ANNUAL REPORT OF THE GLOBAL PREVENTION COALITION

Annual progress report on HIV Prevention 2020

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Acknowledgements

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Acronyms and Abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AYP	Adolescents and young people
BMGF	Bill and Melinda Gates Foundation
CSE	Comprehensive sexuality education
CSO	Civil society organisation
DExD	Deputy Executive Director
DRC	Democratic Republic of Congo
EECA	Eastern Europe and Central Asia
EMTCT	Elimination of Mother-to-Child HIV Transmission
ER	External Review
ExD	Executive Director
GAM	Global AIDS Monitoring
GF	Global Fund to Fight AIDS, Malaria and Tuberculosis, Global Fund
GPC	Global HIV Prevention Coalition
GPWG	Global Prevention Working Group
HIV	Human Immunodeficiency Virus
HLM	High level meeting
HTC	HIV testing and counselling
IAS	International AIDS Society
ILO	International Labour Organization
INPUD	International Network of People who Use Drugs
INGO	International non-government organisation
IPV	Intimate partner violence
KI	Key informant
KII	Key informant interview
KP	Key populations
LAC	Latin America and Caribbean
LMIC	Low and middle-income country
M&E	Monitoring and evaluation
MoT	Modes of transmission
NAC	National AIDS Council/Commission
NASA	National AIDS Spending Assessment
NGO	Non-government organisation
NSF/P	National Strategic Framework/Plan
NSWP	Global Network of Sex Work Projects
OPM	Oxford Policy Management
OST	Opioid substitution therapy
PCB	Programme Coordinating Board
PEPFAR	US President's Emergency Plan for AIDS Relief
PHP	Primary HIV prevention
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
PUD	People who use drugs
PWID	People who inject drugs
RD	Regional Director
REC	Regional Economic Community/Commission
SADC	Southern African Development Community
SEA	Southeast Asia
SRHR	Sexual and reproductive health and rights

TA	Technical assistance
TSF	Technical Support Facility
TSM	Technical Support Mechanism
ToC	Theory of change
TOR	Terms of reference
TRP	Technical Review Panel
TWG	Technical Working Group
VMMC	Voluntary medical male circumcision
UCD	UNAIDS Country Director
UCO	UNAIDS Country Office
UHC	Universal health care
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nation Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VMMC	Voluntary Medical Male Circumcision
WHA	World Health Assembly
WHO	World Health Organization
WG	Working Group

Executive Summary

Background and Objectives

In 2017, UNAIDS and partners observed that despite success in the roll out of HIV treatment world-wide since 2010 and the promise of treatment as prevention, the declines in rates of new HIV infections were falling far short of those required to meet the prevention targets in the 2016 UN General Assembly Political Declaration on Ending AIDS.

These shortfalls in HIV prevention progress were attributed to barriers or gaps in political commitment, policy and law, financing, and the implementation of effective interventions at scale. Resulting consultations led to the development of a 10-point plan, the 2020 Road Map, to strengthen programming and help countries focus on bringing five evidence-informed "pillars" to scale: 1) Combination prevention among adolescent girls and young women and their male partners; 2) Combination prevention services for key populations; 3) Condom programming; 4) Voluntary medical male circumcision; and 5) Pre-exposure prophylaxis (PrEP).

In October 2017, 50 like-minded organisations (UNAIDS Cosponsors, civil society, public and private sector funding partners and UN Member States), formed the Global HIV Prevention Coalition (GPC, or the Coalition), co-convened by UNAIDS and UNFPA. They endorsed the 2020 Road Map as the strategy to achieve the 2016 Political Declaration on HIV prevention targets, with a focus on 25 countries that were reporting most of the global total of new HIV infections (GPC countries). A GPC Secretariat headquartered at UNAIDS in Geneva was tasked "to monitor progress and activate a mechanism for rapid technical assistance," and UNAIDS' informal HIV Prevention Reference Group was reconstituted as the Global HIV Prevention Working Group (GPWG) to advise and provide technical leadership for the Coalition. In 2018, three more countries and the Southern African Development Community (SADC) joined the coalition, for a total of 28 GPC countries. To date, GPC countries have made significant strides in implementing their domesticated road maps, as summarized by the GPC Secretariat in scorecards and posters available on the GPC website and in three comprehensive progress reports.

In early 2020, the GPC Secretariat commissioned three consultants to undertake an external review of how the GPC and Road Map have contributed to date in strengthening the primary HIV prevention (PHP) response globally and at country levels, to identify challenges, and to provide recommendations on the way forward. The review included an extensive review of UN, GPC and partner documents as well as almost one hundred consultations and interviews carried out virtually. The GPC countries included for deeper review were Brazil, Côte D'Ivoire, Eswatini, Iran, Kenya, Malawi and Ukraine, selected to represent different global regions and poorer and better-performing countries with different epidemic profiles. In consultation with a core group including the GPC Secretariat, UNFPA and volunteers from the GPWG, the review team consolidated the seven specific objectives in their

> **Key Messages of the Review**
>
> **1. GPC has restored attention to primary HIV prevention in the global health agenda and in national HIV responses, and it should be supported to continue to 2025.**
>
> **2. The GPC has built global consensus and a unifying narrative around the five pillars and around focusing PHP responses on the sub-national locations and populations at highest risk.**
>
> **3. Use and review of GPC scorecards backed by guidelines and tools is strengthening NAC leadership and management of multi-stakeholder PHP programmes.**
>
> **4. Policy and legal barriers and funding gaps have changed little; more unified, focused and practical support on structural barriers is needed from UNAIDS, Cosponsors and the GPWG to address both.**
>
> **5. The architecture of the GPC is fit for purpose, but its geographic diversity should be expanded, and its specific niche in and links to the global PHP landscape, should be clarified.**
>
> **6. Civil society inclusion, and capacity development for PHP, lag behind in Road Map improvement. Both require far more attention and investment.**
>
> **7. UNAIDS should highlight synergies as well as the challenges of HIV and COVID-19 responses, as it is critical that adequate funding be maintained for both.**

Terms of Reference (TOR)[1] into four review questions that framed the assumptions and indicators specified in the study's review matrix.

Key Findings

Review Question 1: How appropriate is the architecture/design of the GPC to achieve operational effectiveness and key activities? Based on successes, ongoing barriers and the changing landscape how should the architecture/ design of the GPC change going forward?

Most of the GPC's key elements[2] and services were well appreciated, although descriptions of the Coalition's mandate and architecture vary. Furthermore, the appropriateness of the architecture ultimately hinges on the Coalition's prime objectives and scope. While some stakeholders suggested the GPC be "the global voice of HIV prevention," others, including the GPC Secretariat, see its work as part of a larger mosaic of organisations and resources, with the GPC's niche being to provide granular support to and monitoring of implementation of the 2020 Road Map and the five PHP pillars.

The GPWG is a key element of the GPC, and its semi-annual meetings represent a unique and valued forum for information sharing and coordination among key actors involved in funding, guiding and implementing HIV responses in GPC countries. Both GPWG members and observers recommended broadening the membership - including more members from civil society, from GPC countries, and from organisations focused on human rights, gender, economics and other structural dimensions of the response, but paradoxically they also wanted it to retain its small size and agility. Key informants recommended the GPWG pay more attention to the priorities of the 10 member countries outside Africa, and address language barriers, so that all members can participate fully. Further, the exact roles and authority of the GPC's co-conveners and co-chairs and of the GPWG merit clarification.

Review Question 2: How successful has the GPC been in addressing political leadership, reducing legal and policy barriers, and increasing HIV prevention funding in line with the country epidemic scenario? What have been the main challenges?

One great success of the GPC has been the effort to strengthen the national AIDS authorities (NACs) in member countries, to "institutionalize prevention stewardship" and to initiate a lasting community of practice where members can learn and share their expertise through south to south learning. The GPC has strengthened leadership for PHP in national HIV responses and increased demand for HIV programming, not just in GPC countries but also beyond. The 2020 Road Map includes tools to revitalize national management and coordination structures for PHP. Both catalytic funding and support to Cosponsors through the country envelope have helped support national HIV prevention coalitions and/or technical working groups under NAC direction. The activity and inclusiveness of these groups varies, and the review found few reports of these structures operating at sub-national levels, or with the inclusion of sectors such as education, justice and labour.

Changing policy and legal barriers to effective PHP programming has shown limited success in influencing obstacles such as criminalisation of same-sex conduct, sex work and illicit drug use, or combatting gender-based violence (GBV). There are examples of important policy changes in a few GPC countries, but there are also examples where the socio-political context has become more restrictive since 2017, making inclusion of key populations and delivery of services by communities more difficult than ever.

The 2020 Road Map envisioned Cosponsors as sources of technical support for interventions to address structural barriers, according to the UNAIDS Division of Labour. The recent external evaluation of the UN Joint Programme Response to HIV/AIDS noted declines in both UNAIDS core and Cosponsor funding for HIV expertise and positions, especially at regional and country levels. However, the GPC Secretariat and GPWG could do more to link GPC countries to the extensive array of Cosponsors' guidelines and tools, as well as provide linkages to the technical support that is available from Cosponsors on a range of critical areas.

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[1] See Annex 1

[2] The GPC's key elements are listed in the TOR as follows: A.o. The 5 pillars, Membership, Chairs, Priority countries, Road Map, the 4 barriers holding back progress, 10-point action plan, the Secretariat (incl housing at UNAIDS), the Dashboard, Country Scorecards 2017, 2018, 2019, Rapid TA provision, Website (& resources), 3 Progress reports & Progress meetings, Updates to PCB, Prevention Advisory group etc.

The GPC's main success in influencing HIV prevention funding has been in collaborating with the Global Fund against HIV, TB and Malaria to modify its application guidelines and technical review criteria to call for PHP and, specifically, targeted and costed proposals for the GPC pillar interventions according to national and sub-national epidemiological profiles. International funding for HIV responses has declined by nearly 10% since 2015, and few countries have increased domestic funding for HIV prevention. Both PEPFAR and the Global Fund have expanded funding for the pillar on adolescent girls and young women and have provided special funds to incentivise and support investment in services for key populations. However, the Coalition has not, or not yet, catalysed a sufficient increase in funding for overall PHP, and the need will only increase as health systems also struggle to respond to COVID-19.

Review Question 3: How far has a wide range of UN, government and CSO stakeholders demonstrated engagement and understanding of the 2020 Road Map and demonstrated political and operational accountability to the 2016 global political commitments?

GPC countries have demonstrated their commitment and accountability to the 2016 global HIV prevention targets and commitments by utilising the 2020 Road Map to define and monitor their improvements in HIV prevention programming, reporting their progress annually, and using their findings to drive further progress. Data on PHP progress tabulated in scorecards and country posters has facilitated clearer understanding of achievements and gaps, and allowed comparisons between countries to stimulate greater efforts. National HIV prevention coalitions and prevention working groups have been convened or energised using GPC guidelines and tools, although they vary in how active they are, the extent to which they include civil society, and whether their reach extends outside the capital city. Indeed, KIs noted that in some countries civil society organisations' awareness of and access to GPC guidelines, tools and other resources seems to be low. The GPWG's intention is to be more supportive of PHP at country level, which would clearly be valued.

Annual reporting from GPC countries on their implementation of the Road Map steps and the configuration of their national HIV prevention responses shows substantial progress. There has been progress in all GPC countries in fulfilling the 10 Road Map steps, in some cases remarkable progress (e.g. no countries implementing needs assessments in 2017 to 90% implementation in 2019). In the words of UNAIDS, "coalition countries have transformed how they frame, measure and organise national prevention responses."[3] Clearly, some steps in the 2020 Road Map are easier to complete than others: social contracting and development of a comprehensive plan for capacity development with a technical support plan were the two least often completed by 2019. The GPC countries' overall commitment to the GPC model is manifest in the active participation of NACs and ministers of health in GPC events and activities, and in their impressive record of timely completion of reporting on their Road Map implementation and PHP programmes against agreed evidence-informed targets.

Review Question 4: To what extent has the GPC contributed to systematic implementation of combination prevention programmes at scale, including the five prevention pillars?

The GPC Road Map and data analytics and the focus on the five pillars have clearly assisted countries to design, prioritise and monitor their prevention programming more systematically. That said, not all countries have benefited equally, and despite demonstrable progress in all coalition countries, none have yet achieved the desired implementation at scale or completed all steps of the road map.

Each of the 28 coalition countries faces diverse technical, political and financial challenges in rolling out combination prevention programmes. Most, however, share difficulty in altering the structural factors that the GPC identified as key barriers to effective HIV prevention programming: gaps in political leadership and financing, and creating a fully enabling legal and policy environment. As well, the five pillars are not equally relevant in all countries, and KIs commenting on this noted the risk that they might lead to neglect of structural considerations.

The technical support that is a core feature of the GPC has been utilised by most countries to strengthen their combination prevention activities. The GPC has provided such support in multiple ways, including extensive tool and guideline development, regional workshops, webinars, consultant and other training, regular conference calls, a trimestral newsletter, and funding for short, medium and longer-term consultancies. However, KIs perceived gaps in

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[3] Hader, S.(2020). The status of HIV prevention and update on implementation of global HIV prevention commitments: a brief summary." Presentation to the GPWG, 24 March, 2020.

available TA in several areas, particularly regarding details of "how to" intervene to shift the structural barriers to prevention, especially for AGYW and KPs. Other areas where more TA was requested include: social contracting and social marketing; condom total market development; programme management; high level advocacy; combatting stigma and discrimination; SRHR integration; developing capacity development plans, and achieving policy and legal reform. Cosponsors and some GPWG KIs observed that extensive guidelines and tools are available in these areas. It appears that, while many are accessible through the GPC website, the GPC has not done enough to make these resources widely known.

On the other hand, the GPC Secretariat has been responsive to country requests for technical assistance and has been alert to emerging needs. The GPC Secretariat's support for the development of a NAC directors' community of practice, mobilising resources to support south to south learning, and development of a prioritisation aide for services for AGYW are three examples.

Looking Ahead: toward HIV Prevention in the UNAIDS 2021-2025 Strategy

There is broad agreement that attention to HIV prevention has been enhanced and prevention programming in GPC countries is being made more strategic and effective, but there remain "miles to go." Unless prevention efforts are intensified, 1.5 million newly HIV positive people will need to be started on life-long HIV treatment every year - a situation that is widely recognised as financially unsustainable. Thus PHP must have a prominent place in UNAIDS' 2021-2025 strategy, not just in the preamble and principles, but in the allocation of effort and resources.

The five prevention pillars will remain essential, even as new biomedical prevention strategies become available. The new UNAIDS strategy should point the way toward beneficial and potentially cost-efficient integration of HIV prevention and treatment and SRHR services. However, increasing efforts to integrate HIV into universal health systems is costly, and they confer both benefits and potential risks, especially to behavioural and structural PHP efforts that demand community involvement, service outreach and leadership.

In addition, managing and driving change while maintaining high quality implementation of the five pillars at scale is labour intensive. Numerous KIs commented on current deficits in countries' capacities to design, implement, monitor and refine their HIV prevention programmes. A clearer understanding is needed of the prevention workforce required in each country to carry out these functions at national and sub-national levels.

An inevitable concern looking forward is that there will be a continued and intensified decline in donor funds for PHP and for HIV in general, with concurrent difficulties in raising domestic funding. This concern is intensified by the urgent demands that saving lives from COVID-19 is placing on health systems in all countries. There could be opportunities here for the HIV world to share the lessons learned in community education and mobilisation, not to mention contact tracing and follow-up, to assist and participate in the response to the COVID-19 pandemic. UNAIDS and the GPC should be spearheading efforts to establish collaboration both internationally and at the country level with those guiding and managing the pandemic response.

Main Recommendations[4]

1. Recommendations to the UNAIDS Committee of Cosponsoring Organisations

1.1 Extend the GPC to 2025 as GPC-2, with the same co-convenors, a redefined membership, structure and funding base, and clear terms of reference for each of its component groups.

1.2 Inventory the initiatives of each Cosponsor that are related to HIV prevention (e.g. human rights, economic empowerment, gender equity, SRHR, workplace standards), establish how they will link actively with GPC processes at global, regional and country levels, and identify and fund a focal point/s to support and report on the linkages.

1.3 While recognising the important work by all Cosponsors that is relevant to HIV prevention, appoint the GPC Secretariat as the hub and data repository for HIV prevention efforts of all the UNAIDS Cosponsors.

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[4] The recommendations are elaborated in the main report, Section V.

1.4 Request Cosponsors to collaborate with the GPWG and GPC Secretariat to formulate a composite indicator that communicates Cosponsor engagement in PHP support at country level, for inclusion in national prevention scorecards and in UNAIDS' annual HIV prevention report to the PCB.

1.5 Mobilise Cosponsor Heads of Agency and other leaders to advocate with their government and private sector peers on the importance of funding PHP within their respective health, development and corporate social responsibility strategies.

2. Recommendations to the GPC Conveners UNAIDS and UNFPA

2.1 Lead design of GPC-2 for presentation to the November 2020 HLM with a clear theory of change and specification of the roles and responsibilities of all component groups.

2.2 Support the GPWG to implement more and higher-level strategic advocacy for primary HIV prevention funding and policy and legal reform, with government policy-makers and influencers in GPC countries and with funding partners.

2.3 Advocate with leadership in each Cosponsor to retain or restore a full-time HIV prevention specialist in their regional offices, to provide prevention leadership and technical support to national PWGs according to their role in the UNAIDS Division of Labour, and to participate in GPWG and other GPC activities where they can add value.

2.4 Advocate with donors to fund dedicated HIV prevention posts in NACs as a strategic investment.

3. Recommendations to GPC Country National Authorities

3.1 Establish or reinforce, support and fund a discrete post in the national HIV/AIDS authority for an HIV prevention leader and coordinator who can convene, coordinate and advise the needed PHP stakeholders (health and non-health sectors) at national and sub-national levels under a unified national PHP brand.

3.2 Commission the national HIV prevention coalition to develop a new or updated national HIV prevention road map, with coverage and outcome milestones and targets for 2021-2025, tailored to the country's gaps and needs, and addressing observed obstacles to implementing differentiated PHP at scale, including the need for an adequate prevention workforce, and structural issues of financing, harmful policies and laws, and political barriers.

3.3 Develop and execute a five-year strategy for mobilising domestic as well as international funding to contribute to national ownership and to the national 2025 road map implementation.

3.4 Recognising the comparative advantage of CSOs in reaching vulnerable groups and KPs with HIV services, increase support for strong civil society engagement in national prevention coalition and technical working group activities, including providing funding for capacity development, and to defray the costs of meaningful participation in planning, implementing and evaluating progress on the national road map.

4. Recommendations to the GPC Secretariat and Global HIV Prevention Working Group

4.1 Continue the assistance to countries to review regularly and report annually on their road maps, pillars and prevention targets, presenting the data in the scorecards and posters; motivate and support sub-national scorecard and poster development. Incorporate analysis and use of the prevention cascade for each pillar.

4.2 Develop a strategic advocacy strategy, with a communication campaign, to raise domestic and international funding to support all aspects of GPC countries' 2025 road maps.

4.3 Develop the methodology and tools for designing the prevention workforce tailored to a country's 2025 prevention road map, targets and context. Support every GPC country to define prevention workforce milestones and 2025 targets and incorporate those into GPC reporting by end 2021.

4.4 Continue partnering with the Global Fund to increase investment in needed PHP capacity development and service delivery.

4.5 Meet the demand for coordination and transparency in HIV-prevention-related technical assistance by tasking the TSM to collate, analyse and publicise to GPC countries the technical assistance available from all partners (Cosponsors, TSM, TSF, Global Fund, PEPFAR, USAID and other bilaterals, implementing organisations and private foundations) relevant to PHP. Include mechanisms to access UN Joint Programme regional offices as sources of technical support for GPC countries.

4.6 Ensure all member countries can engage in and benefit from GPC meetings and discussions by consistently addressing the concerns and priorities of all regions and sectors, e.g. by rotating the location of GPC meetings, addressing translation needs, and by generating opportunities for mutual learning across regions and sectors.

4.7 Support UCOs and UNFPA country offices to expand country-level communications on PHP activities, guidelines and available tools and support under their country's national HIV prevention brand, to reach civil society, private sector and health and non-health stakeholders, with attention to dissemination at the sub-national level.

4.8 Plan and commission a comprehensive outcome and impact evaluation for 2025 that tests key links in the results chain of the theory of change of the GPC and identifies elements to extend, revise or terminate.

4.9 Commission and seek funding for the development and implementation of a layered communication strategy on primary HIV prevention at national and sub-national levels that includes an effective GPC social media presence, and that dovetails with and reinforces communication on COVID-19 prevention, treatment and care.

5. Recommendations for UNAIDS Strategy 2021- 2025

5.1 Intensify UNAIDS' advocacy and support for evidence-informed, combination PHP as a cost-effective, rights-based strategy that also helps assure the sustainability of antiretroviral interventions long term, and equity in access.

5.2 Particularly in light of the massive global COVID-19 pandemic setback, combat declines and seek increases in funding for primary HIV prevention through strategic high-level advocacy with key funders, government leaderships, civil society advocates and the multinational and national private sector, among others.

5.3 Strengthen the linkages and strategic partnerships needed to intensify HIV prevention

5.4 Set standards and support south to south learning for increased investment in CSOs to strengthen effective community engagement and leaderships for HIV prevention as a core platform for success, especially among young people and key and vulnerable populations.

I. Background and Objectives

In 2017, 50 like-minded organisations - UNAIDS Cosponsors, civil society networks, funding partners and 25 member states - joined together to form the Global HIV Prevention Coalition (GPC)[5] to intensify progress on HIV prevention in the countries with the highest numbers of new infections. This was in recognition that, globally, the primary HIV prevention (PHP) response[6] had lagged behind that of treatment, and that no countries were on track to meet the commitments in the UN High Level Meeting's 2016 Political Declaration to achieve a 75% reduction in annual new HIV infections. Indeed, the UNAIDS Global Report in 2018 declared that HIV prevention was in crisis.[7]

Four areas limiting effective prevention had been identified in 2016:[8] insufficient political commitment, harmful policies and laws, insufficient financing, and lack of implementation of effective interventions at scale. UNAIDS developed a 10-point plan, the HIV Prevention 2020 Road Map,[9] to address these gaps systematically at the national level. The Road Map also specified intensified focus on five intervention areas or "pillars":

- Combination prevention for adolescent girls and young women (AGYW) and their male partners
- Combination prevention services for key populations
- National condom and related behavioural change programming
- Voluntary medical male circumcision (VMMC) and
- Pre-exposure prophylaxis (PrEP).

The Road Map outlined steps through which each country could identify the critical policy, programmatic and structural gaps and barriers to build capacity, mobilise resources, and implement these pillars at scale. The steps prioritised practical actions founded on principles (supporting actions that are evidence informed, community owned, rights based) and proven strategies that would expand coverage, include adolescents and key populations, and increase efficiency through "location-population" and people-centred approaches, including through integration with existing services and platforms.

At its inaugural meeting in October 2017, GPC members endorsed this strategic framework and committed to implementing the 2020 Road Map and relevant pillars to achieve the 2016 Political Declaration targets.

In late 2019 the advisory group of the GPC, the Global Prevention Working Group (GPWG), tasked UNAIDS to commission an external review of the GPC to assess "*the role the GPC and the Road Map have played in strengthening the HIV prevention response globally and at country levels in accelerating progress toward the 2016 HLM prevention targets and commitments...*"[10] and to make recommendations for the way forward. The review responded to the PCB45 request that the Joint Programme was to cover the period from the inception of the GPC in October 2017 to early 2020. In addition, the PCB45 requested the Joint Programme to support countries' intensified action on prevention, and report back to the PCB in 2020 on progress made.[11]

The terms of reference (TOR) for the external review (Annex 1) had seven specific objectives, which were specified as:
1. *Describe and assess the architecture/design and operational effectiveness of the GPC and its key activities including key elements of the Global HIV Prevention Coalition[12]*
2. *Examine the successes and challenges of the GPC in:*

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[5] The GPC, co-convened by UNFPA and UNAIDS, consists of the Global Prevention Working group (see Annex 4), the GPC Secretariat in UNAIDS, national prevention coalitions currently in 28 countries and one REC.

[6] In this document, and per GPC usage, primary HIV prevention excludes PMTCT and ARV treatment as prevention.

[7] UNAIDS (2018). Miles to go: closing gaps, breaking barriers, righting injustices. Geneva.

[8] Dehne KL, Dallabetta G, Wilson D, et al. HIV prevention 2020: a framework for delivery and a call for action. Lancet. 2016;3(7): e323–e332.

[9] UNAIDS and UNFPA (2017). HIV Prevention 2020 Road Map. Accelerating HIV Prevention to Reduce New Infections by 75%. Geneva. UNAIDS.

[10] Oxford Policy Management (n.d.). Terms of Reference. A2559 UNAIDS Technical Support Mechanism - 30-048 External Review of GPC and 2020 Roadmap.

[11] UNAIDS. (2019). 45th Session of the UNAIDS Programme Coordinating Board Geneva, 10-12 December 2019 Decisions. Decision point 5.5.

[12] A.o." The five pillars, membership, chairs, priority countries, road map, the four barriers holding back progress, 10-point action plan, the Secretariat (incl housing at UNAIDS), the Dashboard, Country Scorecards 2017, 2018, 2019, Rapid TA provision, Website (& resources), 3 Progress reports & Progress meetings, Updates to PCB, Prevention Advisory group etc."

a. *Addressing gaps in political leadership on HIV prevention*
b. *Addressing funding towards HIV prevention programming*
c. *Addressing the lack of systematic implementation of combination prevention programmes at scale and the scaling up programmes across the five prevention pillars*
d. *Addressing policy barriers*

3. *Assess the role and engagement in accountability of a wide range of UN, government, multilateral and CSO stakeholders and their political and operational commitment to the agenda*
4. *Establish key challenges in the political landscape since the establishment of the GPC in 2017, as well as barriers and challenges that have hindered further progress in HIV primary prevention*
5. *Describe and assess GPC and 2020 Road Map contribution to accelerating progress towards achieving the Global Target on reducing new HIV infections, and the 2016 Political Declaration prevention programme targets, and potential other HIV targets*
6. *Make recommendations with regards to the possible continuation and successor arrangements to the existing GPC and 2020 Road Map*
7. *Make recommendations regarding the future HIV primary prevention agenda for the period 2021-25.*

The review team consolidated these specific objectives into four main review questions:
1. How appropriate is the architecture/design of the GPC to achieve operational effectiveness and key activities? Based on success, ongoing barriers and the changing landscape, how should the architecture / design of the GPC change going forward?
2. How successful has the GPC been in strengthening political leadership, reducing legal and policy barriers, and increasing HIV prevention funding?
3. How far have GPC's stakeholders demonstrated engagement and understanding of the 2020 Road Map and demonstrated political and operational accountability to it and to the 2016 global HIV prevention commitments? What have been the main successes and challenges?
4. To what extent has the GPC contributed to systematic implementation of combination prevention programmes at scale, including the five prevention pillars?

These overarching questions were presented in an Inception Report and discussed with the GPC and review managers in the inception process. They form the framework for the review.

II. Design, Methods and Limitations

Overview of the Review Process

In the inception process the team developed a preliminary theory of change (ToC) for the GPC based on the list of key activities and elements included in the TOR, the 2020 Road Map and three annual progress reports[13] [14] [15] [16] to further orient the review (see Figure 1).

The ToC indicates that the GPC members and their activities are expected to reduce the key barriers and move countries closer to achieving their HIV prevention targets although, after under three years, it is too soon to measure this last crucial step in the impact pathway.[17] Progress towards the GPC goals is influenced by the background conditions in each country and locale (the green ribbon at the base of the ToC). Broader technical and political developments and the increasing emphasis on opportunities to integrate HIV services in health systems were also taken into account.

In addition to the ToC, the review team developed a review matrix (Annex 2) for the four questions, indicating the main assumptions implied in the ToC that were to be tested, and indicators against which to measure them in order to meet

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[13] UNAIDS and UNFPA (2017). HIV Prevention 2020 Road Map. Accelerating HIV Prevention to Reduce New Infections by 75%. Geneva. UNAIDS.
[14] UNAIDS and UNFPA (2018). Implementation of the HIV Prevention 2020 Road Map. First progress report, March 2018. Geneva. UNAIDS.
[15] UNAIDS AND UNFPA (2019a). Global. HIV Prevention Coalition Second Progress Report: April-December 2018. Implementation of the HIV Prevention 2020 Road Map. Geneva. UNAIDS.
[16] UNAIDS and UNFPA (2019). Implementation of the HIV Prevention 2020 Road Map — Third Progress Report, October 2019. Geneva. UNAIDS.
17 Discussion with the review managers confirmed this, especially given that much of the available impact data was collected in 2018.

the review's specific objectives. Both the ToC and matrix were acknowledged to be living documents and were refined as the review progressed. Data collection was planned to obtain information on the 16 key elements and activities that were listed in the TOR (in footnote 1), in order to describe the documented achievements and perceived contributions of the GPC to strengthening prevention responses, as well as the challenges faced and limitations.

Figure 1. Initial Theory of Change for the GPC

Global HIV Prevention Coalition Inferred Theory of Change (May 20, 2020)
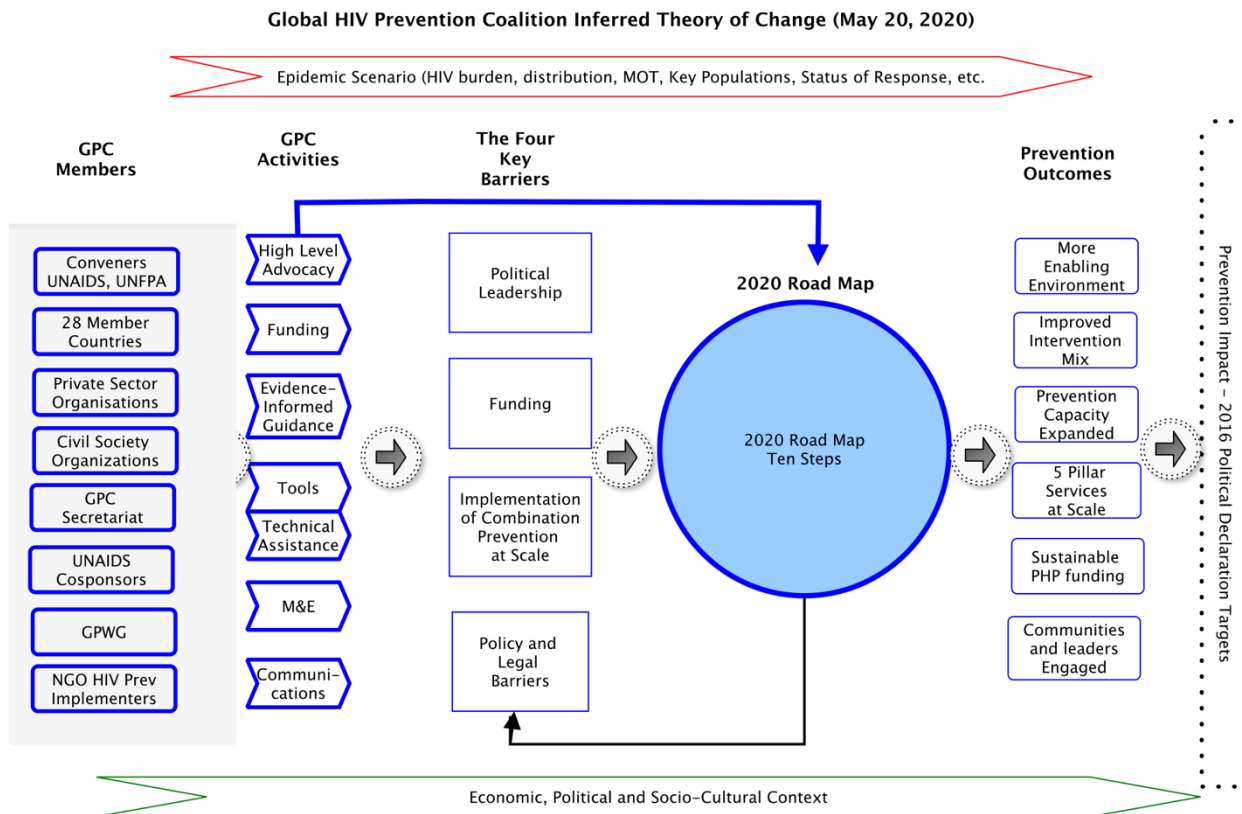
The review design involved two tiers of data collection. The first entailed investigation of the GPWG and GPC Secretariat activities and products through interviews and review of documents that address the Coalition as a whole, with its 28 member countries. The second tier sought information from stakeholders at country level, and involved reviewing country-level documents for a subset of eight GPC countries. Key informants in Tier 2 countries were sought to reflect the views of six stakeholder groups: National HIV programme authorities (NACs); other government; CSO networks; HIV programme implementers; UNAIDS (UCOs) and UNFPA country offices; and others (e.g. academia, donors, private sector). Tier 2 countries were selected to include some that as of 2019 had made more and some that had made less progress on the Road Map, to reflect the Coalition's geographic diversity, and to include both generalized and more concentrated epidemics. In consultation with the GPC Secretariat, Mexico, DRC, Eswatini, Iran, Kenya, Malawi, Mexico, Pakistan, and Ukraine were selected for Tier 2, but because of national issues indicating that respondents would not be available, Mexico was replaced with Brazil and DRC with Côte d'Ivoire. Non-response from Pakistan was evident too late in the process to allow for inclusion of an alternate country. A Tier 3 deeper dive, planned in the inception report, became impossible to undertake because of time constraints.

Methods

As specified in the TOR, the review was conducted mainly through document review and key informant interviews. In addition, late in the review a brief questionnaire was submitted to the GPC Secretariat to assess their views on country engagement and to augment information available about the Tier 1 countries.

All interviews were conducted virtually, using interview guides tailored to the stakeholder group (see Annex 3). All key informants provided verbal informed consent and agreed that their input could be used in the report. Confidentiality was assured by pooling all input by stakeholder group to encourage open dialogue. A small number of key informants provided written responses to accommodate tight timelines. The review team acknowledged the challenges that both the UCOs

and many respondents faced in the context of COVID-19 demands and restrictions. Table 1 highlights the main data sources.

Table 1: Summary of data sources[18]

Document Review	Key Informants
GPC background documents, progress reports, key agenda and meeting reports and minutes, summary notes from the Secretariat	Founder members of the GPC including all GPWG members including UN, INGOs, NACs, civil society, selected bilateral donors and foundations, research organisations
Country data in e.g. scorecards, posters, data spreadsheets, reports of documents produced, commitments for 2020	Beyond the GPWG membership, additional UN Cosponsors at global level and donors at country level in Tier 2 countries
Tools and guidelines on Road Map steps and prevention pillars and on COVID-19	UNAIDS ExD and DExDs, UNFPA ExD and DExD, UNFPA RD a.i., ESARO
Shadow reports; consultations with CSO networks	GPC Secretariat
Extra documents from Tier 2 countries	NAC director and/or prevention focal point, UCD and/or prevention focal point, UNFPA country representative and/or prevention focal point, civil society organisations and donors in Tier 2 countries, and one regional economic community

Data reduction and analysis

The review team summarised their interviews and document reviews using standard templates (see Annex 3) and analysed the material by review question and in terms of the assumptions and indicators specified in the GPC Review Matrix. During data reduction and analysis, the team developed a running list of emerging themes related to the review questions and elements of the ToC (GPC members, GPC activities, the four key barriers, the 10 steps of the 2020 Road Map, and the expected prevention outcomes of the GPC). These themes provided the basis for thematic content analysis of the reviewed documents and the interview summaries to identify preliminary findings. Data analysis involved triangulation of information from the extensive array of documents and the key informant interviews in multiple team conference calls and email exchanges, to confirm or revise the findings and the team's conclusions.

Limitations

In line with the TOR, the review was designed to examine reports and perceptions of GPC-supported activities and products and their perceived effects on the four key barriers to HIV prevention success in the 28 GPC countries, and not to measure the contributions of the GPC to HIV outcomes. While some of the steps recommended by the GPC Road Map could be expected to be implemented in a year or less, to observe outcomes and consequences would take longer. The TOR for the review did not require a study design that would permit attribution of results to the GPC. A number of limitations were noted in the Inception Report, and others arose during the review, as outlined in Table 2. With the mitigation efforts put in place, none were considered sufficiently serious to undermine the validity of the findings and the conclusions of the review.

Table 2: Limitations and Mitigation

Limitations	Mitigation
A number of key processes called for in the Road Map will take 3-5 years to implement, so the 3-year timeline of the review from October 2017 to early 2020 is too short to expect measurable changes in all the outcomes (see Figure 1). Also, the review's data sources were confined to existing documents and KIIs	Despite limitations, it is possible to assess the achievement of most steps of the Road Map and engagement of prevention pillars, access to sustainable funding, increased monitoring and accountability, availability of technical assistance, and views of stakeholders, indicative of the contribution of the GPC towards HIV prevention in the GPC countries

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[18] The documents and key informants are not placed in the table according to linkages between the two.

No country visits feasible as originally envisaged because of COVID-19	Extensive virtual interviews
Challenges securing all planned key informants in a timely manner	Lengthened time frame for interviews and some alternate interviews arranged with Secretariat assistance
Tier 3 not achievable and one Tier 2 country non-responsive	Greater number of interviews in some Tier 2 countries
Challenges in accessing data on financing and resource allocations	Partial information was obtained from key informants through a search of partner websites and recent evaluation of the UNAIDS Joint Programme
Tasks added to the scope of work and complications resulting from the COVID-19 crisis required a level of effort that exceeded the initial contractual consultant days	Additional days were added to the contracts, e.g. to allow for extra interviews and to pursue key informants, and the consultant team streamlined as far as possible the various tasks required; Tier 3 deeper dive was dropped, as was inclusion of ministries other than ministries of health
The review team was reliant on identification of Tier 2 key informants by the Secretariat and UCDs. Individuals proposed in the seven countries may not fully represent the range of views within those countries, or from all 28 GPC countries	The review team provided criteria for identification of in-country key informants (range of stakeholder groups), and asked for civil society and government expertise in HIV prevention, regardless of direct engagement in the GPC, to avoid bias from speaking only with GPC advocates. UCDs provided diverse candidates, from which the review team selected respondents likely to provide diverse perspectives
Virtual inputs to the review from NAC directors from all 28 countries not achieved	Use of reports representing all 28 countries and of available minutes of NAC directors' meetings. Review team attended one NAC virtual meeting. Direct questions to NAC directors beyond the seven Tier 2 countries were not possible given the timeline and the demands NACs face from the COVID-19 crisis

Data Collected

The team reviewed the initial list of 98 documents and web pages provided by the GPC Secretariat. These included: background documents from 2015 through March 2020; GPC progress reviews and updates; reports to the UNAIDS Programme Coordinating Board 2018[19] and 2019[20]; reports of GPC events at global meetings (e.g. IAS 2018; WHA 71; ICPD+25); meetings of and for the NAC directors of GPC countries in 2018[21] and 2019[22]; and 43 documents and tools assembled or developed by the GPC Secretariat and GPWG members regarding each of the five prevention pillars. In April and May the team received lists of documents compiled by the UCD in each of the 28 GPC countries, which included additional information on achievements relevant to each of the 10 steps of the 2020 Road Map. The team examined basic documents (e.g. national HIV strategic plans and HIV targets) for all 28 countries and reviewed the documents listed by the Tier 2 countries in more detail. The documents reviewed by the team are listed in the Bibliography in the Annexes.

As specified in the assignment's TOR and subsequent guidance from the GPC Secretariat, the review team invited for key informant interviews:
- All members of the Global HIV Prevention Working Group (GWPG)
- Executive Directors of the GPC convening organisations (UNAIDS and UNFPA)
- Additional representatives of UNAIDS Cosponsors and partners at regional and global levels
- Members of the GPC Secretariat and UNAIDS Secretariat.

In addition, with the assistance of the UCD in the Tier 2 countries, the review team was able to select, contact and recruit individuals knowledgeable about HIV prevention from six stakeholder groups in seven of the eight Tier 2 countries. In total, the team was able to obtain interviews with at least 10 respondents in each of seven stakeholder groups: GPWG members; UNAIDS Secretariat; UNFPA; other Cosponsors; NACs; civil society networks and NGO implementers; and

[19] UNAIDS (2018). Annual report on HIV prevention 2020.
[20] UNAIDS (2019). Annual report on HIV prevention (2020).
[21] GPC (2018). 1st meeting of directors of National AIDS Commissions. July, 2018. Amsterdam.
[22] GPC (2019) 2nd meeting of Directors of National AIDS Commissions of the Global HIIV Prevention Coalition Member States, May 7-8, 2019, Nairobi, Kenya; GPC (2019) First virtual meeting of NAC Directors, August, 2019

donors, as well as three to six interviews with ministries of health, the GPC Secretariat and other regional and global HIV experts. The 97 stakeholders interviewed, and their affiliations, are listed in Annex 4.

III. Findings

This section presents key findings that answer Review Questions 1 through 4, bracketed by a section at the start on overarching successes and challenges of the GPC and, at the end, a section on key informants' views on the future of HIV prevention over the next five years. Many of the findings draw from the GPC's annual progress reports, which synthesise

Figure 2. GPC country scorecards for 2017, 2018 and 2019 consolidated
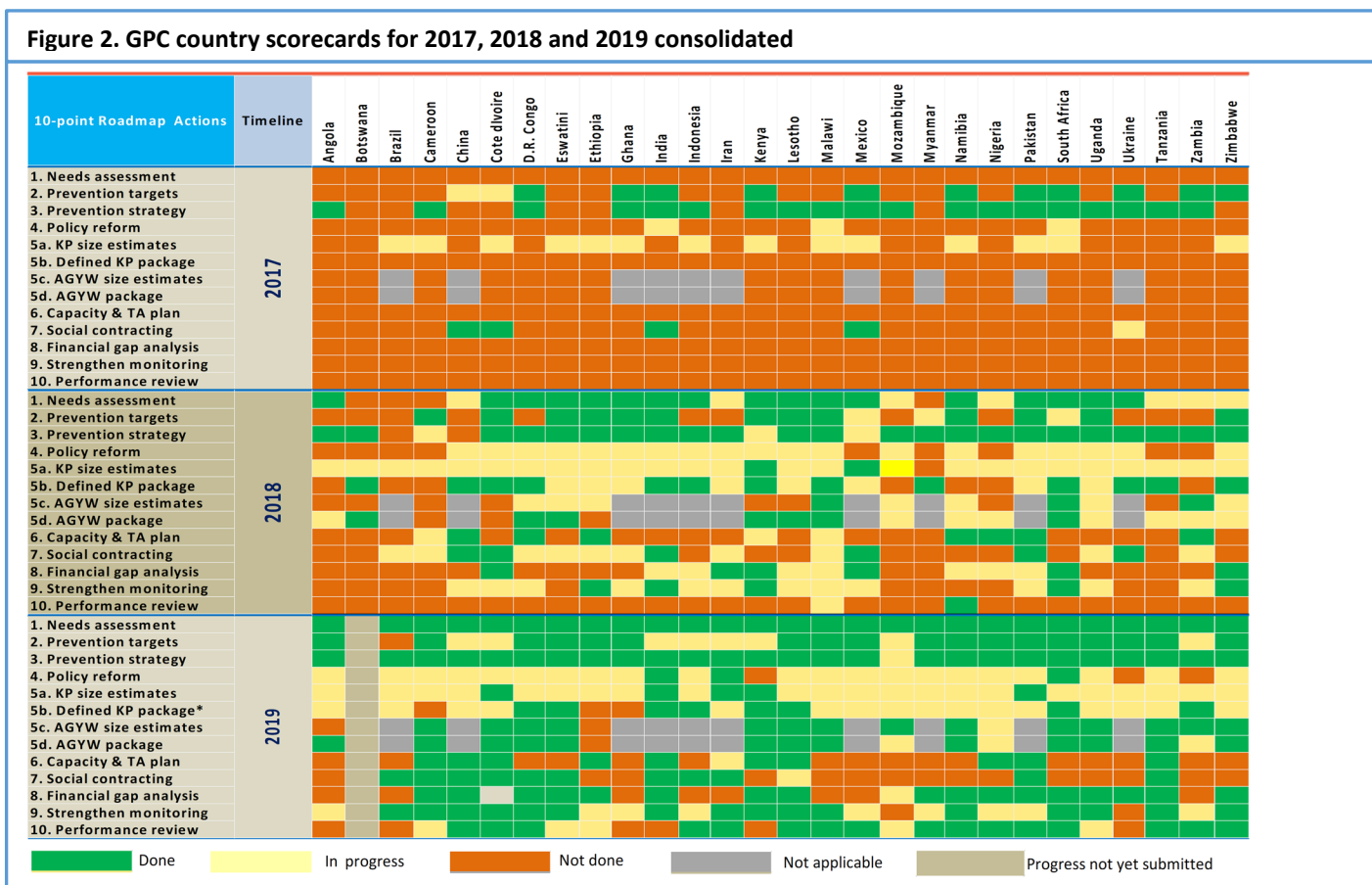
Figure 2 Source: Global HIV Prevention Coalition (2019) Third progress report.

and summarize responses from the GPC countries to an annual survey. Figure 2 illustrates the manner in which the GPC Secretariat transforms the survey responses into the annual scorecards. Individual scorecards allow countries to see where they are on track and where more needs to be done. Composite scorecards, such as Figure 2, invite comparisons across the Road Map steps and GPC countries, and provide a stark visual image of progress from 2017 (mostly orange-not done) to 2019 (mostly yellow and green - in progress and done).

Overarching Successes and Challenges of the GPC

1.   The GPC is universally acknowledged to have restored attention to primary HIV prevention in the global health agenda and in national HIV responses. NACs of GPC countries and all GPWG members want to see it continued

The recent evaluation of the UNAIDS Joint Programme,[23] presentations to the 46th meeting of the UNAIDS Programme Coordinating Board (PCB)[24] and all stakeholder groups interviewed for this review agreed that the GPC endeavour has

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[23] UNAIDS (2020). Independent evaluation of the UN System response to AIDS 2016-2020. Geneva. UNAIDS

[24] UNAIDS (2020) Unified Budget Results and Accountability Framework. Performance monitoring: Strategy Result Area and indicator report. 29 May, 2020. Geneva: UNAIDS

contributed to elevating primary HIV prevention in the HIV agendas of GPC countries and global partners. In addition to more attention, they noted that the GPC has built consensus around a common agenda for primary prevention, focused on implementing the five pillars at scale. The unifying narrative of the Coalition, focusing on delivering the needed services to the populations and locations at highest risk, has "*created a global standard for HIV prevention*" (GPWG). It has helped to overcome fragmentation in the prevention field and presents primary HIV prevention as essential to the long-term sustainability of HIV treatment. Stakeholders also remarked on the systematic programming process represented by the 2020 Road Map's 10 steps. The Road Map emphasises the importance of national leadership and of civil society participation in planning their prevention responses based on granular data on the places and populations most affected by and vulnerable to HIV, thus helping countries to move "*from a generic to a targeted approach to prevention*" (NAC).

2. The GPC is more influential and known at the global than country level. This has limited its direct influence on the underlying barriers impeding effective HIV prevention

Documentation and key informants agreed that the GPC has influenced major donors (including the Global Fund against HIV, TB and Malaria [GF], the Bill and Melinda Gates Foundation [BMGF] and some bilateral donors) to acknowledge that funding allocated to primary HIV prevention has declined as a proportion of total HIV funding, and that it should be expanded.[25] Reports of GPC influence at country level are positive but more varied.

The GPC's third progress report[26] outlined impressive progress in all 28 GPC countries in implementation of the 2020 Road Map (see Figure 2, above). All 28 countries reported appreciation for the GPC in the 2019 annual reporting survey.[27]

That said, interviews with a range of stakeholder groups in Tier 2 countries provided more varied views on GPC influence at country level. [28] For example, the GPC was appreciated in Brazil, but said to have relatively little influence because it was not widely publicised. As well, by 2017 the country had a 20-year history as a global leader in HIV responses, so the 2020 Road Map did not offer much that was new (CSO and MOH). In contrast, in Iran the GPC has been highly influential, helping to expand programming from a focus on harm reduction in people who inject drugs (PWID) to address additional

> "*I have never seen such a huge effect on any programme in 20 years with UNAIDS. The country was ready to embrace the concept of prevention. The results were magnificent.*" (UCD)

vulnerable populations. Respondents in Côte d'Ivoire indicated that the GPC also has had strong influence, both in the provision of guidance and tools for reviving prevention working groups and refocusing the national prevention strategy on the pillars, and also by supporting a national consultant to sit in the NAC and coordinate and manage the roll-out of Road Map activities. In Ukraine, HIV services have been integrated into the public health system where HIV prevention activities are not tracked and reported. And Kenya had already developed its own prevention road map in 2014.[29]

Each of the 28 coalition countries faces diverse technical, political and financial challenges in rolling out combination prevention programmes. Most, however, share difficulty in altering the structural factors that the GPC identified as key barriers to effective HIV prevention programming: gaps in political leadership and financing, and creating a fully enabling legal and policy environment. These are areas where the country-level   NACs and CSOs involved in national HIV prevention work could use more support from the GPC, including from the UNAIDS conveners and cosponsors, and from the GPWG.

III.1 Review Question 1:   How appropriate is the architecture/design of the GPC to achieve operational effectiveness and key activities?   Findings and Discussion

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[25] UNAIDS (2015). Invest in HIV prevention. Geneva. UNAIDS.
[26] UNAIDS and UNFPA (2019). Implementation of the HIV Prevention 2020 Road Map: Third Progress Report, October 2019
[27] GPC (n.d.) Implementation of HIV Prevention Roadmap 2020 Third Progress   Report_Nov_2019. Excel spreadsheet raw data.
[28] Given the design of this review, with no provision for in-country visits, and the limited number and range of key informants per country, it is impossible for the team to make or to verify claims about cause and effect in specific countries.
[29] Kenya Ministry of Health (2014). Kenya HIV Prevention Revolution Road Map, 2014.

1.1. The appropriateness of the architecture of the GPC ultimately hinges on its prime objectives and scope, and these are perceived differently by different stakeholders

GPC documents, from the Road Map[30] to the Coalition's third progress report,[31] describe the purpose of the GPC as follows:

"The overall goal of the coalition is to strengthen and sustain political commitment for primary prevention by setting a common agenda among key policy-makers, funders and programme implementers. It will also ensure accountability for delivering services at scale to achieve the targets of the 2016 Political Declaration." (Road Map p. 22)

The review team has developed a picture of the architecture of the GPC from this kind of statement in a variety of documents and interviews, because it is not prominently or consistently presented in the GPC materials.

The Road Map 2020 specifies commitments for governments (six commitments), civil society (five), donor countries, development partners and global philanthropic institutions (five) and the business community (three), thus delineating five categories of participation, with their expected functions and contributions. It further stipulates the following (p22):

"It will maintain a global accountability process with scorecards, reflecting progress against national targets, to track yearly progress and peer review meetings of country leaders and managers. It will also establish a coordinated and responsive modality for providing support to needs assessments, target setting, planning, implementation, programme reviews and technical and policy guidance through an interagency and technical assistance draw-down mechanism (Annex 3)."

This paragraph indicates the functions to be operationalised by the GPC Secretariat, although it was not labelled as such. UNAIDS Cosponsors, WHO, UNICEF, UNDP, UNODC, UNESCO and UN Women, are listed in an annex of the Road Map that diagrams the planned mechanism at global level for providing technical assistance (see Figure 3, below), but their role is not mentioned elsewhere in the document. National HIV prevention coalitions and technical working groups,[32] including civil society participation, are cited in the Road Map and detailed in the GPC's first progress report,[33] and are additional components of the GPC architecture.

Figure 3: Architecture of the Global HIV Prevention Coalition
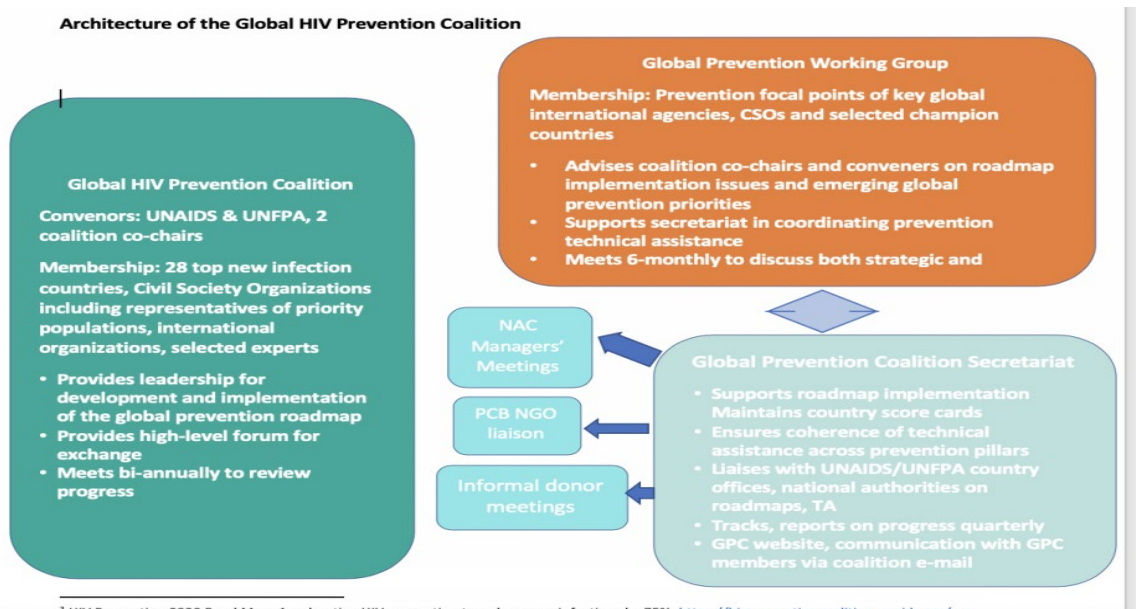
Source: GPC (2018). Global HIV Prevention Working Group. Terms of Reference

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[30] UNAIDS and UNFPA (2017). HIV Prevention 2020 Road Map. Accelerating HIV Prevention to Reduce New Infections by 75%. Geneva. UNAIDS p. 3
[31] UNAIDS and UNFPA (2019). Implementation of the HIV Prevention 2020 Road Map. Third Progress Report, October 2019; p. 4
[32] UNAIDS and UNFPA (2018). Implementation of the HIV Prevention 2020 Road Map. First Progress Report, March 2018. pp. 7-8.
[33] UNAIDS and UNFPA (2018). op cit.

Responses from key informants in this review revealed that by 2020 a wide range of views has emerged on the purpose, scope and structures of the GPC. Most UN and NAC stakeholders at country level were largely unconcerned about the GPC's architecture, beyond questions concerning representation of countries and issues pertinent to their region. Their focus was on GPC support at national level. Civil society stakeholders and networks and NGO implementers beyond the founding members reported little knowledge of the GPC, much less its component parts.

In contrast, stakeholders at global level had diverse views on the GPC's scope and mandate. To some global stakeholders the Coalition is, or should be, "*the global voice of HIV prevention*" (GPWG), while to others, the GPC's purpose is more limited, i.e. that its focus is on programmatic aspects of promoting the implementation and scale of the five pillars. UNAIDS Cosponsors beyond the founding members apparently were not aware of their intended roles in the GPC as lead sources of guidance and technical support in their thematic areas under the UNAIDS Division of Labour.[34]

Several Cosponsors expressed concern that the GPC is disconnected from, and parallel to, their efforts to promote the human rights, gender, education and economic dimensions of successful, multi-sectoral responses to HIV, including in humanitarian settings. The GCP Secretariat and some members of the GPWG were well aware of these Cosponsor initiatives. They emphasised that the GPC (vis GPC structures working together) had a specific niche, "*not to do it all*" (GPWG)*,* but rather to promote prevention leadership and to support countries to tailor, implement and report their progress on the 2020 Road Map and the pillars according to their country needs. They implied that the GPC structures should be seen as parts of a larger mosaic of organisations and services that GPC members could and should be drawing upon. However, this view is not widely known. The review further develops the issue of the architecture of the GPC and linkages with other fields and initiatives below.

1.2. The functions and support of the GPC Secretariat are widely appreciated by GPC members but communications could be improved

The functions of the GPC Secretariat were outlined in the 2020 Road Map[35] and in Figure 3 (above). When asked specifically about the GPC Secretariat, those KIs who were aware of it included the NAC directors, UNAIDS and UNFPA respondents at country level, members of the GPWG and global level UN organisations and donors. Some KIs commented that the GPC Secretariat is appropriately situated in UNAIDS/Geneva, although more participation by UNFPA would be beneficial. All reportedly appreciate and highly value the GPC's analysis and presentation of data from member states in the form of scorecards and the progress reports. They agreed that meetings organised by the GPC Secretariat have been very well prepared and highly successful.[36] Most NAC stakeholders and UCOs reported that communications from and with the GPC were timely and useful, although some also called for more contact, especially more sharing of technical information, and for increased routine communications beyond specific events. Development and dissemination of key messages, and other strategic communication and advocacy support, were also

> **GPC results and services most often praised by key informants**
> - Raising global and country level political commitment to HIV prevention, with reporting against targets and high-level meetings
> - The more systematic structuring of HIV prevention, and identification of strengths and gaps
> - Monitoring, reporting and data analytics producing tools for progress tracking and advocacy (scorecards)
> - Greater attention to key populations and vulnerable groups
> - South to south learning opportunities
> - Strengthened collaboration for prevention, including civil society and key populations.

suggested (GPC Secretariat). However, some expressed frustration over the time-lags entailed by the need for the Secretariat to seek wider UN clearance before issuing GPC documents.[37] The speed at which GPC products are produced and cleared is only partially a function of the intense workload observed in GPC Secretariat staff, but also of the priority given to GPC requests by the UNAIDS units that have the authority to provide clearances. Diverging views on the size and staffing of the GPC Secretariat related to different visions of its functions and are addressed later.

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[34] UNAIDS (2018). UNAIDS Joint Programme Division of Labour. Guidance note. https://www.unaids.org/sites/default/files/media_asset/UNAIDS-Division-of-Labour_en.pdf.

[35] UNAIDS and UNFPA (2017). Road Map.

[36] Key meetings include: the 2017 launch meeting; the 2018 NAC Managers' meeting - Amsterdam; the GPC side-event at IAS2018 in Amsterdam; the GPC side-event at WHA 2018; the High Level Meeting 2019 adjacent to ICPD-25; the NAC Directors' meeting following the HLM, 11 November 2019.

[37] There is now agreement that the GPC can publish documents on its own website without UNAIDS and UNFPA clearance (personal communication, July 28, conference call with the ER management group), including while awaiting clearances for the highly valued UNFPA and UNAIDS logos.

Few KIs in any stakeholder group cited the role of the GPC Secretariat in coordinating technical support to member countries, although this function is variously cited in GPC documents.[38] Key informants in the GPWG and Secretariat indicated that it is beyond the scope of the GPC Secretariat to broker or coordinate the multiple sources of technical assistance, despite the initial intention to do so. Instead, various efforts were made to assist countries to seek technical support from the Technical Support Mechanism (TSM). For example, standard TOR were developed to facilitate use of the mechanism, and in late 2018 the GPC provided training for prevention consultants registered with the TSM. Later sections address technical support further. The Secretariat also aimed to seek from countries consolidated work plans on technical support requirements (step 6 in the Road Map) in order to move away from their reliance on ad hoc requests for technical assistance. However, by the end of 2019 capacity needs assessment and developing a technical assistance plan remained the least developed step of the Road Map (step 6, see Table 5). Several KIs in the GPWG and GPC Secretariat expressed interest in investigating this gap.

The review team learned of multiple sources of technical support being accessed via country level UN joint teams as well as through global partners such as the Global Fund and PEPFAR. This includes extensive guidelines and "how to" tools, and Programme Self-Assessment Tools (PSATs) particularly to assist in south to south learning. Indeed, some GPWG members observed that available technical support is underutilized.

1.3. The GPWG brings together a dynamic and diverse set of HIV prevention experts to contribute to the GPC, but there are questions about its mandate, composition and focus

The GPWG has successfully and consistently engaged diverse PHP experts in support of the GPC, but its mandate, responsibilities and limits are insufficiently defined. The GPWG members stressed that they serve in their individual capacity (not representing organisations). They appreciate and want to maintain the small group size and relative informality which enables the GPWG "*to move fast*" and to "*avoid UN bureaucracy*" and "*organisational politics*." GPWG members increasingly encourage the GPC to prioritise country-level implementation over global advocacy. They highly value the contributions of the NAC directors from Kenya and Zimbabwe and the Co-Chair from Botswana (currently the only country-level members of the GPWG), and all see the limited inclusion of and engagement with country-level stakeholders as a weakness. GPWG members also want to see more civil society representation, and more transparency regarding membership. On the other hand, they fear that expanding membership risks changing the group's agility and overstretching their budget: while many GPWG members are self-financing, the GPC Secretariat funds the participation of NAC directors and representatives of KP networks and young people, and GPC Secretariat funds are limited.[39]

Additional critiques of the GPWG were heard: that the membership is "*Geneva-heavy*," with too much UN and not enough regional and country level membership (GPWG, CSO); that the focus of GPWG meetings has been "*Africa-centric*" although the GPC includes LAC, EECA, SEA, and Asia (CSO networks, NACs, UNAIDS Cosponsors). Some felt actively excluded by the GPWG (Cosponsors), which operates as "*a private club*" (CSO). Insufficient "*airtime*" for the voices of key populations was also cited as a weakness (CSO).

The Terms of Reference of the GPWG,[40] published in 2018, state that the GPWG's functions are two:[41]

- To advise coalition co-chairs and conveners on prevention Road Map implementation issues and emerging global prevention priorities
- To support the Secretariat in coordinating prevention technical assistance to support country level implementation.

While the 2020 Road Map characterized the GPWG as an advisory body, the TOR state that it is "*to serve as the steering committee of the GPC* and be responsible for strategising around HIV prevention and supporting Coalition co-conveners and co-chairs".[42] In the agenda for the GPC session at the World Health Assembly 71 in 2018, the co-chairs of the GPWG

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[38] For example, the GPC's first progress report cites three functions of the Secretariat: "to track progress of Road Map implementation; provide technical support to national HIV prevention coalitions and strategies, and help advocate for adequate investments in HIV prevention" (p. 6)

[39] Details on GPC Secretariat funds and their allocation would be helpful, but without comparative information on other prevention activities in the UNAID Secretariat, or the budgets of other UN initiatives such as the Fast Track, or the Global Partnership against Stigma and Discrimination, the meaning would be unclear.

[40] GPC (2018). Terms of Reference. The Global HIV Prevention Working Group. p.2; UNAIDS and UNFPA (2018). Implementation of the HIV Prevention 2020 Road Map. First progress report, March 2018. Geneva. UNAIDS.

[41] GPC (2018). Op cit. p.3

[42] Report of the Global HIV Prevention Working Group meeting, New York, 8-9 March 2018. https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/03/Notes-on-Prevention-WG-meeting-2018-03-v2-1.pdf

were listed as co-chairs of the GPC as a whole. The exact roles and authorities of the co-conveners, the co-chairs, and the GPWG, as well as its membership, merit clarification.

The critiques cited above concerning the membership and focus of the GPWG have been acknowledged in the GPWG meetings held since its launch.[43] To respond, the GPWG in consultation with the conveners and the GPC Secretariat has set meeting agendas and/or launched consultations progressively to address the needs and concerns of specific populations (people who use drugs, sex workers, gay men and other men who have sex with men, adolescent girls and young women, young women out of school, and male partners of AGYW). Also addressed have been gaps in HIV prevention programmes, notably: condom programming; comprehensive sexuality education (CSE); prevention target-setting; human rights barriers; universal health coverage (UHC) and linkages of PHP with SRHR; HIV prevention trials; HIV prevention and treatment in the context of the COVID-19 pandemic. As of 2020 the GPC Secretariat hosts a key population coordination group

> *"We need to do more in country ownership and in scaling up. But we have seen progress, and change, due to the all-hands-on deck mentality that the GPC represents." (Convener)*

comprised of GPWG members, UNODC, UNDP, and leads from key global networks (NSWP, MPact, INPUD, GATE), formed to prepare and follow up deep dive sessions to improve HIV prevention services with and for KPs.[44]

The semi-annual meetings of the GPWG represent a unique forum for multi-stakeholder information-sharing and coordination among key actors involved in HIV responses in low- and middle-income countries (LMICs). They usually include important updates from PEPFAR and the Global Fund. The session presentations and meeting reports provide valuable, succinct overviews of the state of the art and the state of implementation of PHP globally, and in the GPC countries. The reports are available on the GPC website, with many presentations also available from the GPC Secretariat upon request. These are likely to be of wide interest but, like the TOR for the GPWG, they do not appear to be widely known. These factors may contribute to the diverse views on the GPWG that were heard by the review team.

1.4. Non-GPC key informants expressed concern over the limited involvement in the GPC and the GPWG of organisations that focus on human rights and law, gender, economics, and communications, and over insufficient support for high-level advocacy

Since the inception of the GPC, the Coalition[45] and stakeholders'[46] reports have cited the slow progress against the four key barriers to achieving the HLM 2017 targets as critical concerns. Yet many KIs noted that GPC members (especially NAC directors and GPWG members) are mostly from the health sector and do not reach out to other ministries. Organisations whose central mandates are human rights, gender and funding are not well represented in GPC activities at global or country levels, and the Cosponsors' roles leading TA in these areas appear not to have been realized in the context of the GPC. Key informants cited many of these disconnects. For example, UNDP is responsible for human rights in the UNAIDS Division of Labour,[47] and UN Women for gender issues; neither is a member of the GPWG or an active participant in GPC technical assistance. UNODC leads the biannual production of the World Drug Report[48] and convenes leaders who influence national policies that impede HIV prevention and services for people who use drugs (PUD).

However, differences emerged between Cosponsors' involvement in GPWG reviews and deep dives and their perceptions of being part of the GPC. UNODC was invited and made important contributions to a GPWG session on HIV prevention for people who use drugs[49] yet it does not consider itself a member of the GPC or GPWG (Cosponsor). UNDP and UN Women participated in GPWG deep dives on stigma and discrimination, and they contributed to reporting on stigma and discrimination and intimate partner violence (IPV) in GPC scorecards,[50] yet they too do not perceive their organisations as part of the GPC (Cosponsor). Regional economic communities can either raise the importance of funding HIV prevention priorities or lower it through silence, but the RECs have not been addressed systematically by the GPC so far with the exception of SADC, and the World Bank has had little engagement with the GPC since its launch (GPWG).

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43 GPC GPWG meeting reports - March 2018, September 2018, February 2019, September 2019, and March 2020
44 GPC (n.d.) Agenda_HIV Prevention and KP Deep Dive Series_April 2020_rev6.pdf; GPC (n.d.) Agenda HIV Prevention and KP Deep Dive Series - Session 2_July2020_rev5.
45 E.g. UNAIDS and UNFPA (2017). HIV Prevention 2020 Road Map. pp. 10-12; UNAIDS (2018) First Progress Report pp. 13-14 and 19;
46 E.g. Dehne et al., 2016. Op cit
47 UNAIDS (2018) UNAIDS Joint Programme. Division of Labour.
48 UNODC (2019). 1. Executive summary. Conclusions and recommendations. Vienna: UNODC.
https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_1_EXECUTIVE_SUMMARY.pdf
49 GPC (2019) Global Prevention Working Group meetings
50 GPC (2019) Global Prevention Working Group meeting, March 2019.

Several KIs observed that high-level advocacy and strategic communications plans and skills are required to move country level leaders who are responsible for policy-making, funding and shaping health agendas. KIIs indicated that neither the GPC Secretariat nor the GPWG are staffed or supported for this.[51] The GPC conveners, Co-chairs and many GPWG members and GPC founding members are viewed as having the stature to engage in the needed high-level dialogue in multiple sectors, but they have not been provided with a proposal, workplan or funding to do so.

> "The Working Group was (originally) a coalition of the willing, which was important in the early stages when there was a need of a unified voice…to lobby and to advocate. But whether we are still the right people at this stage is a legitimate question." (GPWG)

These arguments support the call for refreshing the memberships of the GPC and/or GPWG, either on a standing or rotating basis, for reinforcing the role of UNAIDS Cosponsors in GPC technical support, for clarifying and strengthening linkages with key actors beyond the GPC core membership, and for increasing the resources and coordination of this expanded set of leaders in technical assistance and high-level advocacy in support of GPC goals.

1.5. The "global" orientation of the GPC can slide into "one-size-fits-all" approaches which do not address the different epidemic scenarios in different regions or the specific priorities and needs of member countries and stakeholders

The countries originally recruited by the conveners to join the GPC in 2017 were those with high HIV incidence and/or HIV burden: they accounted for over 80% of new infections according to GAM reporting.[52] One KI mentioned that being invited to join the Coalition was recognition of failure in one's national programme: "*being on the 'bad' list*" (UNAIDS). Eighteen of the original 25 member countries were in Africa. Subsequently, Iran, Botswana and Myanmar have joined the Coalition. The African countries in the GPC are diverse in every respect, from population size and area to epidemiologic profile to language. However, they share many challenges with member countries from other regions (Brazil, India, Indonesia, Iran, Mexico, Myanmar, Pakistan and Ukraine) - including reaching key populations, growing a sustainable funding base, and reducing stigma and discrimination - even though their epidemiological profiles differ.

HIV responses have long progressed beyond dichotomizing "generalised" versus "concentrated" epidemics, recognising that all countries have mixed epidemics, and the GPC guidelines - including the steps in the 2020 Road Map - all advise and support tailoring the steps and the pillars to national and, especially, to sub-national needs.[53] Nevertheless, numerous KIs commented that when gathered for GPC meetings, and in GPWG discussions, discussions and examples tend to be drawn from the African countries. Stakeholders from countries and communities where HIV risk and prevention needs are highest among people who use drugs and/or sex workers and/or gay men and other men who have sex with men, reported support for and interest in exchanging knowledge with their African colleagues, but also reported that their issues and voices are not given sufficient attention. In addition, the importance of language differences cannot be underestimated. With GPC meetings being held in English, French-, Spanish-, Portuguese- and Farsi-speakers are less able, or unable, to fully engage, and GPC materials disseminated in English are costly to translate for national and sub-national use.

GPWG KIs acknowledged many of these issues, and the option to change the range and number of GPC countries has been discussed in GPWG meetings.[54] Some of the solutions discussed include: ensuring agenda items and speakers from other regions receive more space in NAC and GPWG meetings; rotating the location of meetings to different regions; and increasingly hosting region-specific meetings convened by regional offices instead of the Geneva-based GPC Secretariat. Providing translation support would also be helpful.

1.6. The GPC does not encompass all important initiatives that support effective HIV prevention, and it should provide clearer linkages to relevant initiatives and actors beyond its scope

One KI reported that the GPC is confusing specifically because it is not global - only 28 of the UN's 193 sovereign countries are members (Cosponsor). There remains debate within the GPWG and GPC Secretariat as to the ideal number of

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[51] The GPC co-chair from Botswana is an exception. She has had a contract and budget to conduct high-level visits and dialogs to advocate for policy and legal reforms and funding increases needed to operationalize the GPC pillar strategies (GPC Secretariat).

[52] GPC (n.d.) Implementation of HIV Prevention Roadmap 2020 Third Progress Report_Nov_2019. Excel spreadsheet, raw data.

[53] E.g. UNAIDS and UNFPA (2017) HIV prevention 2020 road map. UNAIDS and UNFPA (2018) GPC First progress report.

[54] GPC (2018) Global HIV Prevention Working Group meetings 9/18, 3/19, and 9/19

countries to involve in the "global" coalition. While logic of the initial membership is clear (countries contributing the majority of new HIV infections in 2017), a few KIs noted that a more forward-looking approach would be to include countries, and also sub-national locations such as Fast Track cities, that have high or increasing rates of new infections.

Many KIs noted that the GPC does not encompass all the initiatives and partners that are relevant to bringing appropriate HIV prevention services to scale. Specific groups and initiatives were mentioned by global KIIs, with suggestions that they be more systematically engaged in the GPC methodology, or linked with GPC efforts. Examples include the following:

- Regarding partners addressing the concerns of people who use drugs: the Strategic Advisory Group on Injecting Drug Use (SAG),[55] and UNODC, which is listed as a source for technical assistance for this key population. Indeed 10 of the GPC countries were singled out in the PCB report on the Global State of Harm Reduction[56] and 13 GPC countries endorse harm reduction, so could advise other GPC countries where legal and policy reforms are needed to protect PUD.
- Regarding adolescent girls and young women, UNICEF (represented in the GPWG) cited work under the Stay Free initiative to improve mapping of AGYW populations and call for health and development interventions including access to youth-friendly HIV prevention and treatment; and Our Rights, Our Lives, Our Future campaign, launched by Sweden and UNESCO in 2017;[57] and Every Woman Every Child[58] also were cited. Thirteen out of 15 countries involved in PEPFAR's DREAMS Partnership (Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe) are GPC countries.[59] UN She Decides movement and WOMEN's Generation Equality[60] are also extremely relevant.
- Numerous key informants and documents recommend strengthening linkages with sexual and reproductive health and rights (SRHR) actors and initiatives. The GPWG called for a UNAIDS/UNFPA review paper on these linkages.[61] IPPF and the chair of FP2020 bring their SRHR expertise to the GPC through the GPWG and UNFPA's role as co-convener, as does the GPWG member from PEPFAR. Other aspects of SRHR, including CSE are highly relevant. For example, a GPWG report cited a UNESCO review of CSE in 23 African countries, which identified needs for more technical assistance to provide in-school and out-of-school adolescents with access to CSE.
- Regarding gender, human rights and law, Cosponsors drew attention to the Global Partnership to Eliminate all forms of HIV-related Stigma and Discrimination.[62] The Partnership was cofounded in 2018 by UNDP, UN Women, GNP+ and UNAIDS, and the GPC Secretariat stated that it plans to align Road Map indicators with Partnership indicators as soon as the latter are finalised.[63]

The GPC Secretariat is fully aware of these and other relevant UN and partner activities, and many have been featured in GPWG meetings and deep dives. They argue, however (as noted earlier), that "*the GPC is not supposed to be everything*." Rather, the GPC promotes a practical model which encourages countries to look at data, coordinate and work with partners, develop strategies and plans to address observed gaps, to raise funding, and to manage implementation and reporting through the HIV prevention management system of the national programme. The gap appears to be the lack of a larger frame for global HIV prevention - a widely and repeatedly shared document or map - in which all the key actors, their roles and responsibilities, are clearly depicted, and their respective initiatives and resources are made evident to all. Each country could adapt the map to its own configuration of active partners and programmes, as Cosponsor and partner presence and projects vary enormously.

The partial list of themes and entities above illustrates a longstanding challenge in HIV prevention: its complexity.[64] Indeed, GPWG and GPC Secretariat members noted that the aim of the GPC was the opposite of connecting all the many

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[55] The SAG was invited to the GPWG meeting in September 2018, when PUD were on the agenda. Inviting the SAG to join the GPWG had been mentioned but was not followed up.

[56] UNAIDS (2012). The Global State of Harm Reduction 2012: Towards an Integrated Response. Harm Reduction International; 2012; UNAIDS (2014) Halving HIV transmission among people who use drugs. Background note. 25 November. UNAIDS/PCB (35)/14.27.

[57] UNESCO Our Rights, Our Lives, Our Future campaign: https://en.unesco.org/news/unesco-and-sweden-support-countries-expand-comprehensive-sexuality-education-africa

[58] UNICEF and WHO (2015) Partnership for maternal, newborn and child health. Every woman every child.

[59] PEPFAR (2020). US Department of State. DREAMS partnership. https://www.state.gov/pepfar-dreams-partnership/

[60] She Decides (2017) Our Story. https://www.shedecides.com/our-story; UN Women (2019). Generation equality. Realizing women's rights for an equal future. May, 2019.

[61] GPC (2018). GPWG meeting report, September 2018

[62] UNDP, UN Women and GNP+ (2018) Global Partnership for action to end all forms of HIV-related stigma and discrimination. https://www.unaids.org/sites/default/files/media_asset/global-partnership-hiv-stigma-discrimination_en.pdf

[63] https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/01/GPC-welcomes-the-Global-Partnership-to-Eliminate-all-forms-of-HIV.pdf

[64] e.g.UNAIDS (2010) Combination HIV prevention:tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections. A discussion paper. September, 2010; UNAIDS (2020) Annual Report on HIV Prevention 2020. UNAIDS/CB (45)/19,26 rev1.

dots in the HIV prevention picture. Rather, it was to use its finite resources to support implementation of a limited but evidence-based agenda in a limited number of countries, to demonstrate the kind of results that would inspire governments and civil society to carry on implementing, and governments and donors to invest more in PHP.

1.7. Stakeholder groups were consistent in their concerns and recommendations regarding the GPC

The review sought to obtain perspectives on the GPC from its diverse members, categorised into seven stakeholder groups (see Figure 1). The views gathered from both documents and interviews were not as diverse as expected. For example, the seven shadow reports on the GPC that were prepared by Frontline AIDS each end with a list of recommendations addressed to the national government. Although coming from very different countries,[65] the issues cited are well-recognised. These include:

- Creating a more enabling environment for the people most at risk of acquiring HIV, including addressing the remaining structural barriers that prevent marginalised people from accessing HIV services (Nigeria, Ukraine, Malawi)
- Increasing funding for prevention, allocating resources to implement combination prevention services for all marginalised groups, and including funding for groups led by key populations; increasing funding from domestic sources (Nigeria, Ukraine, Kenya, Malawi, Mozambique, Uganda)
- Revising punitive laws that prevent KPs from accessing services free from stigma and discrimination (Kenya, Ukraine, Uganda, Zimbabwe)
- Implementing programmes that decrease stigma and discrimination towards people living with HIV and key populations, focusing on healthcare providers, law enforcement agents and community leaders (Mozambique)
- Greater involvement of civil society in programme planning and implementation, including financing dialogues
- Including all KPs in the programme, especially transgender and PWID (Malawi, Uganda)
- Better size estimates for AGYW and key populations (Kenya, Malawi)
- Strengthening communication and coordination between federal and state level to manage the delivery of services and achieve the necessary coverage (Nigeria).

All these recommendations were variously echoed by NAC, GPWG, GPC Secretariat, Cosponsor and donor KIs, and none were rejected. This reinforces the message that GPC members have a clear picture of the direction for the coalition to pursue in the coming years.

Many of these issues and recommendations are already shaping the work of the GPC Secretariat and GPWG in 2020.[66] While the GPC Secretariat and GPWG may not be designed presently to "do it all," there is a demand for an initiative to "connect the dots" and to make available a map of the full HIV prevention landscape at global and country levels. A clear map of the resources in and beyond the GPC will enable linkages to be strengthened, synergies to be enhanced, and stakeholder groups, including affected communities and networks in specific countries, to see where they can turn for support.

III.2 Review Question 2: How successful has the GPC been in addressing political leadership, reducing legal and policy barriers, and increasing HIV prevention funding in line with the country epidemic scenario? What have been the main challenges?

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65 Shadow reports were prepared by civil society groups in Kenya, Malawi, Uganda, Mozambique, Nigeria, Ukraine and Zimbabwe. Each report is available at https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/

66 GPC (n.d.) workplan

Findings and Discussion

2.1. The GPC has restored attention to HIV prevention among HIV leadership at global and country levels, although the extent of country level leadership varies

GPC documents and KIs in this review agree that at the global level, the GPC has strengthened and aligned political leadership for of primary HIV prevention in national HIV responses.[67] The GPC did not cause this reawakening alone: it was emerging as HIV experts observed that "treatment as prevention" was insufficient to end HIV as a public health threat by 2030.[68] However, there was consensus among all KIs that the voice of the GPC conveners, the GPWG and the GPC Secretariat has led the UNAIDS Programme Coordinating Board (PCB), the Board of the Global Fund and PEPFAR to restore demand for HIV prevention programming and results. There was also agreement among most country-level KIs in the Tier 2 countries that the GPC has been instrumental in raising the profile of PHP programming in ministries of health and national AIDS authorities, remedying what had become a focus on the new UNAIDS push "the 90-90-90s" of HIV treatment, to the neglect of two of UNAIDS' Three Zeros.[69]

> *"It helped to shape the prevention agenda for GF applications. And there has been good work with PEPFAR – compare what PEPFAR was saying about prevention three years ago and what they are saying now".* (GPWG)

At the country level, strengthening national HIV prevention leadership and capacity was a key step in the implementation of the 2020 Road Map.[70] The GPC provided tools, including TOR and SOPs to facilitate and regularise national leadership of primary HIV prevention by the NAC and/or the multi-stakeholder national HIV prevention coalition and/or the national technical working groups under NAC direction. The activities and effectiveness of these country-level structures varies,[71] and countries vary in their NAC's ability to coordinate and support these groups, and to secure participation from related sectors such as education, justice and labour. Changes made to the UBRAF in 2018 that shifted more Joint Programme funds to the country level enhanced the UCOs' and UNFPA country offices' abilities to engage other Cosponsors in HIV prevention efforts. In addition, UCOs in GPC countries have provided catalytic funding to support key Road Map activities, or to fund a long-term national consultant to take on day-to-day operational leadership on implementation of the Road Map under the NAC director's leadership.

2.2. The GPC successfully responded to country demand, and advice of the GPWG, to focus on strengthening the national AIDS authorities (NACs) in member countries, to drive HIV prevention programming

The GPC Secretariat, advised by technical consultations[72] and by the GWPG,[73] saw that sustained progress on HIV prevention at country level depended upon "*institutionalising prevention stewardship*" in the NACs. A successful presentation of the GPC,[74] followed by a meeting of NAC directors, was held during the 2018 International AIDS Society Conference in Amsterdam and the GPC Secretariat and GPWG are now supporting a community of practice among the NAC directors, which is having semi-annual meetings and monthly conference calls, convened by a secretariat in Nairobi. All country level key informants commented on the success of the most recent face-to-face NAC directors' meeting that was held in Nairobi after the GPC High Level Meeting November 2019 which was, in turn, adjacent to the ICPD+25 meeting. NAC directors in all the review's Tier 2 countries applauded the GPC's planning of this sequence of events. It succeeded in drawing ministers of health and other senior officials into in-depth consideration of the need for, and long-range benefits of intensifying PHP and integrating it into SRH services. NAC directors' consultations have also clarified the need for structural reforms for NACs to lead effectively on HIV prevention and provided a platform for sharing lessons on managing concomitant epidemics of HIV and COVID-19.[75]

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[67] UNAIDS (2020). Annual report on HIV prevention 2020; UNAIDS (2020). Independent evaluation of the UN Joint Programme response to HIV/AIDS 2016-2020.

[68] See Dehne et al,(2016) for review.

[69] UNAIDS (2010). The Three Zeros - Zero new infections, Zero discrimination and Zero AIDS-related deaths. UNAIDS (2010). Getting to Zero.   UNAIDS 2011-2025 strategy. Geneva. UNAIDS.

[70] UNAIDS and UNFPA (2018). First Progress Report pp. 7-9.

[71] The details and reasons for this variation merit more in-depth study than was possible in this review.

[72] UNAIDS (2017). Strengthening HIV primary prevention. Five thematic discussion papers to inform country consultations and the development of a global HIC prevention road map. July 2017.

[73] GPWG 2018 and 2019 meeting reports

[74] UNAIDS (2018). IAS prevention leadership session (presentation). https://hivpreventioncoalition.unaids.org/meeting/ias-2018-prevention-leadership-session/

[75] GPC (2019, 2020) NAC Directors meeting reports - Nairobi May 2019, and December 2019; NAC Directors' virtual meeting, April 21, 2020.

2.3. The GPC will benefit from more visible and consistent support from high-level leadership from the conveners and Cosponsors

While recognising these accomplishments, there is more to be done. After the October 2017 launch, the UNAIDS Secretariat and UNFPA conveners of the GPC were less visible in its activities. Both Executive Directors (EXDs) participated in the GPC session at the Amsterdam IAS conference in 2018, but out of six GPWG meetings since the GPC launch in 2017, ExD a.i. UNAIDS has opened one GPWG meeting; ExD UNFPA opened one, and the other four meetings were delegated to DXDs.[76] There has been even less visible leadership on HIV prevention from the leaders of the other Cosponsoring agencies, leaving their global coordinators and other HIV staff to struggle internally for attention and funding. Indeed, the number of full-time HIV positions has dwindled in all Cosponsors, at both global and regional levels, and with declining numbers, their ability to provide technical advice in their organisation's areas of expertise to support HIV prevention has been greatly reduced.[77]

Strong, visible leadership, including championing ambitious but achievable targets and requiring regular reporting of progress against those targets, is the foundation of accountability in the GPC and other multi-partner initiatives.[78] At the PCB's request, the UNAIDS Secretariat reports to it annually on progress in HIV prevention, including both GPC efforts and Joint Programme activities in all countries.[79] Without consistently visible leadership and support for active coordination, a number of global level KIs feared that HIV prevention programmes could return to a state of fragmentation and duplication, and decline into patchworks of projects that compete for attention and funds.[80] The GPC has presented and defended a unifying vision of HIV prevention that requires leaders: a champion and steward and a multi-sectoral leadership forum, if not a single organisational home, to sustain its forward momentum.

2.4. Policy and legal barriers to effective PHP programming have been highlighted as a priority since the launch of the GPC, but progress against them has been uneven and slow

From its beginning, the GPC noted the need for more action on policy barriers and called for member countries to conduct 2-3 actions on policy and legal barriers in the first year.[81] Each subsequent GPC progress report has identified limited progress on mitigating policy and legal barriers, the most often cited being: criminalisation of aspects of sexual orientation and gender identity, sex work, and injecting drug use; age of consent laws that prevent adolescent girls and young women from accessing SRH and HIV prevention or treatment services without parental consent; and lack of legal penalties for gender based violence (GBV).

There have been successes in some countries. For example, in the Tier 2 countries, Malawi passed the HIV Prevention and Management Act (2018), and Iran widened the approach to PHP to include the most vulnerable men and women. Côte d'Ivoire has conducted advocacy to make condoms available in prisons and reported that intensive efforts are ongoing on legal reform, including reversal of the discriminatory practice of charging MSM with indecent assault. A KI from Côte d'Ivoire observed that GPC-recommended policies combatting discrimination against key populations have been put into effect through NSP programme guidance while the slower processes of legal reform are continued. GPC reports cite important achievements in Iran, Myanmar and other countries as well.[82] According to lists of GPC country documents, more activities on human rights barriers took place in 2019 than in 2018.

Naturally, the difficulty and pace of HIV-related policy and legal reform is affected by the broader political and social context and, in some countries, the socio-political context has become more restrictive since 2017, making progressive legal and policy reform more challenging than ever. A few KIs from civil society organisations that have been champions of human rights and gender equality in such countries reported that space for their activity has been shrinking, and both their service delivery as well as advocacy work has suffered. They noted that political support from a multi-national coalition like the GPC could help them, and advocacy for external funding to continue their work would help even more.

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[76] Indicated in minutes of the respective meetings.

[77] UNAIDS (2020). Independent Evaluation of the UN Joint Programme... op.cit.

[78] Collaboratively setting quantified targets and requiring states and/or implementers to report regularly against them is widely viewed as a key secret to success of the Millennium Development Goals: e.g. Manning, R. (2009). Using indicators to encourage development. Lessons from the millennium development goals. Danish Institute for International Studies Report 2009:1.

[79] E.g., UNAIDS (2020) Annual report of progress in HIV prevention 2020. Op cit.

[80] E.g. Hunsmann, M. (2012). Limits to evidence-based health policymaking: Policy hurdles to structural HIV prevention in Tanzania. *Social Science & Medicine* 74:1477-1485; Dehne, et al. 2016 op, cit.

[81] UNAIDS and UNFPA (2017) 2020 Road Map

[82] See also, examples listed in Benomar (2018). Addressing legal and policy barriers to effective HIV prevention. National HIV programme managers consultation. 21 July, 2018. Amsterdam.

2.5. Strengthened guidance and coordination of partners and technical assistance is needed to address structural barriers to evidence-informed PHP

Numerous KIs, including individuals from civil society groups and from national HIV programmes, stated that there was not enough guidance in the GPC materials on the "how to" of policy change and legal reform and other structural interventions and, as noted earlier, they appeared not aware of resources available from Cosponsors or other sources. A few KIs reported that technical assistance in these areas was a weakness of the GPC, with requests for TA not fulfilled (NAC), and lack of expertise in the Technical Support Mechanism (CSO). One CSO informant summarised this as the GPC providing "*lip service to human rights, gender, and stigma and discrimination, but little technical assistance and few tools*." The review team notes that the guidance for each of the five pillars stresses the importance of structural as well as the behavioural and biomedical factors that contribute to effective programming, and in particular they call attention to gender and human rights issues.[83] In addition, the 2020 Road Map clearly outlines that technical support for the packages for key populations and for adolescent girls and young women and their partners in high prevalence settings will be provided by UNAIDS Cosponsors that specialise in gender and human rights, as well as by CSOs (see Table 3). GPC Secretariat staff agree that human rights and other structural issues constitute complementary areas of work that could have designated TA focal points and supporting organisations.

Table 3: Proposed mechanism for prevention technical assistance in 2017

Proposed technical assistance focal points and support agencies, by prevention area		
Area of work	**TA focal points**	**Other organisations providing support**
National prevention road maps, cross-cutting, structural and data issues	UNAIDS Secretariat	UNAIDS Cosponsors
Condoms	UNFPA	USAID, UNAIDS, IPPF
Men, boys and voluntary medical male circumcision	WHO	PEPFAR, UNAIDS Secretariat
Pre-exposure prophylaxis	WHO	AVAC, UNAIDS Secretariat
Key populations	PEPFAR–USAID linkages	HIV Alliance, UNFPA, UNDP, WHO, UNODC, key population networks
HIV prevention among adolescent girls, young women and their male partners (high-prevalence settings)	PEPFAR, UNICEF	UNICEF, UNFPA, UNESCO, UNDP, UN Women, AfriYAN, other civil society organisations and networks

Source: UNAIDS (2017). HIV prevention 2020 Road Map. Annex 3.

Further investigation is needed to determine the possible reasons for KIs not calling for more help to operationalise needed policy and legal reforms. Reasons might include: gaps in the GPC Secretariat's coordination and promotion of TA from Cosponsors and other partners; gaps in availability of support; or gaps in KIs' awareness of available resources and where and how to access them. Given the centrality of technical support to the GPC Secretariat's functions, the answer should be clearly communicated to GPC stakeholders.

2.6. Funding for implementing recommended combination prevention services at scale has not increased to match the need, although the GPC's influence on the Global Fund may yield results in future years

The target for the 2020 Prevention Roadmap was that, as a broad aim, 25% of country HIV budgets should be allocated for primary HIV prevention,[84] and a few GPC countries have met that goal.[85] UNAIDS estimates that global resources needed by the end of 2020 are US$26.2 billion, compared to US$19.8 billion currently available, leaving a gap of several billion dollars. This gap has grown as the number of people living with HIV in LMICs has increased by 25% over the past decade, and the number of new HIV infections remains high.[86]

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[83] E.g. the "key principles" and overview of each pillar in the 2020 Road Map; pages 13-16 and 18 of the First Progress Report, and many more.

[84] UNAIDS' "Quarter for prevention" campaign predates the GPC, having been launched in 2015.

[85] Namibia reportedly increased its allotment for prevention from 17% to over 25% in their 2017-2026 national strategy (GPC (2018). First progress report Op.cit).

[86] Winnie Byanyima, Press conference July 5, 2020; see also https://www.unaids.org/en/keywords/resources-and-funding.

At the UNAIDS PCB meeting in December 2019,[87] it was reported that international development assistance support for HIV prevention decreased by 44% between 2012 and 2017.[88] This was in a climate of an overall drop in total investment in HIV responses in 2018 of US$900 million (to US$ 19 billion) compared with 2017. The declines were across all sources of investment, including domestic, multilateral and some bilateral donor programmes, philanthropic organisations and other international sources. The report noted with great concern the widening gap between resource needs and availability.

In their most recent annual update,[89] UNAIDS notes that financial resources from international sources for the HIV responses in LMICs have declined by nearly 10% since 2015, with a 10% increase in bilateral funding from the United States Government - primarily through PEPFAR - offset by a 3% decline in funding from the Global Fund and a 31% decline in multilateral and bilateral contributions from other sources. Domestic funding increased steadily and, by 2019, it comprised 57% of total investments in the HIV responses of low- and middle-income countries, but it has recently been declining, especially in EECA, ESA and WCA.

Global Fund allocations

When the Coalition was launched in October 2017, most priority countries had already submitted their Global Fund grants and had not yet set targets. Hence, several prevention priorities defined by the Coalition were not funded. Portfolio optimisations were considered as an opportunity to mobilise additional resources for prevention gaps. The GPC explored the possibility of making Prioritised Above Allocation Requests (PAAR) to the Global Fund, and some countries initiated this process for the 2019 Global Fund applications.[90] In 2018 the GPC cited a Global Fund finding that their allocation to HIV prevention had been declining in the three funding cycles prior to 2017.[91]

At the GPWG meeting in February 2019, an analysis on Global Fund investments in HIV prevention based on data from 72 countries showed that, in absolute numbers, the investment in HIV overall and in HIV prevention increased between New Funding Model 1 and NFM 2, but the relative share of investment going into HIV prevention decreased from 21% to 18%. At the same time, the investment in the five priority pillars versus other HIV prevention activities increased, indicating some improvement in the focus of country prevention strategies. Investment in four of the five pillars increased and only VMMC investment declined. The largest share of investment was for programmes for key populations and adolescent girls and young women.[92] The 2020 Global Fund applications include a category of "catalytic funding" for key populations, AGYW, self-testing and condoms, which would be within allocation. It will be of interest to analyse the 2020 round of GF applications to see the proportion allotted to prevention within and above allocations.

In the current Global Fund cycle US$12.71 billion has been made available for country allocations for a three-year period. The GF's 2020-2022 allocation methodology focuses funding on countries with the highest burden and lowest incomes, specifically accounting for, in the case of HIV, epidemics among key populations. Among the 13 countries that especially prioritise adolescent girls and young women, 2020-2022 HIV allocations are 24% higher than in the previous cycle with a total investment of US$3.26 billion. "*Similarly, the 20 HIV prevention coalition countries receive 25% more funding and represent 73% of the HIV funding envelope,*"[93] with the catalytic investment pool (noted above) totalling US$201 million to be directed to AGYW, key populations, HIV self-testing and condom programming.

PEPFAR allocations

Table 4 shows the actual expenditures reported for PEPFAR programmes over the past five years, with projections for the fiscal year 2020. PEPFAR now requires that 50% of their budgets be allocated for treatment. While PEPFAR's total budget has increased by just over US$1 billion since 2015, most of that additional billion can be seen to be for funding care and treatment, which has increased its percentage of the total from 40% to 50%. In comparison, prevention has seen a large increase in funding relative to its low starting level of US$325 million, but only a modest rise in percentage share from 9.75% to 11.65% (with funding for PMTCT and OVC not included as prevention), still far from a 25% allocation.

[87] UNAIDS (2019).Annual progress report on HIV prevention. Op.cit.;

[88] Institute for Health Metrics and Evaluation. Funding Universal Health Coverage and the Unfinished HIV/AIDS agenda. Database. Seattle; 2018

[89] UNAIDS (2020). Seizing the moment— Tackling entrenched inequalities to end epidemics. UNAIDS. Geneva. UNAIDS: Global AIDS Update 2020. July 2020. Geneva. UNAIDS.

[90] GPC (2019). Global Prevention Working Group Meeting - February 2019. The review team was not able to obtain a list of the specific countries. The PAAR allocations are not strictly for prevention, lest the impression be that prevention is an "add-on" after other modules have been funded.

[91] GPC (2018). Implementation of the HIV Prevention 2020 Road Map. First progress report, March 2018. p. 19.

[92] GPC (2019). Global Prevention Working Group Meeting - February 2019.

[93] The Global Fund (2019). Overview of the 2020-2022 Allocations and Catalytic Investments; December 2019.

Table 4:   PEPFAR Funding 2015-2020 – Actual Expenditure and % of total

	ACTUAL 2015 - %	ACTUAL 2016 - %	ACTUAL 2017 - %	ACTUAL 2018 - %	ACTUAL 2019 - %	PLANNED 2020 - %
TOTAL	$3.34b	$3.37b	$3.85b	$4.04b	$4.03b	$4.37b
PREVENTION	$325m **9.75%**	$293m **8.7%**	$392m **10.2%**	$471m **11.7%**	$475m **11.8%**	$509m **11.65%**
CARE & TREATMENT	$1.3b 39.1%	$1.35b 40%	$1.5b 39.3%	$1.6b 40.5%	$1.9b 46.4%	$2.2b 50.6%
TESTING	$140m 4.2%	$261m 7.1%	$265m 6.9%	$435m 10.8%	$401m 10%	$309m 7%
SOCIO-ECONOMIC	$117m 3.5%	$156m 4.6%	$230m 5.9%	$271m 6.7%	$235m 5.8%	$264m 6%
ABOVE-SITE PROGRAMS	$703m 21%	$613m 18.1%	$646m 16.8%	$501m 12.4%	$393m 9.8%	$482m 11%
MANAGEMENT	$746m 22.3%	$721m 21.3%	$803m 20.8%	$724m 17.9%	$653m 16.2%	$591m 13.5%

Source: PEPFAR: PEPFAR Panorama Spotlight; accessed at https://data.pepfar.gov/financial

A large proportion of PEPFAR's prevention funding has been directed to the DREAMS Partnership in 25 African countries, and to supporting VMMC and piloting PrEP, with less focus on key populations and the social and behavioural change communication (SBCC) interventions that are core components of the GPC's recommended packages for both key populations and adolescent girls and young women. [94] However, PEPFAR is also supporting the Key Populations Investment Fund (KPIF) which is providing funds to scale up KP services in more than 20 countries in the Americas, Asia and Africa. KPIF funding is focused on treatment-related programmes but also includes scaling up PrEP, addressing structural barriers and strengthening KP CBOs.[95] This investment is vital given that 62% of new HIV infections globally are in key populations.[96]

This basically mirrors the opinions of External Review respondents who reported that over the past five years there has been little change in total resources for HIV, but more emphasis on biomedical prevention in both USAID and the Global Fund.[97] They offered observations regarding funding of the five pillars:
- AGYW – attention and funds from PEPFAR (DREAMS)
- Key populations – low funding to start with, but major donors have increased funding, with set-asides/programmes to stimulate programming
- Condoms – PEPFAR reducing funding, UK and BMGF prioritising condom programming
- VMMC – some countries close to saturation, PEPFAR reducing funding
- PrEP – is getting funding now to expand from pilot programmes

Complicating the issue of categorising funding into prevention or not prevention has been the fact that categories change: PMTCT and HTC are no longer categorised as "prevention" interventions, and their share of country AIDS budgets is significant. As well, calculating HIV expenditures is a complicated process – National AIDS Spending Assessments (NASAs) are not done regularly,[98] and many countries cannot report expenditures in detail and often omit costs not in the listed budget, such as the spending on condoms. Calculating HIV expenditures requires special studies in countries, such as Brazil and Ukraine, where HIV services are mainstreamed in health service delivery.

However, there are indications that progress is being made. The Global Fund Technical Review Panel (TRP) recently published their assessment of the Window One funding requests that were submitted in March-April 2020. The TRP noted that many funding requests showed increases in attention to human rights and gender, HIV prevention, resilient and sustainable systems for health (RSSH), and financial sustainability and value for money (VFM). In addition, many funding requests evidenced better use of disaggregated epidemiological data for developing the programme rationale, and

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[94] GPC (2020). Decision-making aide for investments into HIV prevention programmes among adolescent girls and young women; GPC (2020) Program self-assessment tool for key populations.
[95] PEPFAR (2019). Update to the GPWG, September 2019
[96] UNAIDS (2020) 2020 Global AIDS Update — Seizing the moment, Op.cit.; (2020). Independent evaluation of the UN system response... Op Cit.
[97] Key informants (global financial analysts, one UN-based and one university-based)
[98] The most recent data reported on the UNAIDS NASA web page are from 2016, predating the GPC.

appropriately applied the newly differentiated application forms to ensure appropriate effort in funding request development and review. Regarding prevention, the TRP said that:

> *"Progress has been made in planning and including priority HIV prevention interventions in the funding requests. These interventions were better articulated and focused, increasingly tailored to key and vulnerable populations. Prevention targets were ambitious and generally aligned to NSPs."*[99]

Whether this has translated into increases in prevention funding sufficient to bring the programmes to scale is still to be determined. Answers to the question of how much has actually been spent on HIV prevention will be better known when the details of the current round of Global Fund grant applications are made public this year, and another round of NASAs is conducted in 2021.

A positive factor is that some countries are increasing their domestic spending on HIV, which hopefully will include more local resources for HIV prevention. For example, South Africa has increased its annual domestic spending for HIV by about USD 650 million in the past seven years, with almost 80% of the total HIV resources now coming from domestic sources.[100] Over the past 10 years Zambia and Zimbabwe have each increased their domestic funding of HIV by 70%, and Kenya and Malawi report a 30% increase.[101] Nevertheless, financing gaps and sources of financing for the HIV response continue to vary widely between countries. With the exception of South Africa, countries in the ESA region on average finance only 20% of their responses domestically,[102] which imperils their sustainability.

Given all of the above, while the GPC appears to be contributing to improved allocation of funding to the five pillars, it is safe to say to that a deficit in funding remains a key barrier to implementing combination HIV prevention at scale, and the UNAIDS target of 25% funding for prevention is still far from being achieved.

III.3 Review Question 3: How far has a wide range of UN, government and CSO stakeholders demonstrated engagement and understanding of the 2020 Road Map and demonstrated political and operational accountability to the 2016 global political commitments?

Findings and Discussion

3.1. The GPC has strengthened institutional and multi-stakeholder collaboration for HIV prevention at global and country levels but there is further to go, particularly regarding civil society engagement

According to GPC progress reports and the lists of GPC documents provided to the GPC Secretariat by all 28 countries, all countries made an effort to revitalise PHP leadership in year 1, but after this the uptake and progress was more variable. Some countries had difficulties sustaining the momentum because of political changes of government. In some countries where the national HIV programme is lodged within the ministry of health, treatment services have thrived while the prevention team/s have struggled for funding and visibility. Some KIs in Tier 2 countries reported shortages of capacity, or in decentralised health systems, "*no-one to champion prevention beyond the capital*." (INGO). GPC countries with strong PHP leadership attributed it to a range of factors, from individual characteristics of the NAC director to pre-existing, strong organisational and management systems.

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[99] The Global Fund (2020) TRP Lessons Learned from Review Window 1 2020-2022 Funding Cycle; June 2020
[100] The Global Fund (2020). TRP Lessons Learned from Review Window 1 2020-2022 Funding Cycle; June 2020
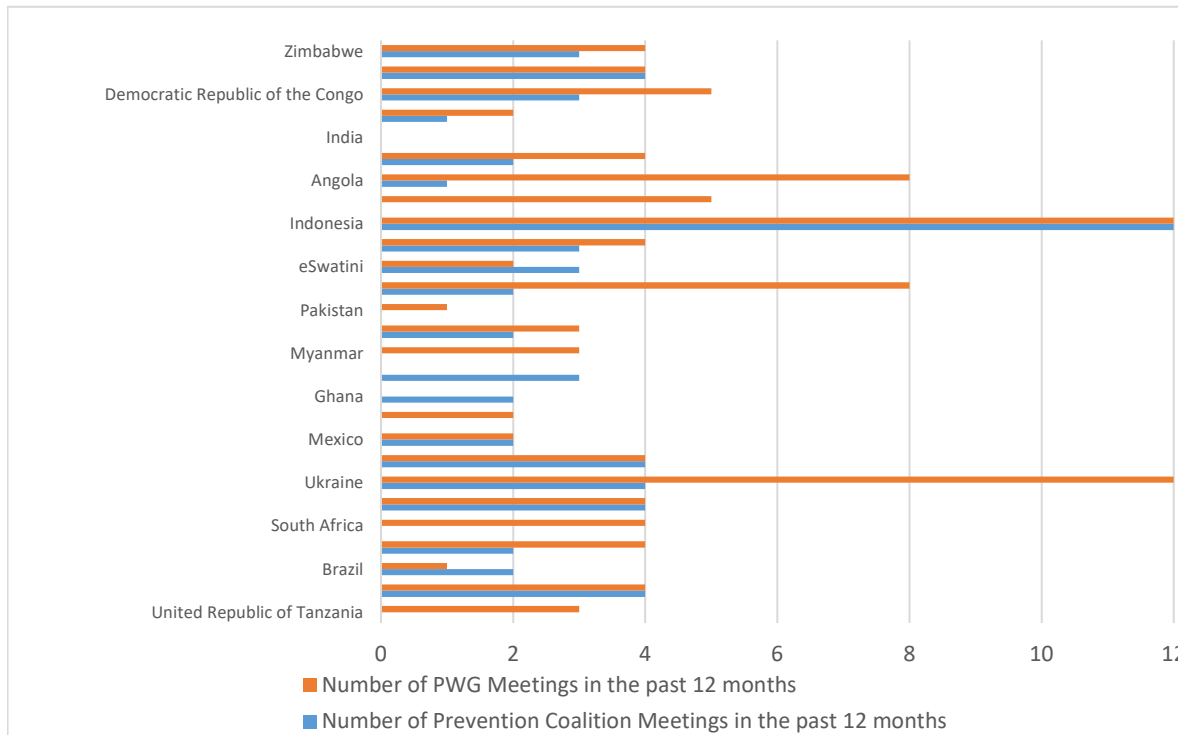[101] ibid
[102] ibid

Overall, institutional and multi-sectoral collaboration for HIV prevention appears also to have been strengthened in the

Figure 4: Reported Meetings of National Prevention Coalitions and Prevention Working Groups

Source: GPC (n.d). Unpublished chart created by GPC Secretariat from the 2019 survey of GPC countries in preparation for the third progress report

coalition countries, for instance in terms of the establishment of a national prevention coalition and a prevention working group, with technical working groups addressing specific pillars. Figure 4 (above) indicates which countries had either or both structures in place, and the frequency of reported meetings. Of the 27 countries reporting (excluding Botswana), 24 had national prevention working groups that met between once and monthly during the previous 12 months, and 20 had national prevention coalitions that had met between once and quarterly. The exceptions were Indonesia, which reported monthly meetings of both the coalition and the prevention working group, and India, which did not report having either structure. Eighteen countries reported having both.

Despite the widespread existence of these structures, KI reports varied on how effective they are in practice, although the review team was unable to do in depth review of their quality or of participation from all relevant sectors. Civil society participation also varied with, for example, late invitations and costs of communications and transport cited as contributing to lower participation. In the way forward it will be important to strengthen the role of the national coalitions and PWGs, and to secure active participation of civil society so that they can play a strategic coordination and motivational role in policy, funding and programming around HIV prevention. Their awareness of and access to GPC tools, guidelines and other resources should also be increased.

> *"We cannot be at the table if we cannot get to the table" (CSO)*
>
> *"This group should make itself better known. For example, ask to introduce themselves at the monthly coordination meetings at the national level. Organise a videoconference with the stakeholders to present the achievements of this group in [country]. (CSO)*

3.2. The Road Map clearly strengthened country programming for prevention, with all countries making significant progress, but the extent of implementation of different steps varied widely

In the words of UNAIDS, "*Coalition countries have transformed how they frame, measure and organise national prevention responses*".[103] Echoing conclusions of the Independent Evaluation of the UN System Response to HIV/AIDS 2016-2019,[104] country-based KIs from NACs and UN partners unanimously reported finding the Road Map and associated guidance and tools of benefit in identifying key requirements for programming and to address operational gaps, with high stakeholder engagement. Progress reports indicate that some countries beyond the Coalition have adopted the 2020 Road Map also.

> "*Most of the countries in our region are not GPC members but have used the 10 steps anyway in their NSPs and GF proposals.*" (UCO)

Table 5: Progress in Completing the 10 Steps of the Road Map by Coalition Countries, 2017-2019

Proportion of GPC countries reporting "Done" or "In progress" on each of the 10 steps of the 2020 Roac Map			
	2017 % (of 28 countries, except where noted)	**2018** % (of 28 countries, except where noted)	**2019** % (of 27 countries except where noted)
1. Needs assessment	0%	86%	96%
2, Prevention targets	39%	57%	93%
3. Prevention strategy	68%	93%	100%
4. Policy reform	11%	68%	89%
5a. Key population size estimates	50%	96%	100%
5b. Defined key populations package	0%	75%	89%
5c. Young women size estimates	0% (of 18 countries)	44% (of 18 co's)	88%
5d. Young women package	0% (of 18 countries)	83% (of 18 countries)	94%
6. Capacity and technical assistance plan	0%	36%	37%
7. Social contracting	21%	57%	44%
8. Financial gap analysis	0%	46%	65%
9. Strengthen monitoring	0%	61%	96%
10. Performance review	0%	7%	78%

Source: Data presented in GPC (2019). Implementation of the HIV Prevention 2020 Road Map: Third Progress Report, October 2019. Table 2.

Data provided in the GPC's comprehensive synopsis of progress as of 2019[105] indicate how far the steps of the Road Map were achieved by each coalition country (see Figure 2, above). As summarised in Table 5, yellow highlights in the table indicate where the most progress was made, showing that there was greater country progress on the steps in the first year (late 2017-2018) than in the second year (late 2018-2019). The red highlight calls attention to a drop in the number of countries reporting progress on social contracting (from 16 countries to 12).[106] Social contracting to strengthen community service delivery and leadership was one of the weakest steps of Road Map achievement, indicative of national authorities' insufficient engagement, capacity development and financing for civil society partners. Civil society KIs tended to be less well-informed about the Road Map and reported being engaged more during the initial 100 days action planning than during implementation.

Some steps were more easily or rapidly achieved than others and, while no country had achieved all by November 2019, several appear on track to complete them by the end of 2020

By November 2019 no country had completed all steps, but 11 of 27 countries had no or only one step not yet initiated. Ten had completed fewer than half the steps. As well as social contracting, particularly underdeveloped steps include

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[103] Hader S. (2020). The Status of HIV Prevention and Update on Implementation of Global HIV Prevention Commitments: a brief summary, presentation to virtual meeting of HIV Prevention Working Group, 24 March 2020.

[104] UNAIDS (2020). Independent Evaluation of the UN System Response to HIV/AIDS 2016-2019.   Geneva. UNAIDS

[105] UNAIDS and UNFPA (2019*). Implementation of the HIV Prevention 2020 Road Map: Third Progress Report,* October 2019.

[106] Pursuing details of this decline would be worthwhile, but was not possible in this review.

legal and policy reform, development of minimum packages for and size estimates of key populations (although most countries indicated these were in process), and assessing capacity needs and establishing a capacity development plan. Financial gap analysis, monitoring and performance review also lagged somewhat behind, although a small number planned National AIDS Spending Assessments in 2020. Review of country submissions to the Secretariat[107] also found that nearly all countries had documents relating to the first five steps, including some developed prior to the GPC, but far fewer relating to other steps of the Road Map. This is evident in the "stoplight" graphic from the GPC Secretariat presented earlier (Figure 2, above). Only seven countries had either shared or indicated that they would soon be able to share one or more products in relation to all steps. A systematic quality analysis of the specific steps and documents produced would be useful.

KIs identified a number of challenges in adoption of the Road Map, in particular: all steps are not equal and differ in complexity and the time and resources needed to complete them; monitoring the different steps is not always easy; some indicators are not sufficiently specific, while others do not allow for differences in country context.[108] With indicators, a "one size-fits all" approach has pros and cons - facilitating country comparisons can lead to healthy competition but can also be demotivating for countries perceived to score poorly, for instance against unrealistic targets. In the way forward, greater flexibility will be helpful, with increasing focus on sub-national epidemics and targets, and each country developing its own road map to build on achievements to date and address outstanding gaps.

Highest implementation of the Road Map may be associated with declining numbers of new infections, but low implementation is not consistently correlated with how numbers changed

Despite the relative success in adopting, domesticating and implementing most steps of the Road Map, across 26 of the coalition countries for which data were provided,[109] it is not surprising that the trajectory of new adult infections in most countries[110] demonstrates little significant change between 2010 and 2018, the last year for which data were available at the time of writing. GPWG members and other experts agreed that population-level changes in new HIV infections take longer than two years to achieve. Estimates in 18 countries (excluding China and India) showed the countries were seeing a relatively steady decline in new infections, albeit at different rates, and with a clearly increased rate of decline latterly in Eswatini. Three other countries had roughly the same number at the start and end of the GPC period (Ghana, Mozambique and Mexico). Three, Brazil, Nigeria and Pakistan showed continuing rises in new adult infections, and two showed slight declines (Angola and Iran). Thus it is not yet possible to say with confidence how far the GPC and implementation of the Road Map have affected the numbers of new adult HIV infections across the coalition countries.[111] However, at a broad level, Hader[112] noted that countries with the highest completion of steps of the Road Map did have the highest rates of decline in new infections (between 25 and 50 percent), although in the nine countries that had implemented the fewest steps the numbers of new infections ranged from significant increases to substantial decreases.

The measurement of a correlation between roadmap implementation and resulting stronger programme approaches and impact will only be possible to verify in the coming years, but the early signs are promising. In the majority of the Coalition countries the decline in new adult infections that preceded the GPC has continued. However, the speed of decline needs to increase markedly in the next few years, with the tailored focus on key populations, young people at high risk, and on sub-national epidemics as the GPC recommends.

3.3. Accountability of stakeholders was demonstrated by high participation in GPC activities, with timely completion of reporting in most cases against agreed evidence-informed targets, but there is insufficient indication of commitments to raising domestic funding

Stakeholder accountability was demonstrated by the high participation of Coalition countries in GPC activities, timely completion of detailed reporting on progress against evidence-informed targets for inclusion in scorecards and country posters which now include some data on structural factors (IPV, school enrolment of adolescent girls), and financing (document review and GPC Secretariat KIs). For example, all but one country had responded to the annual progress survey with data for scorecard completion on the Road Map steps in 2019. In 2018 11 ministers of health joined the

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[107] A standing request that countries make available key reports, surveys and other products in relation to the road map and HIV prevention in general

[108] For example, KIs in Brazil noted that they could not include their people who use drugs in the key population "step" because the predominant drug use is not by injecting.

[109] UNAIDS and UNFPA (2019). Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. October 2019. (P40/41)

[110] Collated from scorecards showing trends in new infections from 2010 to 2018.

[111] The evaluation of the UBRAF made this point for the overall Joint Programme. UNAIDS (2020). Independent evaluation ... Op.cit.

[112] Hader S (2019). Overview on Global HIV Prevention Coalition: Roadmap Commitments and Progress. Presentation to GPC Ministerial Meeting, 11 November 2019, Nairobi.

convenors of the GPC and the Executive Director of the GF to present at the World Health Assembly 71 on primary HIV prevention. The International AIDS Society Conference in Amsterdam also had special sessions on PHP. Participation in the NAC community of practice has been high, and the ministerial meeting in November 2019 was well attended. The latter was especially praised by KIs for bringing together ministers of health, NAC directors and others, comparing country progress and sharing challenges in achieving both the Road Map and the prevention pillars. Twenty-six countries had produced country posters for the meeting.

Table 6 highlights specific commitments made at the GPC High Level Meeting in November to undertake additional steps or strengthening specific pillars in 2020.[113]

Table 6: Priority Commitments from GPC Ministerial Meeting November 2019

Area of commitment on next steps[114] on Road Map	Number of countries
Domestic funding	16
Social contracting/ community system support	12
Strengthening data base and/or monitoring	12
Strengthening SRH and HIV linkages[115]	9
Addressing structural barriers	8
Policy or strategy development	5
Areas of commitment on next steps on strengthening pillars	Number of countries
AGYW and/or AYP	17
Key populations	15
PrEP	7
Condom programming	5
VMMC	4

Source: GPC and ICPD25 Country Commitments 2019 and Next Steps.

At the meeting, countries committed publicly to between three and nine areas of strengthened engagement, including the areas noted above and occasional references to other Road Map steps. Among the pillars, the least frequently cited commitments were on PrEP, condom programming and VMMC, although these areas may be addressed within other stated areas of commitment.

Given the central role of funding limitations as a key barrier to prevention scale up, it is noteworthy that only 16 of 28 countries prioritised efforts to increase domestic funding for prevention. Two others noted that GF and/or PEPFAR applications include prevention, and one indicated undertaking an investment case. Thus 12 countries did not mention efforts to increase funding, and 14 did not specifically indicate that they would make efforts to increase domestic funding commitments for prevention. Even though there is a consensus that low income countries with a heavy HIV burden will continue to need donor financing to sustain their HIV responses,[116] domestic financing is an indicator of shared responsibility and also of country ownership, so the absence of effort does not send a good message. This is of escalating concern given the ubiquitous signs that donor investments are going to decline.[117]

Regional Economic Communities (RECs) provide a key forum where national decision-makers consider funding priorities and share knowledge and strategies to promote regional economic integration toward achievement of the SDGs.[118] As such, they could have an important influence on many GPC countries' allocation of domestic resources to HIV prevention. Their participation in the GPC has been low with the exception of SADC, where almost all countries are Coalition members. SADC was the only REC to fully develop a regional road map to promote accountability among the member states to achieve all the steps, engaging all sectors on HIV prevention through the Council of Ministers. Key informants indicated that the MENA region (Middle East and North Africa) also conducted a regional meeting to build a road map as a regional approach to HIV prevention. In addition, the African Union (KI interview) has championed HIV prevention and has incorporated the GPC Road Map and five pillars into its strategy for HIV and AIDS. It is worth exploring how far other RECs in Africa might be capacitated to contribute. The Asia Pacific regional team of UNFPA and UNAIDS is also reportedly

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[113] GPC and ICPD25 Country Commitments 2019 and Next Steps (from GPC November 2019 HLM, Nairobi). g
[114] These included advocacy for action as well as citing areas for specific actions
[115] Not a specific step of the road map but an important area of focus for ICPD and HIV follow up
[116] E.g. UNAIDS (2019). Annual progress report on HIV prevention 2020. Op cit.
[117] GPWG meeting notes; see also https://www.unaids.org/en/keywords/resources-and-funding and the UNAIDS 2020 Global AIDS Report Pg 215
[118] African Union (2020). Regional economic communities (RECs) https://au.int/en/organs/recs

considering how they might use the UN Regional Economic and Social Commission for Asia and the Pacific (ESCAP) for political advocacy for prevention (KI informant).

III.4 Review Question 4: To what extent has the GPC contributed to systematic implementation of combination prevention programmes at scale, including the five prevention pillars?

Findings and Discussion

As indicated in the inferred Theory of Change for the GPC, its activities and initiatives have been designed to support HIV prevention leadership and programming in the domains of the five pillars, providing guidance to countries on what service components these pillars include, and on how to scale up implementation.[119]

4.1. The five pillars have been an effective vehicle to assist countries in designing, prioritising and monitoring their prevention programming, but countries are far from achieving the desired implementation at scale

The pillars, identified as early as 2014,[120] were recognised as a "*good framework to analyse and plan*" and that they acted as a reference point around which the 2016 Declaration on Prevention was framed. In a complex field with a myriad of players and strategies, the pillars specified tangible activities and populations to work with that can aid in realistic target-setting and systematic management and monitoring of results. That said, as of 2018 (the most recent data available at the time of writing) the achievements of GPC countries in HIV prevention are still not close to achieving the 2020 Prevention Targets:

Table 7: Progress towards the 2020 Prevention Targets – GPC Countries

	Indicator	2017	2018	2020 Target
AGYW	% of high incidence locations covered	<25	34	90
Key pops	% receiving 2 services in past three months	SWs 46 MSM 28 PWID 30	47 33 32	90
Condoms	% of need met	49	55	90
VMMC	% of target achieved	Annual – 83% Cumulative -35%	Annual – 83% Cumulative – 46%	25 million (100%)
PrEP	Number on PrEP	47,000	87,000	2.5 m (in GPC)

Source: Hader, S. (2020). The Status of HIV Prevention and Update on Implementation of Global HIV Prevention Coalition Commitments; Presentation to GPWG meeting; March 24, 2020.

Most striking is the minimal progress between 2017 and 2018 in coverage of services for key populations, with only slightly more progress in covering adolescent girls and young women in high risk locations. This explains the intensive focus on these two pillars in the 2019 activities of the GPC.[121]

Successful implementation and scale up of the five pillars have varied widely between the member countries of the GPC. The results of the scoring in the latest GPC progress report[122] are seen in Table 8. Some countries report on 13 components of combination prevention and others report on only 11. What is notable is that, despite progress in implementation, the number of countries that are rated "very good," "good" or "medium" based on aggregate scores between 7 and 10, is very small. Only one country (Lesotho) had three very good / good scores, and only six countries had two very good / good scores (Côte d'Ivoire, Kenya, Namibia, Eswatini, Uganda, Zambia).

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[119] The relative deficit in guidance on scaling up the structural components of the pillars was discussed earlier.
[120] UNAIDS (2014). Fast-track: Ending the HIV Epidemic by 2030. Geneva. UNAIDS
[121] For example, the GPWG meetings September 2018 and March and September 2019. These pillars also were emphasized in all three GPC progress reports.
[122] UNAIDS and UNFPA (2019). Implementation of the HIV Prevention 2020 Road Map: Third Progress Report, October 2019.

Table 8: Scoring the implementation of the five pillars 2019

	V. good / good / medium (7-10)	Low (5-6)	V. low (1-4)	No data / n/a
AGYW	4- CI, eSwat, Les, Ken	1 - Moz	8 – Bots, Malawi, Nam, SA, Tz, Ug, Zam, Zim,	6 – Ang, Cam, DRC, Eth, Ghana, Nig
KP: Sex workers	3 – CI, Malawi, India	9 – Bots, Ghana, Ken, Les, Moz, Nam, SA, Zam, Ukr	8 – Ang, Cam, Nig, Zim, Braz, Indo, Iran, Pak	8- DRC, Eth, eSwat, Tz, Ug, China, Mex, Myan
KP: MSM	1 – Malawi	3 – Bots, Ghana, India	14 – Cam, CI, Les, Moz, Nam, Nig, SA, eSwat, Tz, Zam, Braz, Indo, Pak, Ukr	10 – Ang, DRC, Eth, Ken, Ug, Zim, China, Iran, Mex, Myan
KP: PWID	4 – China, India, Myan, Ukr	0	10 – Ken, Moz, SA, eSwat, Tz, Ug, Indo, Iran, Mex, Pak	14 – Ang, Bots, Cam, CI, DRC, Eth, Ghana, Les, Malawi, Nam, Nig, Zam, Zim, Brazil
Condoms	6 – Les, Nam, SA, eSwat, Ug, Zam	5 – Eth, Ken, Mal, Nig, Zam	7 – Ang, Cam, CI, DRC, Ghana, Moz, Tz	1 - Bots
VMMC	7 - Eth, Ken, Les, SA, Tz, Ug, Zam	3 – Moz, Nam, Zim	3 – Bots, Mal, eSwat	6 – Ang, Cam, CI, DRC, Ghana, Nig
PrEP	8 - Ken, Les, Nam, eSwat, Ug, Zam, Zim, Brazil	5 – Bots, CI, SA, Tz, Mex	15 – Ang, Cam, DRC, Eth, Ghana, Malawi, Moz, Nig, China, India, Indo, Iran, Myan, Pak, Ukr	0

Source: GPC (2019). Implementation of the HIV Prevention 2020 Road Map: Third Progress Report, October 2019.

Also notable are the large number of countries that are either not reporting or do not have the data to report. That all countries have introduced and are reporting on a new and innovative intervention like PrEP reflects the priorities in PEPFAR funding as well as GPC support reflected in the Global Fund guidance.

4.2. Country-by-country reporting in detail on progress in implementing the pillars is one of the strongest features of the GPC, but it requires a heavy investment both from the country level and from the GPC Secretariat

The scorecard data on outcomes, specifically on coverage of the pillar services, are drawn from the Global AIDS Monitoring (GAM) indicators and UNAIDS HIV estimates. However, extensive additional data are obtained from countries using Survey Monkey™ to allow for detailed review of the completion of Road Map steps: size estimates and services for specific populations, uptake of technical assistance through international consultants and other information.

> "The five pillars are a good framework to analyse and plan. But how do we integrate into the framework the social, legal and human rights enablers?" (GPWG)

Each year, each GPC member country submits the data to the GPC Secretariat in a standardised template.[123] These granular data are transformed by the GPC Secretariat based on several weighted criteria, with a resulting aggregate score for each Road Map step, pillar and sub-pillar. These scores are converted into the green, yellow and red "stoplights" to produce the visually powerful scorecards.

The GPC country level teams, comprised of UNAIDS and UNFPA officers, government focal points, prevention technical working groups and civil society, are asked to review the data to see if they are in agreement with the data presented and with the resulting scoring. Frontline AIDS produced a series of seven shadow reports from seven countries in 2018 and 2019 in collaboration with local civil society organisations, highlighting the interests of civil society in the implementation of the Road Map.[124] Each of these shadow reports (from Kenya, Malawi, Mozambique, Nigeria, Uganda,

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[123] GPC; Scorecards and Country Posters in the Global HIV Prevention Coalition: A country guide to validation and consultation https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/09/Guide-on-Scorecards-Country-Posters-in-the-GPC-August-se2019-1.pdf
[124] Frontline AIDS (2018). HIV prevention shadow reports; Frontline AIDS (2019) HIV prevention shadow reports

Ukraine and Zimbabwe) analyses the progress made in the country in the past year against the 10 steps, noting achievements but also noting where there are gaps or still work to be done, and making recommendations.

Global and country level KIs reported that the main benefits of the reporting mechanisms were a heightened sense of commitment to and visibility of PHP, and the identification of programme gaps. However, both NAC and UCO KIs said that reporting on Road Map progress involved a significant burden, as it is additional to their work of monitoring and reporting on UNAIDS Global AIDS Monitoring indicators, and the reporting requirements of donors such as PEPFAR and the Global Fund. The GPC is the first endeavour to put forward the kind of granular indicators that are required to monitor national HIV prevention programmes as a whole, accounting for the milestones in the prevention cascades.[125] Since the Global Fund, PEPFAR, DfID and other bilaterals are partners in the GPC, it would be beneficial to unify their reporting requirements in this regard.[126]

4.3. All five pillars are not equally relevant outside sub-Saharan Africa, there are many who think that the five packages of services could be more inclusive of gender, human rights, stigma and discrimination and other structural issues, but the consensus is to retain the pillars for now

There is widespread appreciation that the pillars are an effective vehicle to emphasise evidence-informed interventions and to focus resources on those, but the fact that not all five pillars apply outside sub-Saharan Africa was noted as a concern by many informants. The pillars were never designed to be universally applicable. Indeed, the 2020 Roadmap notes that:

> *"Pillar 1 needs to be strengthened in locations where segments of adolescent girls, young women and their male partners are particularly vulnerable and affected, mostly in Africa. Pillars 2, 3 and 5 (KPs, condoms, PrEP) are applicable everywhere, and Pillar 4 (VMMC) is recommended in 14 countries in eastern and southern Africa."[127]*

Nonetheless, there were some respondents who felt that the regional variations in the relevance of the pillars create confusion and that, in addition, some of the pillars overlap, as do the populations.[128] For example, some KIs argued that the elements of the condom pillar are incorporated in the key populations programme in Southeast Asia. Other suggested that the pillars do not cover all of the important areas of prevention, such as basic HIV information and education, PMTCT, prevention engaging PLWHIV, prevention of gender based violence or the wider domain of social and behaviour change interventions to address harmful social norms. As noted earlier, many KIs observed that the pillar guidance does not sufficiently address the "how to" of the cross-cutting structural issues of human rights, governance, gender inequality, stigma and discrimination; a few KIs proposed adding a sixth pillar on these issues in order to generate a higher level of support (see below, section 4.4).

> *"In the five pillars we have the 'what' - what we need now is the 'how'."*
> (UN regional rep)

The seminal paper by Dehne et al.[129] recognised that the pillars are disparate - comprised of population categories (key populations and young women and men in high-incidence settings) and intervention areas (condoms, VMMC, ARV-based prevention and harm reduction). A matrix approach was considered by the GPC, populations versus interventions (GPWG, GPC Secretariat) but was deemed too complex in terms of messaging. There has been discussion in the GPWG of broadening the VMMC pillar to address male involvement and men's broader sexual health, and/or to broadening the PrEP pillar to "ART-based interventions" which would include PrEP, prevention engaging PLWHIV, treatment as prevention, post exposure prophylaxis and the latter two prongs of eMTCT. These modifications would respond to critiques that the current pillars leave out some necessary components of combination prevention. However, the majority view among our KIs is to retain the pillars as they are because changing them now would cause confusion, and because Global Fund budgets have been organised to monitor investment and expenditures in the five pillars as they are.

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[125] E.g. UNAIDS (2017). Strengthening HIV primary prevention op cit.; GPWG (2018) Global HIV Prevention Working Group Meeting. New York, 8-9 March, 2018.
[126] This is an issue that has been challenging for decades.
[127] UNAIDS and UNFPA (2017). HIV prevention 2020 Road Map, Op.cit. , pg 15
[128] For example, all key populations include young women and their male partners; gay men and other men who have sex with men may seek VMMC.
[129] Dehne KL, Dallabetta G, Wilson D, et al. Op cit.

4.4. Most countries in the GPC have utilised technical assistance that is being offered to strengthen prevention activities, but technical assistance is not sufficiently coordinated, and some critical resources are little known

A core function planned for the GPC Secretariat was to coordinate and provide technical assistance (TA) to strengthen HIV prevention activities in the 28 Coalition countries and in certain regional partners, notably SADC.[130] In the 2019 country reporting to UNAIDS[131] 15 of 26 countries reported having utilised short-term international consultants for a variety of tasks, one (Myanmar) documenting nine different activities. Most do not indicate who funded the TA, but among sources that have been mentioned are the Global Fund, PEPFAR and other bilaterals and foundations, UNAIDS and various Cosponsors. The GPC Secretariat has undertaken an extensive range of actions to strengthen capacity for HIV prevention at multiple levels for the GPC countries, from webinars to introducing new tools, to catalysing communities of practice, to short- and medium-term consultancies. *Inter alia* these include:[132]

- Regional workshops in 2017 and 2018 in three regions to update UN country level and regional staff regarding the five pillars and target setting, to track countries' 100-day work plans for Road Map implementation and scorecard development, and to document technical support needs and discuss seed funding[133]
- 10 HIV-prevention-related Webinars for UN staff between October 2018 and January 2020, sometimes including external partners and NAC managers. One country NAC KI noted how useful these were in explaining the "excellent tools" of the GPC, and that more such training events would lead to broader uptake and use of GPC's recommended tools
- A three-day capacity building training workshop for senior HIV prevention consultants in September 2018, which addressed the five pillars and helped bring the consultants up to date on current HIV prevention thinking
- Two face to face meetings and two virtual meetings of NAC directors (2018 and 2019) regarding the Road Map and accelerating national leadership, monitoring and accountability; and, arising from the meeting in May 2019, establishing a community of practice of NAC directors. By May 2020 this had met virtually four times, the fourth discussion focusing on the role of NACs amid the COVID-19 pandemic.[134] These virtual meetings appear well attended and key informants expressed their appreciation of this forum.

The GPC Secretariat can provide limited funding for short-term TA consultants through the pre-existing Technical Support Facility. Since 2018 it has been able to support more TA through the Technical Support Mechanism, which has funding for technical support focused on Global Fund applications,[135] and Cosponsors have provided TA through the country envelope funding.

A less prominent but important source of GPC Secretariat technical support is provided through regular telephone calls with GPC countries to check on implementation and requirements for assistance. In addition to providing management oversight, these calls provide informal trouble-shooting and other advice. In addition, the GPC Secretariat provides all Coalition members with a newsletter each trimester to update them on Secretariat actions (such as consultations convened, documents produced) on Road Map implementation and on upcoming events. However, KI feedback from several countries cited insufficient proactive communication from the Secretariat, perhaps because the regular calls and information sharing go to, and may not be relayed beyond, the UCO, UNFPA and NAC leads and offices.

The GPC Secretariat has provided technical assistance to build country capacity for HIV prevention. It has developed or refined guidelines in response to requests or problems observed[136] and to clarify and support reporting commitments

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[130] UNAIDS and UNFPA (2017) HIV prevention 2020 Road Map Op cit.
[131] UNAIDS website
[132] Communication from GPC Secretariat, April 2020.
[133] Regional HIV prevention capacity building workshops for national and regional staff in Fast Track countries in East and Southern Africa (around 50 staff), Asia Pacific (23 staff) and Western and Central Africa, updating information on HIV prevention and the five pillars, focusing on 100-day action plans, the 10-steps of the Road Map and addressing in-country leadership. The scorecards, technical support needs and seed funding were also addressed. The meetings have been well documented with materials available on line.
[134] Virtual NAC Directors' meeting 21 April 2020, hosted by Kenya NAC.
[135] Benedikt, C. (2018)). Global Prevention Coalition. Roadmap implementation and technical assistance. Global HIV Prevention Coalition Working Group Meeting. Feb 27, 2018.
[136] For example the GPC Secretariat developed a "Decision-making aide for investments into HIV prevention programmes among adolescent girls and young women" to counter the diffuse "laundry list" approach observed in many AGYW plans with concrete guidance for prioritizing components of the AGYW package. GPC (2020). Decision-making aide for investments into HIV prevention programmes among adolescent girls and young women. Also a package of tools to guide condom programming: Condom planning package. Version 1.. https://hivpreventioncoalition.unaids.org/resource/mgh-condom-planning-package-june-2020/

as summarised in Table 9. In 2018 they surveyed a sample of partners and Cosponsors[137] attempting to map available sources of technical assistance, which can complement the TSM's assistance that focuses on Global Fund applications. They noted that much TA is brokered and organised at country level, so it is difficult to track or coordinate centrally.

Table 9: Frequently cited GPC products[138]

Main Tools/Guidance
Rapid review of systems, strategies and management arrangements for HIV prevention
Prevention Self-Assessment Tools (PSAT) across each prevention pillar, for south to south learning
Guidelines for each of the prevention pillars (with priority HIV prevention services)
Tools to develop TOR for different Road Map actions
Tools for annual progress surveys on Road Map implementation
Website
AGYW decision-making aide and a post-ECHO trial brief
3 guides relating to COVID-19
Global Fund checklists on HIV prevention, condoms and KPs and guidance on GF applications
Reports
Scorecards per pillar
Annual scorecards
Country posters summarising the state of the epidemic and responses (late 2019)
Three extensive annual progress reports on GPC
Key meeting reports and minutes
NAC directors meeting reports
Shadow reports e.g. Frontline AIDS
NAC, national prevention coalition and working groups and AGYW implementers reports, national and sub-national prevention targets, statutes, etc. from Tier 2 countries

Gaps in technical support also have been noted

The Road Map and GPC documents stress that combination prevention needs to be community-owned and rights-based,[139] that the implementation of the five pillars must be *"accompanied by political leadership"* that *"brings together different actors and systems"* toward *"creating a legal and policy environment conducive for prevention"* and mobilises sufficient resources.[140] KIs cited a relative deficit in guidance and technical support on *how to* carry out the shifts in the structural barriers that are called for in the five pillars. That is not to say such guidance and support does not exist: KIs asserted that there are multiple guidance documents and tools developed by UN and civil society partners on how to address human rights, gender inequality, gender violence, stigma and other structural factors. The key issue appears to be that those resources are not sufficiently known. Nor do the GPC pillar documents reviewed refer users to Cosponsors who might offer TA, as specified in the GPC's original technical support plan (see Table 3).

Cosponsor activities supportive of PHP at country level are not tracked systematically within the GPC framework.[141] They vary considerably, in level and topic, across GPC countries[142] and the needed Cosponsor assistance to address structural barriers is affected by reductions in staff with HIV prevention expertise at country and regional levels, brought on by resource constraints.[143] Further, technical support through the TSF managed by the UNAIDS Secretariat gender and human rights staff is separate from the TSM managed by the GPC. And while consistently citing the importance of structural factors in GPC documents, KIs report they are the least well delineated, least to be monitored, and the last of the last to be funded. Without a hub that can register and display the full array of technical assistance resources relevant and available for GPC countries and implementers, including those pertaining to the cross-cutting structural and management issues where capacity development is greatly needed, stakeholders can mistake information and coordination gaps for real absences of technical support.

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[137] The survey addressed selected Cosponsors (WHO, UNAIDS, UNFPA, UNICEF), the GFATM, BMGF, and selected networks and INGOs: NSWP, IRGT, MPact, INPUD, Frontline AIDS. Benedikt, C. (n.d.) ibid.

[138] Also in process, a further condom brief, ,s, trusted access platforms and other products, (email communication, UNAIDS Secretariat, 26 May 2020).

[139] UNAIDS and UNFPA (2017). HIV prevention 2020 Road Map, Op.citp. 12

[140] Ibid.

[141] This finding coincides with a finding from the Independent Evaluation of the UN System response to HIV/AIDS 2016-2020 (op cit) pp. 39; 69, i.e. that the M&E framework for UN Joint Teams has no indicators of individual Cosponsor or Joint Team contributions to national HIV programme results.

[142] ER team reviews of Tier 2 county documents; External Review Team (n.d.) Mini-survey of GPC Secretariat staff. June, 2020.

[143] UNAIDS (2020). Independent evaluation - op cit. p.53.

Communications are particularly in need of upgraded strategy and investment

SBCC is mentioned as a core component of the AGYW and KP packages of services,[144] and demand creation is cited as a component of the condom, VMMC and PrEP pillars. Reducing violence and exploitation by the police is a component of the KP package, where south to south learning could be valuable given some countries' success (e.g. India[145]). Schools, especially secondary schools are one of the three platforms identified for providing HIV prevention services to adolescent girls and young women.[146] Since these issues are within the purview of ministries of gender, education and the interior or justice, and of UN Women, UNESCO and UNDP as sources of technical support and as implementation partners, their limited involvement with the GPC at country and global levels is noticeable. It is important to learn whether broader, proactive information sharing would increase their engagement and support, or if advocacy effort and outreach, and funding are required.

Further, on communication, the GPC initially hosted a Facebook page and Twitter feed (Secretariat and CSO KI), but these were subsequently neglected as being excessively labour intensive. The GPC website has been maintained and was reported, by NAC, CSO and Cosponsor KIs who used it, to be a highly valued source of information, guidelines and tools. It could be more widely known if use were supported, e.g. by email blasts and social media. Some comments were received that the website needs to be more dynamic and engaging. Many country-level key informants, notably those involved with young people, would like to see a revival of social

> *"The GPC should have more capacity for strategic communications. We need to realize that -just like back in the 90s - 'silence = death'"*
> *(Convener)*

media, one proposal (KIs at country and Secretariat level) being for recruitment of a suitably qualified junior programme officer or UN volunteer.

4.5. The GPC Secretariat has been responsive to country requests for technical assistance and alert to emerging needs

The GPC Secretariat has shown commendable flexibility and capacity to develop further guidance and opportunities for south to south learning over time in response partly to country requests, and partly through observation of gaps in Road Map implementation and prevention strategies. An example is the establishment of the NAC directors' community of practice, with its leadership now with the NAC in Nairobi, and two south to south platforms, one on key populations and another on condom programming.[147] The GPC Secretariat made catalytic funding available to support implementation of the Road Map including, in some cases, support for longer-term TA such as posting UN volunteers (GPC). Another example is the proactive response of the GPC to the COVID-19 epidemic, using the NAC community of practice as a forum to share responses and the development of three guidance documents.[148]

The technical assistance available and accessed through the GPC was deemed in most cases to valuable and useful, especially long-term technical assistance, the development of situational analyses, and assistance in the preparation of Global Fund requests. Catalytic funding was also made available for this and was greatly appreciated:

> *"... a (long-term) consultant (funded by GPC to the NAC) ... made sure some of the pillars are included.... and mobilised the whole team to support the country (to review the national strategic plan).... This is value for money."* (UCD)

However, there have been criticisms of the TA,[149] some of it related to what were perceived to be overly complex bureaucratic procedures, lack of timeliness in identifying and placing consultants, or consultants not living up to their assignments or possibly not being well-qualified for the tasks they were to undertake. These criticisms cannot be ignored, but they may stem from challenges in communication between the recipient country and the TA provider, lack of clarity

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[144] GPC (2020) Decision-making aide - op cit
[145] UNAIDS (2019). Communities make the difference. World AIDS Day. 1 December, 2019. Geneva. UNAIDS.
[146] GPC (2020) Decision-making aide, op cit
[147] GPWG (2019) meeting reports
[148] The GPWG developed guidance leaflets on HIV amid Covid-19 pandemic, addressing commodity supply chains, service access, responses to disruption of peer-led outreach, and lessons learned in the HIV community that can serve COVID-19 responses as well: GPC (2020). Maintaining and Prioritizing HIV Prevention Services in the Time of COVID-19; GPC (2020). Condoms and Lubricant in the Time of COVID-19: Sustaining Supplies and People-centered Approaches to Meet the Need in Low and Middle Income Countries; GPC (2020). Lessons from HIV Prevention for Preventing SARS-CoV-2 in Low and Middle Income Countries
[149] A question not asked of country representatives was from where their TA had been sourced – from UNAIDS directly, through the UNAIDS Technical Support Mechanism (TSM), from another donor or elsewhere.

in TORs for assignments that are not settled before the initiation of the TA, leading to differing expectations, and the timing of TA requests that come with little lead time before the work is to start, not giving enough time to find the best consultants for the task.[150]

4.6. There are some criticisms that the technical assistance being offered is not addressing the TA needs of some member countries

The GPC Secretariat reported that in-country capacity development is seen as the highest priority to strengthen HIV prevention, including in CSOs.[151] A few informants raised the possibility that the TA being offered through the GPC is so focused on Global Fund applications and Road Map steps that it does not address the TA needs of some member countries. One informant suggested that "*most of the TA that has been offered to date has been too process oriented – ticking boxes, reviews, assessments – the 'nuts and bolts' TA is lacking – how to make programmes more efficient, provide direction in scaling up ……*".[152] As noted earlier, gaps have been noted in TA for countries seeking assistance in shifting on policy barriers, harmful social norms, and other structural interventions. Areas where more TA is needed include: social contracting; social marketing; condom total market development; programme management; high-level advocacy; combatting stigma and discrimination; SRHR and HIV integration; assessing capacity needs and developing capacity development plans; and achieving policy and legal reform. It was suggested that the GPC management could play a role in tasking the various national UCO/UNFPA offices to prioritise and assist with the articulation of local needs, so that the specific TA required can be sourced and supported.

Other TA gaps were noted: NAC, CSO and donor KIs in one Tier 2 country called for an algorithm to support monitoring and analysis of their prevention cascades. The Road Map's emphasis on social contracting, supported by Global Fund and PEPFAR guidelines, means that civil society, including community-based organisations, are expected to play an increasingly large role in PHP interventions, given their superior capacity to reach and inspire trust in vulnerable groups and locations. Yet capacity development among civil society organisations has lagged behind, and needs were expressed by a range of KIs for specific kinds of technical assistance that were perceived as hard for CSOs to get: training in strategic advocacy, management, community mobilisation, and other areas to enable them to hold decision-makers accountable to their constituents. Tier 2 countries' capacity development plans, or lack thereof, suggest the need for a clearer vision of the capacity development goal: what is the multi-sectoral PHP workforce that countries need to build, in order to design, implement, manage and sustain their planned pillars at scale, including their structural components?

Another issue raised is that the amount of south to south TA over the past three years is small compared to the amount of north to south TA, not taking advantage of the technical expertise that exists in, for instance, Africa, Asia, and Latin America. The recent development of a formalised South to South Learning Network (SSLN), funded by the Bill and Melinda Gates Foundation (BMGF),[153] includes an initial 12 countries in Africa, mainly ESA. Countries were selected in February 2020 to focus for 18 months on sharing lessons learned around key populations and condom programming. A further four countries will follow. KI feedback suggests this is a highly welcome development to increase south to south learning.

However, it is clear that more and better TA would be welcomed. Funding for TA is always an issue, but accessing funds, especially for long-term TA should be a priority. As well as taking advantage of south to south consultancies, more attention should also be paid to retaining HIV prevention expertise in the UN regional joint teams,[154] and to utilising the HIV prevention expertise that is present in the regional offices. This resource has also been underutilised.

III.5 Looking Ahead: toward HIV Prevention in the UNAIDS 2021-2025 Strategy

Findings and Discussion

The findings reported here are aligned with recent UNAIDS, GPC and independent conclusions that attention paid to HIV prevention has increased since 2016 and that GPC countries have strengthened their HIV prevention responses and set

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[150] Personal communication – TSM focal point
[151] ER team (n.d.) Mini-survey of GPC Secretariat staff. June 2020.
[152] UN Regional Rep
[153] Genesis Analytics, University of Manitoba Kenya, NAC South South Learning Platform secretariat Kenya, GPC, BMGF
[154] UNAIDS (2020). Independent evaluation… Op cit.

ambitious preventions targets.[155] However, there remain "miles to go".[156] National HIV responses worldwide must continue to emphasise finding HIV-positive people, initiating them on treatment, and supporting PLHIV already on treatment, but the case for also investing more in primary HIV prevention is clear.[157] Unless prevention efforts are increased, 1.5-2 million people per year will be added to the number of HIV-positive people who require lifelong ART – a situation that is widely recognised as financially unsustainable.[158]

5.1. Over the next five years, the need to intensify primary HIV prevention will be greater than ever, by scaling up the five pillars and incorporating new biomedical prevention tools that become available

While there is agreement that there is a need to increase PHP in order to meet the 2030 targets in a sustainable manner, different agencies are taking different approaches to prevention in the next five years. The CDC is taking a biomedical approach, not only promoting intensified testing and putting HIV-positive people on treatment, but also promoting PrEP in high-risk and vulnerable populations, including adolescent girls and young women in high risk locations, and supporting increases in VMMC. WHO has recommended oral PrEP since 2015 for anyone at substantial risk for HIV infection.[159] As of mid-2019, over 50 countries have national policies or guidelines recommending PrEP for populations at high risk of HIV acquisition.[160] Since 2017, PrEP drugs have also been included in WHO's Essential Medicines List. With key donors and technical agencies focused on biomedical strategies it will be more important than ever for NACs and national prevention coalitions to ensure that the full, locally tailored key and vulnerable population and condom packages are implemented consistently and to scale in the locations and populations that need them.

For sub-Saharan Africa, an increase in PrEP utilisation may very well be an important component of increased prevention efforts in the coming years. Expanded access to PrEP is supported by representatives of key populations (linking PrEP to increased SBCC efforts, community engagement and demand creation) as it adds to the choices available on how to protect individuals and communities. The recently-reported results of the HPTN 083 study interim analysis, which demonstrated that long-acting injectable cabotegravir (CAB LA) administered every two months was 69% more effective than daily pills in preventing HIV acquisition in MSM and transgenders[161] is heartening news. If the same results can be demonstrated in other key and vulnerable populations, it could mean a way of overcoming two of the major barriers to PrEP efficacy – irregular adherence in most users, and issues of stigma in adolescent girls and young women or key populations who do not want to be seen to be taking antiretrovirals. As well, there are already efforts underway to integrate PrEP into the general public health practice, such as linking PrEP to STI services.[162]

Strengthened linkages between HIV and other services are also on the increase. A global initiative for the triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis has been underway for the past three years.[163] Strategies to increase integration of HIV and TB testing and care services are now a standard component of many countries' strategic plans. And the recently completed ECHO study trial, which demonstrated no substantial difference in risk of HIV infection among women using one of three contraceptive methods,[164] should reduce any doubts about the value of increased integration of HIV and SRHR services.[165]

155 E,g, GPWG (2019. Global HIV Prevention Working Group meeting. London 10-11 September, 2019; UNAIDS (2019) Global AIDS update 2019 — Communities at the centre, 10 December 2019; UNAIDS   (2020), Annual progress report on HIV prevention 2020 (op cit.); UNAIDS (2020) Independent evaluation ... Op cit.

156 UNAIDS (2018). Miles to go. Closing gaps. Breaking barriers. Righting injustices. Global AIDS update 2018. Geneva. UNAIDS.

157 Sources are numerous, beginning around 2015. For example: UNAIDS (2016). Global AIDS update. Geneva: UNAIDS. https://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf;

158 UNAIDS; Seizing the moment: Global AIDS Update 2020; July 2020

159 WHO; Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: 2016 https://www.who.int/hiv/ pub/arv/arv-2016/en/

160 Hodges-Mameletzis I, Dalal S, Msimanga-Radebe B, Rodolph M, Baggaley R. Going global: the adoption of the World Health Organisation's enabling recommendation on oral pre-exposure prophylaxis for HIV. Sex Health. 2018;15(6):489–500

161 https://viivhealthcare.com/en-gb/media/press-releases/2020/may/global-hiv-prevention-study-to-stop-early-after-viiv-healthcares/

162 WHO; Prevention and control of sexually transmitted infections (STIs) in the era of oral pre-exposure prophylaxis (PrEP) for HIV. Geneva: 2019; https://apps.who.int/iris/bitstream/handle/10665/325908/WHO-CDS-HIV-19.9-eng.pdf?ua=1

163 Lei Zhang et al; Integrated approach for triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis is highly effective and cost-effective: An economic evaluation; Int J of Epidemiology; 48(4) March 2019

164 Baeten J et al; HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper IUD, or a levonorgestrel implant for contraception: a randomized, multicentre, open-label trial; Lancet; June 13, 2019; https://doi.org/10.1016/S0140-6736(19)31288-7

165 UNFPA discusses in some depth the benefits and challenges of integrating HIV services into SRHR services: UNFPA (2020).   UNFPA. (2020). Evaluation of the UNFPA support to the HIV response (2016-2019).   Volume 1. New York. UNFPA Evaluation Office.

Managing and driving change while maintaining high quality implementation of the five pillars is labour intensive. It requires dedicated, expert staff with the time and resources to convene, coordinate, monitor and reach out to relevant partners at sub-national as well as national levels. A number of KIs cited the importance of staffing, both to provide political leadership, and with the technical skills required to study, design and implement behavioural and structural interventions. Going forward, UNAIDS has an opportunity to reframe the tired tropes of capacity building around the concrete objective of building a prevention workforce, one that includes a multi-sectoral array of government, civil society, private sector and academic actors and institutions, and that can be built over a five-year period. Building a workforce is one established way[166] to institutionalise a field of endeavour. To be successful over time, GPC countries need data systems to provide information for planning, and the workforce to design, implement, resource, coordinate and monitor the five pillars at scale and to shape a more enabling policy and legal environment for those efforts, as well as to pilot, assess and incorporate new biomedical technologies as they emerge.

> "The coalition should be aiming to get commitment from people and following up with them...It might be things that don't cost a huge amount but have a big impact. For example, if the GPC could get leadership of EVERY country to have a dedicated prevention coordinator in their NAC, things could move a bit. Just one person can make a huge difference in focus." (Donor)

5.2. There is serious concern that there will be a continued and intensified decline in donor funds for PHP and for HIV in general

The evidence-based drive to increase HIV prevention activities is being dampened by a climate of uncertainty about the levels of HIV funding. As noted earlier, declining funding flows from Europe have been offset so far by increases in PEPFAR allotments, but increases in HIV funding in recent years have been earmarked almost entirely to support treatment and care. Without continued increases, what funding is available will be needed to support people on ART. Prevention measures such as PrEP will have support, but the non-biomedical aspects of prevention – communications, community engagement, condom supply and promotion, and addressing human rights and stigma – which "have always had to fight for what is left over after treatment" (GPWG) – are likely to suffer even more. The

> " Apart from gaps in HIV prevention financing, there is also insufficient political will to mobilise investments from sources other than HIV funding for critical enablers such as education (including comprehensive sexuality education), social support systems, sexual and reproductive health and rights (SRHR) as well as youth-friendly health systems."
> (GPC [2020] Decision-making aide for investments into HIV prevention programmes among adolescent girls and young women, p2)

decrease in HIV funding may be even more severe in the face of the downturn in most donor economies as a result of the COVID-19 pandemic and countries retrenching their donor commitments in order to pay for domestic economic recovery and support programmes. The prospects for mobilising domestic funding from government or private sector sources are further dimmed by the impact of COVID-19 on employment, consumer spending and tax revenue.

5.3. Increasing efforts to integrate HIV into health systems confers both benefits and potential risks, especially to behavioural and structural PHP

Integrating HIV programmes into broader health systems including TB, infectious disease, and/or sexual and reproductive health programmes and making HIV less of a vertical programme was called for by some country level KI and GPWG members. Integration is increasingly part of the national and international debate. There are many reasons for supporting this. First is the move toward sustainability by mainstreaming HIV within government run and financed health systems. Integrated services should provide clients a broader range of information and services when they come for SRH or other health services. Others advocate an integrated approach to services for reasons of efficiency and economies of scale. However, the concept that integration should bring improved services and cost-savings has been known for decades, but the limited evidence of integration has revealed a range of operational and institutional challenges, from insufficient training to territoriality and raw resistance, at individual as well as organisational levels. There is also the danger that HIV within the larger health system will be seen largely in terms of its biomedical characteristics, and the important social and structural drivers of HIV, stigma, discrimination, human rights and gender issues, poverty and other social determinants, will be ignored or minimised. As well, keeping HIV "in the clinic" in the SRHR silo can also act to reduce the

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[166] Compare, for example, Chen, L., Evans, T., Anand, S., Boufford, J.I., Brown, H. and Chowdhury, M. (2004). Human resources for health: overcoming the crisis.   Lancet Public Health. 364 (9449):1984-1990; UNAIDS (2017) Strengthening HIV primary prevention. Op Cit.

component of community empowerment and involvement in HIV prevention, a component that is of greatest importance in the work of key and vulnerable population peer networks and outreach.[167]

5.4. "COVID-19 has changed everything"

This review of the GPC has taken place in the midst of the global COVID-19 pandemic. The depression experienced by the world's economies and their need to focus on local issues gives credence to the proposition stated above that the funding for all international development, not just in the HIV/AIDS arena, is going to be affected in the coming years. Thus the GPC members' aspirations to dramatically increase funding for HIV prevention face intensified challenges. The events of the past six months have also demonstrated the fragility of health systems, even in high income countries, which is a cause for concern, not only for innovating and integrating new prevention strategies, but also whether ongoing HIV prevention, treatment and care activities are going to be maintained in the coming months, where health systems are being overstretched by the pandemic.

> *"We cannot have poor countries at the back of the queue. It should not depend on the money in your pocket or the colour of your skin to be protected against these deadly viruses (COVID-19 and HIV). We cannot take money from one disease to treat another. Both HIV and COVID-19 must be fully funded if we are to avoid massive loss of life."*
>
> *(UNAIDS Press Release, 6 July 2020)*

That being said, countries being affected by COVID-19 can learn a great deal from their experiences with HIV.[168] Techniques of community follow-up, contract tracing and index testing developed for the HIV pandemic can be applied to tracking and tracing COVID-19 contacts. The HMIS systems developed for HIV can be applied to keeping registries of COVID-19 patients. Important lessons can also be learned from the HIV community on addressing fear, stigma and discrimination against current and recovered COVID-19 sufferers in and beyond the clinic. Reciprocally, the revolution in use of virtual technologies instead of face-to-face communication, necessitated by the novel coronavirus pandemic, can bring enduring efficiencies to work in HIV responses. One KI (CBO) noted that virtual platforms such as Zoom or Skype can greatly expand inclusion and participation of people from different countries and regions in GPC consultations of all kinds since the costs of airtime are so much more affordable than in-person travel.

IV. Conclusions

The GPC has accomplished a great deal in under three years. Together, its global and country-level participants have reawakened attention to primary HIV prevention, and applied technical and political strategies honed over the past 15 years - including target setting and regular, public reviews and reporting - to focus HIV prevention resources on interventions most likely to bring down new HIV infections. The GPC methodology, outlined in the 2020 Road Map, requires use of granular epidemiological data to map the populations and locations most in need, and offers an operational model in which the differentiated responses for those populations and places are unified as the most efficient strategy for achieving national HIV prevention targets. While there are still "miles to go," this methodology has accomplished increases in programming to provide services to key populations and to work with and through civil society organisations, often against political headwinds.

The review team heard that the social and structural components of the five pillars, including interventions to engage and build the PHP capacity of civil society actors and to promote gender equality, protect human rights, and combat HIV-related stigma and discrimination, merit more focus and investment. The team observed that the GPC's activities have not so far increased the funding available for HIV prevention in most GPC countries. In addition, a range of legal and policy barriers remain. However, the uptake of methods and tools to incorporate the pillars into GPC countries' prevention strategies, and the GPC scorecards and key informant reports indicate that GPC countries have improved their intervention mix and engaged more leaders and communities in HIV prevention. In addition, through ongoing interaction and review in and between country teams, the GPC Secretariat and the GPWG, ideas have emerged on what should stay the same and what should change in the GPC.

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167 UNAIDS. (2019). Communities make the difference. World AIDS Day. 1 December, 2019. Geneva. UNAIDS.
168 GPC. (2020). Briefing notes on lessons learned from HIV applied to Covid-19 responses.

Small changes in GPC and GPWG membership, adding countries with burgeoning epidemics and more countries from EECA, SEA, and LAC, strengthening engagement of regional HIV teams, and rotating meeting locations will enrich the mutual learning and make the GPC more global. The GPWG has already concluded they need to refresh their membership and shift their focus to address more directly country level challenges. They are in a good position to clarify their mandate and to reconfigure their plans to focus more on lending high-level advocacy support to country teams.

A process is needed to renegotiate and update the description of the niche of the GPC in the broader landscape of HIV prevention and the SDGs, with a complete list of the GPC's components/members, and the roles and responsibilities of each. The GPC Secretariat's work supporting and consolidating the monitoring and reporting on PHP by GPC countries is a cornerstone of the Coalition's success. At the same time, the GPC Secretariat should articulate its relationship to the rest of UNAIDS and to the larger HIV prevention landscape, and more proactively include and link with other initiatives that contribute to HIV prevention outcomes. This will enable everyone to know what to expect from the GPC and what to seek elsewhere. A complete mapping of the initiatives, allies and organisations that contribute directly and indirectly to delivering the pillars at scale, and that constitute that broader landscape, was beyond the scope of this review. However, the team did update the Theory of Change diagram (see Figure 5) to capture the groups and structures that should be considered and referenced systematically in depictions of the GPC's work.[169]

It is evident from GPC documents and the perspectives of the review's key informants that the prevention strategies and management structures of GPC countries have advanced in all 28 countries since 2017 - a remarkable achievement in a short time. The review was not asked or structured to compare GPC and non-GPC countries. However, the team concurred with GPWG members who expect to see measurable changes in the 2016 HLM outcome targets within the next several years. Thus the GPC should be extended and formally evaluated in 2025.

The challenge remains to shift the key barriers that impede evidence-informed PHP scale-up. Figure 5 conveys that insufficient political leadership, insufficient funding, and policy and legal barriers are not obstacles that can be eliminated as part of the GPC's results chain, as implied in the team's first ToC (Figure 1). Rather, they are likely to constrain the implementation of all the steps of the Road Map, and require on-going effort and action, indefinitely. The High Level meetings organised by the GPC (WHA and IAS-Amsterdam in 2018, HLM in Nairobi in 2019) showed the power of convening high-level decision-makers to review their country's progress on their prevention plans in the company of their international peers. Yet the Coalition does not yet appear to have a strategy for reaching the range of decision-makers who do have the power to enlarge the overall funding envelope for those plans. These are, not only ministers of health who play a lead role in deciding the HIV budget within health, and the PHP within HIV, but also the political decision-makers (e.g. ministries of finance, heads of state) who can influence the overall financing of health.

It is clear that funding levels for HIV responses and the share devoted to prevention must expand if the 2016 prevention and treatment targets are to be approached by 2030, even in the face of competing concerns - notably COVID-19. The ExD of UNFPA observed an urgent need to strengthen domestic advocacy on domestic financing for PHP, and that "*COVID itself is not an excuse either - keep your eye on that zero [new HIV infections]- don't get derailed.*"

The ExD of UNAIDS[170] asserts the critical importance of HIV prevention and that in the coming strategy more emphasis will be placed both on prevention and on the structural causes behind new infections, through building better and stronger coalitions. Finally, as the Executive Director of the Global Fund put it during a recent replenishment meeting, it is essential to continue to invest and progress in countries' HIV responses, because "*Against adversaries as formidable as HIV, TB and malaria, there is no middle ground. We're either winning or we're losing.*"[171] The GPC, in collaboration with other efforts, is making an important contribution to winning.

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[169] A limitation of the review is that it did not delve into the relationship between the GPC Secretariat, which sits in the Fast Track department of UNAIDS, with other teams in the UNAIDS Secretariat, although the GPC Secretariat confirmed that they collaborate extensively, for example with the Strategic Information team.

[170] Key informant interview

[171] Sands, P. (2019). Peter Sands makes the case.   https://www.theglobalfund.org/en/video/2019-10-18-the-world-stepped-up/?m=2

Figure 5. Revised, simplified GPC Theory of Change

Global HIV Prevention Coalition Observed Theory of Change (June, 2020)

Epidemic Scenario (HIV burden, distribution, MOT, Key Populations, Status of Response, etc.

GPC Members → **GPC Activities** → **Reduce Deficits and Barriers** → **Implementation of Combination Prevention at Scale**

Global Level

- Conveners UNAIDS, UNFPA
- GPWG
- GPC Secretariat

Country Level

- GPC Country National Authorities NACs
- UNAIDS co UNFPA co office, and Joint Team
- Gov and Non-gov Implementers
- National Prev Coalition & WGs

Global, Regional, Country

- Technical Support Partners
- Cosponsors UNFPA, WHO UNICEF UNESCO UNDP UNODC UN Women ILO, WFP UNHCR World Bank
- Global Fund PEPFAR
- Others SADC, RECs, INGOS Private Sector

GPC Activities:
- High Level Advocacy
- Convening, Meetings
- Communi-cations
- Catalytic funding
- Evidence-Informed Guidance
- Tools
- Technical Assistance
- M&E

Political Leadership ← → **Policy and Legal Barriers**

2020 Road Map 10 Steps

Funding for Prevention

Bilateral Donors; GPC Ministries of health, education, justice, interior, finance, etc.

- Efficient focus on (5) Pillars
- Communities and leaders Engaged
- Prevention Capacity Expanded
- More Enabling Environment
- Sustainable Sources of PHP funding

Prevention Impact – 2016 Political Declaration Targets

Country Economic, Political and Socio-Cultural Context

V. Recommendations [172]

1. Recommendations to the UNAIDS Committee of Cosponsoring Organisations

1.1 Extend the GPC to 2025 as GPC-2, with the same co-convenors, a redefined membership, structure and funding base, and clear terms of reference for each of its component groups. [0.1; 1.1; 4.1]

1.2 Inventory the initiatives of each Cosponsor that are related to HIV prevention (e.g. human rights, economic empowerment, gender equity, SRHR, workplace standards), establish how they will link actively with GPC processes at global, regional and country levels, and identify and fund a focal point/s to support and report on the linkages.[O.2; 1.1; 1.4; 1.6; 2.5; 4.4]

1.3 While recognising the important work by all Cosponsors that is relevant to HIV prevention, appoint the GPC Secretariat as the hub and data repository for HIV prevention efforts of all the UNAIDS Cosponsors. [1.1; 2.5;   4.2].

1.4 Request Cosponsors to collaborate with the GPWG and GPC Secretariat to formulate a composite indicator that communicates Cosponsor engagement in PHP support at country level, for inclusion in national prevention score- cards and in UNAIDS' annual HIV prevention report to the PCB. [1.1; 4.4]

1.5 Mobilise Cosponsor Heads of Agency and other leaders to advocate with their government and private sector peers on the importance of funding PHP within their respective health, development and corporate social responsibility strategies. [1.4; 2.3; 2.6; 5.2]

2. Recommendations to the GPC Conveners UNAIDS and UNFPA

2.1 Lead design of GPC-2 for presentation to the November 2020 HLM with a clear theory of change and specification of the roles and responsibilities of all component groups. [1.1; 1.3; 1.7]
The updated design should consider:

    2.1.a Expanding GPC membership from LAC, EECA and SE Asia regions that have rising HIV incidence, within practical parameters imposed by available funding and staff support for allied GPC Secretariat functions.   [1.3; 1.5; 1.6; 3.3; 5.4]

    2.1.b Highlighting the ownership of the GPC by the GPC member states, represented by their NAC directors, and underscoring   the role of NACs in disseminating the GPC resources they deem useful to CSOs and sub-national levels. [2.2; 3.1; 4.4]

    2.1.c Updating the TOR of the GPWG as an informal advisory group, revising the balance of its membership to achieve greater representation of CSOs, NACs and Cosponsors while retaining its small size and agility, and rotating the GPWG co-chairs ensuring that one is always drawn from civil society .[1.3; 1.4]

    2.1.d Constituting a small subcommittee of the GPWG to meet more regularly and interact with the GPC countries, Secretariat and UNAIDS leadership on emerging issues, reporting back to the larger GPWG. [1.2; 1.3]

2.2 Support the GPWG to implement more, higher-level strategic advocacy for primary HIV prevention funding and policy and legal reform, with government policy-makers and influencers in GPC countries and with funding partners. [1.4; 2.6]

    2.2.a Leverage all GPC members' networks (including Co-sponsor Heads of Agency), to engage powerful allies to advocate with donors (foreign and domestic) on the importance of supporting PHP within their HIV, health, development and corporate social responsibility strategies. [1.4; 2.3]

    2.2.b Support GPC countries to prepare or update their business case for PHP to strengthen their domestic advocacy and funding requests. [2.6; 3.3]

    2.2.c Add an indicator to GPC Road Map reporting regarding presence/absence of a high-level post in the national authority for coordination of PHP during the 2021-2025 period. [2.3]

2.3 Advocate with leadership in each Cosponsor to retain or restore a full-time HIV prevention specialist in their regional offices, to provide prevention leadership and technical support to national PWGs according to their role in the UNAIDS Division of Labour, and to participate in GPWG and other GPC activities where they can add value. [2.3; 2.5; 4.4]

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[172] These recommendations are based on the review team's findings, which are indicted by number in square brackets.   Many   are interconnected and mutually   reinforcing   (e.g. Findings 1.5, 2.2, 3.4, 5.2, 5.2c).

2.4 Advocate with donors to fund dedicated HIV prevention posts in NACs as a strategic investment. [2.1; 2.2; 2.3]

3. Recommendations to GPC Country National Authorities

3.1 Establish or reinforce, support and fund a discrete post in the national HIV/AIDS authority for an HIV prevention leader and coordinator who can convene, coordinate and advise the needed PHP stakeholders (health and non-health sectors) at national and sub-national levels under a unified national PHP brand. [2.1; 2.2; 2.3]

3.2 Commission the national HIV prevention coalition to develop a new or updated national HIV prevention road map, with coverage and outcome milestones and targets for 2021-2025, tailored to the country's gaps and needs, and addressing observed obstacles to implementing differentiated PHP at scale, including the need for an adequate prevention workforce, and structural issues of financing, harmful policies and laws, and political barriers. [1.2; 3.2]

3.3 Develop and execute a five-year strategy for mobilising domestic as well as international funding to contribute to national ownership and to the national 2025 road map implementation. [2.6; 3.3]

3.4 Recognising the comparative advantage of CSOs in reaching vulnerable groups and KPs with HIV services, increase support for strong civil society engagement in national prevention coalition and technical working group activities, including providing funding for capacity development, and to defray the costs of meaningful participation in planning, implementing and evaluating progress on the national road map. [1.7; 2.4; 3.2]

4. Recommendations to the GPC Secretariat and Global HIV Prevention Working Group

4.1 Continue the assistance to countries to review regularly and report annually on their road maps, pillars and prevention targets, presenting the data in the scorecards and posters; advocate standardising PHP reporting among major technical and funding partners; motivate and support sub-national scorecard and poster development. Incorporate analysis and use of the prevention cascade for each pillar. [1.2; 2.1; 3.2; 4.2; 4.6]

4.2 Develop a strategic advocacy strategy, with a communication campaign, to raise domestic and international funding to support all aspects of GPC countries' 2025 road maps, including capacity development and civil society inclusion. [2.6; 3.3]

4.3 Develop the methodology and tools for designing the prevention workforce tailored to a country's 2025 prevention road map, targets and context that addresses capacity for IEC, SBCC, advocacy, programme management and structural interventions to promote human rights and gender equality. Support every GPC country to define prevention workforce milestones and 2025 targets and incorporate those into GPC reporting by end 2021. [1.2; 3.2; 4.6; 5.1]

4.4 Continue partnering with the Global Fund to increase investment in needed PHP capacity development and service delivery. [2.6]

    4.4.a Advocate with the Global Fund to include in the application guidelines, the call for countries to define and seek funding for a five-year plan to build and engage the multi-sectoral HIV prevention workforce required to operationalise and sustain their HIV prevention response, with appropriate costing and targets. 3.2; 5.1]

    4.4.b Advocate increasing support for the communities of practice and south to south learning among NAC directors and for each prevention pillar.[2.2; 4.5; 4.6]

    4.4.c Consider including recommendations for GF application guidelines to encourage countries to request funding for translation and for downstream dissemination of PHP guidelines and tools, to reach sub-national actors. [0.2; 1.2; 3.1]

4.5 Meet the demand for coordination and transparency in HIV-prevention-related technical assistance by tasking the TSM to collate, analyse and publicise to GPC countries, the technical assistance available from all partners (cosponsors, TSM, TSF, Global Fund, PEPFAR, USAID and other bilaterals, implementing organisations and private foundations) relevant to PHP. Include mechanisms to access UN Joint Programme regional offices as sources of technical support for GPC countries. [1.2; 1.4; 1.7; 2.5; 4.4; 4.5]

    4.5.a Identify, source and offer assistance in an expanded range of technical skills (e.g. social marketing; human rights; legal reform; social media communication; costing; social contracting; capacity needs assessment and planning;

programme management; M&E); intervention areas (e.g. condom total market approach; opioid substitution therapy; combatting stigma and discrimination); and diverse modalities (e.g. long-term training; task-based consultancies; webinars).   [1.3; 1.6; 4.6]

4.6 Ensure all member countries can engage in and benefit from GPC meetings and discussions by consistently addressing the concerns and priorities of all regions and sectors, e.g. by rotating the location of GPC meetings, addressing translation, and by generating opportunities for mutual learning across regions and sectors. [1.5]

4.7 Support UCOs and UNFPA country offices to expand country-level communications on PHP activities, guidelines and available tools and support under their country's national HIV prevention brand, to reach civil society, private sector and health and non-health stakeholders, with attention to dissemination at the sub-national level.   [1.2; 1.3; 3.1]

4.8 Plan and commission a comprehensive outcome and impact evaluation for 2025 that tests key links in the results chain of the TOC of the GPC and identifies elements to extend, revise or terminate. [3.2; 4.3]

4.9 Commission and seek funding for the development and implementation of a layered communication strategy on primary HIV prevention at national and sub-national levels that includes an effective GPC social media presence, and that dovetails with and reinforces communication on COVID-19 prevention, treatment and care. [1.4; 3.1]

   4.9.a Stimulate use of the global and national prevention coalition websites where guidelines, tools and technical assistance are available, e.g. through social media, text messaging and email blasts reaching stakeholders at all levels, supported by dedicated staff such as a UNV or JPO. [1.7; 4.4]

5. Recommendations for UNAIDS Strategy 2021-2025

5. 1 Intensify UNAIDS advocacy and support for evidence-informed, combination PHP as a cost-effective, rights-based strategy that also helps assure the sustainability of antiretroviral interventions long term and equity in access.   [2.3]

   5.1.a Retain the five-pillar framework, but heighten the profile of and provide more concrete guidance for operationalising their structural elements (e.g. addressing stigma and discrimination, punitive laws, gender inequality, and poverty), including specifying actionable interventions, targets, and budget requirements. [1.4; 1.6; 1.7; 2.5; 4.1]

   5.1b Elevate the perceived value and urgency of intensified PHP among HIV programme planners and policy-makers through communications and actions of respected leaders. [0.2; 2.3; 5.1; 5.4]

   5.1c Promote emerging biomedical developments that lead to more efficient and effective services and to widening choices for all, particularly for key and vulnerable populations. [5.1]

5.2 Particularly in light of the massive global COVID-19 pandemic setback, combat declines and seek increases in funding for primary HIV prevention through strategic high-level advocacy with key funders, government leaderships, civil society advocates and the multinational and national private sector, among others. [1.4; 5.4]

   5.2.a Prepare and disseminate estimates of the escalating long-term human and financial costs of inaction and the benefits of investing in responses to both viruses, noting that the UNAIDS Three Zeros apply equally to COVID-19.   [5.4]

   5.2.b Ensure that interests in new biomedical interventions do not divert funding required to implement the proven prevention methods at scale, including the combination HIV prevention packages specified in the five pillars.   [1.7; 2.6; 5.2]

   5.2.c Explore innovative funding sources and strategies within countries, and as incentives, offer media attention and international acclaim.

5.3 Strengthen the linkages and strategic partnerships needed to intensify HIV prevention. [2.4; 5.3]

   5.3.a Inventory and publicise the contributions of HIV research, policy and practice to SRHR, health systems strengthening, global health security, private sector engagement, the SDGs, engagement and empowerment of AGYW and KPs, and to M&E for programme improvement, and their relevance to broader health and development challenges, including COVID-19. [1.4; 1.6; 2.2; 2.5]

5.4 Set standards and support south to south learning for increased investment in CSOs to strengthen effective community engagement and leaderships for HIV prevention as a core platform for success, especially among young people and key and vulnerable populations. [1.7; 5.1]

VI.   Annexes

Annex 1: Terms of Reference for the External Review

Terms of Reference-External Review of the GPC and the 2020 Road Map [Received March 20 2020]

1. Background

The 2016 Political Declaration on Ending AIDS provides the overarching framework for taking forward HIV responses and monitoring progress. It has set the ambitious impact target of reducing the annual number of new HIV infections globally to fewer than 500 000 by 2020, and for the first time in the history of the HIV response, this high-level impact target for HIV prevention was accompanied by global programmatic primary prevention targets.

The Global HIV Prevention Coalition was established in October 2017 to galvanize greater commitment to and investment in HIV prevention and agreed on a road map to achieve the 2020 HIV primary prevention targets. Ministers of health and other government officials from 25 countries with a high number of new HIV infections [173]and leaders of more than 20 international and civil society organisations participated in the inaugural meeting. Together, they endorsed the HIV Prevention 2020 Road Map. The Road Map identifies four main factors that were holding back progress:
1. Gaps in political leadership.
2. Legal and policy barriers.
3. Gaps in prevention financing.
4. Lack of systematic implementation of combination prevention programmes at scale.

Participating countries committed to implementing the Global Prevention Road Map 2020, which contains a 10-point action plan to address these factors. It also features broader commitments by development partners and civil society with clear targets and milestones. In 2018 an additional four countries and SADC joined the GPC.

The Global Prevention Road Map 2020 focus on strengthening national HIV primary prevention responses around five central pillars including 1) Prevention among adolescent girls and young women and their partners, 2) Key populations, 3) Condom programming, 4) VMMC and 5) PrEP.

The Global HIV Prevention Coalition Secretariat was established within UNAIDS in Geneva to monitor progress and activate a mechanism for rapid technical assistance. A global HIV prevention working group composed of technical experts from relevant UNAIDS Cosponsoring organisations, donors, civil society, National AIDS Programme Managers and academics meets twice a year and provides advise to the GPC.

Monitoring of progress is done through country calls and online surveys with the UNAIDS and UNFPA country and regional offices, National AIDS Commissions directors' and ministerial level Coalition meetings. Progress in terms of the 5 primary prevention pillars is specifically monitored through the use of scorecards, and more recently the country posters, which synthesize progress made at the level of programmatic coverage, outcomes and impact, and serve as an entry point for comparisons and as an accountability tool that governments have to validate on yearly basis.

Since the launch two progress reports of the implementation of the Road Map have has been published, the first covering the six-month period from the inaugural meeting in October 2017 to March 2018. The second progress report summarises progress for the period of April to December 2018. Progress in implementing HIV prevention programmes is tracked through the Global HIV Prevention Coalition dashboard and country scorecards. The scorecards synthesize progress made at the level of programmatic coverage, outcomes and impact, and they allow for comparing progress across countries. Scorecards are available for 2017 (baseline), 2018 and 2019.

The third progress report covering May to October is under preparation and will be launched at the ICPD High Level Meeting in November 2019. In addition, UNAIDS provide yearly updates to the PCB. The first report was presented in December 2018.

2. Overall purpose of the external review

With the Global Prevention Road Map ending in 2020, the review will examine the role the GPC and the Road Map have played in strengthening the HIV prevention response globally and at country levels in accelerating progress towards the 2016 HLM prevention targets and commitments since its inauguration in October 2017. Against the backdrop of the

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[173] Contributing to a collective burden of >85% of annual new infections

current policy environment, it will also address the main successes and failures, and make recommendations for the HIV primary prevention agenda for the period 2021-25, including possible continuation and successor arrangements to the existing GPC and Road Map.

Specific objectives:
- Describe and asses the architecture/design and operational effectiveness of the GPC and its key activities including key elements of the Global HIV Prevention Coalition[174]
- Examine the successes and challenges of the GPC, in:
  - Addressing gaps in political leadership on HIV prevention,
  - Adressing funding towards HIV prevention programming
  - Addressing the lack of systematic implementation of combination prevention programmes at scale and the scaling up programmes across the 5 prevention pillars
  - Addressing policy barriers.
- Assess the role and engagement in accountability of a wide range of UN, government and CSO stakeholders and their political and operational commitment to the agenda
- Establish key challenges in the political landscape since the establishment of the GPC in 2017, as well as barriers and challenges that have hindered further progress in HIV primary prevention
- Describe and assess GPC and 2020 Road Map contribution to accelerating progress towards achieving the Global Target on reducing new HIV infections, and the 2016 political declaration prevention programme targets, and potential other HIV targets
- Make recommendations with regards to the possible continuation and successor arrangements to the existing GPC and 2020 Road Map
- Make recommendations regarding the future HIV primary prevention agenda for the period 2021-25.

3. Methodology
The consultants will be tasked with:
- Developing an inception report proposing a methodology and analytic framework
- Undertaking a desk review of key documents incl on policy context and progress in implementing the Road Map, including the Milestones.
- Examine scorecards, country posters and global reports with an aim to look at relevance and success of the GPC and the Road Map.
- Conducting key informant interviews with all prevention working group members, governments, regional prevention focal points of UNAIDS, UNFPA, and selected civil society partners, foundations and donors, and selected country stakeholders. These interviews will be done remotely.

Outputs/deliverables
- Draft an inception report for consultation with the GPC secretariat and UNFPA as co convenor, and with the PWG.
- A final report of no more than 25 pages incl an introduction, methodology, the findings and recommendations.
- A power-point presentation that supports the report findings.

The findings will be shared in a timely manner with stakeholders to ensure learning from the implementation of the agenda and forward-looking process to inform future priorities.

It is also proposed that the findings be presented to the PCB for further recommendations for the HIV prevention response and UNAIDS Strategy.

4. Timeline
Timeline for the review will be April - July 2020 and the review will cover the period Oct 2017 to Feb 2020.
Milestones:
- Inception report April 2020
- Draft report mid-June 2020

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[174] A.o. The 5 pillars, Membership, Chairs, Priority countries, Road Map, the 4 barriers holding back progress, , 10-point action plan, the Secretariat (incl housing at UNAIDS), the Dashboard, Country Scorecards 2017, 2018, 2019, Rapid TA provision, Website (& resources), 3 Progress reports & Progress meetings, Updates to PCB,
Prevention Advisory group etc.

- Final report, PowerPoint mid July 2020

5. Reference group

The existing Global Prevention Working Group (PWG) will function as a reference group for the review. The PWG group will provide strategic guidance for the evaluation, and be invited to provide inputs at 2 key stages of the review:
1. Inception report with detailed approach and methodology
2. Draft report of findings and recommendations

The external review will be funded by and will be commissioned by the Prevention Coalition Secretariat based in UNAIDS, Geneva, in close consultation with GPC co convenor, UNFPA, the co-chairs and the PWG members. The Consultant or Consultancy Team will be selected by competitive bidding.

6. Qualifications

Overall the Consultant or Consultancy Team should demonstrate qualifications, experience and competencies in the following areas:
- a) Demonstrated expertise in evaluation methodologies; understanding UN organisations
- b) Excellent knowledge of HIV prevention including the 5 pillars and Road Map components
- c) Excellent knowledge of linkages between HIV prevention and testing, treatment and care and broader health aspects including SRHR.
- d) Excellent understanding of country prevention programme implementation
- e) Experience engaging with and soliciting the views of a broad range of stakeholders, including bilaterals, foundations, funding mechanisms and NAC Directors, civil society from across regions and constituencies;
- f) Superior oral and written and communication skills.
- g) Ability to meet tight deadlines with quality products.

7. Team roles and responsibilities

Team Leader (22 days)
- Provide technical and strategic guidance to the team
- Liaise with the GPC team in Geneva
- Review relevant documents
- Conduct interviews where appropriate
- Lead the analysis of the findings from the evaluation
- Lead the writing of the inception, interim, and final reports

Support Consultants x 2 (18 days each)
- Review relevant documents
- Conduct interviews
- Support the analysis of the findings from the evaluation
- Contribute to the writing of the inception, interim, and final reports

Annex 2. Review Questions Matrix

1. How appropriate is the architecture/design of the GPC to achieve operational effectiveness and key activities?

Assumptions to be tested	Indicator	Sources of Information	Data Collection	Comments
1.1. The GPC Secretariat and GPWG are appropriately constituted for operational effectiveness and key activities	➢ Map of the structure, roles and responsibilities of the GPC Secretariat, Founders and GPWG ➢ Staffing, in-house skill sets and housing in UNAIDS ➢ Types and degrees of leverage or traction the GPC Secretariat and GPWG hold ➢ Membership representativeness of the GPC ➢ Membership of and linkages between secretariat and GPWG	GPC documents GPC and GPWG members Regional and country HIV focal points Meeting reports	KIIs Document review	
1.2. The GPC operates effectively to influence progress on-HIV prevention	➢ How the GPC actors are set up to influence all 10 steps of the Road Map at country level ➢ GPC financial resources provided to implementing countries (amounts, how allocated) to implement GPC activities ➢ Stakeholder assessments of the value of GPC activities ➢ Communication and linkages between global, regional and national levels of the GPC elements/actors ➢ Design of key activities of GPC and GPWG ➢ Implementation of key activities of GPC ➢ Country selection criteria ➢ Website management and use	GPC and PWG members GPC and PWG work plans Meeting reports Updates to PCB and to PWG Website, hits	KIIs Document review Website review	Technical assistance and contribution to 10 steps and pillars addressed below

2. How successful has the GPC been in addressing political leadership, reducing legal and policy barriers, and increasing HIV prevention funding?

Evaluation question / outcome	Indicators	Data sources	Methods	Comments
2.1. The GPC has strengthened political leadership for HIV prevention	➢ Advocacy by leaders for primary prevention in the HIV agenda, and the overall health agenda ➢ Changes in identified barriers and challenges in the political landscape, at global, regional and national levels ➢ Continuing barriers and challenges ➢ Stakeholder perceptions of the contribution of the GPC	GPWG CO HIV focal points (NACs, CS)	KIIs Document review	This addresses key challenges in the political landscape
2.2. The GPC has contributed to addressing funding allocations for HIV prevention	➢ Changes in guidance and support for primary HIV prevention in funding mechanisms like Global Fund and bilateral donors such as PEPFAR, DfID, and other bilaterals (guidance, technical support to countries, and, if available, amounts) ➢ Changes in domestic funding for HIV prevention (amounts, sources, allocation) ➢ Stakeholder perceptions of the contribution of the GPC to these changes	BMGF and other foundations Global Fund, PEPFAR and other bilateral donors GPWG members CO HIV focal points (NACs, CS)	KIIs/group interviews Document review	
2.3. Legal and policy barriers to HIV prevention have been reduced by GPC activities	➢ Changes in laws, policies, regulations and guidelines at regional and country level ➢ Other factors or changes in the political landscape at country level ➢ Stakeholder perceptions of the contribution of the GPC	Country UN teams, NACs Scorecards, laws, policies, NSPs etc	KIIs Document review	
3. How far has a wide range of UN, government and CSO stakeholders demonstrated engagement and understanding of the 2020 Road Map and demonstrated political and operational accountability to the 2016 global political commitments?				
3.1. Diverse stakeholders have demonstrated increased accountability and commitment to the HIV prevention global political commitments	➢ Amount of institutional and multi-sectoral collaboration for HIV prevention ➢ Degree of integration of HIV prevention in wider SRHR and health and welfare needs ➢ Responsiveness and participation in GPC activities (GPC meetings, South-South consultations; communities of practice) ➢ Uptake of the 10 steps of Road Map to 2020 in national and sub-national plans ➢ Timely submission data for of GPC scorecards, surveys and	UN prevention focal points and UNCT, NACs, CS Global reports Country scorecards and posters Shadow reports Meeting reports Dashboard	KIIs Document review	This goes beyond the GPC/Road Map and may overlap with some other questions, e.g. funding, policy, implementation

	reports	4. To what extent has the GPC contributed to systematic implementation of combination prevention programmes at scale, including the five prevention pillars?		
4.1. Technical assistance to address the gaps is efficient and effective	➢ Gaps in country capacity to implement the 10 steps are defined and costed ➢ Extent and timeliness of TA provided ➢ Quality of TA ➢ Staff and organisational capacity to plan, implement, monitor and evaluate primary prevention in countries	Country feedback (NACs, CS, other) Records of TA	KIIs Document review	
4.2. GPC countries have addressed the 10 steps of the Road Map and the five key pillars in line with strategic information and gaps	➢ Population estimates and gap analyses are updated for the 5 pillars ➢ Affected communities are effectively engaged ➢ Resource needs are defined ➢ National strategic and operational plans are placing emphasis and resources towards 10 step activities			
4.3. The GPC and 2020 Road Map are contributing to achievement of combination programmes at scale	➢ Increase use of in strategic information including size estimates of key and vulnerable populations ➢ Implementation of five prevention pillars according to epidemic profiles	GPWG Global reports Country scorecards and posters Meeting reports Dashboard	KIIs Document review	Too early to measure changes in HIV incidence and HIV service coverage and

Annex 3. Instruments (Illustrative)

Annex 3.A   Document Review Template

DATE REVIEWED:	
REVIEWER:	
SOURCE (FROM WHOM)	
TITLE:	
AUTHORS (APA FORMAT):	
YEAR OF PUB	
CITATION (APA FORMAT):	
DATA OR QUOTES FOR THE REPORT (IF RELEVANT) WITH PAGE LOCATION FOR CITING	

This document contains data supporting or not supporting the assumption	Info Supporting	Not Supporting
1.1. The GPC Secretariat and GPWG are appropriately constituted for operational effectiveness and key activities	➤	➤
1.2. The GPC operates effectively to influence progress on-HIV prevention	➤	➤
2.1. The GPC has strengthened political leadership for HIV prevention	➤	➤
2.2. The GPC has contributed to increasing funding allocations for HIV prevention	➤	➤
2.3. Legal and policy barriers to HIV prevention have been reduced by GPC activities	➤	➤
2.4. GPC countries have addressed the 10 steps of the Road Map and the five key pillars in line with strategic information and gaps	➤	➤
3.1. Diverse stakeholders have demonstrated increased accountability and commitment to the HIV prevention global political commitments	➤	➤
4.1. Technical assistance to address the gaps is efficient and effective	➤	➤
4.2. The GPC and 2020 Road Map contributed to achievement of combination programmes at scale	➤	➤
Other Notes:		

Annex 3.B. GPC External Review Information and Informed Consent

Informed Consent Statement for Key Informant Interviews

Draft 04-16-2020

To reinvigorate national and global efforts in primary HIV prevention (PHP), 50 like-minded organisations - UNAIDS Co-sponsors, civil society networks, funding partners and 28 UN Member States - have joined to form the Global HIV Prevention Coalition, co-led by the UNAIDS Secretariat and UNFPA, and overseen by the Global HIV Prevention Working Group. After three years of implementation, the working group has tasked UNAIDS to commission an external review of the Coalition, examining its support to countries in implementing the 2020 Road Map and to make recommendations for the way forward both for the GPC and for the agenda for HIV prevention for 2021-2025.

The review is being designed to address four over-arching questions:

1. How appropriate is the architecture/design of the GPC to achieve operational effectiveness and key activities?
2. How successful has the GPC been in addressing political leadership, reducing legal and policy barriers, increasing HIV prevention funding and implementation of HIV programming to scale, congruent with the country's epidemic scenario? What have been the main challenges?
3. How far has a wide range of UN, government and CSO stakeholders demonstrated engagement and understanding of the 2020 Road Map and demonstrated political and operational accountability to the 2016 global commitments?
4. To what extent, and how, has the GPC contributed to systematic implementation of combination prevention programmes at scale, including the five prevention pillars?

You, as a key informant, will be a vital source of information regarding the experiences and insights of the Coalition's stakeholders regarding these four broad issues and we solicit your cooperation to join in a 30-60 minute interview by telephone or Skype. The interviews will be based on a discussion guide and the interviewer may ask that your discussion be recorded, to help him/her to draft an accurate summary after the interview. If a recording is made, it will be erased after the interview summary is completed.

Interview summaries will remain confidential, accessed only by the three-member review team. The information you provide will not be linked to you personally. Your opinions will be synthesized with those of other informants, but we might include noteworthy quotes in the report, which will be identified only by the speaker's gender and stakeholder group (e.g., Civil Society Organisation). If you do not wish to have anything you mention quoted, please let us know now.

Your participation in this discussion is completely voluntary. You may choose to refuse to participate or not answer some questions, or to terminate the interview. There are no consequences for non-participation. Nor will there be any payment or allowances for your participation.

We value your contribution to this review and look forward to speaking with you. Your consent to be interviewed by the ER team will indicate your consent to these conditions.

Thank you very much for your consideration.

Annex 3C. Illustrative Key Informant Interview Guides

GPC External Review Interview Guide[175] for GPWP

Interviewer: BdeZ   **LG**   **HJ**

Date and Time:	#
Interviewee(s) name(s), position(s) and organisation(s):	
Contact information (lead person):	

Q#	Overarching questions and assumptions and areas to probe
	Warm up **Welcome, introduction and purpose of interview, assurance of confidentiality and note re recording (plus request for follow up by email if needed)**
	General orientation: Length of involvement in GPWG and roles, including at regional or country level (probe what, where, e.g. including re 10 steps)
	On a scale of 1-5, how effective would you rate the GPC in influencing the HIV prevention agenda globally, and in GPC countries (5 being most effective)? - Brief probe as to why. What was most or least effective?
	On a scale of 1-5, how effective would you rate the GPWG in influencing the HIV prevention agenda globally, and in GPC countries (5 being most effective)? - Brief probe as to why. What was most or least effective?
1	**Focus Question 1: How appropriate is the architecture/design of the GPC to successfully execute activities to achieve the 2020 Road Map?**
1.1	**Assumption: The GPC Secretariat and the GPWG are appropriately constituted for operational effectiveness**
1.1.1	Are the respective roles and responsibilities of the **GPC** co-**chairs,** the **Secretariat** and the **GPWG** clear? Are they effectively undertaken? What improvements would you like to see in clarity and /or efficiency?
1.1.2	How relevant is the work of the GPC Secretariat to the overall HIV and AIDS response?
1.1.3	Do the GPC, Secretariat and GPWG have the appropriate membership and structure? Might any changes in the membership or structure of the GPC, Secretariat or GPWG make them more effective? Probe, including a focus on greater regional level involvement.
1.2	**Assumption: The GPC operates effectively to influence progress on primary HIV prevention**
1.2.1	Does the GPC Secretariat have adequate funds and other resources to expedite or support the GPC activities? What might it do with greater resources? Would you recommend changes to the allocation of the resources it has?
1.1.2	How effectively do the GPC Secretariat and GPWG communicate? Probe re any changes needed in communication with GPWG, country and regional focal points, TSM, et al.
2	**Focus Question 2. How successful has the GPC been in addressing political leadership, reducing legal and policy barriers, and increasing HIV prevention funding in line with the country's epidemic scenario. What have been the main challenges?**
2.1.	**Assumption - The GPC has strengthened political leadership for HIV prevention**
2.1.1	How have changes in the global/regional political landscape in the past three years contributed to increased or decreased emphasis on primary HIV prevention? Probe for country examples
2.2	**Assumption: The GPC has contributed to increasing funding allocations for HIV prevention**
2.2.1	Any comment on changes in HIV funding allocations for HIV prevention in the past three years? Which components of combination prevention are being best funded? Least funded? How have major donor agencies including the Global Fund and private funding sources changed their prevention funding

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[175] Note that items in bold provides background; they will not be spoken.

	priorities? How did the work of the GPC contribute to these changes? Probe for examples
2.3	**Assumption: Legal and policy barriers to HIV prevention have been reduced by GPC activities**
2.3.1	How far did the GPC Secretariat contribute to changes in laws, policies, regulations or guidelines at regional and country level? Probe
2.3.2	How far did the GPWG contribute to changes in laws, policies, regulations or guidelines at regional and country level? Probe
2.3.3	How is the GPC Secretariat contributing to HIV prevention amid the COVID-19 epidemic?
2.3.4	How is the GPWG contributing to HIV prevention amid the COVID-19 epidemic?
3	**Focus Question 3: How engaged are UN, government and CSO stakeholders in the 2020 Road Map and how far do they demonstrate political and operational accountability to the 2016 prevention commitments?**
3.1	**Assumption: diverse stakeholders have demonstrated increased accountability and commitment to the HIV prevention global political commitments through implementation of the 2020 Road Map**
3.1.1	Do you consider the 10 steps of the Road Map to be the most appropriate and useful to strengthen HIV combination prevention? Probe (including re possible gaps)
3.1.2	How far do you think the GPC Secretariat has influenced government, multilateral and CSO commitment to and accountability for achieving the 10 steps of the 2020 Road Map? Probe
3.1.3	How far do you think the GPWG has influenced government, multilateral and CSO commitment to and accountability for achieving the 10 steps of the 2020 Road Map? Probe
3.1.4	Has the GPWG directed extra effort to support any particular steps of the Road Map that countries found challenging? Probe
4	**Focus Q 4: Extent of GPC contribution to systematic implementation of combination prevention programmes at scale, including the five prevention pillars** **General/coordination/ etc; AGYW; KP; Condoms; VMMC; PrEP; Other**
4.1	**Assumption: Technical assistance to address gaps in combination prevention at scale is efficient and effective**
4.1.1	Do you consider the 5 prevention pillars to be the optimal way to focus on combination prevention? Probe regarding pros and cons of this structuring of the response
4.1.2	How well has the coordination of the technical assistance worked to provide timely and quality TA in response to country requests for assistance toward prioritizing and implementing each of the 5 pillars/priority HIV prevention services? Probe regarding country feedback received
4.1.2	Which of the following GPC materials have you found to be most used and most productive (most worth the cost and effort)? • Tools for rapid review of systems, strategies and management arrangements for HIV prevention • Prevention Self-Assessment Tools (PSAT) across each HIV prevention pillar • Standard ToR for different Road Map actions • Guidelines for each of the 5 pillars/priority HIV prevention services • Annual progress survey on Roadmap implementation • Annual scorecards • Summary scorecards per pillar • Country posters • Social media platforms [GPC website; Facebook page; Twitter feed] • GPC reports, such as semi-annual progress reports; NAC Directors' meeting reports • Other?
4.2	**Assumption: The GPC and 2020 Road Map contributed to the achievement of combination programmes at scale**
4.2.1	What do you consider have been the most effective contributions of the GPC and GPWG to the achievement of combination programmes at scale? Probe for country and regional examples
4.2.2	What do you consider have been the least effective efforts of the GPC and GPWG to the achievement of combination programmes at scale? Probe for specific reasons and examples
	GENERAL PROBE
5.1	**Recommendations for the continuation of/changes to the GPC and GPWG structure and membership**

5.2	**Recommendations for changes in how the GPC and GPWG operate (developing and supporting priority activities)**	
5.3	**Recommendations for the future direction of HIV prevention**	
5.4	**Is there anything else you would like to share?**	

Thank the interviewee, reconfirm confidentiality and confirm the possibility of brief follow up for clarification should this be needed.

Annex 3.D.   Illustrative Key Informant Interview Summary Form

Interviewer: BdeZ   LG   HJ

Date & time of interview:	#
Interviewee(s) name(s), position(s) and organisation(s):	
Contact information (lead person):	
Interviewee was (circle one): Alone &uninterrupted Alone & interrupted Others present	

Role of KI/institution (in relation to HIV prevention and to GPC):				
Main area of interview focus:				
Relevance - check all that apply				
RQ1	RQ2	RQ3	RQ4	Other
Summary of key points:				
Conclusions:				
Recommendations:				
Gaps:				
Any other points of note:				
Further references:				

Annex 4.   Key Informants Interviewed

Name	Post/title and Organisation
Global Prevention Working Group Members and GPC Founders **(* Also Cosponsors)**	
Rachel Baggaley	Coordinator Testing, Prevention and Populations, Global HIV, Hepatitis and STIs, WHO
Elizabeth Benomar*	GPWG Co-Convenor, UNFPA
Alvaro Bermejo	Director General, International Planned Parenthood Federation, GPWG Co-Chair
Gina Dallabetta	Senior Program Officer, Bill and Melinda Gates Foundation
Nduku Kilonzo	NACC Chair, Kenya
Marie Laga	Professor, Institute of Tropical Medicine, Antwerp
Chewe Luo*	Chief of HIV/AIDS Section, UNICEF
Susie McLean	Senior HIV Prevention Advisor, PEPFAR
Nyasha Sithole	Regional Programmes Administrator AfriYAN Regional Lead, Young Women's Advocacy, Mentorship & Training AfriYAN/Athena
Christine Stegling	CEO, Frontline AIDS
Ruth Morgan Thomas	Global Coordinator, Global Network of Sex Work Projects
Sheila Tlou	Ex RST ESA Regional Director, UNAIDS, GPWG Co-Chair
Heather Watts	Director of HIV Prevention, PEPFAR
David Wilson*	Global AIDS Program Director, The World Bank
Raymond Yekeye	Director of Programmes, NAC Zimbabwe
UNAIDS Secretariat and UNFPA (GPC Co-conveners) and GPC Secretariat	
Clemens Benedikt	Senior Advisor, Prevention, UNAIDS
Winnie Byanyima	Executive Director, UNAIDS
Justine Coulson	Regional Director ai UNFPA ESARO
Bidia Deperthes	Global HIV Prevention Advisor, UNFPA
Shannon Hader	DExD Programmes, UNAIDS
Jose Antonio Izazola	UNAIDS, Special Advisor on Resource Tracking and Financial Analysis
Natalia Kanem	Executive Director, UNFPA
Wiebke Kobel	Programme Officer, Prevention, UNAIDS
Alankar Malviya	UNAIDS Fast Track Advisor ESA Region
Tim Martinau	DExD Management, UNAIDS, UNAIDS Director Fast Track Implementation
Innocent Modisaotsile	ESARO Regional Advisor, HIV Prevention, UNFPA

Paula Munderi	GPC Coordinator, UNAIDS
Souad Orhan	Technical Officer, Prevention, UNAIDS
Salil Panakadan	UNAIDS Fast Track Advisor, AP Region
Andrey Poshtaruk	UNFPA HIV Advisor, EECA
Hege Wagan	Senior Advisor, Prevention, UNAIDS
Donors, UNAIDS Cosponsors, Global and Regional HIV Focal Points, and other HIV Prevention Experts	
Quarraisha Abdool Karim	Associate Scientific Director, CAPRISA, South Africa
Taryn Barker	Children's Investment Fund Foundation, UK
Chris Castle	Global Coordinator for HIV, UNESCO
Judy Chang	ExD, International Network of People who Use Drugs
Mandeep Dahliwal	Director of the Health Group, UNDP
Nazneen Damji	Policy Advisor on Gender Equality, HIV and Health, UN Women
Karl Dehne	Founding head of GPC Secretariat, retired from UNAIDS
Kene Esom	Policy Specialist and Advisor, UNDP
Andreas Hilmersson	Councillor for Health and Development Issues, Swedish Embassy, Geneva
Sandra Jordan	Consultant, FP2020
Lamboli Kumboneki	Programme Officer for HIV and AIDS, SADC
Binod Mahanty	Referent, BMG, Berlin
Alankar Malviya	UNAIDS Fast Track Advisor ESA Region
Rukian Manikko	Advisor AGYW, GFATM
Innocent Modisaotsile	ESARO Regional Advisor, HIV Prevention, UNFPA
Salil Panakadan	UNAIDS Fast Track Advisor, AP Region
Andrey Poshtaruk	UNFPA HIV Advisor, EECA
Ehab Salah	Advisor on Prisons and HIV, UNODC
Fariba Soltani	Global HIV Advisor, UNODC
Ariana Stahmer	Focal Point for Prevention, UNESCO
Country Level: Brazil	
Astrid Bant	UNFPA Representative, Brazil
Clarissa Barros	International Advisory of DCCI
Marcelo Araujo de Freitas	National AIDS Coordinator, DCCI, Secretariat of Health Surveillance, MoH
Cleiton Euzebio de Lima	UNAIDS Country Director, a.i., Brazil
Juliana Givisiez	International Advisory of DCCI
Alessandra Nilo	ExD NGO Gestos, Recife
Casio Oiveira	Programme Officer for Youth, HIV and Humanitarian issues, UNFPA

Gerson Pereira	Director, Dept of Diseases of Chronic Condition and STIs (DCCI), MoH
Vieriano Terto	Vice President, ABIA NGO
Country Level: Côte d'Ivoire	
Adingra Patrice Ahoua	Consultant, HIV Prevention
Eboi Ehui	Professor, Director, Programme National de Lutte contre le SIDA (PNLS)
Venance Kouakou	Chief of Party, Heartland Alliance International
Ives Roland Koussan	HIV Program Manager ANSCI
Sandra Moulod	Director of HIV/SIDA Programme, UNFPA
Brigitte Quenem	UNAIDS Country Director, Côte D'Ivoire
Gisele Semde Abla	Chief of Party, Reve Côte d'Ivoire (DREAMS)
Country Level: Eswatini	
Wendy Benzerga	Country Director for PEPFAR, USAID
Thembisile Dlamini	Prevention Focal Point
Khanya Mabuza	Director, NERCHA
Mandisa Zwane Machalata	Country Representative, SAfAIDS
Muziwethu Nkambule	HIV Prevention Advisor, USAID (ex NERCHA)
Tim Rwabuhembat	UNAIDS Country Director
Precious Shongwe	Programme manager, SNYP+
Nqobile Tsabedze	Director of Grant Management Unit, CANGO
Country Level: Iran	
Shahab Azemati	CCM Oversight, CS Network
Mina Bahramabadian	Chair of Board, Chatra NGO
Fardad Doroudi	UCD UNAIDS
Leila Joudane	UNFPA Representative
Parvin Kazerouni,	Head of HIV/AIDS Dept, MoHME
Hedieh Khaneghahpanah	Global Fund, Iran
Hengameh Namdari,	CDC Prevention Focal Point and M&E Specialist NAC (SIP), Iran
Country Level: Kenya	
Parinita Bhattacharjee	PHDA, MoH TSUs for KPs and VMMC
Gloria Bille	Fast Track Advisor, UNAIDS Kenya
Lilian Langat	Programme Officer, UNFPA Kenya
Catherine Ngugi	Director NASCOP, Ministry of Health
Ademola Olajide	UNFPA Representative, Kenya
Medhin Tsehaui	UCO, UNAIDS Kenya
Country Level: Malawi	
Nuha Ceesay	UCD Malawi, UNAIDS

Andrew Gonani	Director, NAC
Elin Henrysson	Senior Programme Officer UNAIDS
Won Young Hong	UNFPA Representative, Malawi
David Kamkwamba	JONEHA
Grace Kumwanda	Pakachere
Chimwemwe Mablekisi	Director of HIV and AIDS Programme, NAC
Humphreys Shumba	HIV Prevention Focal point, UNFPA
Country Level: Ukraine	
Anastasia Dieiva,	Executive Director, 100%Life NGOL
Marina Novachuk	Senior Advisor, UNAIDS Ukraine
Elena Voskresenskaya,	Executive Director, AIDS Foundation East-West, Ukraine
Pavlo Zamostian	UNFPA Assistant Representative, Ukraine

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