Agenda Item 3

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ANNUAL PROGRESS REPORT ON HIV PREVENTION 2020

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

See draft decision points in the paragraphs below

110. *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":

111. *Take note* of the 2019 progress report on HIV prevention 2020;

112. *Request* Member States, in collaboration with community-based organizations, civil society and partners, to accelerate 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, taking on board lessons learned through the work of the Coalition and its focus countries;

113. *Underline* the importance for Member States and donors to increase investments in HIV prevention, with no less than one quarter of HIV spending to be invested in prevention programmes, and *request* that Member States, with the support of the Joint Programme, move expeditiously to develop and submit funding proposals to the Global Fund that reflect the key elements described in this report, include a full expression of priority gaps for HIV prevention, optimize resource allocation and leave no-one behind in the national response; and

114. *Request* the Joint Programme to support countries in developing and implementing robust prevention plans that are comprehensive, equitable and people-centred and that address key persistent obstacles, including the need to overcome implementation barriers, further reduce stigma and discrimination, and strengthen community engagement in prevention service delivery, and to report back to the Programme Coordinating Board on progress made on HIV prevention in 2020.

Cost implications for the implementation of the decisions: none

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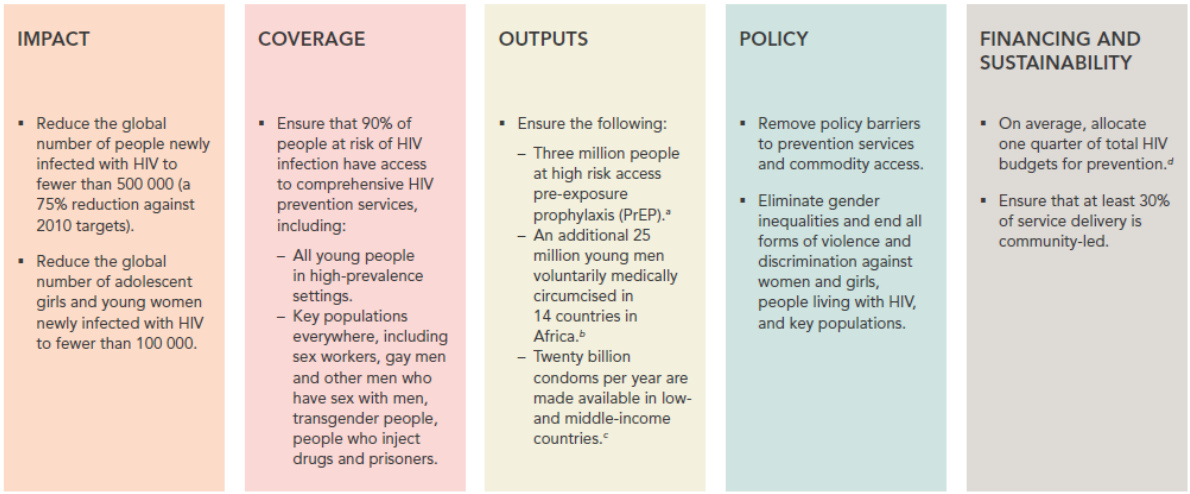
INTRODUCTION

1. In the 2016 Political Declaration on Ending AIDS (Political Declaration), countries committed to an unprecedented strengthening of HIV prevention efforts, towards the goal of reducing the annual number of new HIV infections globally to fewer than 500 000 by 2020, or by 75% compared to 2010. To achieve this target, countries committed in the Political Declaration 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).

2. The Political Declaration provides that no less than 25% of overall HIV spending should be directed towards primary HIV prevention.

Figure 1. 2020 HIV prevention targets and commitments in the 2016 Political Declaration on Ending AIDS



[a] Equals approximately 10% of people at high risk.
[b] This equates to 90% of voluntary circumcisions among those aged 10–29 years.
[c] Equals 25–50 condoms per male per year in high-prevalence countries.
[d] Depends on HIV prevalence and treatment costs.

Source: Global HIV Prevention Coalition. Implementation of the HIV Prevention 2020 Road Map. Second progress report, April–December 2018. Geneva: UNAIDS; 2019

3. The Global HIV Prevention Coalition reflects the international community's determination to fast-track national responses to achieve these ambitious global targets. Established in 2017, the Coalition seeks to galvanize a major acceleration of commitment, efforts and investments for HIV prevention. The Coalition's HIV Prevention 2020 Road Map outlined 10 key actions to strengthen prevention responses. Since the launch of the Coalition, a total of 28 countries have joined and committed to implement the Road Map, with the support of the Joint Programme and other partners.

Figure 2. Ten-point plan for accelerating HIV prevention at country level

4. The Programme Coordinating Board (PCB) has strongly and repeatedly endorsed a vigorous global effort to sharply reduce new HIV infections. The PCB has urged members, stakeholders and partners to "[t]ake bold and decisive actions to scale up prevention programmes and meet the agreed targets and commitments in the 2016 Political Declaration on Ending AIDS", and to establish concrete targets in line with the Political Declaration[1].

5. To help fast-track HIV prevention efforts, the PCB asked the Joint Programme to support Member States, civil society and key populations to strengthen and sustain prevention efforts, to accelerate efforts to synergize primary prevention with relevant initiatives to achieve the Sustainable Development Goals, and to provide technical support to countries along the five pillars of the Road Map, including the behavioural and structural components of these programmes[2]. The PCB also recommended that "Member States and key donors ... 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"[3].

6. This background note responds to the PCB's request to the Joint Programme at its 41st meeting for an annual report on progress made on HIV prevention[4]. It summarizes recent progress made in HIV prevention responses at country, regional and global levels with support from the Joint Programme and its partners. It builds on previous PCB

discussions and papers on HIV prevention, including the background notes for the Board's 40th, 41st and 43rd meetings.

7. As this background note shows, the Coalition has had a marked effect on the prevention agenda, elevating prevention as a priority in many countries. It is galvanizing greater commitment to invest in prevention programmes and supporting countries to align their national responses with the 10 key action items in the Road Map.

8. The current pace of progress in preventing new HIV infections is too slow to achieve the prevention targets set out in the 2016 Political Declaration. Whereas the Road Map called for radically accelerated action, the progress achieved to date has been comparatively modest and uneven, underscoring the need for redoubled action to strengthen prevention efforts.

9. This background note describes some of the lessons that have been learned as countries align their responses with the Road Map, focusing on successes in both Coalition and non-focus countries. This can inform how national responses can be rapidly accelerated and a markedly more effective prevention effort can be achieved.

10. Several countries have taken bold actions to extend the reach and increase the impact of prevention programmes, including by removing legal, policy and financial impediments to prevention service provision and use. Moving forward, a key priority is to replicate these successes in more countries and in all regions, and to reach the accelerated decline in new HIV infections envisaged in the Political Declaration. In this regard, the recent, successful replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) offers a critical opportunity for countries to obtain substantial new financing to strengthen primary prevention efforts.

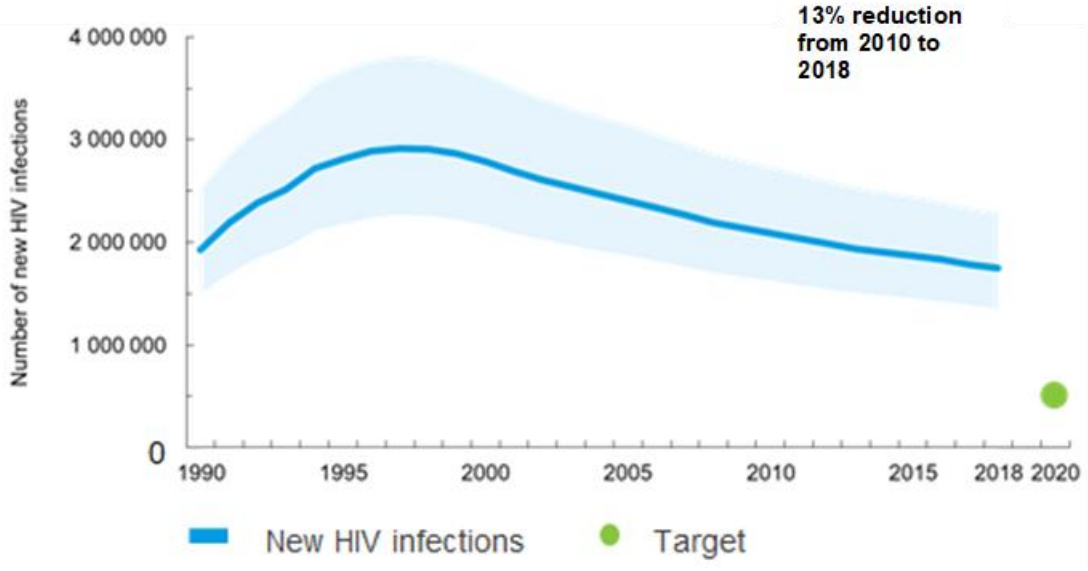
TRENDS IN NEW HIV INFECTIONS

Gains continue to be made in reducing new infections, but progress is uneven between countries

11. The world continues to make important gains in the HIV response. The remarkable progress in increasing access to testing and treatment is continuing. In 2018, almost 4 in 5 people living with HIV globally knew their serostatus and almost two thirds of all people living with HIV were receiving life-saving antiretroviral therapy, more than 3 times as many as in 2010[5]. The treatment scale-up has reduced the estimated number of in deaths due to AIDS-related illness from a peak of 1.7 million [1.3 million–2.4 million] in 2004 to 770 000 [570 000–1 100 000] in 2018[6].

12. In addition, a combination approach to HIV prevention—including behavioural, biomedical and structural approaches—has achieved notable reductions in HIV infections in a variety of settings[7]. Globally, the annual number of new infections continues to decline, from 2.1 million [1.6 million–2.7 million] in 2010 to 1.7 million [1.6 million–2.3 million] in 2018, a 16% reduction[8]. New HIV infections among adults (aged 15 years and older) declined by 13%, from 1.8 million in 2010 [1.4 million–2.4 million] to 1.6 million [1.2 million–2.1 million] in 2018.

Figure 3. Number of new adult HIV infections, global, 1990–2018



Source: UNAIDS 2019 estimates

13. A widening array of effective HIV prevention tools and methods (including the massive scale-up of antiretroviral therapy in recent years) is available and countries have shown that these tools can be used successfully. Yet progress in reducing new HIV infections among young people and adults has been slower than anticipated, even in countries and settings where the 90–90–90 treatment targets have been met or are within reach. The 13% reduction in new adult HIV infections globally from 2010 to 2018 (and the 15% reduction in Coalition countries) is much too slow to achieve the 2020 targets or the 2030 target of a 90% reduction in new infections[1]. Reaching the 2020 target required reducing the number of new infections by 60% in 2010–2018.

14. Eastern and southern Africa has made the strongest progress in reducing new HIV infections, reporting a 28% decline from 2010 to 2018. This compares with a 16% decline in the Caribbean, a 13% decline in western and central Africa, a 12% decline in western and central Europe and North America, and 9% decline in Asia and the Pacific. By contrast, the annual number of new HIV infections rose by 29% in eastern Europe and central Asia in that same period, by 10% in the Middle East and North Africa, and by 7% in Latin America. Outside of sub-Saharan Africa, a mix of gains and setbacks have yielded a flat 10-year trend in new HIV infections.

Table 1. Changes in the annual number of new adult HIV infections, by country, 2010–2018

New HIV infections decline category	Countries
Decrease of ≥50%	Singapore, Viet Nam, Comoros, Cambodia, Thailand, Nepal, Burundi, Rwanda, Portugal, Sri Lanka
Decrease of 25 – 50%	Kyrgyzstan, El Salvador, Mauritania, Norway, Burkina Faso, Lao People Democratic Republic, Libyan Arab Jamahiriya, Republic of Moldova, South Africa, Democratic Republic of the Congo, Central African Republic, Uganda, Spain, Lesotho, Namibia, Italy, Cameroon, Somalia, Myanmar, Eswatini, Senegal, Indonesia, Zimbabwe, Tajikistan, Japan, Gabon, Botswana, Bhutan, Côte d' Ivoire, Nicaragua, Eritrea, Morocco
Decrease of 5 – <25%	Denmark, Guinea-Bissau, Cuba, Togo, Colombia, Liberia, Bahamas, Kenya, Armenia, Cape Verde, Guyana, Guinea, Malawi, Ethiopia, United Republic of Tanzania, Sierra Leone, Mongolia, India, Iran (Islamic Republic of), Haiti, Ecuador, Ukraine, Estonia, Dominican Republic, Syrian Arab Republic, Germany, New Zealand, Georgia, Zambia, Paraguay, Hungary, Romania, Panama, Benin, Latvia, Mauritius, Congo, Suriname, Barbados
Decrease of ±5%	Barbados, Sudan, Peru, Chad, Ghana, Mozambique, Niger, Mexico, Argentina, Belarus, Malaysia
Increase of 5 – <25%	Israel, Belize, Angola, Nigeria, Australia, Ireland, Croatia, Uruguay, France, Luxembourg, Guatemala, Honduras, Finland, Slovenia, Serbia, Gambia, Kuwait, China, Tunisia, Iceland, Oman, Costa Rica, Brazil
Increase of 25 – <50%	Lebanon, Bolivia, Algeria, Kazakhstan, Uzbekistan, Chile, Equatorial Guinea, Yemen, South Sudan, Jordan, Djibouti, Russian Federation*
Increase of ≥50%	Bosnia and Herzegovina, Afghanistan, Pakistan, Papua New Guinea, Bangladesh, Mali, Bulgaria, North Macedonia, Slovakia, Czech Republic, Montenegro, Egypt, Philippines, Madagascar

Source: UNAIDS 2019 (in descending order of changes in the annual number of new adult HIV infections).
* Since 2016, the Ministry of Health of the Russian Federation has reported that newly diagnosed HIV infections in Russia have stabilized at approximately 86,000 new cases per year (ECDC/WHO Euro, 2019, 2018 data: ECDC 2019, https://www.ecdc.europa.eu/sites/default/files/documents/HIV-annual-surveillance-report-2019.pdf)

15. The fastest gains in HIV programming have been made in increasing access to HIV testing and treatment. Recent evidence from population-based trials, however, confirms that the *current* approaches to scaling up HIV testing and treatment alone are not sufficient to reach the HIV prevention targets. The reasons include the possibility of onward transmission before diagnosis, persistent service coverage gaps (especially among key populations and young adults at high risk of acquiring and transmitting HIV) and uneven outcomes in terms of viral load suppression[9 10 11]. To achieve the sharp reductions in new infections envisaged in the Political Declaration, the prevention benefits of antiretroviral therapy must be complemented by robust primary prevention efforts.

The epidemic is shifting, with key populations and their sexual partners accounting for a growing proportion of new HIV infections

16. Settings with a high prevalence of HIV infection in the general population have tended to experience greater progress in reducing new infections than settings where the epidemic's burden is heavily concentrated among key populations who are criminalized and marginalized[12]. Partially as a result, it is estimated that more than half (54%) of new HIV infections in 2018 globally were among key populations—including people who inject

drugs, gay men and other men who have sex with men, transgender people, sex workers and prisoners—and their sexual partners[13].

17. Gay men and other men who have sex with men accounted for an estimated 17% of new HIV infections globally in 2018, including more than half of new HIV infections in western and central Europe and North America, 40% in Latin America, 30% in Asia and the Pacific, 22% in the Caribbean, 22% in eastern Europe and central Asia, 18% in the Middle East and North Africa, and 17% in western and central Africa.

18. People who inject drugs accounted for an estimated 12% of new HIV infections worldwide, including 41% of new infections in eastern Europe and central Asia, 37% in the Middle East and North Africa, and 13% in Asia and the Pacific.

19. Sex workers accounted for about 6% of new HIV infections globally, with that share ranging from an estimated 14% in western and central Africa to less than 1% in western and central Europe and North America.

20. Transgender women made up a small proportion of new HIV infections globally but accounted for an estimated 5% of new infections in the Caribbean and 4% in Latin America and western and in central Europe and North America.

Adolescent girls and young women continue to face unacceptably high risks of HIV in high-burden countries

21. Globally, new HIV infections among adolescent girls and young women (aged 15–24 years) declined by 25% between 2010 and 2018, compared to a 10% reduction among women aged 25 years and older. This is likely due to a combination of factors including in some locations increasing coverage of multi-sectoral HIV interventions directed at young women and their male partners.

22. Nonetheless, adolescent girls and young women continue to face unacceptably high risks of HIV in some regions, as highlighted in the population-based Evidence for Contraceptive Options and HIV Outcomes (ECHO) study conducted in Eswatini, Kenya, South Africa and Zambia[14]. Among sexually active young women aged 16-35 years who participated in the study, HIV incidence averaged 3.8% a year.

PROGRESS AND LESSONS LEARNED FROM THE GLOBAL HIV PREVENTION COALITION AND OTHER COUNTRIES

23. Experiences in several countries in the Global Prevention Coalition show that it is possible to accelerate the decline in new HIV infections. The 28 countries in the Coalition accounted for 1.2 million new HIV infections among adults in 2018, which is 75% of all new HIV infections among adults globally. In the 28 Coalition countries new HIV infections among adults declined by 17% against 2010. Reductions in new HIV infections were greater in several countries with stronger HIV prevention and treatment programmes such as South Africa (39%), Uganda (36%) Lesotho (33%), Eswatini (30%) and Zimbabwe (28%). The Coalition in a broad sense (Member States, together with major funders such as the Global Fund and PEPFAR and technical agencies) is achieving progress based on an overarching fast-tracking of the HIV response.

Coalition countries have transformed how they frame, measure and organize their national prevention responses.

24. The third progress report of the Coalition, shared as a conference paper at this PCB meeting, describes in some detail the achievements and lessons to date in Coalition countries. Focus countries have now made good progress in relation to the majority of the Road Map's 10-point actions, with support from UNAIDS Secretariat, Cosponsors and civil society, development and funding partners.

25. All Coalition countries report that they have revitalized in-country HIV prevention and leadership structures, either by establishing a national prevention coalition or by designating or reaffirming existing structures to oversee the national prevention response. However, many countries struggle with limited capacity for coordination and for defining national prevention programmes that go beyond individual projects.

26. All the reporting Coalition countries have developed or are developing comprehensive national targets for the relevant prevention pillars defined in the Road Map.[*] Twenty-seven of the 28 Coalition countries[†] submitted detailed reports in August 2019, all of which indicated that they have now developed new strategic plans or Road Maps that address HIV prevention. Increasingly, Coalition countries are prioritizing the development of sub-national targets.

27. Countries are making progress in translating national commitments into costed national operational plans for addressing relevant national prevention pillars. Defined service packages are reported to be in place for the vast majority of Coalition countries, including packages for sex workers, gay men and other men who have sex with men, and adolescent girls and young women and their male partners. The development of service packages for prisoners, transgender persons or people who use drugs requires greater attention.

28. Many Coalition countries have made considerable advances in data systems and have improved the alignment of monitoring and reporting systems. Most reporting countries indicate that the Coalition has strengthened accountability at country level through the use and review of scorecards, which enable routine tracking of progress across high-priority prevention programme areas. Some countries (e.g. Uganda) have conducted joint annual reviews among stakeholders to take stock of HIV prevention progress. Regular reporting and the availability of new data have also facilitated the engagement of civil society, although this can improve further.

Countries are acting to remove legal and policy barriers to effective HIV prevention

29. Some countries have taken important steps to address legal and policy barriers that impede efforts to reduce new infections. In many cases, those actions were informed by detailed legal environment assessments supported through the United Nations Development Programme (UNDP)[15] and various partners.

30. A few countries report progress in addressing factors that increase the HIV vulnerability and risk of adolescent girls and young women. For example, in Eswatini a national

[*] The pillars are: combination prevention for adolescent girls, young women and their sexual partners in high-prevalence locations; combination prevention for all key populations; strengthened national condom and related behavioural change programmes; voluntary medical male circumcision; and PrEP.
† The 28 Coalition countries are: Angola, Botswana, Brazil, Cameroon, China, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Indonesia, Iran (Islamic Republic of), Kenya, Lesotho, Malawi, Mexico, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, South Africa, eSwatini, Uganda, Ukraine, United Republic of Tanzania, Zambia, Zimbabwe.

Sexual Offences and Domestic Violence Act was enacted in 2018 to enable the protection of adolescent girls and young women against abuse. In Lesotho, a Gender Policy was endorsed in 2019 to address gender-related barriers to access to services, while Namibia used the Child Care and Protection Act to lower the age of consent for use of health services from 16 to 14 years. The newly enacted AIDS law in the Philippines has lowered the age of consent for HIV testing from 18 years to 15 years old.‡

31. Several countries have taken encouraging steps towards the removal of laws that criminalize key populations and their behaviours:
    - in recent years, Argentina, Brazil, Chile, Pakistan and Uruguay have moved to recognize diverse gender identities and to offer legal protections to trans populations;
    - judicial verdicts in Botswana and India have led to the removal of decades-old laws criminalizing same-sex relations;
    - Myanmar is developing a new "Law on Sex Work"; and
    - several Latin American countries have relaxed criminal penalties for possession of illicit drugs, following the example of Portugal, which since 2001 has treated drug use as a public health issue rather than a matter of criminal law.

32. Seven opioid substitution therapy clinics have been set up in Kenya and the Southern African Development Community (SADC) has completed a key population strategy for the region.

33. Gains are being made in many countries against HIV-related stigma and discrimination, as called for by the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination[16]. In countries with multiple household surveys during 2000–2018, reported stigmatizing attitudes towards people living with HIV have declined in most countries, although the prevalence of HIV-related stigma remains far too high[17].

34. In 2018–2019, Colombia and the Veracruz State of Mexico invalidated laws that had criminalized HIV non-disclosure, exposure or transmission. In Eswatini, standard operating procedures for reducing stigma and discrimination in health-care facilities have been developed to promote key population-friendly services. In Botswana, legal action has been taken with the support of civil society to uphold the rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) persons and address the discrimination that they face when seeking health care.

35. Structural approaches are being used to tackle harmful gender norms, gender inequality and gender-based violence. Efforts to address these include the HeForShe community-based initiative in South Africa, which is supported by UN Women. This has resulted in positive changes in the behaviours and attitudes of men relative to HIV and violence prevention, including improved health-seeking behaviours and enhanced uptake of local HIV counselling and testing services[17].

Progress has been made in implementing key elements of combination HIV prevention

36. Several countries have successfully scaled up key elements of **combination HIV prevention for adolescent girls and young women** in line with the approach

‡ https://cnnphilippines.com/news/2018/12/28/minors-hiv-testing-parents-consent.html

recommended in the Road Map. Eswatini and Lesotho report high coverage of priority locations with dedicated programmes for adolescent girls and young women and their partners (100% and 71% respectively), including high levels of condom use among both young women and men in non-regular partnerships and increasing HIV treatment coverage in this age group. In South Africa, the nationally funded She Conquers campaign of the National Department of Health brings together different sectors to implement comprehensive HIV prevention interventions for adolescent girls and young women in districts with a high HIV burden. In all three countries, overall HIV incidence reduction accelerated in a context of scale up of these programmes and other HIV interventions.

37. HIV prevention among adolescent girls and young women was scaled up in thirteen countries in sub-Saharan Africa through the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) initiative supported by PEPFAR and similar programmes implemented with Global Fund support. In 2017, the majority (>60%) of DREAMS districts showed a decline in new HIV diagnoses among AGYW attending antenatal care clinics. In 2018, new diagnoses among adolescent girls and young women continued to decline in 85% of communities/districts implementing DREAMS. The programme continues to evolve through continuous evaluation.[18]

38. Several countries are showing strong commitment to respond effectively to HIV among **key populations**. Kenya is expanding national multi-site programmes for key populations—including sex workers, gay men and other men who have sex with men and people who inject drugs—even though the behaviours of these key populations remain criminalized. Côte d'Ivoire, South Africa and Zimbabwe are among other countries that have large-scale programmes for sex workers.

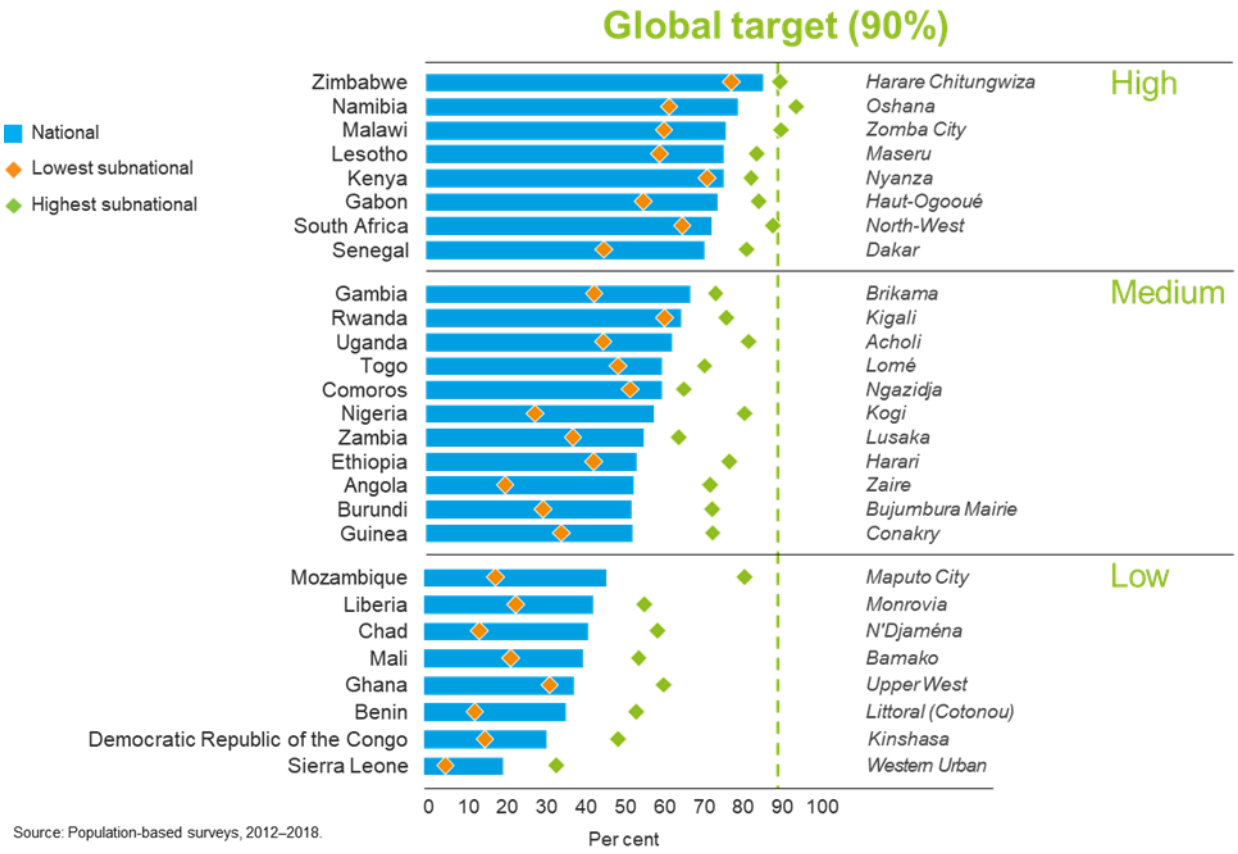
39. Austria, Luxembourg and Norway report achieving the recommended coverage levels for harm reduction services, while Brazil and Jamaica are expanding services for gay men and other men who have sex with men and transgender people. Indonesia has begun to expand HIV services in prisons.

40. A number of countries have started using digital communications tools such as social media to increase demand for HIV and other health services, and to link people to population-friendly services. For example, in the city of Jakarta, an online framework is being used to reach gay men and other men who have sex with men who socialize online, while social media communities are being forged in Jamaica to facilitate outreach to transgender people and other sexual minorities. These innovations are still at start-up phase and need to be refined and expanded.

41. Progress in **condom programming** remains uneven with positive examples and continued gaps. In 27 sub-Saharan African countries with recent data, median condom use by men at last sex was only 59%, although it was higher in specific urban districts in 11 of those countries (at least 80%). Among 29 countries with relevant data, condom use at last sex among sex workers exceeded 80% in 21 countries, although only 4 countries reported levels of *consistent* condom use of 80% or higher.

42. While there is evidence of progress towards increased condom use, the levels of use still fall short of global targets in all countries (in some by a substantial margin) (Figure 4). There is considerable variation between countries and major condom supply and demand gaps persist. Two decades of active condom distribution and promotion in Namibia and Zimbabwe has led to high levels of condom use at last sex with non-regular partners. However, those achievements are not commonplace elsewhere and condom use among younger populations is stagnating or decreasing in a few key countries, including Uganda and the United Republic of Tanzania.

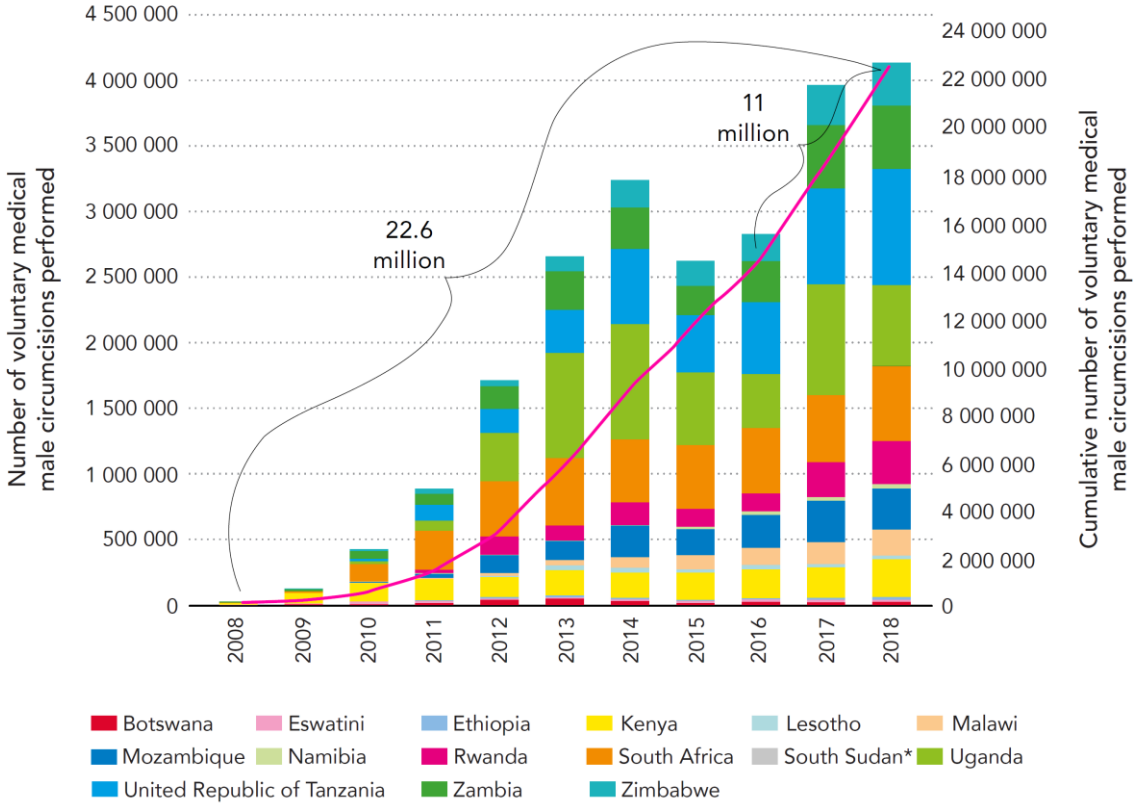
Figure 4. Percentage of people (15–49 years) who used a condom at last sex with a nonregular partner



Source: Communities at the centre: defending rights, breaking barriers, reaching people with HIV services. Global AIDS update 2019. Geneva: UNAIDS; 2019 (using data from population-based surveys).

43. Uptake of **voluntary medical male circumcision** increased in the 15 priority countries in eastern and southern Africa, but that momentum must be maintained in order to reach the target of 25 million by 2020 (Figure 5).

Figure 5. Numbers of voluntary medical male circumcision interventions performed in 15 priority countries, 2008–2018.



Source: Communities at the centre: defending rights, breaking barriers, reaching people with HIV services. Global AIDS update 2019. Geneva: UNAIDS; 2019. Based on Global AIDS Monitoring data.

44. The **PrEP** rollout is expanding, though it needs to accelerate markedly if the world is to achieve the target of 3 million PrEP recipients by 2020. Globally, about 300 000 people were receiving PrEP in 2018, with the United States of America accounting for the largest share of PrEP prescriptions (130 000 people receiving PrEP in 2019).

45. Countries are gradually adopting PrEP as an additional HIV prevention option for key populations and for young people in high-prevalence settings who are at high risk of HIV infection. Kenya was one of the first sub-Saharan African countries to roll out PrEP as a national programme in the public sector. More than 30 000 people were accessing PrEP there in mid-2019, making it Africa's largest PrEP programme.

46. In Asia, both Thailand and Viet Nam have moved beyond the pilot phase for PrEP programming to launch more extensive scale-up, with Thailand's Princess PrEP programme being led by key populations. In Viet Nam, PrEP is now available in seven provinces. There are plans to reach at expand provision to 11 provinces by 2020. A pilot programme has achieved high retention rates for people who initiate PrEP.

47. PrEP is also available in government clinics in Brazil, reaching an estimated 14 000 –15 000 people in 2019.[19] In North Africa, Morocco is expanding PrEP access. Based on experiences to date, setting PrEP targets and standardizing scale-up approaches are often key to expedited scale-up.

The Coalition has built political momentum at regional and global levels for HIV prevention

48. The Coalition's early experience implementing the Road Map has informed subsequent activities in other countries and regions and helped build momentum for HIV prevention action beyond the current 28 focus countries. Such increased effort is especially needed in countries with growing HIV epidemics among key populations, but which do not yet belong the Coalition, such as the Philippines and Madagascar. In 2019, the Coalition Secretariat reached out to UN Country Offices in those countries to initiate support for accelerating HIV prevention, testing and treatment using the Coalition model.

49. The Coalition is helping identify lessons and share best practices, for example at the meeting of Directors of the National AIDS Commissions of Coalition members in May 2019. Other opportunities are being used to take stock of progress and promote stepped-up HIV prevention efforts, including the International Conference on Population and Development (in November 2019) and a planned Ministerial meeting on HIV Prevention in 2020.

50. Regional and global entities, including intergovernmental organizations such as SADC, and development partners have also supported the prevention drive, through high-level advocacy and financial and technical support. Regional platforms are being used for evidence sharing, capacity building and South-South learning. Consultations on sustainable financing for prevention are planned to inform the development of a monitoring framework for SADC-specific commitments.

SUPPORT OF THE JOINT PROGRAMME

The Joint Programme is supporting the strengthening of HIV prevention activities in the 28 Coalition countries

51. The Joint Programme continues to enable a stronger and more effective focus on HIV prevention. UNAIDS and civil society, development and private sector partners supported countries in making progress against most of the Road Map’s 10-point action agenda.

52. The Coalition Secretariat, which is hosted by the UNAIDS Secretariat, has established a community of practice on condom programming and it plans to replicate this approach for the other four pillars of HIV prevention. Countries have increasingly requested support in the form of critical staff positions rather than consultants. The Coalition Secretariat has established a dedicated pool of catalytic funds for short- and medium-term staff positions to lead work on key elements of the prevention response.

53. Countries are also using the UNAIDS Technical Support Mechanism, which was established in May 2018 to facilitate high-quality technical assistance. Programmatic self-assessment tools for the five pillars of prevention are being developed and will be used to improve implementation of prevention interventions in the Coalition countries.

54. In line with the 10-point action plan of the Road Map, the Coalition’s Secretariat is supporting countries to strengthen their HIV prevention monitoring systems and enhance accountability. The UNAIDS Secretariat is supporting countries to develop or revise national targets, develop strategic and operational plans, address policy and programme barriers, and strengthen national prevention leadership.

Assistance from the Joint Programme helps countries address legal and policy barriers

55. The Joint Programme is supporting countries to remove impediments to effective HIV prevention for key populations. For example,
    - UNDP and the World Bank developed a proposed set of indicators for tracking LGBTI inclusion, including access to HIV and other health services,
    - the UNAIDS Secretariat, UNFPA and Sex Worker Networks in Myanmar is supporting the Myanmar Ministry of Social Welfare, Relief and Resettlement to develop a new law on sex work,
    - UNODC, backed by the advocacy work of the UNAIDS Secretariat, played an important role in the establishment of seven opioid substitution therapy clinics in Kenya,
    - a UNDP legal aid network in eastern Europe and central Asia supported more than 10 000 members of key populations in 2018, and
    - UNDP and UNFPA supported the completion of the SADC key population strategy.

56. The Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination (Global Partnership)[§] is co-convened by the head of GNP+ (on behalf of the NGO Delegation), UNAIDS, UNDP and UN Women. Its implementation phase began in November 2019 and will continue in 2020. Based on a joint assessment of their readiness, 30 countries[**] from all regions have been invited to join the Global Partnership as part of its first phase roll out. Key criteria for inclusion included implementation of matching-fund grants for human rights from the Global Fund and having UNAIDS Joint Plans that focus on addressing stigma and discrimination in the context of HIV.

57. In 2019, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) engaged with and supported the Global Partnership. The Global Fund's catalytic investments on human rights (matching fund grants) and the "Breaking down barriers to access" initiative for scaling up programs to remove human rights-related barriers to health services have led to unprecedented increases in funding allocations to human rights programming in 20 countries. The total funding has not been measured but it is estimated that US$123 million of Global Fund funding has been invested to remove human rights-related barriers in the current 2017-2019 allocation cycle. These programs are aligned with UNAIDS' key recommended programs for addressing stigma and discrimination.

58. The UNAIDS Secretariat and Cosponsors played a key role in supporting the Global Fund's in-country roll-out of the "Breaking down barriers to access" initiative—from grant application writing and baseline assessments of human rights-related barriers to national multi-stakeholder consultations for the elaboration of five-year country plans.

59. UN Women worked with partners in 10 countries to integrate gender-responsive components in national HIV strategies, including actions to address unequal gender norms, and to reduce violence and discrimination against young women. UN Women promoted young women's access to economic resources, including in Jamaica, where it mentored young women living with HIV in starting their own businesses.

[§] https://www.unaids.org/sites/default/files/media_asset/global-partnership-hiv-stigma-discrimination_en.pdf

[**] Indonesia, Vietnam, Laos, Thailand, Nepal, PNG, Kyrgyzstan, Tajikistan, Moldova, Ukraine, Kazakhstan, Lesotho, Kenya, South Africa, Uganda, Zimbabwe, Mozambique, Panama, Argentina, Brazil, Honduras, Jamaica, Islamic Republic of Iran, Tunisia, Côte d'Ivoire, Ghana, Senegal, Democratic Republic of Congo, Sierra Leone, Central African Republic.

The Joint Programme supports implementation of the five pillars of HIV prevention

60. The Joint Programme has continued to support countries in strengthening **programmes for adolescent girls and young women** through providing overall programming guidance and strengthening education sector, health sector and community-level programmes.

61. The Joint Programme (notably UNICEF, UNFPA and UNESCO) supported countries to implement comprehensive sexuality education. UNESCO supported the delivery of comprehensive sexuality education in 63 countries in 2018.

62. With support from UNICEF, UNFPA and UNESCO, Ghana and Uganda have made progress in: (a) adopting comprehensive sexuality education in schools as part of the curriculum; (b) addressing persistently low levels of HIV knowledge among adolescent girls and young women; and (c) increasing access to sexual and reproductive health services for adolescents and young people in schools or other nonformal settings. Similarly, the Bending the Curves programme in South Africa includes activities to help high school students make informed decisions about their sexual and reproductive health and to reduce new HIV and tuberculosis infections. Another example is the RAPARIGA BIZ Joint Programme in Mozambique, supported by UNICEF, UNFPA, UN Women and UNESCO. The programme aims to ensure that sexual and reproductive health and rights of girls and young women are fully realized by improving capacities to make informed choices and access to sexual and reproductive health services.[20]

63. The 2gether 4 SRHR programme (supported by UNAIDS, UNFPA, UNICEF and WHO) is linking efforts to strengthen sexual and reproductive health and rights and reduce the impact of HIV in eastern and southern Africa. This has resulted in the 10 participating countries developing or reviewing laws, policies, strategies and guidelines related to sexual and reproductive health and rights and HIV service provision and strengthening the capacity of health facilities to provide rights-based, responsive, fair and efficient quality services.

64. In support of **key populations programming** working across all regions and in a range of partnerships, Cosponsors and the Secretariat:
    - collected, analysed and shared data-driven evidence,
    - developed and supported the use of policy guidelines and implementation tools (including community-led evaluation frameworks), and
    - supported trainings for community-led networks, law enforcement agencies and the judiciary.

65. WHO commissioned a review of national HIV strategic plans in 47 countries to assess strengths and gaps in key population programmes. UNFPA worked with key population networks in 18 countries in Africa, Asia and eastern Europe to promote prevention programmes, including the provision of integrated HIV, sexual and reproductive health and rights and gender-based violence services for sex workers.

66. To harmonize technical assistance to countries, UNDP, UNFPA and UNICEF led the development of a programming toolkit on HIV prevention for young members of key populations. A UNAIDS report, Health, rights and drugs: harm reduction, decriminalization and zero discrimination for people who inject drugs, was published in March 2019. The report reviews in detail the availability, gaps, enablers and barriers to comprehensive harm reduction services. UNFPA and UNHCR are developing operational guidance on protecting people who sell sex in humanitarian settings.

67. Cosponsors are active in a range of multilateral initiatives to strengthen **condom procurement, promotion and distribution**—with a focus on reaching high risk and remote locations. UNFPA supplied more than 1.2 billion male condoms, 12.9 million female condoms and almost 50 million sachets of lubricant globally in 2018. Moreover, the Africa Beyond Condom Donation initiative (or “ABCD”, previously the “20 by 20 coalition”), led by UNFPA, has set the stage for further progress by bringing together condom manufacturers, international donors and NGOs to leverage public-private collaboration and increase the supply of male and female condoms in low- and middle-income countries to 20 billion by 2020.

68. UNAIDS, in close collaboration with UNFPA and partners, has taken a range of steps to reinvigorate condom programming, including:
    - disseminating a condom landscaping analysis to global, regional and country stakeholders,
    - developing a condom needs estimation tool to facilitate target setting and planning,
    - launching a community of practice for condom programming,
    - updating comprehensive condom programming guidance to make programmes fit-for-purpose, and
    - agreeing with the Global Fund to establish catalytic funding for condom programmes to strengthen condom programme stewardship and demand generation.

69. WHO is leading the updating and development of new guidance focused on **voluntary medical male circumcision** for HIV prevention. Modelling done by the World Bank demonstrates that voluntary medical male circumcision is a highly cost-effective prevention tool, and that its impact and cost savings will continue to grow as circumcised boys become sexually active. Research conducted in Kenya and Uganda indicates that the antiretroviral therapy and voluntary medical male circumcision scale-up has contributed to sharp declines in HIV incidence [21 22].

70. UNAIDS, via the Coalition, coordinates the voluntary medical male circumcision global stakeholder committee, which supports the identification of key programmatic areas for improvement, as well as leadership and coordination mechanisms. It also engages stakeholders to provide quality and sustainable voluntary medical male circumcision services in priority countries. UNAIDS has also developed a draft Fast-Track plan for men and HIV in eastern and southern Africa, which positions voluntary medical male circumcision as part of a male health agenda and outlines a vision for expanding gains and ensuring sustainability.

71. WHO continues to support the **PrEP** agenda globally by providing updated guidance and implementation support. In 2019, this support included the release of a technical brief regarding "event-driven PrEP", which lays out an option for a shorter dosing strategy for gay men and other men who have sex with men. WHO also developed core PrEP indicators and it is supporting countries in all regions to monitor and evaluate their PrEP programmes.

72. UNAIDS has mobilized the East African Community to join in prevention efforts and it has invited the African Union to participate in the Coalition. UNAIDS supported the African Union to launch a policy brief on HIV prevention in Africa, which highlights thematic priorities and best practice examples. SADC adopted the HIV prevention scorecard developed by the Global Coalition, while the Middle East and North Africa region has developed a regional version of the global Road Map.

PREVENTION FUNDING

73. To stay on-track to end the AIDS epidemic by 2030, adequate and predictable financing is essential, both for the HIV response and for addressing the related health needs and social drivers of the epidemic.

74. In 2016, the UN General Assembly agreed to a steady expansion of investment in the HIV responses of low- and middle-income countries. The minimum amount required to scale up programmes and meet the targets agreed to in the 2016 Political Declaration on Ending AIDS was USD 26 billion by 2020[23]. Complementing the call in the Political Declaration for increased overall financing for the HIV response, the Road Map also called for a marked adjustment in the allocation of HIV resources, with at least 25% of financing allocated to HIV prevention activities. Neither the required increase in overall funding for the HIV response nor the envisaged shift in HIV resource allocation has occurred.

75. International development assistance support for HIV prevention decreased by 44% between 2012 and 2017[24]. Furthermore, total investment in HIV responses dropped sharply in 2018, down USD 900 million (to USD 19 billion, in constant 2016 US dollars) compared with 2017[25]. One-year declines were reported across all sources of investment, including domestic, multilateral and some bilateral donor programmes, philanthropic organizations and other international sources. The widening gap between resource needs and availability is of great concern, given evidence that progress at the country level closely follows investment availability[26].

76. Against that backdrop, good news arrived in October 2019 when the Global Fund raised USD 14 billion at its sixth replenishment conference, the highest amount ever for the partnership[27]. This infusion of resources has the potential to address the under-investment in HIV prevention and enable countries to develop strategic national proposals that align with the Road Map and remove gaps in national prevention efforts.

77. To effectively seize the opportunity afforded by the Global Fund's successful replenishment, countries will need to address gaps in their strategic approaches to prevention planning and investment. Seventeen of 27 countries reported that prevention targets were used to estimate prevention financing gaps, a major improvement compared with previous years. In some of the most affected countries, closing the financial gap for key population and condom programmes—essential steps to meet prevention goals—would require a relatively small proportion of total HIV funding. Under the global Fast-Track model, those combined programmes are expected to contribute between one third and one half of averted HIV new infections in various settings[28].

78. In addition to maximizing the mobilization of resources from the Global Fund, countries urgently need to increase their domestic investments in the HIV response, including HIV prevention. South Africa now has a costed national strategic plan (2017–2022) and has increased its annual domestic public spending for HIV by about USD 650 million in the past seven years[29]. Almost 80% of total HIV resources in that country is from domestic sources.

79. Other countries in eastern and southern Africa have also increased domestic funding since 2010: by 70% in Zambia and Zimbabwe, and by 30% in Kenya and Malawi[30]. Nevertheless, countries in that region (except for South Africa) on average finance only

20% of their responses domestically. Financing gaps and sources of financing for the HIV response continue to vary widely between countries.

80. To maximize the impact of finite resources, countries must sharpen their focus on the priority pillars of HIV prevention. The Coalition Secretariat has developed a financial gap analysis template to help countries estimate overall or prevention pillar-specific financing gaps for achieving the HIV prevention targets. The World Bank will continue to work with countries to make the best evidence-informed decisions about financing priorities so that comprehensive and multisectoral AIDS responses are equipped to meet the needs of diverse populations. UNDP will ensure that HIV financing and programming opportunities are integrated in its broader global programmes for low- and middle-income countries.

81. A combination of increasing investment into prevention and increased efficiency in using resources is needed to close the resource gap. Progress towards the 2020 and 2030 targets will depend on continuing support from development partners for primary prevention, while countries adjust their financing models to manage required transitions in the future. Innovative mechanisms to raise funds and build new partnerships should be explored, including sourcing funds from the taxation of goods or services and public-private partnerships. South Africa's recent work in developing a new social impact bond to help meet the needs of girls and young women and advance HIV prevention is an inspirational example.

82. At the same time, allocative efficiency, implementation efficiency and equity require greater attention at country level. In some cases, small shifts in investment that target resources and increase coverage for populations who are most at risk can substantially boost programme impact. Also required are strengthened efforts to support innovations in technology, as well as improvements in data systems to help refine targeting. This combined set of needs requires strengthened stewardship and accountability at all implementation levels to ensure that clear criteria guide funding decisions and that results are scrutinized by all key stakeholders.

ONGOING CHALLENGES AND IMPERATIVES FOR ACTION

83. Although the 2016 Political Declaration and the launch of the Coalition have galvanized numerous countries to reinvigorate their HIV prevention strategies, progress in reaching 2020 targets remains inadequate—globally and in most countries. For example, 310 000 [59 000 – 380 000] adolescent girls and young women acquired HIV in 2018, a 25% decline since 2010 but still more than three times higher than the global 2020 target, underscoring the degree to which essential prevention programmes are not reaching this population. Major gaps persist, particularly with regard to financing for HIV prevention, the strengthening of systems to provide services at scale, and working with communities to deliver services and build an enabling environment for prevention.

Persistent implementation challenges

84. Coverage of combination HIV prevention programmes among adolescent girls, young women and their male partners in locations with high HIV incidence in sub-Saharan Africa remains too low. UNAIDS estimates that only 34% of locations with high HIV incidence in 13 priority countries have dedicated prevention programmes for adolescent girls, young women and their main partners. There is need to develop scalable programming models that ensure access to youth-friendly HIV prevention in health facilities, provide effective HIV prevention in schools as part of comprehensive sexuality education and strengthen community programmes generating demand for HIV prevention and transforming norms.

85. Large coverage gaps for key populations are a particular concern, including among gay men and other men who have sex with men, transgender people and young members of key populations. Coverage of basic services varies widely, from as low as 1% to over 65%, although data reliability is often a concern due to inadequate or missing population size estimates.

Among sex workers, coverage with dedicated prevention programmes also remains insufficient. Reported coverage among female sex workers ranges from 1% to 96% but is below 50% in most countries. Major gaps in access to harm reduction services for people who use drugs exist in many countries and regions, with only a few countries providing at least the recommended 200 sterile needles-syringes annually per person who injects drugs.

86. Levels of condom use and uptake of PrEP are far off the track for achievement of the 2020 targets. The pace of the voluntary medical male circumcision scale-up has to increase in order to achieve the designated target.

87. In the short term, greater effort is required to strengthen planning and management at all implementation levels to enable programme scale-up across priority locations and populations. Achieving this demands much stronger systems to drive and manage these expansions.

88. Management capacity within decentralized government structures (such as sub-national AIDS council offices) for planning, implementation and monitoring also needs attention in many countries, as does planning management and monitoring capacity in the nongovernment sector.

89. Also required are strengthened and harmonized (across programmes and sectors) data systems that support evidence-informed decision-making and accountability at all levels, including through community monitoring. In particular, granular, disaggregated and geo-specific data are needed for underserved and key populations. This would help focus interventions where they can have the greatest impact (although care is needed to avoid exposing people to further discrimination and punitive measures).

90. There is a continued need to improve integration of HIV with other sectors and programmes. In many settings with high HIV incidence in eastern and southern Africa, HIV prevention is not at all – and in other settings not sufficiently – integrated into contraceptive service delivery, which is a major missed opportunity, because large proportions of young and adult women at high risk of HIV are using these services. Countries are also not yet sufficiently using opportunities to harness the potential of the education, social development and labour sectors to promote HIV prevention and deliver relevant services.

91. In the health sector, more effort is required to co-locate HIV services with broader health services where appropriate, with the aim of improving both HIV-related and non-HIV-specific health outcomes. Services for HIV, tuberculosis, viral hepatitis and sexually transmitted infections have obvious synergies. Integrated services, particularly HIV services with sexual and reproductive health services—including family planning and gender-based violence prevention and management services—are also important to reach vulnerable adolescent girls and young women and their sexual partners with the comprehensive services that they need. Integration in the context of Universal Health Coverage (UHC) must be leveraged further.

92. Examples of successful scale up of combination prevention—including condom programming, voluntary medical male circumcision, PrEP, viral load suppression through antiretroviral therapy, and the prevention and treatment of sexually transmitted infections—exist in many settings. Replicating these successes remains central to reducing the annual number of new HIV infections to fewer than 200 000 and achieving the goal of ending AIDS as a public health threat by 2030. There is general agreement that this will entail building a system that can maintain momentum around HIV responses, while still providing access to quality services \at affordable prices for all in need. This is the central premise of UHC, to which countries have also committed as part of the Sustainable Development Goals (SDGs).

93. UHC provides vital opportunities to meet the multiple health needs of people, including those at risk of or affected by HIV. Some countries, such as Myanmar and South Africa, are implementing policy reforms and are seeking to include the HIV prevention, treatment, care and support services that people need in packages of essential health benefits. In the coming years, more countries need to strengthen the linkages between the HIV response and the UHC movement to enable the expansion of truly people-centred systems for health. The inclusion of key populations in such efforts is a particular challenge, making the scale-up of community-based and community-led interventions critical[31].

Eliminating stigma and discrimination and removing legal and policy barriers

94. Some countries have achieved inspiring successes in removing legal and policy barriers to effective HIV prevention. Generally, however, too little is being done to eliminate stigma and discrimination against key populations and people living with HIV, which remain very high in far too many countries and lead to highly inequitable prevention outcomes.

95. Even though the proportion of the world's population living in countries that criminalize same-sex relations has declined, most countries in Africa and Asia still have such laws. Among 126 countries reporting these data, 107 have no legal protections in place for sex workers. Among 109 countries with data, 41 have constitutional protections in place against discrimination based on sexual orientation and 44 protect against employment discrimination based on sexual orientation, but 41 countries have no such legal protections in place.

96. Only eighteen countries reported having legal protections in place protecting people who use drugs, compared to 112 which have no such protections. Only 15 countries officially recognize transgender identity, with a majority (73 of 129 reporting countries) providing no specific legal protections of any kind for transgender people. Forty-eight countries or territories have restrictions in place on the entry, stay or residence of people living with HIV. Seventy-two countries have specific HIV-related criminalization laws, while in some countries prosecutions of people living with HIV occur under non-HIV-specific statutes.

97. Other policy barriers also impede effective prevention efforts. In 2018, 106 of 142 countries reporting to UNAIDS had laws in place requiring parental consent for adolescents to access HIV testing.

98. Such counterproductive and unsound laws and policies increase vulnerability to HIV and deter people from seeking the services they need. Reaching global prevention targets will only be possible if an enabling environment exists for HIV prevention efforts.

Strengthening the role of communities in prevention

99. Communities are central to ending AIDS. Across all areas of the HIV response, community empowerment and ownership have resulted in increased uptake of HIV prevention and treatment services, reduced stigma and discrimination and enhanced protection of human rights. Community organizations play key roles in reaching adolescent girls and young women and key populations.

100. Impressive results have followed when intensive community led HIV programmes have been taken forward in countries.[32] In the city of Saint Petersburg in the Russian Federation, community-led HIV prevention services for people who inject drugs, supported by the city government through a multidisciplinary approach, are associated with the steady decline in new HIV infections among people who inject drugs. As a result, Saint Petersburg has achieved sustained progress against HIV.[33] Insufficient funding for community-led responses, along with social and gender inequalities, and negative policy environments prevent similar successes in many settings globally.

101. Greater effort is needed to include community actors and civil society networks in national dialogues throughout the programme cycle, from the participation of representatives of key affected populations in national programme planning and review bodies, to the establishment and funding of community-led monitoring mechanisms.

102. Member States must also make good on their commitment in the 2016 Political Declaration to expand community-led service delivery to cover at least 30% of all service delivery by 2030. This requires investments in strengthening community-led service delivery platforms, such as peer outreach for key populations and adolescent girls and young women. In support of the global target on community-led responses, UNAIDS has convened dialogues with communities to precisely define community-led responses and initiate development of indicators to track progress.

103. In many settings, strengthening community systems requires lifting restrictions on the operating space and funding options for civil society organizations, especially those that work with key populations. It also requires political will to take forward policy reforms and meet commitments to transition towards domestically funded HIV responses, as well as make greater use of social contracting (as Namibia is doing).

104. In this regard, inspiration can be taken from countries that have effectively prioritized well-resourced community responses. India, for example, was an early leader in this respect, scaling up community-led programmes for key populations under a clear national management model and implementation system. This approach proved particularly effective in improving access, service quality, uptake and community engagement—and helped bring the HIV epidemic under control[34].

105. Some countries are making provisions for financing the engagement of civil society. In Ukraine, for example, the Cabinet agreed to allocate savings from antiretroviral medicine procurement to social contracting of organizations for HIV prevention interventions. Lesotho has indicated that it is increasing its focus on NGOs (including faith-based organizations) to expand prevention activities at community level. Despite these steps, however, the future of funding for civil society organizations is uncertain, although some countries are being proactive through programme and financial sustainability planning.

CONCLUSIONS AND RECOMMENDATIONS

106. The Global Coalition has elevated a shared primary prevention agenda to the centre of the global HIV response. Aligned with the Road Map, countries have transformed the

ways in which they frame, organize and measure their national prevention responses. Coalition countries have rallied to reaffirm and strengthen leadership for prevention, and similar leadership on prevention is evident in several non-Coalition countries.

107. At country level, national responses have been aligned to global targets and HIV prevention strategies have been strengthened. Focus countries report that the Coalition has promoted a more systematic and structured approach to prevention programming. The focus on consistent and results-oriented framing of HIV prevention and on strengthened accountability frameworks is supporting programme scale-up.

108. The added value of the Coalition is visible in several focus countries and beyond. It is encouraging to note the progress achieved in eastern and southern Africa in reducing new HIV infections.[35] This momentum must be sustained by stepping up investment, improving efficiency, leveraging innovation and integration, and learning from successes. This will drive continued efforts to address gaps in programme coverage and ensure that services are available to everyone in need.

109. Key lessons thus far include the importance of target-setting and accurate strategic data to drive progress and ensure accountability, and the need for stepped-up domestic and international financing for prevention. These lessons should be taken aboard in Coalition and non-Coalition countries. It is important that countries, with support from the Joint Programme and other partners, immediately leverage the Global Fund's successful replenishment to increase prevention resources and ground national responses in the principles and approaches outlined in the Road Map.

PROPOSED DECISION POINTS

110. *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":

111. *Take note* of the 2019 progress report on HIV prevention 2020;

112. *Request* Member States, in collaboration with community-based organizations, civil society and partners, to accelerate 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, taking on board lessons learned through the work of the Coalition and its focus countries;

113. *Underline* the importance for Member States and donors to increase investments in HIV prevention, with no less than one quarter of HIV spending to be invested in prevention programmes, and *request* that Member States, with the support of the Joint Programme, move expeditiously to develop and submit funding proposals to the Global Fund that reflect the key elements described in this report, include a full expression of priority gaps for HIV prevention, optimize resource allocation and leave no-one behind in the national response; and

114. *Request* the Joint Programme to support countries in developing and implementing robust prevention plans that are comprehensive, equitable and people-centred and that address key persistent obstacles, including the need to overcome implementation barriers, further reduce stigma and discrimination, and strengthen community engagement in prevention service delivery, and to report back to the Programme Coordinating Board on progress made on HIV prevention in 2020.

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