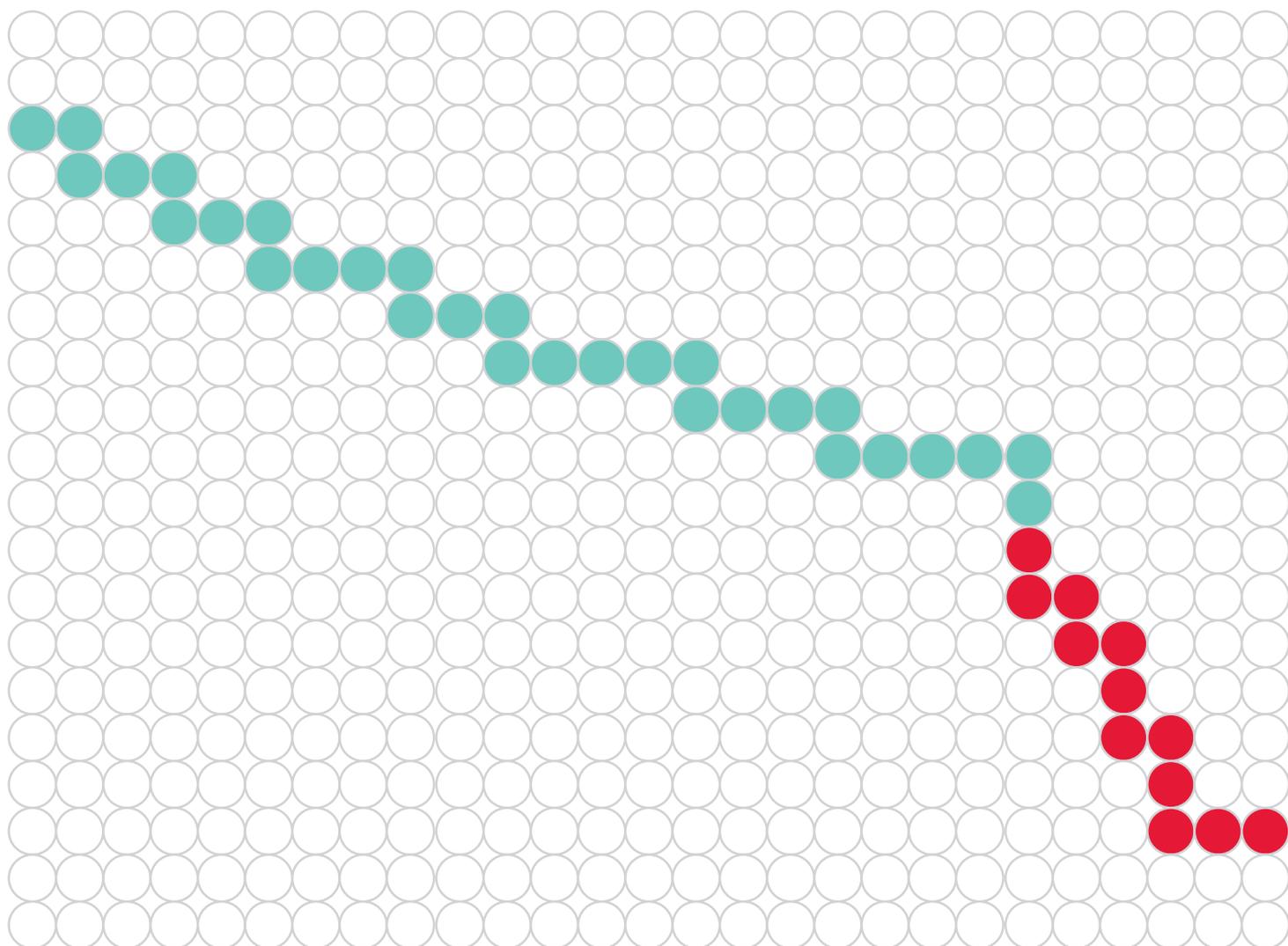


HIV Prevention 2020 Road Map

Accelerating HIV prevention to reduce new infections by 75%



2016 United Nations political declaration on ending AIDS: 2020 Global Prevention Targets and Commitments

Impact

- Reduce the global numbers of people newly infected with HIV globally to fewer than 500 000 (75% reduction against 2010 targets)
- Reduce the number of adolescent girls and young women newly infected with HIV globally to below 100 000

Coverage

- Ensure that 90% of people at risk of HIV infection have access to comprehensive HIV prevention services, including:
 - all young people in high prevalence settings, and
 - key populations everywhere, including sex workers, men who have sex with men, transgender people, people who inject drugs and prisoners

Outputs

- Ensure that:
 - 3 million people at high risk access pre-exposure prophylaxis*
 - an additional 25 million young men are voluntarily medically circumcised in 14 countries in Africa**
 - 20 billion condoms per year are made available in low- and middle-income countries***

Policy

- Remove policy barriers to access to prevention services and commodities
- Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations

Financing and sustainability

- Allocate 'one quarter' of total HIV budget for prevention on average****
- Ensure that at least 30% of service delivery is community-led.

* Equals approximately 10% of those at high risk

** 90% of 10- to 29-year-olds circumcised

*** Equals 25–50 condoms per male per year in high-prevalence countries

**** Depends on HIV prevalence and treatment costs

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About the Prevention 2020 Road Map

The Prevention 2020 Road Map provides the basis for a country-led movement to scale up HIV prevention programmes as part of Fast-Tracking a comprehensive response to meet global and national targets and commitments to end AIDS as a public health threat by 2030.

The Road Map was prepared through a consultative process that brought together more than 40 countries and organizations, including civil society organizations, networks of people living with HIV, faith-based organizations, networks of key populations¹ and international organizations and foundations, to chart the way forward to achieving global HIV prevention goals by 2020. Country assessments and national consultations were organized in participating countries towards reaffirming national leadership for HIV prevention, reviewing progress and discussing accelerated action for prevention. Thematic consultations and case study reviews were also conducted to develop key elements of the Road Map, most of which are also contained in a global results framework first proposed in a journal article in 2016 (Annex 1).

The Road Map is relevant for all low- and middle-income countries, but it focuses on 25 countries² with high numbers of new infections in adolescents and adults in 2016 (referred to in this document as “coalition countries”). Exceptional international and national efforts are needed in these countries, which account for almost 75% of new adult HIV infections globally. All countries, however, need to intensify HIV prevention efforts to meet commitments to end the AIDS epidemic.

The focus of the Road Map is on HIV primary prevention and the promotion and provision of effective tools to prevent HIV infections. It emphasizes the empowerment of adolescent girls, young women and key populations at risk so that they can protect themselves and stay free of infection. Primary prevention complements the preventive effects of treatment—they are mutually supportive. Primary prevention programmes are often the first entry point for individuals to HIV testing and treatment. Community peer-led prevention programmes are also critical to reduce stigma and discrimination, which is key to the success of both prevention and treatment. Meanwhile, expanded access to testing and treatment encourages people at risk to check their HIV status; this in turn provides the opportunity to retain people who test negative in ongoing prevention programmes.

Combination prevention packages all comprise a range of biomedical, behavioural and structural approaches, including testing and linkage to care, and efforts to address policy and human rights barriers.

*In the past and present,
and well into the future,
primary prevention is an
essential component of
the HIV response.*

¹ Includes sex workers, men who have sex with men, people who use drugs (particularly people who inject drugs), transgender people and people in prison.

² Angola, Brazil, Cameroon, China, Côte d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mexico, Mozambique, Namibia, Nigeria, Pakistan, South Africa, Swaziland, Uganda, Ukraine, United Republic of Tanzania, Zambia and Zimbabwe.

Declines in new HIV infections remain too slow

Tremendous progress in the AIDS response over the past 15 years has inspired new commitments and targets. In 2016 United Nations Member States committed to reducing new HIV infections to fewer than 500 000 annually by 2020—a 75% reduction compared with 2010—and ending AIDS as a public health threat by 2030.

The United Nations General Assembly agreed in June 2016 that ending AIDS as a public health threat by 2030 requires a Fast-Track response, with three milestones to be reached by 2020:

Reduce new HIV infections to fewer than 500 000 globally.

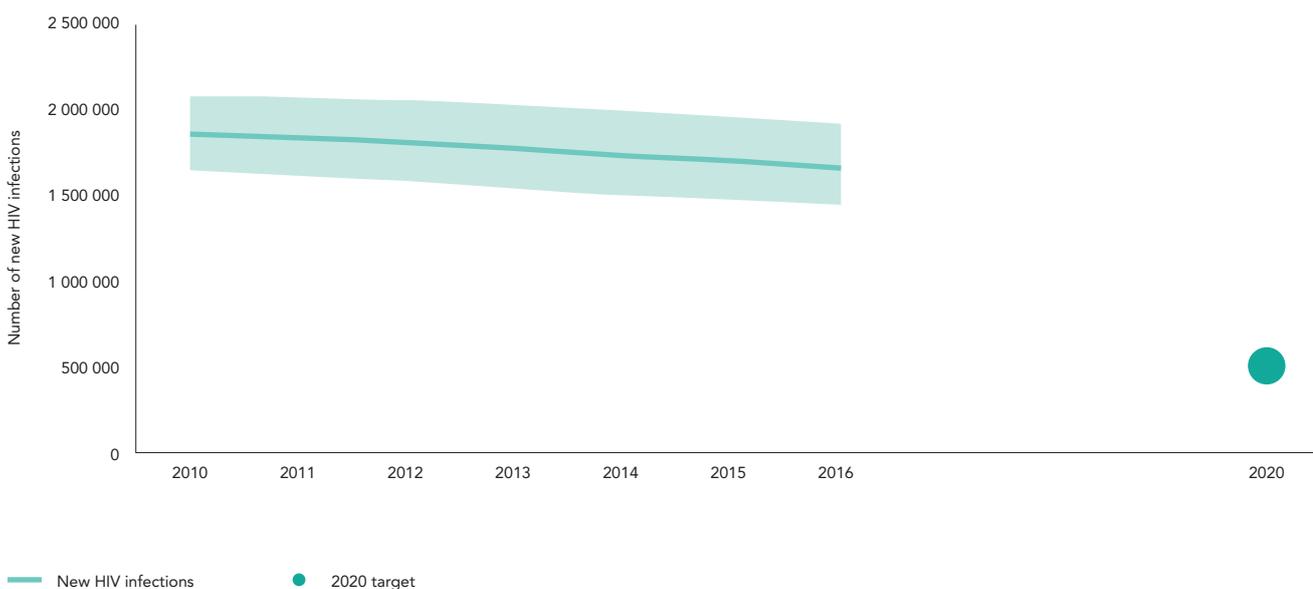
Reduce AIDS-related deaths to fewer than 500 000 globally.

Eliminate HIV-related stigma and discrimination.

The remarkable scale-up of antiretroviral therapy has put the world on track to reach the target on AIDS-related deaths. Intensive efforts to eliminate new HIV infections among children and keep their mothers alive have achieved steep declines in the annual number of new infections among children. Declines in new HIV infections have been too slow, however, and global HIV prevention targets are being missed by a wide margin, with 1.7 million new infections among adults still estimated to have occurred in 2016, a decline of only 11% since 2010 (Figure 1). Most reductions have occurred in high-prevalence countries in eastern and southern Africa, whereas new HIV infections in other regions have declined more modestly or even increased, as in eastern Europe and central Asia. Trends in new infections among key populations globally have either stagnated (among sex workers) or increased (among people who inject drugs and men who have sex with men).

UNAIDS and partners are considering new metrics related to epidemic transition and progress toward the end of AIDS. These measurements will be included in global and country frameworks as they become operational.

Figure 1. New HIV infections among adults (15+ years), globally, 2010–2016 and 2020 target



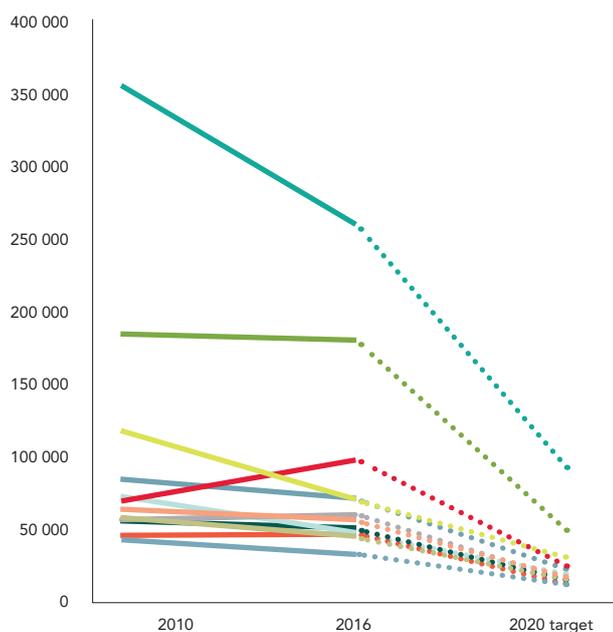
Source: UNAIDS Global AIDS Update, 2017.

* The 2020 target is fewer than 500 000 new HIV infections, equivalent to a 75% reduction since 2010.

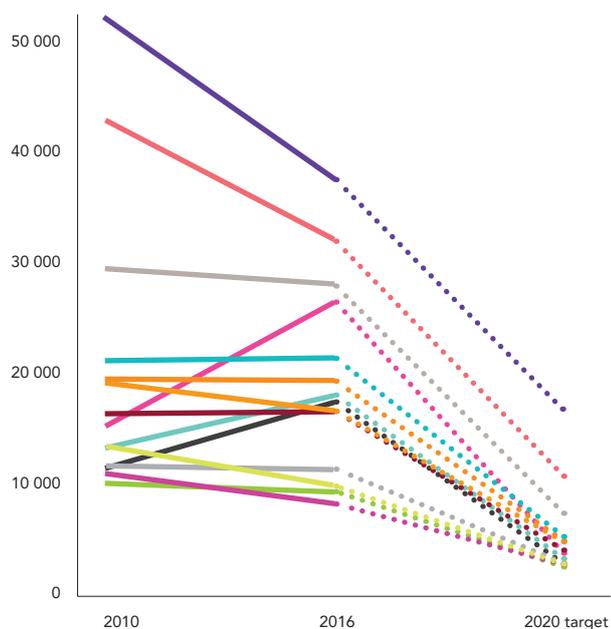
Although a few countries have achieved declines in new HIV infections among adults of 50% or more over the past 10 years, most countries have not made significant progress, and yet others have experienced worrying increases. Among the 25 prevention coalition countries, between 2010 and 2016 only 3 countries showed a decline in new infections of more than 30%, 14 countries had a modest decline of less than 30%, and 8 countries had either no decline or an increase in the number of new infections (Figure 2). No country achieved the target of the 2011 United Nations Political Declaration on HIV/AIDS to reduce sexual and drug-related transmission by 50% by 2015.

The slow decline of new HIV infections threatens further progress towards ending AIDS. It increases the need to expand treatment programmes further, incurring significant additional costs in future years, with every new infection requiring lifelong treatment. It also leads to an unabated need to maintain programmes to eliminate HIV infections among children. These programmes have been successful in providing pregnant women with access to HIV testing and early antiretroviral treatment, but have not yet sufficiently reduced HIV incidence among women of reproductive age.

Figure 2. New HIV infection trends among adults (15+ years), by country*, 2010–2016, and 75% reduction targets



	Country	2016	2020 target
	South Africa	260 000	88 000
	Nigeria	180 000	46 000
	Russian Federation**	100 000	21 000
	India	70 000	21 000
	Mozambique	70 000	30 000
	Kenya	56 000	16 000
	Zambia	50 000	14 000
	Brazil	47 000	11 000
	Uganda	47 000	18 000
	China***		
	United Republic of Tanzania	45 000	14 000
	Indonesia	45 000	15 000
	United States of America****	38 000	11 000



	Country	2016	2020 target
	Zimbabwe	37 000	16 000
	Malawi	32 000	11 000
	Cameroon	28 000	7 000
	Ethiopia	26 000	4000
	Angola	21 000	5000
	Lesotho	19 000	5000
	Pakistan	18 000	3000
	Ghana	17 000	3000
	Ukraine	16 000	4000
	Côte d'Ivoire	16 000	5000
	Mexico	12 000	3000
	Dem. Rep. of Congo	10 000	3000
	Namibia	9000	3000
	Swaziland	8000	3000

* Coalition countries, Russian Federation and United States of America.

** HIV infection in the Russian Federation on 31 December 2016. Federal Scientific and Methodological Centre for Prevention and Control of AIDS, Federal Budget Institution of Science, Central Research Institute of Epidemiology of The Federal Service on Customers' Rights Protection and Human Well-being Surveillance.

*** Data will be available end of December 2017.

**** S Singh, R Song, AS Johnson, et al. HIV Incidence, Prevalence, and Undiagnosed Infections in Men Who Have Sex with Men. Conference on Retroviruses and Opportunistic Infections. Seattle, February 13-16, 2017. Abstract 30.

A call to action: a 10-point plan for accelerating HIV prevention at the country level

This 10-point plan for accelerated action lays out the immediate concrete steps that each country can take to accelerate progress towards meeting its 2020 commitments on HIV prevention (Figure 3). All actions need to be adjusted to each country's realities and planning processes, and completed through an inclusive and participatory approach. Proposed milestones and dates are included at the end of the document.

1. Conduct a strategic assessment of key prevention needs and identify policy and programme barriers to progress

Countries will undertake an up-to-date analysis of the epidemic and carry out a stocktaking exercise to review progress in scaling up programmes in prevention priority pillars relevant to the context of their local epidemics. This will include identifying the critical policy, programmatic and structural gaps and barriers to increasing coverage and reducing HIV incidence.

2. Develop or revise national targets and road maps for HIV prevention 2020

National prevention consultations will be organized to define current prevention programme coverage and output levels based on existing data, to identify gaps in relevant prevention programme components, to set national and subnational (including city) targets, and to plan and implement key actions to fill gaps. National and subnational plans or road maps will need to be developed or revised accordingly, specifying steps for rapid scale-up to meet coverage and output targets.

3. Make institutional changes to enhance HIV prevention leadership, oversight and management

Countries will designate or reconfirm and strengthen the national lead entity responsible for coordinating and overseeing implementation of primary prevention programmes across all sectors. This will entail reviewing their mandate and specific capacities to strengthen mechanisms for cross-sectoral collaboration on HIV prevention, initiate policy reviews, design communications around prevention including through the use of new media, maximize synergies between different prevention programme components, and hold all actors accountable against targets. The national lead entity will work to strengthen national HIV prevention management systems to reflect the focus on delivery of core results with the required geographical coverage, intensity and quality.

4. Introduce the necessary legal and policy changes to create an enabling environment for prevention programmes

Countries will take concrete steps to address key barriers and create an enabling environment for successful prevention programmes, with a particular focus on lifting the structural and policy barriers to access for services among most at-risk and vulnerable groups, including young people in and out of school and key populations, reducing stigma and discrimination and providing them with equitable access, thereby ensuring the progressive realization of their human rights. Two or three key policy actions that will facilitate prevention service access will be implemented in the first year.

5. Develop national guidance, formulate intervention packages, identify service delivery platforms and update operational plans

Countries will develop or revise normative guidance for various programmes and interventions across the key pillars of prevention based on international guidance. Combination prevention packages for specific key and priority populations, and required structural and policy actions, will be defined in order to guide activities. Service delivery platforms for various interventions and packages will be identified, promoting the integration of HIV with other services, and standard operating procedures for implementers will be issued for both facility-based and community-based programmes. Based on revised national targets and defined programme packages and operating procedures, countries will develop or update operational plans, including national and subnational programmes and activities.

6. Develop a consolidated prevention capacity-building and technical assistance plan

Planning for technical assistance will form part of operational planning processes. It will involve mapping existing in-country champions and technical experts, including those currently working on prevention projects led by civil society or funded by international donors rather than the national programme. A technical assistance plan may cover mobilizing expertise on high-priority programmes components and cross-cutting and policy issues; facilitating the establishment of implementers' networks for specific pillars and the development of communities of practice; and identifying gaps and developing a consolidated request for international assistance where in-country expertise is lacking.

7. Establish or strengthen social contracting mechanisms for civil society implementers, and expand community-based responses

Countries will implement social contracting and monitoring mechanisms to allow government funding for civil society implementers and, as necessary, provide support for community systems strengthening. This will help generate demand for prevention programmes and services, facilitate access and expand the coverage of community-based programmes. It will also help facilitate, as far as possible, transitions of community-based programmes from donor to domestic funding and achieving the 2016 Political Declaration target to “ensure that 30% of service delivery is community-led”.

8. Assess available resources for prevention and develop a strategy to close financing gaps

Countries will commit to and make concrete plans for adequate investments in HIV prevention as part of a fully funded national response, so that increased domestic resources and a quarter of HIV spending on average goes towards prevention programmes. A dialogue between key domestic and international financing partners will be organized to agree on how acute gaps can be filled and transitions to domestic or private-sector funding be facilitated. All options, including reinvesting efficiency gains made in prevention or other parts of the HIV response, inclusion of specific items in health insurance and private sector schemes, HIV budget prevention earmarks to reach the “quarter for prevention” target on average, and fresh allocation for neglected components, will be considered.

9. Establish or strengthen prevention programme monitoring systems

Countries will improve routine monitoring systems that are gender sensitive and population specific to promptly identify and address implementation gaps and challenges and track programme performance at all levels of implementation, including both health and community components. Where needed and appropriate, electronic health information platforms for monitoring people on and newly enrolled in treatment will be expanded to include indicators on young women and key populations reached for instance by outreach workers, condoms, needles and syringes distributed or sold, pre-exposure prophylaxis and voluntary medical male circumcision, and other indicators as appropriate.

10. Strengthen national and international accountability for prevention

Countries will develop or adjust a shared accountability framework across sectors, civil society and implementers and provide for regular reporting of progress against results at the subnational, national and international level. The HIV prevention scorecard being developed by UNAIDS, in which scores are based on a combination of coverage, output and outcome indicators for key programme components in the Global AIDS Monitoring system, can serve as a useful tool for a regular review of performance at all levels.

Figure 3. Ten-point plan for accelerating HIV prevention at the country level



What is holding us back?

Slow progress is due to inadequate focus, scale and quality of implementation of HIV prevention programmes. Good practices exist, but they have remained the exception. In many settings, proven interventions have simply not been delivered at a large enough scale among high-priority populations to make a difference. Meanwhile, the preventive effect of antiretroviral therapy has not been fully realized because many people with HIV still do not know their HIV status or are unable to access treatment or achieve viral suppression.

There are four main, interrelated reasons for insufficient progress:

1. Gaps in political leadership

HIV prevention has often lacked resolute political leaders to champion ambitious prevention targets and plans, defend progressive public health and social policies, and advocate for the most vulnerable and marginalized people who need prevention and sexual and reproductive health services. Although there are several examples of leadership making a major difference at national or local levels, strong leadership for prevention has often been lacking where it matters most, or leadership has not been translated adequately into effective programme implementation.

2. Policy gaps

Achieving the desired prevention results often depends on additional efforts to create a conducive policy environment for prevention and address a range of factors that increase vulnerability or hinder HIV prevention service demand, access, uptake and adherence. These include punitive laws, policies and practices related to sex work, same-sex relations, and drug use and possession for personal use; stigma and discrimination, including in health-care settings; and restrictions on health services in prisons. Young people, especially adolescent girls and young women, also face many barriers in accessing comprehensive sexuality education and health and HIV services, for example due to age-of-consent policies that restrict access of adolescents to contraception, HIV testing and condoms. Extraordinary efforts are also required in humanitarian situations to ensure that people affected are protected against violence, including sexual violence, and have access to HIV prevention and treatment services and commodities.

3. Gaps in HIV prevention financing

Although high-impact prevention programmes are cost-effective and cost-saving, insufficient resources are invested in HIV primary prevention. About a quarter of HIV budgets should be allocated to prevention programmes at the country level, depending on HIV prevalence and treatment costs. In 2016, however, too many countries were spending less than 10% of HIV funds on primary prevention, while international donors were also spending less than a quarter of their budgets on HIV primary prevention. Inefficiencies in the allocation and use of available resources are also of concern. Gaps exist in all aspects of HIV prevention, but condom promotion and key population programmes are particularly underfunded. This includes gaps in funding structural interventions, such as programmes to reduce stigma and discrimination against key populations and people living with HIV.

4. Lack of systematic implementation at scale

An effective HIV prevention response requires collaboration across various sectors and the engagement of a diverse set of actors. Many programmes remain fragmented, low scale and of uncertain quality, even where funding is available and the policy environment would allow for it. Underlying causes of weak implementation include a lack of clarity about who is responsible for which programme component and weak intersectoral collaboration, a lack of country-specific programmatic targets and inadequate monitoring, and insufficient engagement of key stakeholders in the design and implementation of programmes.

How to get there

Getting back on track to reducing new HIV infections by 75% to less than 500 000 globally by 2020 requires an intensive focus on primary prevention, together with continued progress towards the treatment 90–90–90 goals³. Individual countries have shown that barriers to services can be removed and that prevention programmes can be brought to scale within a few years. Attention must be paid to the following:

Key principles and approaches

Lessons learned from countries point to three principles and two key approaches that need to be followed for prevention success. All combination prevention needs to be:

- Evidence-informed.
- Community-owned.
- Rights-based.

Only if programmes embrace interventions that have been proven to be effective and are accepted and owned by the communities they are meant to serve will they be successful. Furthermore, the right to prevention is an important element of the right of all people to the highest attainable standard of health.

Two approaches for programme design are critical:

1. A location–population approach that addresses the heterogeneity of the HIV epidemic and ensures effective and efficient planning and programming of HIV prevention services;
2. A people-centred approach that responds to the different needs of people at risk and their communities and empowers them to make informed choices about different prevention options at different stages during their life cycle.

These principles and approaches call for greater attention to providing differentiated HIV prevention packages to specific target groups, disaggregated by age, sex, gender and other characteristics, in different settings.

In most countries HIV incidence varies enormously across different populations and locations. It is vital to identify the multiple epidemics that are under way in a given country in order to identify the people that are most at risk, and to select accordingly the interventions that are likely to be most effective in reducing transmission. This process may include identifying subnational trends in the numbers of new HIV infections, categorizing geographical areas and populations according to incidence levels, and pinpointing key locations. It also involves analysing epidemic patterns by age and

³ 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment, and 90% of people on treatment have suppressed viral loads.

gender, identifying the main modes of transmission and underlying behaviours, norms and structural factors in specified geographical areas, and establishing data systems to monitor shifts in epidemic dynamics.

A consistent combination HIV prevention approach is required that provides defined packages of services, including behavioural, biomedical and structural components, tailored to high-priority population groups within their specific local contexts. A focus on supporting prevention choices helps to overcome the fragmentation of prevention programmes into distinct streams for each prevention tool or intervention, often championed by different agencies and implemented separately. This does imply, however, that local stakeholders—including local government, local civil society organizations and local communities—are at the centre of their own responses. In particular, community-based organizations can play a unique role in generating demand for various prevention options and in delivering services, and thereby can help reduce the burden on the formal health system.

The critical role of civil society

Of critical importance for the future of the prevention response is the relationship between government and community actors. Renewed prevention activism and a new compact between government and civil society organizations are needed.

Civil society is a key sector for facilitating change and achieving prevention targets, for two main reasons. Community-based organizations in all their diversity can deliver relevant and valued HIV prevention services to young people and key populations in circumstances where governments may struggle. Civil society organizations can also advocate for legal and policy reforms that would enable effective programmes to be provided at scale.

Too few governments in low- and middle-income countries provide adequate funding and support to civil society organizations that are active in HIV prevention.

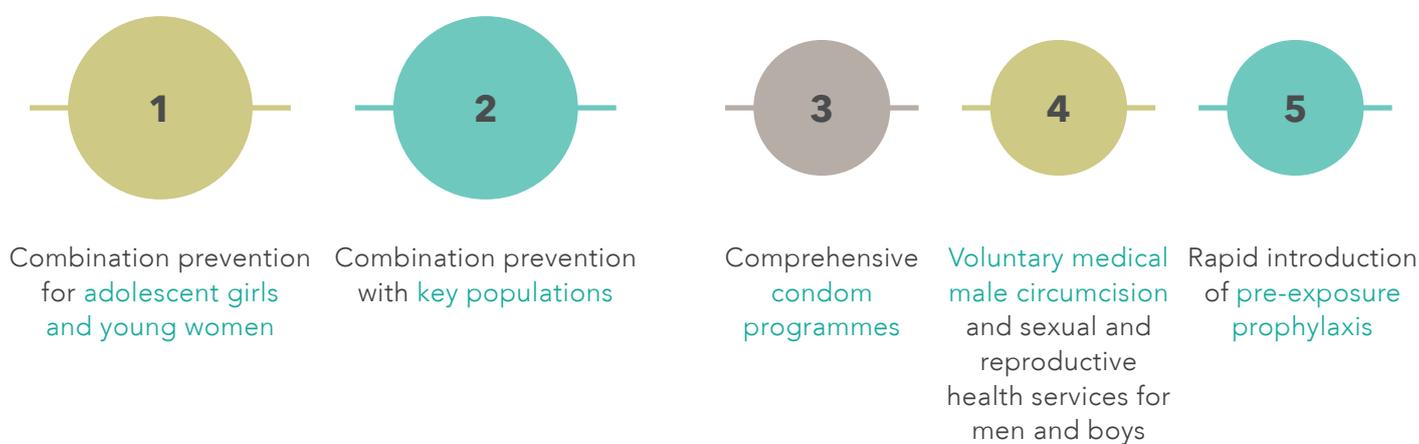
Focus on five prevention pillars

Continued HIV testing and treatment scale-up must be accompanied by a much stronger primary prevention response comprising biomedical, behavioural and structural dimensions, closely integrated with treatment. National HIV primary prevention responses must be strengthened around five central pillars, as follows, depending on epidemiological country context (Figure 4):

- 1. Combination prevention for adolescent girls, young women and their male partners in high-prevalence locations, mainly in Africa**, including the provision of information and demand generation for HIV prevention, comprehensive sexuality education, economic empowerment, such as cash transfers as appropriate, addressing harmful masculinity and gender norms and gender-based violence, and access to sexual and reproductive health services and rights, including contraception. This effort should move forward in close partnership with existing initiatives such as DREAMS, the All-in initiative, and the Ministerial Commitment on Comprehensive Sexuality Education and access to Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa.
- 2. Combination prevention programmes for all key populations** that are evidence-informed and human-rights-based, including community empowerment, peer outreach and condom distribution, harm-reduction services for people who use drugs, and access to stigma- and discrimination-free HIV testing and referral to treatment. Strengthened programmes should be implemented at scale, community-based and community-led, and tailored to the HIV and wider sexual and reproductive health needs of key populations.
- 3. Strengthened national condom and related behavioural change programmes**, including behavioural change communication and condom demand creation, adequate male and female condom and lubricant procurement and supplies, free distribution, social marketing and private-sector sales to ensure access everywhere, towards an expanded and sustainable condom market.
- 4. Voluntary medical male circumcision (VMMC)** in countries with high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health (SRH) service provision for men and boys.
- 5. Offering pre-exposure prophylaxis (PrEP)** to population groups at substantive risk and experiencing high levels of HIV incidence, with the meaningful involvement of these groups in programme design and implementation.

Pillars 2, 3 and 5 are applicable everywhere. 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. Pillar 4 is recommended in 14 countries in eastern and southern Africa.⁴

Figure 4. Combination prevention: five pillars



Source: Prevention Gap report 2016.

⁴The 14 priority countries include Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia, Zimbabwe.

Leadership for success

Government and civil society leadership needs to focus on three areas, recognizing that many countries have shown strong leadership in one or more of these dimensions at various times, but that a push in all three at once will be required to achieve the 2020 targets:

1. Leadership for measurable results

Strong political leadership at all levels is required to champion ambitious prevention programmes and impact targets and plans that address sensitive issues related to young people's sexual and reproductive needs and rights, key populations and harm reduction; to defend progressive public health and social policies; and to advocate for the most vulnerable and marginalized people who require access to prevention programmes. Bold government leadership brings together different actors and systems, promotes clear prevention strategies and targets, coordinates activities, and drives a results-oriented approach to HIV prevention. Accountability for results needs to be enforced at all levels of implementation, with regular review of progress against key targets. Mechanisms for maintaining a sense of purpose and urgency around prevention and for strengthening accountability as part of monitoring progress towards international commitments are also required at the regional and global level.

2. Leadership in creating a legal and policy environment conducive for prevention

Success depends upon efforts to create a conducive policy and legal environment for change. Strong leadership is required to promote evidence-informed and human rights-based prevention programmes and address the barriers that negatively affect HIV prevention demand, access, uptake and adherence, such as punitive laws, policies and practices, and stigma and discrimination directed at key populations. Changes may also be necessary to remove barriers faced by young people, especially adolescent girls and young women, in accessing comprehensive sexuality education and health and HIV services, such as policies and laws that prevent access without parental consent, and to provide social protection measures to reduce gender-based violence.

3. Leadership in mobilizing adequate financial resources for HIV prevention

Countries and key donors need to commit to and make plans for adequate investments in HIV prevention as part of a fully funded global response. About a quarter of HIV budgets should be allocated to prevention programmes, depending on HIV prevalence and treatment costs. Increased domestic financing for prevention in combination with efficiency gains will be needed in most cases and represents a smart investment, but international donors also need to play their part. Mobilizing resources for prevention will require coordinated national and international action. For example, sufficient consideration needs to be given to secure funding for neglected components of prevention programmes such as condom promotion and key population programmes, as well as address the structural barriers to prevention.

The sustainability of the HIV response depends on reducing the number of new infections. Effective investment in primary prevention is an investment in sustainability.

Leadership is critical to establish an enabling environment for prevention

All prevention programmes require a strong community empowerment element and specific efforts to address legal and policy barriers, as well as the strengthening of health systems, social protection systems and actions to address gender inequality and stigma and discrimination. Necessary improvements include changing legal and policy provisions and practices to remove barriers that prevent full access to education and to sexual and reproductive health, harm reduction and HIV services. As country leaders engage to address the legal and policy barriers, they will find practical rights-based solutions, to allow young people and key populations to organize themselves for risk reduction and HIV prevention, and to provide them with easy access to prevention programmes and services.

HIV prevention and Sustainable Development Goals

Efforts to scale up HIV prevention can build synergies with broader efforts to achieve the 2030 Agenda for Sustainable Development. Primary prevention of HIV contributes directly towards achieving six of the Sustainable Development Goals (SDGs), where ongoing HIV transmission currently holds back progress (Figure 5). For example, transformative AIDS responses can provide an important impetus to social protection schemes, using cash transfers to reduce HIV vulnerability and risk in ways that contribute to gender equality and the empowerment of all women and girls, support education and reduce poverty. Similarly, progress on other SDGs contributes to HIV prevention through policies that seek to leave no one behind. For example, improved opportunities for education, including comprehensive sexuality education, will empower young people and promote improved health outcomes. HIV-sensitive universal health coverage policies can play a vital role in ensuring access to key HIV prevention interventions.

Hence, HIV Prevention 2020 contributes to the Sustainable Development Goals. Efforts to achieve these goals will in turn support HIV prevention outcomes.

Figure 5. HIV prevention and the Sustainable Development Goals

3 GOOD HEALTH AND WELL-BEING 	4 QUALITY EDUCATION 	5 GENDER EQUALITY 	10 REDUCED INEQUALITIES 	16 PEACE, JUSTICE AND STRONG INSTITUTIONS 	17 PARTNERSHIPS FOR THE GOALS 
Healthy lives and well-being for all, at all ages	Inclusive and equitable quality education and promotion of lifelong learning opportunities for all	Gender equality and empowerment of all women and girls	Reduced inequality within and among countries	Reduced violence including against key populations and people living with HIV	Global partnership for sustainable development
Universal health coverage, including HIV prevention services	High-quality education, including on comprehensive sexual and reproductive health	Sexual and reproductive health and rights	Protection against discrimination alongside legal services	Promotion of the rule of law	Policy coherence
Universal access to sexual and reproductive health	Empowerment of young people and life skills for responsible and informed sexual and reproductive health decisions	Elimination of violence and harmful gender norms and practices	Rights literacy, access to justice and international protection	Effective, accountable and transparent institutions	International support for implementing effective capacity building
Universal access to drug dependence treatment and harm reduction			Empowerment of people to claim their rights and enhance access to HIV services	Inclusive, participatory and representative decision-making	

Focusing on results: towards a country-level prevention results framework

Global targets need to be domesticated to meet country contexts through a systematic country-by-country prevention target-setting process. Impact and outcome targets need to be disaggregated by population group to ensure no one is left behind. Subnational targets should also be set where appropriate. For example, all districts and cities could establish their own targets for a reduction in new infections and major programme pillars plus treatment, as appropriate.

Monitoring progress against targets and establishing accountability for achieving them remains a powerful motivating tool in the global AIDS response. What gets measured gets done. A joint results-based framework for implementation serves as the basis for monitoring implementation progress and ensuring accountability for results at the national and subnational level. An example is given in Table 1.

Ideally, the country-level organizational entity responsible for coordinating prevention maintains this framework, and ensures that progress towards results is tracked and regularly reviewed, thereby ensuring shared responsibility and accountability at various levels of implementation. An HIV prevention scorecard, in which scores are based on a combination of coverage, output and outcome indicators for the key pillars of prevention, can serve as a useful tool for regular review of performance at all levels of implementation. Real-time monitoring, such as through a “situation room” mechanism, is essential for remedial action if implementation on a pillar or by one actor falls behind.

Table 1 provides an example of a country-level results HIV prevention framework. Countries may want to monitor additional indicators related to HIV vulnerability and barriers to prevention service access, including indicators of discriminatory public attitudes; stigma and discrimination in sectors other than health; the legal status of sex work, sexual orientation and gender identity, and drug use and possession for personal use; and the status of women and their decision-making power.⁵

⁵ See http://www.unaids.org/sites/default/files/media_asset/2017-Global-AIDS-Monitoring_en.pdf and <http://dhsprogram.com/data/Survey-Indicators.cfm>.

Table 1. Example of country-level results HIV prevention framework (consisting mostly of UNAIDS global monitoring indicators)

	Indicator	Baseline 2016	Target 2020			
Impact	Number of new HIV infections among youth and adults ¹		75% reduction from 2010			
	Number of new HIV infections among adolescent girls and young women (aged 15-24) ²					
	Number of new HIV infections among key populations (combined and separately) ³					
	Adolescent girls and young women, and male partners	Baseline 2016	Target 2020	Key populations ⁴	Baseline 2016	Target 2020
Access/coverage	% of high-prevalence districts covered with comprehensive prevention programmes ⁵			% of key population reached with information and services in the past 3 months ⁶		
	% condom use at last sex (by sex and partner type)			% condom use at last sex (by population)		
	% of men who are circumcised ⁷			% of people who inject drugs using sterile injecting equipment last time they injected		
	% of HIV+ adolescent girls, young women and men on treatment and virally suppressed			% of key populations living with HIV, on treatment and virally suppressed		
	Indicator	Baseline 2016	Target 2020		Baseline 2016	Target 2020
Outputs	Number of condoms distributed/sold (total, and per man aged 15-64) ⁸					
	Number of dedicated service sites available for each key population					
	Number of male circumcisions performed					
	Number of people receiving oral pre-exposure prophylaxis at end of reporting period (by population group, if feasible)					
	Number of needles and syringes distributed per person who injects drugs					
	Adolescent girls and young women and male partners	Baseline 2016	Target 2020	Key populations ⁹	Baseline 2016	Target 2020
Policy Environment	% of girls who complete lower secondary school education			Population size estimates (by population)	Yes/No	Yes/No
	% of women who experienced physical or sexual violence from a male intimate partner			Number of cases of police violence against key populations reported		
	% of women and men living with HIV who report discriminatory attitudes in the health sector			Number of key populations who report discriminatory attitudes in the health sector		
	Indicator	Baseline 2016	Target 2020		Baseline 2016	Target 2020
Prevention Financing	% of total HIV expenditure allocated for prevention (by financing source)					
	% of service delivery that is community-led					

1. Disaggregated by sex.

2. In high-prevalence countries.

3. Country-level estimation methods under development.

4. Results to be tracked separately for sex workers, men who have sex with men, transgender people, people who inject drugs and people in prison.

5. See HIV prevention among adolescent girls and young women. Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. Geneva: UNAIDS; 2016.

6. See implementation guidance in Annex 4.

7. In 14 high-priority countries.

8. In high-prevalence countries. Target-setting guidance available from UNAIDS.

9. Results to be tracked separately for sex workers, men who have sex with men, transgender people, people who inject drugs and people in prison.

A global coalition for HIV prevention

With countries and communities at the centre, an intensification and acceleration of HIV prevention will put the world on track to achieving a 75% reduction towards fewer than 500 000 infections by 2020, and to ending the AIDS epidemic by 2030. A global coalition of United Nations Member States, donors, civil society and implementers has been established to support this global prevention effort. 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.

The coalition therefore focuses on generating commitment, speed, investment and accountability towards large-scale, high coverage and good-quality implementation in all high-priority countries. Its work is guided by a worldwide plan with ambitious targets for investments and results. It will maintain a global accountability process with score cards, 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).

Commitments towards reducing new HIV infections by 75% to fewer than 500 000 by 2020

Governments will:

- **Lead on the implementation of the 10-point action plan**, including a Fast-Tracked start-up phase for the first 3 months or 100 days. As part of the 10-point plan, governments will specifically prioritize the following actions.
- **Set national prevention programme, financing and impact targets for 2020 in line with the 2016 Political Declaration and adjust national results frameworks** to ensure 90% of high-priority groups in high-prevalence settings and key populations access combination prevention.
- **Strengthen the national lead organizational entity for prevention and empower it to hold actors accountable**, increase national HIV prevention management capacity, and strengthen national accountability frameworks, including establishing real-time data monitoring and annual peer performance reviews.
- **Introduce the necessary policy changes** to address legal, social, economic and gender-related barriers to prevention programme demand, access and uptake, and create an enabling environment for prevention programmes for adolescents, young people and key populations.
- **Develop operational plans** for key prevention programmes in line with scale-up targets, including definitions of locations and populations, service packages and standard operating procedures.
- **Commit to, and make concrete plans for, adequate and sustainable investments in HIV primary prevention**, as part of a fully funded national response, so that increased domestic resources and a quarter of HIV spending on average go towards such programmes. This includes social contracting and monitoring mechanisms to allow government funding for civil society implementers in order to reach global commitments for community service delivery.

Civil society will:

- **Reinvigorate prevention activism and sensitize decision-makers at all levels** about the continued importance of primary prevention, together with the 90–90–90 treatment agenda, and advocate for evidence-informed decision-making and adequate investments using all appropriate materials and channels.
- **Strengthen the meaningful engagement** of young people, women, men, representatives of key populations and people living with HIV in HIV prevention programmes.

- **Participate fully in designing and implementing programmes** and monitoring and accountability structures to deliver HIV prevention services, and be provided with funding and support for capacity-building accordingly.
- **Hold governments and others accountable for progress towards prevention targets** through constructive advocacy and further develop community accountability structures for feedback, communication and problem-solving between community entities and government systems.
- **Unify global, regional and national civil society and activist groups and networks** in their advocacy for concrete action by governments, donors and international agencies in support of primary prevention.

Donor countries, development partners and global philanthropic institutions will:

- **Intensify support for primary prevention, considering the need to scale up both treatment and prevention**, while mobilizing resources to finance the implementation of the Road Map activities.
- **Place increased emphasis on HIV primary prevention targets** in international global and regional fora and conferences to share lessons and promote best practices in prevention policy, planning and management.
- **Sustain funding for HIV prevention across pillars, allow for sufficient transition time to increase domestic financing** and management capacity, expand on existing funds, and provide fresh resources to fill gaps in neglected prevention components such as condom programming and key population programmes, and support community-led implementation and advocacy.
- **Establish fit-for-purpose mechanisms for technical assistance for HIV prevention**, develop and disseminate implementation tools, and collect best practice examples with designated leads for each pillar's key functions (see Annex 3).
- **Provide support to set up and use harmonized accountability mechanisms** that take stock of progress towards global, regional and national prevention targets, for example in the form of scorecards or dashboards.

The business community will:

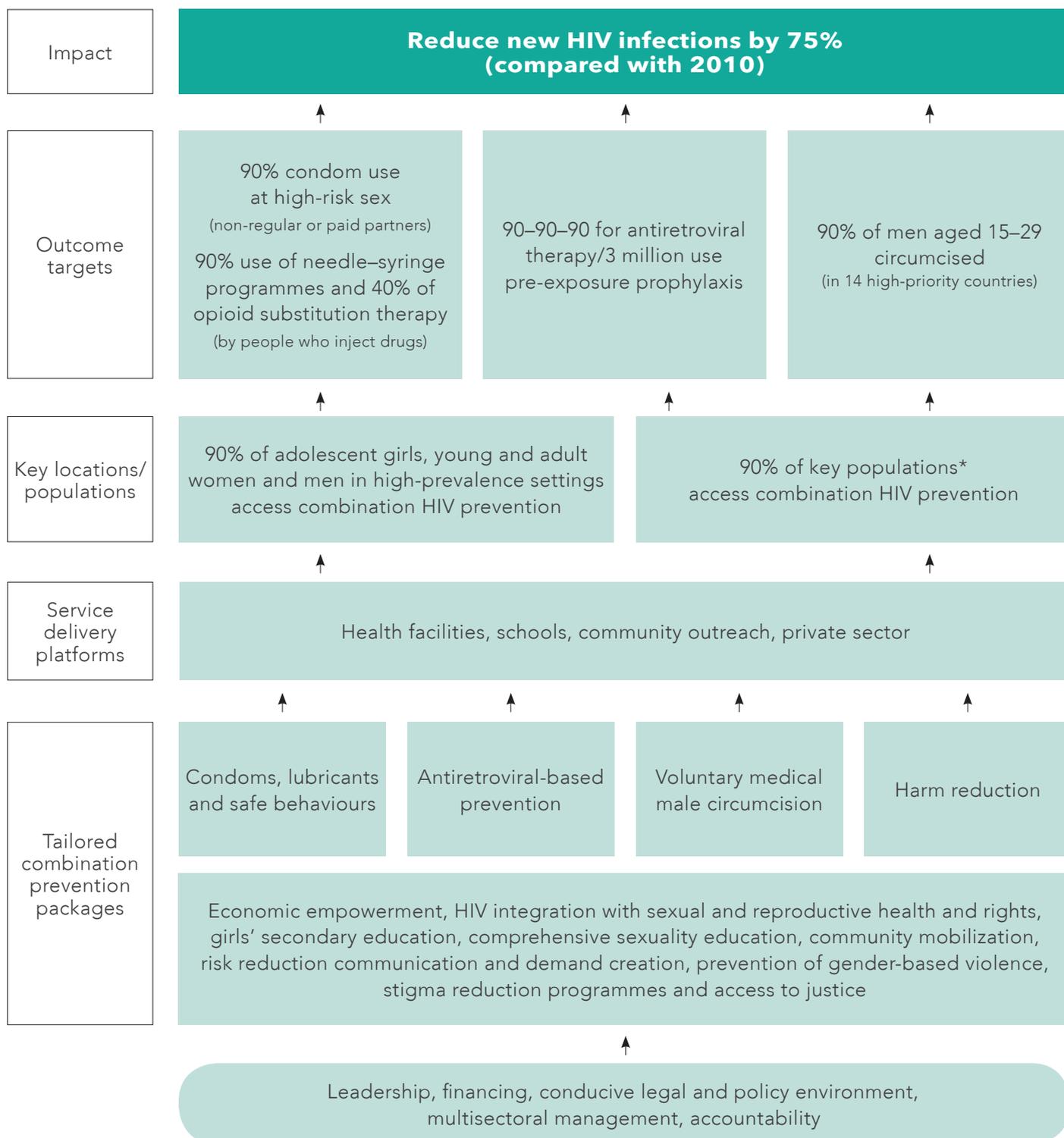
- **Take forward corporate responsibility schemes** to ensure comprehensive primary prevention services for employees, their families and communities, and advocate to reduce stigma and discrimination and all policy and legal barriers to access to prevention services.
- **Strengthen innovations in programming and service delivery approaches** for HIV prevention interventions and commodities, such as condoms.
- **Provide lessons from the private** sector that can be used to strengthen or support results-based planning and service delivery systems, such as logistics, supply chain management systems, and the use of new media technology, and provide technical support in these areas and directly support implementation as required.

Targets and milestones

2017	OCT	Global HIV Prevention Coalition and the Prevention 2020 Road Map launched
		Coalition endorses metrics for measuring progress in primary prevention using country and coalition scorecard in line with existing global AIDS monitoring system
		Countries decide on immediate actions for first 100 days (100-day plan)
	NOV	Coalition Secretariat overseen by two Coalition co-chairs, and a robust and inclusive interagency coordination mechanism established
		Global agencies disseminate guidance, and Coalition Secretariat provides appropriate tools for target-setting, assessments, planning, implementation and policy support, monitoring and evaluation
	DEC	Coalition Secretariat establishes and activates mechanism for rapid response technical assistance
		All countries, in an inclusive process, take stock of where they stand with reaching HIV prevention targets and addressing key legal, social, economic and gender-related barriers to service demand, access and uptake
		All countries have taken action to strengthen HIV prevention management and oversight capacity
	2018	FEB
All countries have set or updated national HIV prevention programme and impact targets, defined standard service packages, and updated their country road maps and plans		
All countries have identified actions for key policy changes to create an enabling environment for prevention		
MAR		All high-priority countries have a consolidated plan for prevention capacity-building and technical assistance
		All high-priority countries have organized a prevention financing dialogue exploring all options for adequate resource allocation for prevention
MAY		Initial progress against Coalition milestones and targets is presented and discussed at a ministerial meeting at the World Health Assembly, including use of the agreed Coalition scorecard
		All countries have completed or updated key population size and coverage estimates (or an approximation) and established viable mechanisms to contract, finance, support and monitor civil society organizations
		High-level political meetings on prevention have been held or other opportunities used in three regions to develop a regional prevention agenda in support of Road Map objectives, with high-priority regional actions
JUL		National HIV prevention programme managers' meeting held at International AIDS Society conference in Amsterdam to discuss progress towards targets and milestones and to share lessons learned
2019		FEB
	MAY	Second full Coalition meeting held to review progress in implementing Road Map activities and in moving towards Political Declaration commitments, using the agreed Coalition scorecards
		All countries are implementing the Road Map in line with the 2016 Political Declaration targets
	OCT	Second country prevention programme managers' meeting held to discuss results, management and capacity issues, share experiences and identify changes in technical support needs
2020	MAY	Progress against prevention coalition milestones and targets is presented and discussed at a Ministerial meeting during the World Health Assembly
	JUL	UNAIDS reports new infections and programmatic trends for 2019 showing significant improvements
2021		UNAIDS confirms that globally new adult infections declined by 75% to less than 500 000
		Estimated number of new HIV infections reduced by 75% from 2010 level in 20 of 25 high-priority countries
		All regions declare they have reached the regional initiative targets

Annexes

Annex 1. Global results framework



* Sex workers, men who have sex with men, transgender, people who inject drugs, prisoners.

Annex 2. Founding Members of the Global HIV Prevention Coalition

CO-CONVENERS

Michel Sidibé, Executive Director, Joint United Nations Programme on HIV/AIDS

Natalia Kanem, Executive Director, United Nations Population Fund

UNITED NATIONS MEMBER STATES

Angola	Mozambique
Brazil	Namibia
Cameroon	Netherlands
China	Nigeria
Côte d'Ivoire	Pakistan
Democratic Republic of the Congo	South Africa
Ethiopia	Swaziland
France	Sweden
Ghana	Uganda
Germany	Ukraine
India	United Kingdom of Great Britain and Northern Ireland
Indonesia	Ireland
Kenya	United Republic of Tanzania
Lesotho	Zambia
Malawi	Zimbabwe
Mexico	

INTERNATIONAL ORGANIZATIONS

African Union

Bill & Melinda Gates Foundation

Children's Investment Fund Foundation

Joint United Nations Programme on HIV/AIDS Secretariat and Co-sponsors

The Global Fund to Fight AIDS, Tuberculosis and Malaria

United States President's Emergency Plan for AIDS Relief

CIVIL SOCIETY ORGANIZATIONS AND NETWORKS

African Youth and Adolescent Network on Population and Development (AFRIYAN)

AVAC

Global Action for Trans Equality (GATE)

Global Forum on Men who Have Sex with Men and HIV (MSMGF)

Global Network of People living with HIV (GNP+)

Global Network of Sex Work Projects (NSWP)

International Community of Women Living with HIV (ICW)

International HIV/AIDS Alliance

International Network of People Who Use Drugs (INPUD)

International Network of Religious Leaders Living with or personally affected by HIV and AIDS (INERELA+)

International Planned Parenthood Federation (IPPF)

OTHERS

Centre for the AIDS Programme of Research in South Africa (CAPRISA)

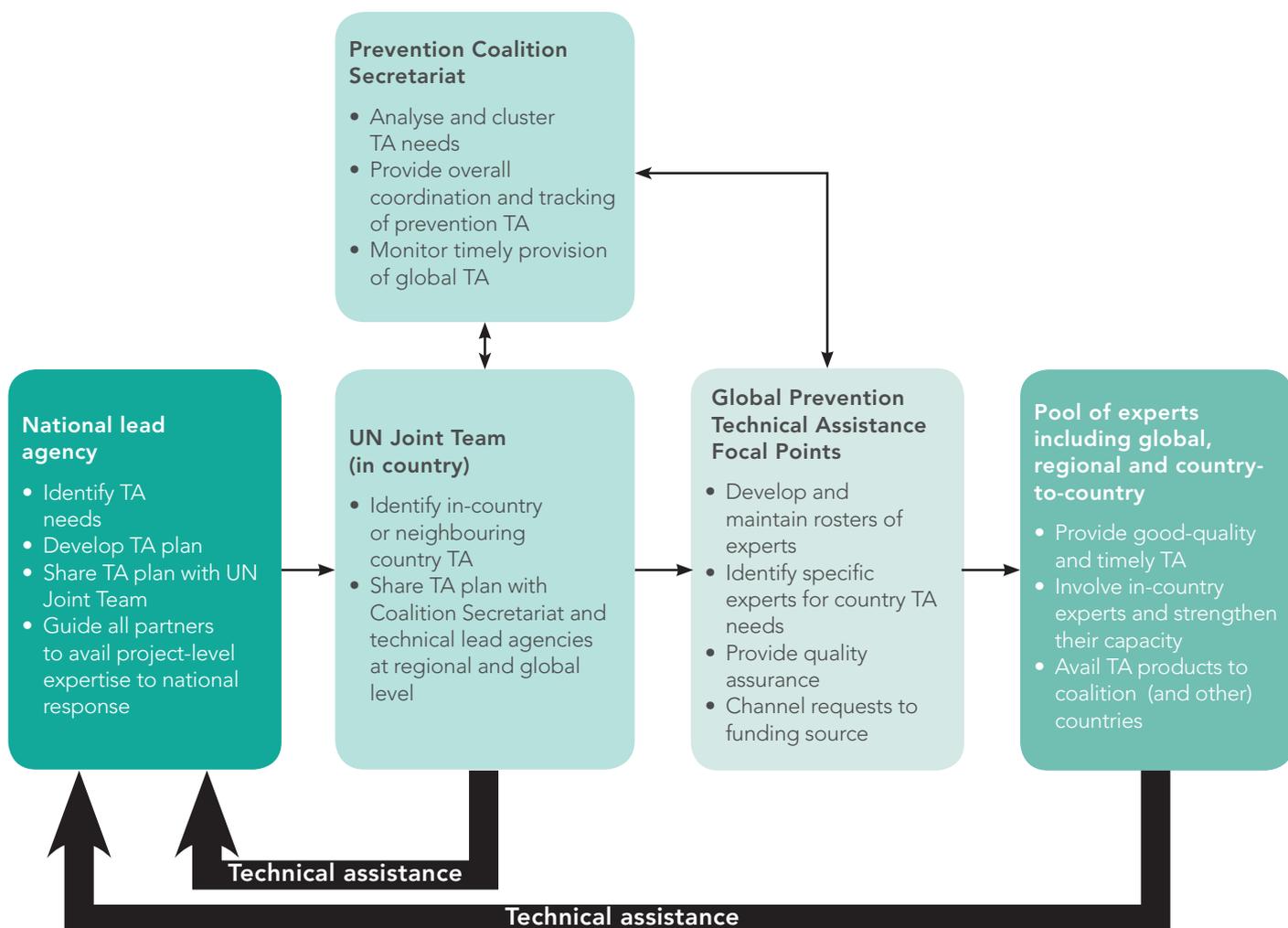
Hornet

International AIDS Society (IAS)

Joint United Nations Programme on HIV/AIDS Reference Group on HIV and Human Rights

StarTimes, China

Annex 3. Proposed mechanism for prevention technical assistance (TA)



Proposed technical assistance focal points and support agencies, by prevention area

Area of work	TA focal points	Other organizations 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 organizations and networks

* To be confirmed.

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Accelerating HIV prevention programmes

1

Conduct a strategic assessment of key prevention needs and identify policy and programme barriers to progress.

2

Develop or revise national targets and road maps for HIV prevention 2020.

3

Strengthen national prevention leadership and make institutional changes to enhance HIV prevention oversight and management.

4

Introduce the necessary policy and legal changes to create an enabling environment for prevention programmes.

5

Develop guidance, formulate intervention packages and identify service delivery platforms, and update operational plans.

6

Develop consolidated prevention capacity-building and a technical assistance plan.

7

Establish or strengthen social contracting mechanisms for civil society implementers and expand community-based programmes.

8

Assess available resources for prevention and develop a strategy to close financing gap.

9

Establish or strengthen HIV prevention programme monitoring systems.

10

Strengthen accountability for prevention, including all stakeholders.



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