

2025 AIDS TARGETS

Second face-to-face meeting of the Steering Committee on Target Setting,
Impact, and Resource Needs



24-26 September 2019
Durban, South Africa

MEETING REPORT

Summary

Programmatic targets for 2025 and resource needs estimates for 2021–2030 are being developed by UNAIDS in close collaboration with its partners. As in past years, the outputs are timed to serve as key components of the next UNAIDS strategy, a possible future United Nations General Assembly High Level Meeting on the global HIV response, Global Fund replenishments, World Health Organization health sector targets, national target-setting and strategic planning and the decision-making of major global partners.

A multi-stakeholder Steering Committee is tasked with guiding the process. The Steering Committee held its second meeting in Durban, South Africa, on 24-26 September 2019. In between those two meetings, four technical consultative meetings were convened (testing and treatment, primary prevention, PMTCT, and social enablers), and summary reports from those meetings were shared with Steering Committee members.

This mid-point meeting of the Steering Committee is a critical point in the process. Four of seven planned technical consultations have been held, and the outlines of the 2025 targets are beginning to take shape. Gaps in the process can also be identified, and at this midpoint it is not too late to make course corrections, seek additional information and consider additional critical inputs that are needed.

The technical consultations have produced compelling results, which include in-depth analyses of what is working and what is not, and draft targets in key areas of interventions. Heterogeneity is a common issue across all programme areas: progress varies geographically and by sub-population. HIV prevention efforts are lagging behind testing and treatment programmes, and this imbalance that must be addressed as the HIV response moves forward. The Steering Committee wrestled with the need for a discrete number of simple targets, but also the need to acknowledge the complexity of achieving reductions in HIV incidence and providing useful guidance to countries with vastly different epidemics in order to create more efficient and effective programmes.

Decisions

Social enablers

- The term “social enablers” as expressed in the previous target-setting exercise needs to be re-examined.¹ The process to date has catalogued an extensive list of interventions, and has highlighted the following issues:
 - Some of the interventions suggested during the consultation are related more to process and not to targets or impact.
 - The term “enablers” has been used in the existing frameworks to indicate a modifier of the effectiveness of basic programmes. There are “enabling” interventions or factors that contribute to HIV-related outputs (e.g. addressing barriers and improving access to services) and impacts (e.g. reducing HIV infections and AIDS-related deaths). Among these there is a sub-set of interventions with a strong evidence base that would support quantifying their impact within the model.

¹ The technical meeting on social enablers also noted a need for further elaboration of the definition social enablers, noting that communities themselves are a form of social enabler.

- Differentiated delivery of care, treatment and prevention requires cross-cutting social enablers at both national and community-level.
- There are also cross-cutting interventions or programmes on protecting the human rights of PLHIV, key populations and vulnerable/marginalized populations. These interventions also contribute to the 2030 goal of reaching zero HIV-related discrimination.
- The above sets of interventions are not mutually exclusive and can be mutually reinforcing.
- The right of self-determination and community-led service delivery is an important aspect of the HIV response that must be reflected within the target-setting exercise even if not directly linked to the impact. On the one hand, being “community-led” is an enabler, but on the other hand it is a mode of service delivery. The process needs to carefully consider how to position community-led service delivery in a meaningful and measurable way.
- Among the long list of social enablers, particular emphasis should be placed on a set of well-defined, measurable indicators and targets. For example, the stigma and discrimination summary measure being developed by UNAIDS as part of the epidemic transition process should be considered, although the draft presented to the Steering Committee appears to require some refinement (e.g. add decriminalization of same-sex sexual relationship).

Programme enablers

- Programme enablers are important to include in the exercise, but there should not be a separate group or meeting on this subject.
- The integration group has been asked to additionally look at programmatic enablers.
- The costing group will be charged with costing these enablers, as many (e.g. procurement and supply-chain management) provide benefits to the broader health system and/or socio-economic development efforts. However, there is an understanding that there may be insufficient country inputs in many areas, which will require the use of estimates.

Modelling

- There will be an assessment of global and regional achievement based on countries’ 2020 estimates and Global AIDS Monitoring reports, including analysis of progress and gaps. Modelling will start from those levels of achievement.
- High-level prevention targets are needed to mobilize action to reduce new HIV infections.
- The draft targets also need to be as people-centred as possible. The outputs of the model need to reflect the heterogeneity of the epidemic, guiding the definition of targets for the coverage of specific packages of services for each sub-population within a specific geographic area and guide the provision of packages of services—including community-led services and integration of related health services—that meet the different needs of different sub-populations in different geographic areas.
- The outputs should be as granular as possible. Regional targets should be part of the target package so countries with smaller epidemics do not get lost within one global target.
- Explore the epidemiological impact of setting higher targets (e.g. 95-95-95) for key populations and other sub-populations who are at higher risk of acquiring and transmitting HIV, as the impact of these individuals protecting themselves from acquisition or from transmitting to others will be greater. It will also be important to recognize that setting higher targets for specific populations could lead to stigma and discrimination.

- Ensure that the distribution of sub-populations is in line with UNAIDS' estimates, both in terms of the categories (e.g. the current category of "low-risk females" should be broken up to ensure due attention to clients of sex workers and other sexual partners of key populations) and the distribution itself.
- Modelling team to incorporate work by UNAIDS Secretariat on risk stratification among three key populations (gay men and other men who have sex with men, people who inject drugs and transgender people).
- The target-setting for PrEP needs to consider several risk thresholds (HIV incidence, age ranges, etc). In particular, the modelling group should consider using a 20-24-year-old age range for young people in high-prevalence settings. Different adherence rates and different ways to use PrEP should be incorporated into the model.
- The model should include as many social enablers as possible where we have data on impact (see social enablers decisions for more details). The literature review aims at providing specific inputs to the model.
- The model should include the working assumptions on the costs, benefits, efficiencies that will emerge from HIV integration technical consultation.
- Include in the targets a calculation of the cost of past and future inaction (or delayed action), expressed as infections not averted, deaths not averted and future additional costs resulting from these missed opportunities.
 - These could be expressed as scenarios of "scale-up paths".
- The modelling team needs to develop a process and tools so that it can regularly report to the Steering Committee in more detail on how the model has changed since the previous Fast-Track target-setting process. In addition, the Steering Committee would like more information on how the model translates the scale up of individual interventions into impact (reductions in infections and AIDS-related deaths).

Integration

- The planned review of evidence was endorsed; it should seek the views of (a) individuals who are deeply involved in the practical integration of HIV and non-HIV at the service-delivery level, (b) individuals who are engaged in efforts to integrate HIV within the Universal Health Care agenda, and (c) the end users of integrated services. The technical working group on integration that oversees the review should also include representatives from these stakeholder groups.
- The review should request data on integration from PEPFAR, the World Bank and other large programmes that have been grappling with this issue for many years.
- The development of an index to measure the integration of the HIV and other disease-specific approaches within universal health coverage could be explored in order to capture the ability of disease-specific programmes to contribute to health sector capacity building.

Costing

- The proposed way forward for costing was broadly accepted. While an overall price tag is felt to be useful by many Steering Committee members, the Steering Committee also called for the consideration of alternative ways to present the results of its work, including additional metrics, such as per capita costs or percentages of national income, or gaps, and defining costs based on

source, such as domestic channels, international donors, etc, in collaboration with the UNAIDS Communications and Global Advocacy Team.

- The costing group should explore efficiency gains as a target in and of itself.

Communications and dissemination

- AIDS 2020 in Oakland/San Francisco and HIV 2020 in Mexico City are two important opportunities to update the global AIDS community on the process. The Steering Committee offered to contribute to the UNAIDS Executive Director's talking points related to the 2025 Targets process.
- The 2020 World Health Assembly is an opportunity to engage the global health community.
- Need to engage countries before the process is finalized, but not too early as we don't want to open the door to the potential of reducing global ambition.
- An online consultation should be held to collect the views of stakeholders from country level and to ensure more community engagement in the process.
- The UNAIDS Secretariat will meet with Geneva-based missions to solicit input and reactions to the upcoming analyses.
- The UNAIDS Secretariat will negotiate with academic journals regarding the publishing of a series of articles within a supplement. UNAIDS Secretariat to share a proposed breakdown of the articles within the supplement.
- UNAIDS will invite relevant staff from the UNAIDS Communications and Global Advocacy Team to upcoming Steering Committee Quarterly Conference calls and the next "face to face" meeting.
- The advice of communications experts should be sought regarding how best to disseminate the results of the target-setting process.

Introduction and background

UNAIDS-led target setting

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 those targets. UNAIDS estimations of targets, resource needs and impact have informed multi-year strategies for the global response, Global Fund replenishments and United Nations General Assembly high-level meetings.

These processes have been ambitious by nature. In 2014, as the Millennium Development Goals drew to a close and the Sustainable Development Goals were being conceived, UNAIDS convened a panel of leading scientists, politicians, implementers, activists and people living with HIV to consider potential long-term goals for the global response to the AIDS epidemic. The panel agreed on "ending AIDS as a public health threat" by 2030 as an ambitious yet feasible goal for policies and strategies. This goal was defined as 90% reductions in the incidence of HIV infections and AIDS-related deaths.

UNAIDS worked with technical partners to develop a model that would project the service coverage required to achieve the 2030 goal. This would require rapidly accelerated programme coverage and

reaching 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—that would establish the required momentum to reach the 2030 impact goals.³ Annual financial resources needed for this Fast-Track response for all low- and middle income countries (LMICs) peaked 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 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

Setting 2025 targets

From late 2018 to the middle of 2021, programmatic targets for 2025 and resource needs estimates for 2021–2030 are being 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, a 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 objective of the target-setting, and impact and resource needs estimation process is to bring together the expertise and experience of a range of partners around three related areas of work:

1. Programmatic targets focused on 2025, plus resource needs and impact estimates through 2030. This process will not change the 2030 impact goals already agreed by the United Nations General Assembly within the 2030 Agenda for Sustainable Development: 90% reductions in HIV incidence and AIDS-related mortality, compared to a 2010 baseline. The focus will be on incorporating new research, programmatic and costing data, new metrics for measuring impact and the existence of new medicines and service-delivery tools within a revised target-setting model, and taking achievements-to-date into account.
2. Explore in depth the potential synergies to be gained through integrated delivery of HIV, health and social services, including through a universal health coverage framework, as well as the potential risks.
3. Consider the potential long-term impact of future technologies, including broadly neutralizing antibodies, vaccines and a cure.
4. Consider the critical social and programme enablers that will address barriers to service uptake and help to achieve the 2030 goals of zero discrimination.

A multi-stakeholder Steering Committee is tasked with guiding the process (see list of members in Annex 1). The Steering Committee initially agreed to conduct face-to-face technical consultative

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.

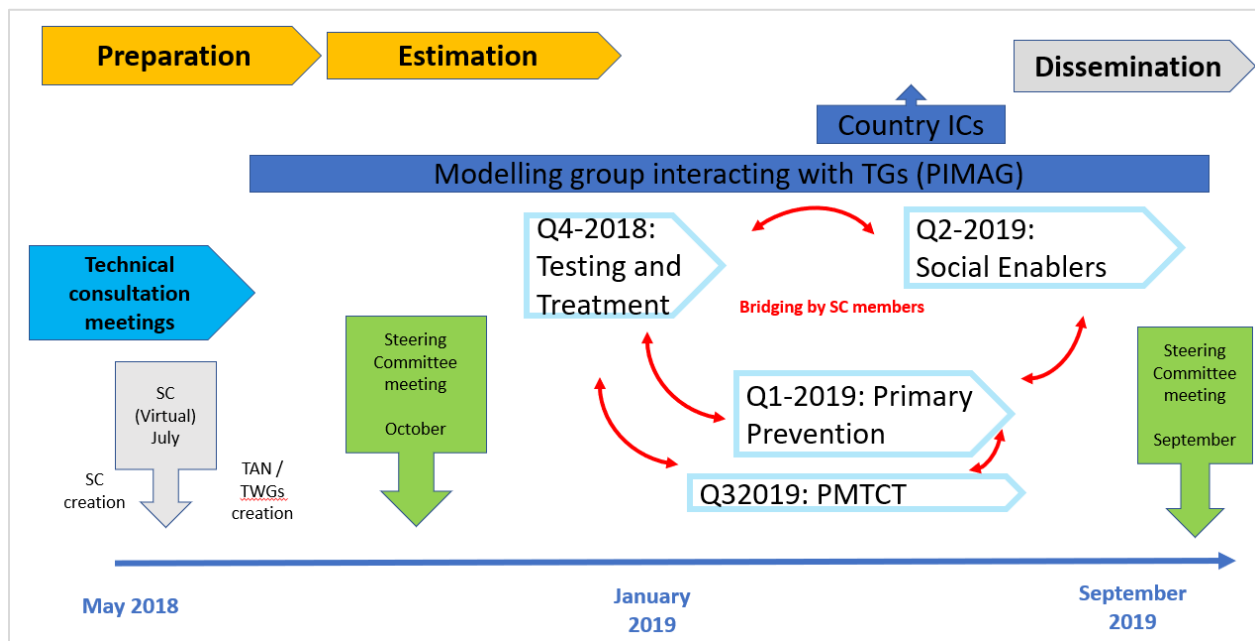
³ Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD et al. What Is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track approach. PLoS ONE. 2016;11(5):e0154893. doi:10.1371/journal.pone.0154893.

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).

meetings 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. An additional virtual technical consultation on preventing mother-to-child transmission of HIV (PMTCT) was later added.

The Steering Committee for the target-setting process held its first meeting in Glion, Switzerland on 10-12 October 2018, and its second meeting in Durban, South Africa, on 24-26 September 2019. In between those two meetings four of the seven technical consultative groups met and provided their inputs to the process. Reports from those meetings were shared with Steering Committee members, and the co-chairs of those meetings summarized the deliberations and results at the Durban meeting.

Figure A. 2025 AIDS targets process—progress to date



The co-chairs of the four technical consultative group meetings—testing and treatment, primary prevention, social enablers and PMTCT—presented summaries of their groups’ deliberations, proposed targets and follow-up issues. The draft targets are annexed to this meeting report, and the full meeting reports are publicly available on the UNAIDS website.⁵

Technical consultations on programmatic targets

Testing and treatment

The HIV testing and treatment technical consultation was held on 5-7 December 2018 in Geneva, Switzerland. The consultation reviewed progress to date, the models used to estimate the impact of future levels of service coverage, innovations that are currently being evaluated, implemented or are expected to be available in 2025–2030, the importance of social enablers on service coverage and

⁵ https://www.unaids.org/en/topics/2025_target_setting.

outcomes, and the opportunities and challenges related to the integration of HIV services with the delivery of other health services. Consensus was achieved on the following:

- The 2025 targets for both testing and treatment should not differ by country.
- Scale-up trajectories will need to be different. Countries with lower coverage and poorer outcomes should be encouraged to put in place and implement catch-up plans.
- Targets for all sub-populations (see box) should be at least 90–90–90 by 2025.
- Sub-populations need to be prioritized without stigmatizing them.
- Countries need to employ a range of high-volume (e.g. provider-initiated testing and counselling) and high-yield (e.g. assisted partner notification) testing modalities, with a particular focus on:
 - Scaling up approaches for key populations, men and young people.
 - Linking people who test negative to HIV prevention services and people who test positive to treatment.
- HIV self-testing could potentially replace voluntary counselling and testing as a high-volume, low-yield testing strategy.
- Dolutegravir (DTG)-containing regimens and injectable antiretrovirals will make important contributions to the effectiveness of treatment in the near future, but will not be sufficient on their own.
- Adherence/retention support (including treatment literacy) is also needed, especially for key populations, other people who are marginalized and mobile populations.
- Reductions in the cost of viral load testing and wider rollout of assays that facilitate quicker return of results are expected to improve progress towards the third 90.

Sub-populations for testing and treatment target-setting

- Key populations (people who inject drugs, transgender people, sex workers, incarcerated people and gay men and other men who have sex with men)
- Men and women under the age of 35
- Men and women aged 35 and over
- Children (<13, but recognizing the fluidity of this definition)
- Sub-national (as defined and appropriate for the country)
- Pregnant women (95% target)

- Differentiated service delivery (DSD) and community-led services will play an important role in improving access to antiretroviral therapy, even beyond stable patients, and should thus be integrated into the modelling.
- Health systems strengthening will be required to manage the additional patient load, and also to avoid antiretroviral stockouts through improved procurement and supply chain management.
- The future frequency of viral load testing for stable patients and the use of 1000 copies/mL as the threshold for viral load suppression should be informed by the WHO guideline revision process during 2019.

Integration was also discussed at length at the technical consultation. It was agreed that a deeper discussion on integration is needed. Integration means different things to different people, and integration can occur at different levels, such as service delivery or programme development and management. It was also agreed that efforts to

integrate HIV services into broader health services should be people-centred—focused on increasing access and uptake of quality services, not just achieving cost efficiencies.

Steering Committee discussion

Some concern was expressed regarding the proposed 2025 target of 90–90–90 for all sub-populations, as 90–90–90 globally is already a UN General Assembly target for 2020 and 95–95–95 by 2030 is already a UNAIDS target. The proposed 2025 target may be viewed as lacking ambition. It was noted that the aggregate of all sub-populations reaching 90–90–90 would in fact be higher than 90–90–90, but it is unclear how that would be captured in the model and in the communications strategy.

However, the sub-populations approach was widely agreed, as it will encourage programmes to generate and analyse disaggregated data and focus on the populations and locations in greatest need. It was proposed to divide the children sub-population into two or three age groups, as the challenges and strategies are different for exposed new-borns, exposed older infants and exposed children (18 months to 13 years old). It was noted that sexual partners of key populations and people living with HIV are important groups to reach, while at the same time civil society representatives warned that active case finding and partner notification services have been aggressively applied in some settings, leading to breaches in confidentiality. They also warned that high targets could also encourage forcible treatment practices. There were also questions regarding how the term “index case” will be defined by this process, as different countries have different definitions.

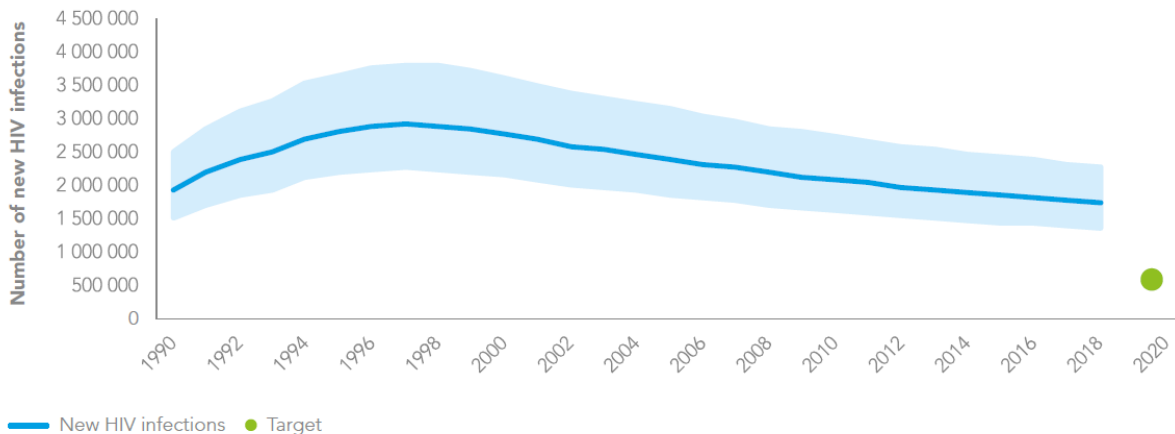
Concern was expressed regarding the suggestion that self-testing could replace voluntary counselling and testing (VCT), as some national programmes have struggled to link self-testers to confirmatory testing. Clarification was made that the group did not propose to do away with VCT altogether, but that the yield of VCT is low, and that the rollout of self-testing is an alternative and cheaper modality that testing programmes will undoubtedly consider.

The Steering Committee wrestled with the question of how much detail to get into, with some suggesting that the process should focus more on setting targets and less on how to achieve the targets. Concerns were expressed that the 90–90–90 and 95–95–95 targets were in the eyes of many the primary areas of focus for HIV programmes, and that achieving these service delivery targets would not, in isolation, lead to achieving 90% reductions in incidence and mortality.

Primary prevention

The primary prevention technical consultation was held on 27-29 March 2019 in Geneva, Switzerland. The group agreed that 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 (Figure B). Progress differs by region and by country, as do HIV transmission dynamics. The group agreed that a granular approach that focuses on the locations and populations at greatest need is required.

Figure B. Number of new HIV infections, global, 1990–2018 and 2020 target



Source: UNAIDS 2019 estimates.

It was also agreed that HIV prevention requires a context-specific, combination approach that includes behavioural, biomedical and structural components. Comprehensive packages of services have been defined and refined for each population at high risk of HIV acquisition. There is no need for the target-setting process to re-invent the wheel, but it must take into consideration emerging innovations such as vaginal rings and long-acting, injectable or implantable antiretroviral medicines.

The issue of integration was explored by the prevention consultation. Inconsistent efforts to address sexually transmitted infections (STIs) within HIV prevention programmes and integrate HIV prevention into sexual and reproductive health services were considered as lost opportunities. 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.

It was agreed that an enabling environment is required for service access and uptake, and that 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.

The prevention consultation 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 proposed service packages, critical enablers and differentiated 2025 targets for various at-risk populations that reflect this heterogeneous risk (see annex and full report for details).

Steering Committee discussion

Steering Committee members agreed that most parts of the world are not living up to their commitments to scale up primary prevention services, and that the 2025 targets must include a strong statement on HIV prevention. Following the success of 90-90-90 as a target that has rallied global action, a “fourth 90” for HIV prevention was proposed. Although the power of a simple target was recognized,

Steering Committee members were also cognisant of the need for the 2025 targets to reflect the complexity of different packages of combination prevention that would be required by different sub-populations, and for the targets to ensure the sub-populations most likely to transmit/acquire HIV are prioritized.

Prevention of mother-to-child transmission

Prevention of mother-to-child transmission (PMTCT, also known as vertical transmission) was not explicitly considered in the testing and treatment consultation, and it was decided that a separate virtual consultation was needed. Three teleconferences with experts and stakeholders were held in July-August 2019, and set of proposed targets were developed (Figure C). In addition, the group proposed for the 2025 targets process to (a) recommend improved linkages between PMTCT programmes and adult and child antiretroviral therapy programmes, and (b) for modelling of the estimated number of new HIV infections in children (with a focus on 2025 and 2030) to be updated, based on the latest data on epidemiology and achievement of PMTCT programmes, as well as the 2025 targets.

Figure C. Proposed targets for the prevention of mother-to-child transmission

	Target for 2025	Target for 2030
1. % of pregnant women living with HIV (PWLHIV) receiving antiretroviral therapy	95% of PWLHIV	(>95% of PWLHIV)
2. % of PWLHIV receiving antiretroviral therapy before current pregnancy	85%	(>85%)
3a. % of PWLHIV on antiretroviral therapy with suppressed VL ¹ at delivery	95%	(>95%)
3b. % of breastfeeding WLHIV on antiretroviral therapy with suppressed VL ¹ (to be measured at 6-12 months ²)	95%	(>95%)
4. % of women aged 15-49 years who have their need for family planning satisfied with modern methods ³		75%
5a. % of HIV-exposed infants tested by 2 months ²	90%	(95%)
5b. % of HIV-exposed infants tested by 9-18 months ²	90%	(95%)

Besides the indicators that measure the above targets, the group stated that countries and institutions should be encouraged to use additional indicators to track important programmatic elements, such as:

- Awareness of HIV status among pregnant women.
- Percentage of pregnant women living (or diagnosed) with HIV starting antiretroviral therapy during pregnancy.
- Retention on antiretroviral therapy during pregnancy (especially where viral load data is not available).
- Retention on antiretroviral therapy during breastfeeding (especially where viral load data is not available).
- Retesting of HIV-negative women during pregnancy and breastfeeding.

Steering Committee discussion

The Steering Committee welcomed the group's work. The following suggestions were made:

- Ensure there is linkage with the above targets to targets on prevention HIV infections among women of child-bearing age.
- Consider including a target on the percentage of children who are linked to care and treatment after being diagnosed with HIV.
- Targets 1 and 2 could be combined into one target.
- Target 4 on family planning may be too broad and not sufficiently linked to PMTCT for this exercise. If it is included will it mean the cost of family planning will be included in the costing part of the 2025 targets exercise?
- There is a need to adjust targets 5a and 5b to encourage high-prevalence countries to diagnose and initiate treatment among the increasingly higher percentage of children living with HIV who are older than 18 months. It was noted that the frequency of testing HIV-exposed infants is often linked to other perinatal health-care visits, such as nine-month vaccination.

Rethinking enablers

Social enablers consultation

The technical consultation on social enablers was held in Montreux, Switzerland, on 19-21 June 2019. Participants emphasized that programmatic targets for HIV prevention, testing and treatment must be accompanied by targets that address the barriers to accessing services. These barriers include:

- Legal and policy barriers (e.g. criminalization)
- Stigma and discrimination
- Education and economic empowerment
- Addressing gender-based power imbalances and gender-based violence
- Poor service quality
- High opportunity costs (long travel and wait times)
- Cost barriers—even when antiretrovirals are free, patients need to pay for travel costs, diagnostics, doctor’s fees and so much more.
- Treatment illiteracy
- Stockouts

A list of social enablers and cross-cutting issues was agreed by the participants of the technical consultation:

- Social enablers:
 - Laws, policies, practices and law enforcement (including decriminalization)
 - Access to justice
 - Community-led organizations
 - Addressing stigma and discrimination
 - Gender equity
 - Sexual rights and reproductive rights
 - Addressing violence
 - Economic justice, security and livelihoods

- Changing public views/attitudes
 - Education - upstream, comprehensive sexuality education, sensitization
 - Knowledge skills and training
- Cross-cutting issues:
 - Human rights
 - Political will and commitment
 - Community system strengthening

Specific targets were proposed for consideration by the Steering Committee.⁶ The participants of the social enablers consultation also agreed that it is no longer possible to claim that there is not enough evidence on the multiple barriers to HIV prevention, treatment and care or the impact of addressing those barriers with social enablers. However, there is still a limited amount of information regarding the effectiveness and impact of the enablers listed above with respect to reducing HIV infections and AIDS-related deaths. A follow-up action from the meeting is a review of the existing literature on the impact of social enablers. The results of this review, which is scheduled to be completed by end of the year, will be provided to the modelling team.

Doing more than enabling services

A set of social and programme enablers that increase the effectiveness of HIV programmes were included in the Investment Framework model that informed the setting 90-90-90 and other Fast-Track targets for 2020. That model did not include the “zero HIV-related stigma and discrimination” goal within the UNAIDS “Three Zeros” vision.⁷ Targets on gender equality, community-led service delivery, empowerment of people living with HIV and key populations and access to justice were added later, during the development of 2016-2021 UNAIDS strategy and the 2016 Political Declaration on HIV/AIDS.

The Steering Committee was asked to consider whether any changes were required for the modelling and target setting for 2025. An option proposed by the UNAIDS Secretariat was to include within the model an expanded list of social and programme enablers where there is sufficient evidence to quantify their contribution to service delivery and impact, and then to find another way to include interventions and other actions (e.g. legislation change) that strengthen the ability of people living with HIV and key populations to claim their rights and contribute to reductions in HIV-related stigma and discrimination.

It was also noted by the UNAIDS Secretariat that the large number of targets proposed by the social enablers technical consultation would likely not be practical to include in the final set of targets. In follow up to a consultative process on epidemic transition measures, UNAIDS is working with partners to aggregate data against each set of indicators into a summary measure that groups social enablers within five domains:

- Social norms and attitudes
- Laws and policies and access to justice
- Addressing violence

⁶ See meeting report from the social enablers consultation.

⁷ The Three Zeros—zero new HIV infections, zero AIDS-related deaths and zero stigma and discrimination—were initially included in the 2011-2015 UNAIDS strategy. They were retained as vision statements and long-term goals in the subsequent 2016-2021 UNAIDS strategy.

- Anticipated and experienced stigma and discrimination
- Internalized stigma and self-stigma

The indicators within each of these five domains vary by population group.

Separately, programme enablers have not yet been discussed in detail within the 2025 target-setting process. The Secretariat proposed convening a new stakeholder group to consider how the following topics related to programme enablers:

- Absorptive capacity
- Country bottlenecks to scale up
 - Procurement / supply chain
 - Price of commodities / market dynamics
 - Human resources for health
 - Management and incentives
- Strategic information
 - Monitoring and evaluation
 - Influence in the execution of strategic/operation plans
- Programme effectiveness
- Quality assurance
- System requirements for differentiated service delivery
 - Community system strengthening
- Community-led responses
 - Planning and funding
 - Bringing programmes to scale and sustain
- Non-health sector planning and implementation

Steering Committee discussion

Steering Committee members agreed that “zero HIV-related stigma and discrimination” is an important aspect of the HIV response at the same level as the “zeros” for HIV infections and AIDS-related deaths, and that targets must be set for things that are either not directly related to impact or there is insufficient evidence to quantify their impact—for example, ending criminalization of HIV transmission. It was also noted that cost-effectiveness is not an appropriate metric for many human rights-related efforts.

A major challenge will be the establishment of interim or operational targets, because any level of stigma and discrimination is unacceptable. One option would be to establish a relative target, such as a 50% reduction in a certain indicator by 2025.

On both social and programme enablers, there is an additional challenge of building selected details into the 2025 targets to underscore their importance, without drilling too far down into implementation approaches that will necessarily vary among national and sub-national contexts.

Multiple Steering Committee members called for community-led services to be prominently included in the 2025 target framework, reflecting the fact that they are a “social enabler” for service delivery, a

mode of service delivery and an indicator of empowerment and self-determination. There may also be a need to set a target on funding for community organizations.

Decisions

Social enablers

- The term “social enablers” as expressed in the previous target-setting exercise needs to be re-examined.⁸ The process to date has catalogued an extensive list of interventions, and has highlighted the following issues:
 - Some of the interventions suggested during the consultation are related more to process and not to targets or impact.
 - The term “enablers” has been used in the existing frameworks to indicate a modifier of the effectiveness of basic programmes. There are “enabling” interventions or factors that contribute to HIV-related outputs (e.g. addressing barriers and improving access to services) and impacts (e.g. reducing HIV infections and AIDS-related deaths). Among these there is a sub-set of interventions with a strong evidence base that would support quantifying their impact within the model.
 - Differentiated delivery of care, treatment and prevention requires cross-cutting social enablers at both national and community-level.
 - There are also cross-cutting interventions or programmes on protecting the human rights of PLHIV, key populations and vulnerable/marginalized populations. These interventions also contribute to the 2030 goal of reaching zero HIV-related discrimination.
 - The above sets of interventions are not mutually exclusive and can be mutually reinforcing.
- The right of self-determination and community-led service delivery is an important aspect of the HIV response that must be reflected within the target-setting exercise even if not directly linked to the impact. On the one hand, being “community-led” is an enabler, but on the other hand it is a mode of service delivery. The process needs to carefully consider how to position community-led service delivery in a meaningful and measurable way.
- Among the long list of social enablers, particular emphasis should be placed on a set of well-defined, measurable indicators and targets. For example, the stigma and discrimination summary measure being developed by UNAIDS as part of the epidemic transition process should be considered, although the draft presented to the Steering Committee appears to require some refinement (e.g. add decriminalization of same-sex sexual relationship).

Programme enablers

- Programme enablers are important to include in the exercise, but there should not be a separate group or meeting on this subject.
- The integration group has been asked to additionally look at programmatic enablers.
- The costing group will be charged with costing these enablers, as many (e.g. procurement and supply-chain management) provide benefits to the broader health system and/or socio-economic

⁸ The technical meeting on social enablers also noted a need for further elaboration of the definition social enablers, noting that communities themselves are a form of social enabler.

development efforts. However, there is an understanding that there may be insufficient country inputs in many areas, which will require the use of estimates.

Initial impact estimation through 2030

The outputs of the technical groups convened to date have been used by the modelling team from [Avenir Health](#) to develop preliminary simulations for 20 countries that accounted for an estimated 78% of new HIV infections in 2018.⁹ The modelling team is being guided on technical modelling aspects by a Programme Impact Modelling Advisory Group (PIMAG). As the targets are refined, the model will be expanded to 100 countries, and it will be fitted to UNAIDS 2020 HIV estimates (based on 2019 country data) when they are finalized in mid-2020.

Granular targets

The draft model includes packages of HIV prevention and treatment service coverage targets for the following sub-populations:

- Sex workers
- Gay men and other men who have sex with men
- Transgender people
- People who inject drugs
- Prisoners and other people in closed settings
- Adolescent girls and young women (aged 15–24 years)
- Adolescent boys and young men (aged 15–24 years)
- Adults age 25 and older with multiple sexual partners

The proposal from the HIV prevention technical consultation for granular targets reflecting differentiated levels of risk of HIV acquisition/transmission within a sub-population has been built into several targets, including pre-exposure prophylaxis (PrEP), STI screening and treatment and economic empowerment (see Figure C). Estimates of the population sizes in high-prevalence settings of various age/sex populations (e.g. 15–24-year-old females) at low, medium, high and very high risk of HIV infection were generated by a district estimates tool using data from 1,586 sub-national units.

Figure C. Draft differentiated targets for two sub-populations

Adolescent girls and young women

⁹ Angola, Brazil, Cameroon, China, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mozambique, Nigeria, Pakistan, Russia, South Africa, United Republic of Tanzania, Uganda, United States, Zambia and Zimbabwe.

Intervention	Target
Condoms/lube	90% or PrEP
PrEP	
Very high-risk geography	HR: 5%
Medium risk	HR: 5%
Low risk	0%
STI screening & treatment	
Very high-risk geography	80%
Other geographies	10%
Comprehensive sexuality education in schools	90%
Economic empowerment	
Very high-risk geographies	20%
Medium risk	20%
Low risk	0%
Treatment	2025: 90-90-90 2030: 95-95-95

Gay men and other men who have sex with men

Intervention	Target
Condoms/lube	90% or PrEP
PrEP	
High risk stratum	80%
Medium risk	30%
Low risk	5%
STI screening & treatment	80%
Treatment	2025: 90-90-90 2030: 95-95-95

A similar calculation will be done to inform the division of three key populations (gay men and other men who have sex with men, people who inject drugs and transgender people) into different risk strata—for example, what defines a “high-risk” person who injects drugs and a “low-risk” person who injects drugs. There is a compelling argument that all people who inject drugs should be considered high-risk.

Steering Committee members also asked if the model can be used to refine the most effective mix of various services within a package—for example, whether an aggressive PrEP roll-out or an aggressive test-and-treat effort would be more effective for a high-prevalence country. It was suggested that it would be difficult to do this because we lack specific data on “real life” impact of such programs.

PrEP target

The differentiated risk estimate informed a draft PrEP target of 5.3 million people, with more than 60% of that target within sub-populations of sex workers and gay men who have sex with men. Steering Committee members expressed concern that the distribution of the PrEP target may suggest that PrEP is not an important prevention option for adolescent girls and young women in high-prevalence settings. However, experience to date does suggest that PrEP is only cost effective for the general population in geographic areas with extremely high HIV incidence. For example, within a population with 1% incidence, would need to provide PrEP to at least 100 people for one year to prevent one HIV infection.

Social enablers

Social enablers—such as stigma reduction, human rights protections, decriminalization, preventing gender-based violence and community (key population) involvement—are assumed to affect transmission by supporting the uptake of services such as condoms, treatment, PrEP and voluntary medical male circumcision (VMMC). However, so far the exercise is not explicitly modelling the impact of social enablers. For each social enabler, the specific activities and coverage targets, the mechanisms of action and quantification of the impact still need to be defined and refined.

It was noted that evidence is available to link some social enablers to HIV-related impacts, and that this should be reflected in the model. However, the process must also consider that social enablers do more than just contribute to the prevention of HIV infections or AIDS-related deaths. For example, keeping girls in school provides lots of other benefits.

Model outputs

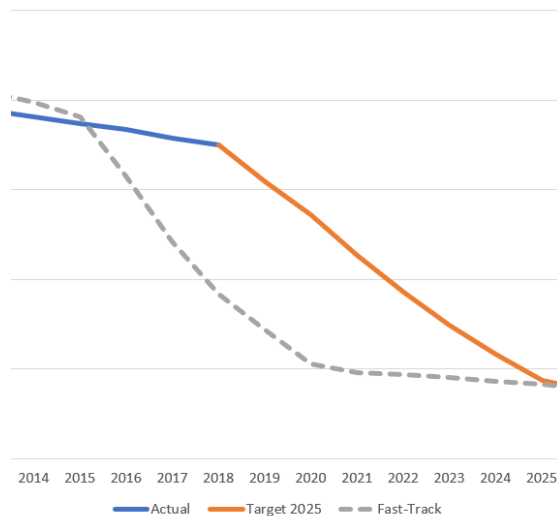
The Steering Committee reviewed projections of annual new HIV infections and AIDS-related deaths (total and age/sex disaggregations) from 2019 to 2030 estimated to occur if the draft targets are achieved by 2025 and sustained until 2030. Additional 2019-2030 projections provided by the modelling team included an incidence-mortality ratio, an incidence-prevalence ratio, the annual number of people living with HIV and the number of people living with HIV on treatment, the annual number of people living with HIV, the mother-to-child transmission rate and the distribution of annual new HIV infections by sub-population.

The modelling team has concluded that achievement of the draft targets would result in impact that is close to the 2030 targets included in the Sustainable Development Goals, and that refining the targets to provide more differentiation of risk would likely reduce the cost of the AIDS response but not result in much greater impact. The modellers also noted that some countries already have service coverage that is near the proposed 2025 targets, while others are far behind and would need to make rapid progress.

Some Steering Committee members expressed concerns about the model outputs, especially regarding the estimates and projections of new HIV infections. In the three years of data since the Fast-Track approach was agreed by the UN General Assembly (2016-2018), there is no inflection in the global curve of new HIV infections (however, this has occurred in a small number of countries, especially within eastern and southern Africa). Despite this lack of Fast-Track progress, the new model calls for an even sharper reduction in new infections between 2020 and 2025. Other participants noted that the point of the exercise was to set targets for 2025 that will put the world on track to achieve the 2030 targets in the Sustainable Development Goals, and that past failures to scale up should not be viewed as discrediting the previous Fast-Track model and target-setting exercise. However, Steering Committee members also expressed concern that the real-life challenges of scaling up a comprehensive prevention and treatment package are not well recognized, as reflected in the disappointing results of the past five years. There would be a loss of credibility if this exercise resulted in merely moving the previous Fast Track scale up curves on the model forward by five years.

There was also confusion regarding when the scale up towards the proposed 2025 targets begins. The presentation of the draft model states that current coverage trends were extrapolated to 2020, and then scale-up to 2025 targets starts in 2021. However, the curves suggest that scale up begins immediately.

Figure D. Illustrative projection of HIV infections from the draft model



Some Steering Committee members called for regional, national and sub-national targets to be produced. However it was noted that model was not designed to produce outputs at national and sub-national levels, as target-setting at those levels are generally done within countries using country-specific data and engaging national stakeholders.

Cost-effectiveness analysis and cost-benefit analysis are tools that could help identify efficient ways to achieve a particular target or to control cost in reaching a target. It was pointed out during the discussion that financial and economic considerations should not be the only criteria in determining resource allocation. An ongoing incremental cost-effectiveness ratio (ICER) analysis being conducted by the World Bank and other partners could be a meaningful input to this work.

Decisions

- There will be an assessment of global and regional achievement based on countries' 2020 estimates and Global AIDS Monitoring reports, including analysis of progress and gaps. Modelling will start from those levels of achievement.
- High-level prevention targets are needed to mobilize action to reduce new HIV infections.
- The draft targets also need to be as people-centred as possible. The outputs of the model need to reflect the heterogeneity of the epidemic, guiding the definition of targets for the coverage of specific packages of services for each sub-population within a specific geographic area and guide the provision of packages of services—including community-led services and integration of related health services—that meet the different needs of different sub-populations in different geographic areas.
- The outputs should be as granular as possible. Regional targets should be part of the target package so countries with smaller epidemics do not get lost within one global target.
- Explore the epidemiological impact of setting higher targets (e.g. 95-95-95) for key populations and other sub-populations who are at higher risk of acquiring and transmitting HIV, as the impact of these individuals protecting themselves from acquisition or from transmitting to others will be greater. It will also be important to recognize that setting higher targets for specific populations could lead to stigma and discrimination.

- Ensure that the distribution of sub-populations is in line with UNAIDS’ estimates, both in terms of the categories (e.g. the current category of “low-risk females” should be broken up to ensure due attention to clients of sex workers and other sexual partners of key populations) and the distribution itself.
- Modelling team to incorporate work by UNAIDS Secretariat on risk stratification among three key populations (gay men and other men who have sex with men, people who inject drugs and transgender people).
- The target-setting for PrEP needs to consider several risk thresholds (HIV incidence, age ranges, etc). In particular, the modelling group should consider using a 20-24-year-old age range for young people in high-prevalence settings. Different adherence rates and different ways to use PrEP should be incorporated into the model.
- The model should include as many social enablers as possible where we have data on impact (see social enablers decisions for more details). The literature review aims at providing specific inputs to the model.
- The model should include the working assumptions on the costs, benefits, efficiencies that will emerge from HIV integration technical consultation.
- Include in the targets a calculation of the cost of past and future inaction (or delayed action), expressed as infections not averted, deaths not averted and future additional costs resulting from these missed opportunities.
 - These could be expressed as scenarios of “scale-up paths”.
- The modelling team needs to develop a process and tools so that it can regularly report to the Steering Committee in more detail on how the model has changed since the previous Fast-Track target-setting process. In addition, the Steering Committee would like more information on how the model translates the scale up of individual interventions into impact (reductions in infections and AIDS-related deaths).

Integration

The 2016 Political Declaration on HIV/AIDS includes 2020 targets that have taken the HIV response further out of isolation: to reduce by 30% new cases of chronic viral hepatitis B and C; to treat 5 million people with hepatitis B and 3 million people with chronic hepatitis C; to reduce tuberculosis-related AIDS deaths by 75%; and to reach 90% of all people who need tuberculosis treatment, including 90% of populations at higher risk, and achieve at least 90% treatment success.

The 2016 Political Declaration also includes commitments to build people-centred systems for health by strengthening health and social systems, and to work towards achieving universal health coverage that comprises equitable and universal access to quality health-care services.¹⁰ The integration agenda has

¹⁰ The 2016 Political Declaration commitment on people-centred systems for health includes sexual and reproductive health, social protection, financial risk protection, access to safe, effective, quality and affordable essential medicines and vaccines for all, the development of new service delivery models to improve efficiency, lower costs, and ensure delivery of more integrated services for HIV, TB, viral hepatitis, sexually transmitted infections, non-communicable diseases, including cervical cancer, drug dependence, food and nutrition support, maternal, child and adolescent health, men’s health, mental health and sexual and reproductive health, and to

been boosted in recent years by the strengthening movement towards universal health coverage. The 2025 target-setting process needs to take advantage of and contribute to the universal health coverage movement, and also to make the HIV response more sustainable. The work of the technical consultation on integration will be informed by a review of evidence conducted by a team of experts from the Harvard T.H. Chan School of Public Health, the Heidelberg Institute of Global Health and the UNAIDS Secretariat. The review has three aims:

- Comprehensively identify and synthesise the evidence on the costs, benefits and efficiency gains of HIV integration with other health services.
- Quantify and categorise these costs, benefits and efficiency gains by modality of services delivery and the level and degree of service integration.
- Establish a conceptual framework to aid in optimising HIV integration tailored to country and (sub)population needs, based on the local HIV epidemic, HIV service delivery, and health systems capacity and organization.

The conceptual framework will be reviewed by the technical consultation in February 2020, and the results forwarded to the modelling and costing working groups. The Steering Committee was presented with elements that require clarification as the work progresses:

- The distribution of additional costs and benefits attributed to the HIV response.
- How to measure the progression in terms of integration from 2020 to 2030?
- How to coordinate the integration and UHC agendas and timeline?
- How best to reflect on programme enablers, many of which are cross cutting or are the responsibility of other health services for which the HIV response has no control over?
- How to select which pieces of integration will be considered in the target-setting exercise? Should economies of scale or economies of scopes drive the selection?
- Can HIV integration also consider community-led health services?
- Would it be possible to develop an index for HIV integration? Can this process build one?
- Does integration mean the same thing in low-prevalence and high-prevalence epidemic settings?

Steering Committee discussion

Steering Committee members noted that integration is an ongoing process that is often deeper in lower-prevalence settings where the HIV response is smaller aspect of the overall health-care system. It was also stressed that several aspects of integration are multisectoral, such as harm reduction, which requires strong collaboration between the health system and public security forces. It was also agreed that integration is not binary, and that an index could be one way to reflect a continuum on integration.

It was also noted that integration appears to be viewed at the global level as invariably a good thing. However, when done poorly or where there isn't a clear advantage to do so, integration has overstretched service providers and degraded the quality of services. This can particularly be the case in settings with low-quality primary health services—providers who are already only have the capacity to deliver episodic care can struggle to take on the challenge of HIV testing and chronic care for people

address gender-based and sexual violence, and to equip fragile communities to cope with these issues as well as future disease outbreaks.

living with HIV. On the other hand, in some high-prevalence settings, a relatively well-funded HIV response has strengthened primary health care delivery.

Steering Committee members encouraged the review team to seek on-the-ground, service-delivery experience, and to collect data on HIV integration from major HIV and health systems donors such as PEPFAR and the Global Fund. The UNAIDS Secretariat reminded that the team's findings would be reviewed by a multi-stakeholder technical group that will include Steering Committee members.

Decisions

- The planned review of evidence was endorsed; it should seek the views of (a) individuals who are deeply involved in the practical integration of HIV and non-HIV at the service-delivery level, (b) individuals who are engaged in efforts to integrate HIV within the Universal Health Care agenda, and (c) the end users of integrated services. The technical working group on integration that oversees the review should also include representatives from these stakeholder groups.
- The review should request data on integration from PEPFAR, the World Bank and other large programmes that have been grappling with this issue for many years.
- The development of an index to measure the integration of the HIV and other disease-specific approaches within universal health coverage could be explored in order to capture the ability of disease-specific programmes to contribute to health sector capacity building.

Costing

A critical aspect of the 2025 targets exercise is calculating the cost of reaching the targets. The technical group on costing, efficiencies and other resource-related inputs is scheduled to meet in the second quarter of 2020, after the other groups have finished their work. The costing group is tasked with identifying relevant data sources and developing the inputs for the model: unit costs or expenditure per units for each intervention or the use of cost functions. Within that work it will estimate the cost of integrated and standalone services and estimate efficiencies that should be included within the assumptions of the model

Initial questions are (a) which costing approach to use, (b) whether the scope of the costing will include all countries or only low- and middle-income countries, as was the case for the costing of the 2020 targets, and (c) which assumptions to use. Emerging challenges are how to cost social enablers and community-led services (how much does it cost to repeal a punitive law?); what proportion of an integrated service or an output that has broader benefits than HIV should be "charged" to the HIV response; ensuring that unit costs and other inputs to the costing are of sufficient quality; and calculating the costs of differentiated service delivery approaches. Some countries have good unit cost data available, others don't. For those that don't, assumptions must be made based on other countries' data.

Steering Committee discussion

Steering Committee members debated the importance of having a global price tag. Some argued that other global health and development initiatives, such as the universal health coverage, have taken different approaches. Others felt that it was critical to have a global price tag developed using a credible

methodology and as much data as possible so it can be defended against stakeholders who feel it is either too low or too high.

It was agreed that the final output of the 2025 targets exercise should encourage countries to adopt more efficient and cost-effective approaches—to “squeeze more juice out of the orange”, while also ensuring that the services provided are of sufficient quality. It was also noted that “the last mile” of the HIV response will be more expensive as it gets harder and harder to find undiagnosed people living with HIV. The outputs of groups and institutions already working on this topic—including the Global Health Cost Consortium, the Bill and Melinda Gates Foundation, the Global Fund, the Harvard T.H. Chan School of Public Health and UNAIDS—need to be incorporated into the targets and resource needs estimates.

Decisions

- The proposed way forward for costing was broadly accepted. While an overall price tag is felt to be useful by many Steering Committee members, the Steering Committee also called for the consideration of alternative ways to present the results of its work, including additional metrics, such as per capita costs or percentages of national income, or gaps, and defining costs based on source, such as domestic channels, international donors, etc, in collaboration with the UNAIDS Communications and Global Advocacy Team.
- The costing group should explore efficiency gains as a target in and of itself.

Conclusion

The next milestones in the 2025 AIDS Targets process will be a November meeting of the PIMAG modelling advisory group and the Q1/2020 meeting of the integration group and the Q2/2020 meeting of the costing group (Figure E). The Steering Committee will be briefed on developments and consulted through three virtual meetings (Figure F).

A progress update could be provided to stakeholders at the December 2019 International Conference in AIDS and STIs in Africa (ICASA), and some initial results of the process could be shared at the two July 2020 International AIDS Conferences. Efforts to consult with a broad base of stakeholders may be supplemented by an online consultation. The Steering Committee will hold its last face-to-face meeting in September 2020, and final results may be presented to the UNAIDS Programme Coordinating Board in December 2020 along with a draft UNAIDS five-year strategy.

Different options should be explored regarding the dissemination of the results to ensure they gain traction. A journal supplement is planned to share the technical details of the process, and UNAIDS flagship publications such as the 2020 World AIDS Day report will also promote the results.

Figure E. 2025 AIDS Targets—next steps

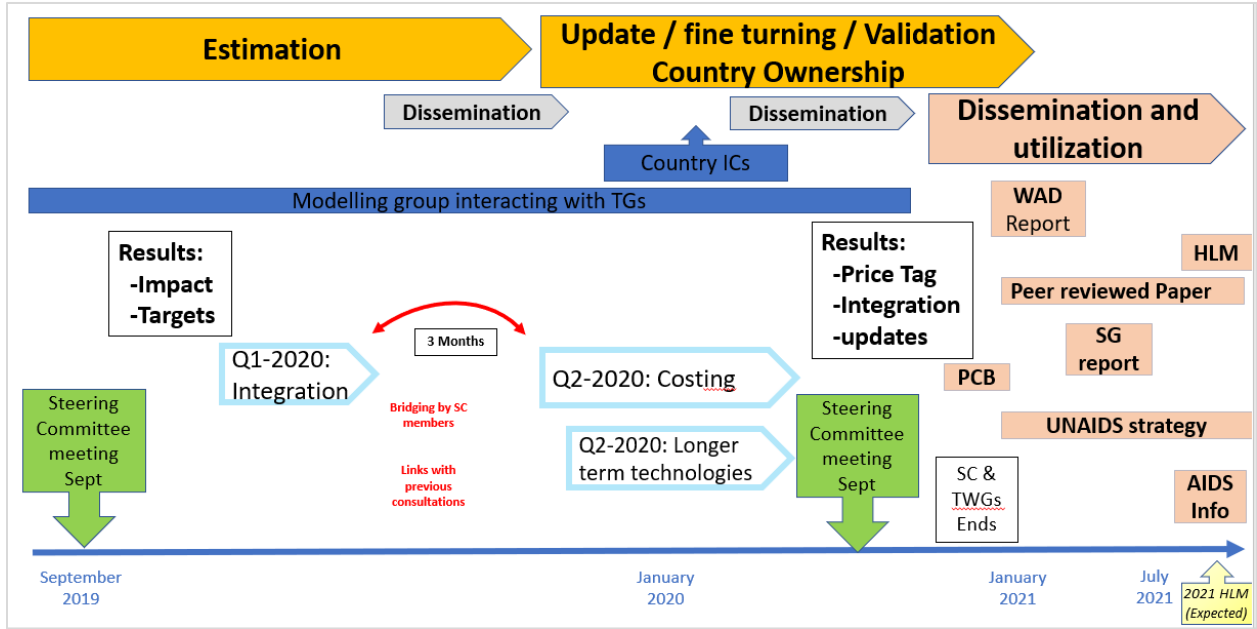
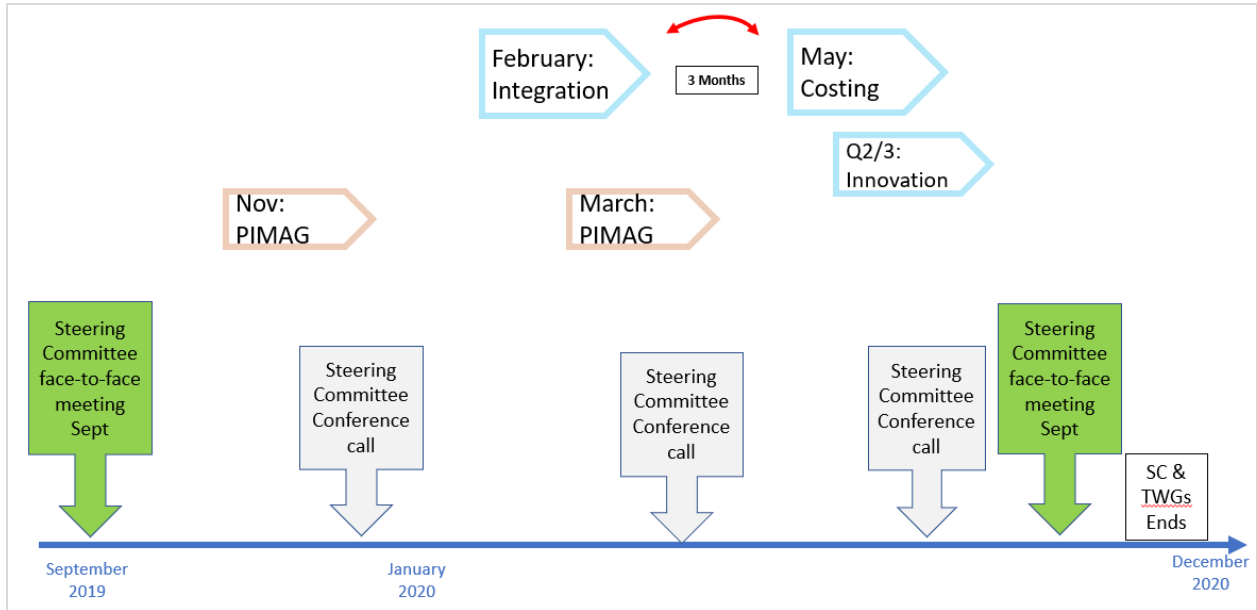


Figure F. 2025 AIDS Targets—Steering Committee events and meetings



Decisions

- AIDS 2020 in Oakland/San Francisco and HIV 2020 in Mexico City are two important opportunities to update the global AIDS community on the process. The Steering Committee offered to contribute to the UNAIDS Executive Director's talking points related to the 2025 Targets process.
- The 2020 World Health Assembly is an opportunity to engage the global health community.
- Need to engage countries before the process is finalized, but not too early as we don't want to open the door to the potential of reducing global ambition.
- An online consultation should be held to collect the views of stakeholders from country level and to ensure more community engagement in the process.
- The UNAIDS Secretariat will meet with Geneva-based missions to solicit input and reactions to the upcoming analyses.
- The UNAIDS Secretariat will negotiate with academic journals regarding the publishing of a series of articles within a supplement. UNAIDS Secretariat to share a proposed breakdown of the articles within the supplement.
- UNAIDS will invite relevant staff from the UNAIDS Communications and Global Advocacy Team to upcoming Steering Committee Quarterly Conference calls and the next "face to face" meeting.
- The advice of communications experts should be sought regarding how best to disseminate the results of the target-setting process.