

# People-centred HIV Prevention Design and Communication

A programming brief on new ways in promoting prevention choices

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## Executive summary

If the world is to end AIDS as a public health threat, new HIV infections must decrease at a much faster rate. The estimated 1.3 million new infections in 2024 were only 40% fewer in 2010—a long way from the 90% reduction by 2030 that would put the world on-track to end AIDS. A decrease on that scale requires that virtually everyone who needs HIV prevention options can access and use them.

HIV prevention needs a big momentum boost. For that to happen, people have to understand their HIV risk, know how best to protect themselves from HIV, and be able to use suitable prevention tools and services. Crucially, they must also *want* to do so.

Initially, HIV prevention strategies relied heavily on mass information, education and communication campaigns that sought to raise awareness and generate behaviour changes (1). Then the emphasis shifted to encouraging people to adopt specific products or prevention methods and on small-scale peer outreach, which was often effective, but limited in reach. The approaches tended to neglect the fact that people have different needs, norms and motivations for using HIV prevention and that many factors also affect their abilities to act on those decisions. They were also often not strategic when to go for large reach and when for more intensive support.

Four decades of struggle against AIDS has taught us that HIV prevention has a bigger impact when it is centred on people's realities and needs and puts them at the heart of programming decisions. That implies a profound shift in perspective: from tackling complex challenges *on behalf of* people, to doing so *with* them. It also requires replacing generic, one-size-fits-all interventions with more nuanced ones that go beyond intuitive assumptions about what works best.

HIV prevention has a bigger impact when it is centred on the lived realities and needs of people

The goal is to reduce HIV incidence by designing and rolling out highly effective, user-centred prevention programmes and communication strategies that promote sustained uptake of interventions. Rather than simply “marketing” and “promoting” interventions, the emphasis is also on understanding and empathizing.

This short programming brief addresses this urgent need to shift HIV prevention from being product- and service-centred to being genuinely *people-centred*.

It presents practical advice for designing and implementing effective, evidence-based **people-centered design and communication strategies for HIV prevention**. It also offers suggestions for prioritizing, planning and budgeting those activities and for tracking and interpreting their results.

The document is intended for country-level HIV programme managers and drafters of HIV strategies and funding proposals (including for Global Fund grants). By incorporating insights and guiding principles from people-centred design and behavioural economics, they can now design interventions that are scientifically sound, as well as psychologically informed, culturally resonant and practically appealing to the people they are intended to benefit.

People-centred design is a problem-solving approach that places the needs, concerns and circumstances of potential service users at the heart of strategy design. It is an iterative approach that involves empathy, the

Understanding prevention needs is the foundation of effective HIV prevention for individuals and for national programmes.

collective generation of ideas, prototyping and continuous testing of interventions. The purpose is to provide accurate, relevant and trusted information to people so they can assess their own risk and take preventive measures that fit their needs, preferences and life circumstances.

The programming brief also surveys different ways of conducting prevention communications—ranging from close interpersonal interactions to community-level interventions, mass media campaigns and digital technology-based engagements via social media and other Internet-based platforms.

These are timely and vital changes, given the disruptive impact of funding cuts for HIV, the generally stagnant uptake of prevention options, and ongoing structural barriers that hinder effective delivery of services and equitable access.

The history of HIV prevention teaches us that it is not enough to make information, services and tools available: the people who stand to benefit from them must be able to use them and must want to do so.

By adopting people-centred prevention design and communication, HIV planners and programmers can unlock new levels of effectiveness, enhance resource allocation and build programmes and communication strategies that are evidence-based, relevant and empowering.

Effective promotion of HIV prevention enables people to make choices and addresses different prevention options. It strategically chooses the right mix of approaches and channels for reaching everyone who needs prevention, while intensifying efforts for the most affected.

# 1. Introduction

Ending AIDS as a public health threat requires reducing new HIV infections at a much faster rate than is currently the case. The estimated 1.3 million new infections in 2024 were only 40% fewer in 2010—a long way from the 90% reduction by 2030 that would put the world on-track to end AIDS. The gains of HIV prevention programmes have slowed, and new HIV infections are increasing in many countries.

HIV prevention requires an urgent boost. Drastic reductions in funding and other resources for HIV heightens the need for creative strategies that can drive HIV prevention forward.

Reducing new infections by over 90% requires that at least 95% of people who need HIV prevention options can access and use them. For that to happen, people have to understand their HIV risk, know how best to protect themselves from HIV, and want to access and use suitable prevention tools services. That can only be achieved if HIV prevention strategies reflect and address the different prevention-related needs and experiences of individuals.

This programming brief responds to that challenge. Based on best practices and lessons learned, it presents a practical approach for designing and implementing effective, evidence-based and **people-centered design and communication strategies for HIV prevention**.

The core objective is to make HIV prevention genuinely *people-centred* by centring it on the perspectives and circumstances of potential users of prevention tools and services and by putting them at the heart of strategy design.<sup>1</sup> In such an approach, prevention strategies become more effective by being more empathetic, inclusive and tailored to the lived realities of the people they are intended to serve. That involves going beyond generic, one-size-fits-all interventions towards more subtle strategies that draw on evidence from behavioural research and on insights from people-centred design and behavioural economics.

This approach is more amenable to prioritization,



Photo: ©UNICEF/Malawi/2019

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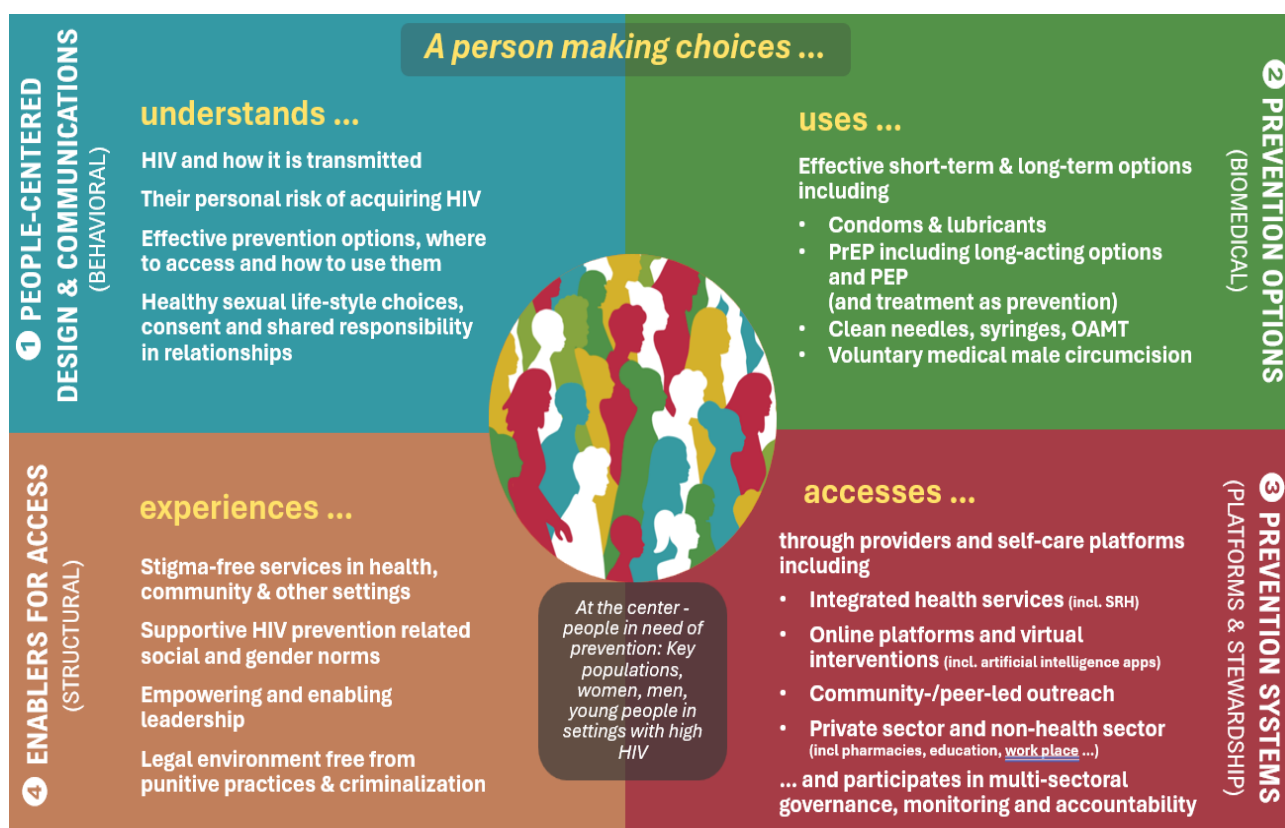
<sup>1</sup> This approach aligns closely with the principles of the Greater Involvement of People Living with HIV/AIDS (GIPA), which prioritize the meaningful involvement and leadership of the people who are most affected by HIV.

more adaptable to evolving risk behaviours and epidemic realities, and more customizable to different policy and institutional environments and programming capacities. It is also timely and necessary, given the impact of severe funding cuts for HIV, the largely stagnant uptake of prevention options, and ongoing structural barriers that hinder effective and equitable delivery of services.

## The four dimensions of people-centered prevention

People-centered prevention encompasses four interconnected components. This brief focuses on the first (behavioural) component: people-centered design and communications.

Figure 1. Four dimensions of people-centred HIV prevention\*



\* Based on the HIV Prevention 2030 Global Access Framework (forthcoming)

**People-centered design and communications.** Understanding is the foundation of effective HIV prevention. Well-informed individuals are better equipped to make appropriate decisions that can safeguard their health. When people understand how HIV is transmitted, they can evaluate their risk and decide which prevention methods are best suited to their needs. This extends also to cultivating a deeper understanding of sexual consent and shared responsibility in relationships.

**Choice of effective prevention options.** Prevention requires choosing the best-suited options. Biomedical interventions cover a range of short- and long-term options that can be tailored to individual needs and preferences. They include condoms, lubricants, oral and long-acting pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), clean needles and syringes, opioid agonist maintenance therapy, voluntary medical male circumcision, and more. The emphasis is on people choosing the most suitable and effective options, rather than on increasing the overall coverage of specific interventions.

**Enablers for accessing and using HIV prevention.** Effective prevention requires the removal of obstacles that stop people from accessing and using tools and services. Structural interventions aim to eliminate stigma in health and community settings, promote supportive social and gender norms, and encourage changes to obstructive laws and regulations. If successful, those efforts can create environments where individuals feel safe and respected and are motivated to seek and use prevention services and tools.



Photo: Promoting choice in prevention. Hands up for HIV prevention campaign. UNAIDS.



Photo: Non-health access platforms meeting people where they are. Condom dispenser in a hotspot.

**A mix of suitable access platforms.** A wide range of service delivery platforms is needed. This can be achieved by, for example, integrating HIV prevention into primary health care and sexual and reproductive health services; expanding community- and peer-led service delivery (especially for people who belong to key populations); introducing telehealth and other “virtual” service platforms; and offering artificial intelligence-enabled tools that can support self-care prevention models.

# What makes people-centred HIV prevention design and communication so important?

## Historical context

HIV prevention strategies have evolved over the decades, building on lessons and new insights. Initially, the Information, Education and Communication (IEC) approach focused on changing people's behaviours by disseminating information and increasing their knowledge about HIV transmission and prevention. This often resulted in generic messages that did not necessarily resonate across different cultural and socioeconomic settings. A reliance on the assumption that more information and knowledge would automatically drive desired behaviour changes ignored the psychological, social and economic circumstances that shape people's choices.

As prevention strategies evolved, the emphasis shifted to "combination prevention", which brought together biomedical, behavioural and structural tactics. This more holistic approach recognized the complexities of HIV prevention and went beyond simply trying to change individual behaviours. Yet even this method sometimes fell short when interventions operated in isolation, leading to "disconnects" between the tools and services that were available, and the ones individuals were actually inclined to use.

Earlier approaches lacked a sense of "ownership" and meaningful engagement for the people who were meant to benefit

Afterwards came a heightened emphasis on "demand creation". Here, campaigns and community mobilization were used to spark interest in HIV prevention and in using prevention services and tools. Although these initiatives initially boosted engagement, they sometimes relied too heavily on generic marketing tactics that neglected the diversity of people's lives. In some cases, products were promoted without a solid understanding of the varied needs and circumstances of the people they were meant to benefit.

## The paradigm shift

Although each prevention approach had its strengths, many of them did not fully engage with the diversity and nuances of human behaviour, nor did they sufficiently address people's different needs. That gradually led to a recognition that the earlier approaches had lacked a sense of "ownership" and meaningful engagement for the people and communities they were intended to benefit. In addition, behavioural science was debunking the assumption that people always make rational decisions based strictly on available information by showing that cognitive biases, emotions and social pressures significantly affect decisions (2).

A profound shift towards empathic, people-centred approaches is now underway. Rather than simply "marketing" and "promoting" interventions, the emphasis is on understanding and empathizing with people's different needs, circumstances and preferences. Instead of one-size-fits-all mass communication, the preference is for meaningful dialogues that can encourage healthy choices.

Those improvements in programme design are being enriched by incorporating people-centred design principles and recent insights from behavioural economics. People-centred design seeks to

address individuals' needs by designing products, services and systems in ways that recognize the various challenges they experience and the different preferences they hold. The goal is to develop interventions that genuinely resonate with people, serve their needs and can have a lasting impact.

This approach hinges on the principle that HIV prevention is a human right, and it aligns with World Health Organization's (WHO) people-centred health-care framework (3) and the "Positive health, dignity, and prevention" concept. Everyone should have access to effective prevention, testing and treatment options that match their personal preferences and circumstances.

A more robust HIV prevention response requires empowering individuals with the knowledge and abilities to make choices that fit their circumstances and needs. It also requires engaging them and their communities as genuine partners and tackling underlying issues like stigma, social inequities, gender inequality and obstructive laws. Communities help deliver HIV and other health services and they play key roles in tailoring stimulating demand for those services (4).



Photo: Engagement through mobile phone technology. UNAIDS.

The goal is to have interventions that genuinely resonate with and serve people—and have a lasting impact

## Who is this document for, and how can it be used?

This briefing document is intended for country-level HIV programme managers and drafters of HIV strategies and funding proposals (including for Global Fund grants). It can be used for designing and implementing national HIV prevention programmes and the communication strategies that accompany them. Specifically, the document can:

- Support countries in developing strategic operational plans (or components of national prevention plans) that cover people-centred HIV prevention design and communications, including their objectives, approaches and activities;
- Enable countries to formulate, plan and budget people-centred design and communication in funding proposals for international donors like the Global Fund and for domestic funders; and
- Support countries in devising innovative ways to undertake people-centred design and communication for HIV prevention.

## 2. The value of people-centred HIV prevention design and communication

### What is it and what should it achieve?

People-centred HIV prevention design and communication is a framework for using inclusive, rights-based prevention methods that prioritize individuals over generic approaches when designing and delivering HIV prevention activities.

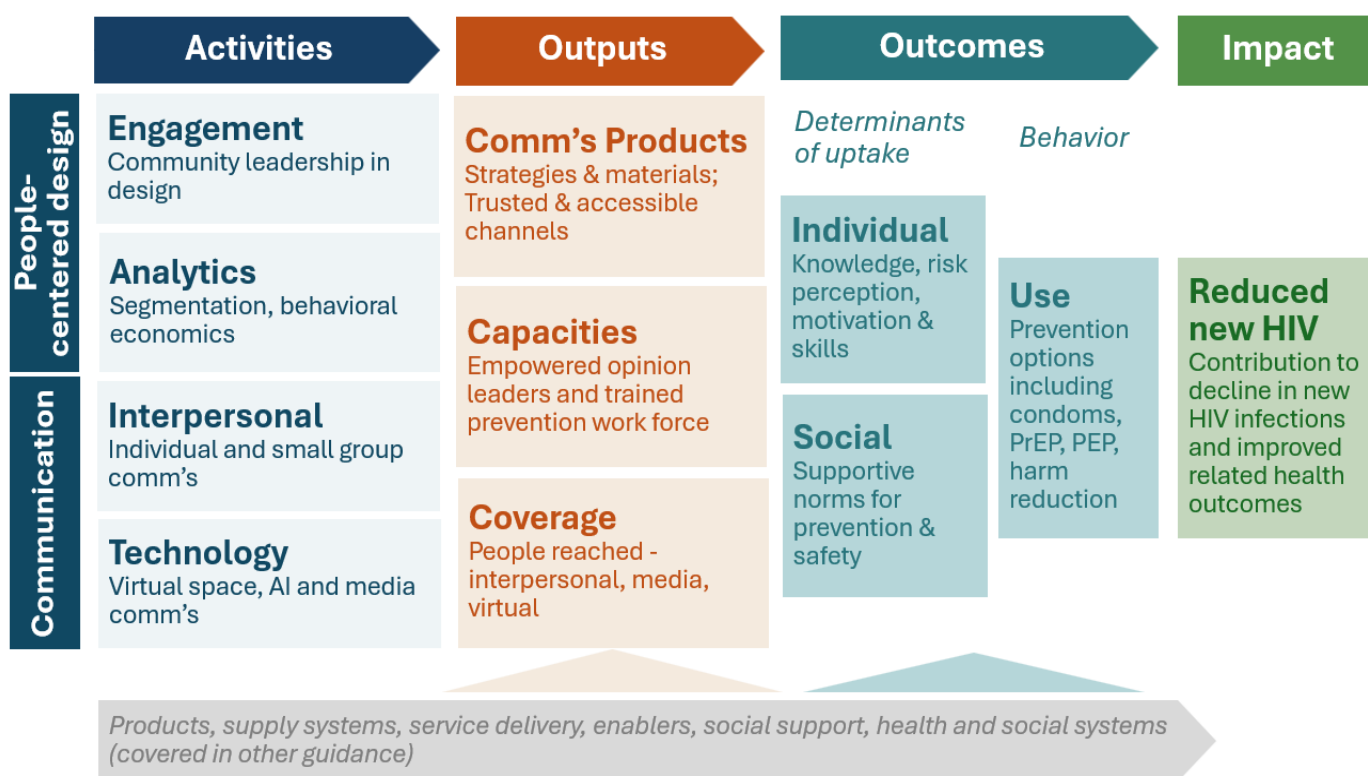


Photo: The “Hands up for #HIVprevention” campaign in 2016 in Tajikistan

The emphasis is on providing accurate, relevant information to a wide range of people so they can assess their own risk and take preventive measures that fit with their needs, preferences and life circumstances. Crucially, this approach incorporates the voices and experiences of potential beneficiaries.

The goal is to reduce HIV incidence by designing and scaling highly effective, user-centred HIV prevention programmes and communication strategies that promote sustained uptake of interventions (Figure 2).

Figure 2. The “theory of change” for people-centred design & communication



## Main elements of people-centred design

Insights from people-centred design and behavioural economics provide frameworks and tools for going beyond general assumptions to truly understand—and then influence—people’s HIV-related behaviours.

People-centred design is a problem-solving approach that places the needs, desires and circumstances of potential service users at the heart of the design process. It entails an iterative approach that involves empathy, problem definition, the collective generation of ideas, prototyping and continuous testing to tackle complex challenges *with* users, rather than *for* them (5).

People-centred design puts the needs and circumstances of service users at the heart of the process

Key principles of people-centred design for HIV prevention therefore include:

- **Empathy.** Go beyond superficial understandings to immerse oneself in users' experiences, circumstances, challenges and aspirations. This can involve ethnographic research, in-depth interviews and other qualitative research to uncover unobvious needs, preferences and motivations.
- **Co-creation.** Actively involve priority populations (for example, adolescent girls and young women, sex workers or gay men and other men who have sex with men) in the design process. This ensures that solutions are relevant, acceptable and realistic.

- **Iterative development.** Recognize that initial solutions are rarely perfect and use quick prototyping and continuous testing with prospective users for feedback and refinement. This "build-measure-learn" loop minimizes risk and advances solutions.
- **Focus on user experiences.** The perspectives of potential users take precedence. The focus is on the suitability, convenience and attractiveness of tools and services and on people's abilities to access them.

Behavioural economics is an interdisciplinary field that combines insights from psychology and economics to understand how psychological, cognitive, emotional, cultural and social factors influence individual decision-making. The evidence shows that human decisions are often irrational yet also predictable. Rather than being based on purely reasoned calculations, decisions tend to be influenced by biases and heuristics (mental shortcuts that help individuals to quickly make decisions and solve problems). We subconsciously rely on those methods, especially when faced with complex problems or when incomplete information is available.

Key behavioural economics principles for HIV prevention include:

- **Defaults.** People tend to prefer pre-set or default options. *Example:* Shifting from an "opt-in" HIV testing approach (where individuals must actively choose to be tested) to an "opt-out" approach in health-care settings (where testing is offered routinely unless explicitly declined) can significantly increase testing rates.
- **Framing.** How information is presented significantly influences choices. *Example:* Framing PrEP as "empowerment for sexual freedom" might resonate more than "disease prevention." Highlighting the immediate benefits of PrEP (such as peace of mind, the ability to remain sexually active) can be more persuasive than focusing on its long-term health benefits (e.g. avoiding HIV infection).
- **Social norms.** Individuals are heavily influenced by the perceived behaviours and beliefs of their peers and social groups. *Example:* Communication campaigns that highlight that "most young people in this community talk about HIV prevention with their partners" can encourage more open dialogue. When peer educators are frank about their PrEP use, other people may be more likely to consider using this prevention method.
- **Loss aversion.** Most people have a strong psychological tendency to prefer avoiding losses over acquiring equivalent gains. *Example:* Highlighting the potential *loss* of good health, relationships or future opportunities due to HIV can be more motivating than emphasizing the *gain* of being HIV-negative.
- **Present bias.** We also tend to overvalue immediate rewards and costs over future ones. *Example:* For HIV testing, emphasizing the immediate benefit of "knowing your status today for peace of mind" can be more effective than focusing strictly on long-term health benefits.
- **Choice overload.** Too many options can lead to decision paralysis. *Example:* Presenting a person with too many different HIV prevention options at once can be overwhelming; simplifying the choices or guiding the person through a decision-making process can avoid that.
- **Scarcity.** People tend to desire things more when they appear to be scarce. *Example:* While ethically complex, some campaigns might subtly highlight the value of certain prevention services as a limited opportunity (for example, during specific campaigns).

By incorporating insights and guiding principles from people-centred design and behavioural economics, HIV programme planners and managers can go beyond intuitive assumptions about what works best. They can design interventions that are scientifically sound, as well as psychologically informed, culturally resonant and practically appealing to the people they are intended to protect.

The emphasis is on providing accurate, relevant information to a wide range of people so they can assess their own risk and take appropriate preventive measures

## **HIV prevention communications—key types of interventions**

Since the early decades of the AIDS pandemic, communications—whether interpersonal or via mass media—have been considered to be vital for HIV prevention.

Prevention communication has been grounded in the assumption that when a person receives, trusts and understands accurate and relevant information about HIV, their knowledge improves, as does their understanding of their own HIV risk. When that happens in an enabling (legal, social, normative and economic) context and when further support is available, the person can be prompted to engage with prevention services and use prevention tools. That desired chain of reactions, however, is highly contingent on other factors and is often short-lived.

Prevention communications can be conducted in a variety of ways—ranging from one-to-one and small group interpersonal interactions to community-level interventions, mass media campaigns or, in recent years, interactive engagement via social media and other Internet-based platforms and channels.

### **Interpersonal communication**

Interpersonal (individual or small group) interventions have been used for decades in HIV prevention. Based on models used for smoking cessation and heart disease prevention, these interactions can be effective for developing more accurate risk perception, influencing attitudes and increasing a person's motivation to use HIV prevention tools and services (6).

Evidence reviews show that interventions which encourage specific actions (e.g. taking an HIV test) or that develop skills (e.g. for condom use) are most likely to be effective. However, the changes may not persist over time: like most other HIV prevention interventions, they require ongoing reinforcement and should be coupled with other prevention components (7).

Effective interpersonal communication requires credible, trained facilitators (e.g. peer counsellors, community health workers or community-based outreach workers) and it often entails multiple sessions, with the interactions “customized” to people's circumstances and needs. This tends to be time-consuming and costly, making it best suited for people who are at elevated risk of acquiring HIV.

#### **Peer outreach**

Peer outreach activities involve one-on-one or group conversations and can be used to reach people in social settings or at “drop-in” centres with information and other support. Since these activities tend to be labour-intensive and expensive, they are also best suited for people who are at

high risk of acquiring HIV. Peer outreach interventions are particularly relevant for key populations, who in many settings primarily trust their peers due to widespread stigma. Rather than using these approaches in isolation, their impact may be greater if they are combined with other ongoing programmes (e.g. condom promotion and regular screening for sexually transmitted infections) that are linked to referral pathways.

### **Counselling**

Similarly, counselling involves a counsellor or health professional who engages intensively with individuals or small groups, either in single or across multiple sessions—making it more personally relevant than mass media campaigns. Active interventions that involve participation and practical scenarios tend to be more effective than passive ones (e.g. lectures) and the impact is enhanced with they are combined or linked with community-wide prevention activities (7). HIV prevention counselling is usually integrated into service delivery. A cost-efficient way to increase reach of prevention counselling is guidance to health workers to make provider-initiated offers for HIV prevention information and options such as condoms and PrEP in specific locations or for specific populations or service delivery areas (such as HIV prevention counselling as part of contraceptive service delivery in settings with elevated HIV).

### **Community mobilization**

Community mobilization and empowerment approaches recognize that people's behaviours and choices are influenced by their social environments and by the perceptions of the peers and communities with whom they associate. Structured interpersonal communication approaches such as Stepping Stones and SASA can be effective in changing behavioral outcomes. Such a structured approach has been used at scale in countries such as Zimbabwe with relatively limited resources, but in other settings can be quite resource-intensive and will be more viable in settings with higher HIV incidence.



Photo: UNFPA Zimbabwe Country Office. Community mobilization followed by structured interpersonal communication for HIV prevention

These activities often combine several interventions and tend to be focused on a particular geographical area or setting (e.g. a workplace). The aim is to foster a sense of shared belonging and confidence to act. People who feel rooted socially and who have trust in fellow community members tend to have greater confidence to take informed decisions (7). These approaches have been associated with increased condom use (8) and improved HIV treatment outcomes (9) among sex workers, and reduced harmful gender norms among men, for example (10).

## Leadership advocacy

Communication activities that enlist trusted leaders have been used to increase awareness and encourage changes in behaviour. The approach is based on “diffusion of innovation” theory which asserts that admonishments from influential figures can encourage people to seek information and consider changing certain behaviours. This is more likely to happen when the advocacy supplements other like-minded efforts. These leadership figures can include faith-based leaders, local community leaders, sports and entertainment celebrities, “social influencers” etc.

## Technology-based approaches

Technology-based communication uses mass media (e.g. print media, radio and television) and the Internet to convey information that tends to be largely generic and undifferentiated. Increasingly, however, much more tailored and direct engagement with individuals is possible through virtual interventions (e.g. telehealth), social media platforms and artificial intelligence-based interactions, some of them involving synthetic or virtual “humans”.

### Mass media

Mass media offer the advantages of scale and the ability to frequently repeat core messages. Sustained mass media campaigns have been credited with contributing to increased HIV knowledge, short-term increases in HIV testing and temporary reductions in HIV-related stigma. However, these campaigns, on their own, are not enough to achieve sustainable changes in behaviour (7). Since these channels offer wide access to the public (or large subpopulations like young people or women), they can be useful for basic, “headline” messages. Over the past decade especially, Internet-based media have increasingly supplanted radio, television and print media as core sources of news and information.

### Virtual interventions

There is great scope for using virtual and online prevention-related interventions (11). The options range from simple, phone-based communication (e.g. voice and text messaging) to more adaptable and differentiated Internet-based options (e.g. via social media platforms (12), messenger apps and other smartphone apps) that allow for mHealth or telemedicine activities. The latter have been shown to boost efforts to prevent the vertical transmission of HIV and increase early infant diagnosis among children who have been exposed to HIV (13).



Photo: Condom demand generation going online. Credit: FHI360. Going Online. Toolkit to Design Social Media Campaigns that Promote Condom Use.

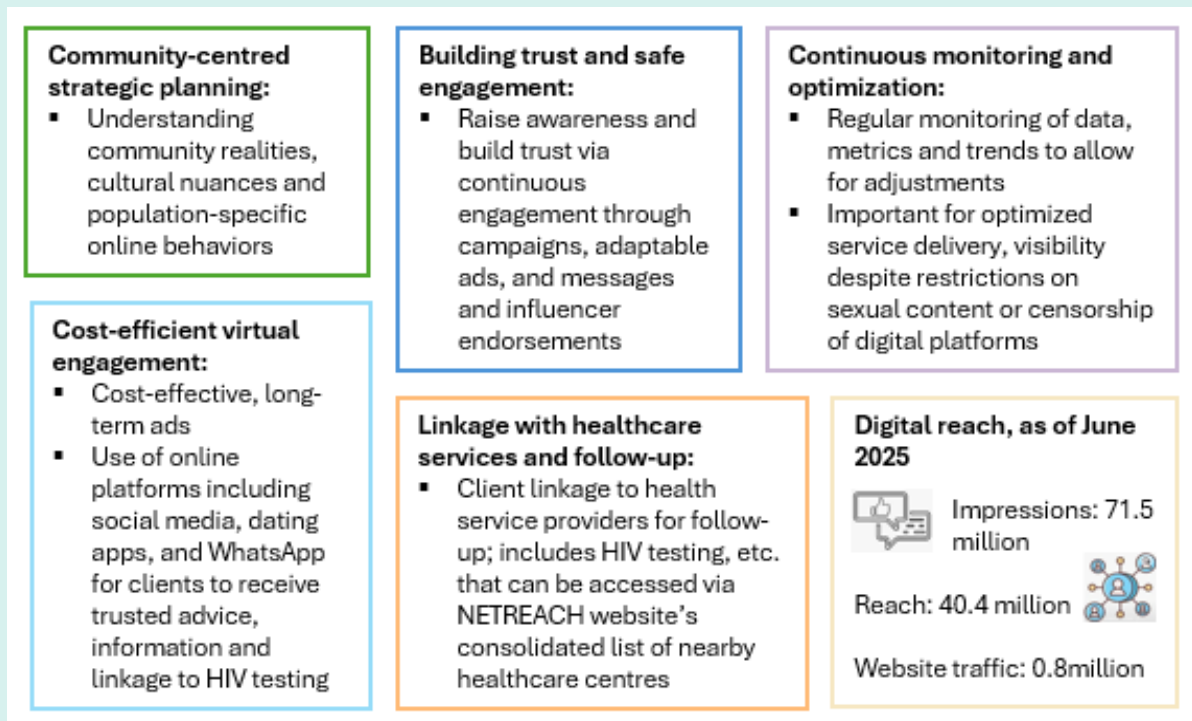
## The NETREACH project in India

NETREACH uses a virtual HIV intervention platform that links people to information on HIV and sexual health, and to HIV testing. The entry point is through advertisements on social media and other digital platforms, which steer users to WhatsApp where they can pose questions and seek information.

NETREACH is successful in reaching at-risk populations and in providing curated information in a discreet, confidential way. Factors that were considered in planning and implementing NETREACH include:

- **Community-center strategic planning.** Experiences and evidence from previous HIV prevention initiatives conducted by the Humsafar Trust in India, were valuable for understanding community realities, population needs and online behaviours. It was also useful for grasping regional and cultural nuances, include around language use.
- **Cost-efficiency and confidentiality.** Data-driven advertisements on social media platforms and data apps link users directly to WhatsApp where they ask questions and seek information. The WhatsApp platform also links users to appropriate HIV testing and other services, as needed. This virtual space is safe and anonymous.
- **Trust and empathy.** The approach prizes trust and understanding, which it cultivates by using sustained campaigns and advertisements, and by enlisting influencers and public figures.
- **Continuous monitoring and optimization.** Metrics and trend analyses can be used to inform adjustments, guide scale up efforts, and test relevance. Artificial intelligence use, behavioural insights and real-time data can also be useful. Continuous monitoring and adaptation are important to maintain a presence in search results and to adapt to possible restrictions on sexual content on social media/digital platforms.
- **Linkage with health-care services.** The NETREACH website links users with health service providers for next steps such as HIV testing via a consolidated list of service providers. It is important to collaborate with national programmes and with local health-care services to ensure continuity of care.

Figure 3. Features of the NETREACH project in India



Digital technologies are evolving rapidly and now include chatbots that simulate human conversations and can facilitate referrals to other prevention services. The interventions can be tailored and focused, and they offer users greater privacy and confidentiality in judgment-free spaces (with less risk of being exposed to stigma and discrimination). WHO has developed guidance with recommendations for digital health interventions (14).

There is great scope for using virtual and online interventions—and studies show they can be as effective as face-to-face encounters for shaping HIV knowledge and prevention behaviours

Studies have shown that interactive virtual or digital interventions can be at least as effective as face-to-face interventions for shaping HIV knowledge and prevention behaviours (15). For example, mHealth HIV testing interventions have increased testing uptake among gay men and other men who have sex with men and other key populations (16) and have improved HIV treatment adherence among people with HIV in Asia (17).

While these virtual interventions can complement and enhance existing health system functions, they do not replace the basic foundations of health systems such as health workers, financing and access to essential medicines. Community engagement and participation in designing virtual interventions are essential to ensure the services are suitable and relevant.

### **Artificial intelligence-based methods**

Artificial intelligence-enabled tools—like synthesized chatbots, virtual check-ins and personalized digital reminders—can support HIV prevention models (18-21) and they are being used in a range of settings, including *in* Ukraine (see box) (22). In Malaysia, a web-based artificial intelligence (AI) chatbot has shown high usability in providing clinical information on HIV testing, PrEP and mental health services for gay men and other men who have sex with men (23).

Digital campaigns, for example, can reach people for a fraction of the cost of traditional outreach activities, making them highly cost-effective. In addition, they are highly adaptable and allow for enhanced monitoring (based on real-time data and metrics), making them ideal for evidence-based design, audience targeting and adaptive messaging.

It is vital to ensure confidentiality and security in online spaces to protect sensitive information and maintain people's trust

These models allow for interactive, two-way conversations that offer privacy and can shield people against the stigma and discrimination they might encounter during in-person interactions. However, it is vital to ensure confidentiality and security in these encounters to protect sensitive information and maintain people's trust, especially in contexts where discrimination or legal barriers exist.

In addition, these communication models are not accessible to everyone, everywhere: internet access, smartphone ownership and affordability are crucial factors. In 2024, about 70% of people globally were using the Internet, but only about 27% of the population in low-income countries was online (24). Whereas four in five people aged ten years and older globally owned a mobile phone in 2024, a little over half of those in low-income countries owned one (25).<sup>2</sup> Cost of data and

<sup>2</sup> This reached 95% in high-income countries, in contrast to low-income countries where ownership levels were about 56%.

infrastructure weaknesses also exclude many people. Ultimately, too, AI-based models are only as good as the data going into them: the information should be accurate and regularly checked and updated (24).

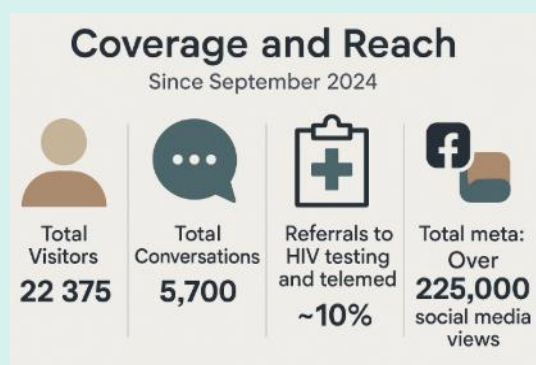
## The TWIIN digital health assistant in Ukraine

TWIIN offers AI-powered, interactive and multilingual dialogue capabilities on HIV and sexual health topics with digital assistants who resemble humans, each with a distinct profile and “life experience”. The model also provides assistance for navigating to related health services.

Developed originally in the Ukraine by the Alliance for Public Health, the service is available in eastern Europe and central Asia, can operate in over 60 languages and offers some 600 different voices that mimic natural speech and emotional cues. Content can be adapted for different demographics and cultural sensitivities. AI is used to analyse users’ requests and retrieve the most relevant information from a dedicated knowledge base which can be updated and expanded. The low-cost, “in-person” and 24/7 support makes TWIIN especially useful in low-resource and humanitarian settings where access to health care can be very limited.

TWIIN can be used as part of a multilayered communication strategy (see Figure 4) that includes the use of social media platforms, influencer engagement, partnerships with nongovernmental organizations and other service providers, and links to health-care professionals—with the website serving as an entry point and hub.

**Figure 4. Features of the TWIIN digital assistant**



## Considerations and principles for people-centred design

When applying people-centred design and communication approaches, it is important to keep in mind the factors that can affect their impact.

- **Political will and funding.** Are sufficient political commitment and financial resources available, including dedicated staff and research budgets?
- **Openness to innovation.** Are HIV programme managers and their teams amenable to using new methodologies and iterative learning and are they willing to revisit long-held assumptions?
- **Access to skills.** Can programme teams access expertise (internal or external) on people-centred design and behavioural economics?
- **Meaningful community engagement.** Are potential beneficiaries willing and able to participate meaningfully in the co-creation processes and will their feedback genuinely be valued and integrated?
- **Ethical considerations.** Can the approach be implemented ethically, ensuring that participants' rights to consent and privacy are respected and that they are protected against harm?
- **Data utilization.** Can the information and insights generated through people-centred design and behavioural economics approaches be synthesized and translated into practical programme and communication strategies?
- **Enabling environment.** Does the broader policy and regulatory environment support the flexible implementation and adaptation of interventions?
- **Sustainability.** Are mechanisms in place to sustain successful people-centred interventions beyond initial pilot phases?
- **Self-care.** Are the activities linked to platforms and support that can facilitate self-care? (see box)

### Facilitating self-care for HIV prevention

Self-care refers to a person's ability to protect their health and cope with illness, with or without the help of health-care workers (27). Self-care for HIV prevention is increasingly important in a context of health worker shortages (28) and declining HIV funding.

Although self-care is in line with a shift away from accessing health services solely at traditional health facilities, it cannot and should not replace all services provided directly by health-care providers. However, it can improve the sustainability, accessibility and acceptability of HIV prevention services, by allowing people who can manage their own healthcare to do so (29).

Several HIV prevention options are potentially suitable for self-care approaches, including self-testing and condom use; oral PrEP and PEP (conditional on regulatory arrangements); and voluntary medical male circumcision and injectable PrEP (which require trained providers but allow for self-care in follow up phases).

Interpersonal (individual and small group) communications and media communications can facilitate self-care, though the biggest potential lies with virtual and AI-based applications. WHO has developed a communications toolkit for self-care for health and wellbeing overall (30). A separate GPC brief outlines actions to enhance self-care for HIV prevention.

### 3. Practical guidance: How to do people-centred HIV prevention design

The iterative processes of people-centred HIV prevention design can be divided into several phases.

#### Phase 1: Empathize (deep understanding of the user)

This is the foundation. Building empathy requires going beyond assumptions and statistics to see a situation or problem from the perspective of the affected person. There are several ways to develop empathic understanding.

##### Activities

- **In-depth interviews.** Conduct one-on-one dialogues to explore personal experiences, beliefs, motivations, fears and daily routines related to HIV prevention. Use questions to uncover underlying sentiments and emotions.
- **Ethnographic studies/observation.** Spend time in the environments where people live, work and interact. Observe behaviours, sentiments and challenges (and how people respond to them).
- **Focus group discussions.** Facilitate discussions to understand group dynamics, shared norms and diverse perspectives. Focus on generating insights, not just achieving consensus.
- **Journey mapping.** Map the entire journey or process a person undertakes when engaging with a prevention service (e.g. from considering PrEP to accessing and using it, obtaining refills, etc.). Identify decision points, causes of stress and moments of satisfaction.
- **Stakeholder mapping.** Identify the actors who influence the person's prevention journey (e.g. peers, health-care providers, family members, community figures and policymakers). Understand their perspectives and potential roles.

##### Tools

- “Empathy maps” are visual tools for depicting and blending insights about what people think and feel, see, hear, say and do, as well as their “pains” and “gains”.
- “User personas” are fictional, but realistic, representations of your key target groups, based on research. These can help teams understand the specific needs, motivations and behaviours of distinct groups of people.

##### *HIV prevention examples*

- **Understanding PrEP adherence.** Rather than assume that non-adherence is due to forgetfulness or apathy, consider using empathic research to uncover the actual reasons for discontinuing use, such as fear of stigma, difficulty storing PrEP medicines discreetly, concerns about side effects, or lack of social support.
- **Barriers to voluntary medical male circumcision uptake.** Similarly, research might reveal that some men fear the procedure, are concerned about its possible effects on their sex lives, lack privacy at health facilities, have unsupportive partners, or are misinformed about the benefits.

- **Adolescent sexual health.** Research might show that adolescents prefer to get sexual health information from peers or social media rather than at health clinics, or that their parents disapprove of them seeking such information.

## Phase 2: Define (synthesize insights and frame the problem)

Once you have gathered those insights, the next step is to make sense of them and clearly define the core problem(s) as seen from users' perspectives.

### Activities

- **Affinity mapping.** Group together similar observations and insights from your research to identify recurring themes and patterns.
- **Synthesis of research findings.** Gather the main insights regarding users' needs and challenges.
- **"How might we" questions.** Reframe problems into actionable, open-ended questions that allow for creative solutions—for example, "How might we reduce the risk of stigma for people using PrEP?". This shifts the focus from identifying problems to exploring remedies.

### Output

- Clearly expressed, user-centred problem statements: for example, "Young women feel shame and judgment when trying to access family planning services," rather than "Low uptake of contraceptives".

### *HIV prevention examples*

- Instead of noting "low PrEP uptake among sex workers", ask "How might we make PrEP access discreet, convenient and empowering for sex workers who fear social judgment and stigma?".
- Rather than state that "people don't get tested frequently enough", ask "How might we make HIV self-testing an easily integrated, private and reassuring part of people's routine health management?".
- Move from "adolescent pregnancies are high" to asking "How might we create safe spaces and trusted information sources where adolescents can openly discuss sexual health without fear of judgment?".

## Phase 3: Develop ideas (brainstorm creative solutions)

Once problems have been clearly defined, the next step is to generate a range of potential solutions by drawing on diverse perspectives and encouraging out-of-the-box thinking.

### Activities

- **Brainstorming sessions.** Facilitate sessions with diverse teams (including, importantly, from communities with elevated HIV prevalence) to produce as many ideas as possible. Emphasize quantity over quality at this stage and defer judgment.
- **Sketching/visualization.** Encourage participants to sketch ideas: visualization helps to express and understand abstract concepts.

- **Analogous inspiration.** Look for solutions in completely different areas or contexts that might offer insights (e.g. where might someone seek trusted information about diets, or with whom would they discuss a problematic relationship?).
- **Behavioural “nudge storming”.** Specifically brainstorm how behavioural economics principles (such as defaults, framing and various biases) could be applied to encourage desired behaviours.

## Tools

- **“SCAMPER”.** This is a creative brainstorming tool that involves **S**ubstituting, **C**ombining, **A**dapting, **M**odifying (magnifying or minimizing), **P**utting to another use, **E**liminating, or **R**eversing existing ideas.

## *HIV prevention examples*

- **For PrEP access,** brainstorm ideas such as PrEP vending machines, online ordering with discreet delivery, peer-led PrEP distribution networks, or integrating PrEP access into existing social spaces (like youth centres and community hubs).
- **For HIV self-testing,** develop ideas for, as an example, packaging designs that can reduce the risk of stigma, or integrating functions on popular smartphone apps that allow people to interpret test results and be linked to care.
- **For partner disclosure,** develop role-playing tools, digital counselling aids or community theatre performances that enact different disclosure scenarios and strategies.

## Phase 4: Prototype (build tangible representations)

Prototypes are rough, easily assembled realizations of your ideas. They can be useful to make abstract ideas tangible so they can be tested and improved. They are not intended to be a final product.

## Activities

- **Low-fidelity mock-ups.** Create simple drawings, paper models or basic digital “wireframes” for services or products.
- **Storyboards.** Illustrate the user's interaction with a new service or intervention.
- **Role-playing.** Act out scenarios involving the new intervention or communication strategy to identify practical challenges and opportunities.
- **Service blueprints.** Map out the front-end (what the user encounters) and back-stage (what happens behind the scenes) processes of a given service or intervention.
- **Annotation.** Emphasize that prototypes are meant to be built and tested quickly; they need not be perfect. Their purpose is to elicit feedback and provide lessons.

## *HIV prevention examples*

- **New communication message.** Create a draft poster with new messaging and visuals, using simple design software or drawings by hand.
- **Digital appointment booking.** Sketch out a basic app interface for booking HIV testing or PrEP appointments.

- **Peer-led support session.** Outline the flow and key activities of a peer-led support group session.
- **Discreet PrEP dispensing.** Design mock packaging for PrEP or a process flow for a discreet PrEP pick-up system.

## Phase 5: Test (gather feedback and iterate)

This phase involves presenting your prototypes to actual prospective users to gather feedback, learn and refine. This is not a final evaluation, but a vital learning opportunity.

### Activities

- **User testing.** Observe how users interact with your prototype. Ask them to think aloud, identify what's confusing, what they like, and what they would change.
- **A/B testing (for communication).** Present two different versions of a message or visual to various prospective users and determine which performs better (e.g. which has higher engagement or recall).
- **Rapid feedback loops.** Incorporate feedback quickly into the prototype and test it again. This iterative cycle is crucial for improvement and refinement.
- **Observation in actual settings.** If feasible, observe how users interact with initial versions of interventions in their own environments.
- **Annotation.** Stress that this is iterative learning, not a final evaluation. The goal is to learn what works, what doesn't work, and why.

### *HIV prevention examples*

- **Test a new communication campaign.** Show different versions of social media posts or radio jingles to focus groups, assess their comprehension and emotional responses, as well as the perceived relevance of the messaging.
- **Test a new “service flow”.** Have a small group of prospective users pass through a simulated process for accessing a new PrEP clinic and identify any hindrances, points of discomfort, etc.
- **Test an HIV self-testing kit design.** Observe individuals using a prototype self-testing kit and note confusion with the instructions, ease of use or challenges with disposal.

## Phase 6: Scale (implement and monitor)

Once a solution has been thoroughly tested and refined through multiple iterations, it can be scaled up for broader implementation. However, the learning process does not stop here.

### Activities

- **Roll out of refined solutions.** Implement the tested and validated interventions, services and communication strategies more broadly.
- **Ongoing monitoring and evaluation.** Continuously track key performance indicators, user feedback and behavioural outcomes.

- **Continuous learning and adaptation.** Be prepared to make further adjustments based on real-world implementation data and changing contexts. The emphasis is on continuous improvement.
- **Annotation.** Highlight the importance of continuous feedback loops even after scaling up, so the solution can remain relevant and effective.

## 4. Practical guidance: How to do effective HIV prevention communication

Communication is not just about transmitting messages: it's about fostering understanding, building trust, influencing decisions and enabling sustained behaviour change. Traditional mass media campaigns often suffer from:

- a **lack of relevance** (due to generic messages that don't resonate with diverse audiences);
- **limited impact on behaviour** (knowledge alone is not enough to change deep-seated habits, subdue concerns or anxieties, or overcome barriers);
- an **absence of feedback** (no mechanisms for people to ask questions, share concerns or provide feedback, which leads to missed opportunities for course correction); and
- a **disregard for decision-making biases** (messages that assume purely rational decision-making often ignore how people actually arrive at decisions).

By drawing on insights from people-centred design and behavioural economics, we can transform HIV communication from one-way conversations into dynamic, two-way dialogues.

### From information to engagement: Tips for effective prevention communication

People-centred design and behavioural economics provide a blueprint for effective and sustainable prevention communication strategies.

#### Tailored messaging (people-centred design)

- **Base messages on user personas.** Develop specific messages for distinct segments (e.g. young women in urban settings, male migrant workers, rural married couples) using language, visuals and stories that relate to their lived experiences, values and concerns.
- **Address perceived barriers.** Craft messages that address the identified barriers (e.g. "PrEP is for everyone, regardless of your relationship status" to counter stigma; "It's normal to feel worried, but here's how other people handled it" for testing anxiety).

#### Channel optimization (people-centred design)

- **Reach people where they are.** Identify the most trusted and frequently used communication channels for specific groups (e.g. social media for youth, community radio for rural areas, peer networks, trusted religious leaders, local health workers).
- **Multi-channel approach.** Use a combination of channels to reinforce messages and reach different sections of populations.

#### Narrative and storytelling (people-centred design & behavioural economics: salience, vividness)

- **Relatable stories.** Use compelling personal stories from people who have successfully adopted prevention behaviours. Stories are more memorable and resonate more than "dry" facts.

- **Emotional connection.** Appeal to positive emotions like hope, empowerment, peace of mind, or protection of loved ones, rather than stoking anxieties or relying on statistics.

### **Clear and simple call to action (behavioural economics: reducing “friction”)**

- **Make it easy.** Clearly state what you wish people to do, how and where (e.g. “Visit your nearest health centre for a free HIV test today”, “Text ‘PrEP’ to #12345 for discreet delivery options”).
- **Keep it simple.** Avoid jargon, complex instructions and too many choices.

### **Feedback mechanisms (people-centred design)**

- **Two-way dialogues.** Create opportunities for people to ask questions, provide feedback and share their experiences (e.g. Q&A sessions, online forums, community feedback boxes, dedicated hotlines). This fosters trust and allows for real-time adaptation.

### **Trusted messengers (behavioural economics: social norms, credibility)**

- **Peer-to-peer communication.** Make use of the legitimacy of trusted peers, community leaders or local influencers to deliver messages; people are more likely to be influenced by those they know and respect.
- **Authenticity.** Ensure messengers are credible and genuinely represent the prospective users.

### **Reframing (behavioural economics: framing)**

- **Positive framing.** Focus on the benefits of prevention (e.g. “PrEP empowers you to take control of your sexual health”) rather than only on the risks associated with inaction.
- **Gain versus loss.** Experiment with framing messages in terms of what can be gained (health, freedom, peace of mind) versus what can be lost (health, relationships, future opportunities).

### **Simplification (behavioural economics: ease of understanding)**

- Break down complex information into easily digestible “chunks”. Use visuals, infographics and short, clear sentences.

## 5. Measuring success

### Track outputs and outcomes

Investments in communications, demand generation and community engagement can absorb substantial proportions of prevention budgets.<sup>3</sup> Yet, these activities are not always adequately tracked and evaluated, which can undermine appreciation of the value of the investments.

To facilitate monitoring, the programmes need to define combinations of coverage and outcome indicators along the lines of results frameworks (see Annex 1). Typically, output and coverage indicators track the efficiency of implementation, while outcome indicators track effectiveness and whether the coverage results in changes. For example:

By using people-centred metrics, programme managers can gain a richer understanding of whether the interventions resonate, foster sustained behaviour change and make a tangible contribution to HIV prevention

- **Output / coverage indicators.** Number and percent of people in the focus population reached with:
  - Interpersonal communication
  - Virtual interventions
  - Media interventions
- **Lower-level outcome indicators on behavioural determinants.** Percent of population with:
  - Correct knowledge of HIV prevention methods
  - Knowledge of sources/access points for HIV prevention
  - Adequate risk perception
  - Self-efficacy (confident to use prevention methods)
  - Ability to negotiate use
- **Outcome indicators tracking changes in behaviours.** Percent of focus population:
  - Using effective prevention methods (condoms, PrEP, PEP, needles, syringes, etc.)

Population-based surveys on attitudes, norms and behaviours are the gold standard for tracking outcomes. The surveys can establish what proportions of a population were reached as well as which determinants of prevention (e.g. knowledge, risk perception, motivation, self-efficacy) were influenced and their effects on sexual or drug injecting behaviours. However, the surveys are expensive and therefore might need to be replaced with lower-cost alternatives, such as simplified bio-behavioral surveillance (“BBS light”) or “polling booth” surveys.

Even substitute surveys may be too expensive to be done regularly. In that case, very basic outcome monitoring questions can be put to people reached by programmes (e.g. by outreach

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<sup>3</sup> In grant cycle 7 of the Global Fund, for example, HIV prevention communication, information and demand creation was allocated more than US\$ 200 million investment.

workers, during site visits or audio-assisted self-interviews on tablets in waiting areas or drop-in centers). When interpreting those results it is important to bear in mind that they are not representative of population-wide behaviours but speak only to the behaviours of the people reached with the programmes.

Coverage of activities can be tracked through programme records or, in the case of media and virtual interventions, through media and online tracking indicators (e.g. “number of visits”, “number of contacts”, etc.).

## Other considerations for measuring and interpreting results

To measure meaningful success, programme managers can consider the following metrics.

### Engagement rate

- **Participation in co-creation.** The number of prospective users who were actively involved in people-centred design workshops, feedback sessions and design iterations.
- **Feedback received.** The volume and quality of feedback on prototypes, communication messages and service delivery.

### User satisfaction and experience

- **Surveys and qualitative feedback.** Regular surveys and in-depth interviews can be used to gauge user satisfaction with the convenience, ease of use and perceived value of the intervention. Use metrics such as Net Promoter Score or Customer Satisfaction, where appropriate.
- **Reduced “friction” points.** Track the reduction in identified barriers (e.g. clinic wait times, stigma, overly complicated documentation) based on user feedback.

### Effectiveness of communication messaging and channels

- **Message clarity and relevance.** Pre- and post-intervention surveys can be used to assess the clarity, relevance and usefulness of the information received and the percentage of users who report understanding the messages.
- **Engagement and responsiveness.** Engagement can also be tracked—via click-through rates, shares and comments for digital channels and platforms, and through attendance and participation for in-person interventions. In the case of interactive platforms like chatbots and hotlines, response times and quality of engagement can be measured.
- **Influence on decision-making.** Surveys can be used to assess the percentage of users who say the communications influenced their behaviour and/or helped them take a prevention-related decision.

### Behavioural intent and self-efficacy

- **Pre/post surveys.** Measure changes in people’s stated intentions to adopt or maintain prevention behaviours.
- **Qualitative insights.** Explore people’s confidence in their ability to adopt prevention behaviours (self-efficacy) and deal with challenges.

### **Uptake and adherence (qualitative and quantitative)**

- **Sustained uptake.** Look beyond initial uptake and track retention rates for interventions like PrEP.
- **Reasons for adherence/non-adherence.** Conduct qualitative research to understand why people adhere or do not adhere, in order to uncover facilitating factors and barriers.
- **“Sticky” interventions.** Measure how well people integrate prevention behaviours into their daily routines.

### **Reduction in barriers**

- Quantify, to the extent possible, the reduction in barriers which had been identified during the empathy phase (e.g. decreases in reported stigma at clinics, shorter waiting times, improved access to services in remote areas).

### **Qualitative insights/stories of change**

- Collect and document compelling qualitative data, such as personal narratives and case studies, that illustrate the impact of the people-centred approach on individuals’ lives. These stories can be powerful for advocacy and learning.

### **Cost-effectiveness (revisited)**

- While traditional cost-effectiveness measures remain important, it is also useful to consider the long-term value generated by sustained behaviour changes and improved user experiences. They can lead to greater impact and more efficient use of resources over time, compared to interventions with high initial uptake but low retention.

### **Proxy measures for “nudges”**

- If a specific behavioural “nudge” is employed (e.g. offering users a default option, like “opt-out” testing), track the behaviour change attributed to that “nudge”.

By focusing on these people-centred metrics, programme managers can gain a much richer understanding of whether their interventions resonate, foster sustained behaviour change and make a tangible contribution to HIV prevention efforts.

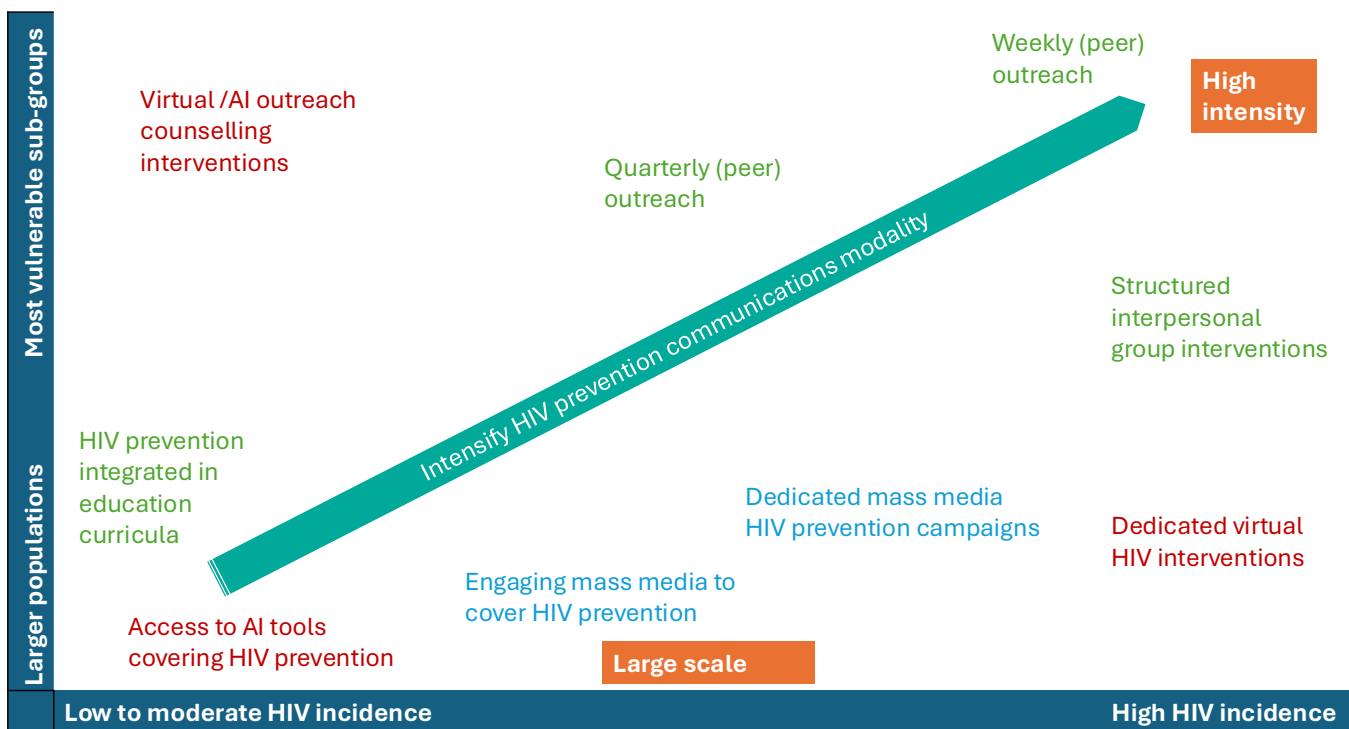
## 6. Considerations for prioritization, planning and budgeting

Funding is typically the primary constraint for health communications. Even in resource-rich contexts, there are limits to the number of health issues that can be publicized and communicated in systematic and sustained ways, as well as limited to what different platforms can cover and communities can absorb. Prioritization is therefore unavoidable.

In prioritizing activities, we have to consider both scalable and intensive communication options. Media and digital approaches are often more scalable, while interpersonal ones tend to be more intensive. Prioritization, though, does not necessarily entail choosing one approach over the other—it’s about selecting the most suitable modalities for a given population and topic. Figure 5 depicts the logic of prioritization for prevention communications.

Funding is a major constraint for health communications. Attention of audiences is also limited—prioritization is therefore unavoidable.

Figure 5. Prioritizing HIV prevention communications approaches by scale and intensity



HIV prevention communications often have been based on generic assumptions, rather than on prioritization and epidemiological realities. For example, interpersonal communication is often thought to be superior to media communication—which it can be when intensity and direct support are the priorities, rather than increasing population-level understanding and knowledge of new products. However, resource-intensive interpersonal modalities are often applied to populations who

are at moderate risk for HIV, and not so much for those who are at high risk. It's now possible to design and customize HIV prevention communications strategies that are better tailored and more versatile and adaptable. Digital interventions, it is important to note, allow for engaging with larger populations in interactive ways that offer both intensity and extensive reach.

Prioritization does not mean choosing one approach over all the others—it's about selecting the most suitable mix of modalities for a given population and topic.

When developing budgets for these strategies, it is important to include data collection (e.g. through online surveys and social media mapping) and monitoring and evaluation activities (see Chapter 5), and to indicate how hybrid delivery channels will be used to reach target audiences and users.

It is useful to use quantitative information in the prioritization process. Figure 6 provides a simplified example of such a matrix. As minimum prioritization should reflect the HIV incidence rate in the population, the cost per person reached and the assumed effect on behavior. All inputs will require use of informed estimates:

- For HIV incidence this can be obtained from an epidemic model like Spectrum or Naomi.
- For the cost per person per year, this can be calculated based on the estimated total cost for an intervention per year divided by the number of people reached, which will depend on population size estimates and prevention denominators from the above mentioned epidemic models.
- For the assumed effect on behavior, effect sizes can be obtained from the literature on specific interventions, but it is important not to overestimate the additional effect of demand side and behavioral interventions, which according to studies are mostly moderate and in the range of the illustrative examples below.

**Figure 6. Prioritization matrix matching populations and approaches – illustrative example**

Population	Intervention	HIV incidence rate in the sub-population (A)	Cost per person reached per year in USD (B)	Assumed effect on behavior /uptake (C)	Cost-effectiveness score (B / A / C)
Young people 15-24	Social media campaign	0.2%	0.5	5%	5'000
Young people 15-24	Interpersonal outreach	0.3%	15	30%	16'667
Key population A	Social media campaign	2%	3	15%	1'000
Key population A	Peer outreach & distribution	3%	40	30%	4'444
...	...	...	...	...	...

\* The cost-effectiveness score expressed here is defined as the cost per person reached who would have acquired HIV but was reached and changed their behavior (based on the effect size assumption). The lower the score, the greater is the cost-effectiveness. It is calculated in a very simple formula. Cost per person year (B) divided by the incidence rate (A) and the assumed effect (C), for example, for row 1:  $0.5 / 0.002 / 0.05 = 5000$ .

## Four examples of cost-saving, sustainable communication strategies for HIV prevention

As donor funding declines and HIV budgets become tighter, countries can use person-centered design, digital innovations and new partnerships to stretch available resources and maximize impact. The four examples below describe practical options for developing funding proposals for cost-saving, sustainable HIV prevention in the context of limited resources.

1

### Adapt proven campaign messages and methods for local contexts



Draw on successful insight-driven messaging from other countries and adapt them for your priority audiences, using existing platforms and low-cost digital channels to maximize reach.

#### ***Cost-efficiency gains***

- Use existing data to develop target audience profiles and user “journey maps” instead of conducting expensive market research studies.
- Supplement that with light, rapid user research as needed to quickly adapt and optimize campaigns.
- Use low-cost AI tools to help summarize interviews or generate candidate message variations.
- Replace costly mass media campaigns with targeted, timely “nudges” via WhatsApp and other social media and text messaging.

#### ***How it supports sustainability***

- User insights and messaging from similar contexts can often be refined and re-used, avoiding the need to start from scratch.
- Existing digital platforms already capture the attention of target audiences, reducing the need for public health managers to invest heavily in building and sustaining engagement from anew.

#### ***Partnership opportunities***

- Local media and digital agencies can adapt core messages into culturally relevant content.
- Popular influencers or community leaders can be enlisted as prevention messengers.
- Mobile telephone service providers may donate SMS airtime or advertising space as part of their health-oriented corporate social responsibility efforts.

## 2

### Offer virtual HIV prevention options through telemedicine



Use telemedicine's potential to support task shifting to lower-cost health service providers for virtual follow-up.

#### **Cost-efficiency gains**

- Reduces travel expenses and time, pressure on clinic infrastructure, and staff workloads by offering: PrEP consultations by phone or video; virtual “check-ins” for adherence support; discreet appointment booking and results collection.

#### **How it supports sustainability**

- Builds on existing private sector infrastructure and promotes strengthening of public health telemedicine infrastructure to support integrated care.
- Promises high cost-efficiency at scale.
- Can support continuity of care during major disruptions (e.g. conflicts, pandemics).

#### **Partnership opportunities**

- Telehealth companies can co-develop virtual PrEP pathways and self-testing support.
- Mobile network operators can be approached to offer discounted data for virtual health tools.
- Logistics partners can help enable discreet delivery of HIV self-tests, PrEP or medication refills.

## 3

### Integrate HIV services into everyday spaces



This activities focus on increasing access to and awareness of HIV prevention services by expanding service and product availability beyond health facilities.

#### **Cost-efficiency gains**

- Leverage trusted venues (pharmacies, schools, workplaces or youth centres).
- Share logistics and staff, so new clinics are not required.
- Offer links to virtual services or self-test orders that are scalable and trackable.

#### **How it supports sustainability**

- Encourages routine engagement with HIV prevention services through everyday entry points.
- Partnerships with private sector can create long-term delivery channels.

#### **Partnership opportunities**

- Pharmacies can host prevention kiosks and distribute PrEP and self-tests.
- Employers and factories can integrate HIV education, self-testing, and peer support into occupational health.

# 4

## Support peer- and community-led models with simple digital tools



This work emphasizes the central role of peer and community-led interventions, along with opportunities to increase efficiency in service delivery by using digital tools and solutions.

### ***Cost-efficiency gains***

- Community and peer educators are cost-effective, trusted and can reach people who tend to be missed by formal systems.
- Group messaging apps (e.g. WhatsApp, Signal) allow for low-cost coordination, supervision and support.
- Digital forms (e.g. Google Forms, KoboToolbox) can streamline data collection and reduce time and other costs.
- Basic transcription or note-summary tools can be used to track trends and issues noted in peer reports to improve learning.
- Digital risk assessment tools can be developed for AI-guided advice, support and referrals.

### ***How it supports sustainability***

- Community-led service delivery can build ownership and resilience even when external funding declines.
- Digital tools help standardize and scale peer-led models without requiring major infrastructure.

### ***Partnership opportunities***

- Tech companies or foundations can be approached to donate tablets, airtime or app use licenses for telemedicine use.
- Employers can sponsor peer-led prevention initiatives for workers and along their supply chains as part of their corporate social responsibility efforts.
- Messaging platforms can offer free or subsidized access to group communication tools for peer networks.
- App developers can co-create lightweight, offline-capable tools for peer data collection, referrals or education.

## 7. Conclusion: Towards more effective and equitable HIV prevention

The push to end AIDS as a public health threat is at a critical juncture. The numbers of people newly acquiring HIV are not falling quickly enough, funding for HIV is under intense pressure, and prevention programmes are being disrupted by budget cuts.

Powerful tools exist for protecting people against HIV, but these tools must reach and be used consistently by the people who need them most. The history of HIV prevention teaches us that it is not enough to make information, services and tools available: the people who stand to benefit from them must be able to use them and must want to do so.

Human behaviour is complex, nuanced and often predictably “irrational”. By making use of people-centred design and insights from behavioural economics, HIV planners and programmers can redefine and accelerate HIV prevention. People-centred prevention communication entails understanding the needs and realities of individuals and putting them at the heart of decisions.

By adopting people-centred approaches, HIV planners and programmers can unlock new levels of effectiveness, optimize resource allocation and build programmes and communication strategies that are scientifically sound and deeply relevant, empowering and sustainable.

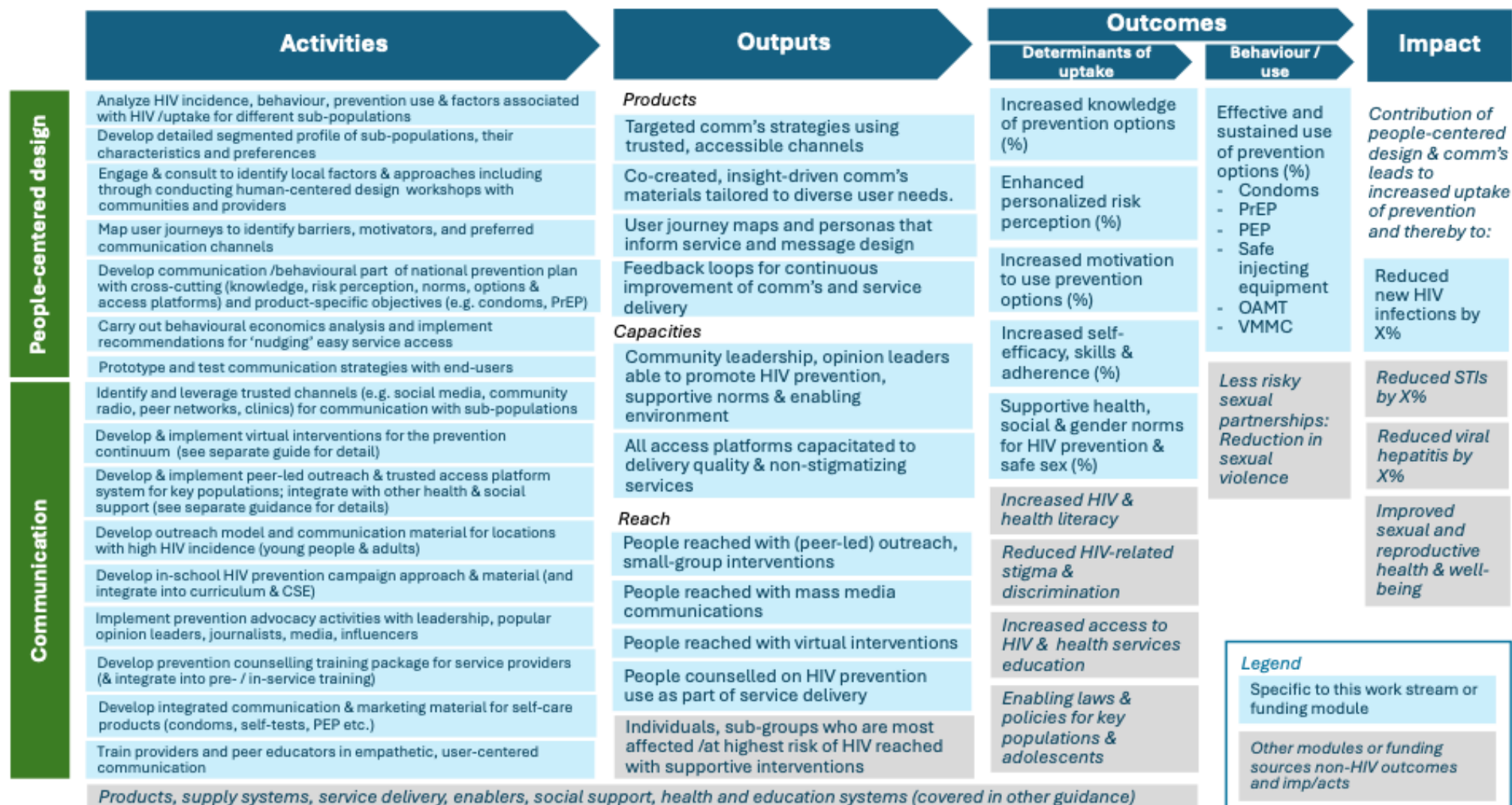
New technologies allow for deploying the strategies across multiple channels. It’s now possible to use the power of digital models in combination with small group or in-person intensive outreach, for example. These different approaches can be blended and delivered in tandem, guided by epidemic conditions, people’s realities and needs, and resource availability. By doing so, we can accelerate towards ending the HIV epidemic, while ensuring that no one is left behind in our prevention efforts.

### Call to action for national programme managers

- **Prioritize evidence-based design.** Map out HIV prevention communication needs by population and then design an optimized mix of messages and channels.
- **Invest in capacity.** Conduct training and skill-building in human-centred design and behavioural economics for your teams or seek out partnerships with organizations that possess that expertise.
- **Champion empathy.** Encourage deep, qualitative research to understand the lived experiences of your target populations. Challenge assumptions.
- **Embrace iteration.** Be prepared to prototype, test, make mistakes and learn through iteration. In the early phases of the design process, perfection is the enemy of the good.
- **Foster collaboration.** Build diverse, multi-disciplinary teams that include behavioural scientists, designers, community members and programme implementers.
- **Shift measurement.** Move beyond traditional output indicators to measure what truly matters: user satisfaction, sustained behaviour change and real-world impact.
- **Share lessons learned.** Document your processes, successes and challenges. Share your insights widely to contribute to the global learning agenda for people-centred health.

## Annex 1. A detailed results framework for people-centred design and communications programmes and funding proposals for HIV prevention.

Note: This example provides a range of options for countries to choose from. In practice, results statements should then be quantified wherever possible:



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