Key messages on HIV prevention for the UNGA High-Level Meeting
8-10 June 2021

This brief provides key messages specifically on HIV prevention for the HLM 2021. The brief does not include all general messages on HIV, health, gender and human rights that go beyond HIV prevention, which are also essential for the sessions but will certainly be covered by the organizers and other contributors.

Panel 1: End inequalities, End AIDS: 10 Years to 2030

- **No prevention - No end.**
  - Available evidence and models suggest that an end of AIDS by 2030 would be possible, but only if proposed targets on prevention, treatment and rights are reached.
  - Without implementing proven HIV prevention programmes at scale, targets will be missed.
  - If we want to achieve 2030 HIV targets, the time for renewed focus and bold action on prevention is not in 5 years or in 2 years, it is <u>now</u>.
- **No prevention with key populations – no end for anybody.**
  - HIV disproportionately affects key populations – sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and prisoners – and their sexual partners account for 62% of new infections globally.
  - There are good examples of programmatic and structural responses for each key population. BUT: Many countries do not implement proven responses at the right scale.
  - COVID-19 reminded us that there is no end for anyone if vulnerable populations are left behind. Strong prevention with key populations is essential for <u>all</u> countries to achieve 2025 HIV targets overall.
- **No end to inequalities in prevention access – No end.**
  - Access to prevention remains unequal, even for the most basic prevention tools.
  - For example, in many highly affected countries in Africa, women with lower education report lower use of condoms, contraceptives, HIV testing, treatment and other services than other women. Young adult men in their 20s and 30s are less likely to be on treatment (and more likely to transmit HIV to their female partners).
  - We need to address inequities in prevention access now by actively expanding access for populations left behind.
- **No bold leadership in prevention – No end.**
  - The COVID-19 response showed that countries with strong leadership in preventing COVID-19 performed well, both in the early stages when few tools were available and now in the roll-out of vaccines.
  - Three decades of HIV prevention teach us that success requires commitment, focus, quality and scale.

- Both experiences confirm that prevention is first of all about leadership making prevention a priority and aligning public communication, evidence-based interventions, bold investments and management for scale.

Panel 2: People at the Centre: Community leadership critical for the HIV response

- **People-centred prevention means taking prevention to *where* people need it**
  - HIV prevention is needed in a diverse set of places: in bedrooms, in bars, in hotels, in places where people meet to use drugs, where women give birth, on the street, in any place where people meet after connecting online.
  - Delivery of prevention tools such as PrEP, Opioid Substitution Treatment and even condoms often remains limited to health settings.
  - The tools need to be where and when communities are able to access them – this includes presence in key locations where people meet and new virtual meeting places.
- **People-centred prevention means expanding trusted access platforms for services**
  - Key populations remain highly stigmatized in many settings and will only access services and counselling, which they trust.
  - This is why we need to go beyond general health services towards building community prevention programmes that are trusted and can be a platform for a combination of prevention, testing and treatment support services.
  - Evidence shows that programmes that prioritize key population-led community outreach are more effective in increasing HIV service uptake among key populations.
  - There is a range of innovative online adaptations to community outreach, which need to be expanded, made safe, confidential and increasingly designed with communities.
- **People-centred prevention means building unity of purpose through country-led and community-led programmes:**
  - Moving from small-scale projects to scaled prevention responses requires unity of purpose between governments, communities (including key populations as well as women, men and young people in settings with high HIV) and implementers recognizing each others' strengths.
  - Evidence-based precision prevention requires dedicated management capacity at national level and implementation capacity at local levels to analyze epidemics, define priority needs, scale programmes, guide communications and constantly monitor and adapt.
  - There is need to strengthen prevention management capacity including both government capacity and capacity of implementers including community-led organizations.

Panel 3: Gender and human rights: Empowering women and girls in all their diversity to enjoy their rights to equality, health and security

- **Reducing new HIV infections among adolescent girls and young women in settings with high HIV in Africa requires better prevention access**
    - In Sub-Saharan Africa, females account for 58% of all new infections, whereas beyond this region, males account for 68% of all new infections.
    - Adolescent girls and young women aged 15–24 years account for 25% of new infections in sub-Saharan Africa, yet make up only 10% of the total population.
    - Only 4 in 10 locations with high HIV incidence among young women, have dedicated prevention programmes. There is need to rapidly scale up priority prevention packages for adolescent girls & young women and in these priority locations (including for young key populations).
- **Reducing new HIV infections requires addressing gender inequalities in service access**
    - Access to prevention remains unequal, even for the most basic prevention tools.
    - For example, in many highly affected countries in Africa, women with lower education report lower use of condoms, contraceptives, HIV testing, treatment and other services than educated women. Young adult men in their 20s and 30s are less likely to be on HIV treatment (and hence more likely to transmit HIV to their female partners).
    - We need to address inequities in prevention and treatment access now by actively expanding access for populations left behind.
- **Reducing new HIV infections among women requires actively expanding HIV prevention through other SRH services, in particular contraceptive services**
    - Contraceptive services need to take a more holistic perspective on women's sexual and reproductive health and rights including HIV prevention
    - There is need to rapidly integrate high-impact prevention including condoms, U=U and PrEP into contraceptive services in settings with high HIV incidence
    - Many women using contraceptives, giving birth or breastfeeding have male partners with unknown HIV status. Men need to be mobilized through gender-transformative approaches to access services, get diagnosed and play their part in prevention.
- **Reducing new HIV infections among young women requires stronger community HIV prevention responses**
    - The large POP-ART trial showed the value of community outreach workers in supporting uptake of HIV prevention, testing and treatment thereby contributing to reducing HIV incidence.
    - Gender-transformative approaches of HIV prevention for women and men have been effective in reducing HIV related risks in some contexts and can be replicated.
    - There is need to rapidly scale up community prevention including women-led prevention and engagement of men in settings with very high HIV incidence.

Panel 4: Investing to end AIDS: Resourcing the response to pandemics

- **COVID-19 reminds us of the need to finance ending all major epidemics**
    - Resources are scarce, but this is not the moment to shift the spotlight from prevention of any of the major epidemics of our time.
    - COVID-19 showed that time lost in preventing new infections led to avoidable deaths, huge social costs, and unforeseeable risks of new epidemic waves. The same is true for HIV, but with much longer consequences – for life-time for individuals and for generations in terms of cost.
    - This is a moment that requires new resources for prevention – not reallocations— as COVID-19 presents a new challenge requiring new resources, renewed energy and robust, enlightened leadership.
- **Invest in prevention now or future generations will continue paying**
    - Failure to meet 2020 targets led to 3.5 million additional people acquiring HIV and needing HIV treatment for life.
    - Investing USD 9 billion per year in HIV prevention - in combination with HIV treatment and enablers – would reduce the number of people newly acquiring HIV from 1.7 million to less than 0.4 million by 2025 thereby preventing a further increase in treatment cost.
    - If we hesitate, the bill will continue growing – if we act now, we will do a service to our generation and the generation of our children.
- **HIV prevention financing needs both increased international solidarity and domestic investment**
    - In many countries, HIV prevention remains highly dependent on international financing, which declined after 2012. Low-income countries and key populations who are criminalized will require increased – not decreased - international investment to meet 2025 targets.
    - In many middle-income countries, HIV prevention and key population responses were the most underfunded components of the HIV response between 2016 and 2020.
    - Examples such as India's key population programme investments and Brazil's investment in rolling out PrEP need to be much more widely replicated.
    - In order to move services from health settings to communities, there is need to establish social contracting to provide public financing to community-based and community-led organizations.
- **Effective precision prevention requires investing in strengthened management capacity**
    - Moving from small-scale projects to scaled prevention responses requires unity of purpose between governments, communities (including key populations, women, men and young people) and implementers recognizing each others' strengths.
    - Precision prevention requires dedicated management capacity at national level and implementation capacity at local level to analyze epidemics, define priority needs, scale programs, guide communications and constantly monitor and adapt.
    - There is need to strengthen prevention management capacity including both government capacity and capacity of community-led organizations.
    - Investing in national and subnational data enables countries to focus high-impact interventions on locations and populations with the highest risk of HIV and monitor the coverage of intervention packages and prevention outcomes.

Panel 5: Re-imagining global health in the context of COVID-19: Shaping the future of the HIV response

- **COVID-19 reminded us of the importance of leadership for prevention**
    - The COVID-19 response showed that countries with strong leadership in preventing COVID-19 performed well, both in the early stages when few tools were available and now in the roll-out of vaccines.
    - Three decades of HIV prevention teach us that success requires commitment, focus, quality and scale.
    - Both experiences confirm that prevention is first of all about leadership making prevention a priority and aligning public communication, evidence-based interventions, bold investments and management for scale.
- **COVID-19 reminds us of the need to finance ending all major epidemics**
    - Resources are scarce, but this is not the moment to shift the spotlight from prevention of any of the major epidemics of our time.
    - COVID-19 showed that time lost in prevention produced huge social costs, avoidable deaths and unforeseeable risks of new epidemic waves – the same is true for HIV, TB and Malaria, but with much longer consequences.
    - This is a moment that requires new resources for prevention – not reallocations – as COVID-19 presents a new challenge requiring new resources, renewed energy and robust, enlightened leadership.
- **COVID-19 illustrates the power of speed in developing and rolling out innovation**
    - The speed at which new diagnostics and vaccines were developed and rolled out during the COVID-19 pandemic, can be an example of how to deploy HIV prevention technology quickly.
    - We need the same urgency in developing new HIV prevention technologies including renewed efforts towards an HIV vaccine.
    - We need the same speed in rolling out existing and new prevention technologies including oral, vaginal and injectable applications of PrEP, condoms & lubricants, harm reduction. The number of people in need for HIV prevention technologies is much smaller than for COVID-19 – rapid and well-prioritized roll-out is feasible and necessary.
    - There is a range of innovative online adaptations to HIV programmes such as virtual outreach, demand generation and monitoring, which can be scaled rapidly and replicated across countries (where they can be applied with sufficient confidentiality and safety).