Agenda item 3

UNAIDS/PCB (47)/20.26

ANNUAL PROGRESS REPORT ON HIV PREVENTION 2020

15-18 December 2020 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 19 November 2020

Additional documents for this item: UNAIDS/PCB (47)/CRP1; UNAIDS/PCB (47)/CRP2

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

1. Request the Joint Programme to:

    a. ensure that HIV prevention is given high priority in the new Global AIDS Strategy and in the new UNAIDS Unified Budget, Results and Accountability Framework (UBRAF).

    b. actively support governments in convening partners at country-level to build unity of purpose among governments, communities and implementing organizations in developing HIV prevention responses that are aligned to country epidemic context and to global principles, implementation guidance and good practices.

2. Requests member states and the Joint Programme to:

    a. Lead a new vision for HIV prevention that intensifies focus and investment in strategies and programs for key and vulnerable populations with a high incidence of HIV in all regions. The strategy should include a clearly defined approach to overcome financing, implementation and legal and policy barriers to HIV prevention, with a particular focus on key populations in all regions and young women in countries with high HIV prevalence. The strategy should equally incorporate strengthening and resourcing of community-led interventions.

    b. Support and advocate for strategic investment in national capacities to manage HIV prevention programs. The PCB also requests the Joint Programme to ensure that adequate technical and implementation support capacity is available in countries.

    c. Reinforce and maintain beyond 2020 the progress made by the Global HIV Prevention Coalition in reinvigorating HIV prevention responses, underscoring national ownership of the coalition objectives and expanding membership to countries and regions with rising HIV incidence.

3. Call on Member States to address key underlying legal, policy and structural barriers affecting key populations and adolescent girls and young women as outlined in the paper

4. Report back to the Programme Coordinating Board in 2021 on progress made in HIV prevention, including the measurable outcomes and efficacy of the Global HIV Prevention Coalition.

Cost implications for the implementation of the decisions: none

Table of contents

Introduction

The Programme Coordinating Board called for strengthened HIV prevention responses

1. The 45th meeting of the UNAIDS Programme Coordinating Board (PCB) requested Member States, community-based organizations, civil society and partners, to accelerate HIV prevention responses in line with the 2016 Political Declaration on ending AIDS and the HIV Prevention 2020 Road Map, taking on board lessons learned through the work of the Global Prevention Coalition (GPC) and its focus countries.[1]

2. The importance of Member States and donors increasing investments in HIV prevention was *underlined* and it was requested that Member States, with the support of the Joint Programme, move expeditiously to develop and submit funding proposals to the Global Fund that reflect a full expression of priority gaps for HIV prevention.[1] This includes investing at least 25% of HIV spending in prevention programmes.

3. The Joint Programme was *requested* to support countries to develop and implement robust, comprehensive, relevant, equitable and people-centred HIV prevention plans that address key, persistent obstacles (including implementation barriers, gender inequalities, violence against women and girls, and stigma and discrimination) and that strengthen community engagement in prevention service delivery.[1]

4. The Joint Programme was *requested* to report back to the PCB in 2020 on progress made in HIV prevention, including measurable outcomes and efficacy of the GPC since its inception.

5. This report responds to the PCB request made in 2019 and provides an update on progress made against global HIV prevention targets and support provided by the Joint Programme. The report recognizes the implications of the COVID-19 pandemic regarding HIV prevention targets. Additional details on the effects of the COVID-19 pandemic on the HIV response are provided in a separate report to the PCB.

6. This report highlights the urgency of reinvigorating the HIV prevention response and provides the basis for a renewed focus on HIV prevention in the new Global AIDS Strategy and the next UNAIDS Strategy in ways that are responsive to the changing dynamics of the HIV pandemic.

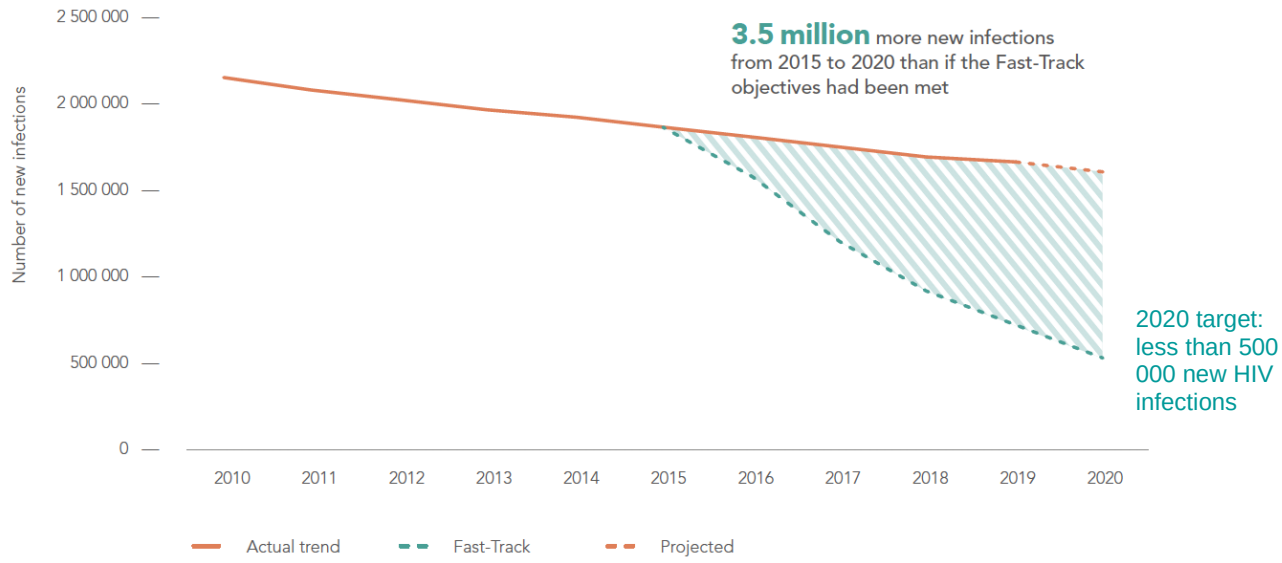
Global trends in reducing new HIV infections towards targets in the current UNAIDS Strategy

Reduction in new HIV infections falls far short of the Fast-Track targets

7. 2020 is a milestone year for taking stock of a decade of progress against the global commitment to end AIDS as public health threat by 2030. The annual number of new infections declined by 23% from 2010–2019, from 2.1 million to 1.7 million (the lowest annual number since 1989). [2] However, progress is highly uneven between and within regions, countries and different communities with substantial declines in new infections in some settings implementing combination HIV prevention and treatment programmes and increases in others. Set against the ambitious 2020 global target of fewer than 500 000 new infections (a 75% decline against the 2010 baseline), there is a shortfall by a factor of three.

8. By the end of 2019, 14 countries globally achieved the 90–90–90 target of 73% viral load suppression and two countries achieved 95–95–95. While slower declines and missed targets are attributable to variations between regions, countries and most affected populations, these successes demonstrate that HIV epidemic control is possible. Nonetheless, had the Fast-Track targets been met by all countries, there would have been an estimated 3.5 million fewer new infections in 2015–2020.

Figure 1. New HIV infections projected through 2020, and modelled prediction resulting from Fast-Track interventions, global, 2010–2020



Source: UNAIDS. Seizing the moment. Tackling entrenched inequalities to end epidemics. Global AIDS Update 2020. Geneva; 2020

9. Increased access to antiretroviral therapy (ART) has averted 12.1 million AIDS-related deaths since 2010. In 2019, there were 690 000 lives lost to AIDS-related illnesses, representing a 39% decline since 2010. Although this is a considerable achievement, had the Fast-Track objectives been met, there would have been an estimated 820 000 fewer deaths over the 2015–2020 period.[2]

10. The treatment and care needs of people living with HIV are lifelong. Not achieving the 2020 and 2030 prevention targets has implications for investment and programming in the immediate period. The financial burden grows if targets are not met and it will weigh over the forthcoming decade and far beyond 2030 as people living with HIV continue their treatment and care.

11. Viral load suppression translates into an undetectable viral load where HIV transmission is not possible.[3] Achievement of the 90–90–90 targets translates into 73% of all people living with HIV having suppressed viral loads. Knowledge of HIV status, uptake of ART and viral load suppression levels have all increased over the past decade. In 2019, an estimated 59% of people living with HIV globally had suppressed viral loads, which means an estimated 15.7 million people living with HIV were not virally suppressed.

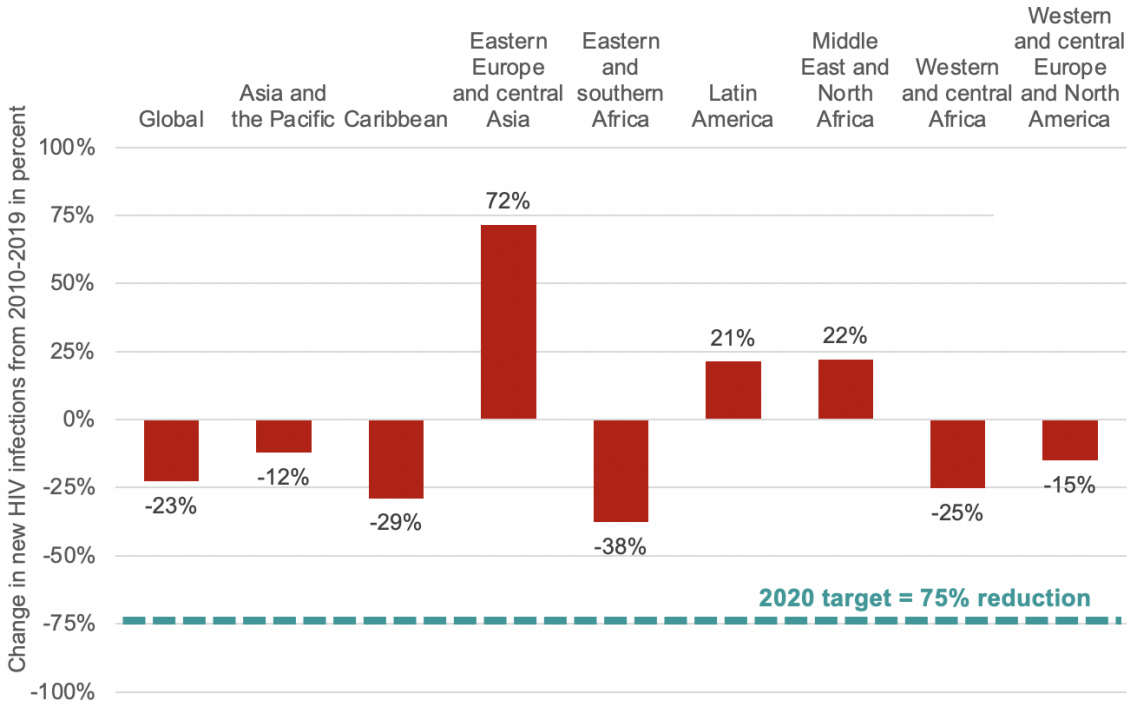
12. At the end of 2019, 14 countries across three regions had achieved the 73% target and two countries—Eswatini and Switzerland—had surpassed 86% viral suppression, which is equivalent to the 95–95–95 target.[2] At the same time, in over one quarter of countries in 2019, less than half of all people living with HIV were virally suppressed.[4] In addition, in many settings, achieving viral suppression among all sub-populations

remains challenging—for example, may be lower among youth than in other age groups.[5]

13. Access to treatment remains uneven among epidemiologically important groups—especially key populations and men. In the Middle East and North Africa, where the vast majority of new HIV infections occur among key populations, only 52% of people living with HIV know their status, 38% are on treatment and 32% are virally suppressed. Twelve percent fewer men living with HIV globally accessed treatment in 2019 compared with women living with HIV. In western and central Africa, the gap is wider, with 69% of women living with HIV on treatment in comparison to 49% of men.[2]

14. Declines in new HIV infections from 2010 to 2019 vary by region, by country and by population characteristics (Figure 2). Sub-Saharan Africa remains the epicentre of the HIV pandemic, despite declines in new HIV infections since 2010. There were modest declines in new HIV infections in the Caribbean and western and central Europe and North America. In sharp contrast, there has been a large proportional increase in new infections in eastern Europe and central Asia, as well as increases in the Middle East and North Africa and in Latin America. [2 6]

Figure 2: Changes in new HIV infections, 2010–2019, against the 2020 target, by region



Source: UNAIDS. 2020 HIV Estimates.

Key populations globally and young women and girls in sub-Saharan Africa continue to be left behind and require urgent focus

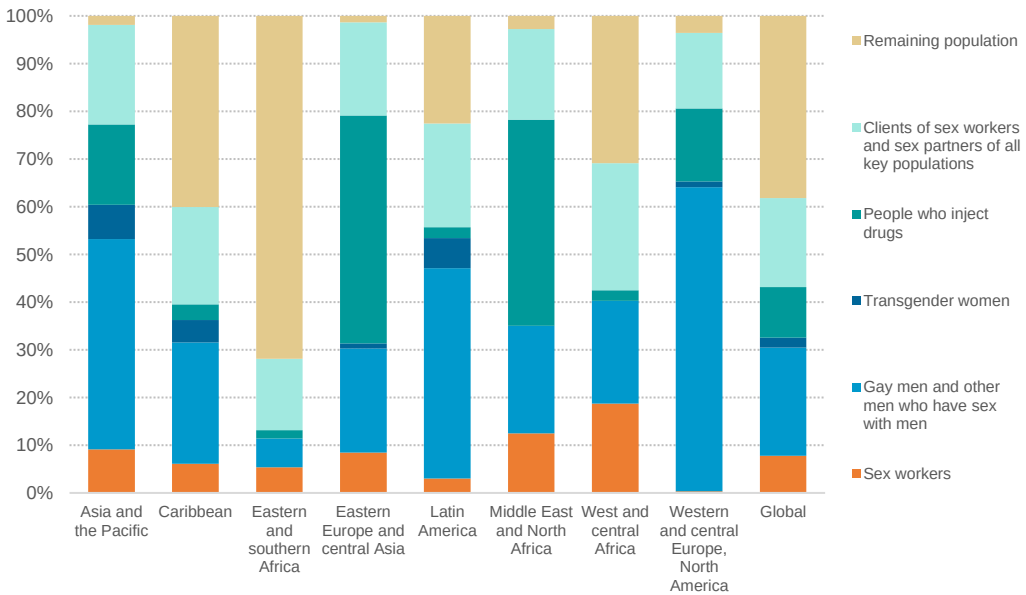
15. Sub-Saharan Africa accounted for an estimated 59% of all new HIV infections in 2019.[2] In this region, females account for 58% of all new infections, whereas beyond this region, males account for 68% of all new infections. Adolescent girls and young women aged 15–24 years account for 25% of new infections in sub-Saharan Africa yet make up only 10% of the total population. Globally, AIDS continues to be a leading cause of death among women and girls aged 15–49 years.[7] Key populations, clients of sex

workers and partners of key populations also comprise a large proportion of new HIV infections in sub-Saharan Africa – especially in West and Central Africa at where 69% fall within these categories.

16. Although there are a number of comprehensive HIV prevention programmes focusing on adolescent girls and young women in sub-Saharan Africa, such programmes are do not adequately reach all the geographies where they are most urgently needed. Only around one third of adolescent girls and young women aged 15–24 years in this region has comprehensive knowledge of HIV. They face ongoing vulnerabilities due to poverty, gender inequality, unequal power relationships, gender-based violence, unequal access to paid work and limited access to schooling. [2]

17. Male engagement and couple-focused programmes have potential to reduce HIV risks among adolescent girls and young women. The focus for young males in settings with high HIV prevalence is mainly on voluntary medical male circumcision (VMMC) and there has been less emphasis on encouraging male partners of adolescent girls and young women to take an HIV test. Male partner services are still under-emphasized and under-resourced, even though a number of gender transformation programmes implemented in sub-Saharan Africa have shown potential for helping to improve gender norms and reduce gender-based violence. [2]

Figure 3. Distribution of new HIV infections by key population, by region, 2019



Source: UNAIDS. Seizing the moment. Tackling entrenched inequalities to end epidemics. Global AIDS Update 2020. Geneva; 2020.

18. New HIV infections among key populations and their sexual partners accounted for approximately 62% of all new infections among adults globally in 2019. With the exception of eastern and southern Africa—where key populations and their partners accounted for 28% of new infections—in other regions those population accounted for the majority in new HIV infections: 60% in the Caribbean, 69% in western and central Africa, and 77% in Latin America. Nearly all new HIV infections in western Europe and North America (96%), the Middle East and North Africa (97%), Asia-Pacific (98%), and eastern Europe and central Asia (99%) occurred among key populations and their partners (Figure 3). [2]

19. Lack of progress in reducing new HIV infections among key populations is a major contributor to missing the global prevention targets. The annual number of new infections among people who inject drugs, female sex workers and transwomen has barely changed since 2010. Among gay men and other men who have sex with men, the number of new HIV infections increased between 2010 and 2019 (Figure 4).

Figure 4. Change in the number of new HIV infections among key populations, 2010–2019

Source: UNAIDS epidemiological estimates, 2020 (see https://aidsinfo.unaids.org/); UNAIDS special analysis, 2020

20. Key populations face stigma, discrimination and harassment, which increases their HIV risks and vulnerabilities. Sex workers are at particularly high risk of exposure to physical and sexual violence, and hostile legal and social environments are a common circumstance for key populations in many countries despite continued emphasis on these concerns.

21. Several countries have managed to reduce new HIV infections among key populations. In Cambodia, Thailand and Viet Nam, for example, new HIV infections declined by more than 60% in 2010–2019, and they declined by about half in El Salvador, Moldova and Sri Lanka—as a result of high coverage HIV prevention and treatment programmes.

22. Condom social marketing and public sector distribution programmes for male and female condoms in sub-Saharan Africa have declined substantially in the past decade. Condom use among male and female youth has decreased in many countries. Adolescent girls and young women and key populations have inadequate access to pre-exposure prophylaxis (PrEP) and VMMC has been insufficiently accessed by men. The 2020 targets for these three vital prevention measures have not been met. [2]

Impacts on children

23. There has been a marked decline in new HIV infections among children due to improved control of vertical transmission. In 2010, 310 000 children aged 0–14 years were newly infected with HIV in comparison to 150 000 children in 2019. Nearly half of those new infections (74 000) occurred in eastern and southern Africa, with a further 52 000 occurring in western and central Africa. Together, those regions account for 84% of new infections among children.[8]

24. Progress towards the elimination of new HIV infections in children has slowed, however, and the 2018 and 2020 targets were missed.[2] Reasons for higher levels of HIV transmission to infants vary. In eastern and southern Africa, newly acquired HIV infections among women during breastfeeding account for a higher proportion of infant infections, whereas in western and central Africa, a higher proportion of new infections are related to HIV-positive mothers not receiving ART during pregnancy or breastfeeding.[9]

COVID-19 has slowed some aspects of HIV prevention, but lessons from the crisis can be a source for innovation

25. The COVID-19 pandemic has exposed and increased the fragility of global health systems and has hampered some aspects of HIV prevention. The supply of medicines, condoms and other health commodities by manufacturing countries has been disrupted by COVID-19 control measures. In countries with high HIV prevalence, travel restrictions, concerns about infection risk, human rights abuses and worsening social and economic circumstances have disrupted continuity of services.[10]

26. COVID-19 has disrupted HIV prevention services and programmes. Negative impacts have been reported in relation to HIV testing and treatment, prevention of mother-to-child transmission, key population programmes, PrEP, VMMC services (which have been suspended in several countries), condom distribution, opioid substitution therapy (OST), sexual and gender-based violence prevention and care, sexual and reproductive health services, and diverse prevention, testing and treatment programmes involving face-to-face interaction.[11] Domestic violence increased in many countries during lockdowns.[12]

27. Extended disruptions of services due to COVID-19 have been documented, and are expected to compound missed targets. However, there are numerous examples of recoveries in reach and delivery being achieved.[13] There were large initial decreases in HIV testing across 18 out of 24 countries where trend data was available for January to September 2020. The remaining countries rebounded rapidly and in a few countries the distribution of self-testing kits increased. Among 10 countries with PMTCT data, only two demonstrated rebounds to January levels, while infant testing did not appear to be markedly impacted. While VMMC programmes were significantly impacted in most countries where these services are prominent, four countries – Botswana, Kenya, Rwanda and South Africa have upward trends in service resumption.

28. While there were dips in HIV treatment in 9 out of 23 countries with trend data, only 6 experienced dips of more than one month and most treatment programmes appear to have recovered during this phase of the pandemic.[13] However, among 28 countries with trend data, only 6 showed rebounds or increases in the number of people newly initiated on treatment. A few countries had declining levels of viral load suppression.

29. Key population programmes have been impacted due to disruptions in access to HIV prevention commodities, ART and OST. Most of the 8-15 countries with trend data for January to September 2020 show declines in reach for sex worker programmes, men who have sex with men programmes, transgender women and injecting drug services. Despite these challenges, however, a number of countries were able to bounce back to previous levels or even exceed them by the end of the period. Vulnerabilities to HIV infection due to disruption of prevention programmes have also increased among children, young women and girls, young men, migrants and refugees, homeless people, and people living in slums and other areas with high population density.

30. Data reported in October 2020 show that, overall, about two thirds of GPC countries had taken steps to continue safe outreach services for young women and for key populations and that about half of the Coalition focus countries provided online counselling for key populations.[14]

31. UNAIDS and Cosponsor leads rapidly developed programmatic guidance on COVID-19 and HIV during the early months of the pandemic. This included action briefs on maintaining HIV prevention services, lessons from HIV prevention for COVID-19 prevention, condom and lubricant programming and implementation guidance for key population programmes. Specific guidance was provided on gender issues, including measures to support women and girls in the context of the COVID-19 pandemic.[15]

32. Responses to COVID-19 were informed by lessons learned during the HIV response over the past four decades, including the importance of global coordination and sustained political will at multiple levels, rights-based and science-based approaches, and community-led responses. Other relevant insights include obtaining granular, real-time data to understand impacts and improve efficiency, following principles of gender equality and adopting multisectoral responses that give attention to social, economic and structural factors.[10] It remains that the threat of COVID-19 to the HIV response varies in intensity due to waves of new infections, with ongoing instability and unpredictability of epidemics in most countries.

33. Of particular benefit in the early response to the COVID-19 pandemic was the inclusion of HIV experts in COVID-19 advisory committees and management teams. National AIDS directors served on these committees in sub-Saharan Africa, Latin America, the Middle East and North Africa. Health services and laboratory systems have been strengthened during the response to HIV, providing a vital foundation for COVID-19 response—especially in low- and middle-income countries.

34. A number of countries across regions accelerated the rollout of multimonth dispensing of ART and HIV prevention commodities to ensure sustained access. This approach also simultaneously reduced contact between health-care workers and people living with HIV, thus reducing COVID-19 transmission risks.[10]

35. The extent to which social distancing and other COVID-19 prevention measures may have increased the potential for unsafe sex, risky sexual practices or unsafe practices involving injecting drug use are yet to be determined. UNAIDS is currently preparing a synthesis of available evidence to assess these risks.

36. Preserving the momentum and focus on HIV prevention includes sustaining HIV prevention leadership and investment synergistically with the COVID-19 response. Listening to key and vulnerable populations and adapting the response in high HIV burden settings is vital when engaging and mobilizing communities—especially in terms of countering misinformation, providing social support and strengthening response systems.

37. Specific innovations developed in response to COVID-19 have the potential for strengthening HIV prevention programmes in the medium- to long-term. For example, multimonth dispensing for ART and PrEP, providing larger allocations of condoms, self-testing for HIV, and take-home dosages of OST—all of which are efficient service delivery options for experienced users of these commodities. Virtual space interventions for populations such as gay men and other men who have sex with men who increasingly use online meeting places remains a relevant complementary approach to interpersonal face-to-face outreach programmes—taking into account the need to ensure privacy and safety of these groups when accessing digital tools.

38. Sexuality education services for young people have included the development of digital applications that provide a substitute for face-to-face meetings for sharing information on sexuality and health. Other innovations include video courses and phone-based information platforms.

39. Communities have demonstrated resilience and innovation in response to COVID-19 and provide insights into the way forward for the continued response to COVID-19 and for HIV prevention.[16]

Notable examples of what works in HIV prevention to take forward into the new Global AIDS Strategy

40. There is clear evidence that combination HIV prevention works, and this is demonstrated by population-level HIV declines in countries and other research.[4 17 18]

Treatment as prevention

41. Trials of universal test and treat programmes in eastern and southern African countries demonstrate that significant progress can be made towards population-level viral suppression.[19] For example, annualized HIV incidence was 20% to 30% lower in two trials. Phylogenetic analysis of data from the PopART trial demonstrated that 40% of new HIV infections were the result of HIV transmission from people who had acquired HIV in the previous 12 months.[20] This finding implies that annual testing followed by treatment alone is not sufficient to drastically reduce new HIV infections. The trial findings therefore substantiate assumptions of the UNAIDS Fast-Track model that HIV treatment is essential but not sufficient to bring HIV under control. Therefore, additional prevention interventions must be integrated into the response to reach 2030 target for ending AIDS as a public health threat.

42. High coverage of ART among pregnant women living with HIV has more than halved HIV infections among children globally over the past two decades.[2] While coverage of 84% of pregnant women living with HIV was achieved in 2019 (against a target of 95%), some countries and territories have suggested that elimination of mother-to-child transmission is feasible. This has prompted a focus on reaching "Super Fast-Track" targets, with an emphasis on the most vulnerable settings.[2] In eastern and southern Africa, 95% of pregnant women living with HIV received ART. In all settings, risks of HIV transmission to infants remain due to women acquiring HIV during pregnancy or breastfeeding. Some of these risks are better managed through primary HIV prevention programmes in conjunction with reproductive health services that reduce the risks of unplanned pregnancies. UNAIDS and PEPFAR's 'Three Frees' framework – start free, stay free, AIDS free – intensifies primary HIV prevention in focal countries and regions to address coverage gaps.[21] Family testing represents an opportunity for improving diagnosis of HIV among children. [2]

Combination HIV prevention is highly effective and urgently needs to be taken to scale

43. When behavioural, biomedical and structural prevention programmes (including testing and treatment) are geographically focused and tailored to the people in greatest need, new infections can be markedly reduced. In addition to previous evidence, recently confirmed analyses of population-based surveys[1] have demonstrated steep reductions in HIV incidence.[3]

44. Differentiated rather than standardized models of prevention and care, including community models, support the efficiency of local health systems and allow for targeting of communities that are at greatest risk of infection.

45. Biomedical prevention methods—including PrEP, condoms and use of sterile injecting equipment—have very high levels of effectiveness (>80%) if used consistently. Opioid substitution therapy reduces the frequency of injecting drug use and halves the risk of HIV and Hepatitus C virus acquisition for people who inject drugs.[22] VMMC reduces HIV incidence among males by 44–70%.[23]

46. Behavioural programming is necessary to support uptake of biomedical prevention methods. A concerted emphasis on consistency of use is required for ART, PrEP, condoms, and for use of sterile injecting equipment, including differentiated and targeted approaches for vulnerable and key populations. Inadequate risk perception is an important reason underpinning inconsistent and non-use of prevention measures.[24]

47. New prevention technologies may become available in the coming decade. The *Dapivirine* vaginal ring recently received a positive opinion for use from the European Medicines Agency, and WHO is currently developing guidance. The ring shows promise as an additional HIV prevention method for women at high risk of HIV infection.[25] One study has found that long-acting injectable PrEP with Cabotegravir is highly effective in reducing HIV acquisition among men[26] and results from a trial among women confirmed this finding. Regulatory approval still needs to be obtained, while additional important safety and implementation questions need to be addressed.[27]

48. Structural interventions can help reduce HIV vulnerability and create a supportive environment for the uptake of services. Community empowerment and mobilization provide complementary support by improving organizing and networking to address barriers and advocate for social and human rights protection.[2]

49. Interventions focusing on ensuring sustained secondary education and educational achievement among girls improve sexual and reproductive health outcomes, delay childbearing, make births safer and may contribute to HIV incidence reduction. In Botswana, each additional year of secondary schooling was associated with an 8.1% reduction in the cumulative risk of HIV infection among adolescent girls.[28] As investments in education go beyond what HIV programmes can finance, they require complementary focus through other financing sources.

50. Cash transfers and other empowerment measures can reduce transactional sex and improve HIV prevention outcomes in some settings,[29] although results overall have been mixed. A recent study in Eswatini, supported by the World Bank, found that grants

[1] In Eswatini, Lesotho and South Africa, and in four large cluster randomized trials of combination prevention approaches involving more than 250 000 people in Botswana, Kenya, South Africa, Uganda and Zambia.

and additional incentives reduced the odds of HIV infection for young women.[30] Such programmes require complementary financing.

51. Combined structural and behavioural programmes—including gender-transformative approaches such as Stepping Stones, One Man Can and SASA!—can reduce risky sex, improve gender equality and reduce gender-based violence in some settings. [2] Layered programmes which comprehensively address risk, vulnerability and service barriers for adolescent girls and young women through holistic, multisectoral approaches are important elements of combination prevention. For example, analyses of the President's Emergency Plan for AIDS Relief's (PEPFAR) Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) programmes indicate reductions of at least 25% in new HIV diagnoses among adolescent girls and young in nearly all DREAMS locations.[31] A study in South Africa found that while the scale-up of DREAMS programmes in a rural setting was successful in reaching adolescent girls and young women, sustained impact requires increased adaptability, economic empowerment and meaningful engagement with participants. [32]

52. Gender-responsive life skills-based HIV and sexuality education are increasingly included in primary and secondary school curricula. Comprehensive sexuality education that focuses on HIV prevention behaviours, gender equality and respect, on addressing violence and sexual abuse, and on avoiding risky relationships and reducing teenage pregnancy can improve reproductive health outcomes and reduce sexual risk-taking. Sexuality education can also help reduce rates of sexually transmitted infections (STIs), HIV incidence and unintended pregnancies. [2]

53. Community-led civil society platforms are essential for empowering and mobilizing response to HIV. Multifaceted community mobilization programmes have been effective for HIV prevention among key populations in a number of regions (especially in Asia) and also contribute to improved HIV service delivery. [2] Promoting community leadership, supporting community-based organizations and fostering community-led activities promote social responsibilities and contribute to innovations that are crucial for sustainable HIV response.[33]

54. Removing laws and policies that criminalize key population, behaviours, practices and activities or that discriminate against key populations reduces violence and stigma and improves uptake of HIV prevention and other services. [2]

Country-level successes in combination HIV prevention show that targets are achievable in different types of epidemics

55. In Uganda, a combination of programmes including VMMC, ART and sexual behaviour change brought to scale over a 10-year period led to a 42% decline in HIV incidence. In Kenya, new HIV infections declined by 44% in a context of high coverage of HIV prevention programmes among key populations, increased ART coverage and rapid scale-up of VMMC. [2] In South Africa, a combination of expanded HIV treatment, VMMC and continued high condom use was associated with incidence declines of 42% among men and 61% among women from 2012–2017.[34]

56. In Zimbabwe, new HIV infections have declined by more than 80% since the late-1990s in a context of continuous build-up of a combination prevention response—a process that started with the scale-up of HIV prevention communications emphasizing risk reduction and of condom programming. After 2010, HIV treatment access rapidly expanded,[35] VMMC programmes were rolled out and a national HIV programme for sex workers was scaled-up. From 2010-–2019, new HIV infections in Zimbabwe have declined by 44%.[2]

57. Cambodia has already achieved the 2020 target of 73% viral suppression among people living with HIV and has scaled up combination HIV prevention programmes over two decades. The country achieved high coverage of HIV treatment among key populations, reported high coverage of combination prevention programming for key populations from 2016–2019, and maintained relatively high use of condoms and safe injecting equipment among key populations. In that context, Cambodia reduced new HIV infections by 62% from 2010–2019 and by more than 90% compared with the peak of new HIV infections in the 1990s.[4]

58. Viet Nam has achieved levels of viral suppression that surpass the 90–90–90 target. The country reports 98% use of safe injecting equipment among people who inject drugs and relatively high coverage of opioid substitution treatment. New HIV infections declined by 68% from 2010–2019.[4] In Thailand, a combination of high viral suppression and high access to combination HIV prevention among key populations led to a decline in new infections by 65% from 2010–2019.[4]

59. Reduced sexual violence, improved contraceptive use, enhanced antenatal health and more equitable divisions of household labour have been achieved through engaging faith leaders in gender-transformative approaches in the Democratic Republic of the Congo, and by involving men in reproductive and maternal health in Rwanda.[2]

Translating what works into national HIV prevention responses

60. Given that the HIV prevention targets for 2020 will not be met, there is a need to recover momentum and realign efforts with 2025 intermediate and 2030 targets. There is an urgent need to intensify the implementation of effective evidence-based combination prevention programmes and bring those to scale. Gains made in the forthcoming period will reduce the extent of resources required for HIV treatment and care in decades to come.

61. While there is increased consensus on what works for HIV prevention, implementation of prevention programmes at scale has been uneven between and within countries. There has been a lack of sustained commitment to the beneficial and well-evidenced synergies that can be achievable through combination prevention programming. A loss of momentum is evident in the missed HIV prevention targets. Underlying factors include insufficient political commitment, insufficient investment, and lack of engagement with the social and contextual complexities experienced by vulnerable groups—particularly young people and key populations.[36 37]

62. In countries where programme scale-up has been successful—such as in Thailand and Zimbabwe—key elements included strong political commitment, a clear vision and a strategy encompassing well-defined core packages, decentralization of service delivery, community-based and -led outreach, and continuous monitoring and quality assurance. Partnerships with civil society and community engagement have markedly strengthened national and subnational responses.

63. Discriminatory laws against key populations persist in many countries. Nonetheless, there are encouraging examples of legal protections being introduced in some countries. For example, Chile, Pakistan and Uruguay now recognize gender identity and offer protections for transgender people. A number of countries have decriminalized personal consumption of drugs. Some laws related to sex work have been clarified (e.g. profiting from sex work is no longer criminalized in Malawi) and prohibitions against same-sex relations continue to decline in some countries, though they remain a major barrier in many countries. [2]

Programmatic progress and key Joint Programme achievements since the last PCB report

The Global Prevention Coalition supported countries in transforming their responses, but continued efforts are needed to close major gaps in HIV prevention

64. An external review of the GPC's contribution to strengthening the HIV prevention response globally and at country-level was requested by the global HIV prevention working group and commissioned by the GPC Secretariat in 2020 (Box 1).[38] Drawing on more than 100 interviews with key stakeholders and extensive review of data, the review found that the GPC has restored attention to primary HIV prevention globally (including among international donors) as well as national HIV responses. Support for a common approach to HIV prevention was successfully marshalled, including a focus on delivering much needed services to populations and locations where risk of infection is highest.

65. Overall, the review found that the GPC has revived the attention of leaders, planners and managers to HIV prevention. It is helping countries refocus their HIV institutions, resources and strategies on proven approaches and interventions. Resource allocations that support enhanced prevention programming in GPC countries are being made more strategic and effective. However, the review also concluded that there remain "miles to go" before a majority of countries will have optimized HIV prevention responses that enable them to achieve the 2030 targets.

Box 1: Key findings and recommendations of the GPC External Review

- The GPC's HIV Prevention Road Map enabled countries to move from generic to targeted prevention approaches. Coalition countries used the 2020 Road Map to guide and monitor their improvements in HIV prevention programming and to regularly report on progress.
- Commitment by countries to the GPC model was evident in the timely completion of reporting on Road Map implementation and prevention programmes. Stronger country programming for prevention has emerged, although no country has completed all 10 priority actions by the end of 2019.
- The five prevention pillars were deemed relevant. Detailed reporting on progress in implementing the pillars was one of the strongest features of the Coalition. The Coalition has strengthened institutional and multistakeholder collaboration for HIV prevention at both global and country levels, albeit with varying intensity.
- The GPC has been especially successful at strengthening National AIDS Authorities in participating countries as institutional stewards of HIV prevention. Consistent leadership and support to coordination are vital to avoiding the repeated fragmentation of HIV prevention programmes into piecemeal projects that compete for attention and funds. Catalytic funding to Cosponsors (via the Joint Programme's "country envelopes") has helped support national HIV prevention coalitions and/or technical working groups under the direction of National AIDS Councils.
- The Coalition has strengthened accountability through the use of prevention scorecards, regular reporting and annual joint reviews among stakeholders. This scorecard methodology improves monitoring and is enabling countries to pinpoint gaps and take remedial steps.
- Most countries have national prevention working groups that meet at least annually, but civil society engagement varies and would benefit from strengthening. Some national prevention structures were struggling to coordinate and support the activities of partners, both in government and civil society, especially at subnational level. Prevention teams in some countries have had difficulty obtaining funding and achieving visibility, while others found it difficult to maintain focus on prevention in decentralized health systems. Subnational support needs to be strengthened.
- GPC countries face diverse technical, political and financial challenges in expanding and improving combination prevention programmes. Most have difficulties changing underlying factors that hinder effective HIV prevention programming, including shortfalls in political leadership and financing, and obstructive legal and policy environments.
- The GPC has successfully collaborated with the Global Fund to modify its application guidelines and technical review criteria in ways that encourage countries to submit targeted and costed proposals for the GPC pillar interventions. However, funding for combination prevention services does not yet match the need, and very few Coalition countries have reached the broad Roadmap target of allocating 25% of country HIV budgets for primary HIV prevention.
- The slow progress in reforming or removing legal and policy barriers to effective HIV prevention was highlighted, especially in relation to the criminalization of same-sex conduct, sex work and illicit drug use, and to combatting gender-based violence. Restrictive sociopolitical conditions in some countries hindered the necessary scale-up of services for key populations and the participation of affected communities in delivering those services. Stronger guidance for partners, coordination support and technical assistance could help remove some of the blockages to evidence-informed HIV prevention.
- The GPC Secretariat has been responsive to country requests for technical assistance and has been alert to emerging needs. For example, the Secretariat supported the development of a National AIDS Council directors' community of practice and its role in mobilizing resources for South-South learning. Most Coalition countries have utilized technical assistance that was offered to strengthen prevention activities, though the assistance was not always adequately coordinated. Some technical assistance gaps were also noted—for example, tackling structural barriers, promoting social contracting, condom market development, programme management and SRHR integration.

66. The independent evaluation of the UN system response to AIDS for 2016–2019 found that key informants appreciated that emphasis was given to HIV prevention through the GPC, especially reprioritizing prevention to address a perceived overemphasis on HIV testing and treatment. [39] It identified a need to build consensus around the scope of combination prevention programming beyond biomedical approaches. The review noted the impact of declining financing on the Joint Programme, which has also affected UN country-level capacity in relation to HIV prevention.

67. A core theme for the GPC in 2019 was to operationalize action towards closing gaps to achieving service coverage targets of 90% for key populations. Large gaps in coverage of HIV services for populations such as sex workers in Africa and other key populations globally remains a top priority in 2020.

68. Gaps in HIV prevention financing have been a critical challenge in the past five years. The current year (2020) provides an opportunity to increase resources for prevention programmes in the context of the Global Fund's successful replenishment and the Global Fund's renewed focus on HIV prevention.

Good examples, but uneven progress in five priority areas of HIV prevention

69. In line with the priorities of the GPC, combination prevention programmes for adolescent girls and young women have received increasing attention. Through the DREAMS programme and with Global Fund support, investment in programmes among young women has increased. Countries such as Eswatini, Kenya and Lesotho cover the majority of priority districts with such programmes. Nevertheless, against a target of 90%, only around of third of young women in locations with high HIV incidence currently benefit from dedicated combination HIV prevention programmes.[40]

70. The Joint Programme has supported partners and countries through subnational estimates of HIV incidence among young women aged 15–24 years. These data have been used by Global Fund and PEPFAR to further prioritize scale-up of HIV prevention programmes among adolescent girls and young women, including in 15 districts in Mozambique.

71. In 2019 and 2020, the GPC called for a strong focus on HIV prevention programming for key populations. In 2020, the GPC convened a series of 'deep-dive' sessions on HIV prevention programming among key populations. They highlighted key policy barriers, the need for effective programming strategies, and financing gaps. Despite some successes with key population programmes, overall coverage of HIV prevention programmes among key populations remains below 50% for sex workers and below 33% for other key populations in GPC focus countries.[40]

72. A new tool supporting planning and budgeting around trusted community access platforms for key populations was used to support Global Fund grant applications.[41] The Joint Programme advocated for, and supported, key population grants within Global Fund applications. In support of such grant applications, UNAIDS and WHO developed a policy brief on how to use realistic population size estimates of gay men and other men who have sex with men in grant applications.

73. After substantial increases in condom use over the 1990 to 2010 period, declines have occurred. Data since 2015 shows that condom use has gone down in several countries, particularly among young people. The Joint Programme is therefore focusing on developing a new generation of condom programmes. Expanding access and increasing use of condoms also remains important for the prevention of unintended pregnancies, HIV transmission and sexually transmitted infection (STI) prevention. In

2020, the Global Fund earmarked funds for the first time for programming of male and female condoms and lubricants. Several countries were invited to include condom programming in their 2021–2023 funding cycle, and additional catalytic funding will be availed to Malawi, Mozambique, Uganda and Zambia.

74. In 2019, good progress was made in providing VMMC services. In the 14 priority countries, 4.1 million VMMCs were carried out, representing 83% of the global annual target of 5 million VMMCs. Five countries (Ethiopia, Kenya, Rwanda, United Republic of Tanzania and Zambia) achieved 100% of their annual target, while four countries (Botswana, Eswatini, Malawi and Namibia) remained below 50%.[2] Despite the good progress made in 2019, the global target of 25 million VMMCs by 2020 will not be met—largely due to slow progress in 2016 and to continuing service disruptions in 2020 due to COVID-19.

75. The number of people on PrEP in low- and middle-income countries increased from less than 50 000 in 2017 to more than 260 000 in 2020. Globally, there were an estimated 590 000 PrEP users in the third quarter of 2020. This amounts to less than 20% of the global target of 3 million people. [2] There are a number of examples of the association between increased PrEP use and reduced HIV incidence including among gay men and other men who have sex with men in high-income countries such as Australia[42] and the United States of America.[43]

The Joint Programme continued to provide technical assistance for Global Fund grant development and across different thematic areas of prevention

76. The Joint Programme provided extensive support to Global Fund proposal development in 2020. This included training of consultants and extensive support to proposal development in countries supported through the UNAIDS Technical Support Mechanism (TSM).

77. In addition to in-country support to proposal development, the Joint Programme supported in-depth expert review of the prevention components of grants in more than 30 countries. As a result, the Technical Review Panel of the Global Fund noted improved inclusion of HIV prevention and improved focus on key and vulnerable populations in most country grants. However, expert reviewers still note that many funding requests fall short in terms of adequate budget allocation and quality of program design. The opportunity exists to address some of these inadequacies during grant implementation on a country by country basis.

78. WHO provided technical assistance to countries on enhancing HIV services across the continuum of prevention, testing and treatment within a wider framework of Universal Health Coverage. WHO and UNAIDS also supported VMMC guideline development.[44] New guidance on event-driven PrEP was also developed.[45]

79. The WHO HIV and Sexual and Reproductive Health departments, working with the UNAIDS Secretariat, developed operational guidance on strengthening HIV prevention in the context of contraceptive services, following the findings of the ECHO trial which indicated continued high HIV incidence among women using contraception.[46] The guidance promotes a women-centred approach and focuses on strengthening HIV and STI prevention among women using contraception through a combination of improved service integration and community linkages. The guidance is currently being used to inform the next phase of the Global Fund strategic initiative on adolescent girls and young women.

80. UNICEF provided technical assistance to countries receiving Global Fund grants to strengthen delivery of combination prevention packages for adolescent girls and young women through nationally owned programmes, including in Botswana, Cameroon, the Democratic Republic of the Congo, Eswatini, Lesotho and Zimbabwe. Recognizing the need for strategic prioritization in western and central Africa, UNICEF is supporting a 10-country regional collaboration to provide national authorities and implementers with analytical tools for strategic prioritization and costing of prevention programmes for adolescent girls and young women.

81. To support the renewed focus on condom programming and to anticipate the need for technical assistance, UNFPA and partners conducted a global survey on the status of condom programming in countries where UNFPA works. Of the 19 African countries that completed the questionnaire, ten do not currently have national condom strategies, while strategies in four other countries expire this year. In the Caribbean, only Jamaica has had a national condom strategy—and it expired in 2012. The review is continuing to identify the countries that will require support.

82. UN Women scaled up evidence-based interventions to transform unequal gender norms and prevent violence against women and HIV across 15 countries. Key national partners were capacitated to implement the SASA! Intervention, reaching almost 20 000 people in Zimbabwe and 21 000 in Kenya with community-based and outreach activities to prevent HIV and violence. From 2018–2019, the UN Trust Fund to End Violence Against Women, managed by UN Women, awarded USD 1.5 million in grants to civil society organizations in Burundi, Cameroon, Chile, Egypt, Ghana, Haiti, Kenya, Myanmar, South Africa, United Republic of Tanzania and Zimbabwe to address violence and HIV. UN Women also supported the involvement of women living with HIV in Global Fund proposal development.

83. UNESCO continues to support over 65 countries to scale up good-quality, comprehensive sexuality education, which can provide young people with the critical knowledge, skills and behaviours they need for HIV prevention. Through the landmark “Our Rights, Our Lives, Our Future” programme, UNESCO has reached over 15 million young people in 33 sub-Saharan African countries with life-skills based HIV and sexuality education, and nearly 25 million learners are expected to be reached by 2022. Globally, a key focus continues to be on supporting countries to implement the revised UN International Technical Guidance on Sexuality Education, published by UNESCO with UNFPA, WHO, UNAIDS, UN Women and UNICEF in January 2018 (which, due to high demand, is being translated into over a dozen languages).

84. Co-led by the principals of UNAIDS, UNFPA, UNESCO, UNICEF and UN Women, the Education Plus Initiative was developed to support adolescent girls in all their diversity in sub-Saharan Africa. Preparations have continued for the new flagship initiative (2021–2025) on the empowerment of adolescent girls and young women and for the achievement of gender equality in sub-Saharan Africa to prevent HIV. This high-level political advocacy initiative is aimed at promoting policy reforms and investments to scale up delivery of a holistic, multisectoral package which can assist adolescent girls in making successful transitions to adulthood by ensuring access to free, quality secondary education.

85. Eighteen countries[2] have joined the Global Partnership for action to eliminate all forms of HIV-related stigma and discrimination, and the Global Fund has joined as a co-

[2] Eastern Europe and central Asia: Kyrgyzstan, Moldova, Ukraine; eastern and southern Africa: Lesotho, Mozambique, South Africa, Uganda; central and western Africa: Central African Republic,

convener. The partnership focuses on six settings: community, workplace, education, health care, justice and emergency. The UNAIDS human rights programme intersects with these settings and allows for prioritization of key actions in each of them. For example, the focus on community addresses communities who are “left behind”, including key and vulnerable populations. This allows for their rights to be clarified and asserted with respect to housing, employment and access to justice. Countries are including more stigma and discrimination activities in their national plans and are identifying related funding needs. Multisectoral partnerships and setting-based interventions and programmes have informed opportunities for institutional training including curricula, resources and linkages towards overcoming marginalization.[47]

Community involvement in the response

86. There is a need to build trusted and scalable community access platforms for promoting prevention, testing, treatment and rights including through peer-led outreach and innovative virtual outreach models.[41] Communities are able to bring about innovations that link community concerns and challenges to contextually and culturally relevant solutions. While such programmes are conducted as part of HIV response in many countries, there is a lack of scaled community responses for HIV prevention—especially in contexts of high HIV vulnerability and among key populations.

87. Communities and networks of people living with HIV, key populations, young people and women are increasingly involved in data collection. A partnership of organizations continues to lead the Stigma Index surveys, while a coalition of 11 countries in western and central Africa is documenting service access and barriers for vulnerable and key populations. Other entities in sub-Saharan Africa are focusing on HIV and tuberculosis treatment accountability.[6]

88. In South Africa and Uganda, the involvement of people living with HIV in ART delivery was associated with significant improvements in viral load suppression, especially among men, compared with clinic-based services.[48] In Kazakhstan, coalitions of people living with HIV and UN Women engaged in stigma monitoring, and women's organizations participated in developing an alternative Convention on the Elimination of all Forms of Discrimination Against Women report. In Estonia, a community-led study on rights violations against women who use drugs led to various actions to address cases of stigma and harassment.[6]

89. There is diverse community representation in HIV leadership structures across regions. Individuals, families and community-led organizations are involved in increasing access to HIV, TB and sexual and reproductive health programmes and services, as well as addressing concerns of key populations and reinforcing health and human rights responses. Faith-based organizations are increasing their involvement in HIV response, recently addressing concerns such as HIV and migration, HIV testing for vulnerable organizations and reducing HIV-related stigma. [2]

90. The Fast-Track Cities Initiative, which currently comprises more than 300 cities and municipalities, has supported city-based HIV strategic plans across the world. These have served to coordinate partnerships and provide strategic information through situation and response analysis to inform HIV prevention and other responses. Political leadership and engagement with stakeholders advanced responses in Johannesburg

---

Côte d’Ivoire, Democratic Republic of the Congo, Senegal; Asia-Pacific: Laos, Nepal, Papua New Guinea, Thailand; Middle East and North Africa: Iran (Islamic Republic of); Latin American and the Caribbean: Argentina, Jamaica.

and Kyiv, while involvement of civil society organizations improved implementation and delivery of HIV services in Athens, Madrid and Thessaloniki, among other cities.[49]

91. In Uganda, UNFPA, in partnership with the International Rescue Committee, is supporting Village Health Teams to raise awareness about HIV prevention and family planning. The teams support young people to test for HIV and facilitate referrals to health facilities. The beneficiaries in turn become advocates for family planning and HIV prevention in their communities, increasing awareness of the interventions during the COVID-19 pandemic.

Expanded support to key population programmes: global and country examples

92. In 2020, WHO convened a process for updating global guidelines for key population programming with a continued focus on HIV prevention, testing and treatment, as well as increasing attention on other sexually transmitted infections and viral hepatitis programming, including prevention and diagnostics and other health services.

93. The Joint Programme supported key population programming across different countries and regions. A regional key population strategy was launched in western Africa in July 2020. Operational research on young sex workers' vulnerabilities in Zimbabwe and mental health issues in young gay men and other men who have sex with men in Zambia was compiled with support from UNDP. Legal environment assessments were finalized in four countries and civil society "engagement scans" were completed in five countries.[50]

94. The Joint Programme advocated for further support to HIV key populations in light of the COVID-19 pandemic, including through a High-Level Political Forum side event, and an interagency working group on the impact of COVID-19 on key populations, which UNDP, UNFPA and UNODC co-convened.

95. Where harm reduction programmes are implemented at scale, new HIV diagnoses among people who inject drugs have declined substantially. In Estonia a robust strategy for drug prevention and comprehensive harm reduction programming resulted in a 93% decline in new HIV diagnoses attributed to injecting from 2006 to 2017.[51] In Portugal, where harm reduction programmes are available at scale, new HIV diagnoses attributed to injecting declined by 96% over the same period.[52] Despite these and other similar country success stories, the vast majority of people who inject drugs do not have access to quality harm reduction services.

96. Continued support was provided to harm reduction among people who inject drugs by UNODC. In Kenya, OST was rapidly scaled up. In line with global recommendations, Viet Nam shifted from compulsory drug treatment to provision of community OST. UNODC also supported introducing OST in prisons.

97. In the Republic of Moldova, the UNAIDS Secretariat and UNFPA supported the development of the "Standard on organizing and functioning of HIV prevention services among key populations, including young key populations." These standard operating procedures were distributed to all health providers who work with key populations. The provisions are also adapted to public health emergencies.

98. UNICEF, in collaboration with the Paediatric Infectious Division, Siriraj Hospital and Bangkok Health Hub, supported the Thai Ministry of Public Health in implementing a demonstration study of PrEP for at-risk adolescents aged 12–20 years. The aim was to influence national guidelines by demonstrating and documenting the feasibility, acceptability and safety of PrEP utilization among young gay men and other men who

have sex with men, transgender women, and other populations who are at high risk of HIV infection. The study informs the validation of adolescent PrEP guidelines.

99. The Joint Programme continued to support policy changes in support of key population programmes. Law reform efforts were supported in the Republic of Ireland regarding to ensure that sex workers are not adversely affected by anti-trafficking measures. In Africa, Gabon has decriminalized same-sex sexual relations, while Angola has decriminalized HIV transmission. The Northern Territory in Australia has decriminalized sex work and now provides legal protection for sex workers.

Prevention financing needs to increase and be used efficiently

100. The funding gap for the HIV response is widening. In low- and middle-income countries, total funding available in 2019 amounted to 70% of the 2020 funding target. Funding for the HIV response has increased over the past decade in all regions except western and central Africa, the Middle East and North Africa and the Caribbean. [2]

101. HIV investment has declined over past decade. One analysis found that international HIV prevention spending declined by 44% from 2012 to 2017, mostly due to a decline in financing from international donors other than the Global Fund and PEPFAR.[53] PEFPAR has sustained high levels of HIV prevention investment, while the Global Fund has increased prevention investments in the 2018–2020 grant cycle,[54] compared to the previous cycle. UNAIDS data suggests that levels of domestic investment on HIV prevention remain depressed in low- and middle-income countries.

102. The UNAIDS Fast-Track model estimated the annual cost of primary prevention programmes in low- and middle-income countries at USD 6.5 billion in 2020. Since the two major international sources of funding for HIV (Global Fund and PEPFAR) currently contribute about one fifth of that amount annually, much of the balance would need to come from domestic investment, especially in middle-income countries. Although there are examples of substantial or increasing domestic HIV prevention investments focused on key populations in countries such as China, India, Mexico and Ukraine, global targets on reducing new HIV infections will not be achieved unless middle-income countries substantially increase domestic HIV prevention investments.

103. An analysis of HIV spending for 2016–2018 in Fast-Track countries with available data suggests that less than 3% of global HIV spending and less than 12% of global HIV prevention spending is being allocated to dedicated key population programmes. Against UNAIDS resource estimates, only 18% of the estimated resource need for key populations was actually met—a gap which is much larger than the overall HIV financing gap. [55]

104. In low- and middle-income countries with high HIV prevalence, a large proportion of spending is committed to HIV treatment. South Africa, for example, allocated only 9% of total spending to primary HIV prevention in 2018. Myanmar, on the other hand, committed 24% of HIV spending in 2017 to primary prevention for populations in greatest need. [2 40] Most countries have not achieved the 2016 Political Declaration on Ending AIDS commitment to spend approximately 25% of the total HIV resources on prevention. That target was a benchmark based on a global average and country-specific needs estimates are still needed.

Priorities for HIV prevention beyond 2020

105. Primary prevention and key population programmes across the continuum of care have not been taken to scale in the majority of countries. The large gap in achieving 2020 HIV prevention targets in countries underlines the urgent need to accelerate HIV prevention.

106. In the context of missed HIV targets there is a pressing need to act more decisively and rapidly. Failure to act now immediately will cost lives, diminish health and lead to further increases in costs of treatment—all of which will burden future generations—noting that resources will be needed for treatment and care programmes well beyond 2030. An additional 3.5 million people already require HIV treatment for life due to the missed 2016–2020 HIV prevention targets.

107. HIV prevention requires renewed leadership, especially at country level. The COVID-19 pandemic has underscored the importance of political leadership in public health and the costs of actions that skirt scientific evidence or are uncoordinated. Countries which currently are not on-track to achieve the 2030 HIV prevention targets need strong leadership immediately to boost their HIV responses. Leadership will need to draw on approaches that are known to work and translate these into concrete improvements. Key considerations are adequate financing, geographically targeted and nuanced programmes, and the removal of legal and policy barriers.

108. The new global AIDS strategy has to formulate HIV prevention programmes with great precision and clear prioritization. It should take into account regional and local heterogeneities, in particular the predominance of new infections among key populations in most regions, while intensifying programmes for vulnerable populations in locations with high prevalence of HIV—particularly adolescent girls, young women and their male partners. This will require investment in strengthened HIV prevention programming capacity at country-level to develop nationally owned, evidence-informed and high-quality HIV prevention programmes.

109. Substantial guidance on community-led responses is available for programmes throughout the prevention, treatment care and rights continuum. It is clear that communities deliver contextually relevant innovations, drive normative shifts, and provide involvement that is sustainable—particularly in low-resource environments.[33] There is a need to advocate for strengthened and resourced leadership by affected communities in HIV prevention as a core platform for success, especially key populations, young people and women and girls—as well as families and communities—in settings with high prevalence of HIV infection. This will improve the long-term sustainability of HIV responses.

110. Leadership and financing are necessary to ensure prioritization of the HIV and COVID-19 pandemics together. COVID-19 presents a new challenge requiring new (not re-allocated) resources, renewed energy and robust, enlightened leadership. Reducing resources for HIV prevention in the face of COVID-19 would exacerbate the current HIV prevention crisis and threaten the gains that have been made thus far.

Proposed Decision Points

111. Request the Joint Programme to:

a. ensure that HIV prevention is given high priority in the new Global AIDS Strategy and in the new UNAIDS Unified Budget, Results and Accountability Framework (UBRAF).

b. actively support governments in convening partners at country-level to build unity of purpose among governments, communities and implementing organizations in developing HIV prevention responses that are aligned to country epidemic context and to global principles, implementation guidance and good practices.

112. Requests member states and the Joint Programme to:

a. Lead a new vision for HIV prevention that intensifies focus and investment in strategies and programs for key and vulnerable populations with a high incidence of HIV in all regions. The strategy should include a clearly defined approach to overcome financing, implementation and legal and policy barriers to HIV prevention, with a particular focus on key populations in all regions and young women in countries with high HIV prevalence. The strategy should equally incorporate strengthening and resourcing of community-led interventions.

b. Support and advocate for strategic investment in national capacities to manage HIV prevention programs. The PCB also requests the Joint Programme to ensure that adequate technical and implementation support capacity is available in countries.

c. Reinforce and maintain beyond 2020 the progress made by the Global HIV Prevention Coalition in reinvigorating HIV prevention responses, underscoring national ownership of the coalition objectives and expanding membership to countries and regions with rising HIV incidence.

113. Call on Member States to address key underlying legal, policy and structural barriers affecting key populations and adolescent girls and young women as outlined in the paper

114. Report back to the Programme Coordinating Board in 2021 on progress made in HIV prevention, including the measurable outcomes and efficacy of the Global HIV Prevention Coalition.

References

1 UNAIDS. Annual progress report on HIV prevention 2020. Geneva; 2019

2 UNAIDS. Seizing the moment. Tackling entrenched inequalities to end epidemics. Global AIDS Update 2020. Geneva; 2020 (https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf).

3 Eisinger RW, Dieffenbach CW, Fauci AS. HIV viral load and transmissibility of HIV infection: undetectable equals untransmittable. JAMA. 2019;321(5):451–452.

4 UNAIDS. UNAIDS data 2020. Geneva; 2020. (https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf)

5 Havlir D, Lockman S, Ayles H, Larmarange J, Chamie G, Gaolathe T, Iwuji C, Fidler S, Kamya M, Floyd S, Moore J. What do the Universal Test and Treat trials tell us about the path to HIV epidemic control? Journal of the International AIDS Society. 2020;23(2):e25455

6 UNAIDS. Evidence review: Implementation of the 2016–2021 UNAIDS strategy: On the Fast-Track to end AIDS. 31 July 2020. Geneva; 2020 [DRAFT]

7 United Nations Economic and Social Council. Commission on the Status of Women. Women, the girl child and HIV and AIDS. Sixty-fourth session. 9–20 March 2020. Geneva; 2020 (https://undocs.org/E/CN.6/2020/6).

8 UNAIDS. Global HIV & AIDS statistics: 2020 fact sheet. [Internet] (https://www.unaids.org/en/resources/fact-sheet).

9 UNAIDS. The "last mile" to EMTCT: A roadmap for ending paediatric HIV worldwide. Geneva; 2019 (http://www.childrenandaids.org/sites/default/files/2019-12/EMTCT-brief_122019.pdf).

10 UNAIDS. COVID-19 and HIV: 1 Moment. 2 Epidemics. 3 Opportunities. Geneva; 2020 (https://www.unaids.org/sites/default/files/media_asset/20200909_Lessons-HIV-COVID19.pdf)

11 UNAIDS. HIV service disruptions in 2020. Geneva; August 2020.

12 UN Women. COVID-19 and ending violence against women and girls. New York; 2020 (https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006).

13 UNAIDS. HIV service disruptions in 2020. Powerpoint presentation. January to September 2020. Geneva: UNAIDS.

14 UNAIDS data summary. October 2020. Geneva; 2020.

15 UNWomen. Six concrete measures to support women and girls and all their diversity in the context of the COVID-19 pandemic. New York; 2020 (https://www.unaids.org/sites/default/files/media_asset/women-girls-covid19_en.pdf).

16 UNAIDS. Rights in the time of COVID-19. Lessons from HIV for an effective, community-led response. Geneva; 2020 (https://www.unaids.org/sites/default/files/media_asset/human-rights-and-covid-19_en.pdf).

17 UNAIDS. Fast-tracking combination prevention: Towards reducing new HIV infections to fewer than 500 000 by 2020. Geneva; 2020 (https://www.unaids.org/en/resources/documents/2015/20151019_JC2766_Fast_tracking_combination_prevention).

18 UNAIDS. HIV prevention 2020: A global partnership for delivery (Background note). Geneva; 2017.

19 Havlir D, Lockman S, Ayles H, Larmarange J, Chamie G, Gaolathe T, Iwuji C, Fidler S, Kamya M, Floyd S, Moore J. What do the Universal Test and Treat trials tell us about the path to HIV epidemic control? Journal of the International AIDS Society. 2020;23(2):e25455.

[20] Fraser et al. Phylogenetic analysis of data from the POP-ART trial. Presentation (unpublished).

[21] UNAIDS. Thematic segment: Reducing the impact of AIDS on children and youth. Background Note. 10-12 December 2019. Geneva; 2019. (https://www.unaids.org/sites/default/files/media_asset/28112019_UNAIDS_PCB45_Thematic-Segment-Background-Note_EN.pdf)

[22] Mukandavire C, Low A, Mburu G, Trickey A, May MT, Davies CF, French CE, Looker KJ, Rhodes T, Platt L, Guise A. Impact of opioid substitution therapy on the HIV prevention benefit of antiretroviral therapy for people who inject drugs. Aids. 2017 May 15;31(8):1181-90.

[23] Farley TM, Samuelson J, Grabowski MK, Ameyan W, Gray RH, Baggaley R. Impact of male circumcision on risk of HIV infection in men in a changing epidemic context–systematic review and meta-analysis. Journal of the International AIDS Society. 2020;23(6):e25490.

[24] Warren EA, Paterson P, Schulz WS, Lees S, Eakle R, Stadler J, Larson HJ. Risk perception and the influence on uptake and use of biomedical prevention interventions for HIV in sub-Saharan Africa: a systematic literature review. PloS one. 2018;13(6):e0198680.

[25] Glaubius R, Ding Y, Penrose KJ, Hood G, Engquist E, Mellors et al. Dapivirine vaginal ring for HIV prevention: modelling health outcomes, drug resistance and cost-effectiveness. Journal of the International AIDS Society. 2019;22(5):e25282.

[26] Canetti D, Spagnuolo V. An evaluation of cabotegravir for HIV treatment and prevention. Expert Opinion on Pharmacotherapy. 2020 Oct 30.

[27] WHO. Trial results reveal that long-acting injectable cabotegravir as PrEP is highly effective in preventing HIV acquisition in women. Departmental news, Geneva, 9 November 2020. https://www.who.int/news/item/09-11-2020-trial-results-reveal-that-long-acting-injectable-cabotegravir-as-prep-is-highly-effective-in-preventing-hiv-acquisition-in-women

[28] De Neve JW, Fink G, Subramanian SV, Moyo S, Bor J. Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. The Lancet Global Health. 2015;3(8):e470-7.

[29] Global HIV Prevention Coalition. The effectiveness of behavioural interventions to prevent HIV. A compendium of evidence. Geneva: Global HIV Prevention Coalition. Geneva; 2019 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/09/The-effectiveness-of-behavioural-interventions-to-prevent-HIV.-A-compendium-of-evidence_final.pdf).

[30] Gorgens M, Ketende S, Tsododo V et al. Sitakhela Likusasa Impact Evaluation: results of a cluster randomized control trial (cRCT) of financial incentives for HIV prevention among adolescent girls and young women (AGYW) in Eswatini. 10th IAS Conference on HIV Science, Mexico City, abstract TUAC0205LB, 2019.

[31] US Department of State. Reflections from AIDS 2020 – Dreams: A movement still in the making. 29 July 2020 (https://www.state.gov/reflections-from-aids-2020-dreams-a-movement-still-in-the-making/).

[32] Chimbindi N, Birdthistle I, Floyd S, Harling G, Mthiyane N, Zuma T et al. Directed and target focused multi-sectoral adolescent HIV prevention: Insights from implementation of the 'DREAMS Partnership' in rural South Africa. Journal of the International AIDS Society. 2020;23:e25575.

[33] UNAIDS. Community innovations. Geneva; 2020 (https://www.unaids.org/sites/default/files/media_asset/2020_community-innovations_en.pdf).

[34] Johnson LF, Chiu C, Myer L, Davies MA, Dorrington RE, Bekker LG et al. Prospects for HIV control in South Africa: a model-based analysis. Global health action. 2016;9(1):30314.

[35] Mahomva A, Greby S, Dube S, Mugurungi O, Hargrove J, Rosen D, Dehne KL, Gregson S, St Louis M, Hader S. HIV prevalence and trends from data in Zimbabwe, 1997–2004. Sexually transmitted infections. 2006;82(suppl 1):i42-7.

[36] UNAIDS. Prevention 2020: A global partnership for delivery (background note). Geneva; 2017 (https://www.unaids.org/sites/default/files/media_asset/20170623_PCB40_Background-Note_17.14_EN.pdf).

[37] UNAIDS. Annual progress report on HIV prevention. Geneva; 2020 (https://www.unaids.org/sites/default/files/media_asset/25112019_UNAIDS_PCB45_Annual-progress-report-on-prevention_EN.pdf).

[38] UNAIDS. HIV Prevention 2020 Road Map. Accelerating HIV prevention to reduce new infections by 75%. Geneva; 2018 (https://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf).

[39] UNAIDS Evaluation Office. Evaluation of the UN system response to AIDS in 2016–2019 Geneva; 2020 (https://www.unaids.org/en/resources/documents/2020/evaluation-of-the-UN-system-response-to-AIDS-2016–2019).

[40] Global HIV Prevention Coalition. Implementation of the HIV Prevention 2020 Road Map Fourth Progress Report. Geneva; 2020.

[41] Genesis Analytics. Key population trusted access platforms. Considerations in planning and budgeting for a key population platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers. Johannesburg; 2020 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/04/Budget-Considerations-for-KP-Trusted-Access-Platforms-April-2-2020-Final-V-1.1a-no-TCs-1.pdf).

[42] Grulich AE, Guy R, Amin J, Jin F, Selvey C, Holden J et al. Population-level effectiveness of rapid, targeted, high-coverage roll-out of HIV pre-exposure prophylaxis in men who have sex with men: the EPIC-NSW prospective cohort study. The lancet HIV. 2018;5(11):e629-37.

[43] Shover CL, Shoptaw S, Javanbakht M, Lee SJ, Bolan RK, Cunningham NJ et al. Mind the gaps: prescription coverage and HIV incidence among patients receiving pre-exposure prophylaxis from a large federally qualified health center in Los Angeles, California. AIDS and Behavior. 2019;23(10):2730-2740.

[44] WHO & UNAIDS. Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations. Geneva; 2020 (https://www.who.int/publications/i/item/978-92-4-000854-0).

[45] WHO. What's the 2+1+1? Geneva; 2019 (https://apps.who.int/iris/bitstream/handle/10665/325955/WHO-CDS-HIV-19.8-eng.pdf?ua=1)

[46] WHO: Preventing HIV and other STIs among women and girls using contraceptive services in contexts with high HIV incidence. Geneva; 2020 (https://www.who.int/publications/i/item/actions-for-improved-clinical-and-prevention-services-and-choices-preventing-hiv-and-other-stis-among-women-and-girls-using-contraceptive-services).

[47] UNAIDS. Evidence for eliminating HIV-related stigma and discrimination. Geneva; 2020 (https://www.unaids.org/en/site-search#?cludoquery=evidence%20review%20stigma%20and%20discrimination&cludopage=1).

[48] Barnabas RV, Szpiro AA, van Rooyen H, Asiimwe S, Pillay D, Ware NC et al. Community-based antiretroviral therapy versus standard clinic-based services for HIV in South Africa and Uganda (DO ART): a randomised trial. The Lancet Global Health. 2020;8(10):e1305-15 (https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30313-2/fulltext).

[49] International Association of Providers of AIDS Care (IAPAC). Fast-Track Cities. Global Web Portal. (https://www.fast-trackcities.org)

[50] The LEAs are published in the GCHL website https://hivlawcommission.org/elibrary-lea/ and the CSES are posted on UNDP website https://undp.sharepoint.com/sites/LPPProject]

[51] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Estonia Country Drug Report 2019 (https://www.emcdda.europa.eu/countries/drug-reports/2019/estonia_en).

[52] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Portugal Country Drug Report 2019 (https://www.emcdda.europa.eu/countries/drug-reports/2019/portugal_en).

[53] Mann Global Health. Donor landscape for condom programming. Geneva, 2019 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/MGH-Rpt-2-Donor-Trends_Condom-Landscape-Analysis_Final.pdf).

[54] The Global Fund. HIV Prevention Budget Analysis. Presentation. Geneva; 2020.

[55] Partnership to Inspire, Transform and Connect the HIV Response; Bridging the Gaps. Fast-track or off track? How insufficient funding for key populations jeopardises ending AIDS by 2030.

[End of document]