role of genuine community participation based on both scientific evidence and international human rights principles.

Symposium Presentations

S01 - A strategy for HIV/STI prevention in low and middle income countries

S01.1 HIV AND STI PREVENTION: WHAT IS AN INTERVENTION?

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Structural intervention approaches for HIV prevention work to remove social barriers to the use of HIV prevention services and promote the adoption of behaviours that reduce the risk of HIV transmission. These approaches act at the health policy level to support the delivery of HIV prevention tools; at the health systems level to support the integration of HIV prevention with other health services; and at the community level to promote of critical enabler interventions, such as peer-based community empowerment programmes developed through safe spaces often physically within health facilities. They also take the form of policy integration and resources with non-health sector structures that reach populations at risk in large numbers, such as in social development, education, microfinance/poverty alleviation. While there have been some evidence syntheses on the effectiveness of specific types of structural interventions, there is no review or summary of the evidence on the effectiveness of such interventions as a whole. This paper will provide a synthesis of the evidence on the effectiveness of structural interventions for HIV prevention, by providing a review of reviews of the literature with a discussion of the strength of the evidence from reviews and primary studies. The paper will summarise the key findings from these reviews with an aim to provide recommendations for the use of structural interventions for HIV prevention.

S01.2 SYSTEMATIC REVIEWS OF THE EFFICACY AND EFFECTIVENESS OF BIOLOGICAL, BEHAVIOURAL AND STRUCTURAL HIV PREVENTION INTERVENTIONS

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Behavioural interventions for HIV prevention work by encouraging people to change behaviours that may make them more susceptible to HIV infection, or more likely to infect another person. There is some evidence that such interventions have led to reductions in HIV risk behaviours, such as having multiple partners, and improvements in other outcomes, such as increased condom use, increased testing, and improved treatment adherence. Behaviour is influenced heavily by socio-cultural contexts and as such, behavioural interventions must be sensitive to these contexts in order to be effective. Examples of behavioural interventions include individual and group level counselling, and providing information and guidelines through community outreach and mass media campaigns.

This paper will provide a synthesis of the evidence on the effectiveness of behavioural interventions for HIV prevention. A review of reviews methodology will be followed to identify relevant primary studies. The strength of the evidence from these reviews will be evaluated and recommendations will be made.

S01.3 DELIVERY OF HIV/STI PREVENTION INTERVENTIONS: PREVENTION CASCADES

Geoff Garnett*. *Bill and Melinda Gates Foundation, Seattle, USA*

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The HIV treatment cascade has been a powerful illustrative tool used to explore the performance of HIV treatment programs. The cascade steps through the recruitment of HIV-infected individuals into treatment programs and the effectiveness of those programs, and despite its conceptual flaws provides an intuitively appealing snapshot of performance. Because of its advocacy potential attempts have been made to generate a prevention cascade, covering those HIV positive and negative or to integrate prevention into the treatment cascade generating a 'prevention, treatment and care cascade'. However, these tend to diminish the focus on prevention, confuse different interventions and do not provide a simple scheme through which to measure performance. Here we explore the required elements for prevention cascades for HIV and other sexually transmitted infections and identify the steps linking the delivery of interventions with their use in populations. Starting from the susceptible population at risk we can consider whether the intervention is available to them, whether they uptake the intervention, whether they adhere to the intervention and what the efficacy of the intervention is. Cascades for the delivery, use and effectiveness of prevention products should be able to identify who has been protected, what the key failures in protection are and the relative importance of system and product characteristics. In explaining theoretically how we might think about prevention programs we hope that empirical studies will consider adopting this framework, which has guided some thinking about voluntary medical male circumcision programs and HIV pre-exposure prophylaxis programs. In HIV treatment global targets and indicators have been set based on the treatment cascade and without similar targets for other prevention interventions they are likely to be neglected.

S01.4 MODELLING THE COST-EFFECTIVENESS OF HIV PREVENTION INTERVENTIONS

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Ambitious targets have been set for HIV prevention. We will begin by examining assumptions for HIV prevention scale-up in the light of the concept of the 'prevention cascade' using available data. Then, we will show that a key part of optimising prevention impact will be in allocating available funding according to four main factors – intervention, population, geography and time. The impact of flexibility or constraint on each of these will be illustrated, providing recommendations for how international and domestic decisions can be taken to maximise epidemic impact. Finally, we will examine methods to evaluate the evidence of new prevention technologies to determine the scale of investment they might optimally attract. We will show that this requires a holistic view of the range of tools available in

combination prevention and across the full prevention cascade, and that without that focus, sub-optimal decisions may be taken.

S01.5 THE ARCHITECTURE FOR PREVENTION AND THE ROLE OF TARGETS AND INDICATORS

Mitchell Warren*. *AVAC Global Advocacy for HIV Prevention, New York, USA*

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There are effective means to prevent every mode of transmission; political commitment on HIV continues to be strong; and financing for HIV programs in low- and middle-income countries increased has surpassed US$17 billion. However, amidst recurring calls for a comprehensive, integrated and sustained AIDS response, funding, targets and delivery are focusing disproportionately on treatment. This presentation will describe the financing, leadership and implementation/delivery architecture for HIV prevention as it exists today, and as it needs to be developed in order to fully realise the potential of existing, emerging and on-the-horizon HIV prevention options.

Beginning with an exploration of the current architecture of HIV prevention financing, the presentation will highlighting current gaps, such as the recent scale back of PEPFAR funding for VMMC and shortfalls in funding and planning for PrEP product introduction, citing these examples to highlight broader issues in the architecture as it exists (e.g. the gap between positive research results and substantive, strategic planning to move to implementation), individual interventions (e.g. VMMC) being "owned" by single donors, and then in jeopardy when funding fluctuates. The presentation will also explore the leadership, describing the actors that influence policy, programming and messaging at global, regional and national levels.

Finally, this presentation will examine the gaps and strengths in current implementation and delivery architecture, focusing on what is available and/or needed to deliver prevention and on the targets that need to be set to help drive implementation and financing; how targets need to be tailored to each specific intervention; and highlight the potential for conceiving and building a comprehensive prevention delivery platform that maximises the use of existing interventions and supports the rapid and effective integration of new options as they become available.

S02 - Education about sex and relationships: new directions in school and beyond

S02.1 SEX AND RELATIONSHIPS EDUCATION IN SCHOOLS: A KEY COMPONENT OF SEXUAL HEALTH PROMOTION

Peter Aggleton*. *UNSW Australia, Sydney, Australia*

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Despite scientific evidence of effectiveness, there continues to exist controversy about sex and relationships education (SRE). Much of this relates to misunderstandings about the form that good quality SRE takes and what it aims to achieve. The evidence reveals that well designed and effectively implemented programs of comprehensive sexuality education have the potential to bring about beneficial outcomes for young people. But such programs often work best when they are implemented through partnership between education and health. Building on the framework offered by WHO in its guidance on Developing Sexual Health Programmes, this presentation highlights some of the ways in which this can be achieved: through the provision of in-school clinics and other health services; through effective signposting and fast-track routes to relevant services; and through health professionals' involvement in the life of the school. It signals the importance of understanding differences in culture and tradition between the education and health sectors, stressing how teachers, educational administrators and health professionals often understand 'intervention' and 'education' quite differently. Finally, it will stress the importance of respect for difference, and respect for the 'other' in work in schools.

S02.2 RELIGIOUS AND FAITH-BASED BELIEFS: A HELP OR A HINDRANCE IN SEXUAL HEALTH EDUCATION?

Mary Lou Rasmussen*. *Monash University, Melbourne, Australia*

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The Reverend Debra Haffner, a former CEO of SIECUS, and the Director of the Religious Institute on Sexual Morality, Justice and Healing objects to the The National Sexuality Education Standards for US Public Schools (2012) published by The Guttmacher Institute in the United States. Haffner questions these standards because they fail to account for values and religious influences on sexuality education and religion. The absence of explicit references to religion and values in such standards reflect longstanding debates about the place of religion within secular states, and about the privatisation of religion and belief. These debates also impact perceptions about the role of religion in sexuality education and shape debates about the place of reason and science in sexuality education.

Haffner's theological commitment to comprehensive sexuality education is accompanied by an expressed desire for a values-based framework for sexuality education. Unlike Haffner, I have no theological commitments in relation to sexuality education provision. However, I have come to question progressive sexuality education standards that do not explicitly engage with questions of faith, belief and their relationship to values. What are the grounds for this separation? Are there ways in which religion and values can be usefully incorporated in progressive sexuality education? Should such topics be left behind in the production of a progressive sexuality education?

S02.3 RESPECTING GENDER AND SEXUAL DIFFERENCE TO PROMOTE SEXUAL HEALTH: MAKING SCHOOLS SAFE SPACES FOR ALL

Kerry Robinson*. *University of Western Sydney, Sydney, Australia*

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Drawing on international evidence of best practice, and recent and ongoing research funded by the Australian Research Council (ARC) and the Young and Well Collaborative Research Centre (CRC), this presentation highlights how teachers and health professionals can most effectively engage with, and approach gender, sexuality, and sexuality education, to ensure that schools offer relevant and informative education, and safe and supportive environments for all pupils irrespective of gender and sexual identity.