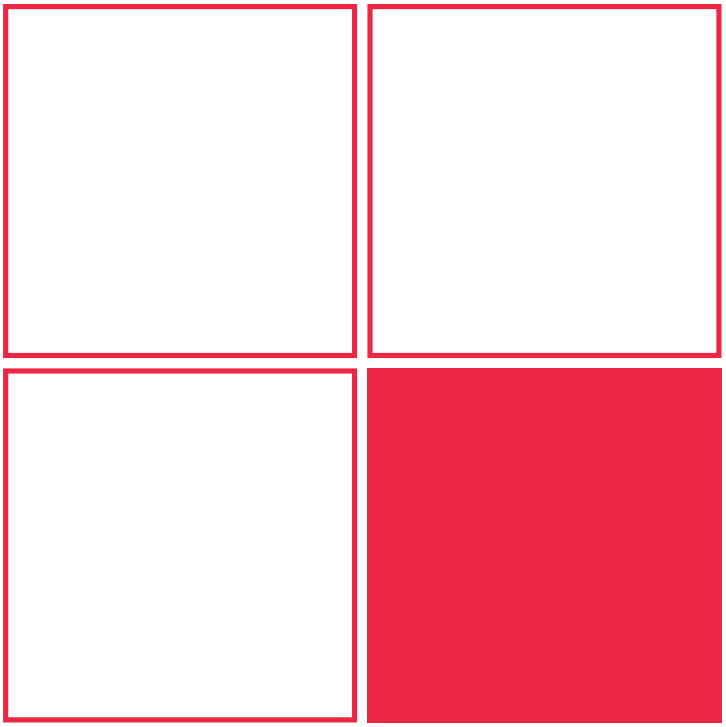
UNAIDS 2015

INVEST IN HIV PREVENTION



QUARTER FOR HIV PREVENTION

UNAIDS / JC2791E

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INVEST A QUARTER FOR HIV PREVENTION

The prospect of a world with zero new HIV infections has never been so real. Time-proven approaches, combined with new tools and discoveries, are providing people with a real chance of protecting themselves and preventing HIV transmission.

There is much to celebrate. More than 30 million HIV infections have been averted over the past 15 years. New HIV infections have declined by 35%. Elimination of new HIV infections among newborns is on the horizon. Antiretroviral therapy is changing the prevention landscape, allowing people to safeguard their health and prevent HIV transmission at the same time. Use of these medicines as prophylaxis can even prevent people from acquiring HIV.

Despite these accomplishments, there are many reasons for concern. The speed at which new adult HIV infections are declining falls short of meeting current targets; in fact, new HIV infections are resurgent in some parts of the world. Every new HIV infection is one too many, and two million per year is simply unacceptable—especially when we have the science to prevent them and means of implementation that are simple and cost-effective.

So what is holding us back?

Some of main reasons are inadequate and unfocused investments. Simply put, we are not doing enough where it most needs to be done. HIV prevention has not been attracting its fair share of investments recently. While HIV resources have grown, HIV prevention spending has not kept pace with investments in other areas of the response. Current investments and actions are insufficient to take HIV prevention programmes to scale and achieve the saturation levels required to significantly reduce new HIV infections towards ending AIDS as a public health threat.

How much is needed? Only a quarter. UNAIDS modelling on resource needs for the AIDS response shows that investing around a quarter of all the resources required for the AIDS response into HIV prevention services is sufficient. An entire range of services—condoms, pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), harm reduction services, empowering young women and girls, and mobilizing and providing essential service packages for and with key populations—are all made possible by investing a quarter of resources towards HIV prevention programmes.

Quarter for HIV Prevention (#quarter4HIVprevention) is a campaign to recapture imagination and hope for HIV prevention. It provides prevention choices for people at risk, and—most importantly—protects them from HIV infection. Most importantly, it leaves no one behind. Let us invest in HIV prevention; let us get to zero new HIV infections.

QUARTER FOR HIV PREVENTION: THE BEGINNING OF A DIALOGUE

Today's decision-makers have to make tough investment choices. What is the right level of investment? What is a fair share for HIV prevention? Where resources should be directed? Who should benefit? What is working and what is not? Should we focus on a single solution, and if yes, what is it?

Global investments for the AIDS response need to increase from US$ 21.7 billion in 2014 to more than US$ 32 billion in 2020. Of that amount, a quarter should be invested in effective and proven HIV prevention services. For some, that amount may seem to be too little; for others, it may seem too high. In either case, Quarter for HIV Prevention starts a long overdue conversation on rights, choices and investments for HIV prevention.

Its most immediate ask is for countries to examine their HIV prevention investment portfolio. Quarter for HIV Prevention creates a dedicated space where HIV prevention priorities can be examined, national and local commitment to ending the epidemic can be renewed, dedicated prevention strategies can be developed, ambitious targets can be set and complex combination prevention programmes can effectively be managed. Each national capital, district and municipality in key locations needs to start a conversation on their approach to HIV prevention.

The dialogue begins with understanding the prevention needs of every population in every location—in cities, districts and schools, in places where sex work and drug use take place, and where gay men and other men who have sex with men network—and it occurs with a single focus: how to stop the next HIV infection.

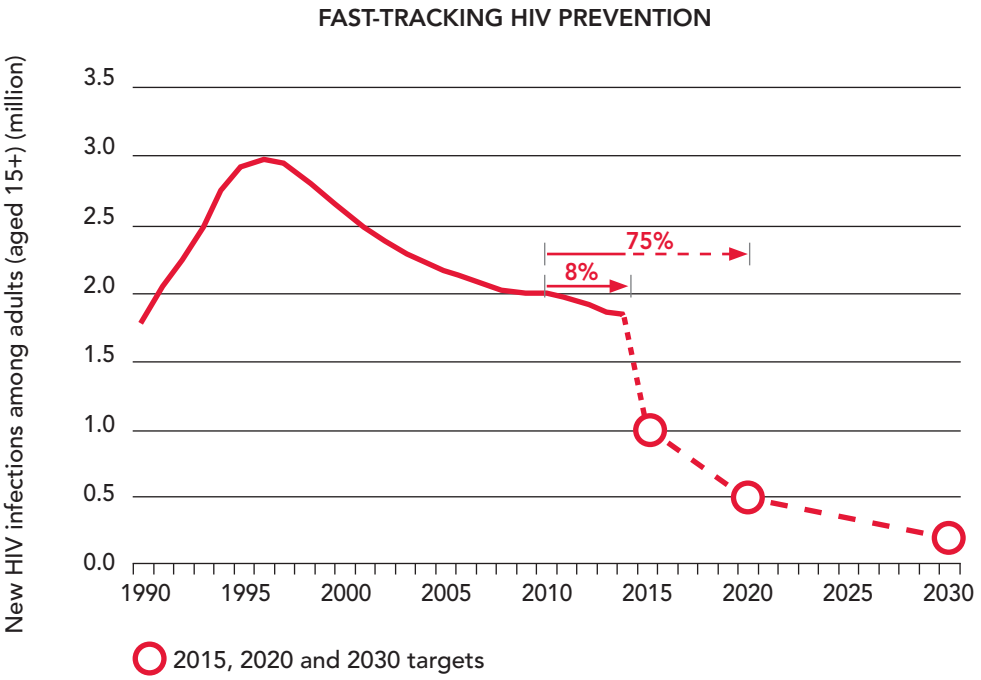
THE RETURN ON INVESTMENT

Two million new HIV infections occur each year—seven out of ten of them in sub-Saharan Africa. The HIV prevention target is to reduce this number to fewer than half a million by 2020 and then to fewer than 200 000 by 2030. New HIV infections will be cut by 75% over the next five years and by 90% within the next 15 years (compared to the 2010 baseline). By scaling up both treatment and HIV prevention, 28 million new HIV

infections will be averted between 2015 and 2030. All of this is the return that the AIDS response can expect by investing a Quarter for HIV Prevention.

Figure 1

New HIV infections among young people and adults (aged 15+) declined by less than 10% between 2010 and 2014



Source: UNAIDS global HIV estimates, 2014.

A QUARTER TO CLOSE THE PREVENTION GAP

To reach these targets, we must close the HIV prevention gap. Nearly 70% of women and 65% of men, including adolescents and young people, do not have basic awareness about HIV. More than half of young men who can benefit from VMMC have yet to access these services, and 68 countries do not have policies or programmes for providing harm reduction services for people who inject drugs. HIV prevalence is several times higher among key populations than others, yet access to HIV prevention services for key populations lags far behind—everywhere. In sub-Saharan Africa, the condom gap is estimated to be about 50%. In fact, only in a few high-prevalence districts in southern Africa do young women and girls benefit from comprehensive prevention services.

HIV PREVENTION IS A RIGHT

Everyone has a right to HIV prevention. Fulfilling that right begins with providing people who are at increased risk of HIV infection—including young women and girls, and their male partners in sub-Saharan Africa, sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender women, prisoners and people living with HIV—with access to effective, unhindered HIV prevention and treatment services.

Everyone should be aware of HIV, and they should have the freedom to select and access prevention methods that fit their lives. For some, the right choice could be condoms; for others, it may be PrEP or adhering to antiretroviral therapy. For still others, it could be protection from violence and sexual abuse, or reducing their vulnerability—what matters is that they are empowered to take steps to protect themselves from HIV.

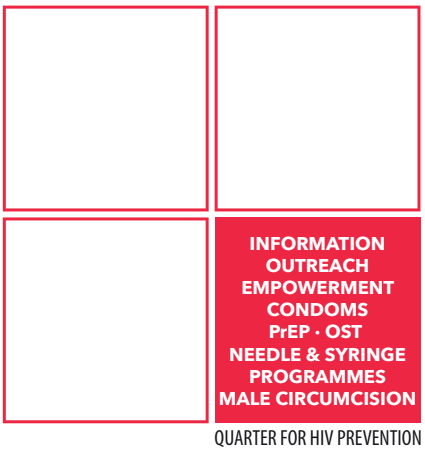
STRENGTH IN COMBINATION

There is no magic bullet for HIV prevention; only a combination of behavioural, biomedical and structural programmes and approaches will fully stop new HIV infections. Antiretroviral therapy and condoms are both more than 90% effective if used consistently, but on their own, they are unlikely to achieve the HIV prevention targets set. Neither can be successful without addressing the legal, policy, and other structural barriers to their use and adherence.

Modelling shows that fully achieving the 90-90-90 treatment target is expected to avert about 60% of all new HIV infections by 2020. The remaining 40% of new HIV infections have to be averted through prevention methods, such as condoms, VMMC, harm reduction services (including opioid substitution therapy and needle–syringe programmes), PrEP, outreach to key populations, education and empowerment of young women and girls. When these (and other) HIV prevention services and tools are combined, the protective effect is much greater than the sum of the individual elements.

DEMAND–DELIVER–ADHERE

Investing a quarter of the fully funded AIDS budget for HIV prevention raises awareness of risk, increases demand for unmet prevention needs and delivers HIV services at scale in places where they are needed. It supports people in choosing the prevention method of their choice— whether it is antiretroviral medicines, condoms, harm reduction, VMMC or a combination of those—and helps them adhere to those methods, all in an environment that is free of stigma, discrimination and punitive sanctions.



A quarter of a fully funded HIV portfolio goes a long way. It educates adolescents and young people about HIV prevention. It empowers young women and girls to reduce their vulnerability to HIV infection. It pays for nearly 20 billion condoms per year and 27 million additional VMMCs. It supports evidence-based HIV prevention services—such as harm reductions services for almost 8 million people who inject drugs—and PrEP for 3 million people from key populations. It supports outreach and builds community ownership of HIV prevention programmes. It leaves no one behind.

QUARTER FOR PREVENTION SUPPORTS THE 90-90-90 TREATMENT TARGET

The divide between prevention and treatment has disappeared or is fast becoming irrelevant. HIV prevention and treatment programmes are not just complementary; they are mutually supportive. The ways of implementing treatment and prevention services, however, are diverse and multifaceted.

Prevention programmes—including providing HIV information, condom distribution, VMMC and outreach to young people and key populations—are often the first entry point for individuals to HIV testing and treatment. Community peer-led prevention programmes also are critical to reduce stigma and discrimination. Meanwhile, expanded access to treatment gives people at risk choices and encourages them to check their HIV status; this, in turn, provides the opportunity to retain people who test negative in ongoing prevention programmes. Immediate initiation of HIV treatment for people who do test positive improves their own health and—once they are virally suppressed—cuts the possibility of HIV transmission to others. Finally, reducing the number of people that acquire HIV and will need treatment makes antiretroviral therapy programmes more sustainable.

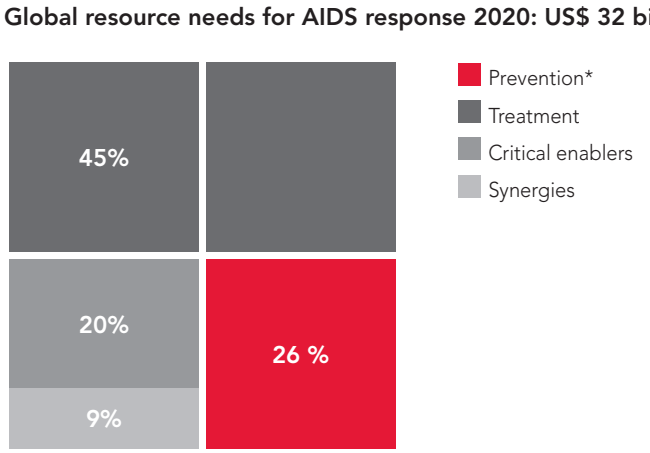
THE INVESTMENT MIX—GETTING THE RIGHT BALANCE

Even as the various AIDS response elements converge, it is critical that the potential of every available HIV prevention tool and approach is fully harnessed by investing the right amount in the right place for the right people.

Investing a quarter for HIV prevention is not a fixed formula that can be applied blindly in all settings. It represents a global benchmark against which investments made by countries towards HIV prevention can be assessed. Investment needs will vary depending upon the disease burden, and upon the progress already made in providing HIV prevention and treatment services (and their cost). Contextual factors—such as gender and social norms, criminalization of HIV transmission, sexual behaviour and drug use—will influence how investments are utilized.

Figure 2

A fully funded AIDS response and a quarter for HIV prevention



** Includes PrEP and a small allocation to cash transfers*

Source: UNAIDS modelling, 2015.

HIV prevention investments have been declining in many countries, with some allocating less than 10% to effective HIV prevention programmes. In such instances, Quarter for HIV Prevention is a wake-up call. In some countries, especially those with growing epidemics, national investment cases show that investment needs for prevention programmes are higher than a quarter of all resource needs. In others, the overall proportion of allocations to HIV prevention are sufficient, but they are not targeted to reach people who are most in need of the services. Quarter for HIV Prevention helps guide investment decisions towards evidence-informed approaches that generate maximum impact.

SHAPE YOUR QUARTER FOR HIV PREVENTION

What does your Quarter for HIV Prevention look like? Does it carry enough weight to get to zero new HIV infections? Will it help stop the next 100 HIV infections? Does it provide choice? Does it protect people without a voice? Does it empower? Does it stop discrimination?

You can have a say in shaping the Quarter for HIV Prevention. Make the quarter count by investing for impact.

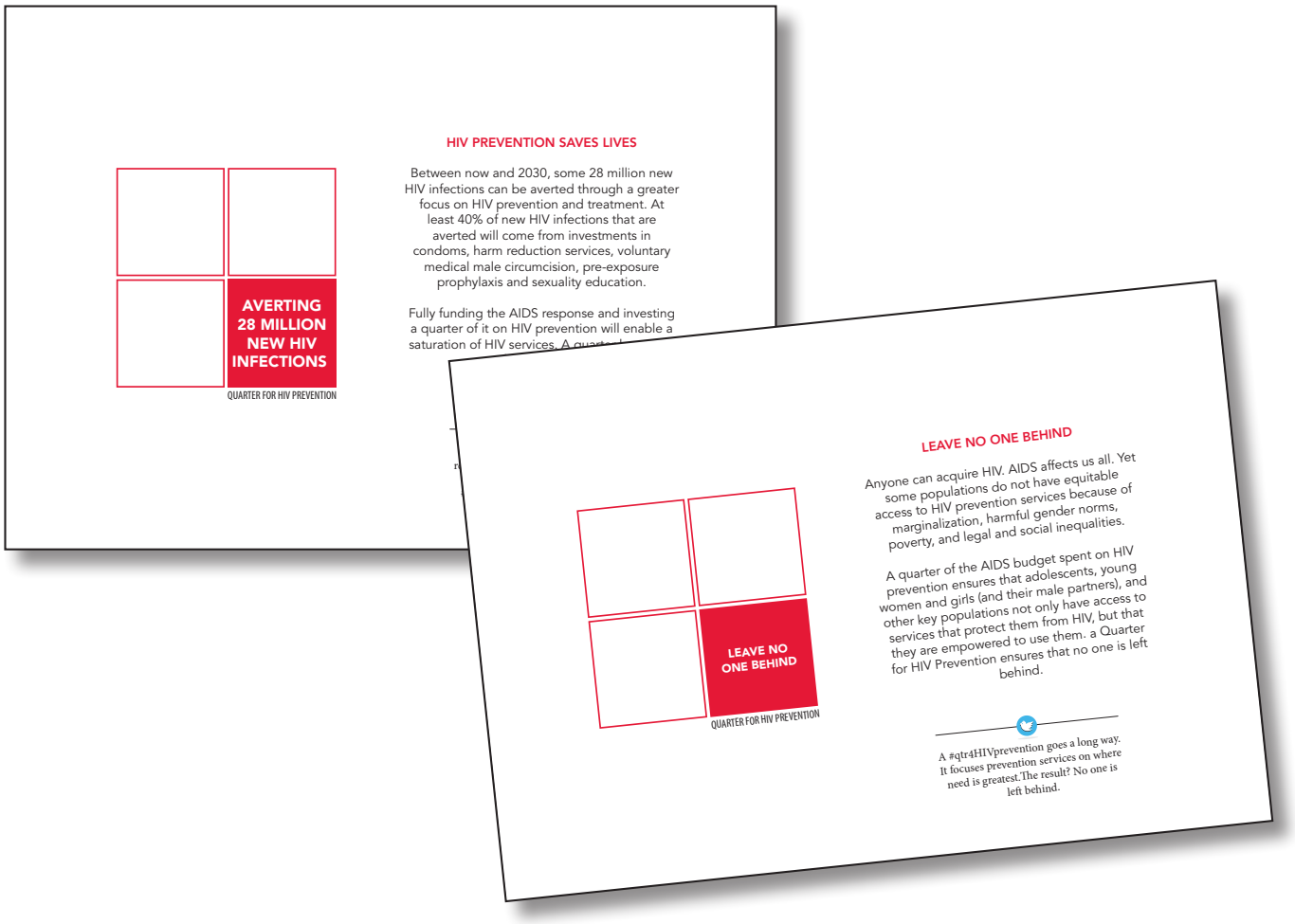
QUARTER FOR HIV PREVENTION: CAMPAIGN FOR IT, SHAPE IT AND BE A PART OF IT

The campaign concept

Quarter for HIV Prevention is a campaign to recapture imagination and hope for HIV prevention. It begins with a demand for the Global AIDS response to be fully funded, and for a quarter of those resources to be invested in global HIV prevention services. It calls for urgent scaling up of core HIV prevention measures—including condoms, harm reduction, pre-exposure prophylaxis, voluntary medical male circumcision and behaviour change—along with global efforts to provide HIV treatment for all people living with HIV. The opportunity to end the AIDS epidemic hinges on the combined force of all prevention tools and approaches, while also giving people the opportunity to use the method (or methods) of their choice.

Quarter for HIV Prevention is more than a call for more resources: it is a call for effectiveness, efficiencies and impact for every quarter that is invested in HIV prevention. It is also a space for dialogue on how to stop new HIV infections—where the inequities, needs, barriers and successes in HIV prevention services can be shared. Most importantly, it is a place where you can make your voice heard, demand HIV prevention and take part in collective action.

Keep the conversation going; keep the quarter working for HIV prevention. Tweet it. Facebook it. Create your own call to action.



BECOME A HIV PREVENTION ADVOCATE

Four steps to become a HIV prevention advocate

Highlight the HIV prevention issue you care about

1

Make your case for HIV prevention

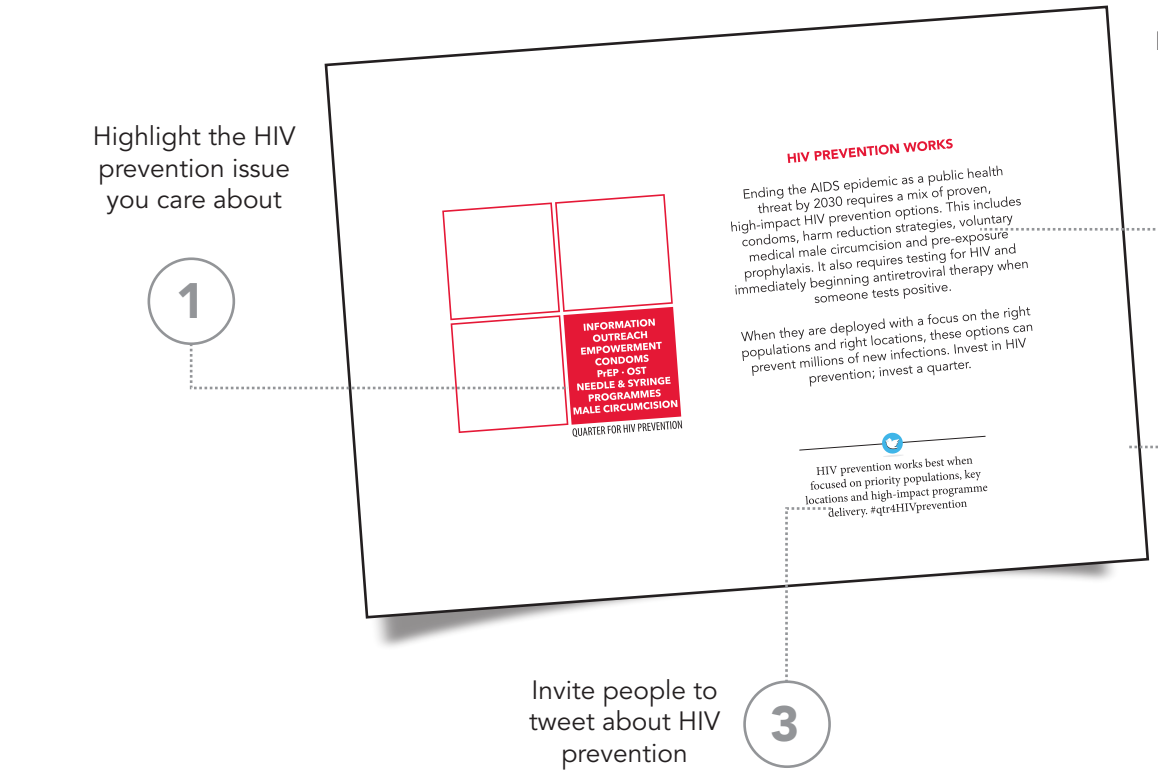
2

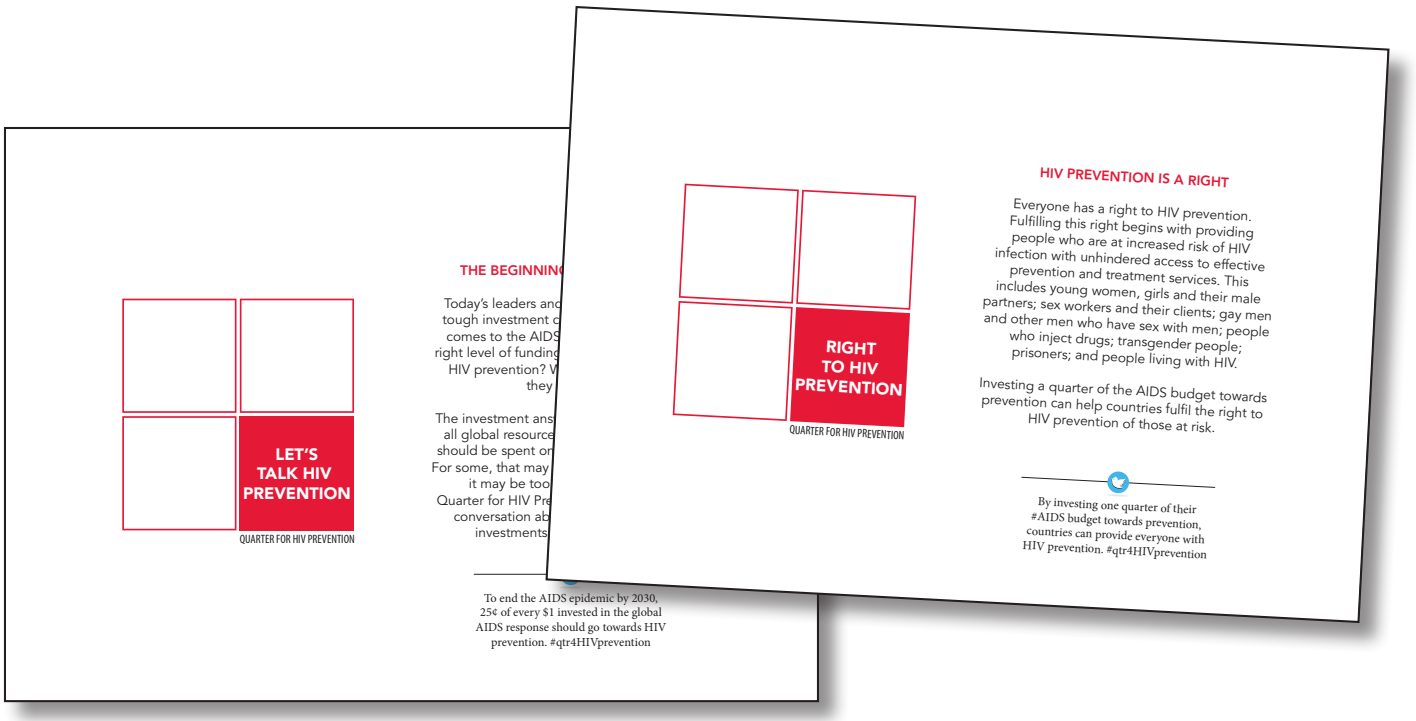
Invite people to tweet about HIV prevention

3

Share the message through your other social media channels

4





COUNTRY CASE STUDIES
QUARTER FOR HIV PREVENTION IN ACTION

BOTSWANA

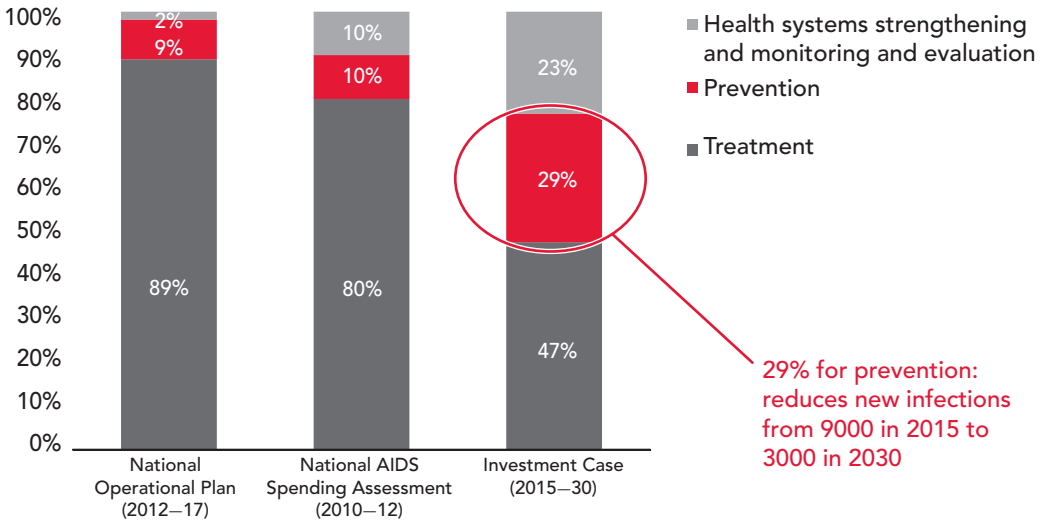
In Botswana, treatment and prevention go hand-in-hand for maximum impact

Botswana has analysed the effects of combining a test-and-treat approach with scaled-up HIV prevention programmes. Between 2010 and 2012, Botswana spent approximately 10% of its HIV funding on prevention, but in the investment case—which covers the period 2014–2030—29% was allocated for prevention. The increase in prevention spending was based on a modelling analysis showing that a test-and-treat approach combined with scaled-up prevention methods would have the highest impact and reduce new infections from over 9000 in 2015 to fewer than 3000 in 2030—a 90% reduction compared to 2000. Achieving this decrease would entail increasing coverage of prevention programmes for all priority populations to 90% by 2030.

An exclusive test-and-treat approach was less effective in the analysis, leading to an estimated 6000 new infections in 2030. Similarly, combination prevention and antiretroviral therapy for anyone with a CD4 count below 500 resulted in 5000 new infections in 2030. Botswana's analysis and investment case demonstrates that in future HIV responses, treatment and combination prevention scale-up must go hand-in-hand to maximize impact.

Figure 3

HIV prevention investment in Botswana's HIV investment case



Source: National AIDS Coordinating Agency. 2015 Botswana at the crossroads: investment towards effective HIV prevention health, system strengthening, and the end of AIDS.

BELARUS

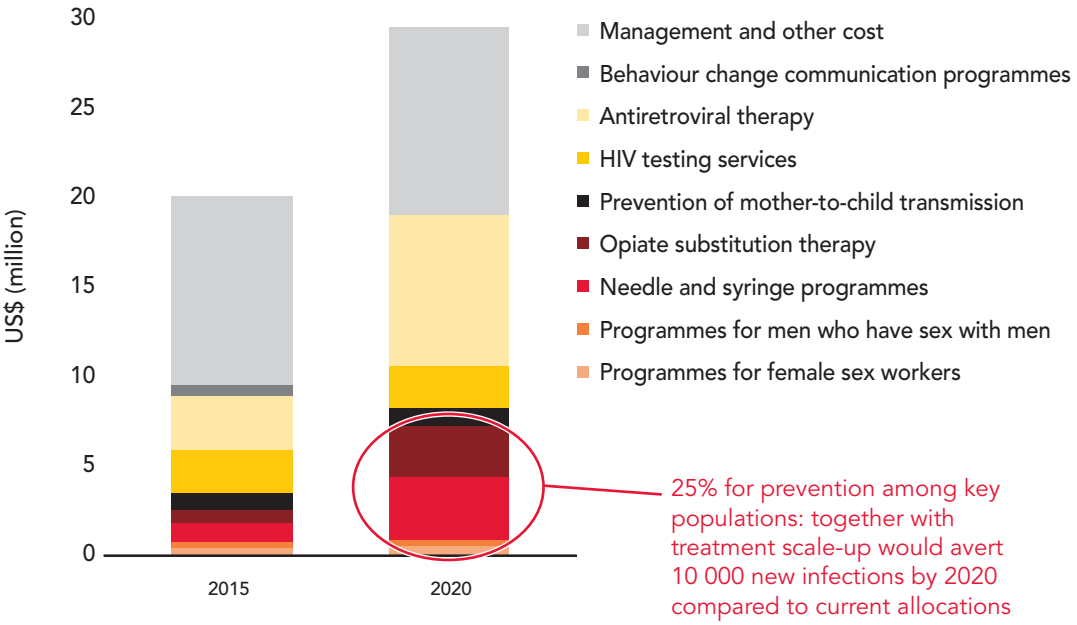
Belarus invests a quarter for prevention among key populations

Belarus is experiencing a concentrated HIV epidemic that most affects key populations, including people who inject drugs, sex workers and men who have sex with men, as well as the sexual partners of these populations. A modelling analysis was carried out to explore how resources could be optimally allocated to maximize impact. The analysis suggested that investment in HIV prevention should be increased, with a focus on needle–syringe programmes for people who inject drugs, opiate substitution therapy and programmes for men who have sex with men and sex workers.

If HIV investment in Belarus could be increased by half—and if 25% of this budget could be allocated to prevention for key populations (instead of the 13% allocated in 2013)—and combined with treatment scale-up, 43% of new infections would be averted. This translates into 10 000 infections being averted by 2020, allowing Belarus to reverse its current path of a growing concentrated HIV epidemic—all for a Quarter for HIV Prevention for key populations.

Figure 4

Belarus: optimized allocations of US$ 29 million



Source: World Bank et al. 2015. Optimizing investments in the national HIV response of Belarus. Final draft report.

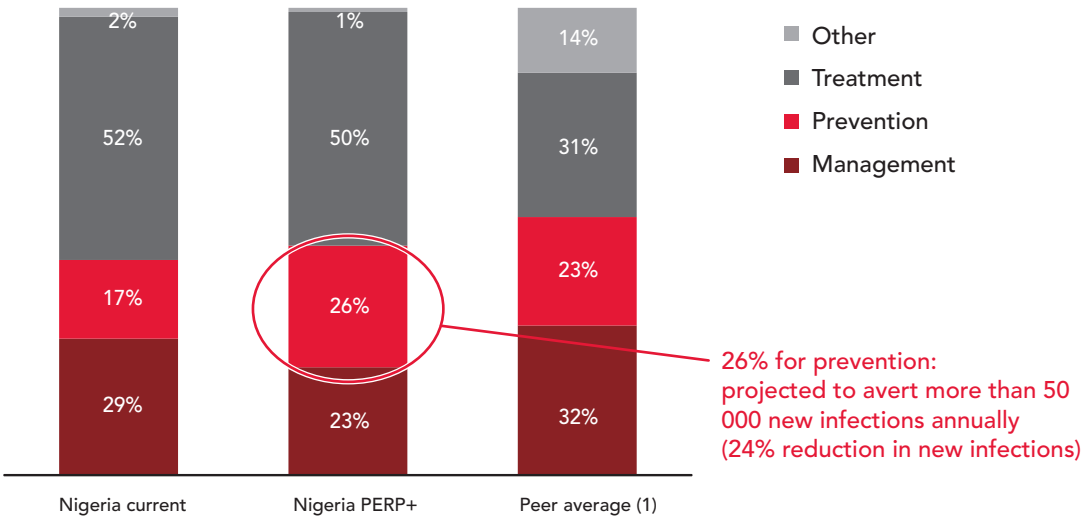
NIGERIA

Nigeria could avert 100 000 new infections in two years

Nigeria has the second largest number of new HIV infections worldwide: an estimated 230 000 people were newly infected with HIV in 2014. Through the President's Emergency Response Plan for HIV/AIDS (PERP), Nigeria defined strategic priorities for HIV programming between 2013 and 2020. In the analysis preceding the development of PERP, large coverage gaps in prevention were identified. The Plan suggests increasing prevention coverage by 140% among key populations (bringing coverage to 680 000), and by 100% among young people in priority regions (expanding coverage to 8 million). Budgets for the HIV response should increase by 45%, and within the increased total budget, the share for prevention should increase from 17% to 26%. This increase was also informed by a review of prevention spending in peer countries in the region that had similar epidemic levels: the review established that other countries were spending nearly a quarter (23%) for prevention. It was projected that the President's Plan would reduce new infections by approximately 24% in the first two years of implementation, translating into 105 000 new HIV infections averted.

Figure 5

Nigeria: President's Emergency Response Plan for HIV and AIDS (PERP): increase prevention and reduce management overheads



1. *Peers with HIV prevalence from 2.5–5.0: Burundi, the Central African Republic, Chad, the Congo, Côte d'Ivoire, Equatorial Guinea, Guinea-Bissau, Nigeria, Rwanda and Togo*

Source: Nigeria National Agency for the Control of AIDS. 2015. President's emergency response plan for HIV/AIDS in Nigeria 2013-2015.

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