Agenda item 3

UNAIDS/PCB (46)/20.7

UNAIDS STRATEGY BEYOND 2021

UNAIDS

23-25 June 2020 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 28 May 2020

Additional documents for this item:

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

5.1 *Recalling* decisions 3.1 and 3.2 from the 45th PCB meeting, *take note* of the progress update UNAIDS/PCB (46)/20.7;

5.2 *Request* the Executive Director to:

- present the findings from the completed review of the current UNAIDS Strategy (2016-2021) and the implications for strategic priorities beyond 2021 for consideration by the multistakeholder consultation no later than September 2020;
- present to the 47th PCB meeting in December 2020 a report on the process and on the outcome of the review and consultations with options for the UNAIDS Strategy beyond 2021 ensuring that it remains ambitious, visionary and evidence-based;
- present to a special session of the PCB, no later than March 2021, the UNAIDS Strategy beyond 2021;

Cost implications for the implementation of the decisions:
In the event that the PCB elects to hold a Special Session to adopt the UNAIDS Strategy beyond 2021, the following are cost estimates:

In-person one-day Special Session (on basis of estimates from the 2019 March Special Session of the PCB): $110,000

Virtual three-hour Special Session: $45,000

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EXECUTIVE SUMMARY

1. At its 45th meeting, the UNAIDS Programme Coordinating Board (PCB) requested the UNAIDS Executive Director to:
    - undertake a review of the current Strategy and its implementation and the results obtained;
    - convene a multistakeholder consultation, with participation of Member States, to present the results of the review and consider the strategic priorities beyond 2021;
    - present, for consideration by the Board at its 46th meeting in June 2020, options, and their respective processes and timelines, to ensure that the UNAIDS Strategy remains ambitious, visionary, and evidence-based beyond 2021; and
    - consult the United Nations Secretary-General to consider options for the timing of the UN General Assembly High-Level Meeting on HIV and AIDS and advise the 46th meeting of the PCB in June 2020.

2. To respond to these requests, an extensive process of qualitative input-seeking consultations have been recently initiated. These include online surveys, interviews and focus group discussions to solicit stakeholder feedback, priorities and needs, with special efforts to engage key groups that are difficult to reach or are at risk of being left behind. These consultations will continue up to September 2020, to allow adequate time for quality engagement. It is envisioned that the qualitative consultations will generate valuable inputs to help define areas where deeper dives on data and evidence are needed.

3. UNAIDS has also initiated a review of evidence to provide a better understanding of the implementation and the results obtained under the current *UNAIDS 2016 Strategy: On the Fast Track to end AIDS,* and to identify strategic priorities beyond 2021 to ensure that the world is on track to reach the target of ending AIDS as a public health threat by 2030 as part of the Sustainable Development Goals. The data review exercise will incorporate the latest Global AIDS Monitoring data provided by up to the end of 2019 as well as additional sources of data and will also assess the implications of the COVID-19 pandemic on the AIDS response. This data review report will be published at the end of July 2020 in order to provide PCB members with time to review the report before the multistakeholder consultation in September 2020. The report will provide a useful frame for the strategy consultations as work advances to develop a visionary, ambitious, evidence-based strategy beyond 2021.

4. Available data indicates that the UNAIDS 2016–2021 Strategy has been used extensively by countries, communities, and partners to advance the global HIV response towards the commitments made by member states in the 2016 Political Declaration on HIV and AIDS. The Strategy set out priority issues and approaches for the global HIV response, provided a roadmap to guide the necessary actions to accelerate progress and rallied countries and stakeholders around ambitious yet achievable targets. Many of these targets were subsequently translated into political commitments in the 2016 UN General Assembly Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to ending the AIDS Epidemic by 2030. Treatment scale-up has seen deaths from AIDS-related illness decline. The annual number of new HIV infections have also declined, although slowly. However, results have been uneven across and within countries and communities. There are significant disparities in HIV service availability, models, and uptake, both geographically and by subpopulation. Gaps in accessing comprehensive package of services are often largest for countries, populations and people who are most in need, and significant differences remain in policy and legal environments and social enablers.

5. The process of ensuring the full engagement of the PCB and its constituencies in the Strategy process is occurring in a context in which countries, communities and global partners, including UNAIDS, are confronting the profound new health, social and economic challenges posed by the COVID-19 pandemic. These extraordinary circumstances present challenges for UNAIDS' stakeholders to fully engage in reviewing the current strategy and optimally participate in consultations in a conducive environment.

6. The full, meaningful engagement of Member States, people living with HIV, key populations, adolescent girls and young women, and other people affected by HIV, as well as of UNAIDS partners and stakeholders, is critical in this process. It is also essential that additional data are compiled and deeper analysis is performed to drive additional comparisons and gain insights. This analysis will identify what has differentiated rapid progress from stalled progress or regress, and most importantly, where targets are still not being achieved, to ensure life-saving interventions reach all people most in need. These evidence-based insights will inform the changes needed in the UNAIDS strategy beyond 2021 to enable countries and the international community to close the gaps and remove the barriers to ending AIDS by 2030. There will also be opportunities to carefully map out impact of the COVID-19 pandemic, and to consider the possible implications of other unpredictable shocks (such as other emerging infectious diseases, natural disasters, or humanitarian emergencies) to the future of the AIDS response.

7. In order to address the current challenges brought about by COVID-19 and to ensure full, meaningful engagement of stakeholders, UNAIDS proposes that the timeframe for the review of the current strategy be extended past June 2020, allowing review consultations (survey, interviews, focus group discussions) to continue and the multistakeholder consultation for PCB members to be organized no later than September 2020. The review of the current strategy, its implementation and results obtained will be presented to the multistakeholder consultation and will incorporate findings from the data review (to be published in July 2020) and inputs from consultations (survey, interviews, focus group discussions).

8. It is also proposed that the 47th PCB in December 2020 receives an progress report on the Strategy process, together with options for the UNAIDS Strategy beyond 2021, and that a special session of the PCB in March 2021 considers approval of a UNAIDS strategy beyond 2021.

I. INTRODUCTION

9. The UNAIDS 2016–2021 Strategy: On the Fast Track to end AIDS was a bold call to action. It set out to inspire the world for a people-centred and rights-based HIV response. It was an urgent call to front-load investments, close the testing gap, reach the 90–90–90 targets, advance tailored HIV combination prevention, drastically reduce new HIV infections among adults and children, and eliminate HIV-related discrimination. Many of the targets and approaches of the Strategy inspired Member States to agree to ambitious commitments in the 2016 UN General Assembly Political Declaration on HIV and AIDS.

10. The Strategy set out the core actions that are needed to ensure that all people, especially key populations, as well as young women and girls in settings with a high prevalence of HIV infection, can access the HIV services they need, and to redress the deplorably low treatment coverage for children living with HIV. Its goals and targets are aligned the 2030 Agenda and have inspired collaborative actions across diverse sectors of society, as well as investments in areas where HIV and other health and development priorities intersect. The Strategy aimed to put the world on-track to achieve the goal of ending AIDS as a public health threat by 2030 as part of the Sustainable Development Goals.

11. At its 45th meeting, the UNAIDS Programme Coordinating Board (PCB) requested the UNAIDS Executive Director to:
    - undertake a review of the current Strategy and its implementation and the results obtained;
    - convene a multistakeholder consultation, with participation of Member States, to present the results of the review and consider the strategic priorities beyond 2021;
    - present, for consideration by the Board at its 46th meeting in June 2020, options, and their respective processes and timelines, to ensure that the UNAIDS Strategy remains ambitious, visionary, and evidence-based beyond 2021; and
    - consult the United Nations Secretary-General to consider options for the timing of the UN General Assembly High-Level Meeting on HIV and AIDS and advise the 46th meeting of the PCB in June 2020.

12. This report provides a summary of progress in responding to these requests. It also lays out key data on the epidemic and response, highlighting successes and shortcomings in the implementation of the UNAIDS strategy. The paper then summarizes the next steps to complete the review of the current strategy and to validate strategic priorities required for the UNAIDS Strategy beyond 2021 and proposes a timeline for the adoption of the Strategy.

Context

13. The process of responding to the PCB requests is occurring in a context in which countries, communities and global partners are confronting the profound new health, social and economic challenges posed by the COVID-19 pandemic.

14. The COVID-19 crisis is severely impacting countries' and communities' often fragile HIV response infrastructure and systems. The UNAIDS Joint Programme is actively responding to this new situation, redirecting attention and resources to support countries in their response to COVID-19 through protecting and preserving gains made in the AIDS response. The Joint Programme's emphasis is on mitigating the impact of the COVID-19 pandemic on people living with HIV and those vulnerable to HIV, while safeguarding access to HIV prevention, testing and treatment and protecting people

against all forms of stigma and discrimination, as outlined in the UNAIDS Strategy. The Joint Programme has also contributed valuable lessons learnt from the HIV response to inform and strengthen the global and country responses to COVID-19.

15. These extraordinary circumstances have limited the ability of UNAIDS and its stakeholders to fully engage in reviewing the current strategy and in participating in consultations as the same key stakeholders are now charged with additional burden: maintaining the HIV response while tackling additional challenges brought on by COVID-19.

16. On 6 May 2020, the UNAIDS Executive Director received a request from the PCB NGO delegation to extend the timeline for the review of the current Strategy to ensure that communities affected by HIV, as well as civil society, are able to meaningfully engage in the consultation process. The NGO delegation was concerned that the attention of PCB members, governments and civil society alike, was focused on the COVID-19 crisis and that this would prevent stakeholders from engaging meaningfully in the Strategy review.

17. At its meeting on 7th May, the PCB Bureau stressed the importance of an in-depth review as the starting point for the next Strategy. The Bureau agreed that the original timeline was too compressed in light of the challenges posed by COVID-19, which presents a high risk of inadequate engagement of key stakeholders.

18. Support was expressed for extending time for the strategy process – to allow up to September 2020 to complete review consultations and the multistakeholder consultation. Flexibility was encouraged. Members stressed, however, the importance of ensuring that a Strategy is in place ahead of the planned High-Level Meeting in 2021. The Bureau also discussed the options for the Strategy agenda items at the 46th PCB, which could include presentation on data as well as a procedural update with an anticipated timeline.

19. Full and meaningful engagement of Member States, people living with HIV, key populations, adolescent girls and young women, and other people affected by HIV, as well as of UNAIDS partners and stakeholders, is of utmost importance for ensuring that the UNAIDS Strategy beyond 2021 is fully owned by all relevant actors and stakeholders. It is also vital to build momentum for the next phase of the global HIV response through an inclusive consultation process.

20. UNAIDS considers that a robust review and analysis of the available data is required to provide a thorough picture of the implementation of the UNAIDS Strategy to date, including the recommendations emerging from the Independent Evaluation of the UN system response to AIDS in 2016-2019, and to understand the reasons behind its successes and shortcomings. The next UNAIDS Strategy will be implemented either in a post-COVID context or in a context where the world continues to respond to the COVID-19 pandemic. It is therefore important to take into account and learn from the global, regional and country responses to COVID-19 to arrive at a clear understanding of how the pandemic will affect the HIV epidemic and response.

21. In light of those concerns, UNAIDS proposes the following timeline for the Strategy process.
    - **May–September 2020:** UNAIDS has initiated a data review of the current UNAIDS Strategy, its implementation and the results obtained. Consultations with stakeholders have also begun. Online survey, interviews and focus group

discussions on the next phase of UNAIDS Strategy are currently being carried out and will continue up to September 2020.

- **46th PCB meeting 23–25 June 2020:** Update on progress will be presented to the PCB. The PCB is expected to take a decision on the proposed next steps in the process.
- **End of July 2020:** Data review of the current Strategy, its implementation and results obtained will be completed. Results of the review will inform subsequent consultations.
- **September 2020:** The review of the current Strategy, its implementation and results obtained, based on data review and consultations, will be presented to a multistakeholder consultation. The consultation will discuss lessons from the implementation of the current Strategy and strategic priorities beyond 2021. It will also consider options for the next steps in ensuring that the UNAIDS Strategy remains ambitious, visionary and evidence-based beyond 2021.
- **October 2020**: UNAIDS will finalize targets and resource need estimates for 2025.
- **December 2020:** The 47th PCB will receive a progress report on the process options for the strategy beyond 2021 ensuring it remains ambitious, visionary and evidence-based.
- **March 2021:** A proposed Special Session of the PCB will adopt the UNAIDS Strategy past 2021.
- **January-June 2021:** UNAIDS Budget, Results, Accountability and Resource Allocation Framework to support the implementation of the global AIDS Strategy will be developed through a consultative process.
- **June 2021:** The PCB will adopt a new accountability and resource allocation framework to operationalize the UNAIDS Strategy.
- **June or September 2021:** General Assembly High-Level Meeting on AIDS will adopt a new Political Declaration with 2025 targets.

II. STEPS TAKEN TO RESPOND TO THE PCB REQUESTS

22. Guiding the review of the current Strategy and the development of the Strategy beyond 2021 are the key principles that underpin the work of UNAIDS. The work is data-driven, multisectoral and consultative, and it involves UNAIDS Secretariat, Cosponsors, Member States, civil society, communities, people living with and affected by HIV, key populations, women and girls, young people, faith-based organizations, representatives of various government sectors (including health, education, finance and justice), as well as national AIDS commissions, parliamentarians, science and academia, philanthropists, donors, the private sector and global health partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

23. The following steps have been taken to date to respond to the requests of the PCB.
    - **Establishment of a Strategy development team**. The UNAIDS Executive Director has established a UNAIDS Strategy Development team, comprising over 20 UNAIDS Secretariat staff from across the organization. The Strategy team works in collaboration with UNAIDS Cosponsors, and manages and facilitates the Strategy review, development and consultation processes, ensuring inclusive, participatory approaches with a diverse group of partners.
    - **Joint Programme Retreat.** The Secretariat and the cosponsors met for a retreat in February 2020 and discussed the lessons learnt from the implementation of the current strategy. Deep dives into country data were initiated to better understand

the reasons behind rapid progress in some locations and stalled or regressed HIV responses in others.

- **First phase of Strategy Data Review**. Desk review of available reports and data have been initiated to review the successes achieved and challenges encountered in the implementation of the Strategy. The process is on-going and is expected to produce final report by end of July 2020.
- **First phase of consultations.** To gauge stakeholders needs and identify the priority issues they would like to address in the strategy process, the following qualitative input-seeking consultations have been initiated: (i) Multilingual Online Survey; (ii) Dialogue Interviews; and (iii) Focus Group Discussions.
- **Discussions of the Committee of Cosponsoring Organizations (CCO).** The CCO met "virtually" on 15 May 2020. It discussed the risks posed by the COVID-19 pandemic to the HIV response and reflected on the added value of the Joint Programme in the response to COVID-19. The CCO also discussed the implications of the pandemic on the timeline for the Strategy review and development process, and expressed support for an extended timeline to ensure full engagement of stakeholders and to learn from the COVID response.

III. PRELIMINARY FINDINGS FROM DESK REVIEW OF AVAILABLE DATA

24. The UNAIDS 2016–2021 Strategy was based on the vision of zero new HIV infections, zero discrimination and zero HIV-related deaths, and it was aimed at achieving fewer than 500 000 new HIV infections and HIV-related deaths by 2020, and eliminating HIV-related discrimination.

25. The Strategy is aligned with the 2030 Agenda, and its targets served as the basis for commitments made by Members States in the 2016 Political Declaration on HIV and AIDS. The strategic directions, as well as the eight result areas of the Strategy, cover a broad range of evidence-based, people-centred and rights-based interventions across multisectoral areas and partnerships (governments, civil society, the private sector, the scientific community, academia, foundations and local authorities).

26. The UNAIDS 2016–2021 Strategy has been used extensively by countries, communities and partners to advance the global HIV response. The strategy identified priority issues and approaches for the global HIV response, provided a roadmap to guide the necessary actions to advance progress and rallied the world around ambitious yet achievable targets, such as 90-90-90. Much of the progress has been made possible through Joint Programme support to countries, including in coordinating HIV investments from partners such as the Global Fund and PEPFAR and increasing domestic investments in HIV.

27. However, results have been uneven across and within countries, and many of the global 2020 targets will not be reached, despite remarkable progress in some countries. There are significant disparities in HIV service availability and uptake, both geographically and by subpopulation. Gaps in the provision of a comprehensive package of services are often largest for the people who are most in need. There are major differences in legal and policy environments and other social and structural factors that either help or hinder national AIDS responses.

The 2016-2020 Strategy at a glance

The UNAIDS 2016-2020 Strategy is based on a vision of zero new HIV infections, zero discrimination and zero AIDS related deaths. It set out to achieve by 2020:

- **Fewer than 500 000 people newly infected by HIV**
- **Fewer than 500 000 people dying from AIDS-related causes**
- **Elimination of HIV-related discrimination**

The eight results areas of the strategy are aligned with the **2030 Agenda** and organised around the five **Sustainable Development Goals** that are the most relevant for the AIDS response. There is no substantive difference between the 10 targets in the UNAIDS Strategy and the targets of the 2016 Political Declaration. The implementation of the UNAIDS strategy contributes therefore directly towards the Political Declaration targets.

Result area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment.

Result area 2: New HIV infections among children eliminated and their mother's health and well-being is sustained.

Result area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV.

Result area 4: Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants.

Result area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV.

Result area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed. Punitive laws, policies and practices removed, including overly broad criminalization of HIV transmission, travel restrictions, mandatory testing and those that block key populations' access to services.

Result area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information.

Result area 8: People-centred HIV and health services are integrated in the context of stronger systems for health. HIV-sensitive universal health coverage schemes implemented.

Key achievements

28. Impressive progress has been made towards the 90–90–90 testing and treatment target – a major achievement in the implementation of the Strategy. Almost 4 out of 5 people (79%) living with HIV knew their status at the end of 2018, 78% of people living with HIV who knew their HIV status were on treatment, and 86% of people who were on treatment were virally suppressed.

29. These achievements reflect the continued increases in the numbers of people receiving antiretroviral therapy. An estimated 24.5 million [21.5 million–25.5 million] people living with HIV were on treatment globally in mid-2019. The 770 000 [570 000 – 1.1 million] people who died of HIV-related illnesses in 2018 were fewer than at any point since 1994, although the number of deaths is still too high to reach the Strategy target of 500,000 deaths by the end of 2020.

30. The 90-90-90 target guides countries to address gaps in the cascade of services from HIV testing to confirming HIV-positive diagnosis to initiating antiretroviral therapy and achieving and sustaining the viral suppression needed to improve health outcomes for the individual and help prevent further spread of the virus. If all aspects of this target are met, at least 73% of people living with HIV in a country are virally suppressed. Fifteen countries[1] had reached the 90–90–90 target in 2018, including three countries with large HIV burdens: Botswana, Eswatini and Namibia. At least 60% of people living with HIV were virally suppressed in 6 other countries with large HIV epidemics in 2018.[2] A total of 19 countries reached the first 90 – 90% of people living with HIV knew their status.

31. Among women living with HIV 84% know their status, 68% of all women living with HIV are accessing treatment and 59% are virally suppressed, while among men living with HIV 75% know their status, 55% of all men living with HIV are accessing antiretroviral therapy and 47% are virally suppressed. The data is higher for women largely due to the success of EMTCT efforts. Low rates of treatment coverage and viral suppression among men is a driver of continued HIV transmission, including among adolescent girls and young women. However, there is wide regional variation. In western and central Africa, only 40% of men living with HIV were accessing HIV treatment, compared to 61% of women living with HIV. Treatment coverage for men differed by at least 10% in Asia and the Pacific, the Caribbean, eastern and southern Africa and eastern Europe and central Asia.

32. Countries have committed to eliminating all new HIV infections among children by 2020. An estimated 1.5 million new HIV infections in children were averted between 2010 and 2018. During the start of the decade, more extensive testing and wider provision of effective antiretroviral therapy to pregnant women living with HIV (82%) drove progress towards the elimination of mother-to-child transmission of HIV and greater success in protecting the health and lives of mothers living with HIV. The proportion of pregnant women living with HIV who receive antiretroviral medicines to prevent vertical transmission increased from 44% [33–54%] globally in 2010 to 80% [62–>95%] in 2018. Leading progress were high-performing programmes in many countries in eastern and southern Africa, where 92% [69–>95%] of all pregnant women living with HIV received antiretroviral therapy in 2018. However, since 2015, the progress in preventing vertical transmission of HIV as well preventing new infections in reproductive age women has slowed. Between 2010 and 2016, the number of new infections in children declined by over 10% per year while between 2016 and 2018, new infections only dropped by 4% per year. In 2018, 160 000 [110 000–260 000] children (<15 years) were newly infected.

[1] Australia, Botswana, Cambodia, Denmark, Eswatini, France, Germany, Iceland, Ireland, Namibia, Netherlands, Rwanda, Spain, Thailand and the United Kingdom.

33. The combination approach to HIV prevention (which includes behavioural, biomedical and structural interventions) has resulted in reductions in HIV infections in a variety of settings and countries.

34. Political commitments to advance the HIV prevention agenda were elevated as a result of the Global HIV Prevention Coalition, which was convened in 2017 by UNFPA and the UNAIDS Secretariat with participation across the Joint Programme and among key strategic partners. The Coalition has supported countries in reframing HIV prevention around priority populations and high-impact interventions. The 28 participating countries renewed political commitment to prevention and developed ambitious national HIV prevention targets for relevant priority pillars of HIV prevention. The Global Fund aligned its prevention investments to the priority pillars defined by the Coalition and reported a relative increase of investment in the five priority pillars of prevention over time. Coverage of priority HIV prevention programmes in participating countries has increased moderately between 2017 and 2018, although major gaps towards 2020 targets remain in a context of continued financing and prevention implementation capacity gaps as well as policy and service access barriers that still need to be addressed.

35. Condom use has increased in several countries in sub-Saharan Africa in the past decade, with the most recent survey data showing at least 70% of men reported using a condom at last high-risk sex in, for example, Kenya, Lesotho, Malawi, South Africa and Zimbabwe. Nonetheless, median condom use by men at last higher risk sex in 27 sub-Saharan African countries with recent data was only 59%, far from the global target of 90% by 2020.

36. An increasing number of countries are providing pre-exposure prophylaxis (PrEP) as an additional HIV prevention option to people who are at high risk of infection. By early 2019, over 20 countries globally were managing national PrEP programmes[3] and a further 40 were operating pilot or demonstration projects. However, few national programmes are providing PrEP at the scale envisioned in the UNAIDS Strategy and the 2016 UN General Assembly Political Declaration, which set a target of 3 million people on PrEP annually, focused particularly on key populations and people at high risk in high prevalence settings. Only approximately 500 000 people took PrEP at least once in the previous 12 months as of April 2020, and nearly half were in North America and Western Europe[4].

37. Approximately 11 million voluntary medical male circumcisions were performed in 15 priority countries between 2016 and 2018 against the target of 25 million by 2020, including more than 4 million in 2018.

38. Some progress has been made in reducing HIV-related stigma and discrimination, especially in the high-prevalence countries of eastern and southern Africa, where population-based surveys show lower levels of stigmatizing attitudes and declines in 9 of 10 countries with sufficient data to track long-term trends. However, discriminatory

[3] Including Brazil, Kenya, Lesotho and South Africa.

[4] Source: Global AIDS Monitoring, 2017–2020; amfAR: PEPFAR Monitoring, Evaluation and Reporting Database [Internet]. amfAR; c2020 (https://mer.amfar.org/Manual/PrEP_NEW); Hayes R, Schmidt AJ, Pharris A, Azad Y, Brown AE, Weatherburn P et al. Estimating the “PrEP Gap”: how implementation and access to PrEP differ between countries in Europe and central Asia in 2019. Eurosurveillance. 2019;24(41); Country Updates In: PrEPWatch [Internet]. AVAC; c2020 (https://www.prepwatch.org/in-practice/country-updates/); and country documents and meeting reports (available on request).

attitudes towards people living with HIV remain extremely high in far too many countries. Across 26 countries with recent population-based survey data for a composite indicator collected by UNAIDS, more than half of respondents expressed discriminatory attitudes.

Uneven progress, gaps and challenges

39. The UNAIDS Strategy calls for 90% coverage of combination prevention options for key populations and women and men in high-prevalence settings. Available evidence suggests that countries and locations with higher coverage of focused prevention programmes have made progress in reducing HIV incidence. However, at the end of 2018, only around a third of locations with high HIV incidence had dedicated HIV prevention programmes for adolescent girls and young women, and less than 50% of key populations were reached with combination prevention services in more than half of the countries that reported data to UNAIDS.

40. Shortcomings on HIV prevention will leave the world far short of the 2020 target of less than 500 000 new HIV infections. Globally, new HIV infections have declined only by 16% since 2010 although the target entailed a 75% reduction. The estimated 1.7 million new infections (all ages) in 2018 were more than three times higher than the 2020 target of fewer than 500 000 new infections.

41. Results are uneven between different regions, countries and populations. In eastern and southern Africa, new infections were reduced by 26% (all ages) in 2010–2018. The reduction was greatest among young women (aged 15-24) – a 28% decrease, including a 13% decrease in 2015–2018. Strong country leadership and global support in eastern and southern Africa, reflected in high levels of domestic and donor investments, are making an impact. Despite the progress in eastern and southern Africa, 310 000 [190 000-4600] adolescent girls and young women [aged 15-24 years] acquired HIV globally in 2018, way above the target of 100 000 by 2020. Among older women (aged 25 and above), the reduction in new infections globally was only 10% between 2010 and 2018, from 480 000 to 430 000, and 19% in eastern and southern Africa, from 260 000 to 210 000.

42. Results in other regions are less encouraging. New infections (all ages) in western and central Africa decreased only 13% in 2010–2018, reflecting continuing difficulties to scale up effective prevention, testing and treatment services for most affected populations often in challenging circumstances. There has been a slight decrease in new HIV infections in Asia and the Pacific (9%). But there have been disconcerting increases over the same period in the annual numbers of new HIV infections in eastern Europe and central Asia (29%), the Middle East and North Africa (10%) and Latin America (7%).

43. There are also varied trends within regions. In Latin America, for example, strong reductions in new HIV infections since 2010 in El Salvador (48% decrease), Nicaragua (29% decrease) and Colombia (22% decrease) are offset by increases in new HIV infections in Chile (34% increase), the Plurinational State of Bolivia (22% increase), Brazil (21% increase) and Costa Rica (21% increase).

44. Adolescent girls and young women (aged 15-24) continue to account for a disproportionately high number of new HIV infections, especially in sub-Saharan Africa, a disparity that is driven by age-disparate sexual partnerships, low HIV risk perception, and low prevention and treatment coverage among young women and their male partners. These factors are often rooted in gender inequality, violence, food

insecurity and inadequate access to sexual and reproductive health and rights, and an HIV service gap among men. In 2018, approximately 6 000 adolescent girls and young women globally acquired HIV each week, accounting for 310 000 (60%) of the estimated 510 000 [300 000–740 000] new HIV infections in that age group.

45. Large gaps in knowledge of people's HIV-positive status and in the coverage of antiretroviral therapy among men living with HIV contribute to HIV infections among women. Harmful gender norms, poor health-seeking behaviour and the relatively less frequent interaction of men with the health system compared with women result in men experiencing longer periods of time between infection and diagnosis, later initiation of treatment and lower rates of viral suppression. These in turn lead to poorer clinical outcomes and a greater likelihood of death from AIDS-related causes among men, as well as a greater risk of transmission of HIV to sexual partners. Voluntary medical male circumcision (VMMC) is potentially an entry point for providing men and boys with broader, more appropriate health packages to improve their health outcomes, and also to indirectly benefit women and girls. Specific efforts to reach men through workplace and community outreach campaigns have had mixed results.

46. HIV prevention efforts are too often leaving behind the people at highest risk. As a result, an important shift is underway in the global HIV epidemic. Larger proportions of new infections are occurring among key populations and their sexual partners. Those populations typically are socially marginalized and targeted with punitive laws and practices, which places them at great risk for HIV infection and other health threats. In 2018, 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 partners accounted for more than half (54%) of new HIV infections globally.

47. Progress towards ensuring key populations have access to combination prevention has varied considerably depending on the population and the country. Some countries[5] reported reaching the 90% target in access to appropriate prevention services for at least one key population. In others[6], less than 10% of at least one key population were accessing multiple prevention services. Overall, less than 50% of key populations were reached with combination prevention services in more than half of the countries that reported data to UNAIDS in 2018. In 28 countries accounting for 75% of new infections, an average of 47% of sex workers were reached with HIV prevention services in 2018 and only a third of gay men and other men who have sex with men and people who inject drugs. Needle–syringe distribution and opioid substitution therapy coverage remain low in most of the 54 countries that have reported data for both indicators to UNAIDS in recent years.

48. Some countries are not reporting data on key population HIV prevention indicators, and many countries leave out certain key populations, especially transgender women. Varying quality of population size estimates for key populations from country to country adds uncertainty to service coverage measures for these populations, and there is ongoing concern of underestimated size estimates and thus overestimated coverage. More accurate and up-to-date data is essential to facilitate programme scale-up.

49. Discriminatory attitudes towards people living with HIV and key populations remain high in far too many countries, including in health-care settings with structural and social elements driving stigma and discrimination. Criminalization of HIV-transmission,

[5] For example, Armenia, Côte d'Ivoire and Singapore.
[6] For example, Ageria, Bangladesh, Dominica, the Lao People's Democratic Republic, Malaysia, Pakistan, Senegal, Sri Lanka, Tunisia and Uganda.

non-disclosure of HIV status or exposure to HIV infection was still reported in 86 countries and jurisdictions in 2018, despite evidence that it does not serve any public health benefit[7], may lead to miscarriages of justice, perpetuates stigma and acts as a barrier to effective AIDS response.[8] 48 countries still have some form of travel restrictions in place for people living with HIV.

50. Key populations continue to face high levels of criminalization. 67 countries still criminalized same-sex sexual activity in 2018. Only 7 countries report not criminalizing possession of drugs for personal use and only 23 countries report no laws criminalizing some aspect of sex work. 17 countries still criminalize gender diverse people. In the last few years, while there has been some movement in relation to removing laws criminalizing same-sex sexual activity, there has been minimal movement in relation to drug decriminalization or removal of laws criminalizing sex work.

51. In many countries, people who are at greatest need of HIV services continue to be denied health care, employment, housing and social protection, and face stigma and discrimination from their families, communities, employers, teachers, healthcare workers, police, prosecutors and judges because of their HIV status and/or because they are suspected of being sex workers, people who inject drugs or lesbian, gay, bisexual, transgender and intersex (LGBTI) people. National authorities in 128 of 195 reporting countries stated in 2019 that they had policies requiring health-care settings to provide timely and quality healthcare without any discrimination, but 42 of them admitted these policies were not consistently implemented (civil society organizations in 77 countries reported that these policies were not adequately implemented).

52. In 2018, there were an estimated 770,000 HIV-related deaths. Progress in reducing HIV-related deaths also varies across regions. Eastern and southern Africa (which is home to over half of the world's people living with HIV) reduced HIV-related deaths (all ages) by 44% in 2010–2018, and western and central Africa achieved a 30% reduction. By contrast, HIV-related deaths in eastern Europe and central Asia and in the Middle East and North Africa rose by 5% and 9%, respectively in that same period. Tuberculosis remains the leading cause of death among people living with HIV, causing one in three AIDS-related deaths. The 2016 Political Declaration set a target of reducing TB-related deaths among people living with HIV by 75% (from a 2010 baseline). There were an estimated 250,000 [220,000-280,000] TB-related deaths among people living with HIV in 2018. TB-related deaths among people living with HIV declined by 52% between 2010 (from an estimated 520,000) and 2018.

53. Despite the impressive progress towards the 90–90–90 targets, there are significant gaps to be closed in some regions and countries.

54. **Knowledge of HIV-positive status.** Eight million (21%) people living with HIV did not know their positive HIV status in 2018 and were not receiving antiretroviral therapy. The global figure conceals differences between regions. Whereas 85% of people living with HIV in eastern and southern Africa[9] and 80% of those in Latin America knew their HIV status in 2018, only 64% of their peers in western and central Africa and 47% in

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[7] Global Commission on HIV and the Law. Risks, rights and health: supplement. New York: UNDP; July 2018 (https://hivlawcommission.org/wp-content/uploads/2019/11/Hiv-and-the-Law-supplement_EN.pdf).
[8] Expert consensus statement on the science of HIV in the context of criminal law. J Int AIDS Soc. 2018 Jul; 21(7): e25161 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6058263/)
[9] In Botswana, Malawi, Namibia, Rwanda, South Africa and Zimbabwe, more than 9 in 10 people living with HIV knew their HIV status.

the Middle East and North Africa knew they were living with HIV. In all regions, men living with HIV are less likely than women to know their positive HIV status. Data on knowledge of HIV status among key populations living with HIV is not widely available.

55. **Treatment**. Despite the massive scale-up of HIV testing and treatment, 14.6 million people living with HIV globally (38%) were not accessing HIV treatment by the end of 2018, including 56% of children (though this was an improvement compared with the 52% treatment gap in 2015). This treatment gap leads to the ongoing deaths due to HIV-related illnesses, including 770,000 deaths in 2018, with one third (251 000) of them related to tuberculosis. In all regions, the treatment gap is bigger for men. Treatment access also varies among different key populations and in different regions. Punitive laws, social stigma and structural discrimination often block key populations from accessing the HIV testing and treatment services they need. In humanitarian contexts, the treatment gap remains significant: 54% of all adults, 43% of pregnant women, 65% of children and 79% of adolescents living with HIV do not have access to treatment. Variations in coverage highlight the important work of community-based groups and other civil society organizations in overcoming service access barriers.

56. **Viral suppression.** Gaps along the HIV testing and treatment cascade and lack of access to viral load testing ultimately left about 18 million (47%) people living with HIV globally with unsuppressed or unknown viral loads in 2018. The gap in viral suppression was even wider in the Caribbean, eastern Europe and central Asia, and western and central Africa. Rates of viral suppression are also considerably lower for men than for women and lower for children and adolescents than for adults. Countries need to optimize their mix of HIV testing services to reach the populations and locations that currently are left behind. Urgent investment in comprehensive services is needed to support linkage to and retention in care and sustained viral load suppression, including optimised antiretroviral treatment regimens for adults and children, treatment literacy, food and nutrition support, community dispensing of antiretroviral medicines, multi-month dispensing, adherence clubs, viral load testing, and switching to second- and third-line regimens after confirmed treatment failure.

57. Progress towards the elimination of new HIV infections in children has also been uneven and has stalled in recent years. Between 2010 and 2015, the average annual decrease in new child HIV infections was 6.7% compared to between 2015 and 2018 when the average annual decrease was only 3.8%. Globally, there were 160,000 new child infections in 2018. Several countries have reduced new infections among children by at least 65% in 2010–2018, but progress has stalled.[10] In some countries,[11] the annual number of children newly infected with HIV has risen since 2010.

58. Of the 160 000 new child infections in 2018, 44% were in five countries: Kenya, Mozambique, Nigeria, South Africa and Tanzania. Missed opportunities to prevent these infections vary by country. In Nigeria, the majority of the new infections occurred because pregnant or breastfeeding women living with HIV were not reached with HIV services. For Kenya, Mozambique and Tanzania, most of the new infections were due to pregnant and breastfeeding women not being retained on treatment or because women seroconverted while pregnant and breastfeeding. If pregnant and breastfeeding women are not reached with services, it is unlikely that their infants will be reached with early infant diagnosis. The global coverage of early infant diagnosis at 2 months was only 59% in 2018. In addition, slow progress in preventing HIV and

[10] For example, Botswana, Cambodia, Malawi, Malaysia, Namibia, Nicaragua, Portugal, Rwanda, Thailand, Uganda and Zimbabwe.
[11] For example, Angola, Indonesia, Madagascar and Pakistan.

unintended pregnancies among adolescent girls and young women has further hampered elimination of new infections in children. In 2018, 310 000 [190 000-460 000] adolescent girls and young women (aged 10-15 years) acquired HIV, more than three times the 2020 target of fewer than 100 000.

59. Treatment coverage among children living with HIV is increasing at slower rate than among adults. The estimated 940 000 [820 000–970 000] children (aged 0–14 years) living with HIV globally who were on antiretroviral therapy in 2018 was almost double the number on treatment in 2010, but well short of the 2018 target of 1.6 million. Paediatric treatment coverage has stalled at an unacceptably low level with treatment coverage at 54% in 2018. Fewer than 30,000 more children were on ART in 2018 than in 2015. In 2018, there were 790,000 children living with HIV but not receiving antiretroviral therapy. Most of these children (480,000) are 5 years or older and are not likely to be reached without special effort, such as index testing through parents, targeted community outreach or household testing, and focus on specific health care settings where HIV-positive children may be, including inpatient and failure to thrive clinics.

60. Insufficient availability and suboptimal use of financial resources threaten hard-won gains. International and domestic investments in the HIV response do not yet match global commitments. In 2018, resources available for HIV responses in low- and middle-income countries totaled approximately US$ 19 billion, about US$ 900 million less than in 2017. Domestic spending, which has risen substantially since 2010, accounted for about US$ 10.7 billion of that total. Investments will almost certainly fall short of the annual target of US$ 26 billion that would be needed in 2020, as stipulated in the 2016 Political Declaration on HIV and AIDS. The four regions with the largest shares of the global resource gap were western and central Africa, Asia and the Pacific, eastern Europe and central Asia, and Latin America.

61. The year 2020 marks the deadline for several of the targets agreed to in the 2016 Political Declaration on HIV and AIDS. 2020 also brings massive new challenges, not least the COVID-19 pandemic, which in many ways reflects the early days of the HIV epidemic, when the world struggled to understand and respond to a deadly new virus. As with HIV, the COVID-19 pandemic is exposing health inequities, gender inequality, weaknesses in health systems, and insufficient action against the social, economic and structural factors that fuel the epidemic and hold back effective responses.

62. An understanding of the possible interactions between HIV and COVID-19 is still emerging, but there are already valid grounds for grave concern about the disruption of HIV prevention, testing and treatment services—and the debilitating impact this will have on the global HIV response and related progress towards the Sustainable Development Goals.

63. Recent modelling by a consortium of modelers with input from WHO and UNAIDS offers a glimpse of the impact of a 6-month disruption of ART, which threatens to double the number of HIV-related deaths in sub-Saharan Africa alone in one year, adding an additional 500 000 deaths in 2020-2021.This would effectively turn the clock back to 2008, when the ART rollout was still gathering pace and almost 1 million people in that region died due to AIDS-related illnesses.[12]

[12] Jewell B, Mudimu E, Stover J, ten Brink D, Phillips AN, Smith JA et al for the HIV Modelling consortium, Potential effects of disruption to HIV programmes in sub-Saharan Africa caused by COVID-19: results from multiple models. Pre-print, https://doi.org/10.6084/m9.figshare.12279914.v1, https://doi.org/10.6084/m9.figshare.12279932.v1.

64. The current UNAIDS Strategy recognizes the need to include HIV in emergency preparedness and response, and to reach fragile communities in humanitarian situations. One in fourteen people living with HIV was affected by such a situation in 2016. Fragile situations such as conflicts and natural disasters and epidemics interrupt the supply lines of prevention and treatment commodities; constrain often already sub-optimal public health services through the loss or absence of staff and infrastructure, and separate people from their caregivers and supplies; increase individual and household economic insecurity, resulting in the need for coping strategies that may include greater risk-taking behaviours; increase food insecurity; and increase violence, notably sexual, gender-based and conflict-related sexual violence.

65. The impact of the COVID-19 pandemic may have severe impacts for many populations in vulnerable situations and for those most affected by HIV. Confinement policies have increased gender-based violence towards women. People in prisons and other closed settings, a population for which physical distancing is not an option, are also at heightened risk for HIV, TB and COVID-19 because of overcrowding and other prison conditions. Migrants and refugees may be confined to camps and settlements, or living in urban slums with overcrowding, poor sanitation, and overstretched or inaccessible health services. These connections need to be better understood as we move forward in the planning for the next UNAIDS Strategy. Greater collaboration with the humanitarian system is required as the impacts of the pandemic further destabilize fragile contexts and create new ones.

66. In responding to the HIV epidemic, multisectoral, rights-based and community-led policies and services have been core to many of the most important advances in preventing new infections and reaching and retaining people on HIV treatment. The HIV response has taught that engaging and empowering communities, as well as the promotion of human rights and gender equality, are critical to success. The Greater Involvement of People Living with HIV (GIPA) principle has been a hallmark of the HIV response. In responding to COVID-19, communities have vital roles to play and public health authorities must engage and empower them to participate fully in the response. The HIV response has also taught us that we need political will and strong health systems to ensure equitable access to health technologies, including diagnostics, treatment and vaccines. The same applies for COVID-19.

IV. NEXT PHASE OF THE PROCESS

67. To be able to prepare for the next phase of the HIV response, there is a need to have a deeper understanding of the key factors that have led to successes in the implementation of the UNAIDS Strategy and of the factors that have hindered progress. It is important to better understand how best to further leverage the impact of the Joint Programme in a shifting partner and resource environment and how the post-2021 strategy can provide guidance for the strategies of other HIV stakeholders including the Global Fund, bilateral partners and the strategies and frameworks of cosponsoring organizations. It is also important to assess the early impacts of the COVID-19 crisis, and consider the implications of other unpredictable shocks (other emerging infectious diseases, natural disasters, or humanitarian emergencies), to the AIDS response.

68. The next phase of the review of the current UNAIDS Strategy, its implementation and results obtained (from June to September 2020) will identify and explore key questions in more depth to gain insights into what has enabled progress and what have been the barriers. The review will assess what needs to change to achieve results especially for

those populations who are being left behind and for the world to reach the SDG target of ending AIDS as a public health threat by 2030.

Building blocks for planning the next phase of HIV response

69. The review of the current Strategy will draw on various sources and will bring together different processes that will add important insights and perspectives to the planning for the next phase of the HIV response beyond 2021 and the development of UNAIDS Strategy.

UNAIDS LED PARTICIPATORY STRATEGY REVIEW AND DEVELOPMENT PROCESS

<u>Review of data</u>

70. UNAIDS will complete strategy data review and analysis by end of July 2020. This data review and analysis will frame discussions to finalize the UNAIDS strategy beyond 2021.

<u>UNAIDS Performance Monitoring Reports (2018-2019)</u>

71. The Strategy review will also draw on the data and analysis reflected in the four UNAIDS Performance Monitoring Reports (2018-2019) submitted to the 46th Meeting of the PCB in June 2020.

<u>UNAIDS Advisory Group (UAG)</u>

72. Building on the first meeting of the UNAIDS Advisory Group (UAG) in February 2020, the UAG and its break-out groups will continue to provide input into, and support for, the strategy process. The UAG break-out groups, which will be open to participation beyond UAG members, will meet online during this period to explore priority issues

relevant to the strategy review and development process. The results of these consultations will be carefully documented and circulated prior to the multistakeholder consultations in September 2020. Moreover, UAG members will be approached to participate in stakeholder interviews and focus group discussions.

Extensive consultations

73. The data-based review will be complemented by additional consultations among UNAIDS stakeholders, with surveys, interviews, focus group discussions and workshops continuing iteratively throughout the strategy process. The consultations will focus on the strategic priorities and on the implementation and operationalization of the Strategy.

Multistakeholder consultation

74. The results of the data analysis and conclusions from consultations will be synthetized and presented to a multistakeholder meeting in September 2020.

Independent Evaluation of the UN system response to AIDS in 2016–2019

75. The Strategy review and planning for the UNAIDS Strategy beyond 2021 will take note of the findings and recommendations of the Independent Evaluation of the UN system response to AIDS in 2016–2019 as well as the UNAIDS management response to these findings. The evaluation was commissioned by the UNAIDS evaluation office and was carried out by an independent evaluation team, ITAD Limited, from August 2019 to March 2020. It focused on the contribution of the UN Joint Programme to the goals and targets of the UNAIDS 2016-2021 Strategy. The evaluation report will be presented to the PCB in December 2020 along with the management response.

Target setting for 2025

76. UNAIDS is leading a process to develop updated HIV targets and resource needs estimates. This process includes new elements on social enablers, service integration, and innovations. The outputs are timed to serve as key components of the next UNAIDS Strategy, the upcoming High-Level Meeting on AIDS, future Global Fund replenishments and Strategy development, World Health Organization health sector targets, national target-setting, and strategic planning and decision-making of major global partners. This process will feed into the planning for the next UNAIDS Strategy.

Implications of the COVID-19 response

77. The multisectoral HIV response has produced many lessons that are relevant to the current response to the COVID-19 pandemic. At the same time, the COVID-19 pandemic is disrupting essential health services, including HIV services, and poses massive health, social and economic challenges. In some cases, however, this has led to rapid implementation of long-standing recommendations for differentiated service delivery and community-led innovations. The pandemic holds important implications–-and potentially also lessons—for the HIV response. UNAIDS will examine these during the Strategy review and planning.

V. CONCLUSION

78. UNAIDS has responded to the PCB's request to review the current UNAIDS Strategy, as well as its implementation and results by launching the strategy consultations with survey, interviews and focus group discussions with diverse group of stakeholders and initiating data review of the current strategy.

79. Initial review of available data demonstrates that the UNAIDS 2016–2021 Strategy has served as a roadmap and inspiration in the global HIV response. The rapid review indicates that, when stakeholders have demonstrated political will and taken concerted and coordinated action, major successes have been achieved. However, data also show that there are several bottlenecks to implementation of the Strategy and that most targets will not be reached by the end of 2020. In-depth analysis is needed to fully understand what has worked well and why, what has presented obstacles to progress and what needs to change as we chart the way towards the next stage of HIV response, beyond 2021.

80. As we approach the deadline for the 2020 targets, the world has been confronted by a new health, social and economic threat: COVID-19. The UNAIDS Joint Programme, along with UN Member States, civil society organizations working on HIV, community groups and other UNAIDS stakeholders are all engaged in the COVID-19 response at all levels. This context has complicated meaningful consultation with stakeholders during the first phase of the Strategy review and made it difficult to reach people most affected by HIV and/or COVID-19.

81. Considering the current context and short timeframe for consultations, it is proposed that the PCB requests the Executive Director to extend the Strategy review period past June 2020, with a multistakeholder consultation taking place no later than September 2020 and an update to be provided to the PCB in December 2020, and to consider the possibility of holding a special session of the PCB in March 2021 to consider adoption of the Strategy beyond 2021. This extended timeline will allow for full engagement of all stakeholders in shaping the Strategy that will steer the next phase of the global AIDS response and guide the development of strategies of countries, UNAIDS cosponsors, bilateral agencies and partners such as the Global Fund.

PROPOSED DECISION POINTS

82. The Programme Coordinating Board is invited to:
    - *Recalling* decisions 3.1 and 3.2 from the 45th PCB meeting, *take note* of the progress update UNAIDS/PCB (46)/20.7;

    - *Request* the Executive Director to:
        - present the findings from the completed review of the current UNAIDS Strategy (2016-2021) and the implications for strategic priorities beyond 2021 for consideration by the multistakeholder consultation no later than September 2020;
        - present to the 47th PCB meeting in December 2020 a report on the process and on the outcome of the review and consultations with options for the UNAIDS Strategy beyond 2021 ensuring that it remains ambitious, visionary and evidence-based;
        - present to a special session of the PCB, no later than March 2021, the UNAIDS Strategy beyond 2021;

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