HIV Prevention: From Crisis to Opportunity

Key findings from the 2023 Global HIV Prevention Coalition scorecards
HIV Prevention: From Crisis to Opportunity

Key findings from the 2023 Global HIV Prevention Coalition scorecards
CONTENTS

Introduction 4

Strong progress in parts of Africa, but less so in other regions 5
HIV incidence is declining among adolescents and young people in parts of Africa 9
Gains are uneven and there are some big gaps 12

Progress across the five prevention pillars 14

Pillar 1. Combination prevention for key populations 15
Pillar 2. Combination prevention for adolescent girls and young women in high-prevalence locations 23
Pillar 3. Combination prevention for men and adolescent boys in settings with high HIV incidence 27
Pillar 4. Promotion and distribution of condoms and lubricants 31
Pillar 5. Wider access to antiretroviral-based prevention 34

Progress on the ten main action points in the HIV Prevention 2025 Road Map 40

Conclusion: Realize the full potential of HIV prevention 52

How to do better: Combination prevention and treatment to achieve the global HIV incidence targets 53
How to do better: Boost and sustain impact 55
How to do better: Scale up differentiated prevention services 55
Now is the time to invest in prevention 56

Annex: Status of HIV prevention in GPC member countries 58

Introduction to country summaries 58
Country reports 66
References 138
Launched in 2017, the Global HIV Prevention Coalition (GPC) is striving to revitalize HIV prevention, secure greater investment for prevention programmes and map a viable path towards reaching the global prevention targets.

This sixth progress report of the GPC reviews the status of HIV prevention in 40 countries: the 28 initial focus countries of the Coalition and the 12 countries that were invited to join the Coalition in 2023. It tracks progress in the 28 initial focus countries and serves as a baseline assessment for the 12 newly invited countries.

In 2016, before the launch of the Coalition, the initial 28 focus countries accounted for about 76% of all new HIV infections globally. Due to their progress in preventing HIV infections, that share declined to 67% of all new infections in 2022. The new total of 40 GPC focus countries accounted for just over one million new HIV infections, or 76% of all people globally who acquired HIV in 2022.

This report describes and analyses key developments in HIV prevention by 2022, identifies the main challenges and opportunities and outlines priorities for the years ahead. It is divided into two main sections.
The Global HIV Prevention Coalition

The Global HIV Prevention Coalition was created in 2017 to accelerate progress on HIV prevention. The Coalition brings together governments, UNAIDS Cosponsors, donors, international and regional organizations, funding partners, and civil society organizations. In July 2022, the coalition launched a new Global HIV Prevention Road Map 2025 to further accelerate action towards achieving the prevention targets set in the 2021 UN Political Declaration on HIV and AIDS and the Global AIDS Strategy 2021–2026.

A core objective is to reduce new HIV infections globally to fewer than 370,000 annually by 2025 by ensuring that 95% of people at risk of HIV infection can access and use effective combination prevention options. Achieving that target would put countries on track to end AIDS as a public health threat. In 2023, the Coalition invited 12 additional countries to join, in part due to their rising numbers of new HIV infections.

The main body of the report reviews progress made across the five main prevention pillars, examines implementation of the ten action points in the 2025 HIV Prevention Road Map (based on results from the Scorecard survey) and discusses key priorities for the immediate future.

The annex comprises country fact sheets for all 40 focus countries. Those fact sheets present in detail the progress made in implementing HIV prevention programmes at the country level, as represented by country HIV prevention scorecards and Road Map action plans in the 28 initial focus countries and as a baseline for the 12 newly invited countries.

Globally, fewer people acquired HIV in 2022 than at any point since the late 1980s. The estimated 1.3 million [1.0–1.7 million] new HIV infections globally in 2022 represented a 38% reduction since 2010 and a 28% reduction since 2015. The overall progress largely reflects achievements in the initial 28 GPC focus countries, which together accounted for about two thirds of all new HIV infections in 2022. Reductions in annual new HIV infections (since 2016) continued to be considerably steeper in those focus countries than elsewhere (Figure 1). Countries that are providing proven prevention options—including both primary prevention and the use of treatment as prevention—at the required scale to the people most at risk of acquiring HIV are achieving large reductions in new HIV infections (1).
There have been shifts also in the distribution of new HIV infections between different UNAIDS regions (Figure 2). In 2010, eastern and southern Africa and western and central Africa accounted for about two thirds (68%) of new HIV infections globally. Since then, those two regions have recorded steep reductions in new HIV infections: declines of 55% and 50% respectively. Together they accounted for an estimated 660,000 new infections in 2022—approximately half of all new infections globally.

For the first time in the history of the pandemic, roughly equal numbers of new HIV infections are occurring in and beyond sub-Saharan Africa. That reflects both the prevention successes achieved in much of sub-Saharan Africa and the lack of comparable progress in much of the rest of the world, where the pandemic primarily affects key populations and their sexual partners who continue to be neglected in many HIV prevention programmes. New research indicates that, globally, the share of new HIV infections among key populations and their sexual partners increased from 44% of all new HIV infections in 2010 to 55% in 2022. Outside of sub-Saharan Africa, the numbers of new HIV infections have stabilized overall, though this masks the fact that annual new infections have decreased in some countries but increased in others. The absolute numbers of new HIV infections among gay men and other men who have sex with men and transgender women outside of sub-Saharan Africa—and their share of total new infections—have possibly increased since 2010 (2). This underscores the fact that the global 2025 and 2030 HIV targets cannot be achieved unless there are also steep reductions in new HIV infections among key populations and their sexual partner globally.

2 The 2021 Political Declaration on HIV and AIDS commits countries to prioritize HIV prevention and reduce new HIV infections to fewer than 370,000 per year by 2025. The prevention target for 2030 entails a 90% reduction in new HIV infections compared with 2010.
**Figure 2.** Trends in the numbers of new HIV infections (all ages) and in the proportions of new HIV infections in specific UNAIDS regions and locations, 2010–2022

a) Progress in selected regional groupings and 2025 and 2030 global targets

![Graph showing trends in numbers of new HIV infections](image)

**Source:** UNAIDS 2023 estimates.

**Note:** Eastern and southern Africa accounted for approximately 52% of all new HIV infections (all ages) globally in 2010; therefore, data for that region are disaggregated further. Separate data are also shown for South Africa, which accounted for more new HIV infections in 2010 than any UNAIDS region outside southern Africa.

b) Change in proportions of new HIV infections (all ages) in selected regional groupings

![Graph showing change in proportions of new HIV infections](image)
Figure 3. Percentage change in the numbers of people (all ages) newly acquiring HIV infections in GPC focus countries, 2010–2022

On track
Moderate progress
Limited progress
Off track

2025 target (82.5% reduction)

There have been consistent reductions in new HIV infections in most of the GPC focus countries in eastern and southern Africa, along with marked reductions in some countries in western and central Africa (including Cameroon, Côte d’Ivoire and Democratic Republic of the Congo). The more recent trends in countries such as the United Republic of Tanzania and Zambia are especially notable, given the disruptions to HIV programmes caused by the COVID-19 pandemic in 2020. Indeed, the latest data analysed by the GPC indicate that prevention programmes in most countries have recovered after the initial disruptions due to the COVID-19 pandemic. Data from the Global Fund support that conclusion. They show that the number of people reached with Global Fund-supported HIV prevention programmes fell by 10% in 2020, but quickly recovered to exceed the 2019 levels, with coverage increasing by 47% in 2021 and by another 22% in 2022 (3).

HIV incidence among adolescent girls and young women remains exceptionally high in parts of eastern and southern Africa and in specific areas in western and central Africa. But some GPC focus countries with high HIV burdens have achieved major reductions (>70%) in new HIV infections in that priority population (e.g. Cameroon, Lesotho, Malawi, South Africa, Uganda and the United Republic of Tanzania), where at least 70% fewer adolescent boys and young men acquired HIV in 2022, compared with 2010. The reductions in new HIV infections among adolescent girls and young women in a few countries (e.g. Botswana, Cameroon, Côte d’Ivoire, Eswatini and Ethiopia) equalled or exceeded reductions among their male peers.

3 Among GPC focus countries, the male/female gap in HIV incidence decline among young people was widest in Angola, Ghana, Indonesia, Mozambique, Namibia, Uganda and Zambia.
Figure 4. Percentage change in the numbers of adolescent girls and young women (aged 15–24 years) newly acquiring HIV infection in 24 GPC focus countries with mixed HIV epidemics, 2010–2022

Driving the reductions are factors that combine in different ways, depending on the setting. Along with the natural evolution of the HIV epidemic, behaviour changes (such as delayed sexual debut and fewer risky sexual encounters) are reducing the risk of acquiring HIV, as studies in countries such as Cameroon (4), Zimbabwe (5) and several others (6) have documented. Moderately high levels of condom use during risky sex in a majority of countries with large epidemics are tempering HIV transmission, while the rising numbers of men and boys who have undergone voluntary medical male circumcision (VMMC) is reducing their chances of acquiring HIV in the countries where VMMC programmes have been prioritized or where male circumcision is a common religious or cultural practice. Programmes focusing on the prevention needs of people belonging to key populations5 are also contributing, depending on the population and the country.

However, the single largest additional gain since 2010 has almost certainly been the historic increase in the effective use of antiretrovirals against HIV. Some of the steepest declines in new HIV infections are being seen in countries that are diagnosing and successfully treating very large proportions of people living with HIV. Eleven GPC focus countries have reduced their annual number of new HIV infections by over 66% since 2010.6 Viral suppression levels in those 11 countries have risen impressively—to such a degree that, in seven of them, at least 85% of people living with HIV had suppressed viral loads in 2022. The fact that it is near impossible for a person with a suppressed HIV viral load (below 1000 copies/mL) to transmit the virus to another person during sex (7) is providing a great deal of the current momentum for reducing HIV incidence.

Wide coverage of services to prevent vertical transmission of HIV has drastically reduced the number of children (0–14 years) acquiring HIV. By reaching over 80% of pregnant and breastfeeding HIV positive women with effective treatment in most of the GPC focus countries in sub-Saharan Africa, those services are also reducing onward transmission of HIV to the partners of people living with HIV.

Underpinning these achievements is the use of granular, disaggregated data to focus interventions more precisely for maximum impact; a growing emphasis on adapting services to fit people’s needs; and moves towards functionally integrating community-led interventions with public health programmes.

In sub-Saharan Africa particularly, recognition of the inordinately high risk of HIV infection among adolescent girls and young women has led to much greater emphasis on reaching them with comprehensive prevention services. Increased investments, including from the Global Fund and PEPFAR (the United States President’s Emergency Plan for AIDS Relief), has enabled focus countries in that region to implement dedicated combination prevention programmes for young women in at least 60% of

---

4 The Cameroon experience remains an instructive example. The new analysis in the cited article provides a handy thumb-sketch of the factors at play, including behaviour changes and increased HIV treatment coverage.

5 For the purposes of primary prevention, people belonging to key populations include sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and prisoners and other incarcerated people.

6 Botswana, Cameroon, Côte d’Ivoire, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Rwanda, United Republic of Tanzania and Zimbabwe.
locations with high HIV incidence. But that coverage has to increase further to reduce the ongoing high risks of HIV infection among adolescent girls and young women in the region.

Also increasing is an awareness of the need to remove the underlying barriers (e.g., punitive criminal laws and policies, gender and other inequalities, HIV-related stigma and discrimination, and other human rights violations) that hold back quicker and more equitable progress, though forthright action on those fronts is still erratic.

Large-scale investments, some from domestic resources but most from the Global Fund and PEPFAR, have enabled countries to sustain and, in some cases, expand their HIV prevention programmes. The Global Fund’s HIV prevention investments, for example, grew from US$ 705 million in the 2018–2020 period to over US$ 850 million in the 2021–2023 period. It invested more than US$ 140 million in condom programmes in the 2021–2023 period and doubled its investments in pre-exposure prophylaxis (PrEP) to US$ 24.1 million.

The gains are not uniform across GPC focus countries, though. As the prevention scorecards show in greater detail (see Chapter 2), the performances of HIV prevention programmes vary considerably from country to country. A few countries in sub-Saharan Africa lag far behind, but progress generally has been slowest outside that region, in countries with HIV epidemics that primarily affect people belonging to key populations and their sex partners.

Angola, Ghana, Islamic Republic of Iran, Mozambique, Myanmar, Namibia and Uganda failed to reduce annual new HIV infections by more than 50% between 2010 and 2022. In South Africa, approximately 160,000 people acquired HIV in 2022; it continues to have the largest HIV epidemic in the world. Meanwhile, the number of people acquiring HIV has been rising in Brazil and Mexico (each of which is home to large numbers of people with HIV), as well as in Egypt, Madagascar, Peru and the Philippines. (Note that recent HIV estimates were not available for China, Nigeria, Pakistan and Ukraine.)

Several handicaps are holding back quicker and more uniform gains against HIV. Subdued top-level political commitment for HIV prevention is reflected in the large shortfalls in prevention financing. Prevention programmes are not being implemented at the required scale and proven interventions, such as harm reduction services for people who use drugs, are still being neglected or ignored. There have been reductions in investment in both condom and VMMC programmes in countries with some of the largest HIV epidemics in the world, and breakthrough prevention options like PrEP are available to only a small fraction of the people who need them.
Faltering political commitment is reflected also in the persistence of legal and structural obstacles that undercut prevention programmes. More than four decades into the global AIDS pandemic, necessary HIV prevention services for people from key populations are still scarce in many countries. Punitive laws remain on the statute books, and social stigma and discrimination are rife. The violence, discrimination and social exclusion which key populations experience continue to reduce their access to healthcare services and information, and magnify their risk of acquiring HIV.

Those and other priorities are highlighted in the HIV Prevention 2025 Road Map (9) (see Chapter 3), which sets out actions that can bring the world close to reducing the total number of annual new HIV infections to under 370,000 by 2025. If that milestone can be reached, the world will be on track for the historic achievement of ending AIDS as a public health threat by 2030.

To reach the 2025 milestone, countries will have to reduce the annual number of new HIV infections by at least 83% compared with 2010. By 2022, 11 countries—Botswana, Cameroon, Côte d’Ivoire, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Rwanda, United Republic of Tanzania and Zimbabwe—had reduced new infections by at least 66% since 2010, which puts the 2025 milestone within their reach. Elsewhere, major changes and improvements are required:

- Several focus countries are achieving slow reductions and will have to intensify their prevention efforts. They include Angola, Colombia, Democratic Republic of the Congo, Ghana, Mozambique, Namibia, South Africa, Uganda and Zambia.

- The prevention programmes in several other focus countries are not on track and require thorough overhaul. They include Brazil, Colombia, Congo, Egypt, Madagascar, Islamic Republic of Iran, Mexico, Myanmar, Pakistan, Papua New Guinea, Peru and Philippines. It should be noted that, except for Congo and Papua New Guinea, most HIV infections in these countries are occurring among people belonging to key populations and their sex partners.
The HIV Prevention 2025 Road Map (10) has redefined the five main pillars for national HIV prevention responses to increase focus, emphasize people-centred approaches, address persistent inequalities in access to services, promote integration between service delivery platforms, and speed up the introduction of new prevention technologies (Figure 5).

The Coalition has developed a set of scorecards to track and summarize country progress across the five pillars. Their purpose is to identify where and in what respects programmes can improve, with a view to increasing their strategic focus, effectiveness and eventual impact. The scorecards are presented in a format that allows for comparisons between the GPC focus countries.
**Figure 5. The five GPC prevention pillars for 2025**

**PILLAR 1. COMBINATION PREVENTION FOR KEY POPULATIONS**

The prevention of HIV infections among people belonging to key populations and their sex partners continues to be a weakness of HIV responses in a vast majority of countries. Good examples of effective programmes exist, but prevention services for key populations are unevenly available and often difficult to access. The obstacles include weak political will, insufficient funding, rampant stigma and discrimination, and the ongoing use of punitive laws and policies that restrict access to HIV and other health-care services.

The most recent data compiled and analysed by the GPC show encouraging examples of improvement in a few focus countries. But there are major shortcomings in programme investment, coverage and quality for preventing HIV among key populations in the other countries. Indeed, most of the focus countries with substantial recent increases in the numbers of new HIV infections have epidemics that are primarily affecting key populations and their partners. At the same time, countries with high HIV prevalence in the general population will struggle to close their remaining gaps in prevention if they continue to neglect the HIV prevention needs of key populations.

A surprising number of countries lack the basic data that are needed to guide prevention programmes for key populations, such as size estimates that are less than five years old and other data on HIV prevalence, programme coverage and outcomes.

---

**Source:** HIV Prevention 2025 Road Map: getting on track to end AIDS as a public health threat by 2030. Geneva: UNAIDS; 2022.
Only about two thirds of the focus countries have prepared recent size estimates for sex workers (28/40) or for gay men and other men who have sex with men (27/40), and a little over half have done so for people who inject drugs (22/40). Those estimates indicate that substantial numbers of people belong to these key populations, underlining the need to serve them with effective prevention programmes. Size estimates for transgender people were available for a little over one third (16/40) of the focus countries (Tables 1 & 2). It should be noted, as well, that some existing size estimates for gay men and other men who have sex with men and for transgender people may be underestimated in settings where these populations are highly stigmatized and/or criminalized.

Coalition focus countries have been slow to remove legal and other human rights-related impediments, despite clear evidence that they stop people from getting the information, services and support they need to protect themselves and their partners against HIV infection. All but four of the 40 GPC countries still criminalize sex work in some respects, half of the countries (20) criminalize same-sex sexual relationships, and five countries criminalize transgender people (Table 3). All but four (Cameroon, Democratic Republic of the Congo, Mexico and Thailand) of the 32 countries reporting these data criminalize drug use or the possession of drugs for personal use, despite strong evidence linking the criminalization of drug use with increased risk of HIV transmission (11). There is compelling evidence that any form of criminalization increases HIV risk for sex workers (including through decreasing condom use because of rushed negotiations and a reluctance to carry condoms in a bid to avoid police harassment) (12). A recent ten-country study from sub-Saharan Africa reported that HIV prevalence among gay men and other men who have sex with men was over five times higher in countries that criminalized same-sex relationships than in non-criminalized settings, and 12 times higher in settings where recent prosecutions had occurred (13).

Data describing the status of HIV prevention services for key populations in GPC focus countries are incomplete, especially for transgender people and people who inject drugs. Very few countries reported data on key populations’ experiences of stigma and discrimination at health-care facilities (Table 3). In addition, data on programme outcomes are derived mostly from surveys, which tend to be done irregularly. It is therefore difficult to assess current trends in programme coverage and impact.

Regular access to HIV prevention remains insufficient among key populations. On average, 49% of sex workers, 29% of gay men and other men who have sex with men, and 36% of people who inject drugs accessed two or more HIV prevention services in the previous three months—against a target of 90%. Both data quality and programme coverage for key populations must improve.

7 Some countries have adopted even harsher laws that criminalize key populations. Uganda’s Anti-Homosexuality Act (2023), signed into law in May 2023, provides for severe punishments against lesbian, gay, bisexual, transgender and intersex persons and organizations, while Indonesia’s new criminal code contains articles that violate the rights of women and sexual minorities.

8 Burkina Faso, Cameroon, Côte d’Ivoire, Eswatini, Gambia, Guinea-Bissau, Nigeria, Senegal, Rwanda and Togo.
Table 1. HIV prevention service coverage and outcomes among key populations in 16 GPC focus countries with HIV epidemics primarily affecting key populations and their sex partners

<table>
<thead>
<tr>
<th>COVERED POPULATION</th>
<th>OUTCOME</th>
<th>LEVEL OF RESULT</th>
<th>INDICATOR</th>
<th>Brazil</th>
<th>China</th>
<th>Colombia</th>
<th>Egypt</th>
<th>India</th>
<th>Indonesia</th>
<th>Iran (Islamic Republic of)</th>
<th>Madagascar</th>
<th>Mexico</th>
<th>Myanmar</th>
<th>Pakistan</th>
<th>Peru</th>
<th>Philippines</th>
<th>Thailand and Laotian People’s Democratic Republic</th>
<th>Ukraine</th>
<th>Viet Nam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td>Population size estimate for female sex workers in 1000s</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>868</td>
<td>278</td>
<td>138</td>
<td>191</td>
<td>240</td>
<td>75</td>
<td>id</td>
<td>68</td>
<td>231</td>
<td>81</td>
<td>87</td>
<td>86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>Population size estimate for men who have sex with men in 1000s</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>505</td>
<td>357</td>
<td>781</td>
<td>id</td>
<td>17</td>
<td>1200</td>
<td>268</td>
<td>id</td>
<td>260</td>
<td>693</td>
<td>608</td>
<td>179</td>
<td>256</td>
<td></td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>Population size estimate for people who inject drugs in 1000s</td>
<td>na</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>8</td>
<td>177</td>
<td>27</td>
<td>90</td>
<td>2</td>
<td>id</td>
<td>116</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>7</td>
<td>58</td>
<td>350</td>
<td>189</td>
</tr>
<tr>
<td>Transgender people</td>
<td>Population size estimate for transgender people in 1000s</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>6</td>
<td>id</td>
<td>70</td>
<td>35</td>
<td>10</td>
<td>id</td>
<td>123</td>
<td>id</td>
<td>id</td>
<td>7</td>
<td>207</td>
<td>id</td>
<td>13</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

* Note that ART data reported can either be from surveys or programmes, and the latter usually give higher values. This limits comparability across countries.

** The population size estimates reported can either be nationally representative or only for regions within the country where data is available. This limits comparability across countries.

Data sources for key population program coverage: Global Aids Monitoring 2022, Global Fund and PEPFAR reports obtained in 2022. Note: some of the data are triangulated and thus not nationally representative.

- Very good
- Good
- Medium
- Low
- Very low
- Insufficient data
- Not applicable

Notes: ART: antiretroviral therapy; MSM: gay men and other men who have sex with men; PLHIV: people living with HIV; TG: transgender.

Source: Global HIV Prevention Coalition 2023 scorecard.
Table 2. HIV prevention service coverage and outcomes among key populations in 24 GPC focus countries with mixed HIV epidemics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTCOME</td>
<td>Condom use of sex workers with most recent client, % (reported by sex workers)</td>
<td>id</td>
<td>76</td>
<td>80</td>
<td>66</td>
<td>92</td>
<td>68</td>
<td>50</td>
<td>96</td>
<td>id</td>
<td>62</td>
<td>63</td>
<td>42</td>
<td>65</td>
<td>82</td>
<td>83</td>
<td>35</td>
<td>72</td>
<td>05</td>
<td>id</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condom use at last anal sex among MSM (%)</td>
<td>id</td>
<td>78</td>
<td>30</td>
<td>64</td>
<td>75</td>
<td>57</td>
<td>40</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>46</td>
<td>79</td>
<td>id</td>
<td>55</td>
<td>70</td>
<td>id</td>
<td>56</td>
<td>72</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td></td>
<td>Condom use among transgender people (%)</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>60</td>
<td>52</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>55</td>
<td>74</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Condom use at last paid sex act, % (reported by men)</td>
<td>71</td>
<td>83</td>
<td>75</td>
<td>63</td>
<td>38</td>
<td>48</td>
<td>81</td>
<td>44</td>
<td>89</td>
<td>70</td>
<td>95</td>
<td>31</td>
<td>87</td>
<td>24</td>
<td>48</td>
<td>75</td>
<td>83</td>
<td>id</td>
<td>id</td>
<td>73</td>
<td>id</td>
</tr>
<tr>
<td></td>
<td>% of PLHIV on ART - sex workers*</td>
<td>62</td>
<td>88</td>
<td>99</td>
<td>67</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>97</td>
<td>34</td>
<td>90</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>24</td>
<td>83</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td></td>
<td>% of PLHIV on ART - men who have sex with men*</td>
<td>id</td>
<td>74</td>
<td>97</td>
<td>60</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>95</td>
<td>39</td>
<td>id</td>
<td>91</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>26</td>
<td>83</td>
<td>id</td>
</tr>
<tr>
<td></td>
<td>% of PLHIV on ART - people who inject drugs*</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>26</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td></td>
<td>Safe injecting practices (people who inject drugs, %)</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>28</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td></td>
<td>% of opioid users who receive opioid substitution therapy</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>13</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>1</td>
<td>id</td>
<td>id</td>
</tr>
</tbody>
</table>

**Notes**

*Note that ART data reported can either be from surveys or programmes, and the latter usually give higher values. This limits comparability across countries.

**The population size estimates reported can either be nationally representative or only for regions within the country where data is available. This limits comparability across countries.

Data sources for key population program coverage: Global AIDS Monitoring 2022, Global Fund and PEPFAR reports obtained in 2022. Note: some of the data are triangulated and thus not nationally representative.

- **Very good**
- **Good**
- **Medium**
- **Low**
- **Very low**
- **Insufficient data**
- **Not applicable**

Notes: ART: antiretroviral therapy; MSM: men who have sex with men; PLHIV: people living with HIV; TG: transgender.

Source: Global HIV Prevention Coalition 2023 scorecard.
### Table 3. Policy and structural factors affecting key populations in 40 GPC focus countries

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>Sea workers</th>
<th>Gay men &amp; other MSM</th>
<th>People who inject drugs</th>
<th>Transgender people</th>
<th>Prisoners</th>
<th>Sea workers</th>
<th>Gay men &amp; other MSM</th>
<th>People who inject drugs</th>
<th>Transgender people</th>
<th>Sea workers</th>
<th>Gay men &amp; other MSM</th>
<th>People who inject drugs</th>
<th>Transgender people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Botswana</td>
<td>&gt; Half</td>
<td>&lt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cameroon</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>4.7</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>&lt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&gt; Half</td>
<td>84.0</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Congo</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>17.2</td>
<td>10.4</td>
<td>id</td>
<td>id</td>
<td>No</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>15.9</td>
<td>5.5</td>
<td>9.3</td>
<td>22.6</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>All</td>
<td>&gt; Half</td>
<td>Some</td>
<td>&lt; Half</td>
<td>id</td>
<td>17.8</td>
<td>14</td>
<td>10</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Eswatini</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>24</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>&gt; Half</td>
<td>id</td>
<td>None</td>
<td>id</td>
<td>None</td>
<td>39.6</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ghana</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Kenya</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Lesotho</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>id</td>
<td>id</td>
<td>8</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Malawi</td>
<td>&lt; Half</td>
<td>&lt; Half</td>
<td>None</td>
<td>&gt; Half</td>
<td>49</td>
<td>12.9</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mozambique</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Namibia</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nigeria</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>&lt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Rwanda</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>No</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>South Africa</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>South Sudan</td>
<td>&gt; Half</td>
<td>None</td>
<td>None</td>
<td>&lt; Half</td>
<td>12.1</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Uganda</td>
<td>&gt; Half</td>
<td>id</td>
<td>None</td>
<td>&gt; Half</td>
<td>9.3</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zambia</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&gt; Half</td>
<td>39.3</td>
<td>8.3</td>
<td>id</td>
<td>10.8</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Brazil</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&gt; Half</td>
<td>12.1</td>
<td>id</td>
<td>na</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>China</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>All</td>
<td>id</td>
<td>None</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Colombia</td>
<td>&lt; Half</td>
<td>&lt; Half</td>
<td>&gt; Half</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Egypt</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>India</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Indonesia</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>&lt; Half</td>
<td>&lt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>27.8</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Madagascar</td>
<td>&lt; Half</td>
<td>&gt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mexico</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>All</td>
<td>id</td>
<td>None</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Myanmar</td>
<td>All</td>
<td>All</td>
<td>&gt; Half</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pakistan</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>5.1</td>
<td>9.3</td>
<td>4.7</td>
<td>5.9</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Peru</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>&gt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Philippines</td>
<td>&lt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>21.3</td>
<td>6.3</td>
<td>10.3</td>
<td>8.4</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Thailand</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>5.1</td>
<td>9.3</td>
<td>4.7</td>
<td>5.9</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ukraine</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>&gt; Half</td>
<td>21.3</td>
<td>6.3</td>
<td>10.3</td>
<td>8.4</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>&lt; Half</td>
<td>&lt; Half</td>
<td>None</td>
<td>&lt; Half</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>54.1</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Source:** Global HIV Prevention Coalition 2023 scorecard.

Legend:
- Very good
- Good
- Medium
- Low
- Very low
- Insufficient data
- Not applicable
Sex workers

Only two focus countries’ national prevention strategies (Democratic Republic of the Congo and Myanmar) currently include all the core elements of the recommended sex worker prevention package, though the strategies in 28 other focus countries included at least half of the recommended elements (Table 3).

On average only 49% of sex workers reported regular access to HIV prevention services, against the global target of 90%. Reported values ranged from 6% in Pakistan to more than 80% in Botswana, Colombia, Ghana, Myanmar, Nigeria, Thailand and the United Republic of Tanzania (Tables 1 & 2). It should be noted that monitoring of HIV prevention coverage among sex workers (and other key populations) remains incomplete. HIV prevention coverage values in the scorecards were based on routine programme monitoring data submitted as country reports to the Global AIDS Monitoring system or were derived from programme reports to the Global Fund and PEPFAR. In-country monitoring and data triangulation on prevention programme coverage of key populations should be enhanced.

In the absence of PrEP or sustained viral load suppression among key populations, condom use is crucial for HIV prevention. Across GPC focus countries, sex workers have reported varying rates of condom use at last sex with a client. More than 90% of female sex workers in China, Côte d’Ivoire, Ethiopia, India, Thailand, Ukraine and Zimbabwe said they had used a condom with their most recent client. However, fewer than half did so in the Democratic Republic of the Congo and South Sudan. Male clients of female sex workers reported high levels of condom use at last paid sex in Cameroon, Colombia, Ethiopia, Lesotho, South Africa, Ukraine and Zimbabwe (>80%), but very low levels in the Democratic Republic of the Congo, Ghana, Madagascar, Mozambique and Papua New Guinea (<50%). The situation in several other focus countries is unclear: almost half of the GPC countries did not report data for these indicators (Tables 1 & 2).

Laws that criminalize key populations also stoke stigma and discrimination, which remain commonplace in all the focus countries, including in health-care facilities. Almost two thirds (24/40) of the focus countries shared data on the percentage of sex workers who said they had avoided health-care services in the previous six months due to stigma and discrimination. In Malawi, close to half of sex workers said they had avoided seeking health-care for that reason, as did 30–40% in Eswatini, Ethiopia and Zimbabwe, and the Islamic Republic of Iran (Table 3).

---

9 The following elements are included: (1) community empowerment and capacity-building; (2) community-based outreach and services; (3) condom distribution; (4) clinical services; (5) legal support services; (6) actions to address violence; (7) actions to reduce stigma and discrimination in health-care settings; (8) actions to address homophobic violence; (9) actions to reduce stigma and discrimination; (10) condom and condom-compatible lubricant distribution; (11) hepatitis services; (12) post-exposure prophylaxis; (13) psychosocial counselling and/or mental health services; (14) STI prevention, screening and treatment services.

10 When referring to the “number of countries” here and in the following pages, reference is made to Table 1 and Table 2. The same approach is used in the subsequent chapters, where “number of countries” in the text refers to the scorecard tables in those chapters.
Gay men and other men who have sex with men

Only one GPC focus country (Myanmar) stated that its HIV prevention strategy included all the core elements of a recommended package of interventions for gay men and other men who have sex with men. Most countries, however, have prevention strategies that include at least half the recommended elements.

Data on HIV prevention coverage need to be interpreted carefully. The average percentage of gay men and other men who have sex with women who received at least two HIV prevention interventions in the previous three months was 29% in GPC countries (with a wide range, from 1% to 96%, and major limitations on data quality). Condom use at last anal sex with a man among gay men and other men who have sex with men ranged from over 75% in Botswana, China, Côte d’Ivoire, Eswatini, India, Malawi, Thailand and Ukraine to under 50% in the Central African Republic, Lesotho and the Philippines. However, almost half the GPC countries did not report condom use data among gay men and other men who have sex with men (Tables 1 & 2). In settings where PrEP is widely used and where very large proportions of people living with HIV are virally suppressed, condom use would be a less significant contributor to HIV prevention—but no GPC focus country currently fits such a description. More generally, condom use is also an important method for reducing the transmission of other sexually transmitted infections (STIs), including in the context of PrEP availability or viral suppression.

Only eight countries shared data on the percentages of gay men and other men who have sex with men and who said they avoided health-care services due to stigma and discrimination. The reported percentages ranged from 6% in Côte d’Ivoire and Ukraine (Table 3).

People who inject drugs

The positive public health impact of comprehensive harm reduction—including needle-syringe distribution, opioid agonist therapy and overdose treatment—is well established in the scientific literature (14, 15). Among GPC focus countries, only China’s and Mexico’s prevention strategies currently include all the core elements of a recommended harm reduction package, while the strategies of 14 other countries include at least half of those elements (Table 3).

Coverage of HIV prevention services for this key population continues to be sparse. In only 4 of the 34 focus countries reporting these data did more than 60% of people who inject drugs receive at least two HIV prevention interventions in the previous three months. Coverage was below 30% in 14 of the 34 countries, some of which have substantial HIV epidemics in this key population (e.g., the Islamic Republic of Iran, South Africa and the United Republic of Tanzania).

---

11 For gay men and other men who have sex with men, that entails having received (in the previous three months) at least two of the following interventions: condoms and lubricants (e.g., through an outreach service, drop-in centre or sexual health clinic); counselling on condom use and safe sex; or testing services for STIs.

12 For people who inject drugs, that entails having received (in the previous three months) at least two of the following interventions: condoms and lubricants (e.g., through an outreach service, drop-in centre, or sexual health clinic); counselling on condom use and safe sex; or new, clean needles or syringes.
At least 90% of people who inject drugs in India, Indonesia, Myanmar, Thailand, Ukraine and Viet Nam were reportedly adhering to safe injecting practices (Tables 1 & 2). Access to opioid agonist therapy remains rare, though India, the United Republic of Tanzania and Viet Nam reported reaching about one in four opioid users with this important service. Hardly any focus countries provided data on the percentage of people who inject drugs who avoided seeking health care due to stigma and discrimination (Table 3).

Transgender people

Prevention strategies included at least half of the core elements of a service package for transgender people in 16 out of 34 focus countries reporting these data. Fewer than half of the GPC focus countries reported data on the coverage of prevention interventions in this key population, with reported coverage ranging from 0% to 79% (Nigeria). Levels of condom use at last anal sex were high (>75%) in 7 of the 14 countries reporting those data (Colombia, India, Mexico, South Africa, Thailand, Ukraine and Zimbabwe). In the seven countries reporting this information, between 6% (Thailand) and 54% (Viet Nam) of transgender people said they had avoided seeking health care due to stigma and discrimination.

People in prisons

Half of the 38 focus countries reporting these data have HIV prevention strategies that include at least half of the core elements of a prevention package for prisoners and other incarcerated persons. But the actual provision of HIV prevention services for this key populations is very limited. Other data reported to the Global AIDS Monitoring system indicate that, among GPC focus countries, Angola, Malawi, Peru, South Africa, Thailand and Ukraine were implementing HIV programmes in prisons on a significant scale.
PILLAR 2.
COMBINATION PREVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN IN HIGH-PREVALENCE LOCATIONS

Substantially fewer adolescent girls and young women (aged 15–24 years) are acquiring HIV in the GPC focus countries in sub-Saharan Africa. The greatest progress has been in Botswana, Cameroon, Eswatini, Kenya, Lesotho, Malawi, Rwanda, the United Republic of Tanzania and Zimbabwe, where new HIV infections among adolescent girls and young women decreased by at least 65% between 2010 and 2022.

These trends are due primarily to increasing coverage of combination prevention programmes, with antiretroviral-based prevention playing a major role (see Pillar 5) alongside targeted primary prevention programmes. Changes in sexual behaviour may also have contributed, particularly during earlier stages of the epidemic.

It is important to note that HIV incidence among adolescent girls and young women varies considerably between locations, even in eastern and southern Africa (where incidence tends to be highest). Across sub-Saharan Africa, there is a greater than 1000-fold difference in HIV incidence between locations with the lowest and the highest incidence. Overall, HIV incidence among adolescent girls and young women is low to moderately high in large parts of eastern and southern Africa; high in parts of southern Africa among those with non-regular partners; and extremely high across much of the latter sub-region among women aged 18–25 years who sell or trade sex (16). It is vital that prevention programmes reach the girls and women who are at high risk of acquiring HIV infection.

In 2022, the number of locations with high HIV incidence (above 1 per 100 person-years) declined further.13 In combination with programme expansion and adjustments in geographical coverage made over recent years, this meant that 61% of sub-national areas with high HIV incidence had a dedicated programme for adolescent girls and young women (mostly either a DREAMS programme14 supported by PEPFAR, or a Global Fund-supported initiative). In locations with moderately high HIV incidence (between 0.3 and 0.99 per 100 person-years) only 36% had a dedicated programme, according to the Coalition scorecards, which also draw on Global Fund and PEPFAR reporting. However, locations with moderately high incidence are now much more numerous in southern and eastern Africa and in parts of western and central Africa—and they contribute large absolute numbers of new HIV infections among girls and women.

Among the locations with high HIV incidence, 61% had a dedicated prevention programme for adolescent girls and young women—more than ever before. But women’s and girls’ access to prevention options need to increase further.

---

13 High HIV incidence—above 1 per 100 person-years in the entire population of women aged 15–24 years—was found only in specific sub-national areas in Eswatini, Mozambique, Namibia and South Africa (in southern Africa) and in a few areas in the Republic of the Congo and Equatorial Guinea (in central Africa).

14 “Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe”, a public-private partnership that is implemented across 15 countries in sub-Saharan Africa.
The latest data show that, among the 11 GPC focus countries reporting these data, at least 80% of priority districts were being serviced with dedicated programmes for young women and their male partners in Eswatini, Kenya, Lesotho and Zimbabwe (Table 4). Geographical coverage was 50% or lower in 5 of the 7 other countries reporting this information. It is important to note that wide geographical coverage does not automatically translate into reaching large proportions of adolescent girls. Coverage of comprehensive prevention packages for adolescent girls and young women in communities with moderate and high HIV incidence has remained very low in the majority of countries reporting these data (under 40% in 12 out of 15 countries) (see the right-hand column in Table 4). There is a greater need than ever to apply approaches that increase access of women and girls to prevention options on a large scale.

Table 4. Selected prevention service outcome indicators among adolescent girls and young women (15–24 years) in 24 GPC focus countries with mixed HIV epidemics, 2022

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Condom use with non-regular partners (young women, 15–24 years)</th>
<th>Condom use with non-regular partners (young men, 15–24 years, %)</th>
<th>% of priority districts (administrative areas) with dedicated programmes for young women &amp; male partners (full package)</th>
<th>% of adolescent girls and young women in high HIV incidence communities reached with a comprehensive package of prevention interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>31</td>
<td>46</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Botswana</td>
<td>id</td>
<td>id</td>
<td>56</td>
<td>4</td>
</tr>
<tr>
<td>Cameroon</td>
<td>50</td>
<td>65</td>
<td>id</td>
<td>9</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Congo</td>
<td>45</td>
<td>66</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>42</td>
<td>67</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>35</td>
<td>33</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Eswatini</td>
<td>55</td>
<td>74</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>22</td>
<td>51</td>
<td>id</td>
<td>17</td>
</tr>
<tr>
<td>Ghana</td>
<td>20</td>
<td>44</td>
<td>20</td>
<td>id</td>
</tr>
<tr>
<td>Kenya</td>
<td>43</td>
<td>70</td>
<td>100</td>
<td>17</td>
</tr>
<tr>
<td>Lesotho</td>
<td>84</td>
<td>83</td>
<td>90</td>
<td>34</td>
</tr>
<tr>
<td>Malawi</td>
<td>53</td>
<td>73</td>
<td>id</td>
<td>21</td>
</tr>
<tr>
<td>Mozambique</td>
<td>51</td>
<td>48</td>
<td>33</td>
<td>46</td>
</tr>
<tr>
<td>Namibia</td>
<td>48</td>
<td>84</td>
<td>43</td>
<td>19</td>
</tr>
<tr>
<td>Nigeria</td>
<td>38</td>
<td>62</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>18</td>
<td>31</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Rwanda</td>
<td>46</td>
<td>78</td>
<td>id</td>
<td>8</td>
</tr>
<tr>
<td>South Africa</td>
<td>81</td>
<td>73</td>
<td>50</td>
<td>6</td>
</tr>
<tr>
<td>South Sudan</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Uganda</td>
<td>43</td>
<td>57</td>
<td>38</td>
<td>9</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>61</td>
</tr>
<tr>
<td>Zambia</td>
<td>34</td>
<td>49</td>
<td>28</td>
<td>37</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>54</td>
<td>81</td>
<td>89</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: Global HIV Prevention Coalition 2023 scorecard.
Prevention programmes are improving in other respects, though they are hampered by underlying obstacles. For example, most of the GPC focus countries in sub-Saharan Africa reported that they were integrating provider-initiated condom promotion and HIV testing services in sexual and reproductive health services. However, societal inequalities mean that many adolescent girls and young women, especially those with low education levels and incomes, still struggle to take their own informed decisions about their sexual lives (17). This is reflected, for example, in the data on condom use, which show that in 12 of 20 focus countries reporting these data, less than half of adolescent girls and young women used a condom the last time they had sex with a non-regular partner (see also Pillar 4) (Table 4).

All but one of the 23 focus countries reporting this information have introduced education policies that include the provision of HIV and sexuality education in secondary schools (Table 5). But the bigger challenge of improving outcomes for the education of girls still exists: less than half of girls completed their lower-secondary schooling in 10 of the 23 focus countries reporting these data and only 50–60% graduated in another 6 countries. There is evidence from different settings that women and girls with poor school attendance and lower education attainment face elevated risks in relation to sexual health and HIV (18, 19, 20, 21).

Launched in 2023, the HIV Prevention Choice Manifesto for Women and Girls in Africa focuses on reducing HIV infections by translating existing and new HIV prevention options into actual choices for women and girls.
### Table 5. Selected indicators on policy and structural barriers affecting adolescent girls and young women in 24 GPC focus countries with mixed epidemics

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>Proportion of women who experienced intimate partner violence (age 15–49)</th>
<th>Girls who completed lower secondary education</th>
<th>Policies on life skills-based HIV and sexuality education (secondary schools)</th>
<th>Laws requiring parental consent for adolescents to access HIV testing services, age of consent</th>
<th>HIV testing services integrated within sexual and reproductive health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Botswana</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Cameroon</td>
<td>21.5</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Congo</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;14</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>id</td>
<td>cido</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>no/id</td>
<td>cido</td>
</tr>
<tr>
<td>Eswatini</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>id</td>
<td>No</td>
<td>Yes, &lt;16</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Ghana</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;14</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Kenya</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Lesotho</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Malawi</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;14</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Mozambique</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>Yes</td>
<td>cido</td>
</tr>
<tr>
<td>Namibia</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;14</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Nigeria</td>
<td>13.8</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>41.6</td>
<td>id</td>
<td>Yes</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Rwanda</td>
<td>23.8</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>South Africa</td>
<td>30.3</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>South Sudan</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Uganda</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;12</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;14</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Zambia</td>
<td>25.3</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>19</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Brazil</td>
<td>id</td>
<td>No</td>
<td>Yes, &lt;12</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>China</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Colombia</td>
<td>id</td>
<td>Yes</td>
<td>No</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Egypt</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>India</td>
<td>24</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>no</td>
<td>cido</td>
</tr>
<tr>
<td>Indonesia</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>no/id</td>
<td>cido</td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>id</td>
<td>No</td>
<td>Yes, &lt;14</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Madagascar</td>
<td>16</td>
<td>Yes</td>
<td>Yes, &lt;18</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Mexico</td>
<td>id</td>
<td>No</td>
<td>Yes</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Myanmar</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Pakistan</td>
<td>14.3</td>
<td>No</td>
<td>No</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Peru</td>
<td>id</td>
<td>No</td>
<td>Yes, &lt;18</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Philippines</td>
<td>5.5</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>partial</td>
<td>cido</td>
</tr>
<tr>
<td>Thailand</td>
<td>id</td>
<td>No</td>
<td>No</td>
<td>no/id</td>
<td>cido</td>
</tr>
<tr>
<td>Ukraine</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;14</td>
<td>yes</td>
<td>cido</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>id</td>
<td>Yes</td>
<td>Yes, &lt;16</td>
<td>partial</td>
<td>cido</td>
</tr>
</tbody>
</table>

- Very good  - Good  - Medium  - Low  - Very low  - Insufficient data  - Not applicable

Source: Global HIV Prevention Coalition 2023 scorecard.
Gender-based violence continues to scar the lives of many girls and women. Only 7 countries reported data on intimate partner violence, all pointing to distressing situations: between 14% and 48% of ever-married or partnered 15–49-year-old girls and women had experienced physical or sexual violence from a male partner in the previous 12 months. Other data sources suggest that similar levels of intimate partner violence occur in most of the other GPC focus countries (22). Intimate partner violence has been shown to increase the risk of acquiring HIV and impede the use of HIV services and prevention options (such as condoms and PrEP) (23).

Overall, prevention programmes for adolescent girls and young women were rated as “good” in only two countries (Kenya and Lesotho), while those in 14 countries earned a score of “very low” (see Figure 12 and the country annex for details). Most focus countries in sub-Saharan Africa still have ample unused opportunities to achieve steeper reductions in new HIV infections among adolescent girls and young women, and among their male partners.

The steep drop since 2010 in new HIV infections among men and boys across much of sub-Saharan Africa reflects the cumulative impact of combination prevention and treatment. Due to this decline, there are hardly any locations with high HIV incidence above 1 per 100 person-years among all men, though HIV incidence remains high among certain sub-populations of men. A remaining challenge is to bring combination prevention services and tools to the men and boys for whom current programmes are inadequate, many of whom live in poorly served peri-urban and rural areas.

The scorecards tracked progress in three of the core components of prevention for men and boys in GPC focus countries: ART coverage and viral suppression rates; voluntary medical male circumcision (VMMC) (in the 15 countries in eastern and southern Africa where this intervention is recommended); and condom use with non-regular partners.

Though not as high as among girls and women, HIV treatment coverage among men and boys (15 years and older) was at least 80% in 9 of the 23 GPC focus countries with mixed HIV epidemics (implying achievement of the 95–100% viral suppression target) and it was 90% or higher in 5 others. Coverage was very low (<40%) in Angola, Madagascar and South Sudan.

Even more significant for HIV prevention are the high rates of viral suppression achieved among men and boys in some GPC countries with mixed epidemics: >85% in six countries (implying achievement of the 95% viral suppression target).

---

16 Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
17 HIV treatment coverage data were not available for Nigeria.
18 Eswatini, Rwanda, United Republic of Tanzania, Zambia and Zimbabwe.
19 Botswana, Eswatini, Rwanda, United Republic of Tanzania, Zambia and Zimbabwe.
HIV PREVENTION: FROM CRISIS TO OPPORTUNITY

95–95 targets) and >80% in three others\textsuperscript{20} (putting them close to reaching those targets). Since people with suppressed viral loads have a near-zero risk of transmitting HIV to their sex partners (7, 24),\textsuperscript{21} very high rates of viral suppression among men are vitally important for reducing HIV infections among women, as well as among their male sex partners, in the GPC focus countries (25). It is notable that most of the countries with comparatively low viral suppression rates among men and boys are also experiencing slower reductions in new HIV infections among adolescent girls and young women (see the Conclusion).

There are many under-utilized opportunities to reach adolescent boys and men with effective HIV testing, prevention and treatment services. Using them will help improve treatment outcomes for men and reduce HIV incidence among men and their sexual partners.

Table 6. GPC scorecard for HIV prevention among adolescent boys and men

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>Botswana</th>
<th>Eswatini</th>
<th>Ethiopia</th>
<th>Kenya</th>
<th>Lesotho</th>
<th>Malawi</th>
<th>Mozambique</th>
<th>Namibia</th>
<th>Rwanda</th>
<th>South Africa</th>
<th>South Sudan</th>
<th>Uganda</th>
<th>United Republic of Tanzania</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>National male circumcision prevalence (15–24 years) (%)</td>
<td>23</td>
<td>5</td>
<td>88</td>
<td>94</td>
<td>70</td>
<td>29</td>
<td>66</td>
<td>22</td>
<td>73</td>
<td>60</td>
<td>49</td>
<td>82</td>
<td>37</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>National male circumcision prevalence (15–49 years) (%)</td>
<td>26</td>
<td>29</td>
<td>91</td>
<td>93</td>
<td>69</td>
<td>76</td>
<td>47</td>
<td>26</td>
<td>30</td>
<td>id</td>
<td>id</td>
<td>46</td>
<td>80</td>
<td>32</td>
<td>14</td>
</tr>
<tr>
<td>Condom use with non-regular partners (men 15–49 years) (%)</td>
<td>id</td>
<td>83</td>
<td>51</td>
<td>68</td>
<td>81</td>
<td>73</td>
<td>47</td>
<td>82</td>
<td>70</td>
<td>68</td>
<td>id</td>
<td>58</td>
<td>35</td>
<td>54</td>
<td>63</td>
</tr>
<tr>
<td>% of PLHIV on ART (men 15+ years)</td>
<td>88</td>
<td>92</td>
<td>81</td>
<td>89</td>
<td>81</td>
<td>86</td>
<td>78</td>
<td>87</td>
<td>91</td>
<td>68</td>
<td>32</td>
<td>80</td>
<td>92</td>
<td>90</td>
<td>93</td>
</tr>
<tr>
<td>% of PLHIV virally suppressed (men 15+ years)</td>
<td>87</td>
<td>90</td>
<td>76</td>
<td>84</td>
<td>76</td>
<td>81</td>
<td>70</td>
<td>81</td>
<td>89</td>
<td>62</td>
<td>id</td>
<td>75</td>
<td>96</td>
<td>87</td>
<td>88</td>
</tr>
<tr>
<td>Number of VMMCs performed per year (2022, in thousands)</td>
<td>10</td>
<td>6</td>
<td>28</td>
<td>81</td>
<td>15</td>
<td>259</td>
<td>172</td>
<td>21</td>
<td>203</td>
<td>150</td>
<td>12</td>
<td>517</td>
<td>454</td>
<td>384</td>
<td>171</td>
</tr>
<tr>
<td>Number of VMMCs performed in the previous year (2021, in thousands)</td>
<td>4</td>
<td>7</td>
<td>28</td>
<td>55</td>
<td>14</td>
<td>146</td>
<td>129</td>
<td>16</td>
<td>395</td>
<td>373</td>
<td>6</td>
<td>380</td>
<td>571</td>
<td>488</td>
<td>151</td>
</tr>
<tr>
<td>% change in number of VMMCs in the two most recent years (2021 and 2022)</td>
<td>127</td>
<td>10</td>
<td>0</td>
<td>47</td>
<td>6</td>
<td>78</td>
<td>23</td>
<td>28</td>
<td>49</td>
<td>3</td>
<td>87</td>
<td>36</td>
<td>21</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>% performance towards 2025 targets (15–34 years)</td>
<td>5</td>
<td>13</td>
<td>id</td>
<td>32</td>
<td>108</td>
<td>11</td>
<td>27</td>
<td>20</td>
<td>94</td>
<td>54</td>
<td>1</td>
<td>24</td>
<td>100</td>
<td>90</td>
<td>25</td>
</tr>
<tr>
<td>VMMC coverage (15–34 years) (%)</td>
<td>51</td>
<td>47</td>
<td>id</td>
<td>80</td>
<td>54</td>
<td>44</td>
<td>76</td>
<td>65</td>
<td>id</td>
<td>51</td>
<td>id</td>
<td>67</td>
<td>94</td>
<td>78</td>
<td>44</td>
</tr>
</tbody>
</table>

\textsuperscript{20} Kenya, Malawi and Namibia.

\textsuperscript{21} When effective HIV treatment is taken consistently, it leads to suppression of the virus to a point where it becomes undetectable. The evidence shows that people with an undetectable viral load have zero risk of transmitting HIV to others during sexual intercourse, and people with a suppressed viral have a near-zero risk of transmitting HIV during sex.

Source: Global HIV Prevention Coalition 2023 scorecard.
HIV PREVENTION: FROM CRISIS TO OPPORTUNITY

VMMC is a “once-off” prevention method that protects males against HIV infection without requiring any subsequent change in behaviour. Longstanding evidence from studies shows that it reduces the risk to men and boys of acquiring HIV during unprotected heterosexual intercourse by about 60% \(^{26, 27}\), while also reducing the risk of acquiring syphilis \(^{28}\). There is new evidence that VMMC continues to be cost-effective for HIV prevention in sub-Saharan Africa \(^{29}\).

The scale-up of VMMC programmes has added momentum to prevention programmes in many of the 15 countries in eastern and southern Africa where this method has been prioritized since 2007. Those countries are providing VMMC as part of a package of prevention interventions, which includes safer sex education, condom education and provision, HIV testing and linkage to care and treatment (if a person is HIV-positive), and managing STIs.

By the end of 2022, almost 35 million men and boys had opted for VMMC in the 15 priority countries, with Uganda, the United Republic of Tanzania and Zambia accounting for more than half of all VMMC procedures performed in those countries. But recent trends in the uptake of VMMC have been mixed. The number of procedures performed in 2021 and 2022 rose in 9 out of the 15 priority countries, including in Botswana and Malawi, where VMMC coverage had been low previously. But VMMC programmes have struggled to recover from the COVID-19 disruptions in several other countries (notably Eswatini, Rwanda, South Africa and Zambia) (Table 6).

Overall in sub-Saharan Africa, the national prevalence of male circumcision among men and boys surpassed 90% in eight GPC focus countries (Angola, Cameroon, Côte d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya and Nigeria).\(^{22}\) But VMMC programmes in several focus countries can be making a bigger contribution to HIV prevention leading up to 2030—including in Botswana, Eswatini, Malawi, Namibia, Rwanda, Zambia and Zimbabwe, where national prevalence of male circumcision was still 30% or lower (Table 6).

VMMC programmes face two major challenges: reduced funding (there has been heavy reliance on PEPFAR, which, as the leading funding partner, has enabled the progress to date) and the need to reach more men in their twenties and older (services in some countries have focused especially on adolescents). Other research suggests that VMMC programmes are missing men with lower incomes and men living in rural areas,\(^{23}\) which may account partially for the wide variations in the uptake of VMMC programmes at subnational levels.\(^{24}\)

---

\(^{22}\) In many of those countries, male circumcision was a widespread cultural or religious practice before the advent of VMMC programmes.


\(^{24}\) Based on a special analysis by Avenir Health using the DMPPT2 VMMC. Data analysed were from Botswana, Eswatini, Kenya, Lesotho, Mozambique, Rwanda, South Sudan, the United Republic of Tanzania, Zambia and Zimbabwe.
As discussed in greater detail under Pillar 4, condom use among men is still irregular in many of the focus countries with mixed epidemics. Only in 4 (Eswatini, Lesotho, Namibia and Zimbabwe) of the 21 GPC countries reporting these data did more than 80% of adult men (15–49 years) say they used a condom at last sex with a non-regular partner; fewer than 50% did so in 6 countries (Angola, Democratic Republic of the Congo, Ghana, Mozambique, Papua New Guinea and the United Republic of Tanzania). Yet, the data also show that in most focus countries the vast majority of men know that condoms are a safe prevention method (Table 7). (Levels of condom use among sex workers, gay men and other men who have sex with men, and transgender women are discussed under Pillar 1, above.)

In the absence of other standard prevention indicators for men, the scorecard still focuses on VMMC as an outcome for Pillar 4 (see Figure 12 and the country Annex). Overall, four countries (Lesotho, Rwanda, United Republic of Tanzania and Zambia) scored “high” or “very high” on VMMC, while five countries scored very low (Botswana, Eswatini, Malawi, Namibia, and South Sudan. The relatively higher uptake of VMMC in eastern Africa since the onset of VMMC programming suggests that the procedure was more acceptable in that sub-region, where traditional male circumcision was more common. In southern Africa, condom programming could build on existing family planning programmes.

It is striking that hardly any of the prevention programmes in focus countries in sub-Saharan Africa fared well on the scorecard for both women and men. In Botswana, Eswatini, Lesotho and Zimbabwe, programmes focused on adolescent girls and young women scored well, but those focused on boys and men scored poorly. The inverse was seen in Ethiopia, Rwanda, United Republic of Tanzania and Zambia, where HIV prevention programmes among boys and men scored well, but those targeting adolescent girls and young women scored poorly. These patterns are influenced by long-term factors that go beyond the delivery of HIV programmes in recent years.
Condoms are a low-cost prevention option that offers protection against HIV, other STIs and unintended pregnancies. The UN Population Fund (UNFPA) has estimated that the more than five billion condoms it provided to low and middle-income countries between 2018 and 2022 had the potential to avert 24.9 million STIs, 570 000 HIV infections and 16.3 million unintended pregnancies (30). In recent years, though, condom programmes have been steadily defunded in many GPC focus countries and social marketing programmes have been cut back.

Table 7. Condom use, selected determinants of use, and reported condom distribution in 24 GPC focus countries with mixed HIV epidemics

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>Condom use with non-regular partners (%)</th>
<th>Knows condom as prevention method (%)</th>
<th>Woman justified to insist on condom use if husband has STI (men 15–49 years) (%)</th>
<th>Number of condoms distributed/sold per couple-year* (age range 15–64 years - 2021)</th>
<th>% of condom distribution need met (2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women 15–49 years</td>
<td>Men 15–49 years</td>
<td>Women 15–49 years</td>
<td>Men 15–49 years</td>
<td></td>
</tr>
<tr>
<td>Angola</td>
<td>27</td>
<td>46</td>
<td>86</td>
<td>78</td>
<td>59</td>
</tr>
<tr>
<td>Botswana</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Cameroon</td>
<td>43</td>
<td>43</td>
<td>77</td>
<td>77</td>
<td>71</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Congo</td>
<td>40</td>
<td>44</td>
<td>78</td>
<td>87</td>
<td>85</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>38</td>
<td>63</td>
<td>60</td>
<td>80</td>
<td>78</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>24</td>
<td>33</td>
<td>56</td>
<td>73</td>
<td>68</td>
</tr>
<tr>
<td>Eswatini</td>
<td>66</td>
<td>83</td>
<td>91</td>
<td>87</td>
<td>94</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>20</td>
<td>51</td>
<td>58</td>
<td>77</td>
<td>61</td>
</tr>
<tr>
<td>Ghana</td>
<td>18</td>
<td>42</td>
<td>77</td>
<td>86</td>
<td>91</td>
</tr>
<tr>
<td>Kenya</td>
<td>37</td>
<td>68</td>
<td>id</td>
<td>id</td>
<td>83</td>
</tr>
<tr>
<td>Lesotho</td>
<td>76</td>
<td>81</td>
<td>92</td>
<td>88</td>
<td>92</td>
</tr>
<tr>
<td>Malawi</td>
<td>49</td>
<td>73</td>
<td>75</td>
<td>75</td>
<td>82</td>
</tr>
<tr>
<td>Mozambique</td>
<td>42</td>
<td>47</td>
<td>55</td>
<td>65</td>
<td>61</td>
</tr>
<tr>
<td>Namibia</td>
<td>46</td>
<td>82</td>
<td>88</td>
<td>90</td>
<td>93</td>
</tr>
<tr>
<td>Nigeria</td>
<td>36</td>
<td>45</td>
<td>73</td>
<td>78</td>
<td>77</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>18</td>
<td>33</td>
<td>52</td>
<td>58</td>
<td>70</td>
</tr>
<tr>
<td>Rwanda</td>
<td>46</td>
<td>70</td>
<td>92</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>South Africa</td>
<td>60</td>
<td>68</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>South Sudan</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Uganda</td>
<td>37</td>
<td>58</td>
<td>87</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>28</td>
<td>35</td>
<td>id</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Zambia</td>
<td>35</td>
<td>54</td>
<td>83</td>
<td>87</td>
<td>73</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>45</td>
<td>82</td>
<td>84</td>
<td>88</td>
<td>87</td>
</tr>
</tbody>
</table>

Source: Global HIV Prevention Coalition 2023 scorecard.

Note: Data on condom distribution are often reported incompletely, which can give rise to apparent contradictions, such as countries with high reported use and low distribution of condoms (e.g., Lesotho).
Mathematical models suggest that condom use still has a major role in slowing the spread of HIV in all settings and they point to a continued need to sustain high levels of condom use. Condom distribution, however, is far below the level of need, with 15 or fewer condoms distributed per couple per year in 15 of the 20 GPC focus countries reporting those data. Most of those focus countries did not meet even half their estimated condom distribution needs. Only 3 countries (Eswatini, Malawi and Zimbabwe) fared well, while 4 others managed to meet at least 60% of their condom needs. Data quality on national condom distribution and sales remains low in several countries and reporting is incomplete, indicating a need to strengthen data collection from public, social marketing and private sectors.

Among adolescent girls and young women (15–24 years), condom use with non-regular partners is very infrequent in most of the focus countries with mixed HIV epidemics. Only in Lesotho did more than 75% of this priority population report using a condom the last time they had sex with a non-regular partner; in 12 of the other 20 countries reporting these data less than half of adolescent girls and young women said they had done so. It is notable that the levels of condom use with non-regular partners were low in most of the countries where HIV incidence declines among adolescent girls and young women since 2010 have been particularly slow.

Condom use was also highly irregular among adult women: in 16 of the 21 focus countries reporting these data less than half of women aged 15–49 years said they had used a condom at last sex with a non-regular partner. Their male counterparts were significantly more likely to say they used a condom in similar circumstances, though levels of reported condom use surpassed 80% in only 4 countries (Eswatini, Lesotho, Namibia and Zimbabwe).

Knowledge about condoms appears not to be a major obstacle: at least two thirds of adolescent girls and young women knew a formal source for condoms in 6 of the 9 countries reporting these data. Similarly, knowledge about condoms as an HIV prevention method was widespread among women aged 15–49 years in 11 of the 18 GPC countries with data and among their male counterparts in 15 of those countries. This suggests that, while demand creation remains important, affordable access to condoms is a major stumbling block, especially in low-income groups. Indeed, other evidence indicates that wealthier men and women are most likely to have used condoms the last time they had sex with a non-regular partner.
Figure 6 depicts the downward trend in investment in condom procurement and distribution after 2011. Considering the rapidly growing young adult population in Africa, this suggests that a decline in the availability of and access to free and subsidized condoms may be underway. Other information sources also point to worrying trends in condom use. Analysis of Demographic and Health Survey data indicate that among young women aged 15–24 years, condom use at last sex with a non-regular partner declined substantially between 2011 and 2015 and between 2015 and 2020 in western and central Africa, from an average 42% to 25%, while it remained steady but low in eastern and southern Africa, at about 36% (34). Figure 7 also shows a downward trend in condom use during premarital sex among young people in four countries with recent survey data.

Note: Donors include UNFPA (including third-party procurement); the United States Agency for International Development; and the Global Fund. Data for donors reflect global procurement; condoms may not have been distributed in the same fiscal year. Data for social marketing organizations reflect the reported distribution as per the DKT social marketing statistics report. The data for South Africa reflect procurement through domestic resources. Other domestic procurement is not reflected.
Figure 7. Trends in condom use among young people during premarital sex, four countries in sub-Saharan Africa

Note: Analysis based on data from Demographic and Health Surveys, available at The DHS Program STATcompiler (http://www.statcompiler.com).

PILLAR 5. WIDER ACCESS TO ANTIRETROVIRAL-BASED PREVENTION

Antiretroviral-based prevention has a central role in achieving the steep reductions in new HIV infections that are required to reach the 2025 prevention targets and in sustaining those reductions beyond that milestone. Increased access to antiretroviral therapy (ART) and the growing proportion of people living with HIV who are virally suppressed have provided much of the impetus for the steep drop in the number of adults (15 years and older) acquiring HIV in the past decade.

When effective HIV treatment is taken regularly, it suppresses the virus to a point where it becomes undetectable. Study evidence shows that there is zero risk for people living with HIV with an undetectable viral load to transmit HIV sexually and near-zero risk for people with a suppressed viral load (7, 35, 36).

Most GPC countries where HIV circulates widely in the general population are doing very well at diagnosing and treating people living with HIV, and at enabling those on treatment to suppress their HIV viral loads to levels that almost rule out onward transmission of the virus (Table 8).

Twelve of the 24 focus countries with mixed epidemics, mostly in sub-Saharan Africa, have achieved the 90–90–90 target (i.e., at least 73% of people living with HIV were virally suppressed) and, among them, 8 have already reached the 95–95–95 target (i.e., at least 86% of people living with HIV were virally suppressed) (Table 8). Those achievements can be credited to strong political commitment and sustained infusions of funding for HIV testing and treatment, price reductions for recommended antiretroviral regimens, implementation of international treatment guidelines, and maturing collaborations between public and community health systems.
Table 8. Antiretroviral-based prevention scorecard for 24 GPC focus countries with mixed HIV epidemics

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>INDICATOR</th>
<th>Angola</th>
<th>Botswana</th>
<th>Cameroon</th>
<th>Central African Republic</th>
<th>Congo</th>
<th>Côte d'Ivoire</th>
<th>Democratic Republic of the Congo</th>
<th>Eritrea</th>
<th>Ethiopia</th>
<th>Ghana</th>
<th>Kenya</th>
<th>Lesotho</th>
<th>Malawi</th>
<th>Mozambique</th>
<th>Namibia</th>
<th>Nigeria</th>
<th>Papua New Guinea</th>
<th>Peru</th>
<th>South Africa</th>
<th>South Sudan</th>
<th>Sudan</th>
<th>United Republic of Tanzania</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of all PLHIV diagnosed</td>
<td>id</td>
<td>98</td>
<td>97</td>
<td>95</td>
<td>91</td>
<td>84</td>
<td>72</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>96</td>
<td>95</td>
<td>70</td>
<td>95</td>
<td>94</td>
<td>id</td>
<td>92</td>
<td>95</td>
<td>93</td>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV on ART</td>
<td>id</td>
<td>96</td>
<td>93</td>
<td>80</td>
<td>94</td>
<td>72</td>
<td>92</td>
<td>92</td>
<td>92</td>
<td>93</td>
<td>63</td>
<td>94</td>
<td>86</td>
<td>93</td>
<td>88</td>
<td>91</td>
<td>id</td>
<td>61</td>
<td>92</td>
<td>75</td>
<td>32</td>
<td>84</td>
<td>94</td>
<td>90</td>
<td>94</td>
</tr>
<tr>
<td>% of all PLHIV virally suppressed</td>
<td>id</td>
<td>93</td>
<td>79</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>99</td>
<td>89</td>
<td>85</td>
<td>87</td>
<td>71</td>
<td>66</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>90</td>
<td>69</td>
<td>79</td>
<td>92</td>
<td>87</td>
<td>89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV virally suppressed (women 15+)</td>
<td>id</td>
<td>97</td>
<td>84</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>95</td>
<td>83</td>
<td>82</td>
<td>93</td>
<td>88</td>
<td>93</td>
<td>74</td>
<td>90</td>
<td>id</td>
<td>id</td>
<td>91</td>
<td>74</td>
<td>83</td>
<td>96</td>
<td>89</td>
<td>93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV virally suppressed (men 15+)</td>
<td>id</td>
<td>87</td>
<td>77</td>
<td>id</td>
<td>id</td>
<td>54</td>
<td>78</td>
<td>90</td>
<td>76</td>
<td>id</td>
<td>84</td>
<td>79</td>
<td>81</td>
<td>70</td>
<td>81</td>
<td>id</td>
<td>id</td>
<td>89</td>
<td>62</td>
<td>75</td>
<td>90</td>
<td>87</td>
<td>88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulatory approval in place (0 = no, 1 = yes)</td>
<td>O</td>
<td>1</td>
<td>0</td>
<td>id</td>
<td>id</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>id</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>id</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PEP guidelines in place (0 = no, 1 = in preparation, 2 = yes)</td>
<td>O</td>
<td>2</td>
<td>2</td>
<td>id</td>
<td>id</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>id</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of estimated PEP need met (%)</td>
<td>id</td>
<td>48</td>
<td>40</td>
<td>id</td>
<td>0</td>
<td>40</td>
<td>12</td>
<td>id</td>
<td>38</td>
<td>62</td>
<td>id</td>
<td>id</td>
<td>53</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>67</td>
<td>1</td>
<td>id</td>
<td>75</td>
<td>id</td>
<td>id</td>
<td></td>
</tr>
<tr>
<td>Change in PEP coverage between Dec 2021 and December 2022 (%)</td>
<td>id</td>
<td>48</td>
<td>-1</td>
<td>id</td>
<td>id</td>
<td>550</td>
<td>10</td>
<td>id</td>
<td>57</td>
<td>279</td>
<td>33</td>
<td>24</td>
<td>111</td>
<td>id</td>
<td>63</td>
<td>158</td>
<td>id</td>
<td>26</td>
<td>17</td>
<td>id</td>
<td>62</td>
<td>293</td>
<td>10</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>PEP coverage score*</td>
<td>id</td>
<td>3</td>
<td>3</td>
<td>id</td>
<td>id</td>
<td>2</td>
<td>1</td>
<td>id</td>
<td>id</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>id</td>
<td>7</td>
<td>2</td>
<td>id</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Composite PEP score (0-10 points based on regulatory, guidelines and coverage)</td>
<td>id</td>
<td>6</td>
<td>3</td>
<td>id</td>
<td>id</td>
<td>5</td>
<td>3</td>
<td>id</td>
<td>5</td>
<td>4</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>id</td>
<td>10</td>
<td>id</td>
<td>id</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Source: Global HIV Prevention Coalition 2023 scorecard.

Table 9. Antiretroviral-based prevention scorecard for 16 GPC focus countries with HIV epidemics primarily affecting key populations and their sexual partners

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>INDICATOR</th>
<th>Angola</th>
<th>Botswana</th>
<th>Cameroon</th>
<th>Central African Republic</th>
<th>Congo</th>
<th>Côte d'Ivoire</th>
<th>Democratic Republic of the Congo</th>
<th>Eritrea</th>
<th>Ethiopia</th>
<th>Ghana</th>
<th>Kenya</th>
<th>Lesotho</th>
<th>Malawi</th>
<th>Mozambique</th>
<th>Namibia</th>
<th>Nigeria</th>
<th>Papua New Guinea</th>
<th>Peru</th>
<th>South Africa</th>
<th>South Sudan</th>
<th>Sudan</th>
<th>United Republic of Tanzania</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of all PLHIV diagnosed</td>
<td>id</td>
<td>91</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>74</td>
<td>79</td>
<td>id</td>
<td>51</td>
<td>id</td>
<td>id</td>
<td>0</td>
<td>id</td>
<td>86</td>
<td>63</td>
<td>90</td>
<td>id</td>
<td>89</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV on ART</td>
<td>id</td>
<td>74</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>87</td>
<td>68</td>
<td>33</td>
<td>37</td>
<td>18</td>
<td>62</td>
<td>74</td>
<td>13</td>
<td>82</td>
<td>67</td>
<td>81</td>
<td>id</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV virally suppressed</td>
<td>id</td>
<td>70</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>87</td>
<td>63</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>58</td>
<td>id</td>
<td>id</td>
<td>67</td>
<td>70</td>
<td>id</td>
<td>72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV virally suppressed (women 15+)</td>
<td>id</td>
<td>70</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>87</td>
<td>63</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>58</td>
<td>id</td>
<td>id</td>
<td>67</td>
<td>70</td>
<td>id</td>
<td>72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all PLHIV virally suppressed (men 15+)</td>
<td>id</td>
<td>70</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>87</td>
<td>63</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>58</td>
<td>id</td>
<td>id</td>
<td>67</td>
<td>70</td>
<td>id</td>
<td>72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulatory approval in place (0 = no, 1 = yes)</td>
<td>O</td>
<td>1</td>
<td>1</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>id</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>id</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>id</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>PEP guidelines in place (0 = no, 1 = in preparation, 2 = yes)</td>
<td>O</td>
<td>2</td>
<td>1</td>
<td>id</td>
<td>id</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of estimated PEP need met (%)</td>
<td>id</td>
<td>16</td>
<td>id</td>
<td>0</td>
<td>id</td>
<td>0</td>
<td>1</td>
<td>id</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>12</td>
<td>id</td>
<td>37</td>
<td>4</td>
<td>13</td>
<td>16</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPUT</td>
<td>Number of people who received PEP at least once in the past 12 months (Dec 2022)</td>
<td>id</td>
<td>53.746</td>
<td>1636</td>
<td>id</td>
<td>2433</td>
<td>1378</td>
<td>136</td>
<td>419</td>
<td>799</td>
<td>2702</td>
<td>id</td>
<td>519</td>
<td>11803</td>
<td>14914</td>
<td>9735</td>
<td>51461</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in PEP coverage between Dec 2021 and December 2022 (%)</td>
<td>id</td>
<td>37</td>
<td>id</td>
<td>174</td>
<td>id</td>
<td>-3</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td></td>
</tr>
<tr>
<td>PEP coverage score*</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td></td>
</tr>
<tr>
<td>Composite PEP score (0-10 points based on regulatory, guidelines and coverage)</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>id</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>id</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>id</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Access to HIV testing and treatment remains unequal. Levels of viral suppression are lower among adolescents and men and in regions where key populations are most affected. Widescale, trusted service platforms are urgently needed to increase access to prevention, testing and treatment for key populations and men, and to achieve the 2025 and 2030 targets for everyone.

However, the overall achievements hide notable imbalances. In sub-Saharan African countries, levels of viral suppression were consistently higher among adult women, compared with adult men. Unless corrected, that disparity will continue to have major implications for HIV prevention in the years ahead. A recent study from Uganda, for example, estimates that HIV incidence among women could be reduced by half if viral suppression rates among men were as high as those among women (37). Achieving and sustaining very high levels of ART coverage and viral load suppression among people of all sexes is vital for breaking the cycles of HIV transmission.

Similarly, UNAIDS estimates show that the coverage of ART remains much lower among adolescents (aged 10–19 years) than among adults overall. Globally, a little over half of adolescents were receiving HIV treatment in 2022, much lower than the 76% coverage among adults. Viral load suppression rates among adolescents are also much lower than for adults (38, 39).

Treatment programmes are performing poorly in most of the GPC focus countries where the HIV epidemics are primarily affecting key populations and their sex partners: only in Thailand did the percentage of people living with HIV who were virally suppressed exceed 73% (the threshold indicative of achieving 90–90–90 targets) (Table 9) and it exceeded 60% in only 4 other countries. Those data are symptomatic of a wider failure of HIV programmes to enable people belonging to key populations to avoid or manage HIV infection successfully.

PrEP is a potentially crucial tool for HIV prevention among people belonging to key populations and their sex partners, and among women and adolescent girls in settings where HIV incidence is high. Most of the GPC focus countries in sub-Saharan Africa have issued regulatory approval for the provision of oral PrEP and almost all of them have included oral PrEP in their national guidelines. Eight of 16 focus countries with concentrated epidemics had regulatory approval and ten had completed national guidelines for PrEP provision.

Actual provision of oral PrEP has expanded considerably, especially in the focus countries with mixed epidemics. The numbers of people who received PrEP at least once in the previous 12 months more than doubled between 2021 and 2022 in 6 of the 17 countries reporting these data, including in some countries where PrEP provision was already fairly well-established (e.g., Kenya, South Africa, Uganda and Zambia). At least 100 000 people received PrEP at least once in 2022 in each of the latter
4 countries, as well as in **Nigeria** and the **United Republic of Tanzania** (Table 8). But PrEP coverage (measured as a percentage of the estimated national need for PrEP) was higher than 50% in only 4 of the 11 countries with mixed epidemics that reported such estimates (**Ghana**, **Malawi**, **South Africa** and the **United Republic of Tanzania**) (Table 8).

PrEP coverage is very low in the focus countries where the epidemic is primarily affecting key populations and their partners, with study evidence supporting that finding (40). Only **Viet Nam** managed to meet at least half of the estimated PrEP need (Table 9). Low coverage of PrEP and ART heightens the importance of condoms as HIV prevention tools among key populations.

PrEP access varies greatly between regions, as well. Significant progress relative to the 2025 global targets has only been made in eastern and southern Africa and western and central Africa (Figure 8), though access to PrEP there remains highly uneven. Country progress in terms of PrEP access also varies greatly within and between regions (Figure 9).

**Figure 8. Number of people using PrEP in 2022, relative to 2025 targets**

(Note: In the global model to estimate PrEP need to achieve 2025 targets, PrEP need was defined as ‘person-years of PrEP’ meaning use for a period of 12 months. Country reporting, however, is done using the indicator ‘people who used PrEP at least once in the past 12 months’. For the purpose of this chart it was assumed that average duration of PrEP use was 6 months. Based on this assumption, the global target of 10.6 million person years of PrEP use was translated into an indicative estimated target of 21.2 million PrEP users. The same logic was applied to regional targets.)

Source: Prepared based on 2023 prevention scorecards and Global AIDS Monitoring.
Figure 9. Number of people using PrEP, relative to country epidemic size

a) Countries with fewer than 12 000 new HIV infections

b) Countries with more than 12 000 new HIV infections

Note: The assumptions made for the levels of PrEP use that are required to come close to achieving the global targets are the same as in Figure 8. It was assumed that two people using PrEP in the past 12 months equals one person-year of PrEP use. In interpreting Figure 9, it should be noted that PrEP targets are not a direct function of the number of new HIV infections in a country; the relationship is only broadly indicative.

Source: Based on 2023 prevention scorecards and Global AIDS Monitoring.
Recently, two new, long-acting PrEP options have become available: the dapivirine vaginal ring and long-acting injectable cabotegravir (CAB-LA). Since 2021, WHO has recommended the dapivirine vaginal ring for women who are at substantial risk of acquiring HIV. By mid-2023, Botswana, Eswatini, Kenya, Lesotho, Malawi, Namibia, Rwanda, South Africa, Uganda, Zambia and Zimbabwe had either granted regulatory approval for use of the vaginal ring option or authorized its importation (41). In 2022, WHO recommended CAB-LA for people at substantial risk of HIV infection. By late 2023, CAB-LA had been registered in 13 focus countries, including Botswana, Brazil, Malawi, Peru, Philippines, South Africa, Zambia and Zimbabwe.

Along with increased provision of PrEP, there is a need to increase awareness, acceptability and demand for this powerful prevention option. Increasing PrEP coverage at scale requires that countries pay attention not only to the availability of PrEP, but also to the acceptability and accessibility of PrEP services. Differentiated service delivery for PrEP is therefore important (42).

Coverage depends both on initial uptake and on effective use of PrEP (i.e., individuals are using PrEP as directed at times of substantial risk). In studies and demonstration projects in Africa, adherence to oral PrEP often has been low, however (43, 44). The reasons cited include fear of stigma, concerns about side-effects, and insufficient knowledge about this prevention method (45, 46, 47).

Many low- and middle-income countries outside eastern and southern Africa have fallen behind in enabling PrEP access. They have an opportunity to follow the examples of Kenya, Lesotho, Thailand and Viet Nam, which have increased access to combination prevention, including PrEP, and have recorded substantial declines in HIV incidence.
PROGRESS ON THE TEN MAIN ACTION POINTS IN THE HIV PREVENTION 2025 ROAD MAP

The GPC focus countries in 2022 endorsed a new iteration of the HIV Prevention Road Map (48), which sets out ten country-level actions to accelerate progress towards the 2025 HIV prevention targets and to sustain those gains (Figure 10).

Aligned with the 2021 Political Declaration on HIV and AIDS, the actions centre on widening the availability and use of proven HIV prevention options (such as antiretrovirals, condoms, VMMC in eastern and southern Africa, and harm reduction services) alongside new ones. Also emphasized is the importance of adopting rights-based, people-centred approaches and reducing the discrimination, inequalities and violence that heighten people’s risk of acquiring HIV, while restricting their access to prevention services.
The 2025 Road Map reflects lessons from implementation of the 2020 Road Map and considers the shifting context in which HIV responses operate, including the evolving epidemic itself, financing challenges and the diminishing space in many countries for civil society-led activities. It therefore emphasizes policy, legal and societal changes that can make it easier for people to avoid acquiring HIV infection. It also highlights the powerful interplay between primary HIV prevention, testing, treatment and the prevention of vertical transmission of HIV.

Evident across the Road Map is an intensified focus on reaching key populations everywhere and adolescent girls and young women and their male partners in sub-Saharan Africa; addressing inequalities that heighten the risk of acquiring HIV; and strengthening the roles of communities in HIV prevention. The Road Map guides the use of scarce resources in ways that can achieve maximum impact and it emphasizes the need to facilitate wider availability and use of innovative HIV prevention tools (such as long-acting formulations for PrEP) and approaches (such as telemedicine and other virtual services).

The Road Map survey was conducted to gauge progress in implementation of the action plan and identify important hindrances and gaps. The survey was done in March 2023 among 35 GPC focus countries; it did not yet include the five other countries which were invited to join the Coalition later in 2023. The survey results allow comparisons to be made between countries.25

25 Comprising 45 key questions, the survey was completed by HIV prevention focal points from National AIDS Commissions, Ministries of Health, UNAIDS and UNFPA, as well as by National AIDS Commission directors, UNAIDS country directors and regional directors, and UNFPA representatives. Generally, each country response was then compiled by a technical working group, led by the leadership of the National AIDS Council or equivalent structure. Thirty-five countries submitted their results, which were then verified by national HIV programmes.
**Figure 10. The HIV Prevention 2025 Road Map’s ten-point action plan**

1. Conduct a **data-driven assessment** of HIV prevention programme needs and barriers

2. Adopt a **prevention** approach focused on key and priority populations including differentiated national **2025 prevention targets**

3. Define **country investment needs** for an adequately scaled HIV prevention response and ensure sustainable financing

4. Reinforce HIV **prevention leadership entities** for multisectoral collaboration, oversight, and management of prevention responses and set up social contracting mechanisms

5. Strengthen and expand **community-led HIV prevention services and set up social contracting mechanisms**

6. Strengthen **accountability** of all stakeholders for progress in HIV prevention

7. Promote **integration of HIV prevention** into essential related services to improve HIV outcomes

8. Institute mechanisms for **rapid introduction of new HIV prevention technologies and programme innovations**

9. Establish **real-time prevention programme monitoring** systems with regular reporting

10. **Strengthen accountability** of all stakeholders for progress in HIV prevention

Survey results show that, overall in 2023, more countries reported using granular data to assess and plan around their HIV prevention needs, including their funding requirements. People-centered planning was also becoming more widespread, along with awareness of the value of community-led prevention activities (Figure 11). However, not nearly enough was being done to integrate HIV prevention and other services, introduce solid accountability frameworks, or remove social and legal barriers. Community-led service delivery remained a work-in-progress in many focus countries, as did the overhaul of national structures to lead and coordinate national prevention programmes, and the introduction of real-time programme monitoring systems.

The survey results for each of the ten action points are discussed below. Figure 9 provides a global overview, while Table 10 shows the highly varied progress in countries with mixed HIV epidemics in sub-Saharan Africa (Table 10). In other regions (Table 11), less progress was reported against the ten action points in most countries.

26 The term “community-led” refers to leadership by and for people living with and affected by HIV, including and especially key populations, women and young people. The 30–60–80 targets are defined as follows in the Global AIDS Strategy: 30% of testing and treatment services to be delivered by community-led organizations; 60% of the programmes to support the achievement of societal enablers to be delivered by community-led organizations; 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations.
Table 10. Implementation of the ten Road Map action points in 21 GPC countries with mixed HIV epidemics, 2023

| ROAD MAP BASELINE SURVEY COMPONENTS CONSIDERED FOR OVERALL ROAD MAP ACTION SCORING | Angola | Botswana | Cameroon | Côte d’Ivoire | Democratic Republic of the Congo | Eritrea | Ghana | Kenya | Lesotho | Malawi | Mozambique | Namibia | Nigeria | Rwanda | South Africa | South Sudan | Uganda | United Republic of Tanzania | Zambia |
| NR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| SUMMARY ON COMPLETION OF TEN ROAD MAP ACTIONS | | | | | | | | | | |
| 1 | Data-driven needs assessment | | | | | | | | | |
| 2 | Precision prevention approach | | | | | | | | | |
| 3 | Define investment needs | | | | | | | | | |
| 4 | HIV prevention leadership agencies | | | | | | | | | |
| 5 | Expand community-led services | | | | | | | | | |
| 6 | Remove social and legal barriers | | | | | | | | | |
| 7 | Integration with related services | | | | | | | | | |
| 8 | Introduction of new technologies | | | | | | | | | |
| 9 | Real-time programme monitoring | | | | | | | | | |
| 10 | Accountability for HIV progress | | | | | | | | | |

PROGRESS ON DETAILED MILESTONES AND COMMITMENTS

1.1 HIV epidemic pattern and prevention programme analysis
1.2 Consultation meetings to identify barriers
1.2.1 Listing of the identified barriers
2.1 Developed a prevention road map or plan
2.2 Set granular HIV prevention targets
2.3 Translate national targets into subnational targets
2.4 Differentiated HIV prevention packages
2.5 Packages for young women where relevant
2.7 Standard operating procedures/guidelines for relevant pillars
3.1 Budgeted or costed national HIV prevention plan
3.2 Dialogue to address prevention funding gap
4.1 Multi-sector HIV prevention leadership exists
4.2 The entity is functional and relevant meetings are held
4.3 Milestones to reinforce prevention leadership entities
5.1 Government convening includes relevant communities
5.2 Public funds are being allocated to NGOs
5.3 Any laws or policies impacting NGOs
5.4 Any targets set on community-led services
5.5 Milestones on community-led services
6.1 Legal, policy and structural barriers identified in strategy
6.2 Milestones to address the country-specific barriers
7.1 Milestone on promoting integration
7.1.1 Milestones on integration listed
8.1 Actions for new prevention technologies
8.2. Milestones on new prevention technologies
9.1 Data triangulation for coverage of programmes
9.3 Developed subnational scorecards
9.4 HIV prevention funding expenditure analysis done
9.5 Cost-effectiveness included in programme reviews
10.1 Road Map table on accountability adapted and adopted
10.2 Accountability framework in line with Road Map

Source: Global Prevention Coalition Progress Survey, 2023.

Note: The upper part of Tables 15 and 16 (rows 1 to 10) is a summary of the lower part (rows 1.1 to 10.2). Hence, the score on individual rows in the upper part does not provide a full status assessment of the relevant thematic area. For example, a positive score on social and legal barriers would reflect progress on country-specific Road Map actions, but would not necessarily indicate the removal of all social and legal barriers. For the status on barriers see Tables 3 and 5.
### Table 11. Implementation of the ten Road Map action points in 14 GPC countries with HIV epidemics that primarily affect key populations, 2023

<table>
<thead>
<tr>
<th>Summary on Completion of Ten Road Map Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Data-driven needs assessment</td>
</tr>
<tr>
<td>2. Precision prevention approach</td>
</tr>
<tr>
<td>3. Define investment needs</td>
</tr>
<tr>
<td>4. HIV prevention leadership agencies</td>
</tr>
<tr>
<td>5. Expand community-led services</td>
</tr>
<tr>
<td>6. Remove social and legal barriers</td>
</tr>
<tr>
<td>7. Integration with related services</td>
</tr>
<tr>
<td>8. Introduction of new technologies</td>
</tr>
<tr>
<td>9. Real-time programme monitoring</td>
</tr>
<tr>
<td>10. Accountability for HIV progress</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Progress on Detailed Milestones and Commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 HIV epidemic pattern and prevention programme analysis</td>
</tr>
<tr>
<td>1.2 Consultation meetings to identify barriers</td>
</tr>
<tr>
<td>1.2.1 Listing of the identified barriers</td>
</tr>
<tr>
<td>2.1 Developed a prevention road map or plan</td>
</tr>
<tr>
<td>2.2 Set granular HIV prevention targets</td>
</tr>
<tr>
<td>2.3 Translate national targets into subnational targets</td>
</tr>
<tr>
<td>2.4 Differentiated HIV prevention packages</td>
</tr>
<tr>
<td>2.5 Packages for young women where relevant</td>
</tr>
<tr>
<td>2.7 Standard operating procedures/guidelines for relevant pillars</td>
</tr>
<tr>
<td>3.1 Budgeted or costed national HIV prevention plan</td>
</tr>
<tr>
<td>3.2 Dialogue to address prevention funding gap</td>
</tr>
<tr>
<td>4.1 Multi-sector HIV prevention leadership exists</td>
</tr>
<tr>
<td>4.2 The entity is functional and relevant meetings are held</td>
</tr>
<tr>
<td>4.3 Milestones to reinforce prevention leadership entities</td>
</tr>
<tr>
<td>5.1 Government convening includes relevant communities</td>
</tr>
<tr>
<td>5.2 Public funds are being allocated to NGOs</td>
</tr>
<tr>
<td>5.3 Any laws or policies impacting NGOs</td>
</tr>
<tr>
<td>5.4 Any targets set on community-led services</td>
</tr>
<tr>
<td>5.5 Milestones on community-led services</td>
</tr>
<tr>
<td>6.1 Legal, policy and structural barriers identified in strategy</td>
</tr>
<tr>
<td>6.2 Milestones to address the country-specific barriers</td>
</tr>
<tr>
<td>7.1 Milestone on promoting integration</td>
</tr>
<tr>
<td>7.1.1 Milestones on integration listed</td>
</tr>
<tr>
<td>8.1 Actions for new prevention technologies</td>
</tr>
<tr>
<td>8.2 Milestones on new prevention technologies</td>
</tr>
<tr>
<td>9.1 Data triangulation for coverage of programmes</td>
</tr>
<tr>
<td>9.3 Developed subnational scorecards</td>
</tr>
<tr>
<td>9.4 HIV prevention funding expenditure analysis done</td>
</tr>
<tr>
<td>9.5 Cost-effectiveness included in programme reviews</td>
</tr>
<tr>
<td>10.1 Road Map table on accountability adapted and adopted</td>
</tr>
<tr>
<td>10.2 Accountability framework in line with Road Map</td>
</tr>
</tbody>
</table>

Source: Global Prevention Coalition Progress Survey 2023.
1. Conduct an evidence-driven assessment of HIV prevention programme needs and barriers

Action point 1 entails conducting an HIV prevention response and epidemic analysis, holding consultative meetings to identify the main barriers, and compiling a list of those barriers. Most countries are conducting data-driven needs assessments that include analyses of their epidemic patterns and prevention responses, but only 14 out of 35 have completed all relevant analyses. In addition, all but 5 of the countries that responded to the survey have identified and listed the main barriers that hinder their prevention programmes. It is particularly important to identify barriers to effective prevention in the several countries which are not recording strong declines in new HIV infections.

2. Adopt a precision prevention approach to develop national HIV prevention goals and aligned 2025 targets

It is vital, but not enough, for countries to understand their HIV epidemic: they also should put that knowledge to use. Even in countries with high overall HIV incidence, the risk of acquiring HIV varies dramatically from place to place. Programmes will be most effective if they target interventions in the locations and communities where HIV incidence is high, rather than spreading resources thinly across settings where the risk of acquiring HIV may be very low. The potential efficiency gains are also obvious. Action point 2 therefore focuses on developing a national prevention Road Map or plan and setting detailed HIV prevention targets.

The survey found that GPC focus countries are gradually adjusting their prevention efforts with greater precision. Almost two thirds of countries (22/35) have established granular prevention targets and 21 countries were in the process of translating their national targets into sub-national ones. Three quarters of the countries (26/35) have developed differentiated HIV prevention packages, including ones for adolescent girls and young women (in countries with mixed epidemics).

Many countries have assessed their HIV epidemics, set granular targets, adapted their Road Maps and developed costed HIV plans. But more focus is needed on sub-national targets and plans—and on allocating investments in ways that will scale up and sustain national prevention programmes.27

Assessed under this action point was whether a country had: translated national targets into sub-national targets; developed differentiated HIV prevention packages, including packages for adolescent girls and young girls where relevant; and had standard operating practices or implementation guides in place for the relevant pillars.
3. Determine country investment needs for adequately scaled HIV prevention responses and ensure sustainable financing

Shortfalls in funding for prevention programmes remain a major handicap. Very few GPC focus countries have raised their HIV prevention spending close to the levels required. HIV prevention programmes typically depend heavily on international resources (principaliy PEPFAR and the Global Fund) and that reliance is especially strong for programmes aimed at servicing the specific prevention needs of women and girls and people belonging to key populations. In a context where overall funding for HIV is stagnating and where donor funding priorities are shifting unpredictably, it is even more important for countries to clearly define and cost their HIV prevention needs and pursue new ways of financing those programmes. Action point 3 requires countries to develop costed HIV prevention plans and stage dialogues to address their prevention funding gaps.

A majority of focus countries (22/35) now have a budgeted or costed plan to achieve the 2025 HIV prevention targets. However, the countries lacking such a plan include some where HIV incidence remains high (e.g., Eswatini, Lesotho, Mozambique, the United Republic of Tanzania and Zambia) or is rising rapidly (e.g., Madagascar). Most focus countries (28/35) have held dialogues with key partners to address HIV prevention funding gaps. Those engagements have generally involved national ministries of health, national AIDS councils, the Global Fund and PEPFAR, and various civil society and community networks. In some instances, national treasuries or ministries of finance, and various UN agencies were also involved.

4. Reinforce HIV prevention leadership entities for multisectoral collaboration, oversight and management of prevention responses

Strong political leadership has been the bedrock of successful HIV responses everywhere. It is especially important for HIV prevention, which requires mobilizing financing and supporting interventions which may take some time to yield demonstrable results. It is also important for promoting policies which may attract controversy from some quarters. Action point 4 expects countries to have a functional multisectoral HIV prevention leadership in place and to have established milestones for that entity.

The Multi-sector HIV Leadership Forum, with support from the Global Prevention Coalition, has developed a position paper on sustaining effective response leadership, including through country-owned prevention systems.
All but three of the focus countries now have a designated entity to lead and manage a multisectoral and collaborative prevention response, and in most of them (20/32) that entity met at least once in the previous 12 months. In most countries, the entities include representation from other sectors, including social welfare and education, as well as from civil society. However, they continue to struggle to influence funding and budgeting decisions and their ability to effectively coordinate prevention activities across sectors also remains a concern. Only seven focus countries have gone on to develop milestones to reinforce these entities.

5. Strengthen and expand community-led HIV prevention services and set up social contracting mechanisms

The importance of community-led HIV prevention activities, especially for serving marginalized and vulnerable populations, is increasingly recognized. However, progress has been mixed for action point 5, which covers key elements that can facilitate the delivery of HIV prevention services by community-led organizations.

A small minority of countries (4/35) have significantly expanded their support for community-led prevention services. Countries are not making adequate use of community-based knowledge, networks and resources to lead and boost prevention efforts.

While most countries (25/35) reported allocating at least some public funding to non-governmental organizations (NGOs, some of which may be community-led) for prevention, this typically was in addition to external financing, which remains the mainstay funding source for those organizations. Several countries noted that staffing and technical capacities remained barriers for NGOs, yet only a few (9/35) have set milestones to strengthen and expand community-led prevention services. About one third of the countries (13/35) reported that they had laws or policies that hinder the registration, funding or contracting of NGOs—most of them countries with HIV epidemics that primarily affected key populations.

Countries have put in place important elements of country- and community-led HIV prevention. However, most countries are yet to define specific actions to strengthen genuine country- and community-led prevention systems.
6. Remove societal and legal barriers to HIV prevention services for key and priority populations

The legal and societal environments in GPC focus countries remain less than ideal and, in some cases, are undermining prevention efforts. While prevention strategies for most focus countries (26/35) identify relevant legal, policy and structural barriers, far fewer countries (11) have set milestones to clear those barriers. This hesitancy is occurring in a wider context where, in recent years, several countries have introduced additional legal barriers, including harsh punishments directed at certain key populations, making it even more difficult to reach those populations with HIV prevention services.

Part of the problem may be that the government departments tasked with enforcing obstructive laws and policies are not the ones that draw up and manage HIV prevention strategies. While prevention plans may identify the barriers, removing them requires overarching political will and multisectoral collaboration, which can be difficult to rally, especially in contexts where conservative political and cultural forces prevail.

7. Promote the integration of HIV prevention into essential related services to improve HIV outcomes

When integrated with other health and social services, HIV services can be more efficient, effective and user-friendly than stand-alone measures. Integration can also save costs for people using the services (by reducing the expense of repeat clinic visits) and achieve cost-savings for service providers (if services can be delivered simultaneously and by using the same platforms) (49).

Survey responses on this action point suggest that the integration of HIV prevention and other relevant services, including for tuberculosis, is proceeding slowly, with about half of the countries (17/35) having developed integration milestones. Most of the integration efforts are focused on sexual and reproductive health services, and on maternal and child health services. The integration of HIV testing with viral hepatitis services is also progressing for key populations in some countries.
8. Set up mechanisms for the rapid introduction of new HIV prevention technologies and programme innovations

Oral PrEP is transforming HIV prevention in some of the high-income settings where it is in wide use among key populations, notably gay men and other men who have sex with men (50, 51). In GPC focus countries, oral PrEP is a potentially powerful additional prevention option for key and priority populations. Long-acting PrEP products, such as injectable cabotegravir and the dapivirine vaginal ring, have only recently become available and hold great promise for enhancing HIV prevention.

Post-exposure prophylaxis (PEP), an important prevention option, is underutilized and poorly accessible, with low awareness among both health-care providers and communities in many countries. HIV self-testing, the development of child-friendly, dolutegravir-based paediatric HIV treatment, and differentiated service delivery are among other important innovations in recent years.

All but one (Democratic Republic of the Congo) of the 35 GPC countries that responded to the survey stated that they were preparing for the rapid introduction of new HIV prevention technologies, though fewer than half (16/34) have set milestones for actual provision of these tools. A few countries in eastern and southern Africa—notably Kenya and South Africa—have gone further and have increased the provision of oral PrEP for female sex workers and adolescent girls and young women in areas with very high HIV incidence. Oral PrEP provision has also expanded in some countries in Asia and the Pacific, with a focus mainly on gay men and other men who have sex with men and on transgender women. However, oral PrEP is still not being provided or used to full effect in many GPC countries. Meanwhile, a few countries have taken regulatory steps towards providing long-acting PrEP options. By late 2023, 13 countries had registered long-acting PrEP products, such as long-acting injectable cabotegravir, for use.

Technological advances offer new ways to achieve scaled-up and cost-efficient HIV prevention communication and services. A wide range of digital and other virtual interventions is already available. Artificial intelligence opens further opportunities for fresh solutions.
9. Establish real-time prevention programme monitoring systems with regular reporting

Focus countries have strengthened the assessment of many of their prevention programmes. According to the survey responses, most countries have triangulated data from programmes and key stakeholders to estimate programme coverage. Several countries are also aggregating data on the provision of PrEP for relevant populations and/or the use of VMMC services (where relevant). However, several countries reported gaps in triangulating data for adolescent girls and young women and for condoms distributed through social marketing and in the public and private sectors.

Detailed programme monitoring, particularly at local levels, is important for introducing more precise prevention activities and finetuning them, but it is still uncommon among GPC focus countries: only 6/35 countries have developed sub-national scorecards. In the current funding climate, financial analyses of prevention programmes are more salient than ever, yet they also remain comparatively rare. In the survey, 13/35 countries reported analysing their HIV prevention funding expenditures, and only 8 reported including cost-effectiveness analyses in their programme reviews.

10. Strengthen accountability of all stakeholders for progress in HIV prevention

A solid accountability system is crucial for both financing and successfully managing HIV prevention programmes. The survey results indicate a marked lack of progress on this front. Only eight countries have developed an accountability framework as proposed in the HIV Prevention 2025 Road Map, while 16 countries have taken none of the steps outlined under this action point. The most commonly implemented elements were quarterly dialogues to track the progress of HIV programmes and solve problems, along with annual dialogues on how to reduce legal and policy barriers, and annual HIV prevention programme performance reviews based on the scorecards of countries. Greater inclusion of civil society, particularly affected communities, in accountability processes is important for strengthening accountability around HIV programmes.
CONCLUSION: REALIZE THE FULL POTENTIAL OF HIV PREVENTION

The GPC focus countries are progressing unevenly towards the goal of reducing HIV infections to levels that would no longer constitute a public health threat. The biggest declines are occurring in eastern and southern Africa and, to a lesser degree, in western and central Africa. Expansion of access to effective ART, combined with an ongoing focus on primary prevention, are driving those achievements.

The pace of the reductions in focus countries in sub-Saharan Africa varies markedly, though. Steep decreases in annual new HIV infections are underway in Cameroon, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, the United Republic of Tanzania and Zimbabwe. But progress is considerably slower in Angola, Ghana, Mozambique, Namibia, South Sudan and Uganda, and new infections are increasing in the Congo and Madagascar.

Outside sub-Saharan Africa—where the HIV burden weighs heaviest on key populations and their sex partners, and where investments in prevention programmes have been low—there has been progress in a few countries only. New HIV infections are increasing in several GPC focus countries which already have substantial epidemics, including Brazil, Egypt, Islamic Republic of Iran, Mexico, Pakistan, Papua New Guinea, Peru and the Philippines.
HOW TO DO BETTER: COMBINATION PREVENTION AND TREATMENT TO ACHIEVE THE GLOBAL HIV INCIDENCE TARGETS

Reductions in HIV incidence over the past two decades have been achieved with major contributions from both prevention and treatment programmes. Historically, condoms and HIV treatment have likely had the biggest impact overall, along with important contributions male circumcision in Africa and harm reduction programmes among drug users. There is great scope for further improvement. The opportunities presented by those interventions are far from being exhausted, and new prevention options hold fresh prospects for further HIV prevention gains.

Meanwhile, disparities in treatment access and outcomes are affecting HIV incidence trends. Even though HIV incidence among women in sub-Saharan Africa is declining, women comprise a growing share of new HIV infections in eastern and southern Africa. That trend appears to be associated with the higher ART coverage and higher rates of viral load suppression in women compared with men (which makes them less likely to transmit HIV to their male partners) and with the impact of VMMC programmes (which offer men direct partial protection against acquiring HIV). Interventions that bring viral suppression rates among men on par with those among women could markedly reduce HIV incidence in women and close the gender disparities in new HIV infections.

The overall mixed picture of progress underscores the ongoing need for effective HIV prevention programmes that serve key and priority populations everywhere. Those programmes require:

1. Financial resources for making prevention options available and accessible;

2. Reliable, disaggregated data (including community-generated data) so planners can focus interventions with greater precision;

3. Differentiated service delivery and innovation and investment in trusted access platforms; and

4. Demand generation among people with the greatest need for prevention services.

5. Address key behavioral and structural barriers for accessing HIV prevention.

---

28 As mentioned earlier in this report, natural epidemic dynamics and behaviour changes—partly due to prevention programmes and partly due to community responses to the observed consequences of AIDS—also played an important role in the reduction of HIV incidence during the earlier stages of the pandemic.
A user-centered approach—built around positive messages about safe and enjoyable sex—would help turn HIV prevention options into actual choices for people. Rather than promote single products or tools, programmes should be increasing awareness about, and demand for, prevention options that are most relevant and suitable for people in their given circumstances.

Other studies (55, 56) confirm the importance, in African epidemics with high HIV prevalence, of intensified combination prevention for women and girls (including convenient access to PrEP), while striving for higher treatment coverage and levels of viral suppression among both women and men. Communication around U=U (“undetectable is untransmittable”) as a prevention option needs to be integrated into prevention messaging and should highlight the prevention opportunities and risks for populations who do not know the HIV status of their sexual partners.

Condom programming needs to be revived in ways that go beyond the provision of condoms and lubricants. Lessons from the past decade suggest that a focus on commodity supplies was not enough to sustain condom use. Dedicated programme stewardship is needed to direct, communicate, monitor and problem-solve, and achieve more effective condom programming. Stronger demand creation is also needed, with an emphasis on the multiple benefits of condoms for preventing HIV and other STIs and for averting unintended pregnancies. VMMC programmes must also be expanded in eastern and southern Africa, especially in countries with currently low uptake.

Crucially, a much stronger focus is needed on services that reach marginalized populations who are at substantial risk of HIV infection and who require more comprehensive and resource-intensive HIV prevention than on services for populations who are at low risk. Those services include PrEP and PEP, harm reduction and intensified outreach support. This is vitally important in countries and settings where most new infections are occurring among people who belong to key populations and their sex partners.

To gain traction and boost impact, the changes must occur in a context of stepped-up actions to reduce stigma and discrimination (especially in health-care settings); remove or relax obstructive policies and laws; safeguard civic space; and ensure more equitable access to the basic means for a dignified life. Closer engagement with community-led organizations and activities needs to become a routine feature of prevention interventions throughout.
Despite the admirable progress achieved in many GPC focus countries, HIV incidence remains much higher in eastern and southern Africa than in the rest of the world and incidence is increasing in several countries in other regions. To reduce those rates to levels as low as the global mean (i.e., less than 1 per 10 000 person-years), countries with high HIV prevalence require adequate and sustained investments in both treatment and prevention over the medium to long term.

Epidemic projections suggest that if the 2025 treatment (95–95–95), prevention and social enabler targets are met, an 88% reduction in HIV incidence can be achieved in eastern and southern Africa between 2022 and 2030. By contrast, current coverage of treatment and prevention programmes would yield only a 17% additional reduction in HIV incidence between 2022 and 2030, and disruptions to treatment coverage and viral load suppression could trigger rebounding epidemics. Countries that reach or come close to reaching the 2025 targets and sustain effective primary prevention programmes can expect HIV incidence to continue to decline for at least 15 years if other prevention elements are continued.

Substantially different considerations are needed for planning sustainable HIV prevention in large parts of the world, including Asia-Pacific, Latin America, the Middle East and North Africa and eastern Europe and central Asia. In those regions, HIV investments have been lower and HIV incidence either has not declined substantially or is on the rise, in particular among key populations and their sex partners. The first priority there is to achieve impact in sustainable ways. Considering the limited progress made thus far, the period up to 2030 will require closing large HIV prevention gaps among key populations. Making those programmes sustainable will require defining country- and community-led programme models that can achieve impact at the required scale and that can be sustained beyond 2030.

Successful HIV prevention must be focused and must occur at scale. A differentiated approach implies making appropriate prevention options easily accessible and normalizing HIV prevention by making those options widely known and available. It also implies promoting and supporting the use of those options in a focused manner.

Convenient and affordable access to effective prevention and testing options for large populations will remain important, particularly in sub-Saharan Africa. Modelling based on South Africa’s HIV epidemic, for example, suggests that a substantial drop-off in condom use and HIV testing would slow and eventually stall HIV incidence reductions even if high levels of ART coverage are maintained among the people who already receive treatment. Thus, there is a powerful rationale for sustaining effective basic primary prevention of HIV over the long term, in addition to sustaining high levels of viral suppression. Importantly, there also is compelling new evidence that the basic components of primary HIV prevention (including condoms, harm reduction, testing and treatment, and, in eastern and southern Africa, VMMC) remain highly cost-effective, essential investments and should continue to be implemented at scale for large populations in sub-Saharan Africa.
People-centered and precise prevention

As outlined in the 2025 Road Map, it is vital to know where and among which populations HIV transmission is occurring and to design prevention access platforms that reach those populations. Doing so will reduce the need to screen for risk at the individual level, which can be a barrier to service access. In the lived realities of many people, HIV-related risk is not necessarily their top concern in their sexual lives and intimate relationships—and the entry points for conversations about HIV prevention need to reflect that. HIV communication should focus also on the concerns that matters most to individuals and communities, which often include themes such as autonomy, choice, trust and the desire for fulfilling relationships.

In addition, settings and sub-populations with high HIV incidence will continue to require intensive combination prevention that involves PEP, a variety of PrEP options, and regular community-led outreach. Recent research suggests that, in some settings, high HIV incidence might persist even in the presence of HIV treatment and basic prevention (59,60). This underscores the need for much wider availability of ARV-based prevention options, including PEP and all forms of PrEP (including new long-acting options). Also needed are tailored demand generation and differentiated access platforms that reflect the realities and needs of the most affected communities, in particular key populations.

Differentiated service delivery and person-centered and community-led approaches for prevention are crucial. There is vast potential for innovation, including through virtual interventions and artificial intelligence, which offer opportunities to increase people's knowledge of, demand for, and access to HIV prevention.

NOW IS THE TIME TO INVEST IN PREVENTION

Despite the multiple opportunities, primary HIV prevention remains underfunded and programmes for key populations are particularly neglected in financing decisions. In 2022, less than 15% of the estimated resources needed for key population prevention programmes and for societal enablers were available in low- and middle-income countries.

Given the limited fiscal capacity in most GPC focus countries and the currently low domestic investment in primary prevention, it is vitally important that PEPFAR and the Global Fund continue investing in primary prevention—in addition to treatment—that prioritizes the populations in greatest need.
While HIV treatment is delivered primarily through existing health system infrastructure, primary prevention requires alternative systems for differentiated service delivery, outreach and demand generation which, in many countries, are established and maintained as part of donor-funded projects. Establishing country-owned prevention systems—including social contracting with key population-, women-, and youth-led networks and organizations—requires dedicated effort, time and, at least initially, financing support from international donors.

In the absence of an HIV vaccine and AIDS cure, the need for an effective and equitable HIV response will persist beyond 2030. Sustainability is of ever-growing importance—especially in a period marked by geopolitical instability, fiscal uncertainty, shifting donor priorities and the erosion of rights-based protections in several countries. In such a context, stronger country ownership and increased country resourcing of national HIV responses is also essential.

However, a range of constraints currently limits the abilities of many low- and middle-income countries to increase their HIV and other health spending. For at least some GPC focus countries, donor assistance will remain necessary in the short and medium term—but as part of a broader push towards increased sustainability. Achieving sustainability will require system-wide adaptations, built around the following components:

- **Strong political commitment** to share financing responsibility and support inclusive multisectoral governance and policies;

- **Mix of domestic and international financing** that is adequate, sustainable and equitable and that includes financing of community-led activities and services;

- **Predictable funding** allocations for science-driven, high-impact prevention programmes that are backed by well-functioning surveillance and data systems;

- **Resilient capacity** to deliver and manage integrated, differentiated and equitable HIV prevention interventions, adopt evidence-based approaches in line with international guidelines, and introduce innovations; and

- **Removal of harmful laws and the implementation of enabling policies** that support accessible, equitable and high-quality HIV services.

Current epidemic trends and the findings of new modelling suggest that the best time for investing in HIV prevention is now—not five or ten years down the line. Immediate investment will capitalize on and boost the momentum that has been built over the past decade, prevent a resurgence of HIV, and save lives and money in the long term.
ANNEX: STATUS OF HIV PREVENTION IN GPC MEMBER COUNTRIES

INTRODUCTION TO COUNTRY SUMMARIES

Annex 1 summarizes in a two-page poster, the status and progress of primary HIV prevention programmes in countries participating in the Global HIV Prevention Coalition.

The country summaries contain information on all levels of the HIV prevention programme results chain, including changes in HIV incidence; programme outcomes for various HIV prevention methods; coverage of programmes; and enablers and structural factors.

Two considerations guided the choice of indicators: the most relevant indicators for measuring impact, outcome and coverage of programmes, as well as for programme enablers; and the availability of data through the Global AIDS Monitoring (GAM) system, UNAIDS estimates and the most-commonly conducted types of population-based surveys, including demographic and health surveys (DHS), multiple indicator cluster surveys (MICS), integrated biological and behavioural surveillance (IBBS), population-based HIV impact assessments (PHIA) and other AIDS indicator surveys.
The data included in the country summaries refer to different time periods.

- The estimates of the number of people newly infected with HIV are based on modelling, using data from population-based surveys which are conducted every two to five years. These surveys are also the source for data on prevention behaviours, such as condom use.

- Programme coverage ideally refers to the most recent calendar year, but reflects financing decisions taken earlier in the response.

As such, progress on one indicator in one year does not necessarily register immediately in another, higher-level indicator, since that progress might only be revealed through a survey (the results of which may only become available years later).

**HIV incidence and prevalence**

Trends in the number of people (all ages) newly infected with HIV are based on UNAIDS 2023 estimates and are shown as line graphs against the 2025 target of an 82.5% reduction. The reduction between 2010 and 2022 is also expressed as a percentage, with 2010 as the denominator. The reduction among adults, young women and children is also shown as a percentage. Estimates of the HIV prevalence among young women and men (based on the UNAIDS 2023 estimates), as well as key populations (based on available bio-behavioural surveillance), are also presented. HIV prevalence among young people—including young key populations—can provide an indication of the level of HIV incidence in recent years, while considering that HIV prevalence may also include long-term survivors of the vertical transmission of HIV. In addition, it needs to be considered that data for young key populations often have limitations in terms of representativeness and sample size.

**HIV prevention outcomes for the five pillars**

The country summaries include information on HIV prevention outcomes, which are generally presented in the form of charts. The information is drawn from several sources.

- The data on condom use among young women, young men and other adults with non-regular partners are based on population-based surveys, such as DHS, MICS and PHIA.

- The data on condom use and the use of safe injecting equipment among key populations are based on IBBS. Programmatic data are used for opioid substitution therapy. Data on condom use among the clients of sex workers are mostly from DHS.
The data on VMMC are from programme records. The data on the prevalence of male circumcision among boys and men (15–24 years) are from population-based surveys, mostly DHS and PHIA.

With respect to ARV-based prevention, information on the number of people using PrEP for the past four years and on the third 95 target (95% of people receiving treatment have suppressed viral loads) is included. PrEP data are based on programme records. The proportion of people living with HIV who are virally suppressed is based on the UNAIDS 2023 estimates.

Most available survey information is from before 2022; hence, there is not yet sufficient information from surveys to analyse trends over time, given that the 2025 Road Map was launched in 2022.

HIV prevention programme coverage

The country summaries include information on programme outputs in terms of availability and coverage of prevention programmes.

For prevention programmes among adolescent girls and young women (15–24 years), coverage is measured geographically in terms of the percentage of high-incidence locations based on UNAIDS sub-national HIV estimates with dedicated programmes for this population (using data reported to the Global Fund, PEPFAR and UNICEF). A more precise indicator to measure coverage is being developed.

For prevention programmes among key populations, coverage is defined as the percentage of people who received at least two HIV prevention interventions in the previous three months. This information is based on the number of people reached, according to programme records, as a proportion of the total estimated population sizes of the key populations. In some countries, this information is also based on population-based surveys such as IBBS.

For condoms, coverage is defined as the percentage of condom distribution need that was met. This represents the total number of condoms distributed in a country in a year, divided by the total estimated condom need (according to the UNAIDS-UNFPA condom needs estimation tool).

For VMMC, the level of coverage is defined as the number of these procedures reported by programmes as a percentage of the annual target derived from the UNAIDS Fast-Track model.

The PrEP score is based on whether regulatory approval and national guidelines are in place and on a PrEP coverage score. The latter is derived from the estimated number of people who received PrEP in the previous 12 months (based on programme records) relative to the epidemic size. PrEP coverage data is based on programme records and country reporting. The number of new adult HIV infections as per the UNAIDS 2023 estimates serves as a proxy for epidemic size.
The ART score is based on the proportion of all people living with HIV who are receiving HIV treatment. The data on the latter are based on UNAIDS estimates (general population) and from programme records (key populations).

The country fact sheets also include a section on the elimination of vertical transmission of HIV, which reports on the rate of vertical transmission of HIV; the percentage of pregnant women living with HIV receiving ART; the number of estimated births to women living with HIV; and the number of children acquiring HIV through vertical transmission. Those data are derived from the GAM system and 2023 UNAIDS estimates.

The programme coverage data are not strictly comparable between countries, since countries use different methods for calculating population size estimates and different approaches for defining and measuring programme coverage. Furthermore, large data gaps persist for ascertaining programme coverage, especially among key populations. An additional, preliminary triangulation of data, using data from Global Fund and PEPFAR reports, was conducted for programme coverage among key populations. Although this exercise has many limitations, it is considered a starting point for making use of existing data. Countries are encouraged to conduct such a triangulation locally in the future as part of country reporting to the GAM process.

Summary scores

Each country page also provides a snapshot of the country’s HIV prevention scorecard in the form of a summary score for each pillar of HIV prevention that is relevant to the country. When interpreting the scores, the following points need to be considered.

Scores are expressed on a scale of 0 to 10, based on programme coverage and outcome information (as described above). If coverage or outcome information is unavailable, the phrase “insufficient data” (or “id”) is shown. This points to a need to improve strategic information, for example by conducting regular population size estimates, monitoring condom availability, or improving the measurement of the numbers of people being reached.

For most indicators, the score is directly aligned to the percentage value of the indicator. For instance, if 20% of a population use a prevention method, the score will be 2; if 80% use the method, the score will be 8. For some indicators that require higher adherence to be effective (such as condom use among sex workers, the use of safe injecting equipment, or treatment coverage among pregnant women), the scale starts at 50%—in other words, 50% utilization is equivalent to a score of 0, 55% use equals a score of 1, and so on.

Coverage and outcome indicators have the same weight (50% each) in the scoring. For example, 44% programme coverage and 57% use of a prevention method yields a composite score of 5.
For prevention programmes among adolescent girls and young women, the score combines data on the percentage of high-incidence locations covered with programmes, levels of condom use among women 15–24 years old, and the percentage of girls completing lower-secondary education.

For key populations, the score reflects the percentage of key populations reached with prevention services, as well as condom use (for sex workers and gay men and other men who have sex with men) and the use of safe injecting equipment (for people who inject drugs).

For condom programmes, the score is based on the percentage of condom distribution need met and the rate of condom use with non-regular partners among women and men aged 15–49 years.

For VMMC, the score considers the percentage of circumcisions conducted as a proportion of the annual circumcision targets (as a measure of recent programme performance) and cumulative circumcision targets (as a measure of overall progress).

For PrEP, the score is based on a combination of preparedness (regulatory approval and guidelines in place) and actual coverage (number of people on PrEP compared with the burden of new HIV infections).

For HIV treatment, the score is based on the proportion of all people living with HIV who are receiving ART.

For eliminating vertical transmission of HIV, the score reflects ART coverage among pregnant women living with HIV.

Scores in the earlier and current versions of the scorecard are not directly comparable, since some indicator definitions have been updated, particularly for PrEP and VMMC.

The country guide to reviewing and consulting on scorecards and country posters in the Global HIV Prevention Coalition describes in greater detail the methods used to develop the scores.

29 For HIV treatment and prevention of vertical transmission, the score is based on the same results as the other thematic areas (i.e., coverage and outcome). The proportion of all people living with HIV who are receiving HIV treatment is a result that necessarily includes both dimensions: the coverage of HIV testing and the outcome in the form of utilization of HIV treatment. In other words, the score reflects the combined result of the first two targets in the 95–95–95 cascade.
Enablers and structural factors

Selected structural indicators are included in the country summaries for this 2023 report. For adolescent girls and young women, this includes completion of lower-secondary education; intimate partner violence; laws requiring parental consent for adolescents to access HIV testing services; and policies on life skills-based HIV and sexuality education (secondary schools).

For key populations, data are provided on criminalization of key populations; whether the national strategy includes critical elements of key population programme packages; and avoidance of health care services due to stigma and discrimination.

Links between HIV and sexual and reproductive health services are reported, specifically whether HIV testing services and provider-initiated condom promotion are integrated in sexual and reproductive health services.

Limitations

The GPC scorecards present a selection of information about the status of national HIV prevention programmes. Only a subset of this information is incorporated in the composite scores, which are therefore indicative rather than definitive and may not show important details that can be derived from examining the source indicators.

Although the national estimates of new HIV infections are derived annually from UNAIDS estimates, many indicators are derived from survey data that are only updated every three to five years. Therefore, not all indicators for a given country represent the same year. The values of some indicators may not reflect the most recent situation, while the values in one country’s scorecard are not necessarily derived from surveys conducted in the same year as those for another country. In addition, the National Commitments and Policy Index (NCPI) survey is an important source of scorecard data, but not all indicators are updated annually.

Given the importance of epidemiological dynamics, trends in the rates of new HIV infections cannot be attributed directly to progress or lack of progress in a country’s HIV prevention programmes, nor to the direct influence of the GPC. In many countries, the numbers of people newly infected with HIV began to decline before 2015 or before 2010; the trends shown in the next section therefore reflect only the most recent phase in their HIV prevention progress.

The summary of all country scores and HIV incidence trends (Figure 12) shows that progress on prevention varies greatly. Good country examples exist for virtually all pillars of prevention, but gaps in coverage, outcomes and data persist in most countries.
Figure 12. Overview on HIV incidence trends and country scores in GPC member countries

Source: 2023 prevention scorecards based on 2023 UNAIDS estimates, Global AIDS Monitoring, other programmatic reports and special analyses.
The State of HIV Prevention in Angola

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

Girls who completed lower secondary education

Policies on life skills-based HIV and sexuality education (secondary schools)

Laws requiring parental consent for adolescents to access HIV testing services, age of consent

HIV prevalence

Change in new HIV infections

TARGET 2010–2025

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Pre-exposure prophylaxis

Antiretroviral treatment

Number of new child infections because mother did not continue ART during pregnancy or breastfeeding

Distribution of new child infections

PREVENTION OF VERTICAL TRANSMISSION OF HIV

MTCT rate 16%

% of HIV-positive pregnant women receiving ART 80%

Number of Estimated births to women living with HIV 24,000

Number of new child infections due to vertical transmission 3,800

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets. A 90% reduction by 2030 is the aim. These reductions are required to achieve a 90% reduction by 2030.

Note: The annual goals set for key populations are realistic targets within the context of the strategies and programmes in place. These targets may be updated and amended as needed.

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Provision of initiated condom promotion integrated into sexual and reproductive health services
The State of HIV Prevention in Botswana

### HIV prevalence

#### 2010-2025 Target: 82.5%

- Adults, 15-45 years: 2%
- Young women, 15-24 years: 2%
- Children, 0-4 years: 1%
- Gay men and other men who have sex with men: 4%
- People who inject drugs: 2%
- Transgender people: 4%
- People in prisons: 6%

Note: 2020 and 2025 targets for reducing new HIV infections represent the country's required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

### Key populations

- **Adolescent girls and young women**
  - Proportion of women who experienced intimate partner violence: Very low
  - Girls who completed lower secondary education: Very low
  - Policies on life skills-based HIV and sexuality education (secondary schools): Very low
  - Laws requiring parental consent for adolescents to access HIV testing services, age of consent: Very low

### Policy and structural barriers

- **Criminalization of the behaviour of key populations**
- **The national strategy includes critical elements of the programme package for key populations**
- **Avoided health care because of stigma and discrimination**

### Population size

- **Adolescent girls and young women**
  - 15-19 years: 13,000
  - 15-49 years: 69,000

### Men and Boys (Including VMMC)

- **Condom use, condom distribution**
- **Preventive measures and VMMC**
- **Pre-Exposure Prophylaxis (PrEP)**

### Antiretroviral Drug-based Prevention

- **Prevention of vertical transmission of HIV**
- **Transmission during pregnancy or breastfeeding**
- **Newborns and infants**
- **People living with HIV**

### Road Map Actions

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health
- Programs initiated condom promotion integrated into sexual and reproductive health services

### Distribution of new child infections

- % of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding
- % of child infections because mother did not receive antiretroviral treatment during pregnancy or breastfeeding

- Note: The 2022-2025 epidemiological estimates are based on data from 2010 to 2022. Other data gaps may arise in various years when the surveys were conducted.

- Note: The 2022-2025 epidemiological estimates are based on data from 2010 to 2022. Other data gaps may arise in various years when the surveys were conducted.

- Note: The 2022-2025 epidemiological estimates are based on data from 2010 to 2022. Other data gaps may arise in various years when the surveys were conducted.

- Note: The 2022-2025 epidemiological estimates are based on data from 2010 to 2022. Other data gaps may arise in various years when the surveys were conducted.
The State of HIV Prevention in Brazil

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services

HIV programme coverage and outcomes

Number of new HIV infections (all ages)

Change in new HIV infections

TARGET 2010-2025

82.5%

HIV prevalence

SCORES (1–10)

Very good Good Medium Low Very low id insufficient data na not applicable

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.
The State of HIV Prevention in Cameroon

Policy and structural barriers

Key populations

HIV prevalence

Percentage of coverage and outcomes

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health if not already available

Prevention of vertical transmission of HIV

% of HIV-positive pregnant women receiving ART

68%

Number of Estimated births to women living with HIV

24,000

Number of new child infections due to vertical transmission

3,400

Distribution of new child infections

% of child infections because mother was on antiretroviral therapy during pregnancy or breastfeeding

86%

% of child infections because mother did not continue antiretroviral therapy during breastfeeding

97%

% of child infections because mother acquired HIV during pregnancy or breastfeeding

100%

% of child infections because mother had an antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemened

100%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

88%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding

97%

% of child infections because mother was treated with antiretroviral therapy during pregnancy or breastfeeding

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

99%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%

% of child infections because mother did not receive antiretroviral therapy during or postpartum

99%

% of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding

89%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

82%

% of child infections because mother was not on antiretroviral treatment during pregnancy or breastfeeding

96%

% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently supplemented

99%
The State of HIV Prevention in Central African Republic

### HIV Prevalence

<table>
<thead>
<tr>
<th>Category</th>
<th>2010</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, 15+ years</td>
<td>2.6%</td>
<td>2.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td>3.8%</td>
<td>3.4%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

### Change in new HIV infections

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, 15+ years</td>
<td>2,000</td>
<td>1,800</td>
<td>1,800</td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td>400</td>
<td>350</td>
<td>320</td>
</tr>
<tr>
<td>Children, 0-14 years</td>
<td>50</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

### Policy and structural barriers

- **Key populations**
  - Gay men and other men who have sex with men (GMSM)
  - People who inject drugs (PWID)
  - Transgender people
  - People in prisons

- **Criminalization of the behaviour of key populations**
  - Yes
  - No
  - Yes
  - No

- **The national strategy includes critical elements of the programme package for key populations**
  - 75%

- **Avoided health care because of stigma and discrimination**
  - 50%

- **Population size**
  - 9,600
  - 8,800
  - 8,000
  - 7,500
  - 7,000
  - 6,000
  - 5,000
  - 4,000
  - 3,000
  - 2,000
  - 1,000

### HIV programme coverage outcomes

#### ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS

<table>
<thead>
<tr>
<th>Category</th>
<th>2010</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use with a non-regular partner among young people, 15-24 years old (%)</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Condom use at last paid sex (%)</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Use of family planning services (%)</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
</table>

#### KEY POPULATIONS

- **Gay men and other men who have sex with men**
  - Condom use with a non-regular partner, 15-49 years
  - Condom use at last paid sex
  - Use of family planning services

- **People who inject drugs**
  - Condom use with a non-regular partner
  - Condom use at last paid sex
  - Use of family planning services

- **People in prisons**
  - Condom use with a non-regular partner
  - Condom use at last paid sex
  - Use of family planning services

#### CONDOM PROGRAMMING

- **Distribution of new child infections due to vertical transmission**
  - % of child infections because mother was on antiretroviral therapy during pregnancy or breastfeeding
  - % of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding
  - % of child infections because mother acquired HIV during pregnancy or breastfeeding

### MEN AND BOYS (INCLUDING VMIC)

- **Pre-exposure prophylaxis (PrEP)**
  - Number of people actively taking PrEP
  - Percentage of HIV-positive people on PrEP

- **Antiretroviral treatment**
  - % of HIV-positive pregnant women receiving ART

### ANTIRETROVIRAL DRUG-BASED PREVENTION

- **Uptake of voluntary medical male circumcision (VMMC)**
  - Number of people who have undergone male circumcision
  - Number of people who have undergone VMMC

### PREVENTION OF VERTICAL TRANSMISSION OF HIV

- **MTCT rate**
  - % of HIV-positive pregnant women receiving ART
  - % of child infections because mother acquired HIV during pregnancy or breastfeeding
  - % of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding
  - % of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding

### Distribution of new child infections

- % of child infections because mother acquired HIV during pregnancy or breastfeeding
- % of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding
- % of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding

### Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health
- Providers initiated condom promotion integrated into sexual and reproductive health services
The State of HIV Prevention in China

Number of new HIV infections (all ages)

HIV prevalence

Change in new HIV infections

TARGET 2010–2025 82.5%

HIV prevention: 77% reduction by 2025 against 2010 as a baseline.

2020 and 2025 targets represent the country’s required contribution to global targets, a 75% reduction by 2020 and 95% by 2025.

HIV programme coverage and outcomes

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration of related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV prevalence

Population size

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services.
**The State of HIV Prevention in Colombia**

**Policy and structural barriers**

**Key populations**

- Gay men and other men who have sex with men (MSM)
- People who inject drugs
- Sex workers
- Transgender people
- People in prisons

**Criminalization of the behaviour of key populations**

The national strategy includes critical elements of the programme package for key populations.

**Avoided health care because of stigma and discrimination**

Population size: id

- 7,600
- 5,900
- 10,000

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**HIV programme coverage and outcomes**

**Number of new HIV infections (all ages)**

- 9,700 (2010)
- 4,400 (2015)
- 2,000 (2020)
- 1,000 (2025)

**HIV prevalence**

- Key populations
  - Gay men and other men who have sex with men
  - People who inject drugs
  - Sex workers
  - Transgender people
  - People in prisons

**HIV programme coverage and outcomes**

- Scheduled ART coverage for the general population: 2010: 50%, 2020: 70%
- People in prisons with scheduled ART coverage in 2020: 50%

**Number of new HIV infections (all ages)**

- 10,000 (2010)
- 12,000 (2020)

**Pre-exposure prophylaxis (PrEP)**

- Number of people actively taking PrEP: id
- PrEP coverage per 100 people in high-risk populations: id

**Antiretroviral drug-based prevention**

- Change in use of PrEP
  - Overall: 50%
  - Gay men and other men who have sex with men: 50%
  - People who inject drugs: 50%

- Antiretroviral treatment coverage
  - Overall: 50%
  - Gay men and other men who have sex with men: 50%
  - People who inject drugs: 50%
The State of HIV Prevention in Congo

**Policy and structural barriers**

**Key populations**

<table>
<thead>
<tr>
<th>Sex workers</th>
<th>Gay men and other men who have sex with men</th>
<th>People who inject drugs</th>
<th>Transgender people</th>
<th>People in prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>id</td>
<td>id</td>
<td>na</td>
</tr>
</tbody>
</table>

**Criminalization of the behaviour of key populations**

<table>
<thead>
<tr>
<th>populations</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young women, 15-24 years</td>
<td>17%</td>
<td>10%</td>
<td>id</td>
<td>id</td>
</tr>
<tr>
<td>Male partners</td>
<td>17%</td>
<td>10%</td>
<td>id</td>
<td>id</td>
</tr>
</tbody>
</table>

**The national strategy includes critical elements of the programme package for key populations**

Avoided health care because of stigma and discrimination

<table>
<thead>
<tr>
<th>Proportion of women who experienced intimate partner violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents (15–19 years)</td>
</tr>
<tr>
<td>10%</td>
</tr>
</tbody>
</table>

**Population size**

Adolescent girls and young women

15–49 years

<table>
<thead>
<tr>
<th>TARGET 2010–2025 Road Map Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 baseline</td>
</tr>
</tbody>
</table>

**HIV programme coverage and outcomes**

**ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS**

Sex workers

- Condom use among young people, 15-24 years old (%): 45%
- Condom use among men (%): 66%

Gay men and other men who have sex with men

- Condom use among men (%): 75%
- Condom use among young men (15-24 years old): 64%

People who inject drugs

- Condom use among young people, 15-24 years old (%): 40%
- Condom use among people who inject drugs (%): 64%

**CONDOM PROGRAMMING**

- Estimated condom distribution need (%): id

**MEN AND BOYS (INCLUDING VMIC)**

- Pre-exposure prophylaxis
  - Uptake of voluntary medical male circumcision
  - Pre-Exposure Prophylaxis (PrEP)

**ANTIRETROVIRAL DRUG-BASED PREVENTION**

- Antiretroviral treatment
  - Number of people on ART
  - Proportion of people on ART

**PREVENTION OF VERTICAL TRANSMISSION OF HIV**

- Antiretroviral treatment coverage
  - Overall
  - Sex workers
  - Men

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**Linkages between HIV and sexual and reproductive health services**

- HIV testing services integrated within sexual and reproductive health services
- Providers initiated condom promotion integrated into sexual and reproductive health services

**Distribution of new child infections**

1. % of child infections because mother acquired HIV during pregnancy or breastfeeding
2. % of child infections because mother did not receive antiretroviral treatment during pregnancy or breastfeeding

**Data sources**

- UNAIDS 2023 household of indicators
- WHO 2023, Revolving 2022, 2021, 2020, 2019
- UNAIDS 2023 Programme

Note: The 2023 UNAIDS household of indicators represents the year 2022. Other data points may refer to various years where the survey was conducted.

Legend: NA = not applicable; id = insufficient data; 0% = not available

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |

**HIV prevalence**

- Number of new HIV infections (all ages)
- Condom use at last paid sex is (%)
- Condom use, coverage of prevention interventions (as shown above)
- Condom use, condom distribution

**HIV programme coverage and outcomes**

- People who inject drugs
- People in prisons
- People who inject drugs

**2010 baseline | 2020 | 2022 |
The State of HIV Prevention in Côte d’Ivoire

### HIV Prevalence

<table>
<thead>
<tr>
<th>Year</th>
<th>Young women, 15-24 years</th>
<th>Adult men, 15-49 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>2015</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>2020</td>
<td>2%</td>
<td>4%</td>
</tr>
</tbody>
</table>

### Key Populations

- Sex workers
- Gay men and other men who have sex with men
- People who inject drugs
- People in prisons

### Change in New HIV Infections

<table>
<thead>
<tr>
<th>Year</th>
<th>Adults, 15 years</th>
<th>Young women, 15-24 years</th>
<th>Children, 0-4 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>10 000</td>
<td>8 000</td>
<td>2 000</td>
</tr>
<tr>
<td>2020</td>
<td>5 000</td>
<td>4 000</td>
<td>1 000</td>
</tr>
</tbody>
</table>

### Policy and Structural Barriers

- Criminalization of the behaviour of key populations
- The national strategy includes critical elements of the programme package for key populations
- Avoided health care because of stigma and discrimination

### Population Size

<table>
<thead>
<tr>
<th>Category</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young men</td>
<td>15-49 years</td>
<td>68 000</td>
</tr>
<tr>
<td>Young women</td>
<td>15-49 years</td>
<td>66 000</td>
</tr>
<tr>
<td>People in prisons</td>
<td></td>
<td>2 000</td>
</tr>
</tbody>
</table>

### Road Map Action 2023

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Linkages between HIV and Sexual and Reproductive Health Services

- HIV testing services integrated within sexual and reproductive health
- Providers initiated condom promotion integrated into sexual and reproductive health services

### Baseline status of 10 HIV Prevention 2025

<table>
<thead>
<tr>
<th>Component</th>
<th>2023 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use with a non-regular partner, 15–49 years</td>
<td>30%</td>
</tr>
<tr>
<td>Condom use at last anal sex, condom distribution</td>
<td>80%</td>
</tr>
<tr>
<td>Use of harm reduction services, condom distribution</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Prevention of Vertical Transmission of HIV

<table>
<thead>
<tr>
<th>Category</th>
<th>2023 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of HIV-positive pregnant women receiving ART</td>
<td>80%</td>
</tr>
<tr>
<td>Number of estimated births to women living with HIV</td>
<td>15,000</td>
</tr>
<tr>
<td>Number of new child infections due to vertical transmission</td>
<td>1,600</td>
</tr>
</tbody>
</table>

### Data sources

- UNAIDS 2020 Baseline Analysis
- ICF – the DHS Program STATcompiler
- Global AIDS Monitoring 2020
- Antiretroviral treatment coverage, ART virologically suppressed.

Note: 2020 and 2025 targets for reducing new HIV infections represent the country's required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.
The State of HIV Prevention in Democratic Republic of the Congo

### ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS

- **Sex workers**
  - Proportion of women who experienced intimate partner violence: 52%
  - Policies on sex-based discrimination: None
- **Gay men and other men who have sex with men**
  - Proportion of men who completed lower secondary education: 90%
  - Antiretroviral treatment coverage: Not applicable
- **People who inject drugs**
  - Proportion of people who completed lower secondary education: 90%
  - Policy and structural barriers: None

### HIV programme coverage outcomes

- **Condom use**
  - Percentage of people who completed lower secondary education: 90%
- **Safe sex education and promotion**
  - Percentage of people who completed lower secondary education: 90%
- **HIV prevalence**
  - Percentage of people who completed lower secondary education: 90%
- **HIV testing services**
  - Percentage of people who completed lower secondary education: 90%

### Key populations

- **Gay men and other men who have sex with men**
  - Condom use: 60%
  - Avoided health care because of stigma and discrimination: 40%
- **People who inject drugs**
  - Condom use: 50%
  - Avoided health care because of stigma and discrimination: 30%

### CONDOM PROGRAMMING

- **Condom use with a non-regular partner**
  - Percentage of people who completed lower secondary education: 90%
- **Condom use at last paid sex**
  - Percentage of people who completed lower secondary education: 90%
- **Condom use at last anal sex**
  - Percentage of people who completed lower secondary education: 90%
- **Safe injection practices**
  - Percentage of people who completed lower secondary education: 90%

### MEN AND BOYS (INCLUDING VMIC)

- **Pre-exposure prophylaxis (PrEP)**
  - Coverage: 30%
  - Antiretroviral treatment coverage: 30%
- **Antiretroviral treatment**
  - Percentage of people who completed lower secondary education: 90%
  - People on ART who achieve virological suppression: 70%

### PREVENTION OF VERTICAL TRANSMISSION OF HIV

- **MTCT rate**
  - Percentage of people who completed lower secondary education: 90%

### Distribution of new child infections

- **Number of new child infections due to vertical transmission**
  - Percentage of people who completed lower secondary education: 90%
- **Percentage of child infections because mother received antiretroviral therapy during pregnancy or breastfeeding**
  - Percentage of people who completed lower secondary education: 90%
- **Percentage of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding**
  - Percentage of people who completed lower secondary education: 90%

### Road Map Action

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Data sources

- UNAIDS 2023 epidemiological estimates
- Global AIDS Monitoring 2023
- Global Fund and PEPFAR reports obtained in 2023
- Other data points may refer to various years when the surveys were conducted.
The State of HIV Prevention in Egypt

HIV programme coverage and outcomes

### Key Populations

<table>
<thead>
<tr>
<th>Population</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use at last paid sex (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: 80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay men and other men who have sex with men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use at last sex (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: 90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who inject drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of harm reduction services (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: 80%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** 2020 and 2025 targets for reducing new HIV infections represent the country's required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

**Data sources:** UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

### Policy and structural barriers

**Key populations**

- Gay men and other men who have sex with men
- People who inject drugs

**Prevention interventions (as shown above), needle and syringe distribution, and safe injection practices**

- Condom use at last anal sex (%)
- Use of harm reduction services (%)

**Pre-exposure prophylaxis (PrEP)**

- Coverage per 100 people acquiring HIV

**Antiretroviral treatment**

- Coverage

**Change in use of PrEP (2021–2022)**

- Not documented

**Antiretroviral treatment coverage**

- Overall

**Road Map Action 2023**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

- Partial
- Yes

**Linkages between HIV and sexual and reproductive health services**

- HIV testing services integrated within sexual and reproductive health
- Provider-initiated condom promotion integrated into sexual and reproductive health services
### The State of HIV Prevention in Eswatini

#### Change in new HIV infections

<table>
<thead>
<tr>
<th>Year</th>
<th>Adults, 18-49 years</th>
<th>Young women, 15-24 years</th>
<th>Children, 0-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>2,300</td>
<td>800</td>
<td>200</td>
</tr>
<tr>
<td>2020</td>
<td>3,000</td>
<td>1,000</td>
<td>300</td>
</tr>
<tr>
<td>2021</td>
<td>3,800</td>
<td>1,200</td>
<td>400</td>
</tr>
<tr>
<td>2022</td>
<td>4,600</td>
<td>1,400</td>
<td>500</td>
</tr>
</tbody>
</table>

#### HIV prevalence

- Young women, 15-24 years: 40% in 2019, 60% in 2020, 80% in 2021, 100% in 2022.
- Sex workers: 20% in 2019, 40% in 2020, 60% in 2021, 80% in 2022.
- People who inject drugs: 80% in 2019, 100% in 2020, 100% in 2021, 100% in 2022.

#### Men and Boys (Including VMMC)

- Condom use with a non-regular partner: 60% in 2019, 80% in 2020, 100% in 2021, 100% in 2022.
- Condom use at last sex with a same-sex partner: 30% in 2019, 50% in 2020, 70% in 2021, 100% in 2022.
- Pre-exposure prophylaxis (PrEP): 20% of those who are sexually active and at risk of HIV exposure in 2019, 40% in 2020, 60% in 2021, 100% in 2022.

#### Pre-exposure prophylaxis (PrEP)

- Use of PrEP in the past 3 months: 10% in 2019, 20% in 2020, 40% in 2021, 100% in 2022.
- People living with HIV (PLWH) receiving antiretroviral therapy (ART) within 3 months of PrEP initiation: 95% in 2019, 90% in 2020, 85% in 2021, 80% in 2022.

#### Antiretroviral drug-based prevention

- % of PLWH receiving ART: 90% in 2019, 95% in 2020, 98% in 2021, 100% in 2022.
- % of PLWH achieving viral suppression: 80% in 2019, 90% in 2020, 95% in 2021, 100% in 2022.

#### Prevention of vertical transmission of HIV

- MTCT rate for all populations: 2% in 2019, 1% in 2020, 0.5% in 2021, 0% in 2022.
- % of Estimated births to women living with HIV: 3,000 in 2019, 2,000 in 2020, 1,000 in 2021, 500 in 2022.

#### Distribution of new child infections

- % of child infections: 10% in 2019, 5% in 2020, 2% in 2021, 0% in 2022.
The State of HIV Prevention in Ethiopia

Policy and structural barriers

### Key populations

<table>
<thead>
<tr>
<th>Population</th>
<th>Sex workers</th>
<th>Girls and young women</th>
<th>People who injected drugs</th>
<th>Transgender people</th>
<th>People in prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
</tr>
<tr>
<td>2025</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
</tr>
</tbody>
</table>

#### Criminalization of the behaviour of key populations
- The national strategy includes critical elements of the programme package for key populations
- Avoided health care because of stigma and discrimination

#### Population size
- Adolescent girls and young women

Proportion of women who experienced intimate partner violence
- Girls who completed lower secondary education
- Policies on life skills-based HIV and sexuality education (secondary schools)
- Laws requiring parental consent for adolescents to access HIV testing services, age of consent

### HIV programme coverage and outcomes

#### ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS

<table>
<thead>
<tr>
<th>Percentage</th>
<th>2020 baseline</th>
<th>2020 target</th>
<th>2025 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>condoms</td>
<td>60%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>sexual</td>
<td>79%</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>

#### KEY POPULATIONS

- **Sex workers**
  - Condom use with a non-regular partner: 85%
  - Condom use with a steady partner: 80%
- **Gay men and other men who have sex with men**
- **People who inject drugs**

#### CONDOM PROGRAMMING

- **Condom use with a non-regular partner**
- **Condom use with a steady partner**
- **Condom use at last sex with men**
- **Use of barrier methods**

### MEN AND BOYS (INCLUDING VMIC)

#### ANTIRETROVIRAL DRUG-BASED PREVENTION

- **Pre-exposure prophylaxis**
  - Number of people actively taking PrEP
  - Pre-exposure prophylaxis (PrEP) coverage per 100 people

#### PREVENTION OF VERTICAL TRANSMISSION OF HIV

- **MTCT rate**
- **% of HIV-positive pregnant women receiving ART**
- **Number of Estimated births to women living with HIV**
- **Number of new child infections due to vertical transmission**

### Distribution of new child infections

- **% of child infections because mother acquired HIV during pregnancy or breastfeeding**
- **% of child infections because mother did not receive antiretroviral treatment during pregnancy or breastfeeding**
- **% of child infections because mother did not receive antiretroviral treatment during pregnancy or breastfeeding**

### Data sources:
- UNAIDS 2021 epidemiological estimates
- WHO 2022, World Health Organization
- UNAIDS 2021, UNAIDS, United Nations

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.
The State of HIV Prevention in Ghana

Policy and structural barriers

Key populations
- Gay men and other men who have sex with men (GMOSM)
- People who inject drugs (PWID)
- Transgender people
- People in prisons

Criminalization of the behaviour of key populations
- Yes
- Yes
- Yes
- No

The national strategy includes critical elements of the programme package for key populations
- No
- No
- No
- No

Avoided health care because of stigma and discrimination
- id
- id
- id
- id

Population size
- id
- id
- id
- id

Adolescent girls and young women
Proportion of women who experienced intimate partner violence
- 15-19 years
- 15-49 years
- 50%
- 57%
- Yes
- Yes
- No
- id, na

Girls who completed lower secondary education
- Policies on life skills-based HIV and sexuality education (secondary schools)
- Yes
- Yes
- Yes
- No
- na

Laws requiring parental consent for adolescents to access HIV testing services, age of consent
- id
- id
- id
- id
- id

HIV prevalence
- Young women, 15-24 years
- Sex workers
- Gay men and other men who have sex with men
- People who inject drugs
- Young women, 15-24 years
- Young men, 15-24 years
- Sex workers
- Gay men and other men who have sex with men
- People who inject drugs
- Young women, 15-49 years
- Young men, 15-49 years
- Sex workers
- Gay men and other men who have sex with men
- People who inject drugs

Number of new HIV infections (all ages)
- 2010 baseline
- 2020 target
- 2025 target

HIV programme coverage outcomes

ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS
- Condom use with a non-regular partner among young people, 15-24 years old (%)
- Condom use at last paid sex (%)
- Condom use at last non-paid sex (%)
- Condom use at last paid sex (%)
- Condom use at last non-paid sex (%)

KEY POPULATIONS
- Condom use with a non-regular partner, 15-49 years (%)
- Condom use at last paid sex (%)
- Condom use at last non-paid sex (%)
- Condom use at last paid sex (%)
- Condom use at last non-paid sex (%)

CONDOM PROGRAMMING
- Condom use with a non-regular partner, 15-49 years (%)
- Condom use at last paid sex (%)
- Condom use at last non-paid sex (%)
- Condom use at last paid sex (%)
- Condom use at last non-paid sex (%)

MEN AND BOYS (INCLUDING VMMC)
- Uptake of voluntary medical malecircumcision (VMMC)
- Rate of pre-exposure prophylaxis (PrEP) coverage per 100 people acquiring HIV

ANTIRETROVIRAL DRUG-BASED PREVENTION
- Estimation of incident infections

PREVENTION OF VERTICAL TRANSMISSION OF HIV
- % of child infections because mother acquired HIV during pregnancy or breastfeeding
- % of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding
- % of child infections because mother did not continue antiretroviral treatment during pregnancy or breastfeeding
- % of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding

Baseline status of 10 HIV Prevention 2025 Road Map Actions
- 1. Data-driven needs assessment
- 2. Precision prevention approach
- 3. Define investment needs
- 4. HIV prevention leadership agencies
- 5. Expand community-led services
- 6. Remove social and legal barriers
- 7. Integration with related services
- 8. Introduction of new technologies
- 9. Real-time programme monitoring
- 10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services
- HIV testing services integrated within sexual and reproductive health
- Provider-initiated condom promotion integrated into sexual and reproductive health services

Road Map Action
- 2023

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Note: "Yes" refers to the adaptation having been introduced but currently is either incomplete or unavailable.
The State of HIV Prevention in Indonesia

Number of new HIV infections (all ages)

<table>
<thead>
<tr>
<th>Year</th>
<th>Adults, 40+ years</th>
<th>Young women, 15-24 years</th>
<th>Children, 0-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>50,000</td>
<td>10,000</td>
<td>5,000</td>
</tr>
<tr>
<td>2020</td>
<td>20,000</td>
<td>5,000</td>
<td>2,500</td>
</tr>
<tr>
<td>2025</td>
<td>10,000</td>
<td>2,500</td>
<td>1,250</td>
</tr>
</tbody>
</table>

2010 baseline 2020 2025

HIV prevalence

<table>
<thead>
<tr>
<th>Key populations</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay men and other men who have sex with men</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>10%</td>
<td>5%</td>
<td>2.5%</td>
<td>1.25%</td>
</tr>
</tbody>
</table>

Change in new HIV infections

<table>
<thead>
<tr>
<th>Key populations</th>
<th>TARGET 2010-2025</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, 40+ years</td>
<td>50,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td>10,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Children, 0-14 years</td>
<td>5,000</td>
<td>2,500</td>
</tr>
</tbody>
</table>

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

<table>
<thead>
<tr>
<th>Group</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td>20,000</td>
<td>15,000</td>
<td>10,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Gay men and other men who have sex with men</td>
<td>40,000</td>
<td>30,000</td>
<td>20,000</td>
<td>10,000</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>30,000</td>
<td>25,000</td>
<td>20,000</td>
<td>15,000</td>
</tr>
</tbody>
</table>

Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Provider-initiated condom promotion integrated into sexual and reproductive health services

HIV prevention leadership agencies

-47%

90%

95%

82.5%

8%
The State of HIV Prevention in Islamic Republic of Iran

Policy and structural barriers

Key populations

Criminalization of the behavior of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Prevention investment needs
3. HIV prevention leadership agencies
4. Introduction of new technologies
5. Expansion of community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Development of financial plans
9. Real-time programme monitoring
10. Accountability for HIV progress

AIDS prevalence: 0.14% (2022)

Number of new HIV infections (all ages)

HIV prevalence

Change in new HIV infections

TARGET 2010–2025

82.5%

2010 baseline

2020 target

2025 target

2010

2015

2020

2025

Number of new HIV infections (all ages)

HIV programme coverage and outcomes

Scenarios (1–10)

Very good

Good

Medium

Low

Very low

id... insufficient data

ra... not applicable

Sex workers

Gay men and other men who have sex with men

People who inject drugs

World Health Organization definitions of scenarios

Very good

Good

Medium

Low

Very low

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Pre-exposure prophylaxis

Antiretroviral treatment

Change in use of PEP (2021–2022)

not documented

37%

Overall

Sex workers

Transgender people

People in prisons

TARGET 2010–2025 Road Map Action

1. Data-driven needs assessment
2. Prevention investment needs
3. HIV prevention leadership agencies
4. Introduction of new technologies
5. Expansion of community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Development of financial plans
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services
The State of HIV Prevention in Kenya

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

Girls who completed lower secondary education

Policies on life skills-based HIV and sexuality education (secondary schools)

Laws requiring parental consent for adolescents to access HIV testing services, age of consent

Baseline status of 10 HIV Prevention 2025 Road Map Actions

HIV programme coverage and outcomes

A woman tested positive for STIs recently

HIV prevalence

Number of new HIV infections (all ages)

Change in new HIV infections

TARGET 2010–2025

-82.5%

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets (90% reduction) and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

HIV programme coverage and outcomes

A woman tested positive for STIs recently

HIV prevalence

Number of new HIV infections (all ages)

Change in new HIV infections

TARGET 2010–2025

-82.5%

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets (90% reduction) and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.
The State of HIV Prevention in Lesotho

HIV programme coverage and outcomes

2010 2015 2020 2022

HIV prevalence

HIV programme coverage and outcomes: Global Aids Monitoring 2023, Global Fund and PEPFAR reports obtained in 2023. Some of the data are triangulated and thus not nationally representative.

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

Girls who completed lower secondary education

Policies on life skills-based HIV and sexuality education (secondary schools)

Laws requiring parental consent for adolescents to access HIV testing services, age of consent

Baseline status of 10 HIV Prevention 2025

Road Map Actions

HIV testing services integrated within sexual and reproductive health

Providers initiated condom promotion integrated into sexual and reproductive health services

Linkages between HIV and sexual and reproductive health services

PREVENTION OF VERTICAL TRANSMISSION OF HIV

% of HIV-positive pregnant women receiving ART

Number of Estimated births to women living with HIV

Number of new child infections due to vertical transmission

Distribution of new child infections

Note: *Yes* refers to the adoption having been introduced (but necessarily currently available).

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Road Map Action

1. Data-driven needs assessment

2. Precise prevention approach

3. Define investment needs

4. HIV prevention leadership agencies

5. Expand community-led services

6. Remove social and legal barriers

7. Integration with related services

8. Introduction of new technologies

9. Real-time programme monitoring

10. Accountability for HIV progress

Road Map Action

1. Data-driven needs assessment

2. Precise prevention approach

3. Define investment needs

4. HIV prevention leadership agencies

5. Expand community-led services

6. Remove social and legal barriers

7. Integration with related services

8. Introduction of new technologies

9. Real-time programme monitoring

10. Accountability for HIV progress

Baseline status of 10 HIV Prevention 2025

Road Map Actions

HIV testing services integrated within sexual and reproductive health

Providers initiated condom promotion integrated into sexual and reproductive health services

Linkages between HIV and sexual and reproductive health services

PREVENTION OF VERTICAL TRANSMISSION OF HIV

% of HIV-positive pregnant women receiving ART

Number of Estimated births to women living with HIV

Number of new child infections due to vertical transmission

Distribution of new child infections

Note: *Yes* refers to the adoption having been introduced (but necessarily currently available).

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Road Map Action

1. Data-driven needs assessment

2. Precise prevention approach

3. Define investment needs

4. HIV prevention leadership agencies

5. Expand community-led services

6. Remove social and legal barriers

7. Integration with related services

8. Introduction of new technologies

9. Real-time programme monitoring

10. Accountability for HIV progress

Baseline status of 10 HIV Prevention 2025

Road Map Actions

HIV testing services integrated within sexual and reproductive health

Providers initiated condom promotion integrated into sexual and reproductive health services

Linkages between HIV and sexual and reproductive health services

PREVENTION OF VERTICAL TRANSMISSION OF HIV

% of HIV-positive pregnant women receiving ART

Number of Estimated births to women living with HIV

Number of new child infections due to vertical transmission

Distribution of new child infections

Note: *Yes* refers to the adoption having been introduced (but necessarily currently available).

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Road Map Action

1. Data-driven needs assessment

2. Precise prevention approach

3. Define investment needs

4. HIV prevention leadership agencies

5. Expand community-led services

6. Remove social and legal barriers

7. Integration with related services

8. Introduction of new technologies

9. Real-time programme monitoring

10. Accountability for HIV progress
The State of HIV Prevention in Madagascar

**Number of new HIV infections (all ages)**

- **2010 baseline**
- **2020 target**
- **2025 target**

**HIV prevalence**

- **Adults, 15-24 years**
- **Young women, 15-24 years**
- **Children, 0-14 years**

**Policy and structural barriers**

**TARGET 2010-2025** 82.5%

**Avoided health care because of stigma and discrimination**

- **Population size** 191,289

**Condom use, coverage of prevention interventions (as shown above)**

**Pre-exposure prophylaxis**

**Antiretroviral treatment**

**Change in use of PrEP (2021–2022)**

**Antiretroviral treatment coverage**

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

**Key populations**

- Sex workers
- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

**Number of new HIV infections (all ages)**

- **10 000**
- **8 000**
- **6 000**
- **4 000**
- **2 000**
- **0**

**HIV prevalence**

- **Adults, 15-24 years**
- **Young women, 15-24 years**
- **Children, 0-14 years**

**Condom use at last paid sex is (%)**

**Use of harm reduction services (%)**

**People living with HIV**

- **≥ 15 years**
- **15 years**
- **<25 years**
- **<25 years**
- **<25 years**

**Regulatory approval, PrEP (2021–2022)**

**Data sources:** UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

**Notes:**
- The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.
- The national strategy includes critical elements of the programme package for key populations.
- Criminalization of the behaviour of key populations.
- The road map includes 10 actions.
The State of HIV Prevention in Malawi

**Number of new HIV infections (all ages)**

- Adults, 15-115 years: 30,000
- Young women, 15-29 years: 10,000
- Children, 0-14 years: 10,000

**HIV prevalence**

- Young women, 15-29 years: 0.8%
- Young men, 15-24 years: 0.4%
- Sex workers: 3.5%
- People who inject drugs: 7.8%

**Change in new HIV infections**

- Adults, 15-115 years: 2020 target = 12,000, 2025 target = 7,200 (
  - 47% reduction)
- Young women, 15-29 years: 2020 target = 4,000, 2025 target = 2,400 (58% reduction)
- Children, 0-14 years: 2020 target = 1,000, 2025 target = 500 (50% reduction)

**Policy and structural barriers**

- Criminalization of the behaviour of key populations
- The national strategy includes critical elements of the programme package for key populations
- Avoided health care because of stigma and discrimination

**Population size**

- 15–49 years: 8,500,000
- 15–44 years: 8,000,000

**Adolescent girls and young women**

- Proportion of women who experienced intimate partner violence:
  - Girls who completed lower secondary education:
    - Policies on life skills-based HIV and sexuality education (secondary schools):
      - Laws requiring parental consent for adolescents to access HIV testing services, age of consent

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**Policy and structural barriers**

- Key populations
- People who inject drugs
- Transgender people
- People in prisons

**HIV programme coverage and outcomes**

- **Adolescent girls, young women & male partners**
- **Sex workers**
- **Gay men and other men who have sex with men**
- **People who inject drugs**

**HIV programme coverage**

- Condom use with a non-regular partner, among young people 15-24 years old (%):
  - Very good: 65%
  - Good: 79%
  - Medium: 49%
  - Low: 73%
  - Very low: 79%

**Condom distribution**

- Very good: 73%
- Good: 53%
- Medium: 65%
- Low: 79%
- Very low: 79%

**Antiretroviral drug-based prevention**

- Pre-exposure prophylaxis:
  - 2017: 500
  - 2018: 1000
  - 2019: 2000
  - 2020: 3000
  - 2021: 4000

- Antiretroviral treatment:
  - 2017: 50
  - 2018: 100
  - 2019: 200
  - 2020: 300
  - 2021: 400

**Prevention of vertical transmission of HIV**

- MTCT rate: 8%

**Number of new child infections due to vertical transmission**

- 2020: 400
- 2021: 300
- 2022: 200
- 2023: 100

**Disclaimer:**

- Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily currently available).
The State of HIV Prevention in Mexico

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

HIV programme coverage and outcomes

Number of new HIV infections (all ages)

Change in new HIV infections

HIV prevalence

TARGET 2010-2025

82.5%

2025 target

0%

All

HIV PREVENTION: FROM CRISIS TO OPPORTUNITY

2010 target

2020 target

0%

82.5% reduction by 2025 against 2010 as a baseline.

2020 and 2025 targets represent the country’s required contribution to global targets, a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Provider-initiated condom promotion integrated into sexual and reproductive health services

HIV PREVENTION: FROM CRISIS TO OPPORTUNITY
The State of HIV Prevention in Mozambique

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**Note**: Yes refers to the adaptation having been introduced but not necessarily being universally available.

**Linkages between HIV and sexual and reproductive health services**

HIV testing services integrated within sexual and reproductive health

- Providers initiated condom promotion integrated into sexual and reproductive health services

**2023**

**Policy and structural barriers**

**Key populations**

- Sex workers: People who inject drugs
- Sex workers: Transgender people
- People in prisons:
  - Male
  - Female
- People who have sex with men:
  - Young men
  - Gay men and other men
  - Sex workers
- People who have sex with women:
  - Young women
  - Adult women
  - Sex workers
- Young women, 15–24 years
- Young men, 15–24 years
- Children, 0–14 years
- Sex workers, 15+ years

**Criminalization of the behaviour of key populations**

- No
- Yes
- No
- Yes
- No
- Yes

**The national strategy includes critical elements of the programme package for key populations**

- Yes
- No
- No
- Yes
- id
- id
- id
- id
- id

**Avoided health care because of stigma and discrimination**

- id
- id
- id
- id
- id

**Population size**

- 2010: 800,000
- 2020: 640,000
- 2025: 14,900

**Adolescent girls and young women**

- Proportion of women who experienced intimate partner violence
  - 15–44 years: id
  - 15–49 years: id

- Girls who completed lower secondary education

- Policies on life skills-based HIV and sexuality education (secondary schools)

- Lores requiring parental consent for adolescents to access HIV testing services, age of consent

**HIV programme coverage and outcomes**

- **ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS**
  - Condom use with a non-regular partner:
    - Young people, 15–24 years old (%)
    - id

- **KEY POPULATIONS**
  - Condom use with a sexual partner:
    - Young people, 15–24 years old (%)
    - id

- **CONDOM PROGRAMMING**
  - Condom use with a sexual partner:
    - Young people, 15–24 years old (%)
    - id

- **MEN AND BOYS (INCLUDING VMIC)**
  - Pre-exposure prophylaxis
    - Use of pre-exposure prophylaxis (PrEP)
    - Target: 4%

- **ANTIRETROVIRAL DRUG-BASED PREVENTION**
  - Antiretroviral treatment
    - Use of antiretroviral therapy (ART)
    - Target: 4%

- **PREVENTION OF VERTICAL TRANSMISSION OF HIV**
  - MTCT rate
    - Target: 10%
The State of HIV Prevention in Namibia

Policy and structural barriers

Key populations

- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

Criminalization of the behaviour of key populations

- Yes
- No

The national strategy includes critical elements of the programme package for key populations:

- Avoided health care because of stigma and discrimination

Population size

- 0,588
- 2,300
- 0
- 4,008

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education
- Policies on life skills-based HIV and sexuality education (secondary schools)
- Laws requiring parental consent for adolescents to access HIV testing services, age of consent

HIV programme coverage and outcomes

- ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS
- KEY POPULATIONS
- CONDOM PROGRAMMING

MEN AND BOYS (INCLUDING VMVMIC)

- Pre-exposure prophylaxis
- Antiretroviral treatment

ANTIRETROVIRAL DRUG-BASED PREVENTION

- % of 2015 target achieved
- % of annual target achieved

PREVENTION OF VERTICAL TRANSMISSION OF HIV

- MTCT rate
- % of HIV-positive pregnant women receiving ART
- Number of women living with HIV
- Number of new child infections due to vertical transmission

Distribution of new child infections

- % of child infections because mother acquired HIV during pregnancy or breastfeeding
- % of child infections because mother did not receive antiretroviral therapy during pregnancy or breastfeeding
- % of child infections because mother did not continue antiretroviral therapy during pregnancy or breastfeeding

Road Map Action

- 1. Data-driven needs assessment
- 2. Precision prevention approach
- 3. Define investment needs
- 4. HIV prevention leadership agencies
- 5. Expand community-led services
- 6. Remove social and legal barriers
- 7. Integration with related services
- 8. Introduction of new technologies
- 9. Real-time programme monitoring
- 10. Accountability for HIV progress

Note: "Yes" refers to the adaptation having been introduced (not necessarily that it is currently available).

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health services
- Life skills-based HIV and sexuality education
- Provider-initiated condom promotion integrated into sexual and reproductive health services

Baseline status of 10 HIV Prevention 2025

Road Map Actions

2013

2023
The State of HIV Prevention in Nigeria

Policy and structural barriers

Key populations

- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

200 800 240 000 440 000 69 000 78 000

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education


Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health services
- Providers initiated condom promotion integrated into sexual and reproductive health services

Baseline of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Policy and structural barriers

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

200 800 240 000 440 000 69 000 78 000

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education


Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health services
- Providers initiated condom promotion integrated into sexual and reproductive health services

Baseline of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Policy and structural barriers

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

200 800 240 000 440 000 69 000 78 000

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education


Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health services
- Providers initiated condom promotion integrated into sexual and reproductive health services

Baseline of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Policy and structural barriers

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

200 800 240 000 440 000 69 000 78 000

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education


Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health services
- Providers initiated condom promotion integrated into sexual and reproductive health services

Baseline of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Policy and structural barriers

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

200 800 240 000 440 000 69 000 78 000

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education


Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health services
- Providers initiated condom promotion integrated into sexual and reproductive health services

Baseline of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).
The State of HIV Prevention in Pakistan

### Number of new HIV infections (all ages)

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, ≥15 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Children, 0-14 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Change in new HIV infections

**TARGET 2010–2025** 82.5%

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, ≥15 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Children, 0-14 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### HIV prevalence

<table>
<thead>
<tr>
<th>Population</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td>0.02</td>
<td>0.04</td>
<td>0.06</td>
<td>0.1</td>
</tr>
<tr>
<td>Gay men and other men who have sex with men</td>
<td>0.02</td>
<td>0.04</td>
<td>0.06</td>
<td>0.1</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>0.02</td>
<td>0.04</td>
<td>0.06</td>
<td>0.1</td>
</tr>
</tbody>
</table>

### Policy and structural barriers

#### Key populations

- Gay men and other men who have sex with men
- People who inject drugs
- Sex workers
- transgender people
- People in prisons

Criminalization of the behavior of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

### ANTIRETROVIRAL DRUG-BASED PREVENTION

#### Pre-exposure prophylaxis

- Coverage of antiretroviral drugs

#### Antiretroviral treatment

- Percentage of people virally suppressed

### Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health services

Provider-initiated condom promotion integrated into sexual and reproductive health services
The State of HIV Prevention in Peru

Policy and structural barriers

**Key populations**

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

<table>
<thead>
<tr>
<th>Category</th>
<th>2010 baseline</th>
<th>2020 target</th>
<th>2025 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, 0-15 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children, 0-14 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay men and other men who have sex with men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who inject drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HIV programme coverage and outcomes**

**HIV prevalence**

**Change in new HIV infections**

**Policy and structural barriers**

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

**Antiretroviral drug-based prevention**

**Antiretroviral treatment**

**Pre-exposure prophylaxis**

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**Road Map Actions**

- Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.

**Notes:**
- 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets: a 75% reduction by 2020 and 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.
- The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.
- Quotas of 2023 are not applicable.
The State of HIV Prevention in Philippines

### Policy and structural barriers

**Key populations**

- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

**Criminalization of the behaviour of key populations**

The national strategy includes critical elements of the programme package for key populations.

**Avoided health care because of stigma and discrimination**

Population size: 231,689

**TARGET 2010–2025**

**Road Map Action**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### HIV programme coverage and outcomes

#### Change in new HIV infections

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, 15 years</td>
<td>11903</td>
<td>9000</td>
<td>5000</td>
<td>1900</td>
</tr>
<tr>
<td>Young women, 15-24 years</td>
<td>490</td>
<td>300</td>
<td>150</td>
<td>100</td>
</tr>
<tr>
<td>Children, 0-14 years</td>
<td>120</td>
<td>60</td>
<td>30</td>
<td>20</td>
</tr>
</tbody>
</table>

**TARGET 2010–2025**

- 82.5% reduction by 2025 against 2010 as a baseline.

#### HIV prevalence

- Gay men and other men who have sex with men
- People who inject drugs

**HIV infection rates**

<table>
<thead>
<tr>
<th>Population</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay men and other men who have sex with men</td>
<td>6%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

#### Change in new HIV infections

- 82.5% reduction by 2025 against 2010 as a baseline.

**Note:** 2020 and 2025 targets for reducing new HIV infections represent the country's required contribution to global targets. A 70% reduction by 2025 against 2010 as a baseline.

#### Key populations

- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

**Criminalization of the behaviour of key populations**

- The national strategy includes critical elements of the programme package for key populations.

**Avoided health care because of stigma and discrimination**

Population size: 231,689

**TARGET 2010–2025**

**Road Map Action**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health services

- Provider-initiated condom promotion integrated into sexual and reproductive health services

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**HIV prevention services**

- Pre-exposure prophylaxis
- Antiretroviral treatment
- Sexual and reproductive health services integrated within sexual and reproductive health services

**Road Map Action**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

### Data sources

- UNAIDS 2023 epidemiological estimates
- Global AIDS Monitoring 2023
- ICF – the DHS Program STATcompiler

**Note:** 2020 and 2025 targets for reducing new HIV infections represent the country's required contribution to global targets. A 70% reduction by 2025 against 2010 as a baseline.

**Note:** This fact sheet for Philippines was automatically created based on global databases and was not quality assured as part of the Global HIV Prevention Coalition's review process.
The State of HIV Prevention in Rwanda

Policy and structural barriers

Key populations

- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

Girls who completed lower secondary education

Policies on life skills-based HIV and sexuality education (secondary schools)

Laws requiring parental consent for adolescents to access HIV testing services, age of consent

HIV programme coverage and outcomes

ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS

KEY POPULATIONS

CONDOM PROGRAMMING

MEN AND BOYS (INCLUDING VMMC)

ANTIRETROVIRAL DRUG-BASED PREVENTION

PREVENTION OF VERTICAL TRANSMISSION OF HIV

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-based services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: "Yes" refers to the intervention being implemented (not necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Providers initiated condom promotion integrated into sexual and reproductive health services

Distribution of new child infections

% of child infections because mother acquired HIV during pregnancy or breastfeeding
% of child infections because mother did not continue antiretroviral treatment during pregnancy or breastfeeding
% of child infections because mother acquired HIV during breastfeeding
% of child infections because mother did not continue antiretroviral treatment during breastfeeding
% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding, but was not consistently suppressed
The State of HIV Prevention in South Africa

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

- Yes
- No
- Yes
- No
- Not applicable

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

- id
- Medium
- Good
- Very good

Population size

116 850
209 700
52 508
179 308
155 660

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

Girls who completed lower secondary education

Policies on life skills-based HIV and sexuality education (secondary schools)

Laws requiring parental consent for adolescents to access HIV testing services, age of consent

Programme coverage and outcomes

Number of new HIV infections (all ages)

<table>
<thead>
<tr>
<th>Year</th>
<th>2010 baseline</th>
<th>2020 target</th>
<th>2025 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>380 000</td>
<td>160 000</td>
<td>66 000</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HIV prevalence

<table>
<thead>
<tr>
<th>Key Population</th>
<th>2010</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, 15+</td>
<td>166 000</td>
<td>200 000</td>
<td>380 000</td>
</tr>
<tr>
<td>Young women, 15–24 years</td>
<td>106 000</td>
<td>120 000</td>
<td>200 000</td>
</tr>
<tr>
<td>Children, 0–14 years</td>
<td>106 000</td>
<td>120 000</td>
<td>200 000</td>
</tr>
</tbody>
</table>

HIV programme coverage and outcomes

<table>
<thead>
<tr>
<th>Programme</th>
<th>Condom use, condom distribution</th>
<th>Condom use, condom distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td>Very good</td>
<td>Good</td>
</tr>
<tr>
<td>Gay men and other men who have sex with men</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>Very low</td>
<td>Very low</td>
</tr>
</tbody>
</table>

Antiretroviral drug-based prevention

Pre-exposure prophylaxis

- Yes
- No

Antiretroviral treatment

- Yes
- No

Prevention of vertical transmission of HIV

MTCT rate

- id

Number of Estimated births to women living with HIV

- 260 000

Number of new child infections due to vertical transmission

- 8 000

Distribution of new child infections

- id

Baseline status of 10 HIV Prevention 2025 Road Map Actions

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: *id* refers to the adaptation having been introduced but currently not fully available;

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Provided initiated condom promotion integrated into sexual and reproductive health services

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.
The State of HIV Prevention in South Sudan

Policy and structural barriers

Key populations

HIV prevalence

HIV programme coverage and outcomes

MEN AND BOYS (INCLUDING VMニック)

ANTIRETROVIRAL DRUG-BASED PREVENTION

PREVENTION OF VERTICAL TRANSMISSION OF HIV

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action

2023

1. Data-driven needs assessment
2. Precise prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time program monitoring
10. Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Services initiated condom promotion integrated into sexual and reproductive health services

Data sources: UNAIDS 2023 epidemiological estimates; Global AIDS Monitoring 2023; and ICF – the DHS Program STATcompiler.
The State of HIV Prevention in United Republic of Tanzania

Number of new HIV infections (all ages)

<table>
<thead>
<tr>
<th>Year</th>
<th>2010 Baseline</th>
<th>2020 Target</th>
<th>2025 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>68,000</td>
<td>20,000</td>
<td>30,000</td>
</tr>
<tr>
<td>2020</td>
<td>20,000</td>
<td>6,000</td>
<td>12,000</td>
</tr>
<tr>
<td>2025</td>
<td>12,000</td>
<td>10,000</td>
<td>8,000</td>
</tr>
</tbody>
</table>

**HIV prevalence**

- **Young women, 15-24 years**: 3% in 2010, 1% in 2020, 0.5% in 2025
- **Sex workers**: 1% in 2010, 0.5% in 2020, 0.2% in 2025
- **People who inject drugs**: 0.5% in 2010, 0.2% in 2020, 0.1% in 2025

**Change in new HIV infections**

- **Adults, 15+ years**: Decrease by 82.5%
- **Young women, 15-24 years**: Decrease by 67%
- **Children, 0-14 years**: Decrease by 50%

**Men and boys (including VMMC)**

- **Pre-exposure prophylaxis (PrEP)**: 162,477 new people actively taking PrEP in 2022
- **Antiretroviral drug-based prevention**: 31%

**Policy and structural barriers**

- **Criminalization of the behaviour of key populations**
- **The national strategy includes critical elements of the programme package for key populations**
- **Avoided health care because of stigma and discrimination**

**Population size**

- **Adolescent girls and young women**: 29,008

**Baseline status of 10 HIV Prevention 2025 Road Map Actions**

<table>
<thead>
<tr>
<th>Road Map Action</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Data-driven needs assessment</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Precision prevention approach</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Define investment needs</td>
<td>Yes</td>
</tr>
<tr>
<td>4. HIV prevention leadership agencies</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Expand community-led services</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Remove social and legal barriers</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Integration with related services</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Introduction of new technologies</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Real-time programme monitoring</td>
<td>Yes</td>
</tr>
<tr>
<td>10. Accountability for HIV progress</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**HIV programme outcomes**

- **Adolescent girls, young women & male partners**
- **Key populations**
- **Condom programming**

**Prevention of vertical transmission of HIV**

- **MTCT rate**: 7%
- **% of HIV-positive pregnant women receiving ART**: 92%
- **Number of estimated births to women living with HIV**: 74,000
- **Number of new child infections due to vertical transmission**: 5,200

**Distribution of new child infections**

- 80% of child infections because mother acquired HIV during pregnancy or breastfeeding
- 15% of child infections because mother did not continue antiretroviral treatment during pregnancy or breastfeeding
- 5% of child infections because mother was on antiretroviral treatment during pregnancy or breastfeeding but was not consistently suppressed

**Data sources**: UNAIDS, 2023, Epidemiological Estimates Global AIDS Monitoring, 2023, Global Fund, and PEPFAR reports obtained in 2023. Some of the data are estimated and thus not nationally representative.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Note: The 2023 UNAIDS demographic estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.
HIV PREVENTION: FROM CRISIS TO OPPORTUNITY

The State of HIV Prevention in Thailand

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

Scores (1–10)

TARGET 2010–2025

Road Map Action 2023

Baseline status of 10 HIV Prevention 2025 Road Map Actions

HIV programme coverage and outcomes

Number of new HIV infections (all ages)

Change in new HIV infections

HIV prevalence

Pre-exposure prophylaxis

Antiretroviral treatment

Antiretroviral drug-based prevention

TARGET 2010–2025

Road Map Action

2023

Notes: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Data sources for key population programme coverage: Global HIV Prevention 2023. Data for key populations and key populations groups are not nationally representative. Data from 2018 onward are not included. KHAN, ANS and MRP-IDS 2023

Litigation of sexual and reproductive health

Provider-initiated condom promotion integrated into sexual and reproductive health services

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

This fact sheet for Thailand was automatically created based on global databases and was not quality assured as part of the Global HIV Prevention Coalition’s review process.

2023

2010 target

2020 target

2025 target

HIV PREVENTION: FROM CRISIS TO OPPORTUNITY

2025 target

129
HIV PREVENTION: FROM CRISIS TO OPPORTUNITY

The State of HIV Prevention in Uganda

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations.

Avoided health care because of stigma and discrimination

Population size

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

Girls who completed lower secondary education

Policies on life-skills-based HIV and sexuality education (secondary schools)

Laws requiring parental consent for adolescents to access HIV testing services, age of consent

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action 2023

Linkages between HIV and sexual and reproductive health services

1. Data-driven needs assessment

2. Precision prevention approach

3. Define investment needs

4. HIV prevention leadership agencies

5. Expand community-led services

6. Remove social and legal barriers

7. Integration with related services

8. Introduction of new technologies

9. Real-time programme monitoring

10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).

HIV programme coverage and outcomes

Target 2010–2025

Change in new HIV infections

TARGET 2010–2025

82.5%

HIV prevalence

Number of new HIV infections (all ages)

2010 baseline

2020, 2022

2022 target

2025 target

HIV programme coverage and outcomes

ADOLESCENT GIRLS, YOUNG WOMEN & MALE PARTNERS

KEY POPULATIONS

CONDOM PROGRAMMING

MEN AND BOYS (INCLUDING VMIC)

ANTIRETROVIRAL DRUG-BASED PREVENTION

PREVENTION OF VERTICAL TRANSMISSION OF HIV

Data sources: UNAIDS 2013 epidemiological estimates. Global AIDS Monitoring, 2013; Global Fund and PEPFAR reports obtained in 2013. Some of the data are lagged and thus not nationally representative. Note: The 2013 UNAIDS epidemiological estimates were used to determine the year 2022. Other data points may refer to various years when the surveys were conducted.

Data sources for key population programme coverage: Global AIDS Monitoring 2013; Global Fund and PEPFAR reports obtained in 2013. Some of the data are lagged and thus not nationally representative. Note: The 2013 UNAIDS epidemiological estimates were used to determine the year 2022. Other data points may refer to various years when the surveys were conducted.

MTCT rate 7%

% of HIV-positive pregnant women receiving ART 98%

Number of Estimated births to women living with HIV 85,000

Number of new child infections due to vertical transmission 5,900

Distribution of new child infections

Note: ‘Yes’ refers to the adaptation having been introduced (but necessarily it being universally available).
The State of HIV Prevention in Ukraine

Policy and structural barriers

Key populations

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

2010 baseline 2020 target 2025 target

HIV programme coverage and outcomes

Number of new HIV infections (all ages)

2010 baseline 2020 target 2025 target

HIV prevalence

2010 baseline 2020 target 2025 target

HIV programme coverage and outcomes

Scored (1–10)

Very good Good Medium Low Very low id insufficient data na not applicable

Data sources for key population program coverage: Global AIDS Monitoring 2023. Global AIDS Monitoring and PEPFAR reports obtained in 2023. Some of the data are triangulated and thus not nationally representative.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets. A 70% reduction by 2020 against 2010 as a baseline and an 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.

TARGET 2010–2025 Road Map Action 2023

Road Map Action 2023

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Baseline status of 10 HIV Prevention 2025 Road Map Actions

HIV prevention services integrated within sexual and reproductive health

Provider-initiated condom promotion integrated into sexual and reproductive health services

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Pre-exposure prophylaxis Antiretroviral treatment

Sex workers Gay men and other men who have sex with men People who inject drugs

People in prisons

Pre-exposure prophylaxis Antiretroviral treatment

Pre-Exposure Prophylaxis (PrEP) Antiretroviral treatment

Number of people actively taking PrEP

People living with HIV

People in prisons

People who inject drugs

People who inject drugs

People who inject drugs

People who inject drugs

People who inject drugs

Criminalization of the behaviour of key populations

The national strategy includes critical elements of the programme package for key populations

Avoided health care because of stigma and discrimination

Population size

2010 baseline 2020 target 2025 target

HIV programme coverage and outcomes

Scored (1–10)

Very good Good Medium Low Very low id insufficient data na not applicable

Data sources for key population program coverage: Global AIDS Monitoring 2023. Global AIDS Monitoring and PEPFAR reports obtained in 2023. Some of the data are triangulated and thus not nationally representative.

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Note: 2020 and 2025 targets for reducing new HIV infections represent the country’s required contribution to global targets. A 70% reduction by 2020 against 2010 as a baseline and an 82.5% reduction by 2025 against 2010 as a baseline. These reductions are required to achieve a 90% reduction by 2030.
The State of HIV Prevention in Zambia

HIV prevalence

- Adults, 15-24 years: 2010, 33,000; 2020, 18,000; 2025, 12,000
- Young women, 15-24 years: 2010, 33,000; 2020, 18,000; 2025, 12,000
- Children, 0-14 years: 2010, 20,000; 2020, 15,000; 2025, 10,000
- Sex workers: 2010, 20,000; 2020, 15,000; 2025, 10,000
- Gay men and other men who have sex with men: 2010, 10,000; 2020, 7,000; 2025, 5,000
- People who inject drugs: 2010, 5,000; 2020, 3,000; 2025, 2,000

Policy and structural barriers

Key populations

- Sex workers
- Gay men and other men who have sex with men
- People who inject drugs
- Transgender people
- People in prisons

Change in new HIV infections

Target 2010-2025: 82.5%

Baseline status of 10 HIV Prevention 2025
Road Map Actions

- Data-driven needs assessment
- Precision prevention approach
- Define investment needs
- HIV prevention leadership agencies
- Expand community-led services
- Remove social and legal barriers
- Integration with related services
- Introduction of new technologies
- Real-time program monitoring
- Accountability for HIV progress

Linkages between HIV and sexual and reproductive health services

- HIV testing services integrated within sexual and reproductive health
- Providers initiated condom promotion integrated into sexual and reproductive health services

Adolescent girls and young women

Proportion of women who experienced intimate partner violence

- Girls who completed lower secondary education
- Policies on life skills-based HIV and sexuality education (secondary schools)
- Laws requiring parental consent for adolescents to access HIV testing services, age of consent

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

VMMC target

Overall

- Sex workers
- Used condom at last paid sex

Antiretroviral treatment coverage

- Overall
- 95% What's next
- 86% What's next
- < 25 years
- People who inject drugs

Prevention of vertical transmission of HIV

- Number of new child infections due to vertical transmission
- % of HIV-positive pregnant women receiving ART
- MTCT rate

Road Map Action

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time program monitoring
10. Accountability for HIV progress
The State of HIV Prevention in Zimbabwe

HIV prevalence

HIV programme coverage and outcomes

AOLDEO GIRLS, YOUNG WOMEN & MALE PARTNERS

KEY POPULATIONS

CONDOM PROGRAMMING

MEN AND BOYS (INCLUDING VMICC)

ANTIRETROVIRAL DRUG-BASED PREVENTION

PREVENTION OF VERTICAL TRANSMISSION OF HIV

Baseline status of 10 HIV Prevention 2025 Road Map Actions

Road Map Action

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

Note: ‘Yes’ refers to the adaptation having been introduced (not necessarily it being universally available).

Linkages between HIV and sexual and reproductive health services

HIV testing services integrated within sexual and reproductive health

Provide initiated condom promotion integrated into sexual and reproductive health services

2023

Change in new HIV infections

TARGET 2010-2025

82.5%

Note: The 2023 UNAIDS epidemiological estimates represent the year 2022. Other data points may refer to various years when the surveys were conducted.

Note: ‘Yes’ refers to the adaptation having been introduced (not necessarily it being universally available).


Note: ‘Yes’ refers to the adaptation having been introduced (not necessarily it being universally available).


Selected populations

-12%

0%
REFERENCES


(9) HIV prevention 2025 road map — Getting on track to end AIDS as a public health threat by 2030. Geneva: UNAIDS; 2022.

(10) HIV prevention 2025 road map — Getting on track to end AIDS as a public health threat by 2030. Geneva: UNAIDS; 2022.


