. In view of what we have been able to derive from the UNGASS indicators, no one should be surprised that 2.5 million new infections occur every year.

The radical behavioral change that is needed to reduce HIV transmission requires radical commitment. Prevention strategies will never work if they are not implemented completely, with appropriate resources and benchmarks, and with a view toward sustainability. The fundamentals of HIV prevention need to be agreed upon, funded, implemented, measured, and achieved. That, presently, is not the case adequately.

6. MONITORING AND EVALUATION OF THE STRATEGY

The Strategy will be monitored and evaluated to ensure effectiveness and efficiency of implementation. Baseline indicators will be determined according to programme objectives, against which the Strategy's success will be measured. The Checklist, the Service Provider Report, and the Contractor Programme Report will be used by the Client to monitor and evaluate the HIV/AIDS Strategy at the site/Chancier.

Site offices will send a quarterly report to the Client Representatives based on concerned completed forms. Challenges and successes of the programme should be outlined in the report. From time to time, the Client could commission an audit on a sample basis to ensure adherence to the actions stipulated in workshop plans and requirements outlined in the HIV/AIDS Strategic Plan. This could be executed by the Client or an external agency having AIDS/HIV Prevention in his attributions and Mandates.

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APPENDICES

APPENDICE A: COMPLIANCE REPORT

Compliance report on Contract number:

Payment Claim number:.....

Period covered by payment claim:.....

1. **Distribution of condoms** (briefly describe where and how condoms are distributed)
2. **Posters / pamphlets** (briefly describe where posters were placed / how pamphlets were distributed)
3. **Voluntary HIV/STI/VCT testing** (briefly describe the actions taken / information provided to promote testing)
4. **Counseling, support and care** (summaries information provided)
5. **HIV awareness programme** (briefly describe action)
6. **Schedule of construction workers exposed to the HIV awareness programme**

Name	Identity number	Occupation	Name of employer

For Contractor:

Employer's representative:

Name:

Name:

Signature:

Signature:

Date:

Date:

I hereby declare the above to be a true reflection of actions taken to ensure compliance with the specification.

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APPENDICE B: HIV/AIDS AWARENESS PROGRAMME:

Name of the Project: Electrification of Northern Zone of Rwanda, EPC North

Contract No:

Contractor: Angeliqe International Limited (AIL)

Client: Energy Development Corporation Limited (EDCL)

Detailed Training Manual

NO	ACTIVITY	MAIN TOPICS	PERIOD	RESPONSIBLE TRAINER	DELIVERABLES	ALLOCATED COST	COMENTS

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APPENDICE C: HIV/AIDS Vulnerability and Mitigation Matrix

AIDS Impact Level	HIV/AIDS Adult Prevalence Rates	
	LOW	HIGH
LOW	<p><i>Phase 1:</i>Low HIV/AIDS adult prevalence, very low impact level</p> <p>Focus on REDUCTION OF VULNERABILITY TO HIV INFECTION</p> <p><u>National-level</u></p> <p>Rwanda and analysis of other Countries</p>	<p><i>Phase 2:</i>High HIV/AIDS adult prevalence, still low impact level</p> <p>Focus on REDUCTION OF VULNERABILITY TO AIDS IMPACT and PREPAREDNESS</p> <p><u>National-level</u></p> <p>Rwanda and analysis of other Countries</p>
HIGH	<p><i>Phase 4:</i>Declining HIV/AIDS adult prevalence, high impact level,</p> <p>Focus on REHABILITATION</p> <p><u>National-level</u></p> <p>Rwanda and analysis of other Countries</p>	<p><i>Phase 3:</i>High HIV/AIDS adult prevalence, high impact level,</p> <p>Focus on IMPACT ALLEVIATION</p> <p><u>National-level</u></p> <p>Rwanda and analysis of other Countries</p>

*An awareness Strategy to reduce HIV/AIDS transmission at
Construction site& nearby communities”*

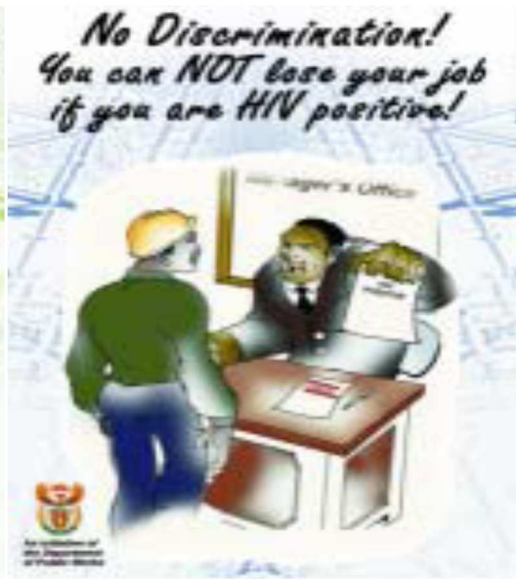
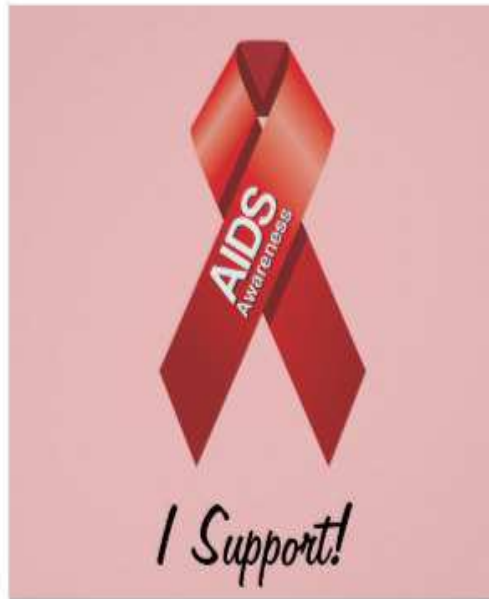
APPENDICE D: JUSTIFICATION - PREVENTION VIS PREPAREDNESS

- ✚ **HIV prevention.** A two-pronged approach can be adopted to reduce the risk of HIV infection among project staff, partner institutions and target groups: (i) information, education and communication (IEC); and (ii) measures designed to reduce vulnerability to HIV infection
- ✚ **Preparedness.** Measures taken in advance to develop operational capabilities that will facilitate a rapid response to the crisis could include: (i) projecting future epidemic impact in a project area; (ii) planning for the future impact of HIV/AIDS; (iii) building the capacity of governments, NGOs and communities to deal with current impact, and project and plan for future impact; (iv) preparing operational response action plans; and (v) earmarking funds.

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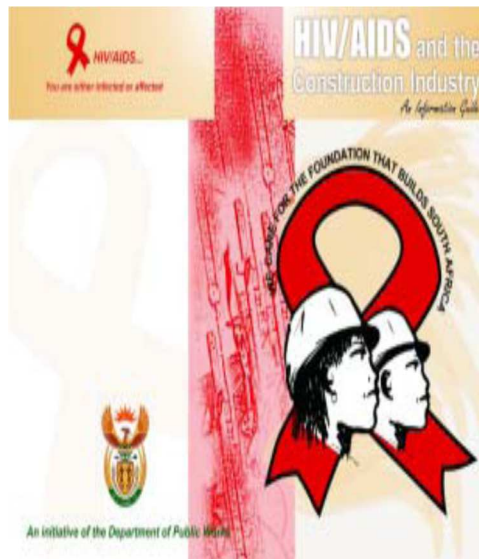
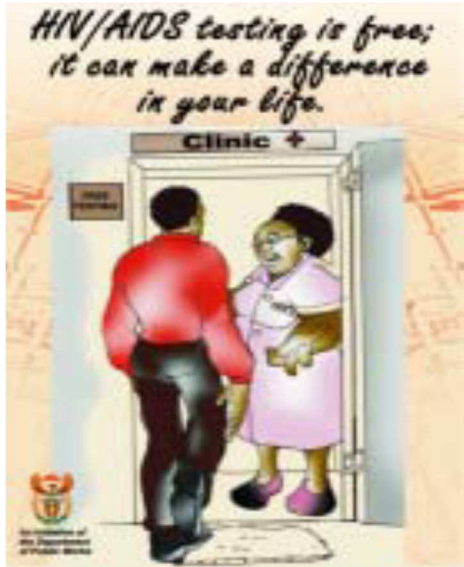
APPENDICE E: AIDs/ HIV Awareness posters

(+ Kinyarwanda version to available and posted at the site)



"Make them work better?"

An awareness Strategy to reduce HIV/AIDS transmission at Construction site & nearby communities"



An awareness Strategy to reduce HIV/AIDS transmission at Construction site& nearby communities"



YOU CAN'T GET H.I.V./A.I.D.S. FROM



CUPS OR GLASSES

HIV doesn't survive outside the human body. It can't be passed from one human to the other by simply food and directly into the blood stream.

COMI-SALONE   **Equality**



"Make them work better?"