
Ending the AIDS epidemic by 2030 Reducing sexual transmission

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Executive summary

Early global HIV prevention efforts generally included awareness-raising to inform people about the risk of HIV and classic sexual health promotion. Guidance in the 1990s on combination HIV prevention led to a gradual scale-up of programming in the mid-2000s. Strong advocacy for an HIV prevention revolution was then spearheaded by the Prevention Commission in 2010. Nevertheless, despite these significant earlier efforts, HIV prevention programmes remain inadequate to meet the global target of reducing sexual transmission by 50% by 2015.

In an effort to re-energize and re-shape global HIV prevention towards reaching the 2015 target and the ultimate goal of eliminating sexual transmission by 2030, UNAIDS convened a meeting of key stakeholders including National AIDS Programme managers from 14 key countries on 10-11 April, 2014 in Geneva, Switzerland.

Opening the meeting, the UNAIDS Executive Director called for action in eight priority areas: i) generation of localized data; ii) development of creative approaches and investments to reach key populations; iii) addressing gaps in knowing one's status – testing; iv) expansion of social transformation action to address gender inequality and gender-based violence, including through cash transfers for young girls; v) increasing demand for and supply of HIV prevention tools such as condoms; vi) ensuring benefit from 'treatment as prevention' (TasP) – eliminating the dichotomy prevention-treatment; vii) addressing punitive laws; and viii) empowerment of young people as agents of change.

There is a strong need for comprehensive combination HIV prevention, including strategies addressing socio-behavioural aspects and the needs of young women. Creative approaches are needed to reach key populations at higher risk, including through condoms and voluntary HIV testing and the use of new media.

Increased investment into HIV prevention is required, including in countries where domestic funding is increasingly focused on HIV treatment programming. There is a need to invest more into condoms and to lower HIV prevention commodity prices. HIV prevention investment needs should be modelled, and national HIV prevention strategies and investment cases developed as appropriate. HIV prevention elements in concept notes for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) need to be strengthened.

The meeting called for an increased focus of HIV prevention efforts on most affected geographic locations and key populations. Excellent examples were provided by Kenya and on the city approach in China. Programmatic guidance on HIV prevention in key locations should be developed rapidly.

National AIDS programmes are called upon to consider integrating new HIV prevention elements into existing strategies, including the use of new and digital media, as showcased through the Blued project in China and the Young Africa Alive project, expansion of business models to scale up key populations interventions such as Avahan in India, enhancement of innovative ways to distribute condoms as seen in South Africa, and promotion of cash transfers for young women, Pre-Exposure Prophylaxis (PrEP), especially for MSM, and new non-surgical male circumcision devices.

An ambitious global HIV prevention target (200,000 new adult infections by 2030 = 90% reduction from 2 million in 2010) was proposed and found broadly agreeable and in line with similar discussions of the African Union regarding the end of the AIDS epidemic. However, further discussions are needed to determine how such a target may translate for individual countries.

Participants were also urged to consider a possible results and accountability framework with a number of programmatic pillars and indicators which could serve to measure progress. Comments made referred to the proposed mixture of population groups and interventions, the

importance of men if the proposed focus is on young women in sub-Saharan Africa, and the role of critical enablers in the framework.

At the meeting's end, participants agreed that this was a first step in a new HIV prevention movement. The UNAIDS Secretariat committed to keep the group engaged and further consult on the proposed global target and action framework.

Background information and presentations from the meeting are available at: <https://www.dropbox.com/l/3hrv8xgJ195dNtv8XjpX5c?> .

Chapter 1

Introduction

Notwithstanding the significant impact HIV prevention has had over three decades, at current pace the decline in new infections remains insufficient to meet the global UN General Assembly (UNGA) target to reduce sexual transmission of HIV by 50% by 2015. A UNAIDS analysis of country progress reports at mid-term in 2013 identified weakened HIV prevention responses in some cases, including scattered evidence of a reduction in HIV prevention funding.

The proven impact of antiretroviral therapy (ART) in preventing transmission of HIV and the recent upsurge in new scientific developments are promising, but at the same time, traditional prevention programmes including the distribution and marketing of male and female condoms, though potentially effective and successful if systematically implemented, may be at risk of losing their appeal and/or funding. Multilevel and sometimes politically sensitive action is needed to reduce risk, promote safe sex and address harmful social norms and structural barriers that drive new infections. No global accountability framework currently exists, against which countries and key partners commit to a set of strategic collective actions to establish and optimize effective prevention programmes, with milestones that are commensurable with nationally and internationally agreed HIV prevention targets.

Objectives

Against this background, UNAIDS called for a global consultation with the following objectives:

- To renew conviction in the importance and impact of HIV prevention in an era of persistently high incidence
- To examine the state of affairs, successes and trends, in preventing sexual transmission of HIV in priority countries
- To shape an energized new phase in HIV prevention, with emphasis on focus, innovation and sustainability
- To identify elements of an action and accountability framework to sustainably reduce new HIV infections in high impact countries by 2030

Participation and stakeholders

The meeting brought together National AIDS Programme managers from 14 of the countries most affected by HIV¹, UN system staff working on AIDS, selected civil society representatives, technical experts, key partners and priority donors. The list of participants and meeting agenda has been annexed to this report.

¹ Brazil, Cameroon, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Nigeria, South Africa, United Republic of Tanzania, Uganda, Zimbabwe

Opening

UNAIDS Executive Director, Michel Sidibe opened the meeting and outlined eight key priorities for HIV prevention:

1. Localized data.

We need programme data and leverage and use local data to target HIV services in real-time.

2. Reach key populations through urgent innovation.

Digital and social media technologies accessed by gay men and other men who have sex with men, sex workers and young people for social and sexual networking offer enhanced opportunities for HIV prevention including creating mass awareness, large scale social change and mobilization, on-demand knowledge and demand generation for and referrals and linkages to off-line services.

3. Close the HIV status knowledge gap.

Over fifty percent of people living with HIV do not know their HIV status. We need a massive push to close the knowledge of HIV status gap.

4. Social transformation through gender equality and ending violence against women and girls.

We need to expand innovative cash transfer initiatives to empower and incentivize young women and girls, and a global public campaign is needed to end violence against women and girls, backed up by HIV skills building.

5. Let's really condomize!

Male and female condoms are an effective HIV prevention tool, yet only eight male condoms per year are available for each sexually active male in Africa and very few female condoms are available for women.;

6. End the treatment-prevention dichotomy.

We must leverage the potential of 'treatment as prevention', but we also cannot put all our HIV prevention eggs in the treatment basket. There is now an urgent moral imperative to use all tools available;

7. Properly address punitive laws.

When laws are punitive, our investments in HIV will not reach their full potential but when laws are fair and empowering, people's behavior can be influenced. Criminalization is not just an African problem - it is an issue in many countries.

8. Young people as agents for change

It is critical to bring young people to the centre of HIV prevention and provide them more opportunities to become engaged. Young people are not enough strategically engaged as actors of change at this stage.

In their introductory remarks, Dr Gundo Weiler, WHO and Michael Johnson, Global Fund representatives stressed HIV prevention as a critical element of the health sector response and underlined the importance of combining behavioural, biomedical and structural tools in unique packages and programmes that suit local populations.

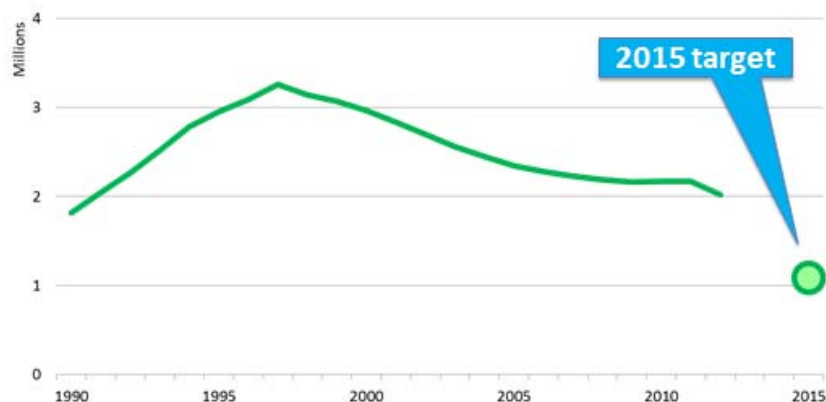
Chapter 2

The state of affairs of HIV prevention

According to Dr Karl Dehne, UNAIDS, around 1.9 million new adult infections occurred in 2013; with just under one third of these occurring among young people aged 15-24, many of them in young women in Africa. This persistently high level of new HIV infections is of grave concern.

The global sexual transmission target is off-track. The bulk of new infections is occurring in 15 countries, mostly in Africa and large population countries in Asia where sexual transmission is the predominant mode. For every new person on treatment there are 1.4 people newly infected, highlighting that there can be no end to AIDS without stronger combination prevention strategies.

Sexual Transmission Target for 2015



A closer examination of incidence data within 14 priority countries shows that HIV transmission is unevenly distributed and often clustered in specific geographic locations. Communities living in, frequenting and transitioning through these areas face increased vulnerability and risk to HIV with unmatched access to HIV prevention and treatment services and commodities.

As the 2011 United Nations Political Declaration on HIV and AIDS noted many national HIV programmes and spending priorities do not adequately reflect commitment to HIV prevention. New HIV prevention technologies are not yet being fully leveraged and sometimes HIV prevention programmes are insufficiently coordinated and/or evidence based. Monitoring of behavioral indicators indicates a decrease in condom use in some high-prevalence countries. In South Africa, home to the largest HIV epidemic in the world, condom use has decreased recently. A number of high-prevalence countries have also reported an increase in the number of casual sexual partners.

At the same time, there has been a growing attention to key populations in many countries which is promising, although very few key population programmes have yet been brought to scale and the legal environment often remains difficult. In some countries stigma, discrimination and homophobia are getting worse, with anecdotal evidence of increased violence against women and key populations, and persecution of gay men and other men who have sex with men and sex workers.

Some countries have made huge efforts to better focus their response where risk is occurring.

Chapter 3

The changed context of sexual risk and HIV prevention

Executive Director, National AIDS Council of Mozambique, Joana Manguiera spoke first and stressed that the complex realities of HIV prevention are longstanding . They include failure to address the socioeconomic, technological and cultural conditions of people's sexual lives. Harnessing the best biomedical interventions will be inadequate. An anthropological vision for long-term planning to 2030 is required. There are so many cultural aspects to sex and sexuality that it is essential to challenge how HIV prevention is considered.

Professor Robert Thornton from University of the Witwatersrand, South Africa reminded participants that HIV infection is shaped by social structures as a consequence of distribution of salience and value across social networks. Sex is not simply irrational or opportunistic, risky, or sporadic. Perception of HIV risk is embedded within broader social lives with multiple and often conflicting risk-based decisions to make. Decisions around sex have to be understood within broader social relations/social discourses/exposures/social capital discourses. Participation in sexual networks is a fundamental part of social structures. It provides access across otherwise unabridged social categories and statuses. Individuals often make risky sexual choices not because they are ignorant, immoral or promiscuous, but because they are trying to build social capital.

Many factors determine the overall large-scale shape of social and sexual networks which in turn determine incidence and spatial prevalence of HIV. Importantly, sex is value and creates value, sex is a relation, sex is cultural and therefore meaningful to people whereas risks such as HIV may have little meaning to people. People prioritize risk to relationships over risk of HIV infection.

Effective social-behavioural HIV prevention must therefore take account not of individual traits but of social structures and value, and with great attention to how social and sexual networks are formed and their dynamic properties. Failing to see sex as social action leads to missed opportunities to HIV prevention and loss of critical prevention investments. This stresses the importance of social and behavioral interventions to look beyond a disease frame.



Leveraging Information and Communication Technologies (ICT) for HIV prevention and using new media entertainment approaches for large-scale behaviour change and social mobilization will be critical for reaching those that are hard to reach and for development of new ways of spreading awareness and building knowledge.

Mr Lye Pie, Chief Content Officer of 'Danlan' Website and 'Blued' dating application in China, as well as Ms Marcha Neethling, Head of Operations in Praekelt Foundation in South Africa, explained how large scale social and behaviour interventions are being pioneered by *Blued* in China and *Young Africa Live* (YAL)

in Southern Africa. 'Blued' 'YAL' is an entertainment-oriented, fun, interactive, and provocative mobile platform that features information, discussions and facts where young people can talk about hot topics that affect their daily lives including love, sex, relationships, gender, cultural issues and HIV. Through its online surveys it provides insight into attitudes towards sex, condoms, relationships, STIs and HIV. 'YAL' also provides information about where to get HIV tested.

Much like 'YAL', 'Danlan' website and 'Blued' dating app in China leverage the opportunities of new media. As the first website to connect gay men and other men who have sex with men, 'Danlan' provides information delivered in an entertaining format and offer linkages between online platform and off-line service delivery. Becoming one of the most widely used dating apps in the world, 'Blued' encourages people to have safe sex and recommends regular HIV testing, providing users with details of the nearest testing sites. In April 2014, Blued reported having 4 million users in total.

These initiatives operate through private partners, take a business perspective and focus on entertainment, sex and relationships rather than disease.

Communities are at the heart of HIV prevention, but after 30 years they still have a marginal role in designing and managing programmes, as stressed by Mr Keletso Makofane and Dr Gitau Mburu, representatives from the Global Forum on MSM and HIV (MSMGF) and the International AIDS Alliance. Just like the roll-out of biomedical interventions and treatment has required investment in the strengthening of health systems, urgent investments are needed into community systems and ensuring cross-community experiences in how to reach the unreached. There is much room for optimizing community-based HIV prevention efforts and lessons learned on effective scale-up strategies and linkages between health and communities can be improved. Governments will need to partner with community-based organizations to reach key populations including sex workers and men who have sex with men. These populations at higher risk must continue to be represented in key planning fora including Country Coordinating Mechanisms (CCM) to ensure that their issues are adequately represented and their service needs met and funded.

A leadership panel of NAC Directors including Dr Kemal Siregar from Indonesia, Dr Fareed Abdullah, South Africa, Dr V.K. Subburaj, India and Dr Thomas Bisika, Malawi provided an update on prevention efforts in their respective countries. A summary of their presentation and remarks have been summarized below.

Preparing for a new national strategic plan in Indonesia

Indonesia is preparing for a new National Strategic Plan (NSP) for the period of 2015-9. Evidence suggests increases in HIV infections in key populations at higher risk, and special considerations must be given to impactful interventions to reach them. The prior plan focused on 137 districts of high prevalence and its operationalization and implementation supported by the Global Fund. New data has been generated to project the trajectory of new HIV infections. Renewed focus in the new plan will be on priority geographic areas, intensified condom programming, and ensuring access to clean syringes for people who inject drugs (PWID). Indonesia is also considering early testing and treatment regardless of CD4 count to increase treatment coverage.

Scaling up HIV treatment and prevention in South Africa

South Africa has experienced a dramatic scale up in HIV treatment coverage over few years, reaching 80% with HIV treatment and care (350 CD4). Yet despite more than two million people on ART, the HIV prevention dividends are lagging. The 2012 South African National HIV Prevalence, Incidence & Behaviour Survey² indicated 469,000 new infections in 2012 with almost 30% of these occurring among young women aged 15-24 years.

The Global Fund has been a critical partner in achieving more balanced investments across the HIV prevention-treatment continuum in South Africa and the predictability of the new funding model provides a way for countries like South Africa to plan for and make long-term investments. A programme serving black gay men in townships, combined HIV/TB services and establishing women's clubs for social and behaviour change are funded through such Global Fund support.

Prevention achievements, challenges and new Initiatives in India

Focusing HIV prevention among key populations has been the cornerstone of the Indian HIV prevention response over the last two decades. India has a concentrated epidemic among key populations and has an estimated 10 million people belonging to key populations for whom a package of interventions has been crafted which include targeted interventions, outreach workers in rural areas, condom promotion, STI/RTI services, integrated counselling, elimination of mother to child transmission (eMTCT), and behaviour change communication and demand generation, etc. The Indian commitment to HIV prevention is also reflected in domestic funding allocations which represent around 2/3 of the total national budget for HIV and are increasing. Prevention efforts in India are making a difference as national HIV prevalence has declined along with HIV incidence and morbidity. National prevalence now stands at 0.27%.

Progress towards global goals in Malawi

Malawi has seen a reduction in new HIV infections but still registers about 55,000 new HIV cases per year. The number of new infections has been reduced by 73% though the decline is less steep lately. Progress has also been made in relation to mortality as AIDS related deaths have been declining and new infections among children have been reduced. The success is considered to be the result of combination prevention including behaviour change communication, reduction of stigma and discrimination, women empowerment, elimination of GBV, prevention of mother to child transmission including option B+, key populations programmes and early diagnosis and treatment of people living with HIV. Specific emphasis has been given to eradicate harmful cultural practices and ensuring male involvement in HIV prevention.

² http://heids.org.za/site/assets/files/1267/sabssm_iv_leo_final.pdf

Chapter 4

Scaling up HIV prevention programming

This session focused on combination HIV prevention approaches, including behavioural, biomedical packages and broader social support programmes which must be urgently scaled up and, where absent, rapidly integrated into existing programmes. A number of excellent examples exist from different countries where HIV prevention interventions have been successfully scaled up.

HIV prevention programmes for young women

Dr Joyce Wamoyi, National Institute for Medical Research (NIMR), Mwanza, United Republic of Tanzania provided a presentation on young women and HIV.

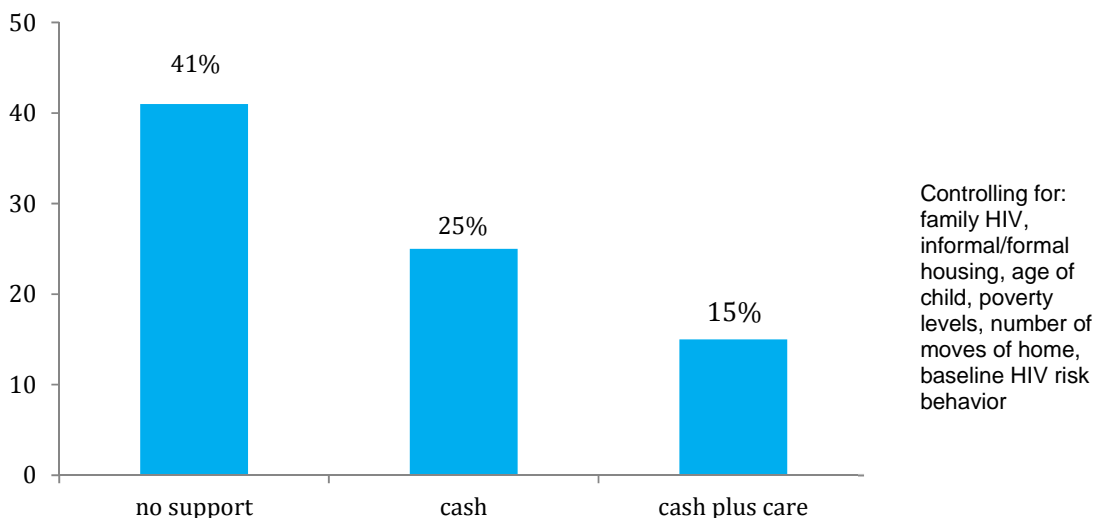
Dr Wamoyi told participants that the elevated prevalence among young women in Southern Africa and other places illustrates the lack of social and economic opportunities for young women. Social, cultural and legal aspects shape the social and sexual networks and exposure to HIV of young women and the means taken to protect themselves from acquiring HIV. Evidence and experience has shown that HIV prevention programmes can work but that it is difficult to achieve and sustain changes unless they are embedded in people's lives and priorities.

Individual behavior change approaches including campaigns to address the sugar daddy phenomenon are unlikely to have population impact on their own as they simplify the complexity of transmission dynamics and fail to acknowledge sex as social action and relationships as pathways to social capital according to Professor Robert Thornton.

Dr Caroline Ryan, PEPFAR and Joanna Herat, UNESCO stressed the need for an integrated approach and truly multi-sectorial agenda and that accountability is needed to address risk among young women and to tackle some of the systemic issues these women are facing in their communities, in and out of school, families in order strengthen the social environment.

Dr Lucy Cluver, Associate Professor, University of Oxford, presented the strong empirical evidence from Sub Saharan Africa reaffirming the results of previous randomized control trials that small cash incentives can impact HIV acquisition in young women. In an evaluation of social grants in South Africa, young women receiving cash transfers sexual risk behavior declined and lower rates of teenage pregnancies have also been observed. Ideally, and for even greater impact, such cash grants should be combined with other HIV prevention interventions like access to education, counselling and care.

% girls HIV risk behavior: Cash plus care = halved risk



*risk behaviors included multiple partners and age-disparate relationship in South Africa (source: Cluver et al, 2013)

Dr Caroline Ryan, PEPFAR outlined six different types of effective interventions to empower young women that have the potential to reduce infections especially if combined with HIV specific services.

- 1) Transforming general norms through training, peer and partner discussion, community-led education questioning harmful norms, testing treatment and care.
- 2) Addressing violence against women and girls, approaches involving men and women towards equitable relationships.
- 3) Tackling legal issues and empowering women by ensuring them inheritance and property rights.
- 4) Promoting women's employment income and opportunities including micro-financing and small-scale income generating activities.
- 5) Advancing education. Increased access to education can decrease risk, abolishing school fees may ensure greater access and providing life skills in school can complement formal education in building knowledge and skills.
6. Reducing stigma and discrimination through community based interventions including media that provide accurate information about transmission and training providers around universal precautions.

Hence, economic empowerment packages with additional prevention and care interventions should be included in HIV prevention programmes serving young women in high prevalence countries in Africa. Countries must determine local objectives, define the activities and determine how and where they should best be implemented.

Scaling up key population programmes

Focus on underserved communities brings urgency to address the enabling environment that shape risk and people's responses to it. Punitive laws hamper access to services in all countries.

Current service delivery systems for HIV prevention are failing to achieve coverage and existing programmes are often using outdated methodologies and system configurations. Community-driven data is needed to identify programmatic gaps and negative laws.

Dr Gitau Mburu from the International HIV/AIDS Alliance, stressed the importance of reaching key and vulnerable populations with services will not be feasible without close collaboration with affected communities as underlined by Gitau Mburu from the International HIV/AIDS Alliance. Accordingly, empowering communities and ensuring that they are adequately resourced and capacitated will be pivotal. Investments in strengthening health systems have brought biomedical interventions but at status quo without adequate investment into strengthening community systems strengthening, such interventions are unlikely to have the impact intended.

HIV prevention among gay men and other men who have sex with men

Successful behavioral interventions in Mexico and China were presented by Mr Ricardo Román, Inspira Cambio AC., and Mr. LYU Pie from 'Blued' in China, who showed how mobile and e-health can be linked to service delivery. Intervention packages for men who have sex with men are well defined in principle, but service delivery and mechanisms for scaling up must be optimized. Understanding risk perceptions and risk management strategies, and defining expectations and objectives outside of the health sector is critical as is using innovative outreach methods to reach and link people into services.

Homophobia and gender based violence against men who have sex with men and other key populations is a common phenomenon, which drives them underground, outside of needed support structures and social networks, often resulting in heightened exposure and vulnerability to HIV. Broader social interventions are needed to tackle structural drivers and needs that are not just disease related as highlighted by Mr Keletso Makofane, MSMGF. The community of men who have sex with men have been at the centre and pioneered solutions for the HIV response since the beginning. But despite this leadership and long community experience, homophobia persists and it is not just an African problem.

Dr Fabio Mesquita, Director, National STD, AIDS and Hepatitis Department in Brazil, stressed the importance of high-level political support for expanding services for key populations. He explained that the President of Brazil, Dilma Rousseff, recently met with representatives of the gay and transgender communities to demonstrate her support to the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. Brazil is committed to not leave key populations behind. However, in many other countries the human rights of gay men and other men who have sex with men, and transgender groups remain severely compromised and very limited access to effective prevention and treatment services is a persistent problem.

To achieve virtual elimination of HIV sexual transmission among gay men and other men who have sex with men, a panel called for three types of action: i) action to avert stigma and discrimination and change social norms ii) action to capacitate and support community-based organizations and leverage their expertise to improve services, iii) action to expand testing, PrEP where appropriate and TasP (in addition to condoms) within a supportive enabling environment.

Sex workers

Dr Sushene Reza Paul, from Ashodaya Samithi in India, and Ms Peninnah Mwangi, representative of the Bar Hostess Empowerment and Support Programme in Kenya, highlighted the lessons learnt from working with sex working communities in the Avahan and the Bar Hostess project in Kenya. Scaling up sex worker programmes is feasible. National ownership, saturation and impact are key to successful scale up, stressed Mr Ganesh Ramakrishnan from the GATES foundation. This implies identifying and defining a standardized prevention programmes for implementation at district level, e.g. a package of condoms, screening for sexually transmitted infections (STI), HIV testing and referral to treatment, , economic and legal support and community empowerment. Ensuring community engagement, collectivism and working through peer educators are critical.

Avahan has established the number of sex workers in different states and implemented specific multi-layered strategies for the sex workers themselves, with their spouses and their long-term and temporary clients in districts within a prioritized number of states. Sex workers may face financial insecurity, violence and arrests, and sometimes even death. These complex and complicated issues require structural interventions including support to deal with arrests and to take violence and rape cases to court emphasized Peninnah Mwangi, Bar Hostess Empowerment and Support Programme, Kenya.

Ms Peninnah Mwangi and Dr Sushena Reza Paul underscored that barriers to 100% condom use must be addressed. Peer education approaches should be promoted, with established programmatic quality standards.

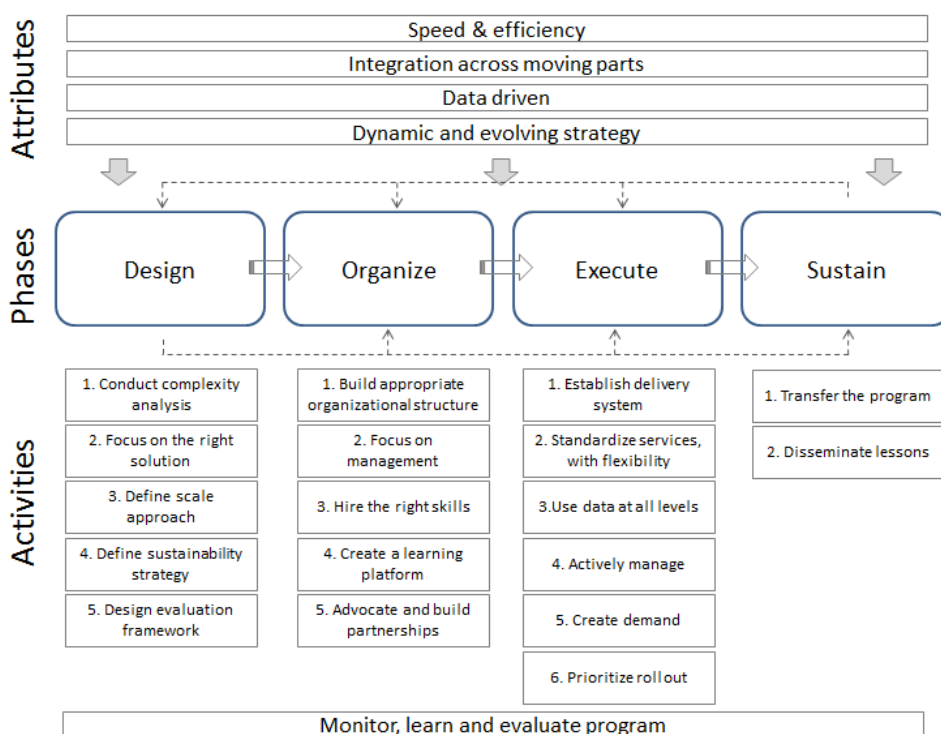
Government programmes will not be able to reach hidden sex workers, bar hostesses, and those working in massage parlors without community and peer led approaches asserted Ms Mwangi.

Community-led HIV preventive interventions among female sex workers in Mysore, India, led to a well-documented decline in risk behavior, STI prevalence and HIV as presented by Dr Reza Paul, associate professor at the University of Manitoba, Canada.

The success of the programme was based on the fact that it approaches sex work as occupational health as opposed to a behavioral issue. Rights based approaches are essential to ensure that sex workers can exercise his/her agency.

The Avahan Project: Providing a defined package of services to greater than 80% of identified target population in order to achieve impact

Avahan DOES framework



- Integrated approach to implementation is critical
- Greater efficiency, speed and impact when you combine principles of scientific inquiry, business, public health delivery

- Important to focus on
 - Active management (define roles, tools, staff ratios, strong field engagement)
 - Standardization of practices with flexibility for each programme area (specify quantity, quality, processes, indicators)
 - Data creation and data use by implementers (engage community)
 - Fostering a “thinking” and “live” programme

Male and female condom programming

Ms Bidia Deperthes, condom expert from UNFPA, reminded participants that male and female condoms are among the most effective technologies for preventing HIV, as well as unwanted pregnancy and STIs. They are low cost and a highly cost-effective component of HIV prevention programmes. Nevertheless, programming for both male and female condoms is far from optimised, and promotion and distribution inadequate. In 2012, only eight male condoms per man per year and one female condom for every eight women were distributed in sub-Saharan Africa. According to reports by the United Nations Population Fund (UNFPA), the number of international agencies that support condom promotion and procurement was levelling-off or declining between 2009 and 2012.

Both Ms Bidia Deperthes, Senior HIV Technical Adviser, UNFPA, and Ms Ghairunisa Galeta, Regional Strategic Services Manager, Population Services International (PSI), stressed that bringing national condom programmes to scale requires intensified promotion, procurement and distribution efforts, with a particular focus on priority locations and areas of high HIV prevalence. It also requires ensuring access to adequate condom supply for people living with HIV. Often the demand creation and promotion side of condom programming is neglected. Condoms are a core component of behavior change programmes and for many people the only viable HIV prevention option.

Ms Deperthes encouraged countries to ensure that taxes and levies imposed on condom imports are removed. Quantifying demand and ensuring adequate and continuous supply of male and female condoms requires a total market approach. Finding innovative and non-clinical settings for mass distribution is key for improving access.

Partnering with the private sector can create new opportunities as presented by Ms Galeta. Through a public private distribution partnership, Population Services International (PSI) partnered with South African Breweries to utilize their transportation routes for expanding condom distribution (volume and access points) to strategic locations at no cost. The partnership resulted in a more than 250% increase in the number of bars covered increased with an increase in distribution from four to 11 million condoms in one month.

Comprehensive programming for male and female condoms

<u>Leadership & coordination</u> <i>Coordination of partnerships</i> <i>Advocacy</i> <i>Policies and regulations</i> <i>Resource mobilization</i>	<u>Supply & commodity security:</u> <i>Forecasting</i> <i>Procurement</i> <i>Quality assurance</i> <i>Warehousing and storage</i> <i>Distribution</i> <i>LMIS</i>
<u>Demand, access and utilization</u> <i>Market research</i> <i>Total market approach</i> <i>Targeted distribution</i> <i>Behaviour change communication</i> <i>Social mobilization</i>	<u>Support</u> <i>Social, behavioural, and operations</i> <i>Capacity and institutional strengthening</i> <i>Integration</i> <i>Monitoring and evaluation</i> <i>Documentation and dissemination</i>

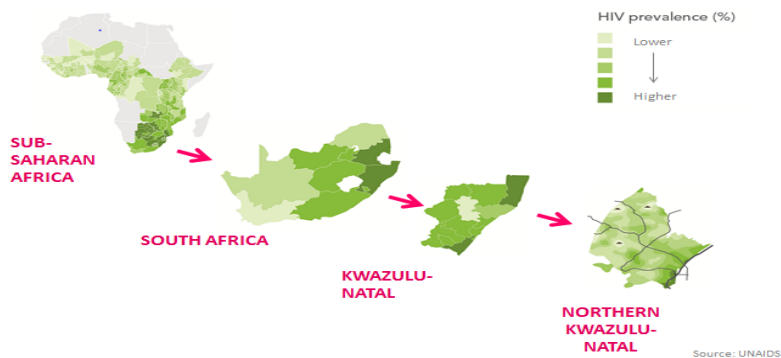
Chapter 5

Focus: critical for impact

Mr Taavi Erkkola from UNAIDS, told participants that more is known now than ever before about the clustering and concentrations of HIV infections and with the use of enhanced data tools, changes in HIV epidemics can be captured as they occur. Mapping, collecting and triangulating data and addressing HIV in context provides purposeful analysis that can be translated into adapted programmatic approaches, involving and owned by local stakeholders. Furthermore access to internet-based BIG data sets offers opportunities for HIV responses in terms of tracking risk behaviors and concentrations of new infections, time trend analysis of population activities and dynamics that can inform programmes in real-time as highlighted in a UN Global Pulse presentation.

With lagging international funding for HIV and for HIV prevention, doing more with less and making impactful and geographically focused investments will be critical. Attention should be given to programmatic performance and learning from successful country efforts that have been brought to scale where it matters and where return on investments is high according to UNAIDS.

HETEROGENEITY OF THE EPIDEMIC



National strategic plans must prioritize areas of high HIV burden and ensure that programmes are intensified in these areas to address the HIV prevention needs and vulnerabilities faced by populations residing in or passing through these localities.

As presented by Dr Nduku Kilonzo, Director, National AIDS Control Council (NACC) in Kenya, after a two-year process of consultations with key constituencies, the Kenyan investment case and HIV prevention revolution roadmap was developed. A common HIV prevention goal was established, a commitment to combination prevention was declared and a range of sectors were mobilized for HIV prevention beyond the health sector. Importantly, a sub-national analysis of HIV prevalence was conducted, counties ranked according to their burden, and programme packages defined for different low, medium and high prevalence categories. Lessons learned highlighted the importance of developing a logical framework for interventions- first, identifying who needs HIV prevention, second, deciding on service delivery options and third, establishing the mechanisms for coordination and delivery, according to location and local context. Investments are optimized by focusing on key population programmes in some geographic areas as well as intensification of all key interventions in areas of high general incidence.

Addressing HIV in key locations will require adapted HIV prevention models and poses new challenges and opportunities in terms of coordination. Dr Qinying He, Deputy Director, and Ms Shuangfeng Fan, Doctor in Charge, of Chengdu Disease control and prevention Center in China, presented that in the city of Chengdu in China, an HIV prevention scheme for HIV prevention among men who have sex with men, which aims at improving service system, expand coverage and enhance quality of services, used a focused city approach to scale up quality HIV testing and counselling, prevention and treatment. It required significant coordination across multiple authorities and sectors and dedicated resources. The project also incorporates innovations including internet mobilization and online demand generation with linkages to offline services, rapid testing and counselling run by community based organizations (CBO), PrEP, and referral to treatment. Similar intensified localized HIV prevention initiatives are underway in more than 20 other cities in Asia.

Nigeria is also moving towards greater geographical prioritization and focused approach to HIV prevention as we learned from Dr John Idoko, Director General, National Agency for the Control of AIDS, Nigeria. With a relatively modest national HIV prevalence of 3.4%, there are states with significantly higher prevalence in this vast country. Tackling this epidemic and building an effective response has necessitated a focus on 12+1 states which are particularly affected. The government of Nigeria has been working to improve coverage and enhance operational research. In neighboring Cameroon, the epidemiological situation is similar with significantly higher HIV burden in some provinces than in others.

Plenary discussion focused on the need for integrated service packages in priority districts must be implemented to ensure high coverage warranting engagement with broader social policy, new partnerships and identifying other health and development synergies. Ms Martina Brostrom, UNAIDS, stressed to participants that service delivery options and mechanisms for scaling up HIV prevention programmes must be optimized and go beyond biomedical interventions and shift focus from national to county clusters. Understanding diversity of demand and defining expectations and objectives outside of health sector is urgently needed.

Chapter 6

Leveraging innovations in HIV prevention technologies

Innovative HIV prevention technologies and approaches were discussed throughout the meeting. This included the use of new media; new approaches to collect and analyze local data; new business models for service delivery like Avahan; new proven effective prevention methods such as 'treatment for prevention', PrEP, cash transfers to empower young women; and new HIV prevention commodities such as rapid HIV tests and newly pre-qualified non-surgical devices for male circumcision. Many of these elements have not yet been systematically incorporated into existing HIV prevention responses.

Innovation

Using social and digital media for HIV prevention



Female condoms for specific segments



PrEP, an effective new tool



Cash transfers to prevent HIV among young women



Self testing, easy, comfortable & convenient



New VMMC devices



Greater speed is needed to adopt new HIV prevention technologies, including registrations for new drugs such as Truvada® (tenofovir/emtricitabine), PrePex™ for Voluntary medical male circumcision (VMMC), re-designed condoms, HIV self-test kits and point-of-care (PoC) testing devices for front line service delivery.

Availing Pre-Exposure-Prophylaxis (PrEP)

PrEP expert Dr Kevin O'Reilly presented the Trial evidence on the efficacy of PrEP which has qualified it for integration into the HIV prevention toolkit. He mentioned that WHO was planning to make a strong recommendation to use PrEP for HIV prevention among men who have sex with men at the International AIDS Conference held in Melbourne, Australia, in July, 2014, and the US Centers for Disease Control and Prevention (CDC) has just issued new guidelines to health care providers for the use of Truvada® as pre-exposure prophylaxis for HIV.

Supporting countries prepare for PrEP entails finding the best opportunities for its use. Priority populations eligible for PrEP include those who are at very high risk, do not use any barrier

methods, people who know their status and want control over primary HIV prevention and populations with otherwise limited HIV prevention options as presented by Dr O'Reilly.

Brazil is planning to incorporate PrEP into their HIV prevention packages for gay men, Dr Fabio Mesquita, Director, National STD, AIDS and Hepatitis Department told participants.

Simplifying Voluntary Medical Male Circumcision (VMMC)

Ms Julie Samelson, WHO, provided an update on male circumcision: She stressed the importance of VMMC for the prevention of heterosexually-acquired HIV infection in men in countries where it is recommended. VMMC services should be an integral part of combination prevention in those countries. Designing and aligning programmes, with standardized package of services, education and counselling and broader work on favourable gender norms is key. Ensuring linkages and integration with sustainable adolescent male services are therefore needed and possible.

In 2013, WHO pre-qualified PrePex™ for non-surgical male circumcision which simplifies the circumcision procedure, allowing for task shifting, and potentially facilitates scale up and expanded reach. Leveraging the full use of new tools for VMMC and simple HIV testing technologies and shifting responsibility and resources for demand creation to community volunteers and schools can help innovate services. However, to be able to achieve desired levels of coverage, task shifting must not become a form of additional burden, or 'task piling' for health workers.

Balancing supply and demand for efficiency including by strengthening human resources and demand creation in local contexts also remains critical. Data gaps in male circumcision must be addressed to demonstrate its value for HIV testing, safe sex and STI management. Despite strong scientific evidence for VMMC scale-up and good progress overall, some challenges remain in relation to demand generation, including with regards to working with and mobilizing traditional and community leaders, and to financing. These challenges demonstrate the need for a multi-partner effort.

New HIV tests --- and referral to treatment

Ensuring ART take-up and maintenance of viral suppression at levels where it might have a population-level impact on HIV transmission dynamics will be challenging but critical according to Dr Mesquita.

GNP+ representative, Mr Nelson Otswana, stressed in his presentation, the importance of scaling up HIV testing and counselling, as a first step in the HIV treatment cascade, with a particular focus on first time testers, key populations at higher risk including adolescents and men, will require innovation in HIV testing. Innovations include scale up of rapid diagnostic tests, community-based testing and counselling models, multi-disease campaigns and self-testing and with strengthened and seamless linkages to care and support for those who find themselves testing positive for HIV.

Policies related to age of consent for testing can pose barriers to adolescents' access to HIV testing and counselling and other health services. While policies on age of consent for HIV testing vary among countries, ministries of health are encouraged to revisit these policies in light of the need to uphold adolescents' rights to make choices about their own health and well-being. Critical elements for scale-up include investment in research to identify optimal HIV testing and counselling strategies for different populations, the conducting of critical review of stand-alone HIV testing and counselling centres and strengthening laboratories and investments in new diagnostics.

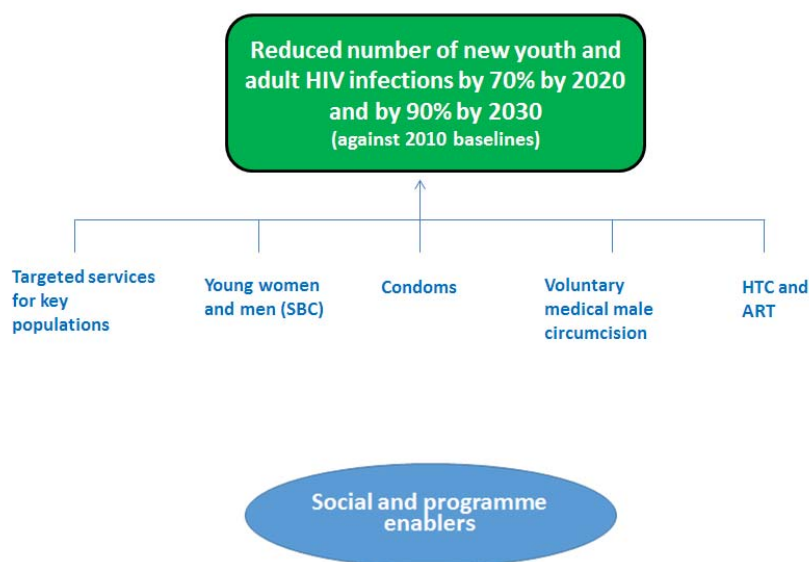
People living with HIV have a critical but often neglected role to play in HIV prevention. People openly living with HIV can educate others of the benefits of testing for HIV. The Positive Health, Dignity and Prevention (PHDP) approach offers an opportunity to leverage the lived experience of people living with HIV to contribute to scaling up HIV testing and counselling and broader HIV prevention. Indonesia and Brazil, among other countries, are

going to offer treatment to all persons living with HIV regardless of CD4 count, for their own health and increased prevention impact.

Chapter 7

Target-setting and accountability

Mr Clemens Benedikt, World Bank consultant, reminded participants that no accountability framework for HIV prevention beyond 2015 currently exists, against which countries and key partners can benchmark their prevention efforts. UNAIDS sought participants input on a bold target of 90% new HIV infections³ to be averted by 2030. Such a new global target will be needed to monitor trends in new HIV infections in regions and countries to ensure political commitment, optimizing programmatic performance in HIV prevention and greater accountability on resource allocation for HIV prevention and treatment. The proposed global target might be agreeable and is broadly in line with existing African Union (AU) discussions regarding the end of AIDS. However, further discussions are needed, particularly with regards to how such a target would translate for individual countries



Plenary discussions focused on a possible results and accountability framework outlined five strategic pillars for generalized epidemics (key populations, young women/social and behavior change (SBC), condoms, male circumcision and HIV treatment) and three pillars in concentrated epidemics (targeted and integrated services for key populations, condoms, HIV testing and counselling and treatment). Comments made through the discussions referred to the mixture of population groups and interventions in the framework, the importance of men if the proposed main focus is on young women in sub-Saharan Africa, and the role of critical enablers in the framework.

Mr Oussama Tawil, UNAIDS, stressed that more work is needed on the accountability framework including consideration of regional frameworks instead of or in addition to the global framework. Programmes for reducing sexual transmission should clearly distinguish between generalized and concentrated epidemics, and implement both approaches where needed, e.g. in mixed epidemics where the epidemic is more severe in certain parts of the country, he suggested. Participants remarked that some priority groups and interventions do

³ 200,000 new adult infections by 2030 = 90% reduction from 2 million in 2010.

not universally apply and country targets will be needed to monitor new HIV infection and response trends.

Mr Mahesh Mahalingam, UNAIDS, stressed to participants that preventing new HIV infections will require broad-based support for HIV prevention, new public-private partnerships and enhanced coordination and collaboration beyond the health sector. Investment cases for HIV prevention are needed for this dialogue and to guide national planning efforts across sectors and ministries according to UNAIDS. He shared the experience with the Global Plan to eliminate mother to child transmission and keeping their mothers alive:

The experience of the Global Plan: ensuring accountability towards EMTCT

In 2009, UNAIDS EXD called for elimination of mother to child transmission (EMTCT) at a Global Fund Board meeting. In 2011, still faced with limited political traction, a 60-day process was launched to define a global framework, later known as the Global Plan for elimination of mother to child transmission (Global Plan). Twenty-five countries were mobilized in support of the Global Plan, contributing political, technical and resource leadership. High political leadership and support from the First Lady of Kenya catalysed a new shift in the Global Plan, identified reprogramming opportunities and increased political commitment and leadership to the EMTCT agenda. A similar dedicated effort might be needed to reduce sexual transmission stressed Mahesh Mahalingam, UNAIDS who gave the presentation.

Chapter 8

Mobilizing and sustaining investments for HIV prevention

HIV prevention investments are at risk, with evidence of a decline in HIV prevention funding in some countries in recent years. Most HIV prevention investments are internationally funded with implications for their sustainability. Dr Hembe Antonica, Head of HIV and AIDS Secretariat, SADC (Southern African Development Community) told participants that SADC countries are over-dependent on international funding and yet the sub-region is home to the countries particularly affected by the epidemic.

Hence, increased investment into HIV prevention is called for. An example was given by South Africa where domestic funding is focused on ART, while international funding for HIV prevention has now been requested from the Global Fund.

Global and country HIV prevention investment needs will need to be determined, e.g. through modelling of scale-up costs, but it is already clear that there is a need to invest more into condoms and other effective interventions including key population HIV prevention programmes, male circumcision, and programmes for young women, stressed Dr Gitau Mburu, Senior Advisor, HIV and Health Systems, AIDS Alliance.

National HIV prevention strategies and investment cases are needed, as part of broader national responses, and HIV prevention elements more prominently included in future Global Fund concept notes. HIV prevention commodity prices need to be lowered, and services delivery models optimized and made more efficient.

HIV prevention requires tailored approaches and resources. Better guidance is needed on how to 'Get to Zero' and how much to optimally invest across HIV prevention and treatment, and across different combination prevention interventions and approaches stressed the International HIV/AIDS Alliance. Some countries have demonstrated significant impact of combination prevention strategies when programmes are holistic, community owned and fully funded.

Behavioural and other interventions are most likely to be sustainable only if they are developed and owned by the communities they aim to serve and address holistic commodity needs, beyond health. Similarly, all HIV prevention interventions need to reflect the local setting within which risk behaviours take place, and understand local decision-making around sex. Further investments into communities are therefore fundamental.

Recent Global Fund grants have almost entirely focused on funding treatment activities, while also remaining a source for funding key population projects and programmes in some countries. Activities focused on the community of men who have sex with men are largely funded through small grants received from private donations according to Mr Keletso Makofane, MSMGF.

Some non-governmental organizations (NGO) may require additional funding and technical support for grant writing, management of grants and so for programmes to be brought to scale and to be expanded beyond biomedical interventions to also include social and legal support to tackle violence and broader issues, as stated by Ms Peninnah Mwangi from Bar Hostess Empowerment and Support Programme, Kenya.

A better case for investing into HIV prevention needs to be made to optimize allocations across HIV prevention and treatment. Life time cost of ART will always be more expensive than HIV prevention programmes and commodities. Better economic analysis of results and forecasting are required to better inform sustainable HIV prevention investments. Modelling the cost of virtual elimination of HIV will help inform the investment case for HIV prevention.

Data gaps in relation to the costs and effects of cash transfers in different settings need to be addressed as was stressed by several participants. Identifying the true and optimal cost of cash transfer as per HIV infection will be needed for countries to advocate for and roll out such interventions at scale.

At a time when international funding is levelling off, ensuring greater domestic investments to be able to sustainably scale up prevention interventions is a priority. A global accountability framework for HIV prevention must be aligned with the African Union roadmap and work of other regional partners stressed Dr Marie-Goretti Harakeye, Head of Division AIDS, Tuberculosis and Malaria.

Chapter 9

Group work: Ending the AIDS epidemic by 2030 – what will take to reduce sexual transmission

Through a group work exercise the participants identified action in four priority areas:

POLICY

- a) Engage with relevant 'sister' movements like women's movement, social protection, employment opportunities for the young, LGBTI etc. that will strengthen our responses in HIV prevention.
- b) Build policy support, legal environment to create space for community-based organisations to work with criminalized populations.
- c) Develop national HIV prevention policies and strategies – clear accountability for who needs to do what, where and when.
- d) Legal reform to decriminalize same-sex relationships, sex work, drug use, condom use for adolescents.

PROGRAMME

- a) Use epidemiological data e.g. to determine concentrated, generalized, mixed epidemics to inform programme efforts.
- b) Countries need to undertake programmatic gap analysis at national and sub-national levels e.g. operating guidelines, mapping data on transmission, analysis of drivers, denominators, and critical funding gaps.
- c) Expand HIV testing and counselling and condoms, including accessibility, availability, create demand.
- d) Bring community based approaches to scale, including the use of successful strategies to rebrand existing services.
- e) Make HIV testing accessible in any form, including self-testing, pharmacy testing, health facility, using simple algorithms.
- f) Customize the response/define standardize package of services for scale-up.
- g) Promote innovative procurement and distribution approaches for condoms, e.g. through soft drink producers distribution channels, new approaches of reaching people where they are e.g. religious gathering, market places.
- h) Optimize resource allocation and give greater attention to allocative efficiency.
- i) More research is needed on the structural drivers/barriers of HIV transmission.
- j) Mobilize broad-based support for HIV prevention, new public-private partnerships and enhanced coordination and collaboration beyond the health sector.
- k) Develop investment cases for HIV prevention to guide national planning efforts across sectors and ministries.

CAPACITY

- a) Strengthen national prevention management and technical support units or teams – to be replicated at decentralised levels.
- b) Strengthen community systems to reach affected populations.
- c) Strengthen legal capacity to change frameworks for sex workers and men who have sex with men.
- d) Develop standard operating procedures for minimum packages for HIV prevention with different groups: MUST-do elements of delivery.
- e) Align leadership around their HIV prevention roles.
- f) Strengthen both health sector capacity and multi-sectoral capacity.
- g) Facilitate horizontal knowledge transfer between countries and different communities within countries.

INVESTMENTS

- a) Generate evidence of the return on investments needed to address sexual transmission and to guide multi-sectoral interventions and funding allocations. .
- b) Focus investments where incidence is high according to country context (geographic clustering/key populations).
- c) Analyze return on investment and frontloading of capacity..
- d) Make the case for Ministries of Finance that investment in HIV prevention will save money in future.
- e) Engage with civil society for service delivery and capacitate them to manage funds.
- d) Invest in partnerships, Corporate Social Responsibility.
- e) Analyze users' willingness to pay for services to ensure sustainability of funding and investment in new partnerships (public/ private partnership) and task sharing.

Chapter 10

Next steps and way forward

Mariangela Simao, Department Director, UNAIDS concluded the meeting underlining that this was just a first step in a new HIV prevention movement, and that the UNAIDS Secretariat would pursue further consultation with key constituencies, countries and partners on a global HIV prevention target, an HIV prevention accountability framework and roadmap for eliminating sexual transmission of HIV by 2030.

Further recommendations included:

- development of an African Union common position and target on HIV treatment and prevention by 2030;
- continued advocacy for better research and development into condoms and a vision of better usability of HIV prevention commodities;
- development of programmatic guidance for an approach to focus on geographical locations and key populations with highest HIV burden or risk, particularly to target investments with a purpose to achieve greater value for money;
- development of a dedicated tool to build an investment case for combination prevention (including social and behavior change); and,
- documentation of the impact of criminalization; and further conversations on HIV prevention in the post 2015 environment.

List of Participants

Virtual Elimination of HIV Sexual Transmission by 2030: What will it take? Kofi Annan, UNAIDS HQ Geneva, 10 – 11 April 2014 List of Participants			
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Agenda

DAY 1: Thursday 10 April 2014		
Time	Session	Chairs/Speakers
08:30	Coffee and Registration	
09:00-09:30	Welcome and introduction	UNAIDS WHO Global Fund
09:30-10:45	Virtual elimination of sexual transmission by 2030? Current trends, changing context, challenges and opportunities Country perspectives CSO perspective	<u>Chair:</u> Mariangela Simao, UNAIDS Karl Dehne, UNAIDS Kemal Siregar, Indonesia Fareed Abdullah, South Africa V.K. Subburaj, India Thomas Bisika, Malawi Gitau Mburu, HIV Alliance
10:45-11:00	Coffee Break	
11:00-12:30	Sexual and social networks - new media and HIV prevention New media - big data Does digital communication help prevent or fuel HIV transmission? Changing sexual networks Young Africa Live	<u>Chair:</u> César Nunez, UNAIDS Miguel Luengo-Oroz, UN Global Pulse Lyu Pie, Danlan Website, China Robert Thornton, Univ. of Witwatersrand, South Africa Marcha Neethling, Praekelt Foundation, South Africa
12:30-13:30	Lunch	
13:30-15:00	Women's empowerment: does it prevent infections? HIV infection and empowerment Money matters: cash transfers, casual sex and partner choice HIV vulnerability of young women in Zimbabwe	<u>Chair:</u> Alti Zwandor, UNAIDS Joyce Wamoyi, NIMR, Tanzania Lucie Cluver, University of Cape Town, South Africa Annah Sango, ICW, Zimbabwe Comments : Caroline Ryan, PEPFAR Vinand Nantulya, Uganda
15:00-15:45	Scaling up integrated programs for key populations: what is new? A new business model for scaling up, South-South cooperation Changing needs of sex work programs in legally constrained environments: India and Kenya	<u>Chair:</u> Oussama Tawil, UNAIDS Ganesh Ramakrishnan, Avahan, India Sushena Reza Paul, Ashodaya Samithi, India Peninnah Mwangi, Bar Hostess Empowerment and Support Programme, Kenya
15:00-15:45	Scaling up integrated programs for key populations: what is new? A new business model for scaling up, South-South cooperation Changing needs of sex work programs in legally constrained environments: India and Kenya	<u>Chair:</u> Oussama Tawil, UNAIDS Ganesh Ramakrishnan, Avahan, India Sushena Reza Paul, Ashodaya Samithi, India Peninnah Mwangi, Bar Hostess Empowerment and Support Programme, Kenya
15:45-16:00	Coffee Break	

DAY 1: Thursday 10 April 2014		
Time	Session	Chairs/Speakers
16:00-16:45	Scaling up integrated programs for key populations: what is new? Continued Preventing HIV infections among MSM, a government perspective Scaling up programs for gay men and other MSM in Mexico HIV programme needs of MSM in Africa and beyond Discussion	<u>Chair</u> : Marie Laga, Institute of Tropical Medicine, Belgium Fabio Mesquita, Brazil Ricardo Vergara, Mexico Keletso Makofane, MSMGF
16.45-17.00	Technical update: Using PreP in key populations and young women	Kevin O'Reilly, Consultant
17:00-18:00	Positive Health Dignity and Prevention in the era of ART The importance of knowing your status Prevention among sero-discordant couples	<u>Chair</u> : Patrick Brenny, UNAIDS Nelson Otwoma, GNP+, Kenya Kathryn Curran, WHO
18.30	Reception	

DAY 2: Friday 11 April 2014		
Time	Session	Chairs/Speakers
8.30-8:45	Update: Young men and male circumcision	Julie Samuelson, WHO
8:45-9.45	Condoms, condoms, condoms State of Condom programming globally: procurement, uptake, use Social marketing of condoms: success stories Innovation: new designs and smart distribution systems	<u>Chair</u> : Tapuwa Magure, Zimbabwe Bidia Deperthes, UNFPA Ghairunisa Galeta, PSI, South Africa
9:45 -11:00	Intensifying HIV prevention in key locations Programmatic and financial implications of a key locations approach Kenya's Prevention Revolution Roadmap Intensifying prevention in Chengdu, China	<u>Chair</u> : Bilali Camara, Nigeria Henk van Renterghem, UNAIDS Nduku Kilonzo, Kenya Quinying He, Chengdu Disease Control and Prevention Center, China
11:00-11:15	Coffee break	
11:15-12:15	Prevention post-2015: Target-setting and accountability An action and accountability framework for preventing sexual transmission What can we learn from existing initiatives to eliminate new child infections?	<u>Chair</u> : Marie-Goretti Harakeye, African Union Commission Clemens Benedikt, World Bank Mahesh Mahalingam, UNAIDS
12:15 -13:30	Lunch	

DAY 2: Friday 11 April 2014		
Time	Session	Chairs/Speakers
13:30-15:30	Virtually eliminating HIV by 2030: what will it take? Group 1: Policy and critical enablers Group 2: Programming (Service delivery and scale) Group 3: Investment needs and opportunities Group 4: Management and capacity strengthening Feedback from group 1 and 2	Group Facilitators, Rapporteurs Maya Harper, UNAIDS Karl Dehne, UNAIDS Michael Johnson, Global Fund / Michael Hahn, UNAIDS Clemens Benedikt, World Bank, United States
15:30 -15:45	Coffee break	
15.45- 16.15	Virtually eliminating HIV by 2030: what will it take? Feedback from group 3 and 4	Group Rapporteurs
16:00-17:00	Next steps Recommendations Milestones Global framework, regional strategies and country action	Mariangela Simao, UNAIDS
17:00-17:30	Meeting Synopsis, Next steps, Closing	UNAIDS

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