Agenda item 6

UNAIDS/PCB (43)/18.26

ANNUAL PROGRESS REPORT ON HIV PREVENTION 2020

UNAIDS

11-13 December 2018 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 15 November 2018

Additional documents for this item: none

Action required at this meeting—the Programme Coordinating Board is invited to:
See draft decision points in the paragraphs below:

74. *Recalling* the decisions from the 41st PCB meeting on the Follow-up to the thematic segment on HIV prevention 2020: a global partnership for delivery:

75. *Take note* of the 2018 progress report on HIV prevention 2020;

76. *Request* Member States, in collaboration with community-based organizations, civil society and partners to continue accelerating a scaled-up prevention response in line with the commitments in the 2016 Political Declaration on ending AIDS and the HIV Prevention 2020 Road Map;

77. *Stress* the importance for Member States and key donors to continue to invest adequately in HIV prevention, with no less than one quarter of HIV spending to be invested in prevention programmes;

78. *Request* the Joint Programme to support countries in developing and implementing robust prevention plans that include sustainable capacity development and resource mobilization strategies and report back in 2019 to the Programme Coordinating Board on progress made on prevention.

Cost implications for the implementation of the decisions: none

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1. INTRODUCTION

1. This background note responds to the Programme Coordinating Board's (PCB) request to the Joint Programme at its 41st meeting to report back annually on progress made on HIV prevention *(1)*. The note builds on a number of previous PCB discussions on HIV prevention, which were comprehensively summarized in an earlier background note for the 40th meeting of the Board *(2)*. This note will not repeat the detailed analyses provided previously. Instead, it summarizes recent developments and the progress made in HIV prevention responses at country, regional and global levels with support from the Joint Programme and its partners.

2. The 2016 Political Declaration on Ending AIDS provides the overarching framework for taking forward HIV responses and monitoring progress (3). The Political Declaration set the ambitious impact target of reducing the annual number of new HIV infections globally to under 500 000 by 2020. This high-level impact target for HIV prevention was accompanied by global programmatic prevention targets. The Political Declaration set out to reach 90% of key populations and 90% of adolescent girls and young women (in settings with high HIV prevalence) with combination HIV prevention programmes; distribute 20 billion condoms per year; initiate 3 million people on pre-exposure prophylaxis (PrEP) by 2020; and, in areas with high HIV incidence, perform 25 million additional voluntary medical male circumcisions (VMMC) *(1)*.

3. At its 41st meeting, the PCB encouraged members, 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;
    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 2016 Political Declaration on Ending AIDS to create enabling legal, social and policy frameworks and rapidly scale up efforts to reach those targets" *(2)*.

4. Furthermore, the Board requested the Joint Programme to:

    a. "Support Member States, civil society and key populations in their efforts to strengthen and sustain, including through, as appropriate, the Global HIV Prevention Coalition, the global prevention agenda and make primary prevention a priority for the Joint Programme;
    b. Accelerate efforts to develop strong synergies between primary prevention and relevant initiatives to achieve the Sustainable Development Goals;
    c. 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 *(2)*.

5. Finally, the Board requested "Member 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, no less than one quarter of HIV spending is invested in prevention programmes, as agreed to in the 2016 Political Declaration on Ending AIDS, to ensure adequate coverage of interventions to reach the stipulated targets" *(2)*.

6. At its 41st meeting, the Board was also briefed on and took note of the HIV Prevention 2020 Road Map *(3)*, as launched at the inaugural meeting of the Global HIV Prevention

Coalition on 10–11 October 2017. The HIV Prevention 2020 Road Map has set out 10 core actions towards strengthening HIV prevention responses. Since the launch of the Coalition, participating countries, with the support of the Joint Programme, have engaged in a wide range of activities towards implementation of the Road Map. Many of these were described in the Coalition's first progress report, published in May 2018 (5) and summarized in this note.

2. TRENDS IN NEW HIV INFECTIONS

Variation between countries, some successes but overall slow progress towards target of 75% reduction in new infections

7. The 2018 UNAIDS estimates confirm the findings of previous reports, which showed that new HIV infections are declining, but not fast enough to achieve the 2020 target of fewer than 500 000 new HIV infections annually. The number of adult HIV infections declined from an estimated 1.9 million in 2010 to 1.6 million in 2017, a reduction of about 16% *(4)*.

8. The biggest reductions in new HIV infections occurred in eastern and southern Africa (30% decline) and the Caribbean (18% decline). In Asia and the Pacific (14% decline), western and central Africa (8% decline) and western and central Europe and North America (8% decline), there were minor reductions. The trend was stagnant in Latin America (1% decline). In the Middle East and North Africa and in eastern Europe and central Asia, the annual number of new HIV infections has doubled in less than 20 years *(5)*. Overall, progress was more pronounced in high-prevalence countries than in countries with epidemics concentrated among key populations.

9. Progress also varies considerably between countries, including in countries with similar epidemics. Only three countries have reduced the annual number of new HIV infections among adults by at least 50% since 2010, although another 17 countries have achieved reductions of at least 25%. But many have not made significant progress and at least 50 countries have experienced increases in new HIV infections since 2010 *(5)*.

10. In the African countries participating in the Global HIV Prevention Coalition, the changes in new HIV infections since 2010 ranged between a 49% decrease and 41% increase, depending on the country *(4)*. In the other countries participating in the Coalition, the trend in that same period ranged from a 29% decline to a 46% increase in new HIV infections, highlighting the need for more urgent action.

Trends in new infections in key populations remain a concern

11. The slow progress seen in regions with concentrated HIV epidemics implies that an increasing proportion of new HIV infections globally will be among key populations and their sexual partners. Available data suggest that 47% of new HIV infections globally in 2017 were among key populations and their sexual partners. In regions outside sub-Saharan Africa, between 75% and 95% of new infections were estimated to have occurred among key populations and their partners *(5)*.

12. Among female sex workers, HIV prevalence remains particularly high in sub-Saharan Africa *(5)*. The estimated number of new HIV infections among people who inject drugs remains high overall despite progress in some countries, while the estimated number of new HIV infections among gay men and other men who have sex with men continues to increase *(6, 7)*. There are limited data available on HIV prevalence in transgender populations and among people in prisons and other closed settings. However, HIV prevalence in these populations continues to be significantly higher than in the general

population in most countries. Yet, coverage of prevention services for those populations remains highly inadequate. Major recent increases in new HIV infections among key populations were recorded in a number of countries, including Pakistan and the Philippines *(8)*.

3. UPDATE ON WHAT WORKS IN HIV PREVENTION

There is a robust evidence base for effective prevention methods across the five "prevention pillars"

13. The prevention programme components reflected in the five priority pillars[1] have all been shown to be effective, as previously stated in the background note for the 40th PCB meeting. There is strong evidence that male and female condoms are effective for preventing HIV, other sexually transmitted infections and unintended pregnancies *(2)*. A recent systematic review, published in 2018, found that HIV incidence was 91% lower among gay men and other men who have sex with men who used condoms consistently *(9)*.

14. VMMC was shown to reduce female-to-male HIV transmission of HIV by 38–66% *(10)*, potentially averting 3.4 million new infections by 2025 *(11)* and providing indirect benefits for women. Evidence from trials shows that PrEP, when adhered to, is highly effective for preventing HIV infections *(2)*.

15. Combination HIV prevention programmes for key populations (including behavioural, biomedical and structural components) have been effective in reducing HIV incidence when they have been implemented well. These include large-scale HIV prevention programmes for female sex workers, community-based programmes among gay and other men who have sex with men, and scaled-up of needle-syringe programmes *(2)*. An earlier meta-analysis of nine studies showed that opioid substitution treatment decreased the risk of HIV infection by 54% *(12)*.

16. Combination HIV prevention programmes have also plausibly contributed to reducing HIV incidence in several countries with high HIV prevalence. New adult HIV infections in Kenya and Zimbabwe declined by 75% and 82% respectively by 2017 compared to their peak in the 1990s, with a 65% reduction achieved by 2003 *before* the roll-out of HIV treatment *(4)*. Trend data from the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) programme point to declining new HIV diagnoses among young women in programme locations *(13)*. However, further analysis is needed to determine the programme's contributions to those trends.

New trials on prevention effects of testing and treatment with mixed results

17. When adhered to, antiretroviral therapy (ART) can suppress the viral load in people living with HIV to undetectable levels *(14)*. Results from recent studies on the effect of treatment on prevention were shared at the International AIDS Conference in Amsterdam in July 2018. The Partners2 study reported that, in serodiscordant gay couples where the HIV-positive partner was virally suppressed, not a single HIV transmission had occurred even though they had had condomless intercourse. However, overall HIV incidence rates in the study population remained relatively high due to HIV transmission during condomless sex with other partners *(15)*. This highlights the ongoing importance of combining effective prevention methods.

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[1] The pillars are: combination prevention for adolescent girls and young women; combination prevention for key populations; comprehensive condom programmes; voluntary medical male circumcision and sexual and reproductive health services for men and boys; and rapid introduction of pre-exposure prophylaxis.

18. Initial findings from several combination HIV prevention trials, which focused on measuring population-level effects of testing and treatment approaches, were presented at the 2018 International AIDS Conference. These showed mixed results. In the Botswana Combination Prevention Project, a package of interventions that included expanded HIV testing, linkage to care, earlier treatment and VMMC, led to a 30% reduction in HIV incidence *(16)*. The SEARCH trial carried out in Kenya and Uganda evaluated an HIV test-and-treat approach with universal ART, using a multidisease community health care model in rural communities. The study found that the intervention reduced AIDS-related mortality. HIV incidence also declined, but the reductions were similar in both intervention and control communities *(17)*.

19. Overall, the studies suggest that while HIV treatment is highly beneficial for the individuals adhering to their treatment and their sexual partners, the effect on HIV transmission at population-level appears to be substantially lower even at relatively high levels of coverage. The lower effects at population-level may be due to a combination of factors including transmission from non-primary partners, limited adherence to ART, loss-to-follow up and treatment disruption, in-migration, onward transmission from recently infected individuals with high viral load and other factors. This points to continued need for primary prevention in the context of increasing treatment coverage.

Other trends affecting the HIV prevention response

20. Data from recent demographic and health surveys in sub-Saharan Africa suggest that reported multiple and non-regular sexual partnerships have increased in a number of countries in recent years, including in some countries where the reported prevalence of those behaviours had declined in the early 2000s. In specific populations and countries, increases in diagnoses of sexually transmitted infections (STIs) have been reported recently *(18)*. Increasing prevalence of STIs was also reported at baseline and follow-up among users of PrEP in high-income countries *(19, 20)*, while high STI rates at baseline have been reported in PrEP programmes for adolescent girls and young women in southern Africa *(21)*. These findings highlight the opportunities for using PrEP services to increase STI diagnosis and treatment in populations who are at high ongoing risk for HIV and STI infections.

21. Substantial changes are also taking place in the patterns and platforms for dating, which increasingly occurs online or via social media. This may affect partner numbers and sexual partnership patterns. Further analysis is required to understand to what extent these trends may or may not be contributing to the slow reductions in new HIV infections in many countries.

22. In light of the existing evidence and trends, the current primary combination HIV prevention package remains valid and relevant. It is therefore critical to accelerate progress by adopting and rolling out appropriate prevention packages for priority populations and locations, while also considering new virtual and online platforms for programmes.

4. GLOBAL HIV PREVENTION COALITION AND ROADMAP

Developments in the Global Coalition

23. The Executive Directors for UNFPA and UNAIDS launched the Global HIV Prevention Coalition in October 2017, with the involvement of Ministers of Health and other Government officials from 25 countries with high numbers of new HIV infections,

together with representatives from more than 20 international and national civil society organizations. The Coalition members endorsed a the global *HIV Prevention 2020 Roadmap* with 10 key actions (Figure 1) *(3)*.

Figure 1. Ten-point plan for accelerating HIV prevention at country level

24. The establishment of the Prevention Coalition was spurred by the need to accelerate prevention programmes and replicate prevention successes, address underlying barriers and build greater momentum at country, regional and global levels. Progress on the Coalition was reviewed at ministerial level in a side event of the World Health Assembly in May 2018, where the first progress report on the Global HIV Prevention Coalition was presented *(22)*. Following the event three additional countries joined the Global Coalition (Botswana, Iran (Islamic Republic of), Myanmar and Norway).

25. A consultation among national AIDS programme managers from 21 countries participating in the Prevention Coalition countries at the 2018 International AIDS Conference in Amsterdam agreed on a number of improvements needed at country level. They included strengthening institutional capacity for prevention, needs-oriented capacity development plans and further defining service packages for key populations, young women and their male partners.

26. A leadership session at the 2018 International AIDS Conference stressed the progress made since the Coalition launch and highlighted the need for increased investment in

prevention, particular key population and condom programmes, and scaling up services. A specific satellite session on condoms underscored the need to address gaps in distribution, demand generation and stewardship of condom programmes.

Country progress on Prevention Coalition priorities

27. Analyses informing the Coalition Road Map had identified four key factors that were holding back progress on primary prevention *(23)*:
    - a lack of political commitment;
    - insufficient investment in prevention;
    - policy and structural barriers, which reflect reluctance among decisionmakers to safeguard the health and other rights of girls and women and of members of marginalized populations; and
    - failure to systematically implement proven programmes at scale.

28. The Road Map adapted by the Prevention Coalition centres on ten core actions to address those factors *(3)*. The Road Map and the initial experience gained by countries participating in the Coalition has informed HIV prevention action in other countries and regions, creating momentum for intensifying HIV prevention beyond the initial 25 high-burden countries. For example, countries in Latin American and the Caribbean are planning, with support from UNAIDS and partners, the expansion of HIV prevention programmes for key populations, with an emphasis on the provision of PrEP. Similar efforts are under way in the Middle East and North Africa to Fast-Track combination prevention programmes.

Strengthened political leadership and commitment

29. Through the launch of the Coalition and subsequent country activities, substantial progress has been made in reinvigorating leadership and political commitment for HIV prevention. This is evident in the launching of national prevention Road Maps by senior political leaders, alignment of country plans with new global targets and the revitalization of national HIV prevention working groups. With support from the Joint Programme and its partners, all the initial 25 participating countries have developed and implemented 100-day Action Plans to reinvigorate their HIV prevention programmes. The majority of participating countries have assessed their HIV prevention activities and are aligning national targets to the global targets set out in the Political Declaration ending AIDS. Many participating countries have also revised elements of their HIV prevention strategies. However, progress has been slower in relation to the other three dimensions, namely funding, removing policy and structural barriers, and implementation at scale.

30. Civil society organizations report improved levels of participation in prevention programme planning in many countries, such as target setting or the development of intervention packages for key populations. However, there is a need to strengthen processes for ensuring meaningful civil society engagement in strategy development, programme implementation, budget planning and accountability systems. Wider communication of the Coalition’s work at country level and wider dissemination of programmatic and financial data would further enhance accountability. In that regard, civil society organizations have signalled their desire to be involved in monitoring Road Map activities, possibly via periodic reviews, policy evaluations or shadow reporting.

Some progress but miles to go in addressing policy and structural barriers

31. Most of the participating countries have identified specific policy and structural barriers that hinder effective prevention, and some of them have undertaken activities to address

those hurdles. Several countries, including Namibia, Uganda and Zimbabwe, decided to focus on barriers impeding young people's access to health services (e.g. by lowering the age of consent for accessing certain HIV services). Mozambique, Namibia and the United Republic of Tanzania are among the countries that have modified condom distribution strategies to improve young women's access to condoms.

32. Almost two thirds of the participating countries have prioritized action to address punitive laws and practices that hinder service access for key populations. Although legal and policy reforms take time, progress has been made already in India (where homosexual relations have been decriminalized) and Pakistan (where an HIV bill and a bill formally recognizing transgender identity are pending).

33. Several countries have taken other pragmatic steps to protect the rights of key populations. Actions include documenting rights violations, expanding access to justice, training law enforcement officials on key population rights, training health-care providers to reduce stigma and discrimination, community dialogues with leaders, as well as increasing access to HIV prevention services in prisons. Despite progress in specific areas, most barriers blocking key populations' access to HIV prevention services remain in place and it has not been possible to expand dedicated key population programmes in some countries.

Gaps in systematic implementation at scale are large, but not insurmountable

34. The programmatic targets set in the Political Declaration on Ending AIDS and pursued by the Prevention Coalition have highlighted the large coverage gaps in providing prevention services to key populations, adolescent girls, young women and their male partners in communities with high-incidence.

35. National targets that were updated after the Prevention Coalition's launch highlighted coverage gaps but resulting efforts to scale up programmes have only started. The vast majority of countries participating in the Prevention Coalition report that defined service packages are in place for sex workers and for gay and other men who have sex with men. However, fewer than half of the participating countries report having defined service packages for people who inject drugs, prisoners or transgender persons. Countries also report implementing service packages for adolescent girls and young women and their male partners. In many cases, however, various projects are implementing different packages; truly scaled-up packages articulated in national strategies with specific targets and delivered through a defined set of platforms, are missing.

36. Progress in implementation is also tracked through the global HIV prevention dashboard and country scorecards *(24)*. These scorecards synthesize progress made at the level of programmatic coverage, outcomes and impact and allow for comparing progress across countries. They are supplemented in six countries by "shadow" scorecards which civil society organizations, supported by the International HIV/AIDS Alliance, have developed *(25)*. Together they highlight striking differences between countries with respect to service coverage levels.

37. Programme coverage among key populations ranges from less than 2% to more than 80% among female sex workers and from less than 2% to more than 70% among people who inject drugs in different countries *(24)*. Coverage of programmes among gay men and other men who have sex with men is generally lower and more difficult to compare due to different approaches to population size estimates. Depending on the country, between about 10% and 100% of sub-national areas with high HIV incidence have specific prevention programmes in place for adolescent girls, young women and their

male partners. Only a few small countries with high HIV prevalence have achieved high national coverage.

38. In countries in sub-Saharan Africa, the average number of condoms distributed annually[2] ranges from less than five to more than 45 *(24)*. Latest available data from sub-Saharan Africa shows that the vast majority of countries recorded increases in condom use in their most recent surveys. However, condom use levels among men vary considerably, with only Namibia and Zimbabwe having achieved 80% condom use with non-regular partners *(18, 26)*.

39. There has been encouraging progress overall in VMMC programmes, with nearly 18.6 million VMMCs performed in the 14 priority countries of eastern and southern Africa between 2008 and 2017, though some gaps remain *(26)*. Some of the countries made substantial contributions towards the 2020 Fast-Track target of achieving 25 million additional VMMCs. In 2017, overall progress against an annual target of 5 million VMMCs was 81% (4 million VMMCs), up from 57% in 2016. However, the range was wide, from 28% to more than 100% across the 14 countries *(24)*.

40. Progress has been strongest in eastern Africa, where male circumcision was already practised before the introduction of VMMC programmes. Progress remains slower in most southern African countries, although the pace did quicken in 2017 in South Africa and Zambia *(24)*. The challenge is to build on the momentum, broaden the impact of programmes beyond VMMC and develop sustainable services.

41. Variations in progress and insufficient coverage levels are particularly marked for condom and key population programmes, despite successful approaches having been documented for three decades. A great deal of progress has been made and condom use has increased substantially in most countries *(18)*. Similarly, HIV programmes for key populations are in place in more countries than ever before. However, these trends are uneven and setbacks are a real risk due to limited programme sustainability and strong reliance on external funding. For example, condom sales through social marketing decreased by 600 million condoms from more than 1.6 billion in 2012 to just over 1 billion in 2017 in sub-Saharan Africa due to decreasing funding and lack of a transition strategy, which results in reduced availability of condoms outside health facilities—a major problem for low-income groups, rural communities and young people *(27)*. It is therefore important to build sustainable national condom programmes and develop condom markets in all priority countries to ensure wide access to condoms through a range of distribution and sales points (including health facilities and non-health sector outlets). Along the same lines, governments, communities and funding partners need to collaborate to scale up sustainable programmes among key populations including sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people and prisoners.

42. Underlying reasons for the large variations in countries' prevention results include differences in how programmes are planned and managed, as well as the policy and structural barriers mentioned above. In many cases, national visions for scaling up programmes were lacking. Prevention approaches or packages were not implementable at scale and/or not sustainable, because they were designed for well-funded, local projects or research studies but were too costly to provide on a large scale. Some countries also focused unduly on discussing strategies, policies, paradigm shifts and pilot programmes for prevention, rather than concentrated on scaling up proven

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[2] Data on trends in condom use are gathered through population-based surveys, which are only published in the years after they were conducted. With a few exceptions, new survey data for 2017–2018 have not been published yet.

intervention packages. Other reasons for the uneven progress include gaps in HIV prevention financing and management capacity.

43. Success factors for scaling up programmes include strong political commitment, a clear vision and strategy for providing defined core packages where needed, a decentralized system for HIV prevention service delivery and community-based outreach, as well as continuous monitoring and quality assurance.

HIV prevention financing: the need for a turnaround

44. Progress relating to HIV prevention financing has also been limited, due largely to three interrelated challenges:
    - lack of realistic estimates of HIV prevention financing needs;
    - lack of focus in HIV prevention spending, which is often spread thin across various projects rather than dedicated to scaling up the most relevant priority pillars in the national programme; and
    - lack of adequate investment into HIV prevention.

45. Countries' abilities to assess their prevention funding gaps depend on the availability of programmatic baselines, targets and unit costs. As part of their national Road Map processes, more than 20 countries have set or updated programmatic targets, 12 countries are planning to undertake expenditure and gap analyses and 4 countries have already reported increasing HIV prevention allocations.

46. PEPFAR has continued to invest substantially in HIV prevention, while analyses suggest that allocations to primary prevention in Global Fund grants have declined over the past five years in both absolute and relative terms *(13)*. Making progress towards 2020 targets will require strategic allocation of prevention resources and at the same time increasing investment for HIV prevention from both Global Fund and domestic resources.

47. Community responses work with and complement public systems. They are key for combating stigma and discrimination and for raising awareness of HIV, human rights and gender equality, as well as for scaling up programmes for prevention. Civil society engagement needs to be fostered and properly resourced using various mechanisms, including social contracting, which means the allocation of resources from government to civil society organizations. Social contracting, if implemented in a spirit of partnership can have multiple benefits:
    - for priority populations, it increases community-based access to programmes;
    - for governments, it provides an opportunity to provide oversight; and
    - for civil society, it provides opportunities of developing a more sustainable funding base.

48. Some countries, including India and Mexico, established social contracting mechanisms early in the response. More recently, China and Nigeria have taken the same route, while Indonesia, Kenya, Malawi and Ukraine are among the countries preparing social contracting mechanisms. These efforts need to increase, particularly for countries that are transitioning from Global Fund support and where government funding remains inadequate for key population programming.

5. NATIONAL HIV PREVENTION CAPACITY AND TECHNICAL SUPPORT TO COUNTRIES

49. Country assessments and reports reveal major capacity gaps in relation to management and implementation of HIV prevention responses in several countries. Although there are significant differences in how countries manage their HIV programmes, the capacity gaps occur at the individual, organizational and system levels.

Developing individual, organizational and systems capacity for HIV prevention

Figure 1. Capacity needs for HIV prevention

50. UNAIDS has identified core sets of capacities that are required in the management of national HIV prevention responses (Figure 1). In most countries, several of the required capacities are already available to some extent. However, many experts are deployed in specific projects or in research and regional or global functions rather than in the management of national HIV prevention programmes.

51. In some contexts, it is also reported that staff tend to move from national programmes into projects, rather than the other way around. Strengthening individual capacities for HIV prevention requires a multi-layered approach. This includes transferring skilled staff into national programmes, retaining qualified staff, developing cutting edge HIV prevention programming skills and making better use of the skills that are present in partner agencies in countries—for both projects and national HIV prevention programmes.

52. In terms of *organizational capacity*, rapid assessments suggested that in many countries there are no dedicated positions to manage the national HIV prevention response overall. In addition, specific priority pillars or core capacities are not covered within the job descriptions for relevant positions. At subnational level, coordination functions are often performed by staff who are only working on HIV prevention part-time and who do not have specific terms of reference describing their actual roles in relation to HIV prevention. Strengthening organizational capacity in HIV prevention therefore requires a combination of actions: creating few specific positions and reviewing the terms of reference of existing positions that are relevant to the HIV prevention response to ensure that core management functions for HIV prevention overall and for the five priority pillars specifically (depending on the country) are performed at national and sub-national levels.

53. In terms of national *systems capacity*, there are specific gaps in relation to implementation frameworks and national standard operating procedures that are suitable for scaling up programmes. In many countries, standard operating procedures for programmes for key populations or young women in communities with high HIV

incidence are only in place in specific projects, but not in the national response. This creates unevenness in the quality of implementation and leads to difficulties in replicating successful approaches at scale.

54. Mechanisms to track and actively manage programme performances at subnational and national levels are often not in place. The involvement of civil society in implementation is often driven by local initiatives, specific projects or funding modalities, rather than by clear management mechanisms for involving CSOs at scale. Strengthening systems capacity for HIV prevention requires standard operating procedures for all implementing agencies and sectors, streamlined systems for engaging civil society implementers at scale and a simple management system for peer review of progress in the core prevention pillars at national and subnational levels.

Towards a capacity development approach for technical support

55. In response to country demand, the Joint Programme continues to provide extensive technical support to prevention overall and across the five prevention pillars. In relation to HIV prevention among adolescent girls and young women, the UNAIDS Secretariat and UNFPA convened global and regional consultations to refine guidance and take stock of country experiences. UNICEF and PEPFAR co-chair the Stay Free working group, which is focused on improving global coordination on programmatic coverage and knowledge, and producing guidance for implementation. UNESCO provided technical support for the roll-out of comprehensive sexuality education programmes, while UNICEF supported countries in relation to HIV programming for adolescents in the context of the All-In initiative.

56. Regarding HIV prevention among key populations, UNAIDS provided technical support to improve the use of strategic information for programming and addressing human rights-related barriers. WHO convened a think tank of experts, partners, donors, civil society and key population representatives to discuss revisiting the strategies for interventions among key populations for HIV to invigorate and refocus HIV prevention efforts in the Asia-Pacific region. This was followed by ongoing technical support across the region. UNFPA and UNICEF supported several programmes, including ones focused on young key populations, UNDP extended technical support for legal assessments, UNODC provided technical support to harm reduction programmes for people who inject drugs and WHO supported clinical aspects of key population programming.

57. In relation to condom programming, UNFPA and UNAIDS collaborated on strengthening needs estimates in countries and reinvigorating comprehensive, people-centred condom programming strategies and plans. WHO provided extensive technical support for the introduction of PrEP programmes in countries in all regions and technical support to countries in eastern and southern Africa to support safe and effective VMMC programmes.

58. HIV prevention capacity gaps also reflect the ways in which technical assistance for HIV prevention has been requested and provided. While a limited number of technical assistance requests for prevention activities were received through Technical Support Facilities, a broad range of technical needs were identified in the context of the first progress review of the Prevention Coalition. Technical needs vary greatly between countries and cover the full spectrum of programming—from population-location analysis, strategies and costed plans to implementation tools across the priority pillars. The progress review suggests that there is a gap in identifying technical and capacity needs and in formulating remedial action. Only a few countries have prepared consolidated capacity development and technical assistance plans for their HIV prevention responses.

59. The achievement of global HIV prevention targets will require a pragmatic but systematic approach for enhancing prevention-related capacity. At national level, rapid assessments of capacity and technical support needs will be required. They need to be translated into concise, focused and implementable capacity development plans. This approach will also require major shifts in the paradigm of technical support—from deployment of consultants for specific processes or products towards a mix of modalities for developing sustained national HIV prevention capacity. The new approach will seek to simultaneously build individual, organizational and systems capacity through South-South collaboration, mentoring, learning by doing and technical assistance with built-in capacity development components.

60. At the global level, the Joint Programme has started to stimulate these changes by developing a template for capacity assessment and planning for prevention and through interactive discussions with countries on technical support needs. In collaboration with the new Technical Support Mechanism more than 40 senior consultants have been trained in designing HIV prevention programmes in line with new global targets, the Prevention Roadmap commitments and latest guidance . Additional trainings are envisaged for UN and partner staff. With support from the Bill & Melinda Gates Foundation, catalytic funds have been made available to bolster national capacity temporarily. However, in the medium-term, countries will need to assign sufficient capacity for prevention. There are also plans to develop communities of practice around HIV prevention. This will engage experts for the five priority pillars by creating email groups and regular virtual meetings to share country experiences, good practices and peer learning.

6. ARE NEW OPPORTUNITIES FOR PRIMARY PREVENTION BEING TAKEN?

Sustainable Development Goals and Universal Health Coverage

61. There are a number of potential linkages between the Sustainable Development Goals (SDGs) and primary HIV prevention. The SDG on education is particularly relevant, since HIV is increasingly affecting less educated population groups in many countries *(28)*. At the same time, improved access to education for girls has been shown to reduce their HIV risk *(28)*. Although secondary school completion rates among girls have improved in many countries, there are additional opportunities for HIV prevention in schools. These opportunities include more active comprehensive sexuality and HIV prevention education, strengthened linkages between health services and schools regarding health promotion and referral for condoms, VMMC for adolescent boys and specific HIV prevention campaigns in schools in communities with high HIV incidence. Goals on gender equality address underlying gender norms, gender-based violence and harmful practices, which lead to increased HIV risk and vulnerability among adolescent girls and young women and impede access to prevention services for both women and men.

62. The SDG on health and the moves towards Universal Health Coverage (UHC) are both opportunities for increasing access to specific HIV prevention services. At a side event on HIV prevention at the 71st World Health Assembly in May 2018, WHO stated that in “leaving no one behind”, specific and special consideration will need to be given to key populations as groups who have greatest HIV risk and vulnerability. UHC cannot be achieved if key populations are not reached. WHO affirmed that HIV prevention services need to be adapted to ensure equitable access for those populations and locations that are most at risk and affected, including through community-based and community-led responses. Particular attention should go to quality-assurance and quality-improvement measures that can ensure that services achieve the greatest possible impact, meet ethical standards and are acceptable to the people who need the services.

63. Despite the existence of a portfolio of effective HIV prevention interventions and services, further innovation will be required to accelerate prevention efforts. The inclusion of HIV testing and treatment in UHC and health insurance schemes could free up resources in HIV programmes, which could then be refocused on primary prevention programmes (including community outreach, which is rarely funded through UHC schemes). Specific HIV prevention services could also be included in UHC and health insurance schemes. In Europe and in the United States, PrEP has been integrated into health insurance schemes. Given the lower cost of generic drugs now available for PrEP, similar moves could be considered also in middle-income countries. Since VMMC is cost-saving in many countries with a high prevalence of HIV infection, its inclusion in health insurance schemes should also be considered. More generally, there is a need to consider that user fees can be particularly problematic for preventive services, as user fees may lead to inequities, be a barrier to access and thereby negatively affect not only individual but also public health outcomes. User fees and out-of-pocket expenditure for HIV prevention should therefore be avoided, in particular for key populations and other priority populations including young people.

64. There are also specific opportunities and potential risks for HIV prevention in the context of UHC programming, particularly for key populations. UHC has a core tenet to "leave no one behind" and it is imperative that the needs of key populations are met through specific services, including the outreach services required for prevention. UHC strategies must ensure that people in greatest need of HIV prevention services do indeed receive them and that benefit packages explicitly include community-led services. The recent Global Conference on Primary Health Care and the resultant Declaration *(29)* emphasized the urgency of reaching beyond formal health services to serve the most marginalized communities in order to redress health inequities and disparities.

HIV prevention linkages and integration

65. A number of initiatives are aimed at strengthening linkages and integration between sexual and reproductive health and HIV prevention. The most significant progress has been made in integrating HIV testing into antenatal care for prevention of mother-to-child transmission. Progress in the integration of primary prevention into sexual and reproductive health programmes has been less successful. The SRHR and HIV Linkages Index suggests that while several countries have made progress in integrating sexual and reproductive health into their HIV strategies, HIV has only been integrated into sexual and reproductive health strategies in a limited number of countries *(30)*.

66. There are gaps in the promotion and availability of condoms in the context of provision of hormonal and other non-barrier methods of contraception in areas with high HIV prevalence. The Global Prevention Coalition will work with relevant partners (including WHO, UNFPA and the International Planned Parenthood Federation) to develop a position statement on sexual and reproductive health and on HIV prevention linkages and integration, which will include the need for specificity on HIV prevention in sexual and reproductive health programmes.

67. With support from Sweden, there are a number of regional initiatives underway to strengthen linkages between sexual and reproductive health rights and HIV. They include a joint initiative in eastern and southern Africa called "2gether 4 SRHR", which involves UNAIDS, UNFPA, UNICEF and WHO. Another initiative, spearheaded by UNESCO, is aimed at improving sexual and reproductive health, gender and education outcomes for adolescents and young people in sub-Saharan Africa region through the delivery of quality comprehensive sexuality education (31). UNFPA facilitates the development of international guidance on out-of-school comprehensive sexuality education for adolescents and young people who are living with HIV, living with

disabilities and/or belong to key populations or indigenous communities. With support from Norway, UNFPA plans to implement out-of-school comprehensive sexuality education programmes in five countries in 2019–2021. The Safeguard Young People Programme implemented by UNFPA with national and regional partners in eight southern African countries addresses adolescents and young people's sexual and reproductive health and rights needs with a focus youth-friendly services, comprehensive sexuality education and youth empowerment. Other activities to strengthen linkages are being explored, including through mapping out potential synergies of HIV prevention with Family Planning 2020, Every Women, Every Child and the Global Financing Facility.

68. The HIV in the Cities initiative, facilitated by UNAIDS and various partners, is another important platform for HIV prevention. In many countries, gay and other men who have sex with men, sex workers and people who inject drugs are more likely to live in urban areas. Recent phylogenetic data on HIV transmission from South Africa illustrated that many new HIV infection in rural areas are linked to travel to cities *(32)*. There are several examples of successful HIV prevention programmes in cities. In San Francisco, for example the roll-out of PrEP, was associated with a decline in previously stagnating HIV incidence *(33)*.

7. CONCLUSIONS AND RECOMMENDATIONS

69. There is renewed commitment to the global HIV prevention response. A growing number of countries and stakeholders are taking practical steps to reinvigorate their primary HIV prevention responses, including actions to address policy and rights-related barriers, which need to be intensified further. However, progress in providing effective prevention services for key populations at any scale remains far from sufficient and structural issues remain unaddressed, with punitive legal and discriminatory social environments presenting significant obstacles in many countries.

70. Countries are also putting in place targets and plans for systematic implementation, which will benefit from developing communities of practice in scaling up programmes in the five priority pillars. HIV prevention financing needs to be focused on the relevant priority pillars, and needs to be increased, in particular through sustained PEPFAR allocations and other bilateral support, strengthened Global Fund requests and increased domestic investments to close financial gaps for prevention.

71. In order to keep up the momentum, continued action on the decisions of the 41st PCB meeting will be critical. This includes the recommendation for the Joint Programme to continue supporting Member States in strengthening prevention programmes from planning to delivery and the recommendation to Member States and funding agencies to invest adequately in HIV prevention.

72. More than three decades into the AIDS response, there is still large variation and major gaps in the coverage of basic programmes, in particular programmes for key populations (globally) and condom programmes (in sub-Saharan Africa especially). If implemented well, these programmes are effective and scalable. There is an urgent need to scale them up, which would benefit both HIV prevention and sexual and reproductive health more broadly.

73. HIV prevention-related capacity requires strengthening individual, organizational and national systems capacities at both national and subnational levels. There is a need to shift from short-term technical assistance and project support towards developing capacities that build sustainable national HIV prevention programmes. This will require a range of measures that include skills-building, improving job descriptions, South-to-South learning, developing national standard operating procedures for programmes, and specific technical support.

8. PROPOSED DECISION POINTS

74. *Recalling* the decisions from the 41st PCB meeting on the Follow-up to the thematic segment on HIV prevention 2020: a global partnership for delivery;

75. *Take note* of the 2018 progress report on the Implementation of the HIV 2020 Prevention Road Map

76. *Request* Member States, in collaboration with community-based and civil society organizations and other partners to continue accelerating a scaled-up prevention response in line with the commitments in the 2016 Political Declaration on ending AIDS and the HIV Prevention 2020 Road Map;

77. *Stress* the importance for Member States and key donors to continue to invest adequately in HIV prevention, with no less than one quarter of HIV spending to be invested in prevention programmes;

78. *Request* the Joint Programme to support countries in developing and implementing robust prevention plans which include sustainable capacity development and resource mobilization strategies and report back in 2019 to the Programme Coordinating Board on progress made on prevention.

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