

**FOLLOW-UP TO THE THEMATIC
SEGMENT FROM THE 40TH
PROGRAMME COORDINATING
BOARD MEETING:**

**HIV PREVENTION 2020: A GLOBAL
PARTNERSHIP FOR DELIVERY**

Additional documents for this item: *Documents: UNAIDS/PCB (40)/17.13; UNAIDS/PCB (40)/17.14; UNAIDS/PCB (40)/CRP4*

Action required at this meeting: The Programme Coordinating Board is invited to:

See draft decisions in paragraphs below:

47. Welcome the background document (UNAIDS/PCB (40)/17.14) and take note of the summary report of the Programme Coordinating Board thematic segment on HIV prevention 2020: a global partnership for delivery;

48. Encourage Member States, stakeholders and partners to:

- a. take bold and decisive actions to scale up prevention programmes and meet the agreed targets and commitments in the 2016 Political Declaration on Ending AIDS, by implementing the HIV Prevention 2020 Road Map, as launched at the inaugural meeting of the Global HIV Prevention Coalition on 10–11 October, 2017;
- b. set national prevention programme, financing and impact targets for 2020, alongside already established 90–90–90 treatment targets, in line with the UNAIDS Strategy 2016–2021 and the Political Declaration on Ending AIDS, introduce the necessary enabling legal and policy changes, and rapidly scale up efforts to reach those targets.

49. Request the UNAIDS Joint Programme to:

- a. support Member States, donors, civil society, networks of key populations and implementers of the Global HIV Prevention Coalition in order to strengthen and sustain the global prevention agenda, and make primary prevention a priority for the Joint Programme;
- b. accelerate efforts to develop strong synergies and linkages with existing sexual and reproductive health, as well as harm reduction initiatives, and with other efforts to achieve relevant Sustainable Development Goals;
- c. establish an accountability mechanism using a “dashboard” and country score cards that take stock of progress against national prevention targets, building on the existing 2017 Global AIDS Monitoring process;
- d. provide countries with technical support for HIV prevention and strengthen overall prevention programme monitoring, management and programme delivery for the five pillars, including the behavioural and structural components of those programmes;
- e. Report back to the PCB annually on progress made with the implementation of the HIV Prevention 2020 Roadmap.

50. Request Members States and key donors to invest adequately in HIV prevention as part of a fully-funded global response and to take concrete steps to ensure that, on average, one quarter of HIV spending is invested in prevention programmes (the target agreed to in the 2016 Political Declaration on Ending AIDS) to assure adequate coverage of interventions to reach the stipulated targets.

SHAPING THE DEBATE

1. The thematic segment focused on increasing the impact of HIV prevention. Presentations and discussions included updates on and analysis of the current status of primary HIV prevention, the effectiveness of different interventions, and gaps in programmes and financing. The emphasis was on identifying ways to achieve rapid, successful scale up of HIV prevention programmes.
2. Introducing the segment, Mr Michel Sidibé, UNAIDS Executive Director, said that the false dichotomy between prevention and treatment had to end, and prevention had to be brought back to the centre of the AIDS response. Too many new infections are occurring, and too many young people lack the knowledge and means to protect themselves against HIV.
3. Dr Natalia Kanem, UNFPA Acting Executive Director, called for a human rights-based approach that ensures quality services that reach everyone in need. Stressing that everyone has the right to the highest attainable health care, she noted that adolescent girls remain at enormous risk of HIV infection, as do key populations. Sexuality education and implementation of evidence-based programmes are essential to reduce HIV incidence.
4. Dr Kanem told the meeting that prevention programmes should use scientific evidence to tackle harmful norms, misgivings and unorthodox understandings of HIV. Successful prevention hinges on young people being able to freely access the services and knowledge they need to manage their sexual and reproductive lives responsibly. Investment in adolescent sexual and reproductive health lies at the heart of successful HIV prevention. However, a renewed pushback against human rights and a reluctance to deal with sex and sexual identity is increasingly evident. She reiterated that condoms provide triple protection: against HIV, other sexually transmitted infections and unintended pregnancies. Modeling showed that if the demand for male condoms were met in 81 high-burden countries, the world could avert 700 million sexually transmitted infections and 17 million HIV infections by 2030.
5. Ms Kyendikuwa Allen Namayanja, Programme Manager of the Uganda Youth Coalition on Adolescent SRHR and HIV, reminded the meeting that women and girls in countries such as Uganda bear a disproportionate burden of HIV, in large part because they are denied the ability to control their bodies and sexual lives. She urged the expansion of access to pre-exposure prophylaxis and female-controlled prevention technologies. Successful HIV programmes need to treat women as active agents, not passive beneficiaries, and should reflect the fact that HIV is one of several pressing challenges that women and girls experience. Policies also need to reflect the different challenges women and girls face at different stages of their lives.
6. The next session focused on the current epidemiology of HIV, evidence of successful interventions, and guidance on how to accelerate combination prevention. Discussants highlighted trends in new adult infections and examined the major gaps in programming and financing. They also focused on ways to address structural barriers that hinder effective combination prevention, and to link prevention interventions with efforts to achieve the Sustainable Development Goals (SDGs) and Universal Health Coverage.

7. Dr Mariângela Simão, Director of UNAIDS' Rights, Gender, Prevention and Community Mobilization Department, told the Board that the decline in new HIV infections has slowed considerably, with 2 million new infections occurring annually, 350 000 of them among young women and girls, mostly in sub-Saharan Africa. Almost 45% of new infections were among key populations, equivalent to almost 1 million people each year.
8. She reminded the meeting that the effective prevention interventions are well-known and include condom and behaviour change programmes, pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction programmes, antiretroviral therapy to reduce onward transmission, women's empowerment programmes such as cash transfers, education support for girls, and community empowerment for sex workers. However, major gaps limit the impact of those interventions. Condom procurement and distribution is inadequate, despite the evidence showing that condom use increases when condoms are available. Demand for voluntary medical male circumcision is also weakening in some countries, while harm reduction programmes are not available at the required scale.
9. The reasons why prevention programmes are not yet at scale vary, Dr Simão said. Political leadership and commitment wavers, there is a reluctance to address sensitive issues (such as sex between men, drug use, sex work or the sexual lives of adolescents and young people), and investment in prevention is inadequate. Weak capacity often hampers the management of prevention programmes and delivery of services.
10. However, she assured the meeting that each of those weaknesses can be overcome. Age of consent barriers for HIV testing and services can be removed, harmful gender norms can be challenged, punitive laws that block prevention efforts can be reformed or repealed, stigma and discrimination can be reduced, harm reduction policies can be developed and implemented. Dr Simão said there is ample proof that effective programmes can be scaled up (as shown in southern India) and condom distribution can be increased massively (as seen in South Africa's KwaZulu-Natal province) if attractive products are developed and sound technical support is available.
11. Access to HIV prevention needs to be positioned as a right, in the same way that people have a right to HIV treatment. Other SDGs can be leveraged to take the prevention agenda forward, and prevention can be advanced as part of the push towards Universal Health Coverage. A global prevention coalition can drive this agenda forward.
12. Dr David Wilson, Director of the Global HIV/AIDS Program at the World Bank, reiterated that effective tools exist, and called on the Joint Programme to focus on improving four aspects of prevention. The first involves acting on the evidence. Noting that human rights-based interventions work the best, Dr Wilson shared study findings showing the protective effect of structural interventions, such as enabling young people (especially girls) to extend their education. Evidence from Botswana showed that each additional year of school for girls reduces HIV incidence by 7%. Social protection and cash transfers also work, as shown by controlled trials and other evidence, and an increasing number of African countries are expanding their cash transfer systems. It is vital, though, to coordinate such interventions across sectors.

13. The second priority is to increase investment in prevention. Dr Wilson cited modelling which showed that if Swaziland increased spending on voluntary medical male circumcision from 1% to 8% of total prevention spending (while sustaining other interventions), it could reduce new HIV infections by 30% by 2018. Reallocation of investment also works, as seen in Sudan where modeling showed that even partial reallocation of HIV funding averted 33% of new HIV infections and 22% of AIDS-related deaths between 2015 and 2017.
14. The third priority is implementation. In Malawi, the use of vouchers increased uptake of voluntary medical male circumcision, for example. Dr Wilson added that improved use of routine programme data (which typically are underused) can also reveal achievements and gaps more clearly. South Africa has done so using viral suppression data to analyse performance and identify improvements. The exercise revealed good overall programme performance, but wide variation depending on place, age and sex. It also showed the key predictors of high performance at each of the stages of the testing and treatment cascade. By focusing on a few key interventions along the cascade, results can be improved by 10% over 3 years substantially without additional investments.
15. A fourth priority is to achieve greater sustainability. Dr Wilson told the Board that about 1% of global health financing is derived from international sources, while 80% of HIV financing is externally sourced. In addition, many crucial services (e.g. for key populations) are heavily dependent on international donor funding, which is unsustainable. However, major constraints also limit increases in domestic spending. Most low-income countries have weak tax collection systems and few of the countries with the biggest HIV epidemics can anticipate strong GDP per capita growth in the foreseeable future. In some regions, the political challenges outweigh the financial ones. Ways forward include optimizing allocations and improving technical efficiency, and integrating HIV into Universal Health Coverage schemes.
16. In his remarks, Mr Sidibé highlighted four key areas for improvement. Firstly, sufficient investment that enables communities to participate in the design, implementation and monitoring of interventions. Secondly, HIV prevention programmes must address gender inequalities. Thirdly, harmful norms and laws must be changed, and reduce stigma and discrimination (including in health services) must be reduced. Fourthly, existing resources need to be reallocated to achieve a more balanced AIDS response.
17. In discussion, Board members emphasized the need to solve financing and sustainability challenges. They urged countries to show stronger leadership by confronting the difficult issues involved in HIV prevention, including the need for comprehensive sexuality education. They also stressed the importance of human rights-based approaches that realize people's right to prevention, protect women's right to control their bodies, promote gender equality, and tackle harmful norms, policies and laws (including age of consent laws).

WHAT IS REQUIRED TO SCALE UP HIV PREVENTION?

18. In this session, panelists focused on the reasons for the insufficient scale up of effective prevention programmes and discussed the main requirements for rapid expansion of combination prevention programmes. Those included political commitment and investment in prevention; willingness to address sensitive societal issues and legal and policy barriers; strengthened implementation and managerial capacities; and strengthened national prevention frameworks and national prevention targets.
19. H.E. Dr Lambert Grijns, Ambassador for Sexual and Reproductive Health and Rights & HIV/AIDS, Netherlands, told the meeting that the Netherlands has among the lowest teen pregnancy rates (4 per 1,000, compared with about 26 per 1,000 in the United States) and abortion rates in the world, and that the average age at first sex has risen from 17 to 18.6 years. This was achieved with comprehensive and quality sexuality education in schools, progressive abortion laws, and openness to discussing and dealing with sex and sexuality in the public domain. Other contributing factors include increasingly liberal parental attitudes, trusting relationships between parents and children, and a retreat from conservative values generally.
20. Dr Grijns suggested that the lesson for the AIDS response was that prevention interventions work best when norms and values are openly debated, and when supportive social norms and relations exist. An active civil society is vital to catalyze and steer those debates. He called on politicians to show courage by acting on the evidence, even if it means challenging prevailing sensibilities. Political will is crucial for success.
21. In her presentation, Dr Monica Alonso, Regional Advisor on HIV Strategic Information at the Pan American Health Organization, said that 80% of countries in the Americas have developed and incorporated prevention targets in their national HIV programmes, with a special focus on key populations. Brazil was setting up a nationwide pre-exposure prophylaxis programme for designated key populations, and eight other countries were introducing pre-exposure prophylaxis pilot projects. Almost 90% of countries also reported stepping up anti-stigma efforts. Dr Alonso emphasized the importance of partnerships between governments and civil society, and of providing funding and other forms of support to communities.
22. H.E. Dr David Parirenyatwa, Minister of Health and Child Care, Zimbabwe, introduced his presentation by reminding the meeting that leaders in all walks of life have to provide the leadership that enables HIV prevention to succeed. They have to confront the facts of the epidemic and act accordingly: if HIV transmission is occurring during sex work or in prisons and an effective intervention such as pre-exposure prophylaxis exists, then it should be provided. Dr Parirenyatwa reiterated the concerns about prevention funding. Zimbabwe's AIDS levy was working well, but other health challenges have led to a decision to share the revenue with cancer programmes. Nevertheless, about 21% of the funds raised through the levy are allocated to HIV prevention programmes.
23. Dr Marijke Wijnroks, Interim Executive Director of the Global Fund, said that the targeting of prevention efforts was improving in the funding proposals received by the Global Fund. She explained that the Global Fund focuses its support where it has a comparative advantage; it focuses on supporting prevention programmes in cases where countries' treatment programmes are already covered, for example.

The Global Fund is setting aside funds to catalyze increased domestic funding and activities for key populations. Asked how the Global Fund encourages appropriate programmes in countries that criminalize key populations, Dr Wijnroks said that public health is often an effective entry point for public debate around such sensitive issues.

24. Ms Christine Stegling, Executive Director HIV/AIDS Alliance, shared examples of successful prevention programmes that were being designed and implemented with civil society organizations, including a programme focusing on transgender populations and men who have sex with men in India, which has reached over half a million people with information and services. However, many governments were not investing one quarter or more of HIV spending on prevention, and fully funded programmes led by key populations were still rare. As a result, fewer than 1 in 5 people at risk of HIV infection had access to effective prevention services. Ms Stegling also emphasized the importance of structural interventions, which should be at the centre of prevention strategies, with defined targets and accountability mechanisms.
25. In discussion, speakers stressed the importance of structural interventions, and called on countries to relax regulatory and legal requirements that impede nongovernmental organizations' ability to receive funding and operate. There was also strong support for the setting of prevention targets (based on accurate epidemiological information) and for tracking the impact of interventions. Speakers stressed that the criminalization of certain risk behaviours constitutes a major handicap for prevention programmes.
26. The Islamic Republic of Iran described how it has based its harm reduction programmes on a public health approach, and has scaled them up by focusing on defined locations and populations, and using clear targets and implementation plans.

REACHING MORE PEOPLE AT RISK WITH PROGRAMMES AND SERVICES

27. Panelists shared experiences and discussed the key elements of effective prevention programmes that reach people at risk on a large enough scale to reduce HIV incidence. Ms Manjula Ramaiah, manager of Ashodaya Samithi in Karnataka, India, described how this community-led nongovernmental organization supports some 6,000 sex workers with its mostly peer-based prevention and care services. The programme helped reduce HIV prevalence from 24% in 2004 to 5% in 2012. It has integrated cervical cancer screening with HIV and other health services, and is introducing community-led pre-exposure prophylaxis provision.
28. Dr Yogan Pillay, Deputy Director General of South Africa's national Health Department reminded the meeting that HIV was a development issue with strong links to the SDGs. He told the meeting that the South African Government has called for a "prevention revolution" and that this will require strong focus on structural interventions. The world needs to drive forward a prevention agenda that is rooted in the right to prevention if it is to end the AIDS epidemic, he said.
29. Dr Pillay described how South Africa has acted to reinvigorate its condom programme. When it became clear in 2012 that condom use was not increasing sufficiently, surveys among young people showed the condoms being distributed were widely shunned as "government issue" products. The survey information was used to rebrand the condoms and add new variants, including coloured and

flavoured male condoms. The overhaul has been highly successful, with 916 million condoms distributed in 2016.

30. Meanwhile, the findings of the CAPRISA study (which have highlighted the cycles of HIV transmission between different age groups of men and women) have led to renewed prevention activities aimed at 15–24 year-old girls and young women. The emphasis is on reducing unprotected sex, teen pregnancies, keeping girls in school, protecting them against violence and empowering them economically.
31. Dr Pillay said uptake of pre-exposure prophylaxis in South Africa was high among gay and other men who have sex with men, but less so among sex workers. Fourteen demonstration projects were underway among adolescent and young women. The intervention was being introduced strictly as part of combination prevention, he said.
32. Dr Dmitry Pinevich, First Deputy Minister of Health of the Republic of Belarus, said Belarus had overhauled its prevention strategy by first identifying the most economic and effective interventions and approaches. This led to a focus on harm reduction programmes, including increasing access to opioid substitution therapy, working closely with priority populations. A new strategy was developed and used to mobilize funding (including by reallocating funding).
33. Dr Robert Grant, Professor at the School of Medicine at the University of San Francisco in the United States, described the scale up of that city's pre-exposure prophylaxis programme. The programme, which has led to major reductions in new infections in the city, was driven by strong political support, which made fundraising easier. It was scaled up through strong collaboration between the city government and civil society, and as part of other HIV strategies (including testing). By bridging the HIV-positive / HIV-negative divide, the programme was also helping to decrease stigma. Similar scale-ups are underway in other US cities, in several states in Australia, and in Brazil, France and South Africa, among others. An important lesson was that pre-exposure prophylaxis is not for everyone, all the time.
34. Mr Jose Yac, political scientist and international relations specialist at the IDEI Association in Guatemala, discussed the challenge of reaching indigenous people with effective prevention services in a multicultural society. It is vital, he said, to communicate with people in familiar and acceptable terms, language and idioms. Since indigenous peoples may not trust mainstream health services, it can help to incorporate appropriate ancestral medicines and knowledge in HIV prevention information, advice and projects. In Guatemala, for example, projects incorporate Mayan cosmology in their HIV information and education campaigns. He noted that there has been a call on UNAIDS and other UN agencies to arrange an international consultation on HIV and indigenous populations by 2019.
35. Other presentations include a description of the multisectoral prevention strategy underway in Côte d'Ivoire, and a brief summary of PEPFAR's ambitious DREAMS partnership to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries.
36. In discussion, participants stressed that leadership was needed in all walks of life—religion, business, sports, entertainment, the media and more. It was suggested that the HIV treatment revolution has avoided confronting some of the contentious realities of the epidemic such as power imbalances, inequality, misogyny, homophobia and the facts of sexual desire. The prevention revolution could not sidestep those realities.

37. UNICEF noted that progress in preventing new infections among young people and adolescents has been much too slow. On current trends, given the demographic shifts that are underway, the number of new infections among 15–24 year-olds would increase by 2030. The “All In” initiative and the Start Free, Stay Free, AIDS Free framework were cited as good examples of the kinds of partnerships that are needed to reinvigorate HIV prevention, as was DREAMS and its focus on girls and young women, and various projects seeking to engage boys and young men and the continued attention to the elimination of mother-to-child transmission of HIV. Speakers drew attention to the Eastern and Southern Africa Ministerial Commitment to scale up comprehensive sexual education for young people.
38. UNICEF called on countries to ensure that funding matches prevention ambitions so that programmes can reach the necessary scale. There was a strong feeling that boutique projects are a thing of the past. Speakers noted that multisectoral alignment is key and that UN country teams have vital roles in guiding and stewarding such coordination. The importance of high-quality monitoring and evaluation was also highlighted, so that results can be assessed, compared and improved.
39. UNODC emphasized the need to remove legal and policy barriers that deprive people who inject drugs and people in prisons of prevention and other HIV services, and to promote their human rights. It pointed out that HIV incidence among people who inject drugs had risen by 33% in 2011–2015. Overall, an estimated 13% of people who inject drugs are living with HIV, mostly in south-west Asia and in eastern Europe.
40. UNDP emphasized the importance of structural interventions, citing evidence that the decriminalization of sex work is highly effective for reducing HIV incidence and improving the health of sex workers. A global coalition for prevention needs to position such structural interventions at the centre of a renewed push to reduce HIV infections; biomedical interventions alone will not bring the desired results. Other speakers emphasized the importance of placing human rights at the centre of HIV prevention programmes and supported calls for the removal of legal barriers, including the decriminalization of risk behaviours.

TOWARDS A GLOBAL PREVENTION COALITION

41. The final session discussed the next steps for a global partnership to reinvigorate primary HIV prevention, including key issues to be addressed at the inaugural meeting of the Global Prevention Coalition in October 2017.
42. Dr Geoff Garnett, Deputy Director in HIV at the Bill and Melinda Gates Foundation, noted that biomedical interventions work best alongside appropriate structural and behavioural interventions. Also emphasized was the need for clear, measurable prevention targets at national level. Dr Laurel Sprague, Executive Director of the Global Network of People living with HIV (GNP+), added that the right to prevention should be a central component of the right to health. Funding has to reach communities.
43. Dr Nduku Kilonzo, Director of Kenya’s National Aids Control Council of Republic of Kenya, told the meeting that the Global Prevention Coalition requires a roadmap

that addresses the need for strong political leadership and prevention champions; adequate financing; clarity around what it means to take prevention to scale; well-defined prevention packages, each with clear targets and routinized data; rights-based and people-centred approaches; and technical assistance.

44. In discussion, members expressed their support for the Global Prevention Coalition. They stressed that human rights, equality for women, an end to violence against women, and the elimination of stigma and discrimination are essential for HIV prevention, and that sexual and reproductive health rights are crucially important for everybody, irrespective of gender identity or sexual orientation. Speakers noted that faith-based entities are major health providers in some regions and need to buy into a new prevention strategy.
45. Dr Luiz Loures, UNAIDS Deputy Executive Director, closed the thematic segment by noting that HIV prevention centres on matters of justice and laws and therefore poses social and political challenges. The treatment revolution was fueled by the insistence that everyone has the right to life and good health; the same should apply to prevention, he said. However, scaling up prevention efforts has to proceed in a more difficult context that is marked by increasing conservatism and the denial of rights.
46. In closing, Dr Loures identified five elements that would propel a prevention revolution:
- committed leadership at all levels and across civil society, with civil society at the centre of prevention strategies;
 - accurate and attractive communication and information that taps into new media and communication technologies;
 - adequate resources, which may need new financing approaches and options;
 - coordinated actions from the Joint Programme that add substantial value; and
 - immediate action in urgent situations.

PROPOSED DECISION POINTS

The Programme Coordinating Board is invited to:

47. Welcome the background document (UNAIDS/PCB (40)/17.14) and take note of the summary report of the Programme Coordinating Board thematic segment on HIV prevention 2020: a global partnership for delivery;
48. Encourage Member States, stakeholders and partners to:
- a. take bold and decisive actions to scale up prevention programmes and meet the agreed targets and commitments in the 2016 Political Declaration on Ending AIDS by implementing the HIV Prevention 2020 Road Map as launched at the Inaugural meeting of the Global HIV Prevention Coalition on 10–11 October, 2017;
 - b. set national prevention programme, financing and impact targets for 2020, alongside already established 90–90–90 treatment targets, in line with the UNAIDS Strategy 2016–2021 and the Political Declaration on Ending AIDS, introduce the necessary enabling legal and policy changes, and rapidly scale up efforts to reach those targets;

49. Request the UNAIDS Joint Programme to:

- a. Support Member States, donors, civil society, networks of key populations and implementers of the Global HIV Prevention Coalition, launched since the 40th PCB meeting, in order to strengthen and sustain the global prevention agenda, and make primary prevention a priority for the Joint Programme;
- b. Accelerate efforts to develop strong synergies and linkages with existing sexual and reproductive health, as well as harm reduction initiatives, and with other efforts to achieve relevant SDGs;
- c. Establish an accountability mechanism using a “dashboard” and country score cards that take stock of progress against national prevention targets, building on the existing 2017 Global AIDS Monitoring process;
- d. Provide countries with technical support for HIV prevention and strengthen overall prevention programme monitoring, management and programme delivery for the five pillars, including the behavioural and structural components of those programmes;
- e. Report back to the PCB annually on progress made with the implementation of the HIV Prevention 2020 Roadmap.

50. Request Members States and key donors to invest adequately in HIV prevention as part of a fully-funded global response and to take concrete steps to ensure that, on average, one quarter of HIV spending is invested in prevention programmes (the target agreed to in the 2016 Political Declaration on Ending AIDS), to assure adequate coverage of interventions to reach the stipulated targets.

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