

# Strengthening HIV Primary Prevention

Five Thematic Discussion Papers to Inform Country Consultations and  
the Development of a Global HIV Prevention Roadmap

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# List of contributors

The five thematic discussion papers in this collection were prepared by members of the Global Prevention Coalition Steering Group and other experts from various institutions and countries. Contributors are listed in alphabetical order. The five papers are meant to inform country consultations and the development of a Global HIV Prevention Roadmap. They do not reflect the views of UNAIDS or any other agency or organization.

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# Contents

Introduction and overview.....	4
<b>Discussion paper 1: Stronger leadership and adequate financing .....</b>	<b>6</b>
Problem statement: .....	6
Key considerations for a strengthened response.....	7
Recommendations.....	9
<b>Discussion paper 2: National Prevention targets and improved accountability .....</b>	<b>61</b>
Problem statement: From global to national targets.....	61
Key considerations for a strengthened response.....	73
Recommendations.....	94
<b>Discussion paper 3: Improved systematic and efficient service delivery at scale .....</b>	<b>11</b>
Problem statement.....	20
Key considerations for a strengthened response.....	21
Recommendations.....	18
<b>Discussion paper 4: Providing prevention choices: a person-centered approach.....</b>	<b>20</b>
Problem statement.....	20
Key considerations for a strengthened response.....	171
Recommendations.....	18
<b>Discussion paper 5: Strengthened technical support for prevention.....</b>	<b>20</b>
Problem statement.....	25
Key considerations for a strengthened response.....	266
Recommendations.....	277
<b>Annexes .....</b>	<b>29</b>
Global HIV prevention results framework and targets.....	29
Division of labour among technical support agencies.....	303
Further reading .....	34

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## Introduction and overview

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### **Global trends in new infections**

Despite the availability of a widening array of effective HIV prevention tools and methods and a massive scale-up of HIV treatment in recent years, the number of new HIV infections among adults globally has not decreased sufficiently. There were more than 1.6 million new infections in adults (15+ years) in 2016, a reduction of 10.6 % from 2010. The estimated numbers of new infections among key populations such as sex workers, gay and other men who have sex with men and people who inject drugs remained either steady or increased, accounting for 45% of all new infections globally in 2016. It is estimated that more than 300 000 adolescent girls and young women were newly infected with HIV in 2016, mostly in sub-Saharan Africa. These trends mean that the prevention target in the 2011 Political Declaration on HIV and AIDS was missed by a wide margin: that target had called for a 50% reduction in new infections acquired through sexual transmission or injecting drug use between 2010 and 2015.

### **A new generation of targets for HIV prevention**

In 2016, United Nations (UN) Member States committed to reducing the number of new adult HIV infections to fewer than 500 000 by 2020, a 75% reduction compared to 2010. Reducing the number of new HIV infections is also an indicator (3.3.1) in the Sustainable Development Goals, among which is the goal of ending the AIDS epidemic by 2030.

Global programmatic targets have been formulated also for primary prevention, underpinning the 75% reduction in new infections. That reduction is to be achieved by reaching 90% of young women and their male partners in high-incidence settings and 90% of key populations everywhere with combination prevention programmes by 2020, while continuing to scale-up HIV treatment. Programmatic prevention targets were also set for condom programmes (20 billion to be distributed annually), pre-exposure prophylaxis (3 million people enrolled) and voluntary medical male circumcision (an additional 25 million circumcisions performed).

In line with those primary prevention targets, HIV prevention responses are to be organized around five central pillars, depending on country context:

- programmes for key populations, including sex workers, gay and other men who have sex with men, prisoners, people who inject drugs and trans-gender people;
- programmes for adolescent girls, young women and their male partners in settings with high HIV incidence;

- condom promotion and distribution;
- voluntary medical male circumcision; and
- pre-exposure prophylaxis.

### **Five transformations for achieving the targets**

The five thematic discussion papers in this collection focus on the following strategic priorities for a Fast-Track approach to HIV prevention:

1. **Strong leadership and adequate financing.** Success in achieving prevention targets will require three types of leadership:
  - Leaders that create space for addressing policy barriers related to sensitive societal issues;
  - Leadership for results, accelerating declines in new infections
  - Leadership in mobilizing or providing resources for prevention, including sustained domestic and international financing.
2. **National programmatic prevention targets and improved accountability.** National prevention targets need to be set to supplement and contextualize the existing 90–90–90 HIV testing and treatment targets, while ensuring that targets build on coherent results chains. Monitoring and accountability mechanisms need to ensure scaled-up service delivery against those targets.
3. **Systematic and efficient service delivery at scale.** Implementation of prevention programmes at sufficient scale requires clear, pragmatic and business-style implementation models for the different epidemic settings in countries and among various populations. A national lead agency needs to be appointed to oversee national and subnational planning, implementation and progress review. Different health and non-health actors need to be brought together to collaborate towards achievement of joint targets.
4. **Prevention choices: a people-centered approach to HIV prevention.** A people-centered approach to HIV prevention recognizes that different prevention options exist, which individuals may choose from at different stages of their lives. Community-based organizations have a unique role in generating demand for various prevention options and delivering services, and can help reduce the burden on the formal health system.
5. **Fit-for-purpose technical assistance for prevention.** Technical assistance for HIV prevention tends to be fragmented and should be focused around improving national programmes to deliver on strategic HIV prevention priorities.

# Discussion paper 1

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## Strong leadership and adequate financing

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### Problem statement

Three, interrelated dimensions of leadership are required for HIV prevention:

- leadership in creating space for policy change to enable prevention success
- leadership for concrete results
- leadership in mobilizing or providing adequate resources for prevention, including financing.

While some countries have seen strong leadership in one of these dimensions at various times, more consistent application in all three dimensions will be required to achieve the 2020 targets.

### Gaps in political leadership

HIV prevention has often lacked resolute political champions. The sensitive nature of HIV prevention – including a necessary public discourse on issue related to sexuality and drug use – and the complexity of the response can make it more challenging to understand, promote and defend. Yet there are several examples of leadership making a major difference – from the early 100% condom use and behavioral change programme successes in Thailand and Uganda to the recent scale up of prevention for young people and key populations in Kenya and South Africa, the rapid introduction of PrEP in several countries and the consistent prevention advocacy in Zimbabwe. Elsewhere, however, strong prevention leadership often has been lacking or leadership has not been translated adequately into effective programme implementation.

### Gaps in conducive, HIV prevention-friendly policies

Achieving the desired prevention results often depends on additional efforts to create a conducive policy environment. A range of barriers currently hinder HIV prevention service uptake. They include age restrictions that prevent young people from accessing sexual and reproductive health services, and gender norms that prevent women from freely choosing when and with whom to engage in sexual relationships. Stigma and discrimination (including in the health sector), sexual violence (including directed sex workers violence by law enforcement staff) and other human rights violations, and punitive policies related to homosexuality and drug possession all limit or deny access to prevention services by key populations.

Hence, the reduction in new HIV infections can be accelerated by changing these policies that affect service delivery and access to services. The legal status of services and the population groups that

use them can be changed, gender norms improved, human rights abuses punished, and harmful traditional cultural practices addressed. Gender and other inequalities have a significant impact on HIV transmission and must be addressed in national HIV, education, human rights and social welfare programmes and instruments.

### **Gaps in HIV prevention financing**

Although high-impact HIV prevention programmes are cost-effective and cost-saving, such programmes are not being implemented at sufficient scale. Coverage gaps are due to a combination of factors, including inadequate resourcing and inefficiencies in the allocation and use of resources. UN Member States committed in the 2016 Political Declaration on Ending AIDS to allocate (as a broad guide) approximately one quarter of HIV resources to prevention. UNAIDS reported in its 2016 *Prevention gap report* that many countries were spending less than 10% of HIV funds on prevention, while international donors were spending less than one quarter of their budgets on HIV primary prevention. HIV investment from international sources has stagnated and proposed allocations to HIV prevention have declined in recent Global Fund applications of several countries. Domestic spending on HIV prevention is also increasing too slowly. Gaps in scale and funding exist in all aspects of HIV prevention, but key populations and condom programmes are particularly underfunded, including in several priority countries.

## **Key considerations for a strengthened response**

### **The need for stronger political leadership for prevention**

Government leadership for HIV prevention is critically important. To reach diverse communities in need of HIV prevention services requires the involvement of various sectors of government at different levels, including public health services, education, law enforcement and the judiciary. However, programme scale-up and results cannot be achieved by governments alone. Providing people with the necessary information to make healthier choices and access to effective services requires the involvement of parents and other family members, community organizations, faith-based organizations, people living with HIV, the private sector, among others.

Mobilizing for such a multidisciplinary approach and bringing the different actors and systems together requires leadership that is capable of promoting clear strategies and targets, coordinating activities, and driving a results-oriented approach to HIV prevention. Some governments have demonstrated exceptional leadership. The Kenyan Government, for example, has prioritized HIV prevention, using a national HIV prevention roadmap that sets national- and county-level targets, addresses the HIV needs of all various populations, and adapts and focuses interventions according to age, sex, population and location.

## **The need for policy change**

A public health approach to HIV prevention focuses on reducing high-risk sexual and drug use practices. To have the greatest impact on HIV transmission, services must reach people who are most at risk of getting infected as well as those living with the virus. This includes people who have multiple unprotected sexual partnerships, young people (15–24 years), gay and other men who have sex with other men, people who sell or trade sex, people who use drugs, and incarcerated persons. HIV transmission in those populations is a driving factor in every country's AIDS epidemic.

There is great variation in governments' commitment to address politically sensitive aspects of HIV prevention, such as providing comprehensive sexuality education, sexual and reproductive health services and/or harm reduction services to the populations that need them. Yet structural and policy barriers have not been successfully addressed in several settings.

Countries that have adopted a public health approach and evidence-based policy framework for harm reduction for people who inject drugs have achieved high coverage of effective programmes and have reduced new HIV infections. The removal of structural barriers to young people's access to reproductive health services in (such as age of consent laws that restrict access to family planning services) has enhanced the use of prevention services including condoms. Community empowerment approaches have increased consistent condom use and reduced HIV and sexually transmitted infections in sex workers. Modelling based on data from Canada, India and Kenya suggests that the decriminalization of sex work could avert up to 50% of HIV infections over a decade. Secondary school attendance is also protective against HIV infection, as is age-appropriate comprehensive sexuality, gender, and HIV education especially when combined with service access.

Civil society is a key sector for facilitating change, for two main reasons. Community-based organizations can deliver relevant and valued HIV prevention services to young people and key populations in circumstances where governments may struggle. Civil society organizations can also advocate for legal and policy reforms that would enable effective programmes to be provided at scale. Important legal and policy challenges include the decriminalization of sex work, of sex between men and of drug use, as well as changes to age of consent laws so young people can access HIV and sexual health information and services, and the provision of comprehensive sexuality education for young people. Too few governments in low- and middle-income countries provide adequate funding and support to civil society organizations that are active in HIV prevention.

## **Adequate HIV primary prevention investments**

Evidence-based HIV prevention programmes such as condoms, voluntary medical male circumcision, key population programmes and pre-exposure prophylaxis have been shown to be cost effective and cost saving when implemented at sufficient scale. Studies in Canada, for example, show that every \$ 1 spent on prevention saves \$ 5 in treatment costs, while in the United States every averted HIV infection has been found to save approximately US\$ 230 000 in lifetime medical costs. The benefits of investing in HIV prevention often extend further: consistent condom use, for example, also reduces the risk of other sexually transmitted infections and of unintended



pregnancies, while harm reduction programmes have been found to reduce both HIV and hepatitis C transmission, as well as reduce drug-related crime.

In order to realize the potential benefits of HIV prevention programmes and achieve the 2020 targets, financing has to improve in at least four respects:

- **Increased domestic financing, specifically for HIV prevention.** HIV prevention programmes in many low- and middle-income countries are funded largely by international partners. But HIV prevention is ultimately the responsibility of national governments and a gradual transition to increased domestic investment for both treatment *and* prevention, including for key populations, is urgently required. The pursuit of universal health coverage and development equitable health insurance schemes offer opportunities to increase resources for some forms of HIV prevention, such as increased access to condoms, pre-exposure prophylaxis and voluntary medical male circumcision.
- **Re-investing efficiency gains in prevention.** The World Bank estimates that focusing the most effective mix of interventions on key locations and populations can increase the impact of HIV investments by 10–30% without additional funding. Implementation efficiencies such as reduced costs for the procurement of antiretroviral drugs and HIV diagnostics and reduced management costs could free up additional resources for prevention.
- **Increased international support for HIV prevention and sufficient transition periods.** International funding has played a critical role in financing cutting-edge HIV prevention innovations and programmes for key populations. As a consequence of an apparent shift in donor priorities, outreach programmes for sex workers and other key populations and condom social marketing have been scaled back in some countries. While incentives for increased domestic funding for HIV prevention are essential, it is also clear that sufficient transition periods and support for adaptation are required if programmes are to be sustained.
- **Investing in community-led HIV programmes.** It is easier to reach at-risk populations with effective and acceptable prevention services when community organizations have prominent roles in the design and delivery of those services. This is especially true for key populations and young people. Experiences from large-scale prevention programmes in India and other countries have confirmed the potential impact of such models. However, in many countries administrative barriers hinder the provision of funding for community-led HIV programmes. Barriers include onerous requirements for registering community organizations, inadequate legal provisions for fund transfers and insufficient contracting modalities.

## Recommendations

1. **Bold prevention leadership is required.** Leaders demonstrate good leadership when they promote evidence-based HIV prevention programmes even when this is controversial. It requires courage to address the needs of people who are subject to stigma and discrimination, such as key populations. Strong leaders adopt pragmatic approaches to address the HIV and sexual and reproductive health needs of young people. They join forces with a variety of

partners and defend progressive public health policies, and invest in the most vulnerable and marginalized people in their societies. Prevailing gender roles may need to be challenged.

2. **Policy-makers should actively address the policy changes on which effective HIV prevention service delivery and uptake depends.** Population-specific prevention policies and programme packages for young people who are at risk and key populations such as sex workers, gay and other men who have sex with men, people who inject drugs, transgender people need to be implemented for each population group and should provide adequate structural and policy support so people can use the services. Necessary improvements may include changing legal provisions and/or practices to ensure non-discrimination and removing hindrances that prevent full access for young people, especially adolescent girls and young women, to education and to sexual and reproductive health and rights, and HIV information and services.
3. **Governments should commit to and make concrete plans for allocating about one quarter of HIV budgets to prevention programmes (15–30% depending on treatment burden).** This can be achieved with a combination of measures. Savings made in other areas of the AIDS response can be re-invested in prevention. Some components can be included into Universal Health Coverage and health insurance schemes (such as pre-exposure prophylaxis, voluntary medical male circumcision and opioid substitution therapy). Funding from other sectors such as education can be leveraged, and certain programmes co-financed, such as social protection and school health programmes. Finally, countries may need to make new investment into neglected elements, such as key population and condom programmes, as well as creating a conducive policy environment for them. National governments also need to commit to establishing social contracting and monitoring mechanisms to allow government funding for civil society implementers.
4. **International donors need to sustain funding for HIV prevention and allow for sufficient transitions to increase domestic financing and management capacity.** International donors and agencies also need to place increased emphasis on HIV primary prevention targets in international fora, especially in international or regional platforms, to share lessons and promote best practices in prevention planning and management.

# Discussion paper 2

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## National prevention targets and improved accountability

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### Problem statement

Establishing targets and then monitoring progress remains a powerful motivating tool in the global AIDS response. ‘What gets measured gets done’. Monitoring progress against targets and establishing accountability for achieving them have been used successfully to achieve significant increases in the number of people receiving HIV treatment and to achieve major reductions in the numbers of new HIV infections in children.

### Moving from global to national targets

In 2016, UN Member States committed to achieve the Fast-Track targets for HIV treatment and prevention, including reducing new HIV infections to fewer than 500 000 by 2020, a 75% reduction as compared to 2010. That target is to be reached by providing combination prevention programmes to 90% of young women and their male partners in high-incidence settings and to 90% of key population at risk everywhere by 2020, while continuing to scale up testing and treatment programmes.<sup>1</sup> Achieving those targets will also require a supportive environment that encourages and allows for the adoption of safer behaviours and the use of prevention services and commodities.

If the global prevention targets are to be meaningful and have an impact, they need to be translated into national and local targets that reflect the specific epidemiological contexts in countries. There has been tremendous progress in the translation of global 90–90–90<sup>2</sup> testing and treatment targets, whereas few countries have aligned their national HIV prevention targets to the (three or) five main global prevention targets, partly because of the perceived complexity of translating the global targets to country realities.

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<sup>1</sup> Prevention targets were also set for condom programmes (20 billion to be distributed annually), pre-exposure prophylaxis (3 million people enrolled) and voluntary medical male circumcision (an additional 25 million boys and men circumcised). A full list of programmatic prevention targets is provided in the annex.

<sup>2</sup> 90% of all people living with HIV have been diagnosed, 90% of those diagnosed are receiving antiretroviral therapy and 90% of people on antiretroviral therapy are virally suppressed.

## Gaps in baseline data

In order to set and measure prevention coverage targets for priority populations, countries require estimates of the sizes of key populations (particularly for sex workers, gay and other men who have sex with men, transgender women, people who inject drugs and prisoners) along with information on the geographic and demographic patterns of HIV among adolescent girls, young women and men who are at high risk of acquiring HIV. Many countries have not yet estimated the number of young people or key populations they need to reach with prevention services. Population size estimates also help guide programming decisions and are a basis for measuring and reporting on progress. Unfortunately, some countries still do not have quality estimates of the populations who are at high risk of HIV infection.

### Example: Setting HIV prevention targets in Zimbabwe

The Zimbabwe Population HIV Impact Assessment for 2015 yielded an estimate of 32 000 new HIV infections in adults in 2015 (the UNAIDS estimate was 36 000) which translates to a 2020 target of 16 000, a 75% reduction against the 2010 baseline.

In the first quarter of 2017, the Zimbabwe Government, in collaboration with major implementers of prevention programmes, including civil society organizations, set provisional national 2020 prevention programme targets to supplement the existing 90–90–90 testing and treatment targets. The current status of HIV prevention services was determined, including through a 2015 baseline description of HIV prevention delivery.

The 90% coverage targets for key populations were provisionally calculated by estimating the number of sex workers at between 42 000 and 84 000, and the proportion of the male population who has sex with other men was estimated at 1–2% (based on global estimates). More precise estimates of sex workers are expected soon, following a mapping exercise conducted in early 2017. Provisional population size estimates have already led to an increase of 1 million in the estimated number of condoms needed per year, specifically for key populations, and to the establishment of an additional 10 sites providing services to sex workers. A rapid increase is also planned in the numbers of people enrolled in pre-exposure prophylaxis programmes.

The number of male condoms distributed in the general populations is to increase from 108 and 137 million per year until 2020, while the number of female condoms distributed is to increase from 5.3 million to 6.5 million. The target for (male or female) condom use in sex work is 90%. In addition, a target of 80% coverage of voluntary medical male circumcision was set and translated into operational annual targets.

## Gaps in routine monitoring of prevention programmes

Monitoring and evaluation systems for HIV prevention are often weak. Data on standard programme outputs are often unavailable (such as key population outreach contacts, the numbers of condoms distributed or various indicators related to adolescent girls and young women). They can also be difficult to compile, given multiple implementers that have to satisfy the different reporting obligations of various funding agencies. Except for certain clearly defined biomedical interventions, such voluntary medical male circumcision, routine tools and mechanisms for prevention data reporting and collation are in short supply. Real-time monitoring based on the integration of HIV prevention indicators in national HIV situation room platforms – as seen in Kenya – is still in its infancy in most countries.

## **Gaps in national and international accountability**

Targets are only meaningful if they are embedded in a national and subnational accountability framework and management system. Successful prevention requires collaboration across different sectors (for example health, education, law enforcement and social welfare). Yet coherent results frameworks and (national and local) management systems are often absent, unused or too abstract to support systematic programme implementation. In addition, progress in the scale up of prevention programmes is rarely reported at international fora and there are currently few incentives for countries to report on their prevention programmes in a consistent and standardized manner.

## **Key considerations for a strengthened response**

### **Definition of priority locations and populations**

Consensus is needed on the priority populations that should be reached with primary HIV prevention programmes. Also vital are accurate data on the sizes of populations at risk, information about their risk environments, and baseline information on the current availability and performance of primary prevention services. Clear responsibility has to be assigned for the implementation and management of the programmes.

### **Establishing effective systems for monitoring HIV prevention**

Once a full set of national and local targets has been agreed, the data sources and mechanisms for assessing progress need to be established, including routine programme data collection and surveys. As part of its Global AIDS Monitoring reporting system, UNAIDS recommends using a series of primary HIV prevention indicators, including the sizes of populations of sex workers, gay and other men who have sex with men, transgender persons, people who inject drugs, and prisoners (estimated every 5 years); the proportions of various population groups that were reached by peer educators and provided with condoms in the previous three months; and condom use indicators. Other indicators include the number of voluntary medical male circumcisions performed, enrolment in pre-exposure prophylaxis programmes, and various measures related to the risks and behaviours of adolescent girls and young women as well as indicators related to the policy environment.

Data and indicators have to be reliable and meaningful so that they can inform planning and performance management decisions. Indicators measuring progress in HIV prevention should be reviewed and interpreted regularly. That process reporting should be supplemented with visits to different implementation sites to gather additional qualitative information, and discuss progress and offer support to local implementers. Focusing strictly on achieving numerical targets can lead to perverse outcomes and dysfunctional activities, such as distributing commodities without due attention to demand and use or the quality of services.

## Prevention cascades

A logical pathway from input to output, outcome and impact should be followed when planning and monitoring prevention interventions. Similar to the treatment cascades that are used to identify gaps and blockages in testing and treatment programmes, HIV prevention cascades may offer a way of tracking changes in the proportions of at-risk populations who are aware of their HIV risks, take up effective prevention methods such as condoms and PrEP, sterile needles and opioid substitution therapy use them consistently and stay negative. For instance, almost 100% of sex workers in a certain country or location may be aware of their risk of acquiring HIV, but only 80% have easy access to condoms, 90% of those report condom use at last sex with a client condoms, and but only 60% report consistent condom use<sup>3</sup>.

## Recommendations

- 1. Countries should set national HIV prevention targets that reflect the global targets and their local epidemic.** Inclusive national prevention consultations should be organized to define current prevention programme coverage and output levels based on existing data, identify gaps in relevant prevention pillars and related policies, set targets, and plan key actions to fill gaps. The sizes and local distribution of priority populations must be determined in order to guide programmes and gauge coverage. Combination prevention packages for specific key and priority populations, as well as required policy actions, should be defined in order to guide activities.
- 2. Governments should designate or re-confirm the entity responsible for coordinating and implementing prevention programmes, and should hold it accountable for achieving the targets.** Clear responsibilities must be assigned for the delivery of the national prevention programme and the various prevention pillars so that resources can be allocated and programmes can be organized and managed effectively.
- 3. To drive success, governments should establish routine monitoring systems to track programme performance.** All prevention services should be monitored– whether delivered in or outside the public health system. Indicators should be selected to help guide and manage implementation and to measure performance. Regular management reviews are needed to identify and address implementation gaps and challenges. Given that indicators based on surveys might not be updated annually, the use of routine programme data should be considered to the extent possible, with validation achieved through consultations with relevant stakeholders.
- 4. Progress should be reviewed against key national and global targets, using information provided to UNAIDS by Global Prevention Coalition Member Governments.** Progress reports should be compiled and disseminated to establish mutual accountability. To visualize progress by country and prevention pillar, a global prevention coalition dashboard should be developed.

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<sup>3</sup> More information on prevention cascades is available at UNAIDS on request.

5. **Key prevention programme performance indicators should be harmonized between UNAIDS and key donors such as of the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR), to facilitate monitoring, reporting and comparison of country prevention performances.**

# Discussion paper 3

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## Systematic and efficient service delivery at scale

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### Problem statement

Despite strong evidence of their potential effectiveness, HIV prevention programmes have not been consistently implemented at sufficient scale across priority countries. However, good practices for implementation at scale exist for all the priority pillars of prevention.

Some of the underlying causes of weak implementation have been addressed in other discussions papers. These include a lack of country-specific prevention targets and a lack clarity about who is responsible and accountable for reaching the targets; national governments' inadequate investments in primary HIV prevention, especially for community-based responses and programmes for key populations and young people; and insufficient engagement of key populations in the design and implementation of programmes. Additional gaps and weaknesses are discussed below.

### Failure to consider “how” to deliver prevention programmes

Policy-makers and programme managers tend to focus largely on *what* to deliver – on the specific HIV prevention commodities and services – at the expense of paying sufficient attention to *how* to deliver those services. The latter requires holistically addressing the realities of people who need prevention services, stimulating demand for those services, and establishing systems that can ensure effective delivery. “One size fits all” approaches are not effective. Interventions must be adapted to the specific needs of population groups and of different locations.

### Fragmentation and insufficient scale

Prevention service delivery is often fragmented, with numerous actors implementing small-scale and localized projects that have limited population coverage and varying programme intensity. Often implementation occurs without the use of agreed prevention toolkits for programmers or standard operating procedures. The intervention packages also vary widely, especially when they involve activities beyond the health sector. Some stakeholders are reluctant to invest in non-biomedical interventions that are aimed at longer-term outcomes. Some donor and technical agencies may be contributing to fragmentation, by focusing on particular prevention components



rather than supporting comprehensive packages. Such disparate approaches can restrict countries' abilities to mount coherent, scaled-up HIV prevention programmes that span different sectors.

### **Lack of institutionalization of HIV prevention**

Contrary to HIV treatment programmes, which are firmly anchored in Ministries of Health, there have been limited efforts to institutionalize HIV prevention within health sector frameworks and across other key/relevant sectors, and to develop national and subnational structures and processes for a cross-sector response. This is partly due to limited attempts to institutionalize HIV prevention services and programmes implemented by non-governmental organizations, which often lack sufficient government support, funding and monitoring.

## **Key considerations for a strengthened response**

The other discussion papers address the obstacles that complicate systematic implementation, including those related to leadership, policies and laws, target setting and financing. This section provides some additional considerations that can support effective implementation.

### **Local epidemics**

In most countries, HIV epidemics are not homogenous across different populations and locations. It is vital to accurately define the micro-epidemics that are underway in a given country in order to identify the populations and locations that are most at risk, and to select the interventions that are likely to be most effective. This process may include identifying subnational trends in the numbers of new HIV infections, categorizing geographical regions (e.g. based on high, medium or low HIV incidence) and pinpointing key populations hot spots (see Annex). It would also involve analysing epidemic patterns by age and sex, identifying the main drivers and modes of transmission in specified geographic areas, and establishing routine data collection systems both in and outside the health sector.

### **Intervention packages**

Having identified and characterized target populations for HIV prevention in different settings, countries need to decide on packages of interventions that are tailored to those populations and on the service platforms that can be used to deliver the combinations of behavioural, structural and biomedical interventions. Programme delivery guidelines or standard operating procedures (if not already available) are needed and should include service delivery, demand generation and adherence support. This also needs to include the development of job-aids and strengthened capacities for both facility- and community-based providers.

### **Prevention service delivery platforms**

For successful, scaled-up prevention implementation, it is important to know which relevant services (in the health sector or elsewhere) can routinely reach the target populations, and to

explore opportunities for integrating prevention activities. This may involve a range of potential service delivery platforms, including sexual and reproductive health including family planning services, and community-related extension services. It may also include private sector platforms such as marketing outlets for condoms (e.g. provided by beverage distribution channels as in some African countries). Schools may serve as platforms for providing comprehensive sexuality education linked to sexual and reproductive health services and generating demand for voluntary medical male circumcision for young men. It is critical to clearly define which services will be delivered through which platform.

### **Priority sectors other than health**

Sectors other than health are essential for the success of scaled-up HIV prevention programmes. School vouchers, cash transfers and other forms of economic and social empowerment are often managed out of the social welfare sectors, while sexual and reproductive health education tends to be the responsibility of the education sector complemented by community programmes. Community-based organizations are often from, or have good access to, key populations, but they often require additional support to deliver services systematically and at scale. Justice, law enforcement and prison authorities are critical key stakeholders for effective access to HIV prevention for people who inject drugs, engage in sex work and/or in prisons. There is therefore a need to define strategies and results for each pertinent sector, decide which entity is responsible for engaging those sectors, determine the expected results, and develop the indicators and reporting mechanisms that can be shared between the various sectors and the responsible agency.

### **HIV prevention management and oversight**

To ensure consistent programme delivery, a national HIV prevention unit or team is required to provide technical oversight, tools development or adaptation, communication products, data review, progress tracking and advice to the agency that is primarily responsible for HIV prevention. The team should meet regularly and support subnational working groups that are assigned the same functions. If suitable structures or committees already exist, HIV prevention may be added to their primary agendas.

The convening function for prevention typically rests with a national AIDS coordinating body. However, in many cases experts for specific elements such as communications, logistics or market research may need to be brought in from other organizations. It is essential to align the capacities around country targets, so that programmes are strengthened and capacities are developed.

## **Recommendations**

The following actions are recommended to address the main challenges and ensure that countries implement HIV prevention programmes coherently and at scale:

1. **Countries need to identify (or re-confirm) the entity that is accountable for achieving the results of the national HIV prevention plan, and that is responsible for driving HIV prevention.** It is vital to ensure strong political leadership and clear responsibility for the coordination, management and implementation of activities associated with each of the prevention pillars. Each country will need to identify the entity that is primarily accountable for overall achievement of the HIV prevention targets. It will be responsible for directing and driving the development of the national roadmap or plan, tracking performances and annually reporting on progress.
2. **Countries should develop or review their national prevention roadmaps.** This will include accurately defining the key populations and locations, and developing country-specific prevention cascades, service packages and service delivery platforms. Country frameworks need to identify partnerships and collaboration with communities and organizations in the general population, key populations and adolescents and young people. The frameworks should outline the strengths of the various groups and indicate how those groups will be engaged in the process of priority setting, services, reporting and performance tracking.
3. **Countries should institutionalize HIV prevention** by clearly defining the desired linkages and results across sectors and strengthening national and subnational prevention coordination structures that are responsible for monitoring and tracking progress against the targets. Countries need to establish mechanisms for social contracting, funding, monitoring and mentoring of implementing civil society organizations. Countries should look to integrate HIV prevention services with other health services, and within other sector programming, and real-time monitoring through the integration of HIV prevention indicators in national HIV “situation room” platforms.
4. **Country road maps plans should outline the prevention capacities that are required in respective government agencies, teams and processes.** Priority capacities include those related to forecasting, quantification, monitoring, HIV prevention commodity supply chain management, coordination and support of nongovernmental implementers, and real-time monitoring of programme implementation.

# Discussion paper 4

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## Providing prevention choices: a person-centered approach

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### Problem statement

#### **From intervention-focused to person-centered approaches**

HIV prevention is frequently organized around specific interventions rather than around people's specific HIV prevention and related health needs. There are pragmatic reasons for focusing programmes on interventions – for example, condom social marketing and access to sterile needles require the involvement of private sector channels and outlets that are not otherwise involved in HIV prevention service delivery. While specific implementation channels will continue to be required for specific interventions, there are now also opportunities for a more integrated approach. Given the past decade's evidence of additional, effective interventions (including voluntary medical male circumcision, treatment as prevention and pre-exposure prophylaxis), a new global HIV prevention drive can be marshaled around people's right to prevention and their right to choose the prevention options that suit them best. This also includes a person-centered approach for people living with HIV, building on the existing Positive Health, Dignity and Prevention concept.

#### **Prevention as a right and prevention choices**

The human right to the highest attainable standard of health, as defined in the International Covenant for Economic Social and Cultural Rights, explicitly addresses treatment and prevention in relation to epidemics. Fulfilling that right requires that people who are at increased risk of HIV infection have access to effective prevention, testing, and treatment services, and can choose the prevention methods that suit them best – such as condoms and lubricants, clean needles and syringes, pre-exposure prophylaxis, antiretroviral therapy etc. That right also entails the ability to make safe sexual choices, to decide whether or not to have sex, and to decide with whom and when to have sex, and which type of protection to use.

The emphasis on prevention choices overcomes the fragmentation of HIV prevention into competing agendas based on different tools, and offers an attractive overarching theme for a new prevention movement. The engagement of communities, key populations and civil society organizations would be central to the creation of a prevention movement built around choice.

## Key considerations for a strengthened response

### Person-centered combination prevention

The WHO framework for integrated and people-centered health services offers the opportunity to shape combination prevention services in a person-centered way that increases people's agency. The framework relies on five interdependent strategies: (1) empowering and engaging people and communities; (2) strengthening governance and accountability; (3) reorienting the model of care; (4) coordinating services within and across sectors; and (5) creating an enabling environment. If fully implemented, those strategies will fundamentally change the way health services are delivered. As the primary custodians of their own health, people would be empowered to take effective decisions about their health and communities would be actively engaged in the delivery of primary health care services.

A person-centered approach acknowledges that people's prevention needs change over the course of their lives, and that those changes are due to a range of factors that related to the individual (age, lifestyle, economic situation etc.) and to the surrounding environment (cultural norms, location, physical security etc). In practice, a person-centered approach to combination prevention means that, in order to deliver targeted packages of combination prevention at scale, planners and implementers have to recognize that:

- people are best placed to decide which HIV prevention method is right for them when they are offered differentiated and integrated choices;
- communities are effective partners in the delivery of prevention and care information and services, and their roles should be leveraged also to alleviate overburdened health facilities; and
- strategic efforts to address the structural drivers of HIV transmission should be part of combination prevention packages.

### Individual agency and choice

Individuals' needs and preferences change, as does their vulnerability to HIV. It is necessary to understand how vulnerability changes in order to select and provide the most appropriate packages of preventive services. In addition, people need to be able to decide which prevention options suit them best, and they need to be supported to adopt health-seeking behaviours and access appropriate, affordable and acceptable HIV services.

#### **Example: A study in South Africa reveals the cycle of HIV transmission and the shifting needs of women**

The CAPRISA study conducted in a rural community of Kwazulu-Natal province in South Africa among adolescent girls and young women highlights how important it is that service packages reflect people's distinct vulnerabilities to HIV, and enhance their autonomy and choice. The study provided a nuanced understanding of the cycle of HIV transmission among three cohorts. It found that adolescent girls and young women aged 15–24 years in the community tend to acquire HIV from 25–40 year-old men (who are an average 8.7 years older than the women). Meanwhile, the men tend to acquire infection from women of similar age to themselves (typically 25–35 year-old

women). The group of men aged 25–40 years who are having sex with adolescent girls and young women, and with women closer to their own age is central to the cycle of HIV transmission in the studied community.

In order to break that cycle of transmission, the CAPRISA study suggested packages of prevention services that are tailored to meet women’s needs at different points in their lives, empowering them to decide which prevention options best suit their changing sexual and reproductive health, and other needs. These packages include interventions such as sexual and reproductive health rights services, pre-exposure prophylaxis, condoms, antiretroviral therapy, social mobilization, prevention of gender-based violence, economic opportunities and intervention to promote adolescent girls’ education.

### **Leveraging the role of communities**

Partnerships that strongly link health facilities and communities can facilitate the shifting of certain primary prevention tasks to community-based organizations. UNAIDS estimates that, in order to maximize gains and improve service uptake, community-based service delivery should cover at least 30% of total service delivery.

By directly providing combination prevention packages at community level and using effective referral systems, communities can stimulate demand and increase people’s opportunities to access a broad range of integrated services, remain healthy and stay in touch with health services. People living with HIV are often at the forefront of the HIV response and for prevention efforts to be effective it is critical to include them. Moreover, greater involvement in HIV prevention can help strengthen communities and community systems, enabling them to partner more closely with formal health services and contribute to building resilient, equitable and sustainable systems for health. Those systems would be better equipped to tackle not only HIV, but sexual reproductive health and rights, malaria, tuberculosis and noncommunicable diseases.

#### **Example: India – community prevention for gay and other men who have sex with men, transgender persons and hijra**

Alliance India (in partnership with the National AIDS Control Organisation) designed and implemented at scale a combination prevention programme (Pehchan) addressing the needs of gay and other men who have sex with men, transgender women and hijra populations across India between 2010 and 2016. Using a rights-based approach, the programme developed community-based organizations’ capacities to deliver combination prevention services that are tailored to the needs of the targeted populations. The number of people benefiting from the programme substantially exceeded earlier national-level size estimates for the targeted priority groups, which prompted India’s Ministry of Health to conduct new key population size estimation studies and which also influenced the National AIDS Control Organisation’s budget allocations for interventions among the targeted populations.

## Addressing structural drivers

Social norms and inequalities underpin people's vulnerability to HIV. Laws that punish instead of protect, stigma and discrimination (including in healthcare settings), gender and other social inequalities, and gender-based violence are among the factors that render people vulnerable, and that deny them knowledge of and access to the prevention services they need. Structural prevention approaches recognize that people have different needs and live in complex circumstances. They promote more equitable societies in which prevention and other health and social services can be scaled up effectively to reach everyone who needs them.

Despite the evidence that structural prevention interventions do work, they are rarely implemented at the moment. HIV prevention budgets are too limited to resource structural interventions; co-financing from other sectors is required. HIV prevention programmes should also not create parallel systems for providing social protection and support. Nevertheless, interventions to reduce stigma, transform harmful gender norms, reduce/eliminate gender based violence, provide comprehensive sexuality education, decriminalize sex work and sex between men, provide alternatives to conviction or punishment for drug use and possession for personal consumption, extend economic support, protect human rights or provide social protection are vital components of a combination prevention package. (see discussion paper 1).

### Example: Uganda's SASA! Programme

SASA! ("now" in Kiswahili) is a community-led programme in Uganda that engages community members and leaders in discussions on gender inequality, gender-based violence and HIV in a bid to discourage the acceptance of violence and change harmful gender norms. When implemented in four communities in Kampala, the programme helped reduce intimate partner violence and promoted more supportive community responses to women who experienced such violence. The SASA! approach is now being used by at least 60 organizations in more than 20 countries.

## Recommendations

1. **HIV prevention should apply a person-centered approach.** This approach should serve people in all their diversity with the services that are most appropriate for the various stages of their lives, and should do so in empowering and responsive ways. Examples include comprehensive HIV, sexuality, gender and life skills education for adolescents and young people; services that reflect the distinct needs and realities of people of different ages, or with different lifestyles; for vulnerable and key populations; integrated harm reduction for people who use drugs; and diversity and hormone education for transgender individuals, and Positive Health, Dignity and Prevention for people living with HIV.
2. **The roles of civil society and community organizations as valuable partners in HIV prevention services delivery and demand creation need to be fully recognized and adequately resourced.** Those organizations should be involved in the use of innovative

technologies, including HIV self-testing and pre-exposure prophylaxis, and in new media outreach and messaging initiatives. Strengthening community and health systems should be as big a priority as supporting the delivery of services, and should include capacity building and empowerment of youth and key population-led organizations.

- 3. Resources should be available for the full set of combination prevention interventions and measurable targets should be set for all programme components, including behavioural and structural interventions.** All elements of the combination prevention packages for young people and key populations should be resourced and measured, since they are all vital for decreasing the number of new HIV infections. The global community has set targets for effective prevention interventions, as outlined in the UNAIDS 2016–2021 strategy and the Political Declaration on Ending AIDS. It is now necessary to translate and apply those targets rapidly at national and subnational levels (see discussion paper 2).



# Discussion paper 5

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## Strengthen technical support for prevention

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### Problem statement

#### **Providing technical support for prevention is important, but demand has been low**

The fact that progress in the coverage and outcomes of prevention programmes varies greatly between countries points to substantial differences in the scale and quality of implementation. Despite large programme gaps and persistently high numbers of new HIV infections, countries seldom request specific technical assistance for their prevention programmes; the focus tends to be on support for treatment programmes or for the development of Global Fund applications.

These gaps are not always recognized, and learning from prevention programmes in other countries is not commonplace either. Experiences from Ukraine's people who use drugs or India's sex worker programmes, and lessons learnt from well-functioning national condom programmes and their total market approach, or from the recent introduction of pre-exposure prophylaxis in some countries are not being applied widely enough. Many countries also lack medium- or long-term technical assistance and capacity strengthening plans for their prevention programmes. It is important to understand the reasons for the low demand for prevention-related technical assistance. Increased recognition of the benefits of scaling up effective HIV prevention programmes alongside treatment would help strengthen demand.

#### **External HIV assistance has had limited focus on prevention and supply was uneven**

Current external technical assistance that is provided via entities such as the Global Fund's Implementation Through Partnership initiative and the UNAIDS Technical Support Facilities has had a limited prevention focus and has not significantly shaped the quality, quantity or impact of effective prevention. For example, the Technical Support Facilities have responded to requests for technical assistance for key population programmes in Asia and the Pacific, but very little assistance has been requested for prevention programmes in sub-Saharan Africa.

Useful prevention technical assistance has been provided by other agencies for specific prevention pillars, such as voluntary medical male circumcision, pre-exposure prophylaxis, condoms, needle and syringe programmes, opioid substitution therapy, and interventions focused on adolescent girls

and young women or key populations. However the requests have tended to be sporadic and often focus on isolated activities with limited reach. Technical assistance for prevention programmes often is fragmented, lacks coordination, and tends to be reactive rather than supporting strategic actions for achieving national targets.

## Key considerations for a strengthened response

### Prevention technical assistance requires a global strategy

A more effective and systematic approach to prevention technical assistance could be articulated in a global strategy for the provision of HIV prevention technical assistance. Building on the global prevention framework, it would cover various domains, including support to clearly articulated national prevention strategies and actions with performance benchmarks; assistance for effective evidence-informed actions for the various prevention pillars (including their structural and enabling environment elements); and sharing learning across countries (including through country-to-country exchanges).

### Different approaches and focus according to country needs

Technical assistance needs and priorities vary between and within countries, depending on the epidemiology, affected populations, and coverage and quality of programmes. Both the overall prevention programme and the individual prevention pillars will need to be considered, although the focus will vary. Some countries may already have a strong condom strategy or may have considered and introduced pre-exposure prophylaxis, whereas others may lack those features or may require assistance to prioritize, introduce and regulate pre-exposure prophylaxis, and identify eligible populations. Strengthening the delivery platforms and creating an enabling environment are also important objectives of prevention technical assistance.

### Technical assistance for national HIV prevention strategies

National prevention strategies may benefit from support in several areas, including: the generation, analysis and compilation of strategic information on populations that are most at risk of HIV infection; advocacy for addressing sensitive issues and increasing prevention financing; developing national prevention roadmaps; setting prevention targets; strengthening prevention coordination and partnerships; and planning medium- and long-term capacity building.

### Technical assistance for individual prevention pillars

Support to programming to prevent HIV among adolescent girls and young women is likely to be most relevant in countries in sub-Saharan Africa (see, for example, the respective priority countries of the *Start Free Stay Free AIDS Free* framework and the Global Fund) and will need to focus on multisectoral coordination, geographic prioritization, the design of comprehensive multilayered programmes, and the development of monitoring and evaluation frameworks. Voluntary medical male circumcision programmes in priority countries may need support around strategic issues such

as demand creation, targeting, and linking those programmes with other programmes for male sexual and reproductive health. Technical assistance for condom programmes may focus on needs and gap estimates, marketing strategies, supply chain management, and suitable private/public sector mixes. Key population programming is currently weak in almost all countries and scale, coverage and experience varies greatly. Technical assistance may be required to improve key population size estimates, design comprehensive and evidence-based programmes, and address structural barriers including legal barriers and punitive policies and practices. In addition, technical assistance could enhance nongovernmental organizations' capacities, strengthen links with relevant ministries and support health worker training. Monitoring and evaluation support that captures both national and nongovernmental organization programmes is needed. Technical assistance may also be needed for introducing innovations such as pre-exposure prophylaxis and HIV self-testing, and for using new media and communications technologies as part of HIV prevention programmes.

### **Sources and quality of technical assistance**

Technical assistance can be provided by global and regional experts or can draw on in-country expertise, or through the facilitation of learning from other countries, best practice documentation and the organization of communities of practice (in-countries or across a given region). Quality assurance is vital. All technical assistance needs should reflect existing global guidance, be human rights-based and should engage recipient populations to ensure that community empowerment and community-led initiatives are at core of the prevention response.

## **Recommendations**

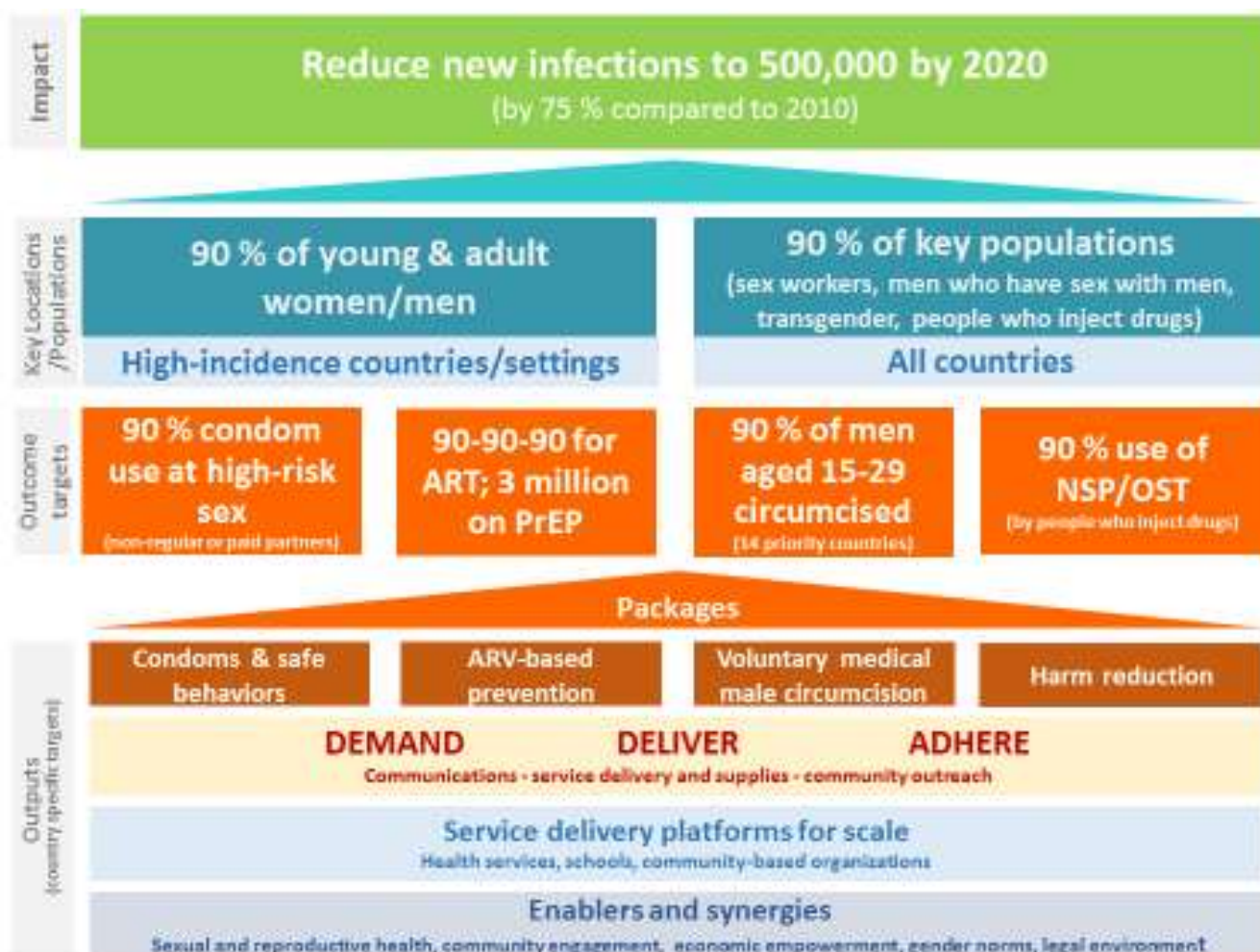
- 1. National governments should identify major gaps in their prevention programmes and in each of the 5 prevention pillars, and formulate key strategic assistance needs in a consolidated prevention technical assistance plan.** This may involve mapping existing in-country technical expertise on the 5 prevention pillars and related cross-cutting issues, facilitating the establishment of prevention implementers' networks, in-country exchanges of experience, and the development of communities of practice for key prevention components.
- 2. Development partners should move from project-based technical assistance towards longer-term technical assistance for national programmes and engage national governments in a dialogue on priority needs.** This may involve training for the use of existing tools and implementation guidance, providing additional in-country expertise through local country offices and through regional offices and headquarters, as needed, and building longer-term prevention capacities, such as facilitating the recruitment of expert prevention staff.
- 3. Establish a global mechanism for providing prevention technical assistance and formalize technical leadership for each pillar** (see the annex for a proposed division of labour). Each lead agency should establish technical assistance coordination capacity in its

specific area, coordinate with other agencies, maintain a roster of vetted technical experts who can provide technical assistance to countries as needed, establish communities of practice and communication strategies for each area, channel technical assistance requests as appropriate including to the Implementation Through Partnership or UNAIDS facility for funding, and assure the quality of technical support.

4. **Global civil society organizations and networks will provide technical assistance to local and national affiliates and other nongovernmental and community organizations.** Global civil society organizations and key population networks should continue providing support to their local and national affiliates to ensure they are fully included in decision-making and agenda-setting processes, and in the provision of technical assistance.

# Annexes

## Global HIV prevention results framework and targets



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

## **Political Declaration on Ending AIDS and UNAIDS Strategy prevention targets for 2020\***

### **Impact**

- < 500,000 new infections (75% reduction against 2010 baseline).

### **Programme coverage – access to combination prevention**

- 90% of young people in high-prevalence settings.
- 90% of key populations.\*\*

### **Outputs**

- 20 billion condoms per year (equal to 25–50 condoms per male per year in high-prevalence countries).\*\*\*
- 3 million people on pre-exposure prophylaxis (10% of persons at high risk).
- 25 (additional) million voluntary medical male circumcisions in 14 countries in Africa (90% coverage among 10–29 year olds).

### **Financing and sustainability**

- Allocate one “quarter” of total HIV budget for prevention on average, e.g. 15-30% (depending on relative treatment burden).
- Ensure that at least 30% of service delivery is community-led by 2030.

\* Target-setting guidance is available on request.

\*\* Includes 90% coverage with outreach and condoms/needles and syringes, and 40% coverage of opioid substitution therapy for people who inject drugs.

\*\*\* Needs and gaps estimate tool available on request.

## HIV prevention packages 1: Generic package for adolescent girls and young women<sup>4</sup>



## HIV prevention packages 2: Generic package for gay and other men who have sex with men



<sup>4</sup> Similar generic packages have been proposed for sex workers and persons who use drugs

### HIV prevention packages 3: Country examples of HIV prevention packages, differentiated by epidemic, population and location, Kenya

Populations	HIV incidence (as determined by specific countries)		
	High	Medium	Low
General population (male)	100% condom programming HIV testing, including self-testing Voluntary medical male circumcision Pre-exposure prophylaxis Antiretroviral therapy	Voluntary medical male circumcision Condom promotion campaigns HIV testing, including self-testing Post-exposure prophylaxis Antiretroviral therapy	Condoms in hot spots HIV testing services Community testing Post-exposure prophylaxis Antiretroviral therapy
General population (female)	HIV testing and risk reduction counselling Family planning and sexual and reproductive health services 100% condom programming Gender-based violence reduction programmes Pre-exposure prophylaxis Antiretroviral therapy	Condoms in hot spots HIV testing services Family planning and sexual and reproductive health services Gender-based violence reduction programmes Antiretroviral therapy	Condom in hotspots HIV testing and family planning services Post-exposure prophylaxis Antiretroviral therapy
Young people (15–19 years)	Pre-exposure prophylaxis HIV testing and risk reduction counselling Self-testing Family planning and sexual and reproductive health services Keep girls in school campaigns Economic empowerment programmes Voluntary medical male circumcision Antiretroviral therapy	Voluntary medical male circumcision HIV testing services Economic empowerment Keep girls in school initiatives Condom campaigns Family planning and sexual and reproductive health services Post-exposure prophylaxis Antiretroviral therapy	Voluntary medical male circumcision HIV testing services Initiatives to keep girls in school Behaviour change campaigns Antiretroviral therapy
Young people (20–24 years)	Pre-exposure prophylaxis HIV risk reduction counselling Self-testing Family planning and sexual and reproductive health services Conditional economic support Gender-based violence prevention programmes Antiretroviral therapy	Condom use Voluntary medical male circumcision HIV testing services Family planning and sexual and reproductive health services Antiretroviral therapy	Voluntary medical male circumcision HIV testing services Condom campaigns Risk reduction campaigns Antiretroviral therapy
Key populations	HIV testing, including self-testing, 100% condom programming, Sexually transmitted infection screening and treatment, Pre-exposure prophylaxis Violence prevention and human rights promotion programmes, Needle-syringe and methadone programmes, violence prevention programmes Antiretroviral therapy	100% condom programming HIV testing, including self-testing Pre-exposure prophylaxis Sexually transmitted infection screening and treatment NSP and MAT programmes Violence prevention and human rights promotion programmes Antiretroviral therapy	100% condom programming, HIV testing, including self-testing, Sexually transmitted infection screening and treatment NSP and MAT programmes Antiretroviral therapy
Other priority populations such as truck drivers, fishing communities	HIV testing, including self-testing 100% Condom programming and promotion Sexual and reproductive health services Pre-exposure prophylaxis Behaviour change communication campaigns Antiretroviral therapy	HIV testing services Condom use campaigns Post-exposure prophylaxis Antiretroviral therapy	HIV testing services Condom use campaigns Post-exposure prophylaxis Antiretroviral therapy



## Proposed global division of labour for prevention technical assistance

Thematic area	Technical support agencies
<b>HIV prevention among young women and adult men in high-prevalence settings in southern and eastern Africa</b>	<i>PEPFAR with UNFPA and UNICEF</i>
<b>HIV prevention among key populations</b>	<i>PEPFAR with Linkages, HIV Alliance, with UNFPA, UNDP, WHO and UNODC</i>
<b>Men, boys and voluntary medical male circumcision</b>	<i>WHO with PEPFAR, BMGF, UNAIDS</i>
<b>Pre-exposure prophylaxis for populations at substantial HIV risk</b>	<i>WHO with BMGF</i>
<b>Condom programmes</b>	<i>UNFPA with USAID, BMGF, UNAIDS</i>
<b>National prevention strategies and cross-cutting and structural issues</b>	<i>UNAIDS Secretariat and co-sponsors, BMGF</i>
<b>Data</b>	<i>UNAIDS, WHO, UNICEF</i>

## Further reading

The publications listed below were used to prepare the discussion papers. Each publication contains detailed referencing.

UNAIDS Programme Coordination Board background note: HIV prevention 2020: a global partnership for delivery. Geneva: UNAIDS; 2017  
([http://www.unaids.org/en/resources/documents/2017/PCB40\\_17.14](http://www.unaids.org/en/resources/documents/2017/PCB40_17.14)).

Prevention gap report. Geneva; UNAIDS; 2016  
(<http://www.unaids.org/en/resources/documents/2016/prevention-gap>).

Dehne KL, Dallabetta G, Wilson D et al. HIV prevention 2020: a framework for delivery and a call for action. *Lancet*. 2016;3(7):e323-e332  
([http://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(16\)30035-2/fulltext](http://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(16)30035-2/fulltext)).