

2025 AIDS targets

Target-Setting, Impact and Resource Needs for the Global AIDS Response

Technical consultation on primary prevention



27-29 March 2019

Geneva, Switzerland

Summary

UNAIDS is leading a participatory process for the development of HIV programmatic targets for 2025 and resource needs estimates for 2021–2030. The outputs from this process aim to serve as inputs to the next UNAIDS strategy, a possible future United Nations General Assembly High Level Meeting on the global HIV response, Global Fund replenishments, national target-setting and strategic planning and the decision-making of major global partners.

A multi-stakeholder Steering Group is guiding the process, and experts' technical inputs are being made within six consultative thematic groups on (1) testing and treatment, (2) primary prevention¹, (3) social enablers, (4) costs and resources, (5) integration and (6) longer-term technologies. The primary prevention consultative group met on 27-29 March 2019 in Geneva, Switzerland. The group was urged to achieve the following over the course of the meeting:

- To discuss what an ambitious AIDS response contains on primary prevention for the 2021-2030 period.
- To propose targets for primary prevention programmes for 2025.
- To propose if and how overall targets may differ for: countries, age/gender groups, population groups - including key populations.
- To discuss how enabling factors interact with prevention programmes and which specific enablers should be part of HIV prevention programmes, the wider HIV response and overall social development response.
- To discuss bundling of primary prevention HIV services including with testing and treatment services and integration with other health services.

Consensus was achieved on the following:

Context

- HIV prevention efforts are off track. Globally, new HIV infections have declined by just 18% since 2010, a rate of decline that is far too slow to reach the Fast-Track milestone of fewer than 500,000 new HIV infections globally by 2020.
- The complexity of HIV prevention, weaknesses in our ability to measure progress, and the difficulty of linking individual programme-level outputs to impact, have all contributed to the de-prioritization of primary prevention programmes within national AIDS responses in recent years.
- HIV transmission dynamics differ greatly across regions and within countries, by modes of transmission and within and between populations groups. A granular approach that focuses on the locations and populations at greatest need, and the right mix of services for those populations, is required to achieve the above global incidence reductions.
- Comprehensive packages of services have been defined and refined for each population at high risk of HIV acquisition. However, primary HIV prevention services are still rarely provided on an adequate scale and with sufficient intensity, despite plenty of evidence showing which

¹ Primary prevention does not include antiretroviral therapy nor the prevention of mother-to-child transmission.

interventions work and the availability of a comprehensive body of scientific evidence and programme guidance.

Critical enablers

- Experience to date shows that the availability of individual HIV services is insufficient to achieve the coverage called for in the 2020 Fast-Track targets and the impact envisioned in the 2030 goal to end AIDS as a public health threat. An enabling environment for access to, and the uptake of services that leaves no-one behind/includes all populations and groups is also required. Participants were united in their view that HIV prevention efforts should not be limited to service delivery. The set of targets for 2025 should call for countries to address structural barriers to services, including through the reform of punitive laws and policies, strengthening social protection measures, strengthening education and economic empowerment, and addressing all forms of human rights violations including stigma and discrimination (real or perceived); gender-based power imbalances and gender-based violence.

Integration

- The 2025 target-setting and 2021-2030 resource needs estimation process must consider the integration of HIV and non-HIV services. An inconsistent effort to address sexually transmitted infections (STIs) within HIV prevention programmes or integration into sexual and reproductive health services was criticized as a missed opportunity. Other integration issues raised included: the screening, prevention and treatment of tuberculosis, especially among prisoners and transgender people; the screening and treatment of viral hepatitis among people who inject drugs; and HPV vaccination and screening and treatment for cervical cancer among women in high-prevalence settings and within key populations.

Setting targets for combination prevention

- The twin challenge facing the 2025 target-setting process is: (a) to translate the complex reality of combination HIV prevention into simple global targets; and (b) to ensure that simple and aspirational global targets are translated nationally and locally into the delivery of robust packages of services for all populations in need.
- HIV prevention guidelines produced by WHO, UNFPA, UNODC, UNAIDS and others call for a combination approach that offers multiple prevention options to people at risk of HIV, integrates services to prevent, screen and treat STIs, viral hepatitis and tuberculosis, and includes the establishment of an enabling environment for service delivery. Meeting participants endorsed this approach and debated ways to better ensure it is reflecting in the 2025 targets and more consistently adopted by national and local AIDS responses.
- While the expansion of evidence-based prevention options has provided an impetus for setting new targets for prevention, these new service options have not resulted in changes in thinking regarding the service access and behaviour change that are needed for individuals depending on the context. The concept of “platforms” of services focused on at-risk communities gained traction. Under this framework, individuals within specific communities would be enabled to choose from the HIV prevention options within a platform. For example, condoms could be used with a casual partner, but a recent HIV-negative test result or knowledge of viral suppression could be sufficient for a regular partner. This “platform” approach requires new ways of thinking about risk assessment, risk reduction, HIV testing and HIV counselling and support services.

- Participants noted that risk of HIV acquisition within sub-populations can vary greatly depending on individual risk behaviours and the severity of the local epidemic. Participants agreed on the development of differentiated prevention targets that reflect this heterogeneous risk.
- In an ideal setting and/or context, the 2025 target would be universal access to all prevention options by all at-risk populations within a supportive environment. However, the reality is that needs and the resources available to meet those needs vary between and within countries and populations. A prioritization cascade of prevention options for individual sub-populations may need to be considered at a local or country level, particularly where resources may be limited or based on the strength of evidence on effectiveness of individual interventions or policies. For example, access to needle-syringe programmes may be a higher priority than pre-exposure prophylaxis (PrEP) for people who inject drugs in some settings.
- It was noted that high coverage of condom use—such as the 90% target for 2020—may no longer be relevant in settings where PrEP is widely available or among sero-discordant couples when the partner living with HIV is virally suppressed. On the other hand, there was recognition that PrEP and viral suppression prevent HIV transmission but do not protect against other STIs and unwanted pregnancy. Promotion of non-barrier methods of HIV risk reduction needs to be more nuanced to ensure individuals know to address other risks.
- Participants proposed service packages, critical enablers and 2025 targets for various at-risk populations (see full report for details).

Introduction and background

Over the past two decades the Joint United Nations Programme on HIV/AIDS (UNAIDS) has played a central role in the development of impact-level and programmatic targets for the global AIDS response, as well as estimates of the financial resources required to reach these targets. UNAIDS estimations of targets, resource needs and impact have informed multi-year strategies for the global response, Global Fund replenishments and three General Assembly high-level meetings. The Fast-Track target-setting and modelling, begun in 2014, focused on the development of 2020 targets that would establish the momentum necessary to achieve the goal of “ending AIDS as a public health threat”, which is defined in the 2030 Agenda on Sustainable Development as a 90% reduction in new HIV infections and AIDS-related deaths and stigma and discrimination, compared to 2010 baseline estimates

This modelling analysis determined that a “Fast-Track” approach was needed: a front-loading of investments to rapidly accelerate programme coverage and reach a set of targets by 2020—including the 90–90–90 testing and treatment targets², 95% coverage of services to prevent mother-to-child transmission of HIV, and access to a package of HIV prevention services to at least 90% of key populations.³ Annual financial resources needed for this Fast-Track response for all low- and middle income countries (LMICs) would peak in 2020 at US\$26.2 billion—including US\$7.4 billion in low-income countries, US\$8.2 billion in lower middle-income countries and US\$10.5 billion in upper-middle-income-countries—before declining approximately 9% by 2030. This resource needs estimate included savings of up to 35%; future efficiencies generated by economies of scale, price reductions and other technical and allocative efficiencies. The outputs of the model

2020 Fast-Track targets for primary prevention

- 90% coverage of prevent service package for female sex workers, men who have sex with men, transgender people and prisoners.
- 40% coverage of opioid substitution therapy for people who inject drugs.
- 90% condom use at last sex among people with multiple partners.
- 30% coverage of cash transfers for adolescent girls in hyper-epidemic settings with low rates of secondary school enrolment.
- 90% voluntary medical male circumcision (focused on 10-29-year-old men in 14 priority countries).
- 10% pre-exposure prophylaxis (PrEP) for female sex workers, men who have sex with men, sero-discordant couples (in generalized epidemic countries) and for 15-24-year-old girls and women (in areas with >3% incidence in hyper-epidemic countries).
- 80% coverage of post-exposure prophylaxis for accidental exposure and victims of rape.

² 90% of people living with HIV know their status; 90% of people living with HIV who know their status are on treatment; and 90% of people on treatment are virally suppressed.

³ Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD et al. What Is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track approach. PLoS ONE. 2016;11(5):e0154893. doi:10.1371/journal.pone.0154893.

served as the basis for the UNAIDS 2016–2021 Strategy and the commitments within the United Nations General Assembly’s 2016 Political Declaration on HIV/AIDS.⁴

New round of target-setting and resource needs estimation

From late 2018 to the middle of 2021, programmatic targets for 2025 and resource needs estimates for 2021–2030 will be developed by UNAIDS in close collaboration with its partners. As in past years, the outputs are timed to serve as inputs to the next UNAIDS strategy, possible future United Nations General Assembly High Level Meetings on the global HIV response, Global Fund replenishments, national target-setting and strategic planning and the decision-making of major global partners.

The multi-stakeholder Steering Committee guiding the process held its first face-to-face meeting on 10-12 October 2018 to define the scope of its work, to establish technical groups to inform the process, and to develop a plan for the dissemination of the outputs of the process. The Steering Committee’s decisions on various operational and technical issues are contained in the report of its first meeting. Of note were decisions to focus the process on:

- Defining what is needed to reach the 2030 impact goals and guide countries to more efficiently and effectively achieve them.
- Setting programmatic targets to achieve high coverage of accessible and quality bundles of people-centred services.
- Ensuring that the contribution of social enablers and their costs are included in the target-setting and resource needs estimation.
- Capturing synergies between the HIV response and other health and development efforts.
- Project the impact of the introduction of new technologies on new HIV infections and AIDS-related deaths.

Primary prevention consultative group

The Steering Committee agreed to convene technical consultative groups for six thematic areas: (1) testing and treatment; (2) primary prevention; (3) social enablers; (4) costs and resources; (5) integration; and (6) longer-term technologies. Linkages between these meeting

The technical consultative group on HIV primary prevention was convened on 27-29 March 2019 in Geneva, Switzerland. The meeting was co-chaired by two Steering Committee members, Quarraisha Abdool Karim from Columbia University’s Mailman School of Public Health and CAPRISA, and Michaela Clayton from the AIDS and Rights Alliance for Southern Africa (ARASA). Group members included experts from government programmes, civil society, research consortia and UNAIDS Cosponsors (see annexed participants list).

The objectives of the meeting were:

- To discuss what an ambitious AIDS response contains on prevention for the 2021-2030 period.
- To propose targets for primary prevention programmes for 2025.
- To propose, if and how, overall targets may differ for countries, age/gender groups and population groups, including key populations.

⁴ Fast-Track commitments to end AIDS by 2030. Geneva: Joint United Nations Programme on HIV/AIDS, 2016 (http://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf).

- To discuss how enabling factors, or barriers, interact with prevention programmes and which specific enablers should be part of HIV prevention programmes, the wider HIV response and overall social development response.
- To discuss bundling of primary prevention HIV services including with testing and treatment services and integration with other health services.

Participants were urged to be bold—to push the world to provide the HIV prevention services needed by people at risk of HIV infection at the scale required to achieve the population-level impact envisioned in the 2030 target to end AIDS as a public health threat. They were also reminded of the heterogenous nature of the global HIV epidemic. HIV transmission dynamics differ greatly across regions and within countries and populations groups. A granular approach that focuses on the locations and populations at greatest need, and the right mix of services for those populations, is required to achieve global prevention targets.

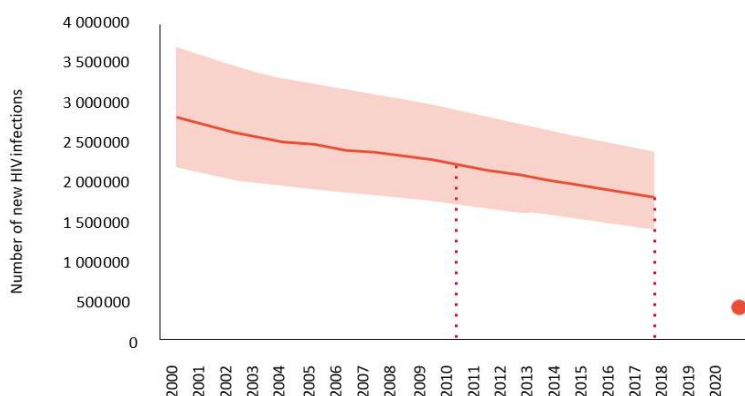
Context

Progress on primary prevention to date

Globally, new HIV infections have declined by just 18% since 2010, a rate of decline that is far too slow to reach the Fast-Track milestone of fewer than 500,000 new HIV infections globally by 2020 (Figure 1). This global average masks differential HIV incidence declines by both region and population. For example, the annual number of new HIV infections has declined by 30% in eastern and southern Africa since 2010, but the region still accounts for 44% of new infections globally. In eastern Europe and central Asia, annual new infections have doubled in less than two decades.

“How do we bend that incidence curve down?”

Figure 1. New HIV infections, global, 2000–2017 and 2020 target



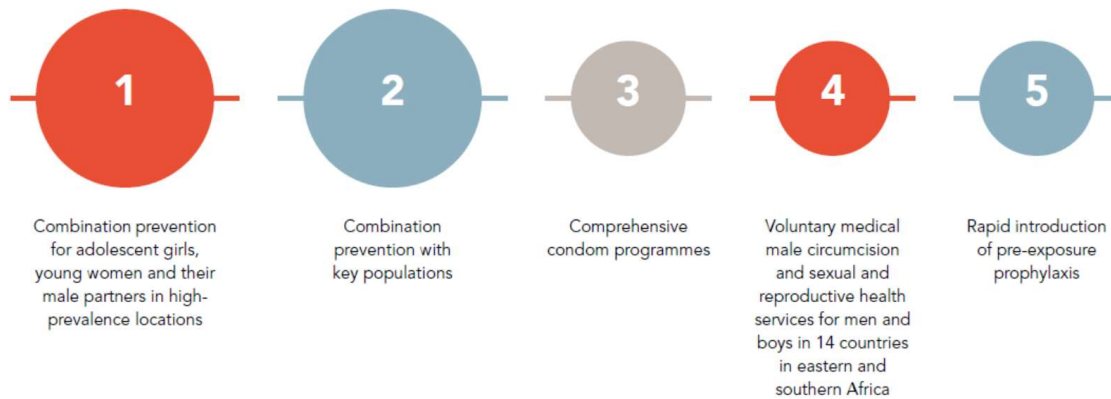
The slow global reduction in new infections reflects the fact that primary HIV prevention services are rarely provided on an adequate scale and with sufficient intensity, despite plenty of evidence showing which interventions work and the availability of a comprehensive body of programme guidance.

The Global HIV Prevention Coalition

The Global HIV Prevention Coalition was established to revive commitment and investment for HIV prevention. The keystone of this initiative is the Prevention 2020 Road Map, which the Coalition

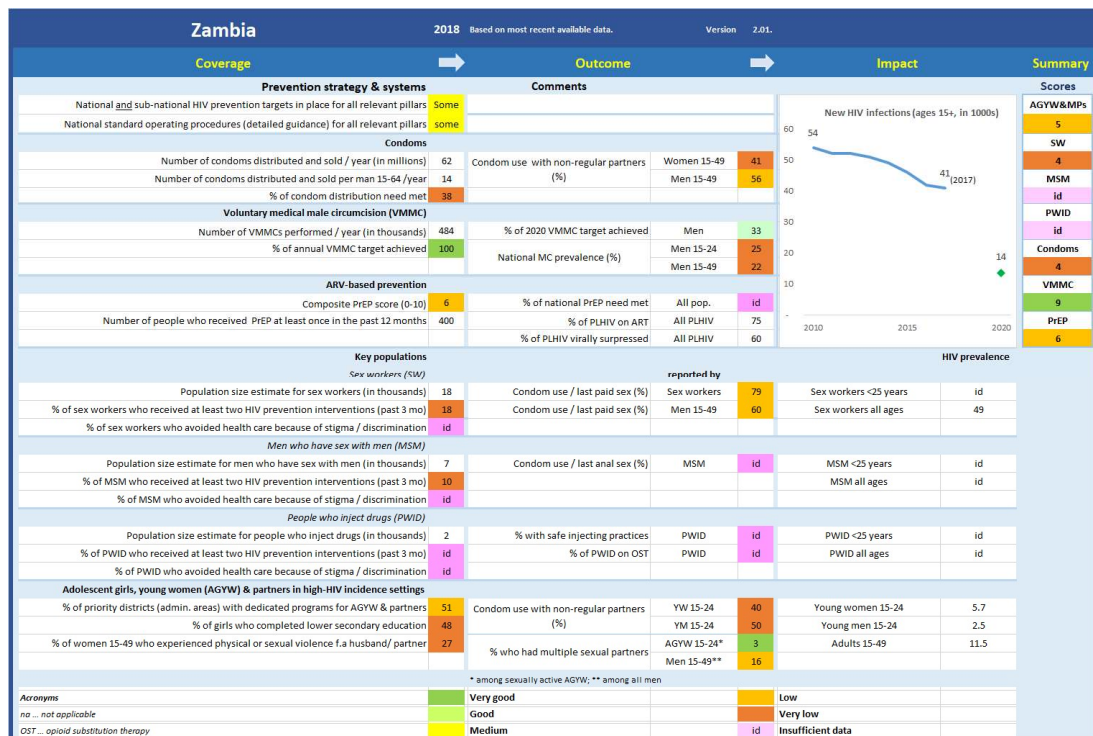
endorsed at its inaugural meeting in October 2017. The Road Map requires countries to strengthen HIV primary prevention responses around five central pillars (Figure 2).

Figure 2. Five pillars of combination HIV prevention



The Global Coalition is tracking progress on HIV prevention with country and global scorecards that compile data on multiple key indicators for each of the five pillars (Figure 3). These scorecards reveal large variation in performance across the coalition’s focus countries: out of 253 total indicator values, 83 show improvement, 59 show deterioration and 111 remained stable.⁵

Figure 3. Country scorecard example



The complexity of HIV prevention, weaknesses in progress measures, and the difficulty of linking individual programme-level progress to impact, have all contributed to the de-prioritization of

⁵ Most of the values that remained stable were indicators that are informed by surveys that are typically conducted every five years, so no new data was available since the baseline.

prevention programmes within national AIDS responses in recent years. The group debated the usefulness of several indicators that are commonly used by national AIDS programmes and by UNAIDS to measure progress. For example, measuring coverage of a package of services is difficult. How is that package defined? How much of the package must be used and within what timeframe to respond affirmatively? How can programme data be used to measure uptake of the package?

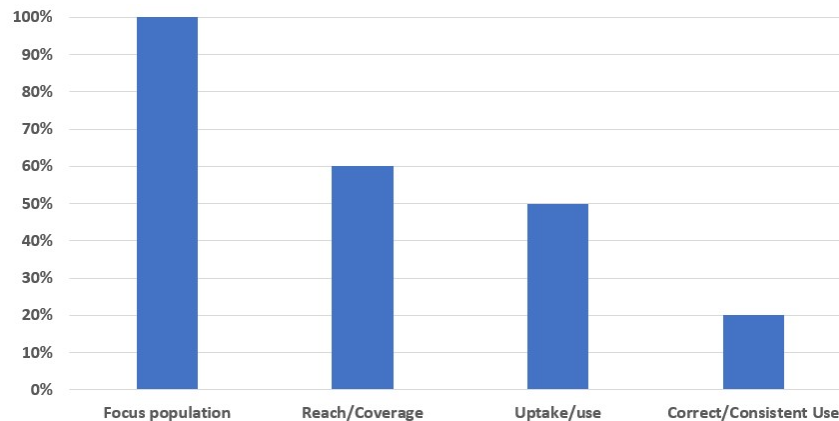
There was also a call for additional indicators to be added to the scorecards, such as indicators for prevention, screening and treatment of sexually transmitted infections (STIs). Participants nonetheless agreed that scorecards are a useful way to summarize country performance across a range of programme areas and indicators.

“How do you measure 90% coverage of a package?”

Prevention cascades are also being developed to track the percentage of focus populations who are reached by individual prevention programmes, the percentage of those who have recently used a particular prevention method, and the percentage of those who are consistently using a particular prevention method (Figure 4).

There was a mixed reaction to these cascades: some felt they were a good way to pinpoint gaps in programming, while others felt that a cascade was not appropriate for HIV prevention because risk varies within populations and over time for individuals.

Figure 4. A proposed basic HIV prevention cascade model



Modelling

Spectrum and Goals

Avenir Health’s Spectrum and Goals models will play a central role in the target-setting and resource needs estimate process. Spectrum uses demographic, programme and survey data to produce estimates of the number of people living with HIV, annual new HIV infections, annual AIDS-related deaths and the numbers of people in need of antiretroviral therapy and services for the prevention of mother-to-child transmission. It looks backwards in time.

The Goals model projects these same outputs forward based on future service coverage and behaviours among various population groups (Figure 5). Goals divides the population of a country into risk groups and uses information from two types of interventions to estimate future transmission of HIV:

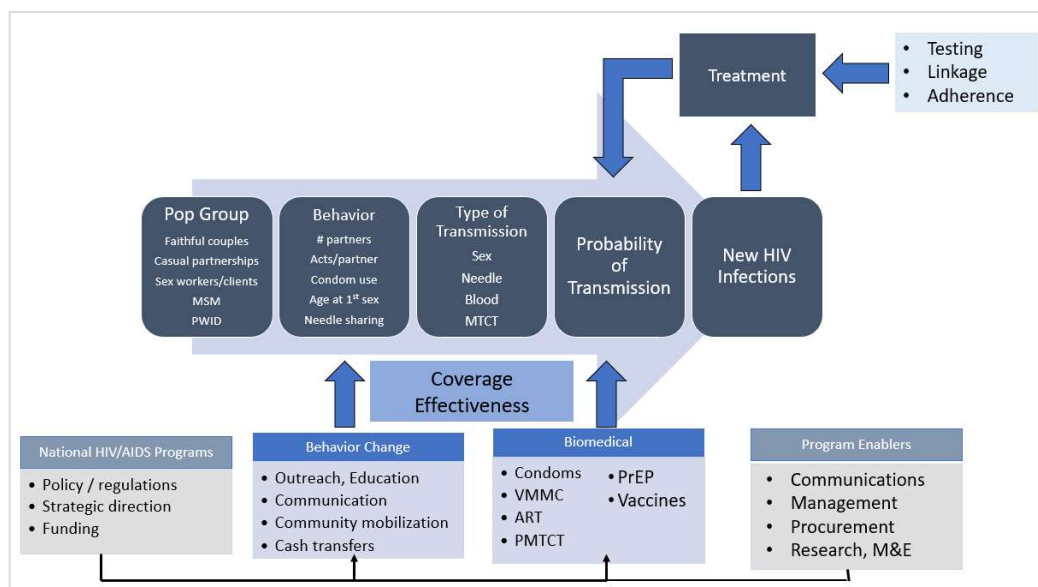
1. Biomedical interventions (condoms, PrEP, voluntary medical male circumcision, antiretroviral therapy, etc), which directly affect the probability of transmission per risky act (sexual intercourse, injection, etc).
2. Behaviour change interventions, which reduce the number of risky acts.

As the Sustainable Development Goals were being negotiated and the United Nations General Assembly considered the inclusion of a target to end AIDS as a public health threat by 2030, Goals was used to model the rates of programme scale-up required in 45 countries (which together accounted for 80% of new HIV infections globally) to achieve a 90% reduction in HIV incidence and a 90% reduction in AIDS-related deaths by 2030. This modelling exercise and technical consultations among stakeholders ultimately produced the UNAIDS Fast-Track strategy and 2020 targets within the General Assembly’s 2016 Political Declaration on HIV/AIDS.

“How do we quantify the effectiveness of outreach?”

The UNAIDS Advisory Group on HIV Programme Impact Modelling for Target Setting, Resource Needs and Impact Estimation (PIMAG) met in November 2018 to begin updating the Goals model for the 2025 AIDS targets. The population groups in the model are being revised to better reflect the populations at higher risk of HIV infection within various epidemic settings, and the package of services are also being revised to reflect the latest evidence of the impact of various interventions. The model will also support the possibility of setting different targets across population group, national/sub-national region and/or age. In addition, the model is being refined to incorporate the dynamics of service linkages (e.g. from testing to treatment initiation to retention), the bundling of individual services into packages aimed at particular sub-populations, the integration of HIV and health services, the role that programme and social enablers play in the cost and effectiveness of HIV interventions, and how the unit costs of interventions may change with scale, scope and time.

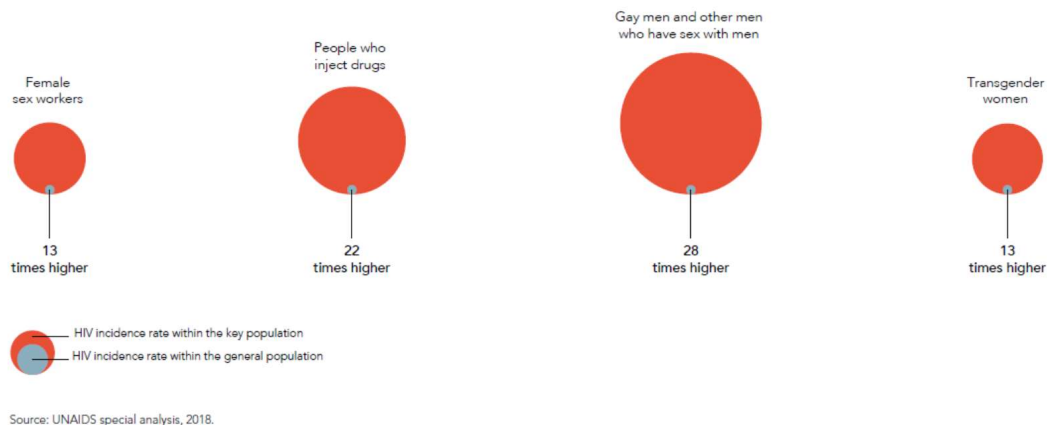
Figure 5. The Goals model



Populations at risk

Approximately 47% of new HIV infections globally in 2017 were among key populations and their sexual partners. Available data suggest that the risk of HIV acquisition among gay men and other men who have sex with men was 28 times higher in 2017 than it was among heterosexual men. Similarly, the risk of acquiring HIV for people who inject drugs was 22 times higher than for people who do not inject drugs, 13 times higher for female sex workers than adult women aged 15–49 years, and 13 times higher for transgender women than adults aged 15–49 years (Figure 6).

Figure 6. Relative risk of HIV acquisition, by population group compared to the general population, global, 2017

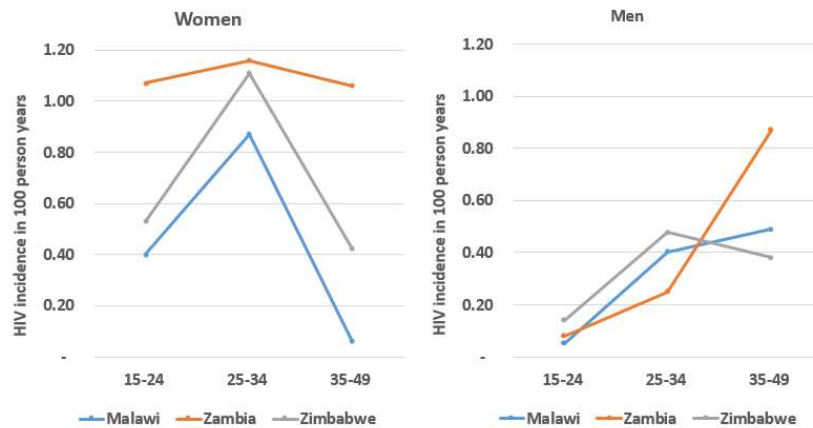


In sub-Saharan Africa, adolescent girls and young women (aged 15–24 years) account for one in four HIV infections in 2017 despite being just 10% of the population. Women represented 59% of new infections among adults (aged 15 and older) in the region in 2017. Recent data from three population-based HIV impact assessment (PHIA) surveys show that this gender disparity persists among 25–34-year-olds, where peak incidence among women occurs. By contrast, HIV infection rates among men are low at young age and peak at later ages (35–49 years) in Malawi and Zambia (Figure 7).

Gay men and other men who have sex with men

Progress on HIV prevention among gay men and other men who have sex with men (MSM) varies greatly among regions and within countries. In multiple urban areas in high-income countries (including San Francisco, London and Sydney), high coverage of antiretroviral therapy and PrEP has coincided with significant decline in new HIV diagnoses among MSM. However, high coverage of a combination of effective HIV prevention options is rare outside these high-income “gaybourhoods”. HIV prevalence among MSM globally remains high, and incidence of HIV appears to be increasing among MSM in many Asian cities. In high-income settings, progress has been slower among immigrants and ethnic minorities.

Figure 7. HIV incidence, by sex, population-based HIV impact assessment (PHIA) surveys conducted in Malawi, Zambia and Zimbabwe



Transgender people

Transgender people are a diverse population estimated at 25 million people globally who are at disproportionately high risk of HIV infection. Complex socio-cultural factors—including high levels of stigma and discrimination and legal barriers—often increase sexual risk behaviours. For example, when authorities refuse to recognize a change in gender identity, transgender people are thrown

“Trans people are a transparent glass. It is not just about our health. It is about being recognized as human beings.”

into limbo, unable to obtain an identity card, to open a bank account or to access welfare and other social safety nets. Social exclusion, economic vulnerability and a lack of employment opportunities means that sex work is often the most viable form of income available to transgender people. Gender transition can be expensive, putting further financial pressure on trans individuals, and also make them vulnerable to dangerous “quack” surgeries. Transphobia also encourages human rights violations such as violence and forced sterilization.

Many national AIDS responses wrongly consider transgender people a sub-population of MSM, an approach that alienates many individuals and discourages uptake of services. A guideline for implementing comprehensive HIV and STI programmes for transgender people, known as TRANSIT, has been available since 2016.⁶ This guideline promotes approaches that integrate HIV services and gender-affirming care (including mental health services), to ensure that services are provided by trans-competent staff and peer navigators, and to ensure that transgender people are engaged in programme design. Argentina, Mexico and New York City were identified as places where enabling environments and easier access to health, HIV and social services have been established.

Sex workers

Similar to TRANSIT, a tool for implementing comprehensive HIV/STI programmes with sex workers (SWIT) has been developed, but it is rarely used for its intended purpose of programme design. It instead more often serves as an advocacy tool, reflecting the fact that HIV responses are rarely tailored to the needs of sex workers.

⁶ http://www.unaids.org/sites/default/files/media_asset/UNDP-et-al_2016_transgender_practical_guidance_collaborative_interventions_en.pdf.

The various forms of criminalization of sex work were identified as a major barrier to HIV prevention and other services. It was noted that condoms are still used as evidence of sex work in many settings where sex work is criminalized, and that sex workers have been arrested on sex work-related charges when they access opioid substitution therapy, a practice that turns away some of the highest-risk sex workers from HIV prevention services. Participants also called for the target-setting exercise to be inclusive to all people who sell sex, including male sex workers, transgender sex workers and minors who sell sex.

People who inject drugs

The latest estimates from UNAIDS suggest that the incidence of HIV among people who inject drugs is at best stable and probably rising, and HIV prevalence within this key population globally is as high as 18%. There are uncontrolled epidemics in Russia, Pakistan and Myanmar, and outbreaks have recently occurred in a variety of settings, including Greece, Israel, Romania, Scotland, Ukraine and the United States.

Needle-syringe programmes and opioid substitution therapy have been repeatedly shown to effectively prevent HIV infections and other harms. Opioid substitution therapy reduces HIV risk by 54%, needle-syringe programmes decrease HIV risk by 34-58%, and the two programmes combined can reduce HIV risk by more than 70%. However, coverage of these proven harm reduction interventions is generally low, as evidenced by continuing high rates of HIV transmission in most settings. Opioid substitution therapy has also been shown to facilitate HIV testing, treatment initiation, adherence and viral suppression among HIV-positive people who inject drugs.

Criminalization of drug use is a major barrier to the provision and uptake of these services. The incarceration of people who inject drugs carries further risks to both HIV acquisition and interruption of service delivery. Injecting of amphetamine-type stimulants is becoming more common, and users of these drugs tend to inject more frequently, which may translate to intensified need of sterile needle-syringes beyond the 200 needle-syringes per injector per year currently recommended by WHO. There are also fewer effective drug dependence treatment options for non-opioid users.

Women who inject drugs face particular challenges. They tend to be disempowered within largely male communities of drug users, and harm reduction services often do not cater to their particular needs.

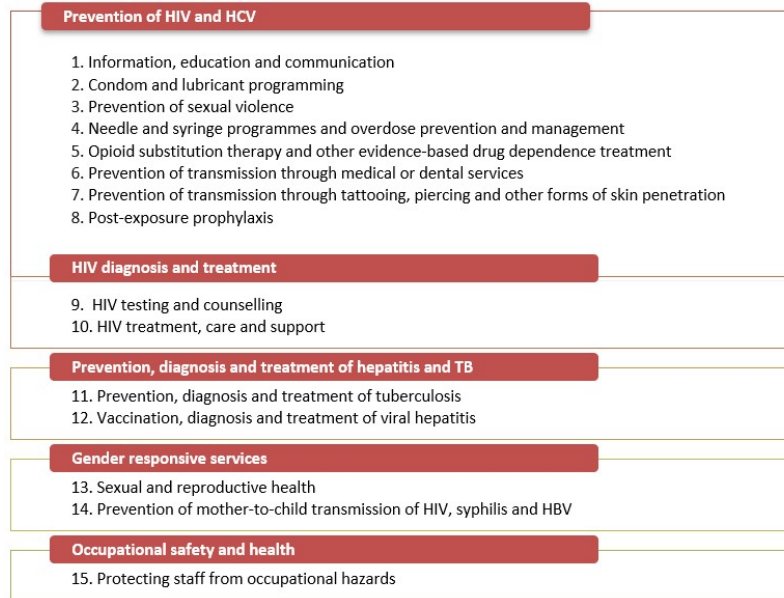
Prisoners

The global push for a drug-free world is swelling prison populations globally, with an estimated 10.7 million people in closed settings. The relatively higher proportion of key populations in prisons combined with often-poor prison conditions results in high prevalence of viral hepatitis and active tuberculosis. The globally agreed Mandela Rules state that prisoners must be provided with free health care that is equivalent to the care available to the general population, and the Bangkok Rules demand protection of the rights of women who make up about 7% of the global prison population.

The United Nations recommends the delivery of a comprehensive package of services to prisoners, including prevention, diagnosis and treatment of HIV, hepatitis and tuberculosis, as well as gender responsive services and occupational safety and health measures (Figure 8), and several guidelines are available for the design and implementation of these services. However, HIV prevention measures such as condoms, sterile needle-syringes and drug dependence treatment are rarely provided. It was also noted that addressing HIV in prisons cannot be separated from broader efforts to reform criminal justice laws, policies and practices. Reducing pretrial detention, increasing the use

of alternatives to imprisonment and non-custodial measures, and improving living and working conditions in prisons is crucial to the development and implementation of effective HIV responses in prisons.

Figure 8. Comprehensive package of services in prisons and other closed settings



Adolescent girls and young women and their male partners in high-incidence settings

UNAIDS guidance calls for the use of a combination of HIV prevention and policy/structural options to address the behavioural, biological and structural factors that lie behind the high HIV risk faced by adolescent girls and young women. (Figure 9).

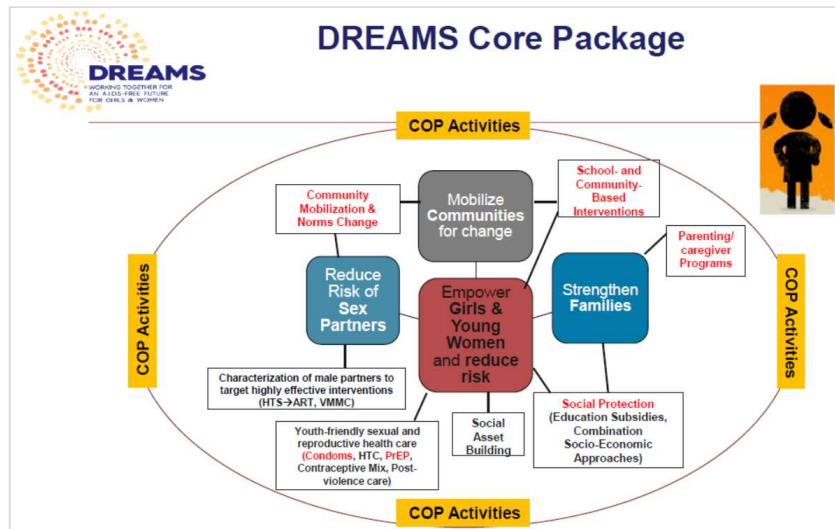
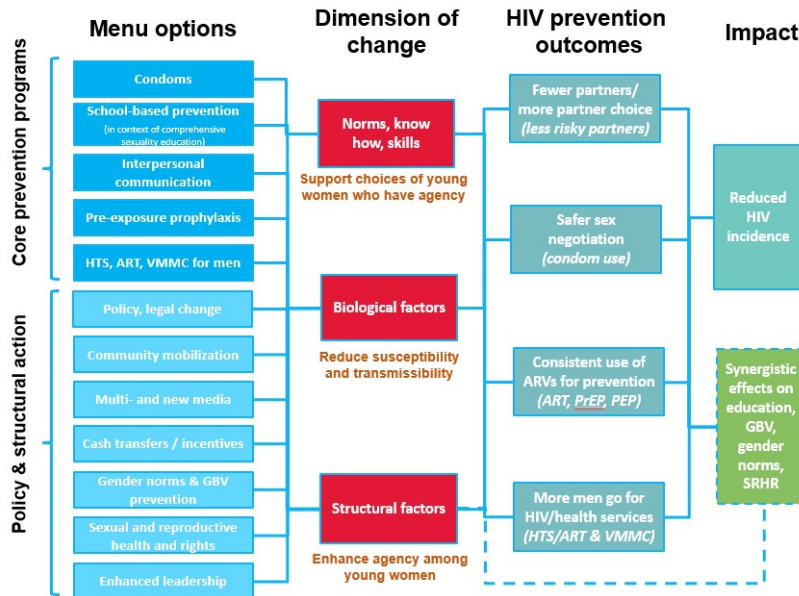
The DREAMS initiative has been applying a similar approach in high-prevalence districts of 15 countries in sub-Saharan Africa. The last five years have seen a US\$ 1 billion investment in a DREAMS core package of interventions that includes community-based and school-based interventions to empower adolescent girls, young women and their sexual partners to reduce their HIV risk, and to provide youth-friendly sexual and reproductive health care.

Population Council has been helping DREAMS to generate evidence and use that evidence to improve programming. Some of that work has focused on identifying and reaching the adolescent girls and young women who are most vulnerable to HIV. Common characteristics of high HIV vulnerability appear to include a lack of parental/adult supervision at home, food insecurity, limited knowledge of HIV, limited knowledge of condoms and highly gender inequitable attitudes.

The Population Council’s work has also reinforced the importance of:

- reaching male partners to address their own vulnerabilities that lead to high HIV risk for adolescent girls and young women;
- engaging adolescent girls and young women, their parents, their sexual partners and others to reduce stigma and support the introduction of oral PrEP; and
- layering programme components for adolescent girls and young women (e.g. providing safe space interventions, educational support and an economic intervention) to improve HIV prevention outcomes.

Figure 9. UNAIDS and DREAMS combination approaches to reducing HIV risk among adolescent girls and young women



Cash transfers

Cash transfers were included in the target-setting exercise for 2020 based on several studies that showed they contributed to reductions in HIV incidence or changes towards safer behaviours among adolescents and young people. For the 2025 AIDS targets, UNAIDS commissioned a systematic review of cash transfers from the Carolina Population Center. This review looked at 24 interventions (including 20 from sub-Saharan Africa) that were documented in peer-reviewed journals since 2000.

The review found limited evidence that cash transfer programmes can reduce HIV-related risk behaviours and HIV infection, with most studies finding no evidence of significant change for these outcomes and impact. Cash transfers reduced HIV incidence in just one third (two of six) of studies where HIV incidence was measured. Fifty-seven per cent of studies (four of seven) had an impact on

STI incidence. The strongest evidence was on delaying sexual debut. Seventy per cent of studies (11 of 16) found that cash transfers led to a significant delay in sexual debut, in some cases only for girls and not for boys. For the majority of other behaviours examined, about a third of the studies found a reduction in risky behaviours. Two of the major mechanisms through which cash transfers are thought to reduce HIV risk, particularly for young women, is by reducing young women's financial dependence on male partners and thus reducing transactional sex. Of the six studies examining an impact on transactional sex, only one of six (17%) found a significant reduction.

The review also noted that seven cash transfer studies are currently in the field, and that the results of these studies could change our understanding of the impact of cash transfers.

Primary prevention services

HIV prevention requires a context-specific, combination approach that includes behavioural, biomedical and structural components. Biomedical interventions such as PrEP and voluntary medical male circumcisions also require behavioural, societal and cultural approaches to ensure that people at high risk of HIV are aware of their HIV risk and able to access several service options so they can choose those that fit their individual needs and circumstances. Peer-designed and peer-led interventions are important for marginalized and alienated populations at high risk of acquiring HIV.

Condoms

Male and female condoms provide triple protection from HIV, STIs and unintended pregnancy. They are cheap, effective and probably the most widely used tool in HIV responses, preventing an estimated 45 million infections since the start of the epidemic. A total market approach to condoms—including free distribution, social marketing and commercial markets—is recommended.

Despite the multi-purpose effectiveness and low cost of condoms, both funding for condom programmes and demand for condoms appear to be on the decline. The experience of South Africa, which greatly increased its condom supply in recent years but did not experience much increase in condom use, suggests that demand creation is a bigger challenge than the condom supply gap.

Measuring condom use for the prevention of HIV has proven difficult. Most measures are derived from behavioural surveys, which may have response biases. For example, respondents may know they should use condoms with a non-regular partner, so they may report what they should have done rather than what they actually did. Participants also noted that power dynamics between sexual partners can undermine condom use. For example, a young woman may not feel empowered to insist on condom use with an older man, and a female sex worker may not be able to negotiate consistent condom use with her clients or with her intimate partner.

There was debate among participants regarding the pros and cons between behavioural survey questions that ask whether condoms were used “at last sex with a non-regular partner” vs “consistent condom use with non-regular partners”. The former tends to elicit much higher positive response rates, while the latter can suffer from recall bias. There was also debate regarding the appropriateness of extremely high condom-use targets in settings with high coverage of PrEP and antiretroviral therapy (see below).

Pre-exposure prophylaxis

Daily oral PrEP is a relatively new HIV prevention tool that has contributed to population-level impact among MSM in several high-income cities. Research suggests that taking oral PrEP four times

a week is sufficient for men to reliably prevent acquisition of HIV. On-demand PrEP also works for men, but is less effective.

While there is extensive and growing evidence on the impact of PrEP use within MSM populations, less evidence is available on the effectiveness of PrEP for women (cis- or trans-) or for people who inject drugs. This is an important data gap for meaningful target setting.

PrEP is now recommended for use by all people at substantial risk of HIV infection, defined by WHO as an incidence of HIV higher than three infections per 100 person-years in the absence of PrEP. Because the risk of HIV acquisition for most people—including many people within key populations—is much lower, PrEP is only cost-effective for those at very high risk.

Initial efforts to provide PrEP to adolescent girls and young women in hyperepidemic settings have faced many challenges. Retention of young women and sex workers on PrEP within pilot projects in eastern and southern Africa has often been very low. Use of PrEP, and measurement of PrEP use, needs to be better understood. Some advocate for continuous PrEP use, while others see PrEP use as intermittent based on “periods” or “seasons” of risk.

Communities of people who inject drugs have expressed concerns that PrEP could be promoted and scaled up in settings where there is high opposition to needle-syringe programmes and opioid substitution therapy, even though harm reduction is clearly more cost-effective for this population. The need for more comprehensive approaches to primary HIV prevention was underscored, rather than a “silver bullet” approach.

Of additional concern is evidence that condom use is decreasing among MSM in areas with high uptake of PrEP⁷, which can lead to a rise in sexually transmitted infections, such as anal gonorrhoea. Although some MSM view STIs as little more than a treatable inconvenience, the emergence of antimicrobial resistant gonorrhoea and the many serious long-term effects of STIs on women should not be ignored.

Demand creation and empowerment appear to be important factors in the high PrEP uptake and retention seen within gay communities in San Francisco and New South Wales. It was noted that PrEP awareness and availability is low in most settings. In eastern Europe and central Asia, for example, PrEP is not being offered commercially even though there appears to be a substantial number of MSM who would be willing to pay for this prevention option.

Efforts to measure PrEP use are also evolving. New PrEP programme expansion focus on new initiations. But as these programmes mature and people cycle in and out of PrEP for various reasons, there is a need to switch to a current use indicator.

All of these challenges make setting a PrEP target within a comprehensive prevention strategy extremely challenging. There was consensus that nothing should get in the way of people who want to take PrEP, but that publicly funded efforts to expand PrEP use should be focused on people at very high risk of HIV acquisition. The high costs of PrEP drugs in industrialized countries were touched on and its implications for state-subsidized access options, particularly when private medical insurance cover is not affordable or accessible to those in need of PrEP.

⁷ Holt M et al. Community-level changes in condom use and uptake of HIV pre-exposure prophylaxis by gay and bisexual men in Melbourne and Sydney, Australia: results of repeated behavioural surveillance in 2013–17. *Lancet HIV* 2018; 5 e448–56.

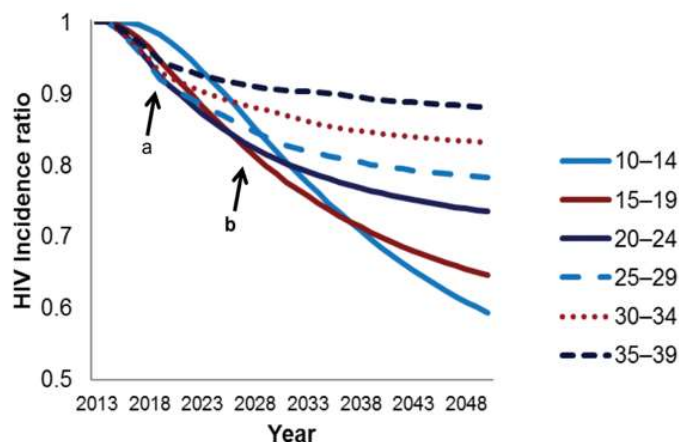
Separately, it was noted that the use of post-exposure prophylaxis (PEP) has changed over the years from an intervention primarily for accidental occupational exposure to an intervention for all individuals who fear that they may have been exposed to HIV either accidentally or by force (e.g. rape).

Voluntary medical male circumcision

Male circumcision reduces the risk of HIV acquisition among males by up to 60% in randomized controlled trials in heterosexual males. Voluntary medical male circumcision (VMMC) is an important additional HIV prevention strategy in high-prevalence settings with low prevalence of circumcision. Effort to scale up VMMC in recent years have been concentrated on 14 countries in eastern and southern Africa. High rates of male circumcision alongside high antiretroviral therapy coverage have achieved population-level impact on HIV incidence. However, the prevalence of circumcision among adult men remains low in many of the 14 priority countries. Stand-alone, highly donor-dependent programmes will need to transition to integrated service delivery to ensure long-term sustainability.

The current global target calls for 90% of males aged 10-29 years to be voluntarily circumcised in the 14 priority countries by 2021. Modelling studies suggest that the short-term impact of voluntary medical male circumcision is greatest when sexually-active men are targeted, while longer-term impact is achieved when children and adolescent boys are targeted (Figure 10). Greater impact can be achieved when the men at highest risk of HIV acquisition—such as men who present for STI treatment—are targeted. Efforts to set targets for 2025 should consider disaggregated targets by age, gender and by risk group.

Figure 10. Modelled reduction in HIV incidence caused by male circumcision, by age group, 2014–2050.



Each line represents HIV incidence ratio under scenario in which only indicated 5-y age group circumcised.

Marker *a* represents 5-yr period from 2014. Marker *b* represents a 15-yr period from 2014.

Innovations

The target-setting and resource needs process has the difficult challenge of predicting the speed and impact of the rollout of HIV innovations. It was noted during the meeting that advances in HIV surveillance, such as recency testing and phylogenetics, will improve efforts to analyse HIV

transmission patterns within and across sub-populations. These data could be used to improve efforts to focus services on the people and places where HIV risk is highest.

There are several new biomedical approaches to HIV prevention that could be ready for rollout by 2020. The Dapivirine vaginal ring could be approved for PrEP among women before the end of 2020. Additional formulations of oral PrEP are also in the pipeline. Long-acting injectable forms of antiretroviral medicines, such as Cabotegravir, could be ready for use by 2022. It may be useful to include targets for some of these innovations as they are likely to have an impact by 2030. Implantable forms of PrEP, broadly neutralizing antibodies and an HIV vaccine could be available by 2025 but are unlikely to contribute to impact by 2030. Nonetheless, continued investments in novel and innovative prevention and treatment modalities remain a high priority to end AIDS.

Critical enablers

Experience to date shows that the availability of individual HIV services is insufficient to achieve the coverage called for in the 2020 Fast-Track targets and the impact envisioned in the 2030 goal to end AIDS as a public health threat. An enabling environment for the uptake of services is also required. For example, stigma and discrimination remain powerful barriers to service uptake. Key populations and people living with HIV may avoid services when health-care workers have and express stigmatizing attitudes towards them or where their behaviours are criminalized.

In recognition of this, the process for developing the 2020 targets included the costs for the following critical enablers:

- Programme enablers, including planning and coordination, administration, supplies and logistics, staff training and monitoring and evaluation, surveillance and information systems.
- Social enablers, including communications for public awareness, advocacy and building political commitment, reform of laws and legal policies, stigma reduction and structural interventions.
- Development synergies: activities wholly or partially supported by the AIDS budget that support broader development objectives such as support for orphans and vulnerable children, AIDS education, and prevention of violence against women.
- Inclusion of peer-led interventions and support of institutions addressing the needs of marginalized populations while efforts to transform mainstream service delivery institutions continue.

Participants were united in their view that HIV prevention efforts should not be limited to interventions that directly lead to impact. The set of targets for 2025 should call for countries to address structural barriers to services, including through the reform of punitive laws and policies, strengthening social protection measures, strengthening education and economic empowerment, and addressing gender-based power imbalances and gender-based violence.

Decriminalization

Criminalization of same-sex relationships, sex work, drug use, cross-dressing and gender transformation were identified as punitive legal environments that encourage human rights violations and block both the offer and uptake of HIV services. This legal barrier is particularly threatening efforts to reach young people with services, as law enforcement may view outreach to minors as supporting paedophilia, child prostitution or illicit drug use among children.

The global war on drugs has undermined harm reduction efforts. The impact of repressive drug policies can be most clearly seen in the Philippines, where a national crackdown on the drug trade

has seen thousands of extrajudicial killings, which human rights groups report has made people who inject drugs afraid to seek out HIV testing and treatment services.⁸

Sex worker advocates argue that all forms of criminalization of sex work can increase HIV risk, including the “Nordic model” that criminalizes the purchase of sex, which makes it harder for sex workers to find clients and as a result could make them more willing to take on clients who are violent or refuse to wear a condom. Conflation between human trafficking and sex work can similarly stymie efforts to provide HIV and health services to voluntary adult sex workers and minors who sell sex.

“Bad laws do not make bad women.”

By contrast, it was noted that sex workers in New South Wales, Australia, where sex work is legal and regulated, have formed community groups that act as unions, pushing government authorities to enforce occupational health and safety standards. A recent analysis of data from 27 European countries found that countries that have decriminalized at least some aspects of sex work have fewer sex workers living with HIV than countries that criminalize all aspects of sex work.⁹

Similarly, countries that have decriminalized drug use and scaled up harm reduction services, such as Portugal, have experienced sharp declines in new HIV diagnoses among people who inject drugs. But activists feel that Portugal—long upheld as a best practice—has not gone far enough. Users must still purchase their drugs on the black market, and the thresholds for possession of drugs without penalty are extremely low.

Empowering at-risk populations

No matter the legal and policy environment, communities of at-risk populations need to be empowered to claim their basic rights, build sustainable livelihoods and access the services they need. Keeping girls in school has been shown to have a high protective effect against HIV in several high-prevalence settings, and social protection schemes have been shown to temper the social drivers of HIV risk for both adolescent girls and key populations. Community representatives listed numerous strategies for supporting key populations, including the establishment of grassroots community organizations, peer-led community research and services, linkage to mental health services and the provision of food, shelter and employment opportunities.

“Getting people a job, decent clothes and a place to stay has made a huge difference in viral suppression rates in our clinic.”

Key considerations for setting HIV prevention targets

Integration

The 2025 target-setting and 2021-2030 resource needs estimation process must consider the integration of HIV services and other services. From a service delivery standpoint, integration may or

⁸ “If you are poor, you are killed.” Extrajudicial executions in the Philippines’ “War on Drugs.” London: Amnesty International; 2017 (https://www.amnestyusa.org/files/philippines_ejk_report_v19_final_0.pdf, accessed 4 March 2019).

⁹ Reeves A, Steele S, Stuckler D, McKee M, Amato-Gauci A, Semenza JC. National sex work policy and HIV prevalence among sex workers: an ecological regression analysis of 27 European countries. *Lancet HIV*. 2017;4(3):e134–40.

may not be better for the client; and from a cost standpoint, integration may or may not achieve economies of scale and/or economies of scope through technical or allocative efficiencies.

An inconsistent effort to address sexually transmitted infections (STIs) within HIV prevention programmes was criticized as a missed opportunity. Because many of the risk behaviours for STIs and HIV are the same, and because STIs are more easily transmitted and more quickly become symptomatic, high prevalence of STIs within a particular population is good indicator of high HIV risk. In addition, symptomatic STIs facilitate the transmission of HIV. Community representatives noted that doctors can be reluctant to check for anal STIs, and that when these STIs go untreated they can be painful and dangerous.

Other integration issues raised included: the screening, prevention and treatment of tuberculosis, especially among prisoners and transgender people; the screening and treatment of viral hepatitis among people who inject drugs; the provision of sexual and reproductive health services (including family planning); and HPV vaccination and screening and treatment for cervical cancer among women in high-prevalence settings and within key populations.

Heterogeneity among sub-populations

Participants noted that risk of HIV acquisition within sub-populations can vary greatly depending on individual risk behaviours. Among MSM within a particular geographic area, for example, there may be individuals who do not have non-regular sexual partners or are empowered to consistently protect themselves from HIV, and on the other hand also chemsex users, people who inject drugs and sex workers who are at much higher risk of both transmitting and acquiring HIV. Similarly, sex workers living and working in settings with very low HIV prevalence are at much less risk than sex workers in urban areas of east and southern Africa. PrEP would perhaps only be a cost-effective intervention for the latter.

Participants agreed on the development of differentiated prevention targets that reflect this heterogeneous risk. Specific proposals were made for several population groups (Table 1).

Combination packages and platforms

HIV prevention guidelines produced by WHO, UNFPA, UNODC, UNAIDS and others call for a combination approach that offers multiple prevention options to people at risk of HIV, integrates services to prevent, screen and treat STIs, viral hepatitis and tuberculosis, and includes the establishment of an enabling environment for service delivery. Meeting participants endorsed this approach and debated ways to better ensure it is reflected in the 2025 targets and more consistently adopted by national and local AIDS responses.

The twin challenge facing the 2025 target-setting process is: (a) to translate the complex reality of combination HIV prevention into simple global targets; and (b) to ensure that simple and aspirational global targets are translated nationally and locally into the delivery of robust packages of services for all populations in need.

It was noted that high coverage of condom use—such as the 90% target for 2020—may no longer be relevant in settings where PrEP is widely available or among sero-discordant couples when the partner living with HIV is virally suppressed. The effectiveness of viral suppression as an HIV prevention method was debated, with some suggesting that it is difficult to be sure that one’s sexual partner is virally suppressed, while others felt that “U=U” is a scientifically proven reality that is empowering people living with HIV to lead normal sex lives.

“More and more prevention tools are becoming available. It will get harder and harder to be tool-specific. What we need to measure is how many people at risk are protecting themselves with an effective intervention.”

The concept of “platforms” of services focused on at-risk communities gained traction. Under this framework, individuals within these communities would be enabled to choose from the HIV prevention options within a platform. Hierarchies of indicators for individual sub-populations were also proposed to reflect, for example, that needle-syringe programmes are more important than PrEP for people who inject drugs.

During group work, intervention packages, 2025 targets, sub-populations for differentiated targets and critical enablers were proposed for individual at-risk population groups (Table 1).

Table 1. Results of group work

Gay men and other men who have sex with men
<p><u>Intervention package</u></p> <ul style="list-style-type: none"> ● Rapid HIV testing and STI testing (including syphilis testing) and treatment <ul style="list-style-type: none"> ○ If HIV positive, immediate initiation of treatment ○ If HIV negative <ul style="list-style-type: none"> ▪ Sexual health risk counselling, (education about safer sex, risk reduction strategies, mental health issues, stigma reduction, issues about drug use): referral services, peer educators should be involved ▪ Condoms and lubricant: social marketing, demand creation, education. Free condom availability in high-risk locations. ▪ Promotion of PrEP/PEP should occur within a combination prevention package. All gay men should be aware of PrEP/PEP (regardless of risk)
<p><u>Differentiation</u></p> <ul style="list-style-type: none"> ● PrEP targets and condom use should vary by risk. PrEP use should not be specifically targeted to low risk gay men. No guidelines for condom use in regular relationships ● Stratify condom use by whether or not the man is using PrEP as above ● No need for targets to differ by age or geography ● Men in a regular relationship with an HIV-positive man with an undetectable viral load do not need to be on PrEP.
<p><u>Proposed 2025 targets</u></p> <ul style="list-style-type: none"> ● 90% access outreach package ● 90% of gay and other MSM use condoms and/or be on PrEP at last anal high-risk intercourse (combination prevention target) ● 80% of gay and other MSM use condoms at last high-risk anal intercourse 80% of gay and other MSM on PrEP at last high-risk anal intercourse
<p><u>Critical enablers</u></p> <ul style="list-style-type: none"> ● Supportive legal environment; decriminalization of same-sex sexual behaviour ● Anti-discrimination and anti-stigma interventions ● Peer-led LGBT health services which are well funded in a sustainable fashion.

Transgender people

Intervention package

- HIV testing
 - Programming led by community
 - Self-testing, health facility-based, CBO-based,
 - Mental health support & counseling
 - Gender affirming care, access to hormones, needles
 - Community empowerment and mobilization
 - Training healthcare workers
 - Community leaders
 - Behavioral change communication Local language
 - Trans inclusive materials
 - Screen for TB
- Condoms and lubricant
 - Programming led by community
 - Mental health support
 - Gender affirming care
 - Community empowerment
 - Training healthcare workers
 - Community leaders
 - Local language
 - Trans inclusive materials
- PrEP
 - Programming led by community
 - Mental health support
 - Gender affirming care
 - Community empowerment
 - Training healthcare workers
 - Community leaders
- Sexual health services
 - STI screening/treatment
 - Programming led by community
 - Extragenital testing
 - Mental health support
 - Gender affirming care
 - Community empowerment
 - Training healthcare workers
 - Contraceptive care, cervical cancer screening (transgender men)
 - Linkage to HIV care
 - HPV vaccination
 - Screen for TB
- Viral suppression
 - Programming led by community
 - Mental health support
 - Gender affirming care
 - Community empowerment
 - Training healthcare workers
 - Community leaders
 - Local language
 - Trans inclusive materials
- Access to comprehensive gender services

- Hormones
- Gender affirming surgeries
- Needles/syringes
- Oral substitution therapy

Differentiation

- Transgender people are heterogenous communities, various identities
- Keep targets the same, ensure interventions are focused to specific communities
 - Transgender women who have sex with men
 - Transgender men who have sex with men
 - Transgender people who use injection drugs
 - Transgender people who are sex workers

Proposed 2025 targets

- 90% of trans people have access to culturally competent sexual health services
- 90% have access to PrEP
- 90% have access to HIV testing
- 90% have viral load suppression
- 0% discrimination
- 0% HIV-related deaths
- 0% new infections

Critical enablers

- One stop shop (co-location of services)
 - Status neutral services
- Research
 - Population size estimation surveys
 - Disaggregation by gender identity of HIV prevention and treatment data, STI data
- Legal
 - Legislation for gender change (name, gender marker)
 - Policy reforms that protect trans people, reduce discrimination
 - Decriminalization
 - Rapid legal response team
- Access to comprehensive preventive care
- Access to safe gender affirmation
 - Transition-related medical services, trans -competent knowledgeable providers
- Sensitization of service providers
 - Military/police
 - Teachers
 - Health-care workers
- Community-specific services
 - Address food insecurity
 - Access to education, employment and skill building
 - Assess for gender-based violence & provide support

Sex workers

Intervention package

- A comprehensive package of structural, behavioural, biomedical interventions based on the WHO guidelines:
 - Peer outreach, education and contact
 - Community-led mapping and estimation
 - Peer education and contact
 - Provision of condoms and lubricants
 - Community empowerment
 - Community-led services

- Violence support
- Community empowerment including community led organising
- Condom and lubricants
- Clinical and community-led services
 - HIV testing (multiple options)
 - Treatment
 - STIs diagnosis and treatment
 - PrEP/PEP
 - Harm reduction services
 - Mental health
 - SRHR (contraception, cancer screening, vaccinations, gender affirming support)

Differentiation

- There should not be different targets by geography, epidemic type or risk factors.
- Disaggregation of data for analyses by age, gender, subnational and sex work setting.
- Note: While young people below 18 years old are not considered as sex workers, all these services should be available for young people who sell sex below 18 years

Proposed 2025 targets

- 90% reduction in incidence of HIV among sex workers
- 80% Reduction in incidence of STI (CT, S and NG) among sex workers
- 90% of sex workers reached with the package of combination prevention services/interventions (This will need a denominator derived by community led mapping and size estimation)
- 50% reduction in violence experiences by sex workers by various perpetrators
- 50% reduction in stigma and discrimination experienced by sex workers by various perpetrators (Stigma Index)
- 30% of countries remove punitive laws against sex workers
- 30% of countries have programmes by sex worker led organizations
- 90% of the countries have peer educators recognized and integrated into services for sex workers (female, male, trans)
- 90% of SWs have correct and updated knowledge on combination prevention package
- 90% of SWs have regular contact with combination prevention services
- 90% of SWs using at least one HIV/ STI prevention technology/ commodities (condoms and lubes, PrEP, PEP)

Critical enablers

- Addressing violence (including sensitization of law enforcement, community, health-care workers)
- Addressing stigma and discrimination (at community and health-care settings)
- Legal environment (removal of punitive laws)
- Addressing legal barriers in place, policy, laws and implementation practices that restrict access to information and services required by young people below the 18 years who sell sex
- Literacy (sex workers informed and educated about existing prevention interventions)
-

People who inject drugs

Intervention package

- Needle-syringe distribution, disaggregated by gender
- Opioid substitution therapy (OST)

- Antiretroviral therapy

Proposed 2025 targets

- 90% of PWID report always having easy access to clean needles and syringes when they need them during the past month
 - Disaggregated by gender
- 75% of PWID being in regular contact with a harm reduction programme, including community development activities (90% in 2030)
- 40% of PWID receive adequate dosage of OST
- 95% of HIV-positive people enrolled in OST on ART

Critical enablers

- Decriminalization to remove all punitive, discriminative and non-supportive policies
- Community mobilization (community-led advocacy, research, program implementation)
- Ability to access services without parental consent/legal sanction for minors
- Integration of services needed by specific sub-populations
- Designated funding for working on critical enablers as part of programmatic funding

Prisoners

Intervention package

- Condom distribution
- Opioid substitution therapy
- Antiretroviral therapy
- Tuberculosis screening and treatment

Proposed 2025 targets

- 90% of PLHIV in prisons are on ART
- 40% of PWID in prisons receive adequate dosage of OST
- 0% of post-release LTFU on OST, TB treatment, and ART
- 100% of prisons implementing condom programs
- 100% of prisons implement an effective TB screening
- 100% of prisoners with active TB infection initiated on appropriate TB treatment

Critical enablers

- Decriminalization to remove all punitive, discriminative and non-supportive policies
- Community mobilization (community-led advocacy, research, program implementation)
- Ability to access services without parental consent/legal sanction for minors
- Integration of services needed by specific sub-populations
- Designated funding for working on critical enablers as part of programmatic funding

Adolescent girls and young women (aged 15-24 years) in high-prevalence settings

Intervention package

- Comprehensive sexuality education
- Comprehensive condom programming
- Access to community-based services
- Safe spaces
- Violence reduction- norms change, skills building
- Economic strengthening

Proposed 2025 targets

- 100% comprehensive sexuality education
- 90% access to appropriate facility or community-based services which would include: testing, condom programming, STI screening and treatment, VMMC, PrEP, PEP, GBV, SRH
- 90% of uninfected adolescents know their status
- 90% condom use at last sex

Adolescent boys and young men (aged 15-24 years) in high-prevalence settings

Intervention package

- Comprehensive sexuality education
- Comprehensive condom programming
- Access to community-based services
- Safe spaces
- Violence reduction- norms change, skills building
- Economic strengthening
- VMMC

Proposed 2025 targets

- 100% comprehensive sexuality education
- 90% access to appropriate facility or community-based services which would include: testing, condom programming, STI screening and treatment, VMMC, PrEP, PEP, GBV, SRH
- 90% of uninfected adolescents know their status
- 90% condom use at last sex
- 90% VMMC- absolute #, %, relative increase

Women and men (aged 25+) in high-prevalence settings

Intervention package

- Risk assessment & risk reduction counselling through different facility and community platforms
- Condom promotion & distribution
- VMMC for men
- PrEP (for highest risk, with STI in discordant couples without VLS)
- PEP
- STI diagnosis & treatment
- (HIV testing and treatment)

Differentiation

- The following sub-populations require particular focus:
 - New, casual, multiple, paid partners or a single partner with high-risk behaviour (unknown status)
 - Having an HIV-positive sexual partner
 - Seeking STI care, diagnosed with STI or STI symptoms
 - Specific sub-populations (mobile men, fishing communities, bar workers, attendees...)
 - History of gender-based violence

Proposed 2025 targets

- 90% coverage with risk assessment and risk counselling in high-incidence locations
- 90% at high risk using effective prevention methods
- Targets for high-risk categories defined above:
 - 80% condom use
 - Consistent condom use – introduce measurement (and aim for 80% at later stage)
 - 80% VMMC among men 25-49
 - 40% PrEP use (HIV incidence >3% / STIs/ multiple partners)
 - PEP – access after high-risk exposure (rape/high-risk sexual/occupational)

Critical enablers

- Strong integration of HIV prevention into HTS, SRH and other health services
- Facility entry point for risk assessment and counselling
- Large-scale outreach on personalized risk perception, demand generation, gender norms & health-seeking behaviour
- Community entry point for risk assessment and counselling)
- Availability of quality STI testing and treatment
- Strengthened prevention response management to address missed opportunities

