UNAIDS September 2020

UNAIDS Strategy Development

Electronic Survey Report

Results from the UNAIDS electronic survey. Gathering voices from over 160 countries and over 8’000 people to inform the next global AIDS strategy beyond 2021.

What will the end of AIDS look like for you?

Contents

Summary of results

More than 8300 voices across 163 countries partook in the Global AIDS Strategy beyond 2021 survey commissioned by UNAIDS, contributing to our understanding of priorities, challenges, and perspectives to end the AIDS epidemic.

There is broad support for UNAIDS Strategy Result Areas (SRAs) as they are laid out in the UNAIDS 2016-2021 Strategy 'On the Fast-Track to End AIDS' and the principles that are guiding the Joint United Nations Programme on HIV/AIDS (UNAIDS).

9 in 10 respondents rated the current strategy result areas as important to end AIDS by 2030. These eight key areas remain current and critical and require continued attention.

Key areas of the current strategy; HIV testing and treatment, prevention for youth and key populations, elimination of mother to child transmission, gender equality and women empowerment, human rights stigma and discrimination, investment and HIV service integration, were rated as remaining either very important or important across all regions, gender and age groups. The importance of providing testing and treatment was especially supported by the respondents but also to address stigma and discrimination in tangible ways, such as an increased focus on access to information and communication campaigns to address misconceptions and misinformation.

Responses to the survey made clear that political will, investment in the HIV response and integration of HIV in health services, as well as a more multisectoral approach is needed to see progress and overcome complex challenges to reaching an end of AIDS as a public health threat by 2030.

Six areas were identified that need more specific attention: Community at the center, political engagement, multisectoral approach, science technology and innovation, quality education and staying in schools and priority on impactful communication.

Highlighted in qualitative and quantitative data, the survey described a need to put communities at the center of the AIDS response, both as decision makers and as implementers of local, strategic evidence-based HIV interventions. Another priority area in the view of the respondents was to continue improvements in access to testing and treatment for example through widespread home testing, development of long acting antiretroviral treatments and better integration of HIV services inside and outside the health sector.

Addressing structural barriers and social determinants of health were highlighted as areas where specific attention was called for to make our response to HIV/AIDS successful. This was further expressed in the considerable number of respondents who called for a more multisectoral approach and by the high number of respondents highlighting important barriers that could be addressed by close collaboration with faith-based organizations or the private sector.

Science, technology, and innovation came out clearly as an area for renewed focus, this included calls for a vaccine, a cure, better treatment options and leveraging technology in HIV services. There was also a call for improved communication, to communicate targets for

the HIV response better and to use modern channels of communication to inform communities, to prevent HIV and to dispel myths and decrease stigma and discrimination. Education came out as a strong gamechanger to ending AIDS, focusing on keeping youth in schools.

97% of respondents endorsed the principles that guide the Joint United Nations Programme on HIV/AIDS as relevant.

Respondents from all regions were asking for regional specificity for policies and programs. There is no one size fits all approach and the disaggregation by region from both qualitative and quantitative data confirmed the need to better understand variance between regions and to contextualize responses, asking for the next Global AIDS strategy beyond 2021 to consider this targeted approach.

The complete dataset from the survey provides a wealth of information that will remain available for the second phase of the strategy development any beyond for country and regional use.

1. Background

In early 2020 UNAIDS launched a broad and inclusive process to collect input into the development of a Global AIDS strategy beyond 2021 building on the current UNAIDS Strategy 2016-2021 'On the Fast-Track to End AIDS'. As a part of the first phase of this consultative process UNAIDS launched an electronic survey to collect perspectives on the priorities, challenges and accelerators toward ending AIDS. The results of this survey should be viewed as a part of a larger puzzle and the key messages from the survey are best understood when studied together with the results from the evidence review of the implementation of the UNAIDS 2016-2021 strategy, the synthesis of perspectives from key informant interviews, as well as the findings from focus group discussions, the independent evaluation of the United Nations system response to AIDS in 2016-2019 and other input through workshops and consultations held as part of the strategy development process.

The survey was launched on May 27, 2020 and remained open until August 2, 2020. During this time, the strategy team leading on the survey met weekly to analyse who was responding and who was not, to target outreach to regions or groups that had not yet been reached by the survey. While the survey was available on UNAIDS website and promoted in social media, UNAIDS regional and country offices were encouraged to share the survey with their constituencies, as were cosponsors and other partner organisations. Some UNAIDS country offices applied specific strategies to distribute the survey, like Congo, who provided targeted outreach through networks of civil society partners or Kazakhstan who hosted a specific webinar around the survey.

The survey was available in 16 languages: English, French, Spanish, Arabic, Chinese, Russian, Portuguese, Persian, Amharic, Bahasa Indonesia, Khmer, Thai, Chinese, Hindi, Urdu and Kiswahili.

When the survey closed 9,470 people had started the survey and 8,369 of those had proceeded to responded to the first mandatory question regarding the country they were connecting from.

While the aimed of the survey was to provide insight during phase I of the UNAIDS strategy development phase by reviewing the current priorities and examining the existing direction and associated barriers or challenges. the vast data gathered through the electronic survey will remain an important source of information for the coming phase, as well as for country and regional level insight and consideration going forward.

2. Design, methodology and limitations

The survey was created to capture a breadth of perspectives from around the world, aiming to respond to questions designed around reviewing the existing UNAIDS Strategy and its Strategy Result Areas, while providing sufficient space for introduction of emerging areas, new priorities, and principles to guide the next strategy.

The survey focused on quantitative data with some narrative options from open ended questions (see original survey in annex 4). The questions were created to align to an overall Analysis Framework used for other exercises included in phase I of the strategy development process. Considerations were made to allow global participation and ensure that a variety of voices were reflected in the results. The survey was aiming to get an idea of priorities and challenges across the world among the various stakeholders that work on HIV/AIDS or in adjacent fields. The survey is not a representation of all the stakeholders nor

is it claiming to describe any evidence-based data about the state of the response to HIV/AIDS.

The first part of the survey asked participants to answer 8 demographic questions to allow a better understanding of who was taking the survey and to allow disaggregation of the results.

The 9 substantive questions that followed asked participants to rank the relative importance of areas of work and of principles guiding the HIV response. Separate questions assessed the perceived challenges in availability, accessibility, and affordability to a list of HIV services as well as structural barriers and the level of importance in addressing these. 6 open-ended questions were posed to get additional unstructured input, allow for additional comments and to ask what 'gamechangers' would be for the HIV response.

To be able to carry out the survey, participants had to answer initial demographic questions, the remaining questions were all optional. Since all thematic questions were optional the denominator for each question varies. The survey was administered through Survey Monkey and took approximately 20 minutes to complete.

The quantitative data was disaggregated against different regions as per UNAIDS classification. Furthermore, disaggregation was done based on the analysis framework and additional cross-tabulation was made available to inform emerging findings from the qualitative data. Those cross-tabulations involved gender, reach of organization, diversity of communities as well as organizational type. The qualitative/narrative answers were first translated back to English before a key word count assessed the most frequent themes mentioned in the responses. As the first three open-ended questions asked for additional areas, specific focus was given to newly emerging themes that the quantitative options did not cover, while still allowing existing result areas to be re-stated and for more details to be provided, adding depth and further understanding of the quantitative findings.

The preliminary findings have been presented to and discussed by a group of UNAIDS technical experts in an analysis workshop, as well as by a strategy-workshop including a diverse group of PCB members, NGO representative and the Joint Programme Secretariat and Cosponsor staff and finally shared internally with UNAIDS Secretariat staff. Input received from the various discussions have been considered to present the data as completely, clearly and accurately as possible.

The survey had the obvious limitation that it required internet access. Differences in response is likely to vary not only between countries depending on access to the internet but also between age groups, genders and with socio-economic status within each country. Since UNAIDS distributed the survey through offices and networks there is also a selection bias in who was reached to participate in the survey. As highlighted, the results do not hold a scientific research rigor and should be seen as descriptive rather than representative. It was noted that open-ended responses in languages that are written from right-to-left - Arabic, Persian, and Urdu - had a lower response rate with approximately 26% of respondents choosing to add free form answers compared to an average of 41% across all 16 languages. This may have been caused by limitations in the multilingual SurveyMonkey platform that does not fully allow right-to-left input within their framework.

3. Who responded?

3.1 Regions

The survey reached all regions of the world with most responses from West and Central Africa. Of the United Nations 193 Member States, our respondents came from 163 different countries. In table 1 distribution of respondents by region is shown. Switzerland is shown separate from Western Europe since many respondents from UNAIDS secretariat and from cosponsors make up this group.

The majority, 54% of the respondents, took the survey in English. Spanish and French made up 13% each of the responses. 8% took the survey in Russian and 6% in Portuguese. All remaining languages had 2% or less of the participants.

Table 1: Respondents by region

Respondents by region	Number	%
Western and Central Africa (WCA)	2320	28%
Latin America and the Caribbean (LAC)	1588	19%
Eastern and Southern Africa (ESA)	1475	18%
Asia Pacific (AP)	1240	15%
Eastern Europe and Central Asia (EECA)	750	9%
Middle East and North Africa (MENA)	414	5%
Western Europe (Except Switzerland) (WE)	287	3%
North America (NA)	138	2%
Switzerland	123	1%
Prefer not to disclose	34	0%
Total	**8369**	**100%**

3.2 Gender and age

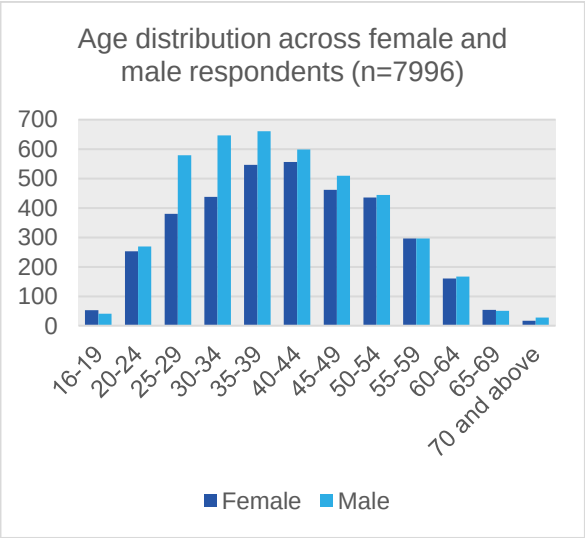
44% of the respondents identified as female and 52% as male. The dominance of male respondents was particularly high in the age groups between 25 and 39 years of age. 2% of the respondents identified as transgender and another 2% said that they were either 'other' or neither male, female, nor transgender. 1% preferred not to answer. Since the number of transgender and other respondents would be too small when disaggregated by age to visualize in the same graph as males and females a separate age breakdown for these groups can be seen below.

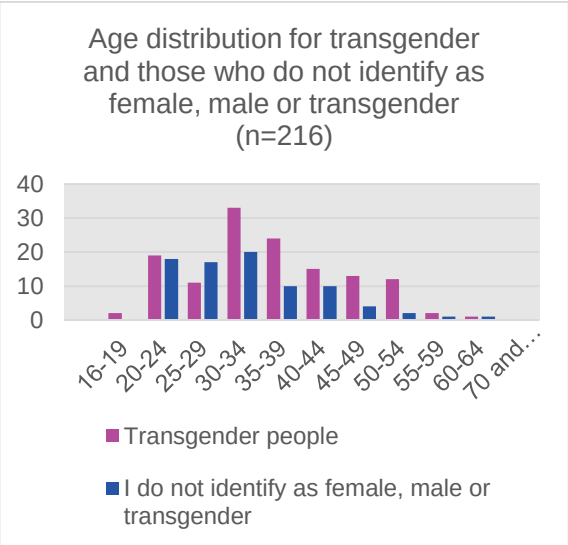
Both in quantitative and in qualitative data, the biggest age groups were between 25 and 49 years of age. 16-19 and 20-24, as well as older age groups did not respond in high numbers. Low response rate from 16-24 year olds was noted for all regions with participation varying from as low as 5% (48) in Eastern Europe and Central Asia to highest with 10% (43) in North America and Western Europe. Age groups above 65 years of age varied between 0% to maximum of 2%.

Table 2: Respondents by gender identified with

What gender do you identify with?	Number	%
Male	4313	52%
Female	3683	44%
Transgender	132	2%
Prefer not to answer	108	1%
I do not identify as female, male or transgender	84	1%
Other	49	1%
Total	**8369**	**100%**

Visual 1 & 2: Respondents by age and gender





3.3 Communities

32% of the respondents identified as people living with HIV and 23% as gay, bisexual or other men who have sex with men. Below tables detail groups that 50 or more people identified with. 24% (1808) of respondents opted for specifying an additional group which was outside of the pre-set list, of those most identified as service provider or heterosexual male/female, further detailed in table 4.

Table 3: Respondents by community they identified with (more than one option could be selected)

Community(ies) identified with	Number	%
People living with HIV	2343	32%
Other *(refer to table 4)*	1808	24%
Gay, Bisexual, or other men who have sex with men	1711	23%
Prefer not to disclose	1050	14%

Table 4: Respondents who identified as 'other', most recurrent responses

Other groups identified with	Number
Service provider/health worker	339

Sex workers	534	7%
Born with HIV or acquired HIV in early childhood	417	6%
People who use drugs	416	6%
Mobile or migrant populations	385	5%
People with disabilities	335	5%
Lesbian or bisexual women	303	4%
Transgender women	226	3%
Transgender men	168	2%
Current or former prisoner and other incarcerated population	145	2%

Heterosexual male	144
Activist	142
General population	133
Heterosexual female	132
Development actor/worker	80
Affected by HIV/TB or other disease	53
Working with people living with HIV	51

3.4 Organizational information

74% (6183) of the survey participants responded to the question on which organization they belong to. The largest group of respondents were those belonging to civil society organisations with 39%. Government employees or elected officials made up the second largest group of respondents with 12% closely followed by UNAIDS Joint Programme cosponsors with 10%. The question also allowed the option of specifying another group if an additional category was identified. 4% (246) of respondents chose that option, most of them indicating different types of civil society organizations, while types such as advocacy organization, media or Global Fund were added to the pre-set list and included in below table.

Table 5: Respondents by organization (only one option could be selected)

Which of the following would best describe your organization?	Number	%
Civil society (including community network or association, faith-based organization, grass-roots organization)	2437	39%
Government	723	12%
UNAIDS Joint Programme: Cosponsor (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO, World Bank)	601	10%
Health care provider	421	7%
UNAIDS Joint Programme: Secretariat	398	6%
Community service provider (non-state provider)	252	4%
Humanitarian organization	227	4%
Donor organization	185	3%
Academic or research institution	183	3%
UN organization (other than the Joint Programme)	157	3%
Development agency	137	2%
Private Sector	112	2%
Prefer not to disclose	90	1%

Inter-governmental organization	75	1%
Human rights institution	65	1%
Religious institution	41	1%
Legal support adviser	36	1%
Parliamentarian	19	0%
Advocacy organization	13	0%
Media	7	0%
Country Coordinating Mechanism (Secretariat, implementing units)	4	0%
Total	**6183**	**100%**

The survey asked respondent to indicate how much of their work was dedicated to HIV. 41% responded that the entirety of their work was HIV related and 32% said most of their work was. 23% indicated that some of their work was HIV related.

The largest group of respondents worked on national level with 55% and about 27% responded that they worked on global or regional level. A substantial proportion of respondents also indicated sub-national reach, such as provincial/district level with 20%, urban (city) areas with 21% rural areas with16%.

Visual 3: Proportion of work dedicated to HIV and reach of the organization

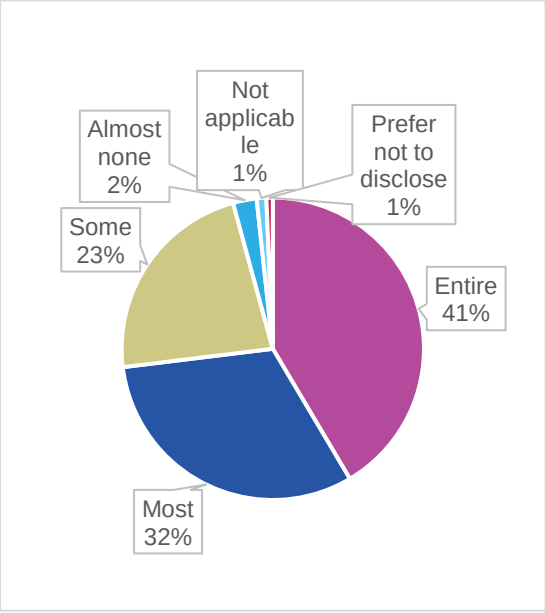


Table 6: Reach of organization (more than one option could be selected)

Reach	Number	%
Global	1797	29%
Regional	1666	27%
National	3347	55%
Provincial and/or district level	1255	20%
Urban (city) areas	1268	21%
Rural areas	984	16%
Prefer not to disclose	32	1%
Not applicable	34	1%

4. What are we hearing?

The survey aimed at describing a broad range of perspectives on the HIV response and common ideas for priorities, barriers, principles and gamechangers going forward.

4.1 Areas that are current and critical for the global AIDS strategy beyond 2021

The survey asked about 21 areas of priority in three different scopes; first on health, second beyond health and third on actions that integrate the AIDS response into other health and development areas. Globally, 9 in 10 respondents said that all areas of work are very important if we are to end AIDS by 2030. The results focused on current strategy (presented below in table 7) showed strong support for all 8 strategy result areas (SRA) in their diversity/complexity. Except for work around removal of punitive laws, policies and practices, all other areas are ranked as either very important or important by more than 95% of respondents. Looking at areas deemed 'very important' separately from those deemed 'important', the strongest support can be found for areas of priority in the current strategy that focus on health. The survey provided the option of adding new priority areas beyond the current strategy (see visual 4 below); the three main areas that emerged were the ask for universal quality education, importance of communication and the need for a multisectoral response. Respondents also frequently re-endorsed various areas within the current strategy, mostly within the area on investment and efficiency, highlighting the need for funding and granularity of data.

Globally, 9 in 10 respondents said that all areas of work are important if we are to end AIDS by 2030.

The survey then considered barriers to 19 different services in terms of challenges to availability, accessibility and affordability[1]. The highest challenges were noted in availability of services, specifically social enablers such as comprehensive sexuality education, social protection services and interventions, psycho-social support, gender-based violence services, sexual and reproductive health and rights services and mental health services. The data is presented in more detail under each corresponding area below.

In addition to barriers to accessing services, the survey looked at 8 different social and structural barriers that relate to the current strategy result areas and provided an open-ended question to gather additional barriers that may not have been captured in the quantitative data. 94% to 98% of respondents rated the different social and structural barriers as important or very important, while as an additional barrier, harmful social and religious practices and norms emerged strongly as additional to currently set key areas that requires more attention.

Respondents highlighted important challenges in availing social enablers and strongly endorsed the need to reduce social and structural barriers

[1] These terms were defined as following in the survey; (a) Availability means sufficient and continuous supply and appropriate stock of health services. (b) Accessibility means equitable/fair distribution of health services. (c) Affordability means “free “/ low cost, including health insurance coverage for health care services.

The survey also looked at 14 principle that support the implementation of the strategy indicating how relevant they are for guiding the health and development responses in terms of equity and equality and the impacts on poor and marginalized groups including people living with HIV and key populations with emphasize on mobilising and partnering with people and sectors. 99% of the respondents saw stigma and discrimination and human rights as still very relevant or relevant. On the open-ended responses, 22% of the respondents further re-emphasised the principles on addressing inequalities and 20% on community engagement. This is also further detailed in section 4.3.

Finally, the survey asked respondents to name the game-changer in ending AIDS. This question was the most responded to in the survey with over 3800 answers from 14 languages, representing 46% of survey participants proving their insight. Gamechangers included HIV testing, treatment and care, political will and funding, community, innovation science and technology and communication with responses for those areas highlighted from 10% or more of participants (see below graphs under visual 4 and section 4.2 for more detail).

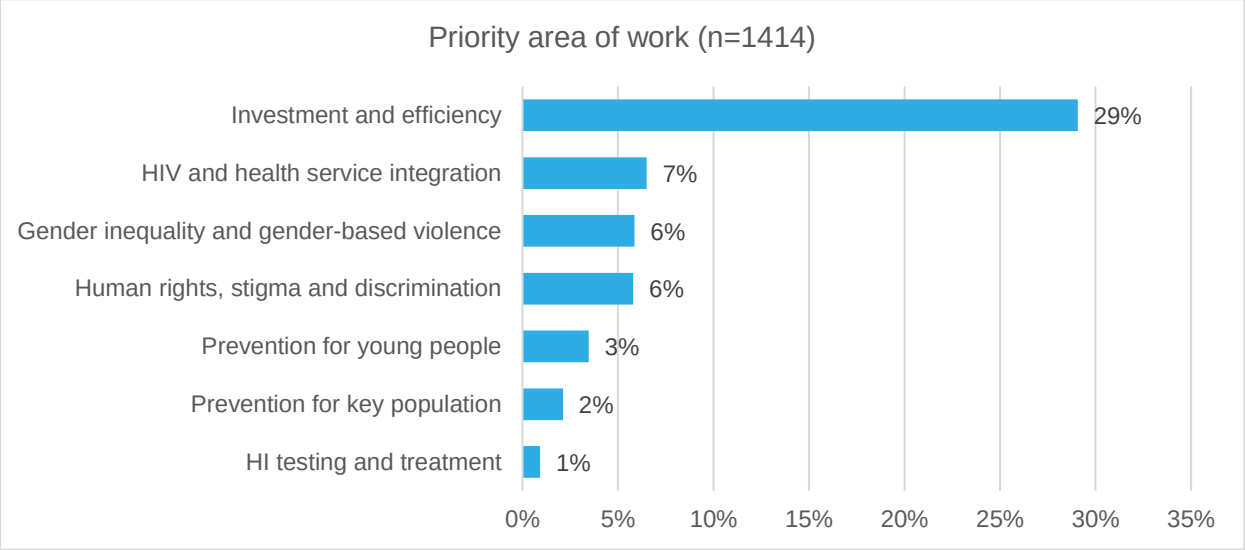
While this sections outlines findings from both quantitative and qualitative survey results linked to the existing Strategy Result Areas (SRA) the next section will look at more detail into those areas that call for consideration and acceleration.

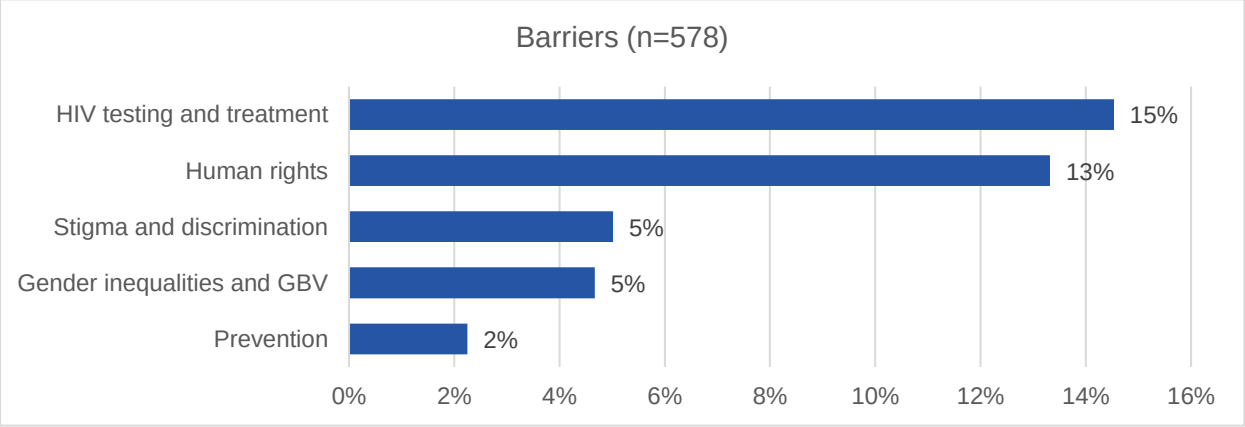
Table 7: Areas of work in **current strategy** and relative importance for reaching the goal of ending AIDS by 2030

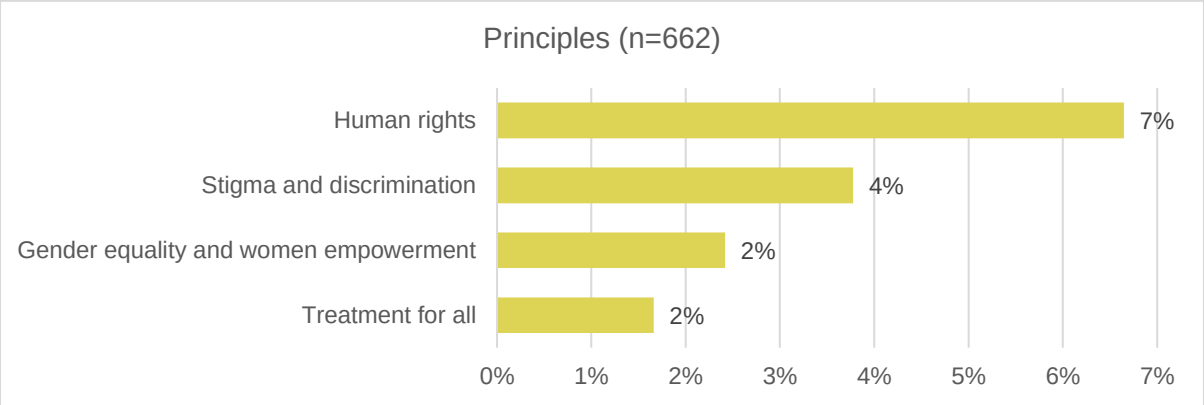
For each of the following, please rank how important you think each area is for reaching the goal of ending AIDS by 2030.	Very important/ important	Not important	I don't know	Linkage to current strategy
Access to testing and treatment for children, adolescents and adults living with HIV	99%	0%	0%	SRA1
Prevention of new infections among children and sustaining the health and well-being of their mothers	99%	1%	0%	SRA2
Access to combination prevention for young people, especially young women, and adolescent girls	99%	1%	0%	SRA3
Building knowledge and skills among young people, including comprehensive sexuality education	99%	1%	0%	SRA3
Access to integrated health care services, including for coinfections (e.g., Tuberculosis, Hepatitis, COVID-19) for people living with HIV	99%	1%	0%	SRA8
Access to combination prevention for key populations; gay men and other men who have sex with men, sex workers, transgender people, people who use drugs and prisoners and other incarcerated people	98%	1%	1%	SRA4
Actions to respond to and end gender-based, sexual and intimate partner violence	98%	1%	1%	SRA5

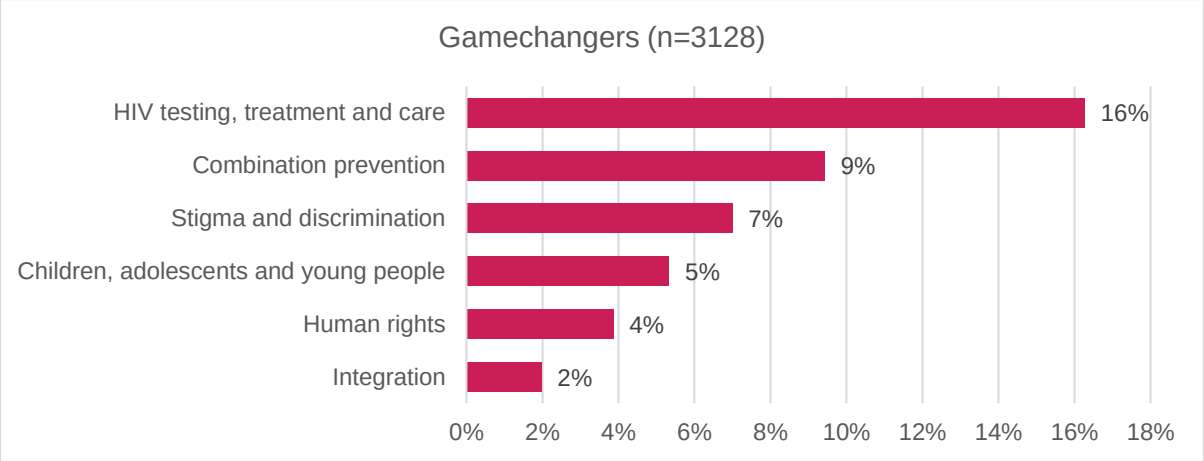
All forms of HIV-related stigma and discrimination eliminated	98%	1%	1%	SRA6
Generate data (strategic information) to guide effective AIDS response	98%	1%	1%	SRA7
Effective and efficient implementation of the AIDS response through a people centered approach	98%	1%	1%	SRA7
Support community-led services and integrate into systems for health	98%	1%	1%	SRA8
Ensuring HIV-sensitive social protection	98%	2%	1%	SRA8
Empowerment and engagement of women and girls, actions to support gender equality	96%	3%	1%	SRA5
HIV response is fully funded with increasing domestic resources of a multi-sectoral response for equitable results	95%	2%	3%	SRA7
Removing punitive laws, policies and practices	89%	6%	5%	SRA6

Visual 4: Open-ended responses that re-iterated current strategy results areas, by question, category and percentage









4.1.1 HIV testing and treatment (SRA1)

HIV testing and treatment remains a critical area of priority

HIV testing and treatment remains the highest priority with 99% of respondents in all regions emphasising its importance.

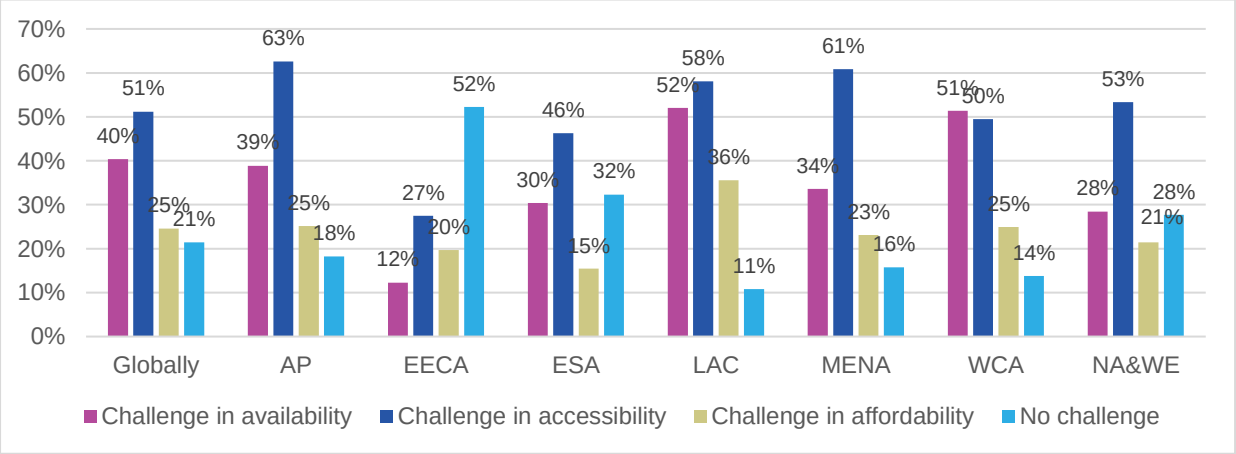
This finding is backed up by the narrative data where HIV testing, treatment and care was the most mentioned 'gamechanger' to end AIDS with inputs from 16% (502 of 3128) of the respondents. Across regions HIV testing, treatment and care was among the top 3 gamechangers, except for Middle East and Northern Africa where this area was 6th in the list of gamechangers.

The importance of HIV testing and treatment is also supported by the question on additional barriers, where 15% (84 of 578) of respondents highlighted that barriers to accessing services, specifically HIV treatment and testing is a critical impediment to ending AIDS. There were some regional variety in how often this was raised as a barrier; in Eastern Europe and central Asia and in Western Europe and North America 18% of respondents brought it up compared to only 9% in West and central Africa and only 6% in Eastern and Southern Africa.

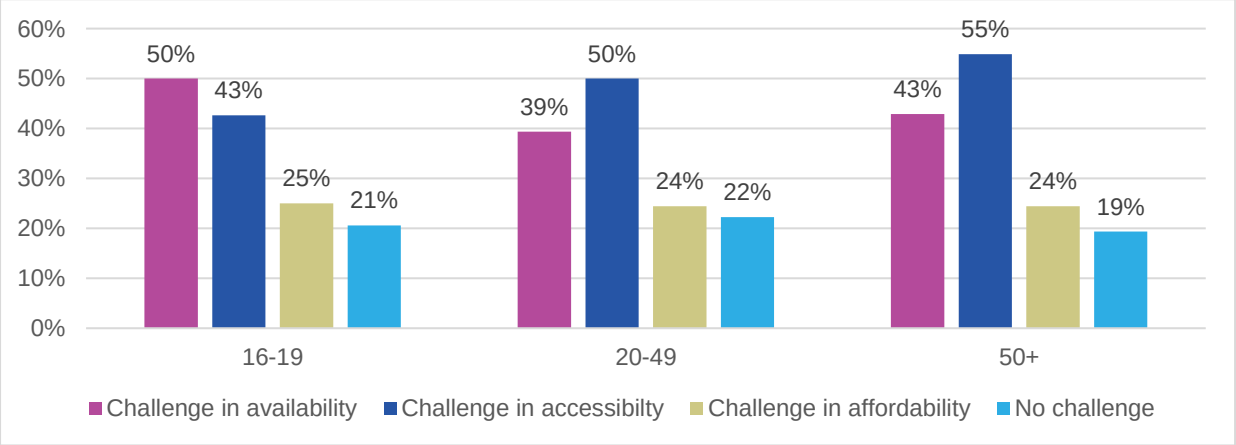
In a quantitative section of the survey where respondents assessed challenges in availability, accessibility, and affordability of services in their country 39% of respondents reported challenges in HIV counselling availability, 40% in HIV testing and 43% antiretroviral drug treatment (ART) availability. Under challenges in accessibility, 51% respondents reported challenges in accessibility both in HIV testing and counselling and 46% in challenges for accessibility for antiretroviral drug treatment. Across all regions, challenges in accessibility for HIV testing, counselling and ART were rated high with considerable differences shown in visual 5 regarding access to HIV testing, varying from 27% of perceived challenges in EECA to 63% in AP. It is interesting to note that comparing HIV testing availability and accessibility by age groups, challenges in availability are more pronounced for younger age brackets while this shifts to accessibility challenges for older age brackets as shown in visual 6. Finally, looking at accessibility of HIV services in prisons and other closed settings, 64% of people who are currently or have been imprisoned perceive challenge in accessibility, compared to 48% of those without that experience.

In the qualitative data 2% of respondents mentioned 'commodity supply' as an additional priority area that needs attention, making this the fifth most mentioned priority area to be added.

Visual 5: Respondents by region perceiving challenges in HIV testing



Visual 6: Respondents by age groups perceiving challenges in HIV testing



4.1.2 Prevention

Elimination of mother to child transmission, and combination prevention for young people and key populations remain critical areas of priority

The survey asked respondents to rate the importance of areas of work within the strategy result areas that look at prevention.

Regarding the Strategy Result Area 2 (elimination of mother-to-child transmission), the survey asked for the importance of 'prevention of new infections among children and sustaining the health and well-being of their mothers' which was globally rated by 88% as very important and by 11% as important.

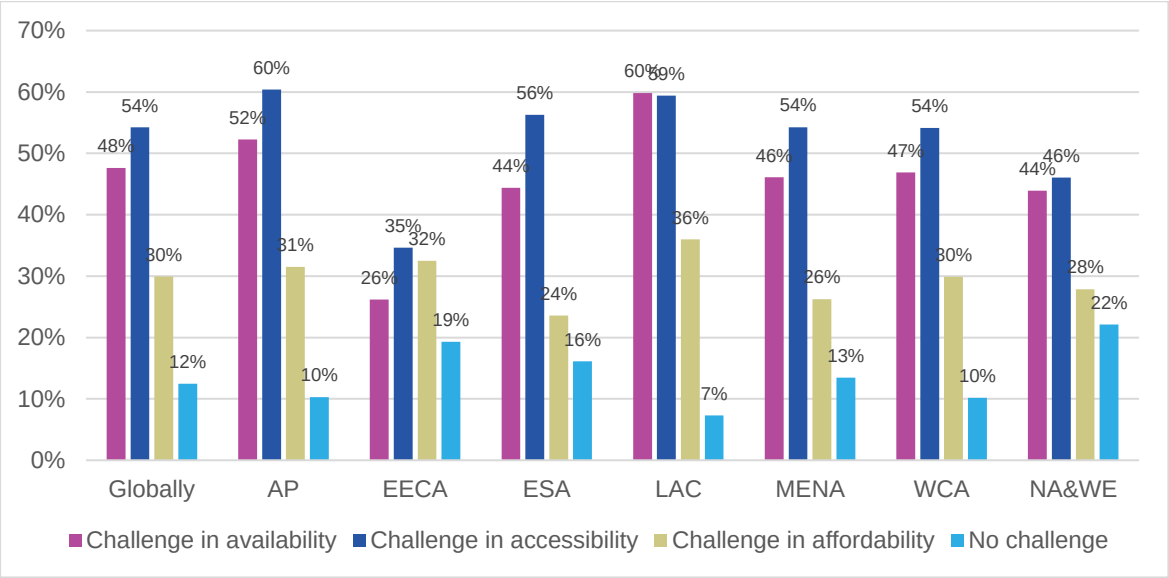
In relation to Strategy Result Area 3 (HIV prevention and young people) the survey asked about the importance of 'access to combination prevention for young people, especially young women and adolescent girls', as well as 'building knowledge and skills among young people, including comprehensive sexuality education'. Both areas were rated as very important by 84% and 82% of respondents respectively. LAC noted the area of children, adolescents and young people as gamechanger number one with 13% (94 out of 707) highlighting the issue.

Looking at Strategy Result Area 4 (HIV prevention and key populations) the survey asked respondents to rate the importance of 'access to combination prevention for key populations; gay men and other men who have sex with men, sex workers, transgender people, people who use drugs and prisoners and other incarcerated people', in 82% of instances it was rated as very important and in 16% as important.

The data shows availability and accessibility of HIV prevention services still being an important barrier. On the challenges in availability, accessibility, and affordability of prevention services; 60% of respondents reported challenges in availability of Comprehensive Sexuality Education (CSE), 55% in gender-based violence (GBV) services, 52% in Pre-Exposure Prophylaxis (PreP), 48% in SRHR, 45% in harm reduction services (including needle and syringe programme, opioid substitution therapy, methadone), 41% in condoms and lubricants and 34% in prevention of mother-to-child transmission services (PMTCT). However, slightly fewer, 54% of respondents reported challenges in accessing CSE, 50% in PreP, 42% in harm reduction services (including needle and syringe programme, opioid substitution therapy, methadone), 42% in condoms and lubricants and 44% in PMTCT. Only for SRHR and GBV services does challenges in accessibility remain higher than challenges in availability with 54% and 57% of respondents describing challenges in accessibility for these services respectively.

The results describe regional differences for areas considered to be social enablers. Shown in visual 7 below for SRHR for example, 19% of respondents did not see any challenges for those services in EECA, while in LAC only 7% did not see any challenges. This goes similarly for CSE which will be further unpacked in the section on education.

Visual 7: Respondents by region perceiving challenges in Sexual and reproductive health and right services



While there is not much difference for other prevention services among different gender or age groups, the harm reduction services show a spike in challenge in accessibility rated by people who use drugs in the youngest age bracket of 16-24 with 72% reporting perceived challenges (versus 58% for people who use drugs in age groups 25-50 and 41% for those 50+).

The open-ended question on the gamechangers to ending AIDS highlighted combination prevention as 6th most frequently mentioned gamechanger with 10% of the responses (259 of 3128). Respondents raised areas such as the importance of prevention for key populations, mitigation of COVID19, access to Pre-Exposure Prophylaxis (PreP), access to information and sexuality education, as well as education in the use of PreP, lubricants and condoms among other things.

It is worth noting that in the open-ended question asking for gamechangers to ending AIDS, prevention was strongly linked to the need for political commitment, as well as technology, innovation, and science to provide research on prevention and improving combination prevention options, including the discovery of a vaccine.

4.1.3 Gender equality and gender-based violence

Promotion of gender equality and empowerment of all women and girls remain critical areas of priority

The importance of gender equality and women empowerment clearly shows from the various quantitative questions on priorities, barriers as well as principles. Many of the areas that create vulnerability for women and girls as well as areas where women and girls might be disproportionately negatively affected have been discussed in other sections of this report such as the barriers to GBV and SRHR services, the importance of quality education, the social enablers and structural barriers that drive the HIV epidemic and the principles around equality and human rights that should guide the HIV response.

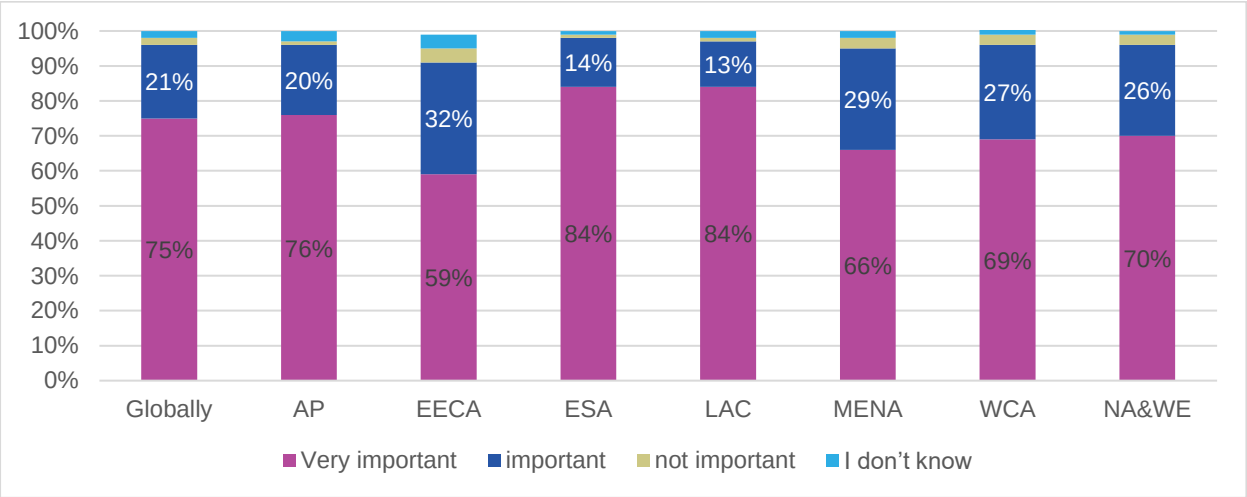
Actions to respond to and end gender-based, sexual and intimate partner violence were found to be very important or important across the different age groups and regions. A notable difference is only seen between male and female respondents, with 82% of female respondents rating it as very important, compared to 76% of male respondents.

LAC is standing out in that for all questions on promoting gender equality or addressing GBV or gender inequalities they are showing the highest level of support compared to all other regions with 87% rating actions to respond to and end gender-based, sexual and intimate partner violence as very important, 83% rating the empowerment and engagement of women and girls very relevant, 87% rating eliminating gender-based violence as very relevant and 85% rating promoting gender equality as very relevant and finally 84% rating addressing gender-inequalities and harmful gender norms as very relevant.

On the relevance of principles guiding the HIV response, support was shown for promotion of gender equality and the empowerment of all women and girls, 97% rating it relevant or very relevant. An approach based on the principle for addressing inequalities was furthermore re-iterated by the open-ended responses, where 19% of respondents (127 out of 662) re-iterated the need to respond to broader social and structural vulnerabilities, such as gender inequality, lack of education and social exclusion. Regional differences are visualized for the question on principles in visual 8 below.

Equally high was the relevance of addressing barriers such as elimination of gender-based violence and reduction of gender inequality at 75% very relevant, 21% relevant. Narrative data on the question of barriers showed that 5% (27 out of 578) of respondents re-iterated the need to end gender-based violence and address power dynamics, especially for young women and adolescent girls.

Visual 8: Respondents by region and percentage rating relative importance of addressing gender-inequalities and harmful gender norms, including gender-based violence and dis-empowerment and lack of engagement of women and girls



Open-ended responses to the question on 'additional priority areas' furthermore seem to suggest that there is a call for more male involvement and for focus on including men and boys in the response, especially from Eastern and Southern Africa and Western and Central Africa. Finally the only notable difference between female and male respondents to the open-ended question on gamechangers to ending AIDS, showed a stronger support from female voices to strengthen our response to human rights and punitive laws, 5% of women (64 out of 1267) noted this as gamechanger, while 3% of male respondents (50 out of 1723) making it the only area where female respondents had higher level of endorsement. Those voices highlighted for example the need to ensure a gender-sensitive approach overall and inclusion of gender inequalities into the human-rights approach.

Voices from the survey

" Strategic HIV Intervention specifically targeting adolescent boys and young men to address gender gaps in the HIV and AIDS response."

"We need to find a way to include gender inequalities and gender-based violence within discussions about human rights violations, stigma and discrimination rather than as a separate item. We need to make gender inequality a clear human rights issue."

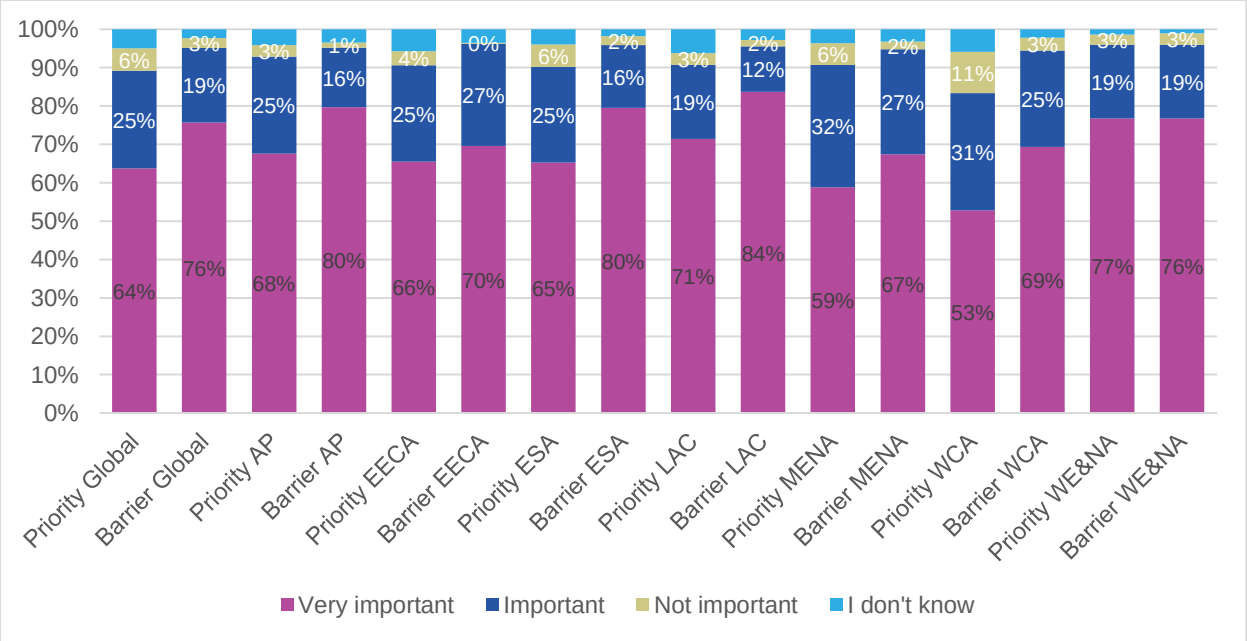
4.1.4 Human rights, stigma and discrimination (SRA6)

Human rights, stigma and discrimination remain critical areas of priority with a need for further attention

This area encompasses both the importance of a human rights-based approach, addressing punitive laws, policies and practices, as well as stigma and discrimination.

As seen above in table 7 'removing punitive laws, policies and practices' was rated as having relatively low importance with 89% of respondents ranking it as very important or important compared to more than 95% of respondents ranking the other areas as very important or important. The breakdown of responses to this question by region can be seen in visual 9 below, showing the regional variances both for ranking relative importance of removing punitive laws, policies and practices as a priority area as well as addressing legal and policy issues as a barrier to ending AIDS. Generally, respondents rate the importance of addressing that area as a barrier more highly than as they rate it a priority area. When the responses to the question on removal of punitive laws was disaggregated by age there was no difference in attitude between the different age groups. The responses to this question should be broken down further and studied in relation to other human rights, discrimination, and punitive law questions to better understand the difference in ranking between these areas and the relation to stigma and discrimination.

Visual 9: Respondents by region and percentage rating relative importance of punitive laws, policies and practices as a priority area and as a barrier[2]



[2] Priority question was asking to rank how important respondent thinks Removing punitive laws, policies and practices is for reaching the goal of ending AIDS by 2030. Barrier question was asking respondent to indicate how important they think it is to address Legal and policy barriers, including: criminalisation of HIV disclosure, exposure or transmission, criminalisation of behaviours and/or population groups (e.g., drug use, same sex sexual relationships, sex work, etc.), and age of consent laws.

98% of respondents rated elimination of all forms of HIV-related stigma and discrimination as either an important or a very important area of the current strategy.

When respondents were asked to indicate how relevant it is to address social and structural barriers to end AIDS; the most important area was 'human rights violations, stigma and discrimination, including towards people living with HIV, towards marginalised and socially excluded populations (e.g., sex workers, LGBTIQ, people who use drugs, migrants, people in prisons, etc.)' 81% saw this as very important and an additional 16% saw it as important. The open-ended question on additional barriers provided respondents the opportunity to add or re-iterate barriers of importance. Addressing human rights and equity to access HIV services was the 3rd most mentioned issues with 13% (77 out of 578) respondents noting those issues, while stigma and discrimination came up as 10th most frequently mentioned barrier (29 out of 578).

Looking at principles guiding the HIV response, the importance of removing stigma and discrimination was again the highest rated principle in the survey. 98% of respondents ranked 'No one should be discriminated against or stigmatised' as important or very important. 98% of the respondents believed in the principle of ensuring access to health and HIV services for all, including for the most marginalised, socially excluded and hard to reach, and 98% affirmed the principle of protecting human rights.

On the challenges in availability, accessibility, and affordability of human rights, stigma and discrimination services; 49% of the respondents reported challenges in availability of legal services and 53% challenges in accessibility to legal services. The challenges in affordability was higher for legal services than for any other of the services listed in the survey with 46% indicating challenges in this area.

Elimination of stigma and discrimination was also mentioned as 8th most prominent gamechanger with 7% of respondents (219 of 3128) and human rights as 10th with 4% of respondent (121 of 3128) detailing this issue.

Voices from the survey

” An effective HIV response contributes to the development of society towards democracy and respect for human rights.”

“Greater confidentiality, respect and less stigma and discrimination in the relationship of doctors and patients newly diagnosed. I suffered with stigmatization from doctors in two health services. Health workers seemed tired, underpaid, with high level of stress and without necessary training and psychological support to perform their functions.”

4.1.5 Investment and efficiency (SRA7)

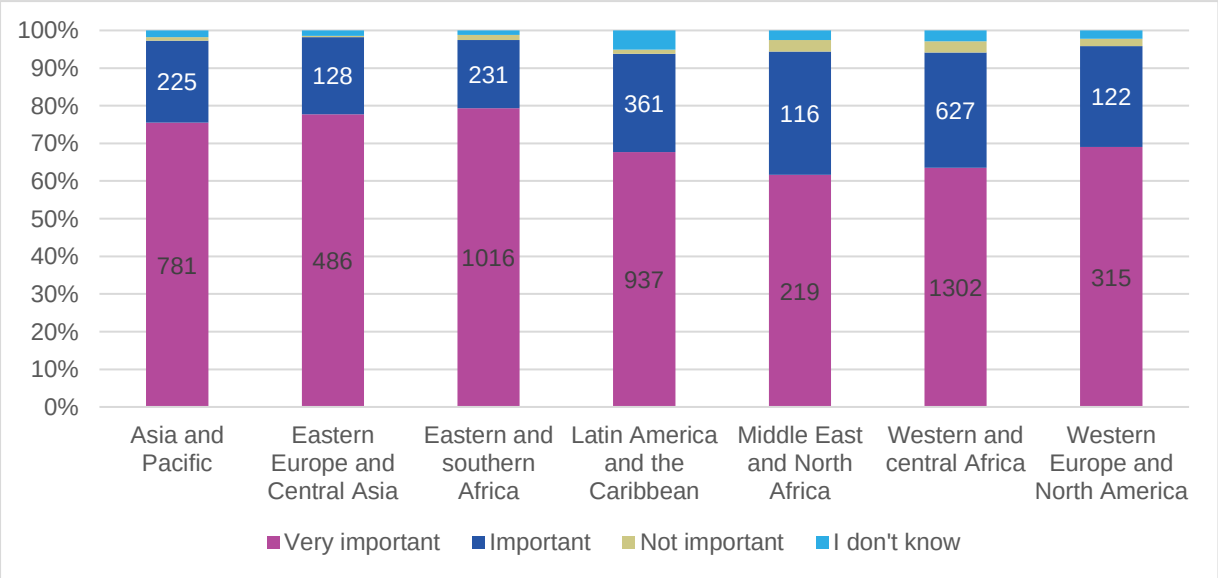
Investment and efficiency remain a critical area of priority with need for further attention

Strategy result area 7, 'the AIDS response is fully funded and efficiently implemented based on reliable strategic information', has a variety of aspects that all came up frequently as priority areas. These aspects include to fully fund or increase the investments to end AIDS; better monitoring and evaluation; financial and political support for community led interventions and; developing a multisectoral response to HIV.

The generation of data (strategic information) to guide an effective AIDS response was rated as very important or important by 98% of respondents. The same percentage wanted to see 'effective and efficient implementation of the AIDS response through a people cantered approach.'

Participants from all regions rated a fully funded multi-sectoral HIV response as very important or important to a high degree, with 95% globally. The regional breakdown is shown in visual 10.

Visual 10: Respondents by region rating relative importance of the priority area on 'HIV response is fully funded with increasing domestic resources of a multi-sectoral response for equitable results



Narrative data suggests that there is a need for further analysis and to prioritize areas within Strategy Result Area 7 on investment and efficiency. Voices for prioritising this area within the open-ended question on 'additional priority areas' are especially high in Western and Central Africa with 32% and in East and Southern Africa with 28% including it in their answer. The question on providing additional barriers that would need to be addressed saw funding mentioned as the 5th most prominent answer with 7% (43 out of 578) respondents highlighting lack of funding and lack of sustainable financing solutions being a danger to achieving our goals.

Within this strategy result area many of the responses from the open-ended question answered with priorities around (1) political will (2) multisectoral approach and (3) community at the center. These priority areas are further unpacked and elaborated in below sections.

Voices from the survey

" Ensure financing of cross-cutting issues through national plans based on evidence. We need to finance gender mainstreaming in the response to HIV"

"A major significant barrier to our meaningful engagement is lack of funding for the work we all do as communities. Yet without us the rest of the work will be extremely hard if not impossible."

4.1.6 HIV and health service integration (SRA8)

HIV and health service integration remains a critical area of priority with further need for attention

Access to integrated health care services, including for coinfections (e.g., Tuberculosis, Hepatitis, COVID-19) for people living with HIV was an area of very high importance both in this quantitative question and in qualitative results where many respondents mentioned integration of HIV services in Primary Care, access to HIV services as a part of Sexual and Reproductive Health Services or HIV integration more broadly in their response.

Input for Strategy Result Area 8, people-centred HIV and health services are integrated in the context of stronger systems for health, came from a quantitative question that asked about integration of the AIDS response into other health and development areas, barriers on access to services, as well as an open-ended question on priorities and 'gamechangers'.

In the quantitative questions around HIV and health service integration, seen in table 8 below, 85% of respondents indicated this as very important and 14% as important. When these results are broken down by region the strongest support for health service integration seem to be coming from the regions and locations with lower access to health services and regions and location with higher access put less importance on integration. Respondents from Western Europe and North America and from Switzerland rated service integration as of lower importance than all other regions. 91% of respondents from rural areas globally described service integration as very important.

The level of importance placed in the other areas of health service integration and Universal Health Coverage were comparable with between 73 and 79 % calling it very important and an additional 19-23% calling it important (see table 8). The results from these areas of priority were similar from all regions.

Respondents report that mental health services have one of the highest levels of challenge in affordability out of a long list of services and support, the only affordability challenge that is greater is for legal services. Around 54% of respondents also reported challenges in availability and accessibility to mental health services.

Other non-HIV specific health service areas with high levels of challenge in accessibility was sexual and reproductive health and rights services, where 54% of respondents noted challenges and primary health care and care for non-communicable diseases where 50% noted challenges. In addition, for social protection services and interventions such as protection from economic and social risks, such as unemployment, exclusion, sickness, disability and old age 54% of respondents reported challenges in availability and even higher level of challenges (60%) were seen in availability of psycho-social support (ongoing support for psychological and social challenges).

Referenced in annex 1 is the full list of services and challenges in availability, affordability, and accessibility. Non-HIV specific service areas such as social protection, legal services and non-HIV health services are highlighted in the table to show how these are the areas where there seem to be more challenges than in the HIV specific areas.

From the open-ended question on gamechangers to end AIDS, integration was mentioned by 2% of respondents with low responses from youth, with no response from younger people aged 16-29.

Table 8: Areas of work in **current strategy** linking to SRA 8 on HIV and health service integration and relative importance for reaching the goal of ending AIDS by 2030

Area of priority linking to SRA 8 on HIV and health service integration	**Very important**	**Important**	**Not important**	**I don't know**	**Link to Fast-track commitment**
Access to integrated health care services, including for coinfections (e.g., Tuberculosis, Hepatitis, COVID-19) for people living with HIV	85%	14%	1%	0%	Commitment 10
Support community-led services and integrate into systems for health	79%	19%	1%	1%	Commitment 7 & 10
HIV response is linked to Universal Health Coverage and integrated in health insurance schemes	74%	22%	2%	2%	Commitment 10
Ensuring HIV-sensitive social protection	73%	23%	3%	1%	Commitment 6

4.2 Areas that need to be accelerated to end AIDS by 2030

In the following sections we will look more in depth at the areas that came up as priority areas for adding or accelerating in the next Global AIDS strategy beyond 2021, these have been identifies as (1) community at the center, (2) political will, (3) multisectoral approach, (4) science, technology and innovation, (5) education, and (6) the priority on communication.

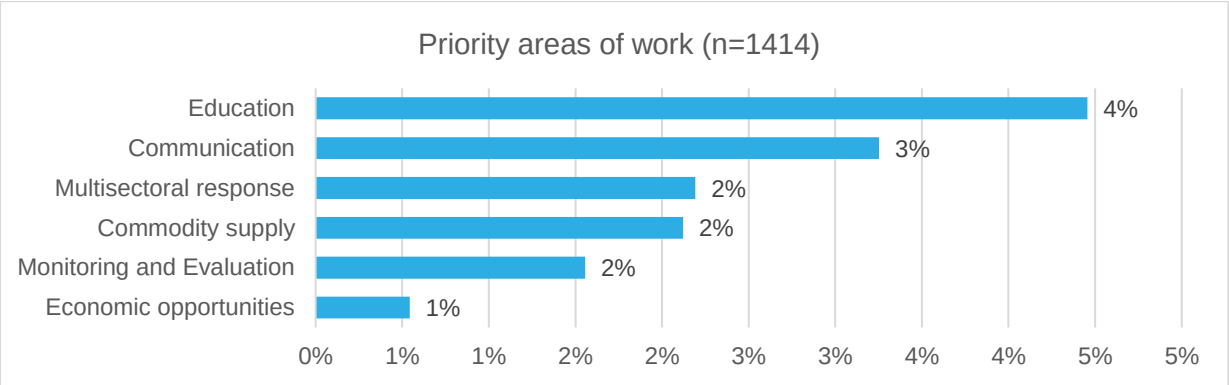
From the quantitative data as shown in table 9 below, 98% of respondents indicated that integrating the national HIV response into the national health agenda and into other sectors, as well as integrating the response to HIV into broader global development frameworks is either very important or important. Similarly, 98% indicated access to HIV prevention, testing and treatment services for all in humanitarian and/or emergency situations to be of importance. Almost as many, 97%, stressed the importance of Science, Innovation and Technology to be used to fast-track the AIDS response. While these areas where the top three they were closely followed by HIV contributing to responses to other emerging health and development crises, such as COVID-19, and that the HIV response contributes to addressing a wider set of challenges beyond HIV that extends to public, private, social development, and civil society sectors, both with 96% of respondents indicating them as very important or important. At the same time as the responses to this question show clear support for the HIV response to contribute to emerging health crises, we have very few mentions of COVID-19 or the Coronavirus in the open-ended question.

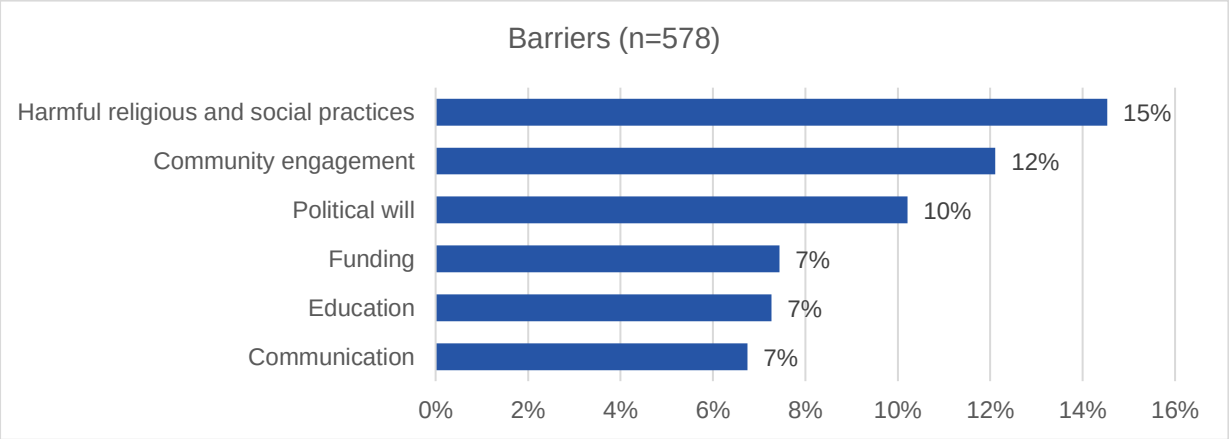
The areas receiving strong support in the quantitative questions were also highlighted by the various open-ended responses, adding most often community engagement, political will and funding, as well as education and communication, which will be detailed in below sections and are indicated in visual 12 below.

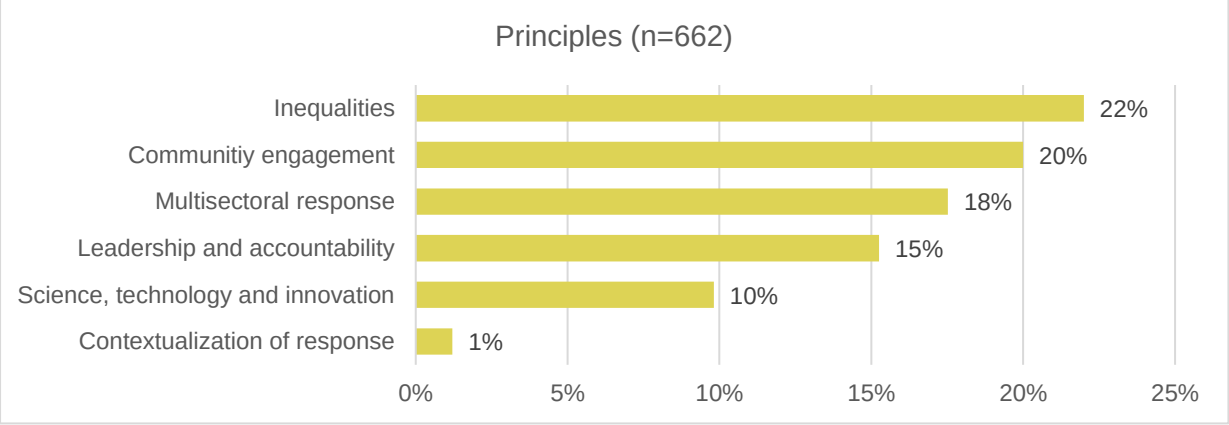
Table 9: Actions that integrate the AIDS response into other health and development areas and relative importance for reaching the goal of ending AIDS by 2030

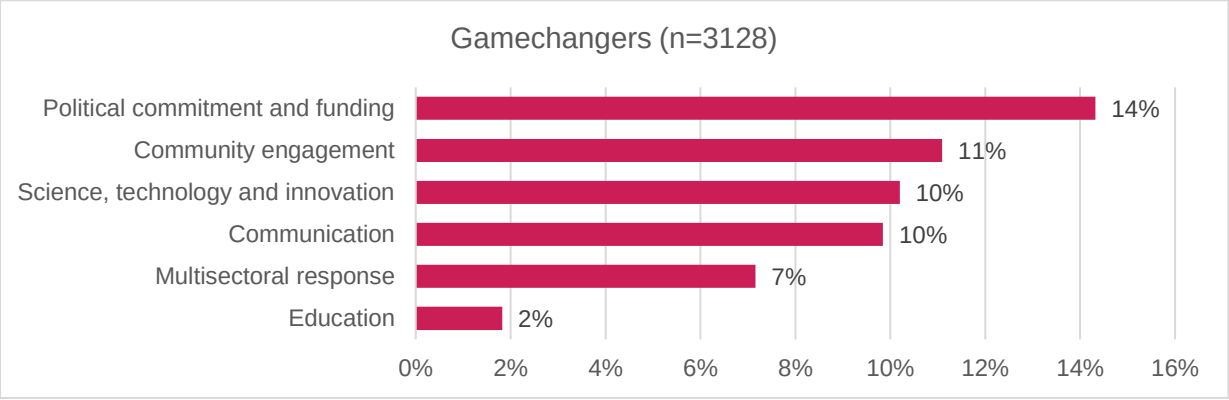
Actions that integrate the AIDS response into other health and development areas	Very important/ important	Not important	I don't know	Broad area
Integrating national HIV response into national health, other sectors, and development	98%	1%	1%	Multisectoral approach
Access to HIV prevention, testing and treatment services for all in humanitarian and/or emergency situations	98%	1%	1%	Humanitarian crises
Science, Innovation and Technology are utilized to fast-track the AIDS response	97%	1%	2%	Science, Innovation, Technology
HIV response contributes to responses to other emerging health and development crises, such as COVID-19	96%	2%	2%	COVID19
HIV response contributes to addressing a wider set of challenges beyond HIV that extends to public, private, social development, and civil society sectors	96%	2%	2%	Multisectoral approach

Visual 12: Open-ended responses that noted areas beyond current strategy result areas, by question, percentage and category









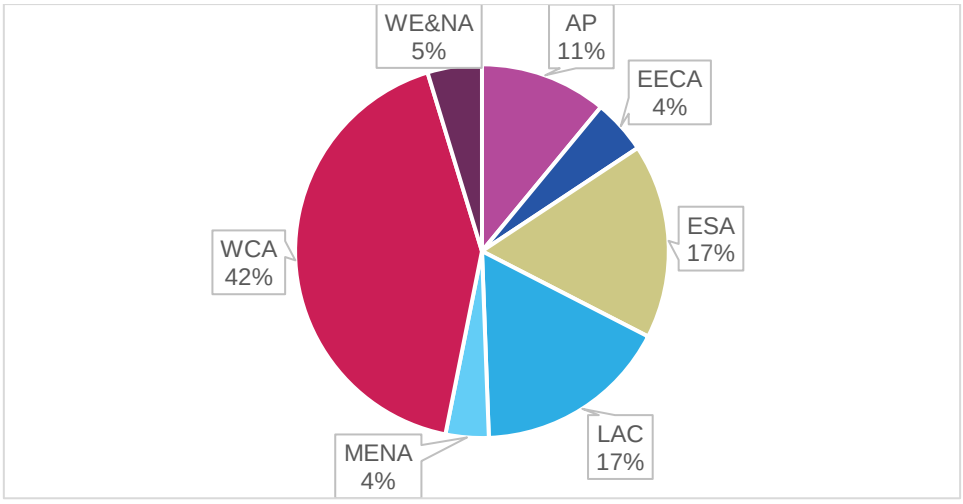
4.2.1 Communities at the center

The qualitative data from the survey indicates high level of importance placed on community involvement. This is especially clear from the open-ended responses on what would be a gamechanger for HIV where putting communities at the center of the response and empowering community actions was frequently mentioned with 11% of the responses. The responses included ideas such as developing granular strategic information for community engagement, give more financial support to communities, focus on community skills development to deliver services, and to create easy access to quality information and services for communities. This principle was especially important for the two sub-Saharan African regions. See visual 13.

The importance placed on communities was further confirmed by the question on relevance of principles guiding the HIV response; the highest relevance was given to engaging affected communities meaningfully and to resource community-led responses. At least 95% of respondents from all different regions rated this area as relevant or highly relevant. When asked for additional principles, another 20% of respondents re-iterated the importance of community-involvement as a principle that should guide the response.

Addressing barriers to meaningful engagement of communities, including legal or other barriers to civil society, this was seen as very relevant by 70% of respondents and relevant by 25% of respondents. This was further underlined by 12% of respondents to the open-ended question on barriers, who noted that lack of community engagement is a true impediment to a successful response.

Visual 13: Distribution of responses by region to the survey question 'what would be the gamechanger in ending AIDS' mentioning category on 'Community engagement'



Voices from the survey

"Empowerment and care for community leaders, women, men, key populations with HIV for strong advocacy."

"We need true commitment from government to work with civil society and grassroot populations and bring them to the decision table."

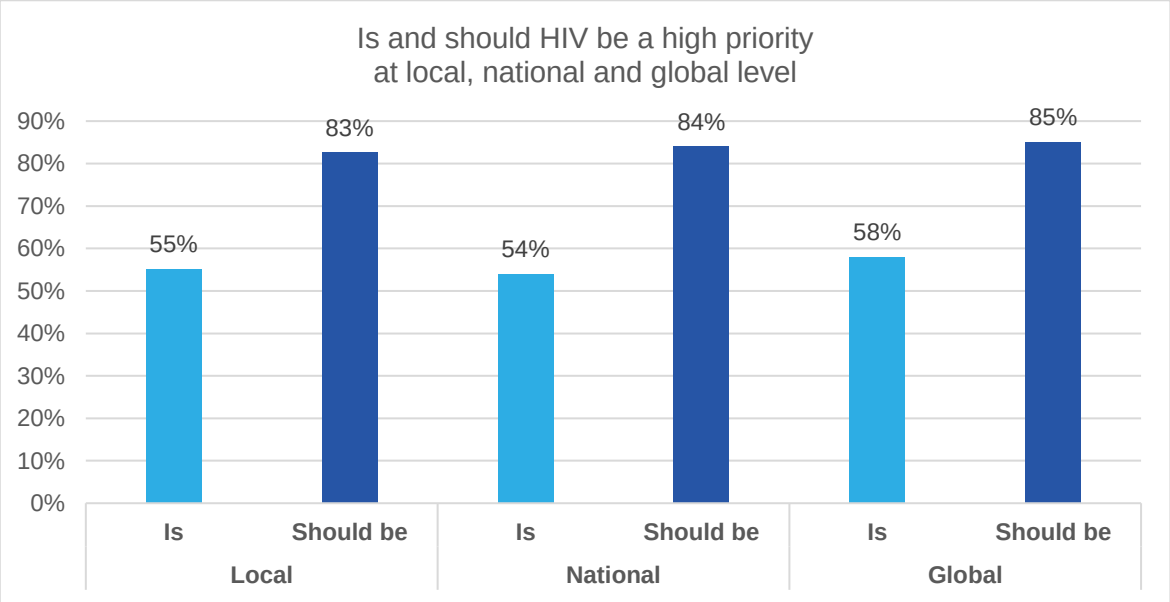
4.2.2 Political will

More than half of the respondents agreed that HIV is a priority at local, national and global levels. An additional ~30% believed that HIV should be a priority at all of these levels. This perceived discrepancy between what is and what should be hold true when the data is disaggregated by region and respondents from all regions agree that HIV deserves a higher level of priority.

Overall, political commitment and funding was the second most mentioned gamechanger to end the AIDS epidemic in our qualitative analysis, 14% of all responses was in this area. For the age groups 40-49, 50-59 and 60-69 political commitment and funding was the most frequently cited gamechanger. At the global level, a trend can be seen that younger age groups place more importance on biomedical interventions, with increase in age political and funding, as well as multisectoral approach issues, increase in importance.

Political will, which is often cited along with a need for investment and commitment on sustainable funding, is also noted as a barrier in cases of poor leadership and lack of commitment. Equally it was highlighted that leadership and accountability is an important principle to align to if we are to end AIDS by 2030.

Visual 14: Responses to is HIV and should HIV be a priority at local, regional and global level. (Responses to 'high priority only)



Voices from the survey

"We need greater involvement of country leaders in the fight against HIV."

"Greater commitment of governments to make financial and scientific resources available."

4.2.3 Multisectoral response

When the survey asked respondents how they valued the principle of 'building multisectoral and interdisciplinary approaches and partnerships and financing, that extend to public, private and civil society sectors' 97% of respondents said it was relevant or very relevant.

A multisectoral response was brought up as an additional priority area by a significant number of respondents as well as a being a 'gamechanger' for many (7% of respondents). Several respondents ask for stronger collaboration with the private sector when working towards ending AIDS. Within the question on barriers, the top response that emerged was the need to address harmful social and religious norms and practices, which can be seen as a call for stronger collaboration with faith-based organizations as part of a strong multisectoral response.

The survey asked respondents to look at barriers to ending AIDS in terms of barriers to access to services and in terms of social and structural barriers. The results show a clear pattern of social enablers being difficult to avail and access, more so than the health services that have been the core of the HIV response since the inception. These harder to access services include legal services, mental health services, sexual and reproductive health and rights services, social protection services and interventions, comprehensive sexuality education, gender-based violence services and psycho-social support.

Voices from the survey

"Inclusion of the faith sector in building multisectoral and interdisciplinary partnerships"

"The private sector should be engaged in a manner that they will understand that contributing to HIV response is part of their corporate social responsibility"

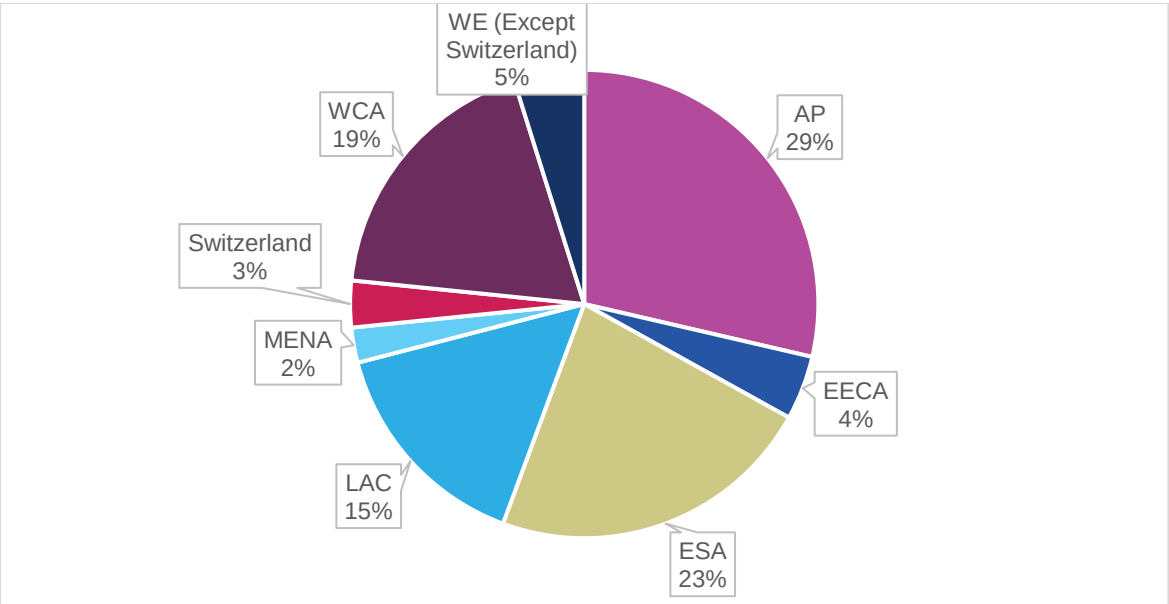
4.2.4 Science, technology and innovation

Quantitative data indicated high level of support for ‘Science, Innovation and Technology are utilized to fast-track the AIDS response’ as a priority area with 96% of respondents finding it relevant or highly relevant.

The survey results on principles confirms 'galvanize research and innovation for essential medicines, and partnerships with private sector to ensure accessibility and affordability' as highly relevant to 78% of respondents. This was further underlined by respondents re-iterating science, technology and innovation as an important additional principle, with 10% of respondents to that question highlighting this area.

In the qualitative analysis on what would be a gamechanger for the HIV response science, technology and innovation was mentioned by 10% of the respondents.

Visual 14: Distribution of responses by region to the survey question ‘what would be the gamechanger in ending AIDS' mentioning category on ‘Science, Technology and Innovation’



Voices from the survey

“We need a cure medication soonest for ending all of this. We are tired to face all this.”

“Newer safer regimens for HIV treatment especially for young children are required.”

4.2.5 Education and Comprehensive Sexuality Education

Education is brought up with several different meanings in the responses to the survey. It is raised as an additional priority specifically as sexuality education, but also more broadly universal quality education is brought up as a gamechanger. The lack of education is highlighted as a barrier to accessibility of HIV services and it is mentioned as one of the ways to overcome stigma and discrimination.

There is strong support (99%) for the importance of 'building knowledge and skills among young people, including comprehensive sexuality education'. In visual 15 below the responses for this question is shown by region.

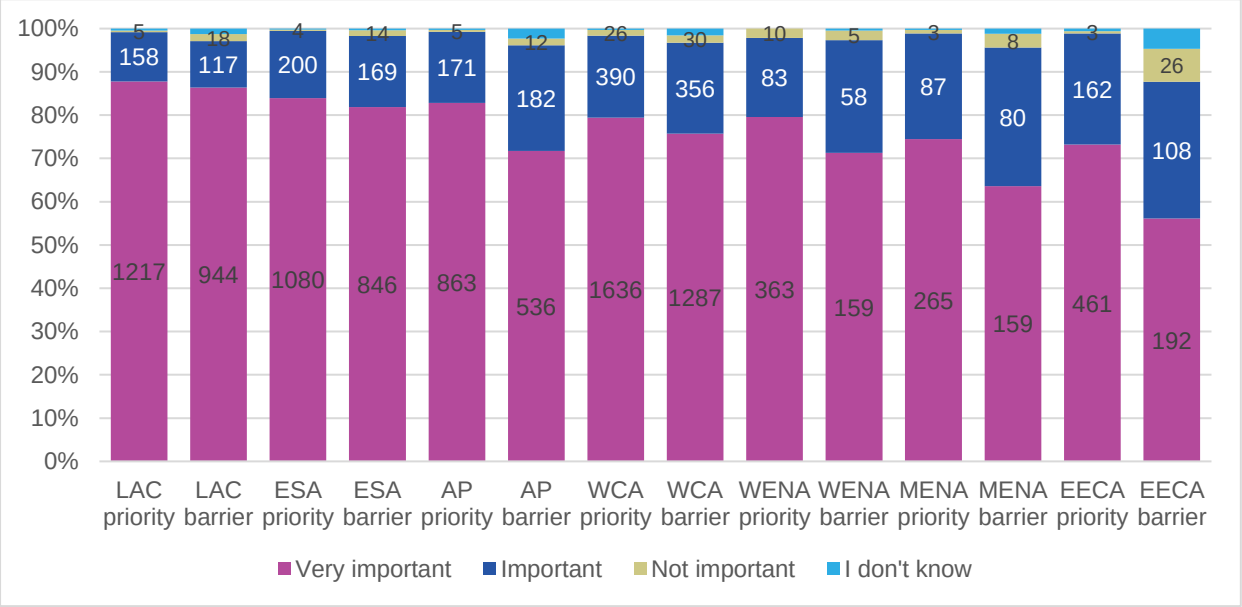
More than 5 out of 10 people who responded to the survey think there remain important challenges in accessing comprehensive sexuality education, and availability is equally challenging, 60% of the respondents said there are challenges to availability of comprehensive sexuality education, this is especially true for transgender people and people who do not identify as female, male or transgender.

Table 11: Percentage of respondents by gender perceiving challenges in availability, accessibility, affordability or no challenge for Comprehensive Sexuality Education

Comprehensive Sexuality Education	challenge in availability	challenge in accessibility	challenge in affordability	no challenge
All	60%	54%	25%	9%
Female (n=2297)	58%	52%	23%	7%
Male (n=2984)	61%	56%	27%	9%
Transgender people (n=94)	66%	53%	32%	8%
People who do not identify as female, male, or transgender (n=57)	84%	77%	35%	4%

The graph below shows how respondents rated the importance of building knowledge and skills among young people, including comprehensive sexuality education, by region. It is presented next to the results from the question on how important it is to address lack of access to quality education and barriers to staying in school, including access to comprehensive sexuality education. In most regions there is not a big difference between the responses to the two questions. Generally addressing barriers to lack of access has slightly lower importance than building knowledge and skills. The notable exception to this is Eastern Europe and Central Asia where there is a bigger gap between the importance placed on building skills and the importance of addressing barriers to access.

Visual 16: Access to knowledge and skills, quality education as a priority area and needed to be addressed as a barrier by regions

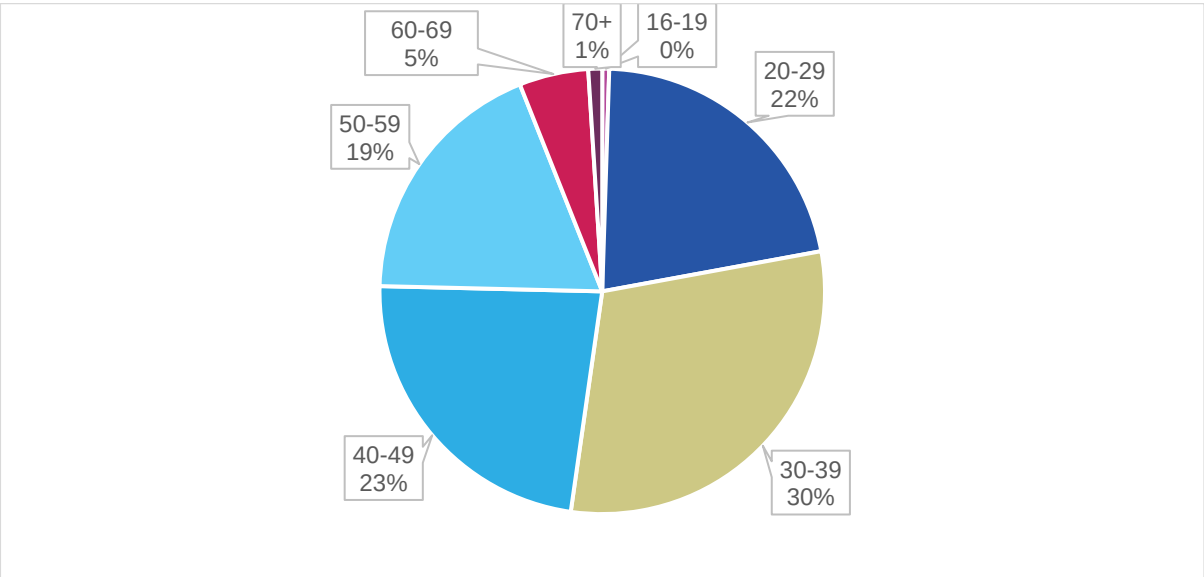


4.2.6 Communication

For the open-ended question on a gamechanger to ending AIDS this area was the 5th most mentioned with 10% of responses. Some of the ideas around communication that were expressed through these answers were on “leading the response in the virtual world” (data-interventions-communication-rights); creating mass awareness and communication campaigns; global communication to eliminate the stigmatization; harnessing the power of social media for communication and information; support to media and; including HIV prevention in soap operas and popular culture.

Confirming this emerging area, when the survey asked respondents about additional priority areas, the importance of information and communication was mentioned 3% of the time, with most mentions percentagewise in Latin America and the Caribbean with 7% followed by Western and Central Africa and East and South Africa with 2% each.

Visual 17: Distribution of responses by age to the survey question ‘what would be the gamechanger in ending AIDS' mentioning category on ‘Putting priority on communication’



Voices from the survey

“Putting priority on communication, helping to capacitate communities, service providers, and other stakeholder to effectively communicate their key messages”

“Leverage social media platform and data use to improve HIV services”

4.3 Guiding principles for a successful HIV response

The results show strong affirmation that principles that currently guide the AIDS response remain relevant.[3] Of the total 6023 respondents, the highest relevance was given to the principle on non-discrimination. 99% saw this as relevant or very relevant. This was closely followed by support for the principle on ensuring access to health and HIV services for all, including for the most marginalised, socially excluded and hardly reached, and on protection of human rights. The full list of principles and their rated relevance can be seen in table 12.

Open-ended responses underlined these areas further and re-iterated principles focusing on addressing inequalities with 22%, followed by community engagement with 20%, multisectoral response with 18% and leadership and accountability with 15% and science technology and innovation with 10%.

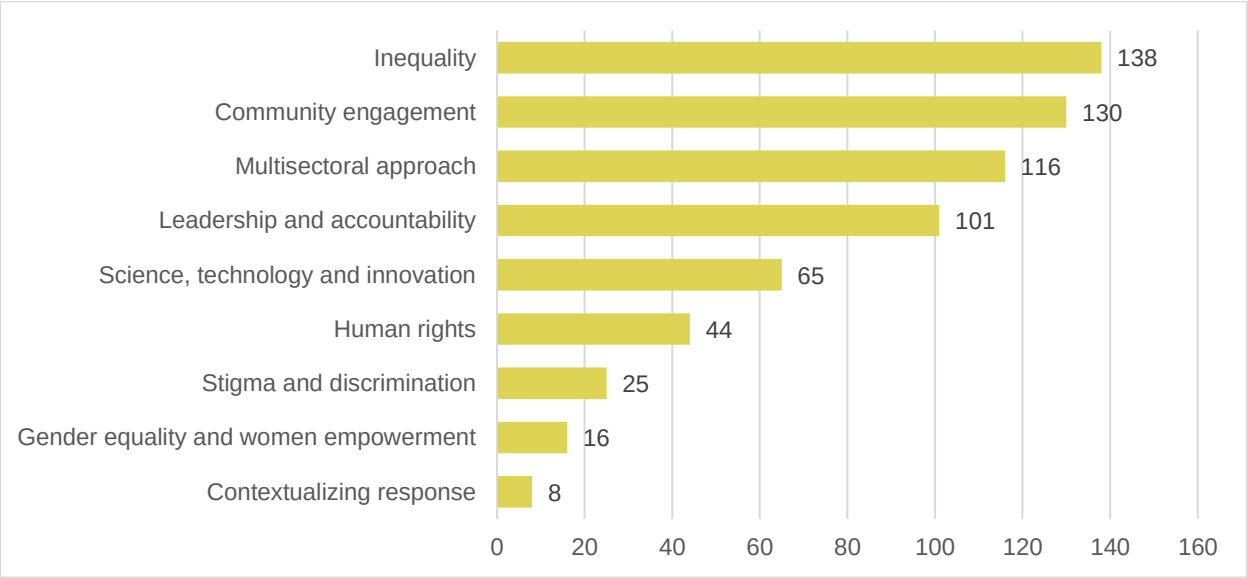
Table 12: Principles that guide the AIDS response and their relevance for ending AIDS by 2030

Principles	Very relevant	Relevant	Not relevant	I don't know
No one should be discriminated against or stigmatized	90%	9%	1%	0%
Protect human rights	87%	12%	1%	0%
Ensure access to health and HIV services for all, including for the most marginalised, socially excluded and hardly reached	87%	12%	1%	1%
Leave no one behind, especially marginalized, and socially excluded populations	84%	14%	1%	1%
Apply human rights-based, evidence-informed policies and programmes, and redress for human rights violations	80%	18%	1%	1%
Eliminate gender-based violence and reduce gender inequality	80%	17%	2%	1%
Engage affected communities meaningfully and resource community-led responses	78%	20%	1%	1%
Galvanise research and innovation for essential medicines, and partnerships with private sector to ensure accessibility and affordability	78%	20%	1%	1%
Promote gender equality and the empowerment of all women and girls	78%	19%	2%	1%
Responding to HIV requires responding to broader social and structural vulnerabilities,	77%	20%	2%	1%

[3] When the survey was first launched the questions on principles and underlying structural and social barriers were asking respondents to rank areas in relative importance to each other. After reconsidering the type of data this would yield and what would be most useful to inform our strategy and our work going forward the mode of answering was reformatted to include the ranking of areas as very important, important, not important or 'I don't know'. 932 responses had been recorded with the original answer format and cannot be combined or compared with these results.

such as gender inequality, social exclusion, etc.				
Build multisectoral and interdisciplinary approaches and partnerships and financing, that extend to public, private and civil society sectors	75%	22%	1%	1%
Uphold humanitarian principles in emergency situations; humanity, neutrality, impartiality, independence	74%	23%	2%	1%
Hold leadership at global, regional and national levels to account	75%	21%	2%	2%
HIV responses contribute to the Sustainable Development Goals	73%	24%	2%	1%

Visual 18: Responses by category to additional principles (n=662)



5. Considerations for the next global AIDS strategy beyond 2021

At a quick glance it might seem like there is little difference in the priority or support given to the Strategy Result Areas and the themes they hold. But because we see this strong affirmation, often more than 95% of respondents rating areas of work or principles as important, it is the relatively weak support of some areas that stand out. One such example is how both the qualitative and quantitative data highlighted stigma and discrimination as one of the most prominent areas of focus and importance while the removal of punitive laws had one of the lowest levels of rated importance. It seems like support for removing punitive laws, policies and practices is seen as separate from the issue of stigma and discrimination and from protection of human rights and that there is less importance placed in the removal of punitive laws. This finding is important to break down further and examine. How can we meaningfully address these issues with a regional lens in our coming strategy? Is there a lesson here in how to talk about human rights and how we could be framing issues of discrimination and punitive laws and policies better?

Strategy Result Area 7 on investment and efficiencies saw a much greater number of suggestions for new priority areas than any other Strategy Result Area. There is a need to further unpack this group of answers into categories of financial investment, political will, monitoring and evaluation and accountability. For each of these areas there are further breakdowns to be made to understand what kind of investments the respondents are suggesting; Increases in domestic funding? Bilateral aid? Multilateral financial support? Private sector investments? What needs to be done differently to renew and sustain political leadership and domestic investments on HIV?

The survey results are pointing to integration of HIV in health services and integration of the HIV response in broader development agendas. As we get closer to our goal of universal access to antiretroviral treatment the lack of availability, access and affordability of other health and non-health services are becoming more of an issue for people living with HIV. The survey results show that clearly when it comes to the challenges of accessing mental health services. This is also the case for many structural barriers and social determinants that our respondents raise as priorities for the HIV response and as gamechangers to end AIDS. How can the next strategy support this integration of services and multisectoral approach without aiming to tackle all social determinants from education to disability to employment to poverty and beyond? How can we begin to remove social and structural barriers that directly prevent access to HIV and health services? How can we maximize the contributions of partners and sectors, including non-health sectors, the private sector and faith communities?

We hear a call from respondents across the world to focus more on science, technology and innovation. Some of our respondents do not believe that the tools we currently have for testing and treating HIV will get us to the end of AIDS and are calling for a vaccine or a cure. Others stress the need for better treatment regiments and the use of technology and innovation in clinical settings. How can our strategy be stronger in the areas of science, technology and innovation and what are some ideas we hear from other sources that can be included to strengthen this area of work?

Communities at the center of the HIV response is not a new principle but it seems to be one we need to refocus on and ask ourselves how, moving forward, we do that with stronger community leadership, local solutions and communities empowered and funded to be the change agents. What strategic actions are needed to ensure that the engagement of people

living with HIV and communities is meaningful? What steps are needed to improve our capacity to measure and monitor community-led responses? How to ensure sustainable multi-year financing of community-led responses?

In all instances where we have disaggregated data the affected group is experiencing bigger challenges than the rest of the respondents; people who inject drugs rate the barriers to harm reduction services as higher than respondents who do not inject drugs, respondents in rural areas find service integration more important than respondents in urban areas, women find addressing gender inequalities more critical than men. We must make sure that each specific group is at the heart of the policy formulation that regards them in the new strategy and that their experiences is guiding the new approach.

Respondents brought out communication as a priority area and as key to ending the epidemic. It was raised in several ways; mass communication as a prevention strategy, communication and access to information as a form of sexuality education, communication as a tool to tackle stigma and discrimination etc. How can the next strategy build communication as an area of work? How can we at global and regional level build or leverage communication channels to support the HIV response?

Education came out strongly as an area to focus more on. Education was seen as an end in and of itself but also as a key to gender empowerment, to tackle social determinants of health, to decrease stigma and discrimination and to increase access to sexuality education. How can the next strategy inspire action across all sectors (including justice, law enforcement, education, social protection, etc.) to address the structural inequalities and marginalization that increase HIV risk and vulnerability?

The contribution from over 8300 people from 163 countries provided this critical input and raised important questions. It helped better understand the various perspectives, experiences and recommendations moving towards the next strategy beyond 2021 and will be a critical enabler to guide its development and ultimately contribute to how we deliver on result for people in the response for the coming years.

Annex 1: Responses to perceived challenges in availability, accessibility and affordability of various services

Table A: Respondents indicating where they think **challenges in availability** of these services in their country.

Services	% of respondents indicating challenge in availability
Safe and voluntary medical male circumcision	25 %
Prevention of Mother to Child Transmission services	34%
Tuberculosis (prevention and treatment)	34%
Maternal and child health care	35%
HIV counselling	39%
HIV testing	41%
Condoms and lubricants	42%
Antiretroviral drug treatment (ART)	43%
Primary health care and care for non-communicable diseases	44%
Harm reduction services (including needle and syringe programme, opioid substitution therapy, methadone)	45%
Sexual and reproductive health and rights services	48%
Legal services	49%
HIV services, in prisons and other closed settings	51%
Pre-Exposure Prophylaxis (PreP)	52%
Mental health services	54%
Gender-based violence services (Post-exposure prophylaxis, counselling, prevention)	56%
Psycho-social support (ongoing support for psychological and social challenges)	56%
Social protection services and interventions (protection from economic and social risks, such as unemployment, exclusion, sickness, disability and old age)	59%
Comprehensive Sexuality Education	60%

Table B: Respondents indicating where they think **challenges in accessibility** of these services in their country.

Services	% of respondents indicating challenge in accessibility
Safe and voluntary medical male circumcision	28%
Harm reduction services (including needle and syringe programme, opioid substitution therapy, methadone)	42%
Condoms and lubricants	42%

Tuberculosis (prevention and treatment)	43%
Prevention of Mother to Child Transmission services	44%
Antiretroviral drug treatment (ART)	46%
Maternal and child health care	47%
HIV services, in prisons and other closed settings	49%
Pre-Exposure Prophylaxis (PreP)	50%
Primary health care and care for non-communicable diseases	50%
HIV testing	51%
HIV counselling	51%
Legal services	53%
Mental health services	54%
Social protection services and interventions (protection from economic and social risks, such as unemployment, exclusion, sickness, disability and old age)	54%
Comprehensive Sexuality Education	54%
Sexual and reproductive health and rights services	55%
Psycho-social support (ongoing support for psychological and social challenges)	56%
Gender-based violence services (Post-exposure prophylaxis, counselling, prevention)	57%

Table C: Respondents indicating where they think **challenges in affordability** of these services in their country.

Services	**% of respondents indicating challenge in affordability**
HIV counselling	19%
Safe and voluntary medical male circumcision	21%
Prevention of Mother to Child Transmission services	22%
Tuberculosis (prevention and treatment)	24%
HIV services, in prisons and other closed settings	24%
HIV testing	25%
Comprehensive Sexuality Education	25%
Antiretroviral drug treatment (ART)	27%
Harm reduction services (including needle and syringe programme, opioid substitution therapy, methadone)	27%
Maternal and child health care	29%
Gender-based violence services (Post-exposure prophylaxis, counselling, prevention)	29%
Condoms and lubricants	30%

Sexual and reproductive health and rights services	30%
Pre-Exposure Prophylaxis (PreP)	32%
Psycho-social support (ongoing support for psychological and social challenges)	35%
Primary health care and care for non-communicable diseases	37%
Social protection services and interventions (protection from economic and social risks, such as unemployment, exclusion, sickness, disability and old age)	37%
Mental health services	38%
Legal services	46%

Table D: Respondents indicating where they think **there is no challenge** for availability, accessibility or affordability of these services in their country.

Services	**% of respondents indicating no challenge**
Social protection services and interventions (protection from economic and social risks, such as unemployment, exclusion, sickness, disability and old age)	6%
Legal services	7%
Mental health services	8%
HIV services, in prisons and other closed settings	9%
Psycho-social support (ongoing support for psychological and social challenges)	9%
Gender-based violence services (Post-exposure prophylaxis, counselling, prevention)	9%
Comprehensive Sexuality Education	9%
Pre-Exposure Prophylaxis (PreP)	12%
Harm reduction services (including needle and syringe programme, opioid substitution therapy, methadone)	12%
Sexual and reproductive health and rights services	12%
Primary health care and care for non-communicable diseases	15%
Maternal and child health care	19%
HIV testing	21%
Antiretroviral drug treatment (ART)	21%
HIV counselling	22%
Condoms and lubricants	23%
Tuberculosis (prevention and treatment)	23%
Prevention of Mother to Child Transmission services	25%
Safe and voluntary medical male circumcision	28%

Annex 2: Reference to Strategy Result Area and Fast Track Commitments, Evidence Review, 20 July 2020

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