A Decade of Business Unusual

UNFPA Framework to Prevent Sexual Transmission of HIV in East and Southern Africa 2021-2030
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### Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AGYW</td>
<td>Adolescent girls and young women</td>
</tr>
<tr>
<td>ARVS</td>
<td>Antiretrovirals</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent-friendly sexual and reproductive health</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>BBSS</td>
<td>Bio-behavioural surveillance survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community based organization</td>
</tr>
<tr>
<td>CRPD</td>
<td>Convention on the Rights of People with Disabilities</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
</tr>
<tr>
<td>eMTCT</td>
<td>Elimination of mother-to-child HIV transmission</td>
</tr>
<tr>
<td>ESA</td>
<td>East and Southern Africa</td>
</tr>
<tr>
<td>ESARO</td>
<td>East and Southern Africa Regional Office (UNFPA)</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>GARPR</td>
<td>Global AIDS Response Progress Report</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund for AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GPC</td>
<td>Global HIV Prevention Coalition</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV testing and counselling</td>
</tr>
<tr>
<td>HTS</td>
<td>HIV testing services</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally displaced persons</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>IPV</td>
<td>Intimate partner violence</td>
</tr>
<tr>
<td>LGBTQI</td>
<td>Lesbian, gay, bisexual, transgender, queer and intersex</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organization</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>US President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>PLWD</td>
<td>People living with disability</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother to child HIV transmission</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>SBCC</td>
<td>Social and behaviour change communication</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and gender-based violence</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>SW</td>
<td>Sex worker</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
</tr>
<tr>
<td>WCA</td>
<td>West and Central Africa</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Our path to ending sexual transmission of HIV in East and Southern Africa

The global commitment to end AIDS by 2030 will, to a large extent, be determined by what happens in East and Southern Africa, which is home to more than 50 per cent of people living with HIV globally. More than 90 per cent of new HIV infections in the region are transmitted through sex. Articulating a clear roadmap on how different stakeholders will contribute towards ending AIDS is critical. This helps not only in demonstrating commitment by organizations, but also in guiding and sharing the chosen pathways to achieving this goal.

Sexual health is at the core of UNFPA, the United Nations agency for sexual and reproductive health's work. The most vulnerable people and key populations are given priority by UNFPA in the broader sexual and reproductive health (SRH) agenda. The organization is therefore well placed to play a leadership role in championing the prevention of sexual transmission of HIV and advocating for human rights and equality for marginalized populations, as well as to spearhead the integration of HIV and sexual and reproductive health and reproductive rights (SRHR) as part of the journey to universal health coverage.

At the Nairobi Summit on the 25th anniversary of the International Conference on Population and Development (ICPD25) in 2019, the global community recognized the unfinished business for SRH. HIV continues to be a major hindrance to the attainment of sexual and reproductive health in East and Southern Africa. Progress in containing the epidemic has been slow and the region remains off-track to meet the 2020 and 2030 prevention targets. For instance:

- By the end of 2019, there were more than double the number of new infections recorded than that required to be on track to meet the 2020 targets;
- New infections had dropped by just 38 per cent by the end of 2019, compared to the target of 75 per cent by 2020;
- Young women, women, and key populations continued to be disproportionately affected;
- AIDS-related illnesses were the leading cause of death among women of reproductive age in the region in the past decade.
The COVID-19 pandemic has made it even more difficult to be on track to meet the HIV prevention targets.

Despite these challenges, UNFPA remains committed to ending sexual transmission of HIV by 2030. This calls for business unusual in the Decade of Action. At the global level, UNFPA, as co-convener of the Global HIV Prevention Coalition (GPC), has facilitated the development of HIV prevention targets for 2025 that can bring the global community back on track to end AIDS by 2030. In East and Southern Africa, UNFPA has prioritized HIV prevention as one of its four transformative results.

To operationalize the transformative result of zero sexual transmission of HIV, UNFPA in East and Southern Africa has developed this ten-year framework to guide its work. The UNFPA Framework to Prevent Sexual Transmission of HIV in East and Southern Africa 2021-2030 describes the strategic interventions to be championed by the organization in accordance with its SRH mandate, as well as UNAIDS’ division of labour on HIV. Advocating for business unusual to prevent new infections in the Decade of Action, this framework will be implemented through UNFPA’s three successive regional programmes that will contribute towards the achievement of the Sustainable Development Goals. The aim of the first five years is to accelerate efforts and scale up HIV prevention interventions to meet the GPC’s critical 2025 targets. The last five years will focus on consolidating and sustaining gains made on HIV prevention.

This Framework will guide UNFPA’s Regional and Country Offices in the fast-tracked HIV prevention response. The document also provides clarity for national and regional partners, as well as development partners, on the work of UNFPA in the region.

In implementing this framework, HIV focal points are encouraged to take into consideration complementary UNFPA guidance documents such as “My Body, My Life, My World: Rights and Choices for All Adolescents and Youth: A UNFPA Global Strategy”, as well as “Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage”.

Finally, this framework should be treated as a living document that will be updated regularly, based on additional evidence and context-specific experiences and insights gained from practical application in the region. This document is being finalized in the midst of a major public health challenge due to COVID-19. Lessons learned in adapting to this new threat should encourage us to be more agile and innovative in our delivery.

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UNFPA Regional Director, East and Southern Africa
Acknowledgments

This document was developed by the UNFPA East and Southern Africa Regional Office in collaboration with the 21 Countries Offices in the region and UNFPA Headquarters in New York. It was informed by the lived experiences of the representatives of communities from the region, who participated in a regional consultation meeting in 2019. These included young people, women, people living with HIV, sex workers, men who have sex with men, and transgender people. In addition, representatives from governments and civil society organizations helped shape the content.

The document has also benefited from representatives from other development partners, including UNAIDS and the Bill & Malinda Gates Foundation.

Innocent Modisaotsile was responsible for providing technical guidance in the development of the document, which was compiled and drafted by Helen Jackson.

Technical contributors to the framework

A number of people reviewed and recommended areas for improvement. These included UNFPA staff at Headquarters, the Regional Office and Country Offices, as well as a number of partners.

We particularly extend our appreciation to the following:

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UNAIDS: Clemens Benedikt
Bill & Melinda Gates Foundation: Gina Dallabeta
Key messages

1. More than half of the global population of people living with HIV are to be found in East and Southern Africa (ESA), making it the most critical region in which to achieve HIV prevention. The imperative is to ensure that the 90 per cent who are HIV negative remain so. This means the prevention of sexual transmission of HIV, which accounts for 90 per cent of new infections in the region.

2. Progress on HIV prevention in ESA varies widely, but all countries need to intensify efforts to address the 2030 goal of fewer than 100,000 new infections per annum.

3. The UN supports five fast-track prevention pillars. UNFPA is uniquely placed within the UN Division of Labour to lead and promote three of these (namely, key and vulnerable populations, adolescent girls and young women, and condom programming) while supporting the integration of the remaining two pillars, i.e. voluntary medical male circumcision and pre-exposure prophylaxis.

4. UNFPA needs to intensify support for comprehensive condom programming to achieve total market coverage through innovative and intensive demand-creation.

5. Each UNFPA country office should scale up technical support for efficient and evidence-informed multi-layered combination HIV prevention according to identified country needs, committing to a minimum of three to four priority actions to bring programming to scale.

6. UNFPA should focus on HIV prevention in the general adult population, particularly women, and key and vulnerable populations, including those in humanitarian contexts, and explicitly include people with disabilities within each population.

7. UNFPA should advocate and provide technical assistance for the ten steps for policy and programming to fast-track HIV prevention, working strategically with key stakeholders and supporting system-strengthening at all levels for the five pillars of HIV prevention.

8. As one of the measures to help countries prepare for increased reliance on domestic funding, UNFPA should advocate for increased government adoption of social contracting to strengthen civil society organizations, promote community engagement and ownership, and empower beneficiary networks to scale up community-led HIV prevention programmes.

9. UNFPA should use its comparative advantage regarding integration to assist the development and scale-up of appropriate models for integration in each country. This should include the integration of HIV prevention with family planning, STI and other SRHR and SGBV services, as well as addressing wider gender inequality and inequity.

10. UNFPA should adopt both proven and innovative approaches to scale up HIV prevention programming, including innovative methods of differentiated service delivery to reach particular populations, emerging social, digital and other communication modalities, and new technologies.
1 Background and Context

1.1 PURPOSE AND DEVELOPMENT OF THE FRAMEWORK

The strategic importance of the framework lies in the urgent need to fast-track the reduction in sexually transmitted HIV infections in adults and key and vulnerable populations in East and Southern Africa (ESA). Despite a regional decline in sexual transmission of HIV, no countries in the region are on track to meet the full 2020 outcomes and targets for HIV prevention, or to achieve the 2030 goal of ending AIDS. The framework provides core guidance on how to end sexual transmission of HIV in line with its transformative regional goal for UNFPA country offices in ESA and for the regional office, ESARO. It also informs partners and stakeholders on UNFPA priorities in order to strengthen coordination and partnership for effective, efficient, evidence-informed action, and to guide critical investments.

The year 2019 was also a seminal year for UNFPA, marking its 50th anniversary, and 25 years since the 1994 International Conference on Population and Development (ICPD), which coincided broadly with peak HIV incidence in the region. This was also the penultimate year to realize the 2020 targets set by UNAIDS for the HIV and AIDS response. It is therefore particularly apposite for UNFPA ESARO to develop a clear and robust framework to guide HIV prevention for the coming 10 years to 2030 in this region, home to over 50 per cent of people living with HIV. Clear direction is needed for the country offices and ESARO to ensure maximum impact through strengthened efficiencies and effectiveness.

The framework is being finalized during an unprecedented public health crisis, driven in part by the COVID-19 pandemic. The emergency response demanded by the pandemic has further exposed the weaknesses in our health systems as well as the massive inequality in access to sexual and reproductive health services. There is a very real danger that COVID-19 may reverse the hard-won gains in HIV prevention, necessitating a more systematic approach to end sexual transmission of HIV.

The framework was developed through a participatory process after an initial situation analysis undertaken through literature review. This took into account trends in new infections and the current state of the epidemic in ESA, programmatic responses and barriers, what works for the prevention of sexual transmission of HIV, and the strategic mandate and role of UNFPA.
In addition to the situation analysis, UNFPA ESARO hosted a regional meeting to share country views and information as well as UNAIDS and UNFPA critical thinking on the epidemic in order to contribute to the framework. The meeting included UNFPA ESARO-supported country office HIV focal points and/or community members from key and vulnerable populations in the region and people living with HIV. Participants represented 19 of the 23 states supported by ESARO.

1.2 UNFPA MANDATE AND COMMITMENTS

UNFPA is committed to addressing the resolutions of the International Conference on Population and Development (ICPD) 1994 and subsequent additions, and the Sustainable Development Goals (SDGs): 3 (good health and well-being); 5 (gender equality); 10 (reduced inequalities); 16 (peace and justice) and 17 (partnership). In accordance with these global commitments, the framework is aligned to the UNFPA Strategic Plan 2018-2021 to ‘achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality... to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality.’ This is exemplified by the UNFPA Bull’s Eye.

UNFPA is co-convenor of the Global HIV Prevention Coalition (GPC) launched in October 2017 and is committed to the UNAIDS Division of Labour 2018. UNFPA and WHO co-convene for the decentralization and integration of sexual and reproductive health and rights (SRHR) and HIV services; UNFPA, UNICEF and UNESCO co-convene for HIV prevention among young people; and, with UNDP, UNFPA co-convenes on HIV prevention among key populations. In terms of direct support to country programming, UNFPA focuses on men who have sex with men, sex workers and transgender people, while UNODC supports people who inject drugs and prisons. The agency is also a committed partner on many other areas of the cosponsor division of labour, including the thematic areas of HIV-sensitive social protection; gender equality and sexual and gender-based violence (SGBV); and addressing human rights, stigma and discrimination. The UNFPA Regional Programme is fully aligned with global and regional commitments.

2 Men who have sex with men, sex workers and young people.
3 The countries represented were Angola, Botswana, Burundi, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe. Not represented were Comoros, the Democratic Republic of Congo (DRC), Malawi and Mauritius.
1.3 UNFPA STRATEGIC DIRECTION

The UNFPA Strategic Plan 2018-2021 reaffirms the goal of universal access to sexual and reproductive health and reproductive rights (SRHR), particularly focusing on women and young people. In line with General Assembly resolution 70/1 on the 2030 Agenda for Sustainable Development, the strategic plan seeks to ensure that no one will be left behind and that the furthest behind will be reached first. The strategic approach to HIV is threefold: preventing sexual transmission of HIV; promoting human rights and reducing inequalities; and integrating HIV responses into sexual and reproductive health care. The current Strategic Plan is the first of three building blocks to contribute to universal access to SRHR by 2030.

The 2016-2021 UNAIDS strategy towards ending AIDS sets the following key result areas for HIV prevention and treatment access, aligned with the SDGs. Those that fall within the mandate of UNFPA are italicized and indicate the direction and action areas for UNFPA in coordination with key partners and stakeholders. Within the 2018 UN Division of Labour, UNFPA also supports other key areas for the sexual prevention of HIV (see Table 1).

### TABLE 1: KEY RESULTS AREAS AND ACTIONS FOR HIV AND AIDS IN RELATION TO THE SDGS

<table>
<thead>
<tr>
<th>Result Area and relation to SDGs</th>
<th>Requirements</th>
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<tbody>
<tr>
<td><strong>Result Area 1: SDG 3: Good health and well-being</strong>&lt;br&gt;Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment.</td>
<td>HIV testing; infant diagnostics; services upon diagnosis; regular monitoring; affordable treatment; <em>humanitarian emergencies addressed</em>; research and development.</td>
</tr>
<tr>
<td><strong>Result Area 2: SDG 3: Good health and well-being</strong>&lt;br&gt;New infections among children eliminated and their mother’s health and well-being is sustained.</td>
<td>Immediate treatment for pregnant women; <em>integration of HIV, sexual and reproductive health, family planning, tuberculosis, and maternal and child health</em>; services for male partners; EMTCT of HIV and syphilis.</td>
</tr>
<tr>
<td><strong>Result Area 3: SDG 10: Reduced inequalities</strong>&lt;br&gt;Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV.</td>
<td><em>Independent and equal access to services; combination prevention; 20 billion condoms; 27 million voluntary male circumcisions as part of a broader package of male SRT services; comprehensive sexuality education; community engagement in settings with high HIV incidence including young people.</em></td>
</tr>
<tr>
<td><strong>Result Area 4: SDG 10: Reduced inequalities</strong>&lt;br&gt;Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants.</td>
<td><em>Combination prevention; community outreach and engagement of key populations and PLHIV, new media; 3 million on PrEP; harm reduction; crisis-affected populations addressed.</em></td>
</tr>
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5  UNAIDS 2016-2021 Strategy: On the Fast-Track to end AIDS
The core indicator for HIV prevention under SDG 3 is 3.3.1: Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations. Achieving prevention of HIV through sexual transmission is most closely linked to further indicators for SDG 3 for reducing the unmet need for family planning (FP) and for coverage of essential health services including for sexually transmitted infections (STIs); and to SDG 5 on gender equality, reducing both intimate partner and non-intimate partner violence and accepting diverse gender identities. The framework for ESA is fully aligned to addressing these indicators.

To strengthen the HIV prevention response, the UN, civil society, and private and national government stakeholders established the Global HIV Prevention Coalition in 2017. The Coalition called for accelerated implementation of programmes delivering combination HIV prevention packages to address the needs of diverse groups and settings and promoted a 10-point action plan for accelerating combination prevention at country level.

### 1.4 GLOBAL AND REGIONAL TARGETS FOR HIV PREVENTION

Internationally agreed development targets and funding commitments have been set for HIV prevention and treatment, including the commitments of the Millennium Development Goals (MDGs) to reduce HIV infections by 75 per cent over the 2000 figures, the renewed commitment of the UN Political Declaration of 2011 to reduce new infections by 50 per cent from
2010 to 2015, and the global target set by the UN Political Declaration 2016\(^6\) to reduce new infections to under 500,000 worldwide by 2020 and by 75 per cent from the 2010 baseline. Overall funding and progress have remained far too slow to meet the various targets, and greatly intensified efforts are needed to achieve the 2030 UN target of fewer than 200,000 new infections globally in 2030, and treatment reaching the fast-track target of 95-95-95.\(^7\) Table 2 indicates the core output, outcome and impact targets for 2020.

In line with addressing the global targets, UNFPA ESARO has established the HIV prevention targets and milestones indicated in Table 3, with indicators and data sources shown in section 5.

### TABLE 2: INTERNATIONAL TARGETS FOR HIV PREVENTION 2020

#### 2020 HIV Prevention Targets and Commitments
(2016 UN Political Declaration on Ending AIDS)

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

**Programme coverage - access to combination prevention**
- 90% of adolescent girls, young and adult women and men in high-prevalence settings
- 90% of key populations

**Outputs**
- 20 billion condoms per year (equal to 25-50 condoms per male in high prevalence countries)
- 3 million people on pre-exposure prophylaxis (10% of persons at risk)
- 25 (additional) million voluntary medical male circumcisions in 14 countries in Africa (90% coverage among 15-29 year olds)

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

### TABLE 3: REGIONAL TARGETS AND MILESTONES

<table>
<thead>
<tr>
<th>2020 commitments made by UNGA in 2016</th>
<th>Indicators</th>
<th>Progress 2010 - 2019</th>
<th>Target 2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce new infections by 75% based on 2010 baseline</td>
<td>% reduction in incidence</td>
<td>38% 75% 85% 90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% of adolescents girls and young women in high prevalence setting have access to comprehensive prevention services</td>
<td>% of high-incidence locations covered with comprehensive programmes for adolescent girls and young women</td>
<td>&lt;40% 90% 95% 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% of Sex Workers have access to comprehensive prevention services</td>
<td>% of sex workers who reported receiving at least two prevention services in the past three months</td>
<td>&lt;50% 90% 95% 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% of MSM have access to comprehensive prevention services</td>
<td>% of MSM who reported receiving at least two prevention services in the past three months</td>
<td>&lt;30% 90% 95% 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% of transgender people have access to comprehensive prevention services</td>
<td>% of Transgender Persons who reported receiving at least two prevention services in the past three months</td>
<td>Insufficient data 90% 95% 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 - 50 condoms per male per year</td>
<td>% of condom distribution need met</td>
<td>55% 90% 95% 95%</td>
<td></td>
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</tr>
</tbody>
</table>

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6 UN General Assembly Political Declaration on ending HIV and AIDS: on the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, 8 June 2016.

7 95% of people with HIV know their status, of whom 95% are on treatment, of whom 95% are virally suppressed.
1.5 EPIDEMIC OVERVIEW IN EAST AND SOUTHERN AFRICA

ESA\(^8\) has long been home to the largest number of people living with HIV globally, with the majority of countries having severe, generalized epidemics. In 2019, there were an estimated 20.7 million people living with HIV in the region followed by Asia and the Pacific with 5.8 million, and Western and Central Africa with around 4.9 million, compared with an estimated 6.6 million in the rest of the world.\(^9\) If the aspirational goal of ending new HIV infections by 2030 is to be achieved, then East and Southern Africa is the most critical region in which to fast-track the HIV response including for prevention and treatment.

For the first time, in 2018 the majority of new infections globally occurred in key populations and their sex partners.\(^10\) In ESA, however, by far the largest numbers of new infections still occurred in the general adult population\(^11\) at 72 per cent\(^12\) (down from 83 per cent in 2017), that is in individuals not reporting HIV risk behaviours. In sub-Saharan Africa, the epidemic remains more severe in women aged 15 and above who accounted for 59 per cent of the global 980,000 (820,000 – 1,100,000) estimated new infections in adults (outside key populations) in 2017. Young people, especially adolescent girls and young women, are disproportionately affected. In sub-Saharan Africa in 2017, females aged 15 to 24 accounted for one quarter of new HIV infections (26 per cent) although they represented just 10 per cent of the total population.\(^13\)

In 2019 among key populations in ESA, an estimated 15 per cent of new infections occurred in clients of sex workers and other sexual partners of key populations, 6 per cent in men who have sex with men, 5 per cent in sex workers, and 2 per cent in people who inject drugs, totalling 28 per cent of new infections\(^14\) compared with 17 per cent of estimated infections in 2018.\(^15\) This may not reflect the population-attributable risk over time, which could be higher. These populations tend to have significantly higher HIV incidence and prevalence than the general population. For example, in Zimbabwe, HIV prevalence in female sex workers was estimated at 58 per cent in 2015-2016, with an annual incidence of 7 to 10 per cent.\(^16\)

The driving forces behind the epidemic in East and Southern Africa are well known: biological, socio-behavioural and structural factors that vary in weight according to different locations, populations and individuals within them. The immediate factors that have led to the high prevalence of generalized epidemics in Southern Africa include the prevalence of multiple concurrent partnerships, including age-disparate sex; insufficient condom use; endemic STIs; and low levels of male circumcision. In East Africa, higher rates of full male circumcision have been partially protective. Unprotected age-disparate and transactional sex put women, especially adolescent and young women, at particularly high risk. Various socio-cultural norms, values and

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\(^8\) The East and Southern Africa region (ESA) covered by UNFPA ESARO includes 23 countries: Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo (DRC), Eswatini, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe. However, regional data and estimates by UNAIDS, include a slightly different country mix.

\(^9\) UNAIDS Data 2020

\(^10\) Ibid

\(^11\) The ‘general adult population’ includes enormous diversity, covering women and men from 15 years up and with a wide range of educational, socio-economic, cultural, religious and other demographic characteristics.

\(^12\) UNAIDS Data 2020.


\(^14\) UNAIDS Data 2020


practices have also increased the risks for women in some cultures, for example, sexual initiation practices, dry sex and wife inheritance and, throughout the region, widespread sexual and gender-based violence (SGBV), and cultural stigmatization of sex work, same-sex relationships and transgender identity. Untreated STIs that, particularly in women, may not be symptomatic, also contribute to biological susceptibility to HIV. Inadequate knowledge and low risk perception, poor access to and uptake of services, cultural, religious and other deterrents to condom use have also hindered HIV prevention in the general and key and vulnerable populations.17

Barriers at the structural level include legal and policy barriers to service access by various populations; pervasive gender inequalities; stigma and discrimination; poverty and inequality, particularly between men and women; marginalization, and multiple factors that increase population mobility and migration, and often separate partners. Both prolonged humanitarian crises and short-term emergencies in the region also contribute to increased HIV infection risks, among multiple other risks and vulnerabilities - especially for people living with HIV and key populations in humanitarian situations. Psychological, economic, and physical and sexual gender-based violence is also prevalent and is associated with a higher risk for HIV. In household studies of intimate partner violence (IPV) in 12 countries in ESA between 2013 and 2016, between 16 per cent (Mozambique) and 30 per cent (Uganda) of adult women reported IPV in the previous 12 months.18

Addressing these multi-level and multi-dimensional factors driving new infections is a massive challenge. Still, the East and Southern Africa region has succeeded in achieving the strongest declines in new infections globally between 2010 and 2019, at 38 per cent. Nonetheless, the region remains off-track to meet the 2020 or 2030 targets.19 The epidemic in the region remains numerically huge, with South Africa (33 per cent), Mozambique (16 per cent) and Tanzania (8 per cent) accounting for over half the new infections in 2017, and over half the AIDS-related deaths.20 Eight countries had adult HIV prevalence over 10 per cent: Botswana, Eswatini, Lesotho, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.

Trends in new HIV infections in different countries, geographic locales and populations in ESA vary widely. HIV prevalence and the rate and direction of HIV incidence change in different populations and geographical locations, and over time, within

18 UNAIDS Global AIDS Update 2018, Miles to Go: Closing gaps, Breaking Barriers, Righting Injustices
19 UNAIDS Global AIDS Update 2020, Seizing the moment: Tackling entrenched inequalities to end epidemics
20 UNAIDS 2018 Estimates
countries. This makes both within-country and across country comparisons complex. New metrics are being developed to provide clearer evidence of success. One metric is the incidence-prevalence ratio that indicates when countries and regions can be said to have declining epidemics taking into account both incidence and improved lifespans of people living with HIV through treatment uptake.\textsuperscript{21} When the incidence-prevalence ratio falls below the 3 per cent benchmark, UNAIDS considers that country responses appear to be broadly on track to end AIDS, as the number of new infections is dropping sufficiently while numbers enrolled on ART are increasing, leading to normal lifespans. As a region, UNAIDS Data 2020 estimated that North America and Western and Central Europe almost reached the benchmark in 2019 (less than 3 per cent) followed by East and Southern Africa, at 3.5 per cent. In Botswana, Burundi, Eritrea, Eswatini, Ethiopia, Kenya, Rwanda, South Africa and Zimbabwe, the incidence-prevalence ratio for 2019 was estimated to be below 3.0 per cent, while Comoros, DRC, Lesotho, Malawi, Namibia, Uganda, Tanzania and Zambia had estimated ratios between 3.00 and 4.99 per cent. In Angola, Mozambique and South Sudan, estimated ratios were between 5.00 and 9.99 per cent, with Madagascar having a ratio over 10 per cent. Overall, from 2010 to 2019, new infections in ESA fell by 38 per cent and AIDS-related deaths by 49 per cent.

With no countries fully on track to meet the 2020 target of 75 per cent decline in new infections or the full 2020 prevention outcome targets of UNFPA – including for condom use and service coverage – prevention efforts need to be intensified everywhere. It is, however, encouraging that four countries in the region reached the incidence-prevalence ratio benchmark in 2018, showing that programming has been relatively successful and that more rapid HIV prevention can indeed be achieved.

\textsuperscript{21} UNAIDS Data 2020.
2 Evidence for what works
to prevent sexual transmission of HIV

The overarching approach to HIV prevention

- Coordinated combination, multi-layered, multi-sectoral HIV prevention approaches based on robust strategic evidence and theory of change and addressing biomedical, socio-behavioural and structural factors.
- Efficient scale-up of proven, sustainable strategies with fidelity to criteria for success.
- Strategies and costed operational plans tailored to specific populations with differentiated service provision and active beneficiary and community involvement at all stages of programming and implementation.
- Integrated services for HIV prevention, full sexual and reproductive health and rights including for family planning (FP) and STI case management, sexual and gender-based violence including intimate partner violence, and integration in ante- and post-natal services and child health.

2.1 OVERVIEW

All the evidence points to the importance of scaling up the intensity and coverage of basic, multi-layered, multidimensional and multi-sectoral programmes for HIV prevention. This includes addressing the interrelated biomedical, socio-behavioural and structural factors that drive HIV transmission. 22,23

Biomedical strategies for HIV prevention require effective social and behaviour change communication (SBCC) and community strengthening and mobilization strategies to raise knowledge and risk-perception, reduce unsafe sexual behaviours and relationship patterns, promote demand for – and uptake of – regular HIV and other STI testing,24 HIV prevention, treatment and integrated SRHR and SGBV services, and to reduce cultural and religious barriers. Socio-behavioural approaches must be rigorously monitored and evaluated to ensure that they are implemented with sufficient scale, intensity and quality to achieve their intended outcomes. Community approaches designed with the active involvement of intended beneficiaries have been shown to have more consistent results when tailored to beneficiary needs.

24 Phylogenetics show that recent infections are at least 30 times more infectious than older infections. Dallabatta G reporting on Fraser C at CROI, 2017.
Enabling legal, policy, and cultural environments are also essential to facilitate the investment of resources and the provision and uptake of HIV prevention, care and treatment services at scale. Much of what works for HIV prevention is well established (see below). The challenge is how to scale up these interventions across all levels, and across all at-risk populations for maximum impact through mutual reinforcement and effective coordination to achieve complementary synergies.

Multiple benefits have also been identified for integrated HIV, SRH and, increasingly, SGBV responses and support at legal, policy, systems and service levels. Integration has been endorsed at the highest policy levels in the UN declarations of 2006 and 2011, and integrated services that are designed both with and specifically for the diverse populations they are intended to serve have a greater chance of being utilized and need to be brought to scale.

Young people are especially vulnerable, particularly adolescent girls and women in general, as is evidenced by the higher incidence rates. HIV prevention strategies specifically addressing boys and men are essential, for their own sake and to protect their female sexual partners. The uptake of health services by boys and men, including HIV testing and treatment, is lower than that of girls and women. Even with lower HIV incidence in boys than girls, AIDS is the leading cause of death in adolescents of both sexes in the region, highlighting the importance of early identification and strong support for adherence to ART. Additionally, this is historically the largest cohort of young people ever, and the demographic dividend needs to be realized to the fullest extent possible.

### 2.2 VAC HIV PREVENTION PILLARS AND RELATED STRATEGIES

The Global HIV Prevention Coalition 2020 Roadmap identifies five key pillars for HIV prevention in 15 priority countries in ESA, namely: HIV prevention in adolescent girls and young women and their male partners; HIV prevention in key populations; comprehensive condom programming; voluntary medical male circumcision (VMMC); and ARV-based prevention, including the rapid introduction of pre-exposure prophylaxis (PrEP) for those at higher risk and viral suppression of HIV-positive people.

With the exception of VMMC, the other four pillars are also priorities for all other countries in sub-Saharan Africa that have high-incidence communities. The pillars are based on the UN Political Declaration on HIV and AIDS 2016, selected on the basis of increasing evidence for what works in HIV prevention and the scale-up of existing and emerging technologies to address populations at higher risk.

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25 New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health, 2004
26 Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, 2004
27 UNFPA ESARO (2016) What is the effectiveness of SRH/HIV Integration
28 UNFPA ESARO (2016) What is the effectiveness of SRH/HIV Integration?
31 UNAIDS (2016) HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%.
32 WHO recommendations in 2018 are to provide PrEP for people with risk estimated at >3% per annum in the absence of PrEP, including men who have sex with men, sex workers, people who inject drugs, known discordant couples, and, in high prevalence countries, adolescent girls and young women at higher risk, and pregnant and lactating women. WHO (2018) Implementation Tool for pre-exposure prophylaxis (PrEP) of HIV Infection
33 UN General Assembly (2016) UN Political Declaration on HIV and AIDS: intensifying our efforts to eliminate HIV and AIDS. 70th Session, New York, 8 June 2016
In assessing the adequacy of HIV prevention responses that focus on the relevant pillars, the road map stresses the need to focus on: whether priority and key populations are clearly identified and precisely described by age, education, economic status and other characteristics; whether programme coverage is at sufficient scale and aligned with geographical patterns of HIV transmission, and includes adequate facilities and outreach; monitoring, management and accountability; and the quality of implementation tools in use, relevant staff skills, appropriateness of communications and the extent of community ownership.\(^{34}\)

In 2016, UNAIDS described a menu of proven strategies to address HIV prevention in adolescent girls and young women and their male sexual partners,\(^{35}\) in recognition of the fact that no single package is applicable in all settings. Given that the incidence in many countries remains high in women in their late twenties or older, and in men well into their thirties, broader relationship dynamics and gender norms in young relationships need to be well understood in local contexts. The options menu for this very diverse cohort includes core prevention actions and policy and structural actions. The former include condom programming; school-based programming; interpersonal communication; and PrEP, with increased HIV and other STI testing, ART and VMMC for age cohorts of their male partners. The latter include legal and policy change; community mobilization; extensive use of multi- and new media; cash transfers and incentives; changing gender norms and reducing SGBV; addressing sexual and reproductive health and rights; and enhanced leadership. In particular, there is mounting evidence that building protective social assets contributes to HIV prevention in adolescent girls and young women (as well as in other key and vulnerable populations).\(^{36}\) This includes keeping girls in school for longer through educational subsidies; unconditional and conditional cash transfers and other financial support; strengthening social networking; combination social and economic empowerment; and programming for parents and caregivers to be supportive to their children and adolescents.\(^{37}\)

Two well-established approaches for HIV prevention and improving the general sexual and reproductive health of young people – male and female – include adolescent-friendly SRHR services (such as HIV and STI testing and treatment) that adhere to agreed high impact practices; and comprehensive sexuality education\(^ {38}\) incorporating all nine essential elements identified by UNFPA. It is also important to strengthen networks and engage skilled young people in programming that affects them.

Effective strategies to reach boys and men include VMMC integrated with other HIV prevention and SRH services, ensuring condoms are available where needed by leveraging public, social marketing and private sector condoms, and addressing information gaps and risk perceptions. Addressing masculinities that endorse risk-taking, gender inequality and gender violence, strengthening demand creation for HIV and other STI testing and service uptake, and strategies to reduce alcohol and drug-taking that overcome inhibitions, also demonstrate results.\(^ {39,40}\)

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34 UNAIDS (2016) HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%.
35 UNAIDS Guidance (2016) HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys
37 AVERT (2018 update). Women and Girls, HIV and AIDS
39 UNAIDS (2017) Blind Spot: Reaching out to men and boys
Strong evidence exists on what works with key populations of sex workers and with men who have sex with men, and guidelines have been developed for this cohort, as well as for transgender and other key populations.

A primary concern is to change the punitive laws that exist in nearly all countries in ESA against either men who have sex with men or some aspect of sex work, or both. Sex workers, men who have sex with men, transgender populations, people who inject drugs, and their sexual partners require a comprehensive, scaled-up, sustainable package of HIV, SRH and SGBV services. Core components of the package include active beneficiary engagement; identifying key geographic locales, and comprehensively assessing risk and service access; identifying HIV and other service gaps and barriers; being open to innovation as new technologies and communication systems gain traction, and addressing structural barriers to information access and service uptake. Immediate HIV programme requirements are for the development of a trusted ‘access platform’ (usually a community endorsed NGO/CBO with peer outreach workers with a consistent presence in the community) that addresses prevention, testing, linkage to care and treatment adherence as well as structural issues. Specifically, a sufficient supply of condoms and water-based lubricant, regular HIV and other STI testing, PrEP, access to ART, and harm reduction strategies for PWID) are needed. They must be assured within a wider programme to reduce stigma and discrimination from the highest political levels to the community and among service providers, police harassment, gender-based violence and other challenges that people in these marginalized populations face.

41 https://www.avert.org/professionals/hiv-social-issues/key-affected-populations
42 UNFPA (2017) Scaling Up Combination Prevention for HIV among Sex Workers in East and Southern Africa: A Primer for UNFPA Country Teams
43 UNFPA (2017) Scaling up Combination Prevention for HIV among Gay, Bisexual and other MSM in East and Southern Africa: A Primer for UNFPA Country Teams
44 WHO (2016) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations
45 USAID (2019) Key Populations: Targeted Approaches Toward an AIDS-Free Generation
Networks of skilled key populations should be involved at all stages from policy development to programme planning, design, implementation and assessment. Community outreach services that have integrated HIV, SRHR and GBV, with active beneficiary involvement have shown better results than top-down approaches. Programmes collect and use monitoring data on a regular basis for problem-solving, and key indicators are reported upward. HIV incidence and prevalence within key populations needs to be measured over time, with programme outputs, outcomes and impacts robustly monitored.

**People with disabilities** also need a particular focus that takes account of their specific impairments and facilitates access to information and services. This means providing information formatted appropriately for people with sensory or mental impairments and ensuring that facilities are wheel-chair friendly, as well as challenging the notion that people with disabilities are, or should be, asexual. Integrated services addressing HIV, SRHR and SGBV are particularly important for girls and women with disabilities who may face sexual and other exploitation. The wide diversity of people with disabilities must be recognized, so that all HIV prevention approaches for the general adult population and key and vulnerable groups take into account people with different disabilities and involve them at all stages of programming.

**Migrant and mobile populations** need the whole range of information and service delivery to address their needs, with particular attention to their increased SRH and HIV risks and, the greater risks posed by SGBV for girls and women. Accessible, integrated facilities at key geographical locations are essential, notably at border crossings and along main highways, within a supportive in-country and cross-border policy environment. It is essential that migrants can access health facilities at all stages of migrancy, both in their own country and the countries of passage and destination. Evidence shows that effective HIV prevention programming must take into account the spatial and temporal dimensions of mobility, types of mobility in different populations and settings, the chain of events that leads to disengagement from HIV prevention and care, and the period following resettlement in new destinations, which is often one of instability. Programme responses need to take into account the full dimensions of mobility and migrancy in the region, which are complex and highly gendered. To be effective, they need to address different aspects of risk in the original environment, at different stages of travel, at the destination and on return home, identifying and responding to where the risks are greatest with appropriately tailored support. Programming needs to address not just individual risk behaviours by providing information, condoms, HIV testing, referral, ARVs and other SRH and SGBV requirements, but also the underlying structural factors promoting risk (such as separation of spouses, single-sex housing, availability of alcohol and of sex workers).

49. Mobile and migrant populations in the region, excluding internally displaced persons and refugees, include military personnel, workers in transport, mining, construction and other industries, agriculture, informal trading and domestic workers.
With regards to people in humanitarian situations, the specific context must be well understood, as attendant risks around HIV and AIDS, wider SRHR and SGBV vary over time and in different settings. To integrate HIV prevention into wider SRHR, and to reduce SGBV in humanitarian settings requires a systematic plan agreed by the identified stakeholders with designated roles and responsibilities. Equally important is the understanding of the humanitarian-peace-development nexus, how resilience cuts across this, and how countries can transition from humanitarian crises to peace and development. HIV, SRHR and SGBV services must be integrated within a coherent, overarching humanitarian response and prioritize meeting the needs of the most vulnerable including young people, particularly girls and young women, people with disabilities and other marginalized populations.

Condoms are estimated to have averted over 45 million new HIV infections worldwide, and increased, consistent, and correct use could prevent many more. Given their low unit cost, efficient condom programming is a highly cost-effective strategy for HIV prevention as well as for wider SRH, preventing other STIs and unintended pregnancy. Despite the extreme efficacy of male and female condoms, population effectiveness for HIV prevention is dependent on consistent, correct use (80 per cent or higher) in sexual intercourse with a risk of HIV and other STI acquisition. Water-based lubricants are also required to reduce breakage, particularly for anal sex and in any sexual intercourse where natural lubrication is insufficient. Appropriate community outlets to reach diverse users, effective demand creation and guaranteed condom supplies based on accurate forecasting are also essential to optimize condom uptake.

The efficacy of voluntary medical male circumcision (VMMC) was demonstrated between 2005 and 2007 in three randomized controlled trials in South Africa, Kenya and Uganda, demonstrating around 60 per cent reduction in HIV acquisition in men through vaginal sex with a corresponding reduction in risk for their female sexual partners (as fewer of their male partners have HIV). VMMC additionally benefits women by significantly reducing human papillomavirus infection and some other STIs. VMMC has not demonstrated efficacy in anal sex, however, whether in sex between men or heterosexual anal sex. In addition to the life-long benefit of one-off VMMC for HIV prevention, services also provide an important opportunity to reach men and boys with sexuality-related education, HIV testing and referral for treatment or other HIV prevention services.

52 UNFPA (2019) Humanitarian Action 2019 Overview
condoms, and STI treatment. Despite high initial costs, VMMC becomes a highly cost-effective HIV prevention strategy with steeply declining costs once roll out of adolescent and adult male circumcision achieves high coverage. Population effectiveness is increasing in the priority countries that have scaled up VMMC.

**ARV-based prevention: Pre-exposure prophylaxis (PrEP)** has also demonstrated high efficacy in key populations such as sex workers and men who have sex with men, and in heterosexual sex in the generalized epidemic of Botswana. PrEP, currently oral tenofovir, has great potential for HIV prevention in adolescent girls and young women at higher risk, and for discordant couples and pregnant or lactating mothers. Strategies to achieve high adherence need to be community-based and must actively involve beneficiaries. In addition, research is underway to develop long-acting injectable antiretrovirals that could transform adherence, as well as sustained-release devices for antiretroviral topical microbicides. In time, topical microbicides may have a significant role to play particularly for young women at high risk and female sex workers. As well as PrEP, early enrolment on ART with viral suppression has also demonstrated strong prevention benefits. Since 2015, WHO has recommended immediate enrolment on ART for everyone after a confirmed HIV positive test result. UNAIDS estimates that this strategy, with high levels of HIV testing, optimal roll out and high adherence, could prevent 28 million new infections between 2015 and 2030 as well as averting 21 million deaths. Challenges lie in achieving optimal and sustained roll-out, HIV testing and adherence. Post-exposure prophylaxis (PEP) has also shown high efficacy if taken within 72 hours of suspected exposure, although it is unlikely to be a feasible approach outside limited settings such as injury in medical settings, or following rape and high-risk sexual situations.

**STI case management** is another important intervention for reducing sexual transmission of HIV via improved STI diagnosis, treatment and care. High circulating rates of STIs – observed across ESA region – help perpetuate HIV epidemics. HIV testing, treatment and prevention services can be provided through STI clinics, and should be offered to all persons diagnosed with an STI as part of comprehensive case management. EMTCT services should also be included within antenatal care for preventing syphilis and HIV in neonates. Comprehensive sexuality education (CSE) is an important avenue for raising awareness of all STIs, not just HIV, and for encouraging safe sex practices that help prevent STIs as well as unintended pregnancy. The multi-sectoral links and benefits of providing integrated HIV and STI services include reduced HIV transmission; sexual partners of people diagnosed with HIV can be tested through STI services for further case finding; condoms and safe sex practices can be promoted; and PrEP can be provided to people identified as being at high risk of HIV acquisition.

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3 Prevention of Sexual Transmission of HIV in East and Southern Africa

3.1. PROGRAMMING OVERVIEW

Development targets and funding commitments by governments and at the United Nations have shaped the HIV response, contributing to combination HIV prevention strategies addressing biomedical, behavioural, social and structural approaches. Countries in ESA have made progress towards combination prevention with regards to policy developments, programming and service provision and community engagement, and this has contributed to the overall declines in new infections since 2010 in most countries. Immediate actions for HIV prevention have been supported to a greater extent by enabling environmental and programmatic factors such as strengthened strategic information and better-tailored responses. International and domestic (public and private) funding for HIV and AIDS also increased substantially over the past decade, exceeding the USD 10.1 billion-target in ESA for 2020 by US$ 500 million in 2017.63 A disproportionate amount, however, went to treatment rather than prevention, prompting UNAIDS in 2016 to call for 25 per cent of allocations to go to prevention (between 15 and 30 per cent depending on the treatment burden).

Despite progress in many countries in different aspects of HIV prevention, challenges remain in achieving sufficient HIV prevention in the general population as well as for key and vulnerable populations and adolescent girls and young women. The central limitation in HIV prevention programming in the region is that sustainable, multi-layered, evidence-informed combination programmes have not yet been scaled up with sufficient quality and intensity to achieve steep population-level declines in new infections. The underlying issue is that funding for prevention is decreasing, while the number of interventions requiring funding is increasing. As well as being sufficiently funded, programmes need to be tailored to the populations and geographical regions where most new infections are occurring, with appropriately differentiated service delivery platforms.64 Multiple challenges for effective implementation have arisen. These include top-down approaches with insufficient community engagement and capacity development; inadequate levels of social contracting; insufficient government ownership, leadership, coordination and investment; gaps in strategic information; significant service gaps; insufficient integration of HIV, SRHR and SGBV services; and investments in strategies that have either not demonstrated substantial results or cannot be brought to scale, and inadequate long-term investment in proven sustainable approaches.

63  UNAIDS 2018 resource availability and needs estimates
Additionally, community monitoring systems are weak or non-existent. These need to be strengthened to ensure an accurate understanding of what is happening on the ground, and for quality assurance regarding programme fidelity to design. Despite progress, various legal, political and cultural barriers to effective programming for HIV prevention remain, particularly in relation to criminalized key populations, adolescent SRHR, gender inequalities and SGBV, and condoms.

Programming to prevent sexual transmission of HIV needs the same clarity of focus, structure, targets and coordination, and a comparable level of investment that has enabled the excellent programming success that led to the elimination of mother to child HIV transmission, and for treatment. HIV prevention is complex, and both vertical and horizontal scale-up is challenging. The transition towards greater domestic investment and ownership presents its own set of challenges, with governments requiring support to take on the substantial additional expenditures required and to develop sufficient management and staffing capacity despite likely drops in staff salaries compared with donor-supported posts. This has given rise to two key concerns: who in government is responsible and accountable for prevention, and is there a robust monitoring system tracking what is taking place and where improvements are most needed?

In addition to overarching programmatic challenges for effective HIV prevention, specific challenges arise in the focal areas of UNFPA. In East and Southern Africa around 83 per cent of new infections occur in the adult population between the ages of 15 and 49, particularly among women, making this by far the largest population to reach for effective HIV prevention (although incidence and prevalence are higher in key populations). Yet many barriers remain in achieving a sufficiently high level of prevention in this widely diverse cohort. In particular, gender inequality and inequity, harmful gender norms and other social, economic and structural factors need to be better addressed, especially for young women. Improvements are needed in knowledge and risk perception, particularly among young people and men, as well as greater demand for condoms, and strengthened delivery and uptake of HIV and other STI testing, VMMC, PrEP and ART. The uptake of HIV testing and counselling and of treatment, if positive, is lower in men than among women, and this also needs to be resolved. Across sub-Saharan Africa, men and boys living with HIV are 20 per cent less likely than women and girls to know their status, and 27 per cent less likely to be on treatment. UNAIDS reports on studies in Kenya, Malawi and South Africa found that only one in three HIV positive men were aware of their status, while in Mozambique, it was fewer than 10 per cent.

Recognizing that prevention efforts have been lagging, the GPC HIV Prevention 2020 Road Map set out ten essential actions to intensify HIV prevention programming in the 28 countries where 75 per cent of new infections were occurring. Within ESA, these countries include Angola, Botswana, Democratic Republic of the Congo, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. The road map is also relevant to all low- and

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67 UNAIDS (2017) Blind Spot: Reaching out to men and boys
68 UNAIDS (2017) Blind Spot: Reaching out to men and boys
69 UNAIDS (2016) HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%
middle-income countries with significant HIV epidemics. Respondents at the UNFPA ESARO knowledge sharing meeting\textsuperscript{70} in March 2019 indicated that no country had fully completed the steps and that while the Road Map Implementation Tracker\textsuperscript{71} shows progress in several areas, implementation and scale-up lag far behind. The most progress was reported in those countries who had assessed their HIV prevention responses, re-established working groups, and renewed strategies and/or domesticated road maps around the five priority pillars. Funding, particularly for condoms and key populations, remains a concern, and while financing dialogues and a move towards social contracting mechanisms are taking place, they need to be strengthened.

Participants also rated the indicators\textsuperscript{72} that challenged HIV prevention programming in their respective countries, and where programming was not on track. Participants from all 19 countries indicated that cultural and religious factors, stigma and discrimination in health facilities, community engagement and one or more aspects of monitoring, indicator-setting and accountability were not on track, with respondents from eight countries indicating that programming was behind on all areas covered. All but two noted insufficient youth-friendly services, and 15 of the 19 participant countries\textsuperscript{73} indicated that government ownership and leadership were inadequate. Costly donor-driven youth programmes were generally considered problematic because, despite their potential at district or sub-district level, they were not scalable or sustainable and did not focus adequately on long-term country and community benefits.

Finally, respondents assessed whether in-country programming was broadly on track relative to key and vulnerable populations, and in relation to the general adult population. They indicated that prevention responses for the adult population are the most developed, with interventions for transgender populations lagging furthest behind, followed by programming for men who have sex with men. While more strategic information and programming is available for sex workers than for the other key population group, the majority of countries are seriously behind in programming for key populations (see feedback on country scorecards\textsuperscript{74} in section 4). Madagascar, with a highly concentrated epidemic, is beginning to see a rise in new infections in the general adult population, mainly because of weak programming with key populations. The reflections on both the domestication of the 2020 road map and the in-country programming gaps are a useful guide to help UNFPA country offices determine where the greatest need for advocacy and technical support lies.

\textsuperscript{70} Report by UNFPA HIV focal points from the listed countries at the UNFPA ESARO Regional Knowledge Sharing Meeting to Accelerate UNFPA Response to End HIV Sexual Transmission in East and Southern Africa, Johannesburg, 27-29 March 2019

\textsuperscript{71} Tracking tool developed by the Global HIV Prevention Coalition

\textsuperscript{72} Challenges on which information was sought included: policy and legislation; culture and/or religion; government ownership, leadership and/or coordination; strategic information; resources (earmarked funding, trained human resources, material resources); implementation and/or targeting; youth friendly health services; stigma/discrimination in health facilities; community engagement; monitoring, indicator setting and accountability.

\textsuperscript{73} Not present were HIV focal points from Malawi (because of the humanitarian crisis due to Cyclone Idai), Comoros, Democratic Republic of Congo (DRC) and Mauritius

\textsuperscript{74} The prevention scorecards aim to measure and track progress on prevention in the Fast-Track countries, measuring all five pillars of prevention. The scores are a composite of outcome measures (service uptake/behaviour change) and coverage at population level
3.2 POLICY AND SERVICE INTEGRATION

Policy and service integration has long been endorsed at the highest political levels globally and in the region, and programme integration is increasing, particularly between HIV, other STIs and family planning, central elements of sexual and reproductive health, and programme integration. In particular, the 2019 ECHO trial results underscore the importance of integrating HIV prevention into family planning settings, and also with the prevention and management of other STIs. A two-way inter-relationship exists between HIV and other STIs such as syphilis, gonorrhoea, chlamydia and trichomoniasis. They share the same transmission routes via anal, vaginal and also oral sexual contact, and the presence of other STIs increases the risk of HIV transmission via inflammation of genital organs and, in some STIs, the presence of ulceration that creates portals of entry for HIV. Left untreated, some STIs can also lead to severe problems such as pelvic inflammatory disease and infertility. Delivery of comprehensive, integrated HIV services and STI prevention and case management is both an effective and efficient intervention for reducing HIV transmission and preventing other serious health issues, yet both remain under-funded.

The Integra Initiative (2008-2013) documented the benefits and costs of different models to deliver integrated HIV and SRH services in high and medium HIV prevalence settings, especially when it comes to reducing HIV incidence and unintended pregnancies. Study results from Eswatini and Kenya showed that integration improved all quality indicators between 2009 and 2012, with staff reporting the added benefits of client satisfaction, strengthened personal skills, better staff communications and increased service uptake. Lessons have also been learned from more recent demonstration projects of integrated HIV and SRH services in Botswana, Lesotho, Malawi, Namibia, Eswatini, Zambia, and Zimbabwe. Among the benefits cited were improved condom use, greater uptake of HTC, a better quality of care, and, to some extent, cost benefits. Key recommendations were to scale up integrated services beyond the initial demonstration sites of the project, and additionally to integrate services for tuberculosis, malaria and SGBV. A second phase of the project, including these three additional areas, began in 2016 and this time included Kenya, South Africa and Uganda.

Various challenges have arisen around HIV, SRH and SGBV coordination both between and within sectors and units. Issues also arise with regards to donor funding and reporting requirements for vertical programmes, differential funding for

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75 SADC Protocol on Health and SADC HIV and AIDS Strategic Plan, and the Maputo Plan of Action on SRHR
77 WHO (2017) Strengthening the Linkages between Sexually Transmitted Infections (STIs) and HIV
78 UNFPA ESARO (2016) What is the effectiveness of SRH/HIV Integration?
79 EU-Sida funded UNFPA-UNAIDS SRH and HIV Linkages Project, 2011 to 2016
3.3 ADOLESCENT GIRLS AND YOUNG WOMEN AND THEIR PARTNERS

Countries are increasingly prioritising HIV prevention as an inter-sectoral issue in this cohort and also in their male partners. However, there is still a long way to go to bring quality programming to scale. Although the majority of countries are not fully on track, the policy environment has strengthened, and programming has increased, particularly for comprehensive sexuality education and for adolescent-friendly health services, including to a lesser extent for early teens (aged 10 to 14). In addition to addressing adolescent boys and girls and young women in HIV prevention, treatment and care in HIV national policies and strategic plans, national youth and gender policies and plans increasingly address HIV, SRH and SGBV issues too, including support for young people’s networks. A clear, overarching adolescent policy is needed.

Twenty-one countries in the region are signatories to the December 2013 Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in East and Southern Africa, pledging to roll out CSE and adolescent/youth-friendly health services. The quality and scale of implementation, however, varies widely. CSE programmes do not consistently incorporate all nine of the UNFPA essential elements and, in many countries, legal and policy barriers prevent adolescents from accessing SRH services, including HIV testing. These include challenges around parental consent, age of consent, provider attitudes, and lack of accessible, confidential, adolescent-friendly SRH and HIV services. Information and services for out-of-school young people lag further behind, although the use of digital and social media for information sharing and service follow-up is gaining ground.

Approaches to address adolescent girls and young women, particularly around social protection, have increasingly been developed in the region but remain mainly at project level, with pilot initiatives in many countries contributing to the evidence of what works (see 2.2).

One such example is the DREAMS project. Rolled out in ten ESA countries, it has a core package combining evidence-based approaches that address the direct and indirect structural drivers that increase the risk of HIV in girls, such as poverty,

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80 Delate R (2019) Presentation to UNFPA Regional Knowledge Sharing Meeting (op cit), UNFPA ESARO
81 Delate R (2019) Presentation to UNFPA Regional Knowledge Sharing Meeting (op cit), UNFPA ESARO
82 PRB and WHO (2018, 2019) Country Score Cards on SRHR policy for young people
83 Determined, Resilient, Empowered, AIDS-free, Mentored and Safe five-year district partnership projects for girls and young women supported by PEPFAR, the Bill and Melinda Gates Foundation and others, with the central aim of HIV prevention
84 Eswatini, Kenya, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe
gender inequality, sexual violence, and lack of access to education. The prospects of scaling up this demonstration project, however, is unlikely, given the high costs involved. Community engagement strategies such as Stepping Stones\textsuperscript{85} have also been implemented in a growing number of countries in ESA with positive results that could be translated into scalable models for community outreach. The global ALIV[H]E Framework is one example of community-centred programming to address violence against girls and women in the context of HIV and AIDS and has implementing organizations in ESA in Kenya, Malawi, South Africa, South Sudan and Zimbabwe.\textsuperscript{86}

In addition to the need to scale up evidence-informed projects into national programmes, countries in ESA need to ensure better coordination of the response, more strategic geographical prioritization to reach the most vulnerable, improved standard packages and delivery platforms, and more robust coverage indicators and monitoring with strengthened accountability mechanisms.\textsuperscript{87}

Reaching out specifically to boys and men with tailored programming is essential for their own sake as well as to prevent HIV in their female partners, particularly for young women involved in age-disparate sexual relationships. Despite widespread awareness and social and behaviour change communication efforts, correct and comprehensive knowledge about HIV remains low among young people in the region, contributing to low personal risk perception and higher risk behaviours. In population-based surveys,\textsuperscript{88} Eswatini, Kenya, Namibia and Rwanda were the only countries where more than half of young women and men surveyed could demonstrate correct and comprehensive knowledge. Likewise, knowledge of HIV status remains too low, particularly among males. Peer pressure has a strong influence on risk behaviours and often includes incorrect information and poor risk assessment.

### 3.4 KEY AND VULNERABLE POPULATIONS

#### 3.4.1 Sex workers, men who have sex with men and transgender populations

Despite their high HIV burden, these marginalized populations generally have poorer access to quality services compared to the general population. Legal and policy barriers are compounded by violence, stigma and discrimination within families, health services and the community at large. Key populations often have to cope with major psychological issues and are frequently drawn into sex work by poverty and lack of opportunities. Programming needs to address all these factors, as well as gaps in size-estimation and other strategic information, and scale up effective strategies to reach them. Information on transgender and intersex populations in the region is particularly sparse,\textsuperscript{89} although some are reached indirectly through programming aimed at men who have sex with men, and sex workers (for instance in Namibia). Guidelines to reach the latter effectively have been

\textsuperscript{85} Welbourn A (2016) Stepping Stones and Stepping Stones Plus; Stepping Stones with Children  
\textsuperscript{87} Dallabetta G (2019) Presentation to UNFPA Regional Knowledge Sharing Meeting (op cit), UNFPA ESARO  
\textsuperscript{88} UNAIDS Global AIDS Update 2018, Miles to go: Closing gaps, Breaking barriers, Righting injustices  
\textsuperscript{89} A review of key populations in sub-Saharan Africa by UNAIDS in 2016 found almost no information on transgender populations
developed and need to be applied. Most countries in the region have low, if any, domestic funds specifically earmarked for any of these key populations, and expenditure of GFATM allocations, particularly for men who have sex with men and transgender populations, are seriously under-spent, jeopardising further allocations. In the ESA countries with high generalized epidemics, interventions for key populations have tended to lag particularly far behind. In most states, where same-sex activity and some aspects of sex work remain illegal, there is a disconnect between legal barriers and progressive policies and programmes, for instance in applications for GFATM grants and through USAID-funded LINKAGES support.

Despite legal barriers, countries are increasingly developing strategic projects based on well-defined service packages to reach these key populations, though rarely at scale and often without sufficiently robust monitoring. There is an urgent need to transform these into national programmes based on strong strategic information that addresses the relevant geographical areas. Countries in ESA are increasingly undertaking bio-behavioural surveillance surveys (BBSS) to assist tailored programming and to raise the visibility of key populations. However, given the high cost of BBSS along with the implementation challenges and the time taken to produce results, simpler community approaches may yield more useful information. In Angola, DRC, Kenya, Malawi, Mozambique and South Sudan the LINKAGES project is implementing direct services and/or provides technical assistance activities with key population-led organizations and other NGOs, public health facilities and ministries of health. In most countries, even where same-sex activity is illegal, networks of lesbian, gay, bisexual, transexual and intersex people

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90 UNDP et al (2016) TRANSIT: Implementing Comprehensive HIV and STI Programmes with Transgender People
91 Dallabetta G (2019) Presentation to UNFPA Regional Knowledge Sharing Meeting (op cit), UNFPA ESARO
92 USAID Linkages across the Continuum of HIV Services for Key Populations Affected by HIV project
93 Examples include WHO (2013) Sex Worker Implementation Tool; UNFPA (2014) Men who have Sex with Men Implementation Tool; UNDP (2016) TRANSIT working with transgender people
94 UNAIDS RST ESA (2016) Regional Synthesis of the HIV Epidemic in Four Key Populations Left Behind. Draft
(LGBTI) are gaining strength and confidence to challenge oppressive laws and to promote positive policies and services to meet their needs. Sex worker networks are also strengthening and one or two countries, such as Zimbabwe, have national programmes to address them. Social contracting mechanisms are insufficiently scaled up to increase and formalize government partnerships with NGO key population allies. Yet, these could increase key population access to HIV and other STI services through community-based, fixed-site drop-in centres and clinics, and mobile outreach and peer-led prevention services. The solution lies in comprehensive, integrated, people-centred services tailored to the needs of key populations and provided by competent practitioners with knowledge of key population issues, including for HIV and full SRHR services, and for tuberculosis, viral hepatitis, harm reduction, drug treatment and counselling services.

3.4.2 People with disabilities

People with disabilities, particularly young people and women, are another vulnerable and relatively neglected population in the HIV and AIDS response in the region. This manifests in lack of access to SRHR services, including for HIV, and is based on the erroneous assumption that people with disabilities are not sexually active (or should not be). As well as the immediate limitations imposed by their disabilities, including easy access to information and services, people living with disabilities frequently face stigma and discrimination. This, in turn, contributes to low self-esteem and limited agency and reduces their capacity to realize their SRH, HIV and other human and citizenship rights. Poor access to employment may force girls and women, and also some males, into selling sex to survive. Girls and women, especially, face a far greater risk of exploitation, including SGBV, as they may be less physically able to protect themselves. UNFPA reports that, globally, girls and young women living with disabilities face up to ten times more SGBV than those without disabilities, thus greatly increasing their risk of contracting HIV and other STIs. Those living as IDPs or refugees in areas facing a humanitarian crisis are particularly vulnerable, while untreated children and adolescents with HIV are at heightened risk for infections that may lead to disabilities, and of HIV-related developmental, mental, physiological, psychological, sensory and motor impairments.

The international adoption of the UN Convention on the Rights of People with Disabilities and its Optional Protocol, in December 2006 underscores the rights of people with disabilities to have access to quality, affordable health care, including sexual and reproductive health. In 2017, UNAIDS developed guidelines on addressing disability and HIV that are gradually being adopted. One such recommendation is for audits to assess service access for people with various disabilities, as undertaken in South Africa in the Closing the Gap project. The global study by UNFPA on ending SGBV and realising the SRH rights of young people has also raised awareness in the region of the importance of inclusion and how to address it. Increasingly, HIV and SRHR

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96 UNFPA (2018) Young Persons with Disability: Global study on ending gender-based violence, and realising sexual and reproductive health and rights
97 https://www.avert.org/people-disabilities-hiv-and-aids
98 UNFPA (2018) Young Persons with Disability: Global study on ending gender-based violence, and realising sexual and reproductive health and rights
100 Jackson H (2018) Zimbabwe HIV and Disability Impact Mitigation Project, End of Project Evaluation
101 UNAIDS (2017) Disability and AIDS
102 UNAIDS (2017) Disability and AIDS
103 UNFPA (2018) Young Persons with Disability: Global study on ending gender-based violence, and realising sexual and reproductive health and rights
management is being offered by rehabilitation services (such as in Zimbabwe) and representative bodies. There is also some progress in the development of information materials on HIV and SRH for people with different sensory or mental disabilities, and increasing awareness of the need for them. Young people with disabilities, in particular, need to be reached as they are often unable to stay in school and hence miss CSE. Notwithstanding the ever-increasing awareness of the needs and rights of people with disabilities and UNFPA’s mandate to treat them as a priority population, much remains to be done.

3.4.3 Mobile and migrant populations

Mobile and migrant populations are often at heightened risk for HIV. With access to their usual services and social networks disrupted, they typically have poor access to health and other protective services. At the same time, women and girls often face increased risk of sexual and gender-based violence, child marriage, exploitation, survival sex and trafficking. Men who migrate to work on mines and farms are often housed in male-only compounds, leading to high-risk sexual activity, particularly with sex workers. If crossing borders, people may have lower or no eligibility for health care. In high-incidence border areas, stand-alone and integrated services have proved valuable, along with accessible and client-friendly services along major trade routes. Various programmes were set up early in the epidemic in Southern Africa specifically to address mobile and migrant populations, recognising both the greatly heightened risks they face, and their role in spreading HIV from high to low prevalence settings, and vice versa. While much progress has been made since the late 1980s/early1990s, further efforts are needed to ensure access to information and continuity of service provision, specifically when it comes to strengthening referral networks to reduce the loss to follow-up, particularly of people accessing ART or PrEP. Further strategic information is required on the full dimensions of mobile and migrant populations in the region, and the impact of mobility on young people, and men and women at all stages of mobility and migration.

As migrant and mobile populations are highly diverse and changing, HIV prevention responses need to be tailored to specific circumstances, risks and needs and address the full range of HIV prevention, SRH and SGBV-related information and services. Risks and needs vary considerably depending on the source of migration, transit, destination and return, with potentially heightened risk not just for mobile and migrant populations themselves, but also within the home setting (as families are often split) and host communities, and in relation to the nature and length of stages of transition. Many of the actions to address key populations also apply to mobile and migrant populations at higher risk for HIV, but with additional specificities according to diverse settings. Of particular concern are girls and women who are at heightened risk for SGBV, HIV and reduced access to SRH and related services. Humanitarian situations, in particular, often give rise to high levels of mobility and migration and are addressed below.

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104 UNFPA (2018) A Call to Protect Women and Girls on the Move
3.4.4 People in humanitarian situations

Humanitarian crises continue to increase in frequency and severity around the world, including in ESA. The reasons vary considerably and include armed conflict, food insecurity, natural disasters and disease outbreaks, with complex interactions between them. While UNHCR is the UN lead for humanitarian situations, all agencies need to play a role, including UNFPA. Common to all humanitarian emergencies and long-term crises are severe disruption of services, and the capacity of affected populations to meet their most basic needs, including for HIV and STI prevention and treatment, and broader SRHR and SGBV services.

The most affected countries in the region in 2018, and those with the greatest anticipated needs for humanitarian assistance in 2019 and beyond, include Burundi, Democratic Republic of the Congo (DRC), Ethiopia, and South Sudan, with millions of internally displaced persons (IDPs), and refugees hosted mainly by the neighbouring countries of Rwanda, Uganda, Tanzania and Kenya. Ethiopia, as well as facing food insecurity, is host to refugees from Somalia, Eritrea and South Sudan. Unanticipated crises continue to unfold too, notably, Cyclone Idai that hit Mozambique, Malawi, Zimbabwe and, to a lesser extent, Madagascar, in March 2019.

People living with HIV and key populations are especially vulnerable in humanitarian contexts. Confidentiality is harder to maintain, and humanitarian responders and service providers need to understand their specific needs and to be sensitive and responsive to address them. Many people are also driven to take up sex work in emergency and conflict situations as a means of survival and have little or no knowledge of HIV and STI prevention, condom negotiation skills, or how to avoid violence, extortion and other human rights abuses.

Among the most vulnerable are children, adolescent girls and women, especially those with disabilities. At the end of 2018, one in four of all people facing humanitarian crises were girls and women of reproductive age (15-49). An agreement was reached in 2016 to coordinate and respond better to young people caught up in humanitarian crises globally, led by UNFPA and the International Federation of Red Cross and Red Crescent Societies. It is a compact between over 50 international organizations, including the UN, governments, and NGOs, including youth organizations. Collectively they are transforming the support for and with young people in many humanitarian crises throughout the region, including for HIV, SRH and SGBV in the context of multiple other needs. Coordination of humanitarian efforts is a major challenge, and this inclusive approach is a significant step forward. The priority roles for UNFPA, depending on country needs, are outlined in section 4 of this report.

106 UNFPA (2018) A Call to Protect Women and Girls on the Move
107 UNFPA (2018) A Call to Protect Women and Girls on the Move
3.5 CONDOM PROGRAMMING

Male and, to a much lesser extent, female condom programming have continued throughout the region, although the drop in funding for socially marketed condoms has left a severe gap in the total market approach. Following significantly expanded programming and uptake from 1990 to 2010, demand for condoms has stagnated, with the result that in many countries, programming can be considered to be in crisis. The table below indicates estimated condom use with a non-regular partner, knowledge and supply in 15 countries in ESA from UNAIDS country scorecard reports.109

TABLE 4: HIV PREVENTION COUNTRY SCORECARD REPORTS ON CONDOMS FOR 15 COUNTRIES IN ESA, 2018

<table>
<thead>
<tr>
<th>Country</th>
<th>Reported condom use, knowledge and supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Mostly low to very low scores,* with 8 condoms per man per year and 40% of condom needs met.</td>
</tr>
<tr>
<td>Botswana</td>
<td>Some data gaps but good scores, with 37 condoms per man per year and 70% of condom needs met.</td>
</tr>
<tr>
<td>DRC</td>
<td>Mostly poor scores, 8 condoms per man per year, 30% of condom needs met.</td>
</tr>
<tr>
<td>Eswatini</td>
<td>Generally good scores, and 39 condoms per man per year and 76% of condom needs met.</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Low to very low scores, though medium level knowledge in men. 6 condoms per man per year, and 52% of condom needs met.</td>
</tr>
<tr>
<td>Kenya</td>
<td>Generally good knowledge, though use by women with non-regular partners only 57%. 13 condoms per man per year and 52% of condom needs met.</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Good scores on all criteria for condom use and knowledge, 46 per man per year, and 80% of condom needs met.</td>
</tr>
<tr>
<td>Malawi</td>
<td>Mixed scores, but overall use of condoms by men with non-regular partners good at 76%. 11 condoms per man per year and 40% of condom needs met.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Low to very low scores on all criteria. Only 7 condoms per man per year and 16% of needs met.</td>
</tr>
<tr>
<td>Namibia</td>
<td>Good scores on almost all criteria for condom use and knowledge, but 66% of women report condom use with a non-regular partner. 39 per man per year, and 79% of condom needs met.</td>
</tr>
<tr>
<td>South Africa</td>
<td>Several data gaps. 69% of men report condom use with a non-regular partner, and 60% of women. 40 condoms per man per year and 85% of condom needs met.</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Little data, but men reporting 60% use with a non-regular partner, and women 51%.</td>
</tr>
<tr>
<td>Uganda</td>
<td>Good knowledge and justification scores, but only 38% of women use condoms with a non-regular partner, higher in men at 62%. 13 condoms per man per year and 51 % of condom needs met.</td>
</tr>
<tr>
<td>Zambia</td>
<td>Low to very low condom use was reported for women and men with non-regular partners, although knowledge and justification for use scored much better. 14 condoms per man per year, and 38% of condom needs met.</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Generally good knowledge and justification scores, and good use by men with non-regular partners, 85%. 27 condoms per man per year, and 79% of condom needs met.</td>
</tr>
</tbody>
</table>

* Scores reflect reported condom use, knowledge and supply of condoms per man per year plus estimated percentage of total condom needs met.

Clearly, countries vary widely in condom uptake, knowledge and supply, with Botswana, Eswatini, Lesotho, Namibia, South Africa and Zimbabwe showing generally better results for condom programming against the criteria cited, and Angola, DRC, Ethiopia, Mozambique and Zambia generally lagging furthest behind (and with some information gaps). Other countries fall in between, with Malawi reporting high use by men with non-regular partners at 76 per cent, despite relatively low levels of distribution. None have yet attained the full forecasted supply needs.

As one of the first proven HIV prevention methods, condom programming suffers from the perception that it is ‘old technology’, which presents multiple challenges for both supply and demand, specifically and most seriously on the demand side.\textsuperscript{110} One contributing factor for this is the emphasis that has been placed on long-acting reversible contraceptives (at the expense of condoms) to prevent unintended pregnancy, particularly in adolescent girls.\textsuperscript{111} Also, as more people are initiated on PrEP or ART, they may consider condoms unnecessary despite their importance in preventing other STIs. Other factors include gaps between country strategies, work plans and resources, with poorly coordinated financing strategies at all programme levels; poor stewardship and leadership; insufficient investment in and uncoordinated SBCC to stimulate demand; poor monitoring and programme intelligence about where the main challenges lie; and the limited role of commercial actors to support long-term sustainability.\textsuperscript{112} Condom use has never been high in long-term partnerships in ESA, but, as shown in the scorecards, it is possible to reach high levels of usage with non-regular partners, and that is where the gains are to be had.

Intensifying condom programming in non-regular partnerships, plus specifically tailoring programmes to address young people and key and vulnerable populations is essential. It is also crucial to go beyond these populations, and address issues around gender, education, poverty and location, given their role in determining access to and uptake of condoms and all HIV prevention, STI and other SRH services.

\section*{3.6 VOLUNTARY MEDICAL MALE CIRCUMCISION}

VMMC is a priority pillar for HIV prevention in Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe. The rate of rollout varies, with Ethiopia and Kenya having almost reached the 2020 target by 2016, while Namibia had reached only 6 per cent.\textsuperscript{113} Uptake has been increased in various countries by creative marketing tailored to different sectors of men and boys, engagement of traditional practitioners and religious leaders, compensation for travel costs, and application of behavioural science and mobile technology.\textsuperscript{114} The contribution of UNFPA to VMMC is primarily in relation to the integration of VMMC with wider SRH and related services. Integration is increasing, including HTC and treatment referral, information, condoms and STI diagnosis and treatment. The data from country scorecards\textsuperscript{115} indicate country progress on VMMC by 2020.

\begin{table}[h!]
\centering
\begin{tabular}{|l|l|l|}
\hline
\textbf{Low to very low} & \textbf{Medium} & \textbf{Good to very good} & \textbf{Not applicable} \\
\hline
South Africa, Botswana, Eswatini, Malawi, Mozambique, Namibia, Zimbabwe & Lesotho, Ethiopia, Kenya, Tanzania, Uganda, Zambia & Angola, DRC \\
\hline
\end{tabular}
\end{table}

\textbf{Source:} Global HIV Prevention Coalition Country Scorecards

\textsuperscript{110} Dallabetta G (2019) Presentation to UNFPA ESARO Regional Knowledge Sharing Meeting (op cit), UNAIDS
\textsuperscript{111} This may need to change in high HIV prevalence settings if further evidence emerges that LARCs contribute to susceptibility to HIV (ECHO trial)
\textsuperscript{112} Dallabetta G (2019) Presentation to UNFPA Regional Knowledge Sharing Meeting (op cit), UNAIDS
\textsuperscript{113} UNAIDS (2018) Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices. Global AIDS Update 2018
\textsuperscript{114} UNAIDS (2017) Blind Spot: Reaching out to men and boys
\textsuperscript{115} https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/
3.7 PRE-EXPOSURE PROPHYLAXIS

Within ESA, South Africa and Kenya have made the most progress with PrEP, with policies in place from 2015/16 allowing access to PrEP for young women at high risk (aged 18 and above) and other key and vulnerable populations. Many other countries are increasingly considering PrEP for populations at high risk in their national HIV policies and strategies, including Eswatini, Lesotho, Malawi, Namibia, Tanzania, Uganda, Zambia and Zimbabwe. All these countries, with the exception of Namibia and the addition of Kenya, Mozambique and South Africa, also have DREAMS projects that include PrEP for adolescent girls and young women at higher risk in their operational districts, (as noted in 3.3).\textsuperscript{116} Challenges to extensive PrEP roll-out include political and financial issues, guaranteeing reliable long-term supply for the populations in most need and, critically, how to achieve long-term adherence. PrEP programming also needs to emphasize consistent condom use, given the risks of low adherence and the fact that PrEP does not protect against other STIs or unintended pregnancy. External support for PrEP has come mainly from PEPFAR (and other external donors) and the long-term domestication of HIV prevention funding, particularly for PrEP and ART, is highly challenging for lower-income ESA countries with high HIV burden. The data from country scorecards\textsuperscript{117} indicate country progress on PrEP by 2020. The role of UNFPA is particularly to promote the integration of PrEP into family planning and broader SRHR services, including for SGBV.

TABLE 6: COUNTRY PROGRESS ON PREP BY 2020

<table>
<thead>
<tr>
<th>Low to very low</th>
<th>Medium</th>
<th>Good to very good</th>
<th>Insufficient data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola, Botswana, DRC, Ethiopia, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia, Zimbabwe</td>
<td>Eswatini, Lesotho, Kenya, Namibia,</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Global HIV Prevention Coalition Country Scorecards

The essential gateway to PrEP or ART is HIV testing, and this has expanded massively throughout the region with multiple delivery channels, both provider and client-initiated, and both facility and community-based. Uptake in women significantly exceeds that in men, and special efforts are required to improve male uptake. Health services in the region increasingly operate an ‘opt-out’ policy, wherein testing requires informed consent but is routinely encouraged and offered. Self-test kits are gradually being made available also, using saliva-based test kits.

\textsuperscript{116} https://www.pepfar.gov/partnerships/PPP/dreams/
\textsuperscript{117} https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/
Throughout East and Southern Africa, UNFPA will intensify its commitment to primary HIV prevention in line with the priorities of the GPC and existing and emerging normative guidance. Approaches to HIV prevention programming need to be efficient and effective, with a commitment to bringing to scale sustainable, coordinated, practical, multilayered and multi-sectoral combination approaches. The core principles behind the intensification of HIV prevention are that all policy and programming should be:

- Human rights-based, people-centred and emphasize choice;
- Community-owned, with strong social contracting, engagement and empowerment, particularly of beneficiaries, at all stages;
- Gender-sensitive and responsive;
- Evidence-informed in relation to diverse situations and populations, with differentiated service delivery that leaves no one behind;
- Flexible enough to incorporate new learning and technology and embrace promising innovation.

UNFPA will tailor responses according to the priority population needs of each country based on their epidemic profile, overarching country priorities and needs, and on the relative success and challenges in programming to date. It is not the intention that all countries attempt to undertake all identified actions, but rather that they select the most relevant priority actions.

Particular attention will be given to those countries that currently have the highest numbers and rates of new infections, and to those where HIV prevention is lagging furthest behind. Where HIV prevention efforts are already showing improved results, UNFPA will draw on lessons learned to assist other countries and will support them to intensify their efforts. Country scorecard results for the three pillars for which UNFPA is the lead are noted below, with those for PrEP and VMMC indicated in section 3 above. The results highlight countries’ current progress with respect to the five prevention pillars, and where most effort is needed to bring them all into the green category by 2030.
UNFPA ESA core commitments towards ending sexual transmission of HIV:

- Most important is supporting government and key stakeholders to seek funding for and to strengthen the three UNAIDS (2015)\textsuperscript{118} HIV prevention pillars that fall within the mandate of UNFPA: addressing adolescent girls and young women and their male partners; key and vulnerable populations; and condom programming;
- Advocacy and support for implementation of the GPC priorities (including road maps) to fast track HIV prevention in line with 2025 targets;
- Advocacy and support for the integrated scale-up of pre-exposure prophylaxis and voluntary medical male circumcision as part of the full integration of HIV, SRHR and SGBV;
- Adherence to UNAIDS Strategy 2016-2021 guidance and subsequent updates while embracing innovative approaches;
- Advocacy and support for the UNAIDS (2018) fast-track commitment to end AIDS through social protection;\textsuperscript{119}
- Ensuring efficient and effective implementation at scale of the minimum three to four actions identified as the highest priorities in each country for the contribution of UNFPA;
- Strengthening social contracting;
- Robust monitoring and quality assurance for results against specific national and local coverage and outcome targets for the three phases of UNFPA programming to 2021, 2025 and 2029/30, including inputs to the GPC HIV prevention monitoring and tracking tools.

Realization of the two HIV prevention pillars, PrEP and VMMC, falls beyond the core mandate of UNFPA. However, UNFPA provides support for these through social and behaviour change communication and community mobilization efforts, service integration, and as part of the minimum packages for the general, key and vulnerable populations as appropriate. In particular, UNFPA needs to promote innovative ways to increase demand and to ensure that condoms and lubricant are sufficiently available and effectively promoted.

Throughout ESA, UNFPA will:

4.1.1 Strengthen a people-centred approach, with active community engagement, especially with the intended beneficiary populations at all stages of policy, planning, programme design and implementation, monitoring and quality assurance. The agency will advocate for and support substantially increased social contracting and will also capacitate networks locally, nationally and regionally of adolescents and young people, people living with HIV, and key and vulnerable populations to participate effectively in all programmes to address their HIV, SRHR and SGBV needs;

\textsuperscript{119} UNAIDS (2018) Social Protection: a fast-track commitment to end AIDS
4.1.2 Through technical assistance, support to access funding (e.g. for GFATM grant applications) and TWG oversight, support tailoring and scaling up of programmes to where new infections are highest, based on robust strategic, local information and innovative thinking;

4.1.3 Contribute to addressing strategic information gaps in line with recommended standards regarding key and vulnerable populations;

4.1.4 Broker and strengthen strategic partnerships to support governments to achieve HIV prevention and integrated services according to the UNAIDS Division of Labour, and with key international cooperation partners and civil society, including public-private partnerships;

4.1.5 Support governments to undertake transition planning for greater reliance on domestic resourcing, ownership and technical capacity, recognising that this is a complex and challenging process that may take years to achieve. UNFPA will develop its own management and technical capacity in relation to different populations and strategies to support government implementation of transitioning with a staggered hand-over plan. UNFPA will also widen exploration of financing opportunities including from government commitment and the private sector;

4.1.6 Take strong action as required on the critical enablers for HIV prevention: advocate for and support the elimination of stigma and discrimination; law reform, legal literacy and legal service provision to address human rights; police training on non-discrimination and harassment, and for effective outreach; and training of health care providers on non-discrimination, informed consent, confidentiality, duty to treat, and infection control; elimination of all forms of gender violence and
harmful gender norms in the context of long-term efforts to reduce gender inequality and inequity; and social protection for key and vulnerable populations in line with the UNAIDS social protection guidelines;

4.1.7 As well as addressing the three fast-track pillars for HIV prevention within the mandate of UNFPA, provide advocacy for PrEP and VMMC, including for funding diversification and sustainability planning for VMMC, and support full-service integration of these pillars with broader HIV prevention strategies, SRH and SGBV services;

4.1.8 Participate in national target setting for ambitious but feasible HIV prevention outcomes and targets in each country against which there are close monitoring and quality assurance and evaluation of results, with targets and milestones for 2021, 2025 and 2029/30. Monitoring should include specificity at least by population, geographical area, sex, age and disability;

4.1.9 Support the full application of country self-assessment tools throughout ESA regarding: the five pillars through scorecards; the road map through the implementation tracker; programme assessment checklists (including for key and vulnerable populations and for condoms); gender audits; the stigma and discrimination index and other tools, and involve beneficiary populations in their application;

4.1.10 Strengthen south-to-south learning within UNFPA, and between UNFPA, governments and other partners, documenting and sharing good practice as advocacy, to assist others, and to publicize the mandate of UNFPA. UNFPA will support the use of multimedia approaches appropriate to diverse audiences and include individual case studies to personalize the achievement of results within different population groups and settings.

4.2 THEORY OF CHANGE

The theory of change is adapted from the UNFPA Evaluation report on HIV. It provides guidance on how to contribute to the ending of sexual transmission of HIV in the context of UNFPA’s mandate. The support to end new sexual transmission of HIV can be achieved through two important strategic outcomes, namely (a) HIV prevention fully integrated into SRHR policies and services, and (b) young people and key populations, including people living with HIV, exercising their right to access HIV-related knowledge and services, free from coercion, stigma, discrimination and violence.

The key activities and investments at both country and regional level include support to young people and key populations, condom programming, primary prevention of HIV, integration of HIV into SRH, support to networks, as well as coordination and strengthening/sustaining political commitment and funding.
UNFPA Activities and Investments

Co-develop and promote HIV-responsive CSE and Youth-Friendly Health Services

Financial and Technical Support provided to Coalitions and Networks of Youth and Key Populations

Develop and Support Comprehensive Condom Programmes (incl. Total Market Approach)

Strengthen/Improve Procurement and Supply Chain Management for Condoms/Lubricants

Demand generation and programme ownership activities

Develop and Support Identification of Models for Linking and Integrating HIV/SRH

Develop, Advocate for and Support Tools for implementing SRHR/HIV/SGBV for youth, women and key populations as well as gender norm change.

Support Lessons Learning and South/South Cooperation on HIV/SRH Integration

Financial and Tech Support to Intergovernmental and CSO Networks on HIV and SRH

Support and Participate in Regional, National HIV/SRH Coordinating Mechanisms

Co-Convene, Regional, National Prevention Coalitions

Participate in and Support Joint UN Team on AIDs

Outcomes/Outputs at Country Level

UNFPA Activities and Investments

UNFPA HIV Strategic Outcomes

UNFPA HIV Goal


TABLE 7: THEORY OF CHANGE ON PREVENTION OF SEXUAL TRANSMISSION OF HIV

Outputs/Outcomes at Country Level

SRH Services in Humanitarian Contexts Integrates HIV Prevention and Treatment

HIV Specific CSE Implemented in and out of Schools [SRA 3, 5, 8]

National HIV Prevention Policies and Programmes Linked to SRH Plans [SRA 8]

Models for Integrating HIV in SRH Tested and Implemented [SRA 8]

Rights-Based FP Services Emphasize Condom Use for HIV Prevention [SRA 6, 8]

National HIV Plans and Programmes Meet Prevention Needs of Key Populations [SRA 4]

Networks of Sex Workers, MSM and Other KPs Influence National Policy to Reduce Stigma and Discrimination [SRA 4, 6]

Girls at Risk of Early Marriage Build Skills to Avoid Coercion and Access HIV Prevention [SRA 3, 5, 6]

Improved Quality and Availability of Condoms and Lubricants [SRA 3, 4]

Implemented National Comprehensive Condom Programmes [SRA 3, 4]

“Condomize” campaigns integrated with HIV testing and treatments [SRA 8]

Prevention and Treatment Services Packages for KPs Integrated in SRH [SRA 4, 6, 8]

Health Care Workers Trained on Stigma and Discrimination (Key Pops and PLWHIV) [SRA 5]

GBV Interventions address HIV Prevention and Treatment [SRA 5, 8]

CSO Activities Address HIV Element in GBV (Including role of men and boys) [SRA 4]

Pregnant women and girls have access to integrated HIV for eMTCT/SRH [SRC 2, 8]

HIV Prevention Integrated into National Plans for Youth Access to SRH [SRA 2, 8]

The UBRAF Strategic Results Areas Targeted by Outputs/Outcomes Above are Indicated in Square Brackets by numbers

UNFPA Strategic Plan Goal (2018-2021)
4.3 PRIORITY ACTIONS TO PREVENT SEXUAL TRANSMISSION OF HIV

The priority commitments and actions of UNFPA to reduce the sexual transmission of HIV are to address three prevention pillars: adolescent girls, young women and their male partners; key populations of sex workers, men who have sex with men and transgender people; and condom programming. Beyond this, UNFPA is also committed to contributing to integrated services for HIV, SRHR and SGBV, including the prevention pillars of VMMC and PrEP; innovative programming to take on board emerging evidence of what works; and addressing HIV, SRHR, and SGBV in the general adult population, especially among those at greater risk such as people with disabilities, mobile and migrant populations, and people facing humanitarian crises.

4.3.1 Adolescent girls and young women and their male partners

The country scorecards (2020) indicate country progress in programming for adolescent girls and young women and their male partners.

<table>
<thead>
<tr>
<th>TABLE 8: COUNTRY PROGRESS ON PROGRAMMING FOR ADOLESCENT GIRLS AND YOUNG WOMEN AND THEIR PARTNERS BY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low to very low</td>
</tr>
<tr>
<td>Angola, Botswana, DRC, Ethiopia, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia, Zimbabwe</td>
</tr>
</tbody>
</table>

Source: Global HIV Prevention Coalition Country Scorecards

Almost all countries in the region have lagged on coverage of adolescent girls, young women and their partners with packages appropriate to their needs in different settings. Recognising the wide diversity of adolescent girls, young women and their sexual partners, a complex response is required that is tailored to their changing needs at different ages, and for both sexes in diverse circumstances. There is no single overarching package that can be adopted, but minimum packages tailored to different settings. Although all adolescent girls, young women and their male partners need to be reached, those at highest risk need to be prioritized, for example, those who are mobile or migrant, impoverished, living with disabilities or are in key populations left behind. Pervasive risk behaviours among adolescent girls and young women, such as transactional sex and age-disparate sex, in particular, need transforming, as do the underlying structural factors related to gender inequality that help drive these behaviours. The risks faced by adolescent girls and young women also relate closely to their sexual networks, making it necessary to consider partner risk factors and to address men and boys.

The Options Menu of the GPC provides an overarching theory of change that can be modified in different situations.

120 https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/
TABLE 9: OPTIONS MENU FOR HIV PREVENTION IN ADOLESCENT GIRLS AND YOUNG WOMEN

<table>
<thead>
<tr>
<th>Menu Options</th>
<th>Dimension of change</th>
<th>HIV prevention outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td></td>
<td>Norms, know-how, skills</td>
<td>Reduced HIV incidence</td>
</tr>
<tr>
<td>School-based prevention (In context of compreh.</td>
<td></td>
<td>Support choices of young women who have agency</td>
<td>Synergistic effects on education, GBV, gender norms, SRHR</td>
</tr>
<tr>
<td>sexuality education)</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Reduced HIV incidence</td>
</tr>
<tr>
<td>Interpersonal communication</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Synergistic effects on education, GBV, gender norms, SRHR</td>
</tr>
<tr>
<td>Pre-exposure prophylaxis</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Reduced HIV incidence</td>
</tr>
<tr>
<td>HTS, ART, VMMC for men</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Synergistic effects on education, GBV, gender norms, SRHR</td>
</tr>
<tr>
<td>Policy, legal change</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Reduced HIV incidence</td>
</tr>
<tr>
<td>Community mobilization</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Synergistic effects on education, GBV, gender norms, SRHR</td>
</tr>
<tr>
<td>Multi- and new media</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Reduced HIV incidence</td>
</tr>
<tr>
<td>Cash transfers / incentives</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Synergistic effects on education, GBV, gender norms, SRHR</td>
</tr>
<tr>
<td>Gender norms &amp; GBV prevention</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Reduced HIV incidence</td>
</tr>
<tr>
<td>Sexual and reproductive health and rights</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Synergistic effects on education, GBV, gender norms, SRHR</td>
</tr>
<tr>
<td>Enhanced leadership</td>
<td>Norms, know-how, skills</td>
<td>Support choices of young women who have agency</td>
<td>Reduced HIV incidence</td>
</tr>
</tbody>
</table>

- 43 -
In ESA, UNFPA will:

a) Assist countries to adopt an effectively monitored strategy and options model and to be accountable for tailoring multi-layered responses appropriately to the needs of diverse populations of adolescent girls and young women and their partners, emphasizing those who are most vulnerable and at-risk, including those who are part of other key and vulnerable populations;

b) Advocate for the removal of all legal and policy barriers to comprehensive SRHR, HIV and SGBV services by adolescent girls and boys (and for women of all ages), and address stigma and discrimination towards adolescents accessing services. The agency will utilize ambassadors or champions to strengthen advocacy efforts;

c) Provide technical support for wider coverage of integrated adolescent-friendly health services with support and quality assurance for minimum standards, and address barriers to access. UNFPA will consider the most strategic approach for investment in different contexts within countries in ESA (large-scale programme delivery, or catalytic support to ensure access);

d) Actively engage and help empower adolescent girls and boys and young women to participate meaningfully in all levels of policy and programming for SRHR, HIV, SGBV and related service provisions designed for them, with broad community engagement;

e) Ensure appropriate, tailored messaging and demand creation activities for male and female condoms, suitable and diverse condom outlets and lubricants as needed, and help empower girls to negotiate condom use;

f) Strengthen efforts to reach out-of-school adolescents with CSE, social and digital media and other platforms to promote social and behaviour change strategies. Strategies will address the needs of boys as well as girls, and address gender inequalities and other barriers to safer sexual behaviour;

g) Advocate and support the expansion of CSE in school that meets all nine criteria for impact and has sufficient government support to provide for adequate numbers of trained teachers and students, and undertake and share mapping of health services close to schools and colleges;

h) Promote social and economic asset-building for adolescent girls and young women, with particular emphasis on keeping them in school, and applying the 2018 UNAIDS guidance for social protection;

i) Advocate for PrEP for adolescent girls and young women at higher risk as part of integrated service provision that includes HIV testing and counselling, condom programming, SGBV services including for intimate partner violence, and full SRHR support. The agency will contribute to developing strong community support for adherence to PrEP and ART.
4.3.2 Key populations

The country scorecards\textsuperscript{121} (2020) indicate country progress in programming for sex workers and men who have sex with men (MSM), although programming for transgender populations is insufficiently tracked.

TABLE 10: COUNTRY PROGRESS ON PROGRAMMING FOR SEX WORKERS, MSM AND TRANSGENDER PEOPLE BY 2020

<table>
<thead>
<tr>
<th></th>
<th>Low to very low</th>
<th>Medium</th>
<th>Good to very good</th>
<th>Insufficient data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex workers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angola, Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe</td>
<td></td>
<td></td>
<td>Kenya</td>
<td>DRC, Ethiopia, Tanzania, Uganda</td>
</tr>
<tr>
<td><strong>MSM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana, Eswatini, Lesotho, Tanzania, Zimbabwe</td>
<td></td>
<td>South Africa</td>
<td>Kenya</td>
<td>Angola, DRC, Ethiopia, Malawi, Mozambique, Namibia, Uganda, Zambia</td>
</tr>
<tr>
<td><strong>Transgender people</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All countries</td>
<td></td>
<td></td>
<td></td>
<td>Insufficient data</td>
</tr>
</tbody>
</table>

Source: Global HIV Prevention Coalition Country Scorecards

The priority key populations, including sex workers, men who have sex with men and transgender populations, face an increased risk of HIV that must be addressed through both legal and policy provisions and service access. HIV prevention must be stepped up as appropriate to local circumstances with particular attention to key populations at higher risk through mobility, migrancy, youth and other factors, and be integrated with wider SRHR, TB, viral hepatitis, harm reduction, drug treatment and SGBV needs. In ESA, UNFPA will:

a) Tailor the response to specific country needs with each identified priority population, supporting the adoption and scale-up of the comprehensive package of HIV, SRH and SGBV services and promoting sustainability;

b) Contribute to resolving strategic information gaps in relation to each priority population within the mandate, including size estimation, identifying where the newest infections in each population are occurring, and what their specific requirements are. UNFPA will advocate for and support the roll-out of a standardized monitoring system across all implementing partners, and periodic bio-behavioural surveillance surveys where appropriate;

\textsuperscript{121} https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/
c) Support the stepping up of expenditure of GFATM funds for key and vulnerable populations, provide technical support for related GFATM proposals and improve the quality and monitoring of programmes, and strengthen visibility around programming. Clear action pathways are needed within a robust theory of change;

d) Advocate for the transformation of legal and policy barriers, building capacity to prevent stigma and discrimination in the health system and more widely;

e) Adopt or adapt existing advocacy toolkits for local use;

f) Advocate for and support the integration of services that go beyond SRHR, HIV and SGBV; e.g. mental health and welfare services and support regarding alcohol and other substance abuse;

g) Utilize social contracting mechanisms for partnering with and engaging CSOs, networks and NGO allies for provision of community-based HIV and integrated SRHR and SGBV services among key populations;

h) Advocate for and support the strategic scale-up of programmes to reach the most marginalized and in need, with sufficient intensity and quality and robust monitoring and quality assurance to measure results, and to identify and address bottlenecks and other challenges.

4.3.3 Condom programming

The country scorecards\textsuperscript{122} (2020) indicate country progress in condom programming.

| TABLE 11: COUNTRY PROGRESS ON CONDOM PROGRAMMING BY 2020 |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Low to very low                 | Medium          | Good to very good | Insufficient data |
| Angola, DRC, Ethiopia, , Mozambique, Uganda, Tanzania, Zambia | Eswatini, Kenya | Botswana, Lesotho, Malawi, Namibia, South Africa, Zimbabwe |

Source: Global HIV Prevention Coalition Country Scorecards

Condoms need to be viewed not as ‘old technology’ but as the only technological intervention that has triple benefits, providing protection against HIV, STIs and unintended pregnancy. Programming needs to avoid being a vertical, donor-driven, single-issue approach with uncertain, short-term funding, and be fully integrated and people-centred, tailored to diverse population needs and interests. Globally, UNAIDS estimates that 20 billion condoms are currently required annually, a figure that may increase over time. By 2030, the target is for 95 per cent use at sex with a non-regular partner. The Global Prevention Coalition, working with the GFATM and others, is developing materials to support a new condom programming module in 2019 for the next round of GFATM applications. Table 7 below provides a model results framework for countries looking to implement a national condom programme.

\textsuperscript{122} https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/
In ESA UNFPA will:

a) Apply condom resources\(^1\)\(^2\)\(^3\) that set out a minimum package for programming, and the 2019 condom programming module for GFATM applications;

b) Invest in the supply of male and female condoms and appropriate lubricants, with demand creation tailored to and including populations at higher risk, keeping abreast of the changing environment and specific needs of key populations;

c) Tailor exciting, innovative SBCC and messaging that addresses the values and needs of diverse populations, going beyond health messaging, and actively involving intended beneficiaries in campaign and programme design, implementation and assessment;

d) Integrate tailored condom programming, including skills-building for condom negotiation and use, into all HIV and STI prevention and treatment systems and for contraception;

e) Invest in leadership and coordination at country level to strengthen stewardship for a total market approach with sustainable domestic funding, and more efficient, tailored public sector supply and distribution;

\(^1\) hivpreventioncoalition.unaids.org/resources/
f) Support social marketing organizations and address barriers facing the commercial sector in order to achieve a total market approach with higher value impact;

g) Strengthen ‘last mile’ condom distribution to multiple community-appropriate outlets, with robust forecasting and assurance against stock-outs;

h) Invest in market data gathering and the capacity to use data effectively;

i) Address cultural and religious barriers to condoms, taking a rights-based approach.

4.4 FURTHER UNFPA COMMITMENTS FOR HIV PREVENTION

4.4.1 Prevention of HIV among adult women (25 years and above)

Adult women aged 15 and above continue to account for the most new infections in ESA (unlike the rest of the world), representing 60% of the 660 000 estimated new infections in adults in 2019. Each year, far more women are infected than men, and in 2019, there were 12.3 million women living with HIV compared to 7.3 million men. While recent efforts have paid special attention to young women, aged 15-24 years, older women remain inadequately supported. This is in spite of the heavy burden of the disease among older women. For instance in Lesotho, HIV prevalence peaks at 50% in women aged 35-39 years. There is therefore an urgent need to strengthen programmes that support adult women regarding HIV prevention and general SRH in ESA. In ESA, UNFPA will:

a) Advocate for evidence generation to make a case for inclusion of adult women in the priority pillars for HIV prevention response in ESA and also to inform appropriate combination prevention;

b) Advocate for an increased investment in SRH for women, especially those 25 years and above, including the adoption of a women-centered approach to health delivery underpinned by the twin principles of human rights and gender equality;

c) Advocate and provide technical support to strengthen integration of HIV and SRH for women;

d) Advocate for the reinvigoration of prong 1 and 2 of the PMTCT/EMTCT strategy;

e) Advocate and provide technical support for laws, policies and programmes that address gender-based violence and intimate partner violence.

f) Promote the use of female condoms as an alternative prevention tool; and

g) Advocate and support effective involvement of men in SRH issues including family planning, antenatal and PMTCT services to improve health outcomes of women and men.
4.4.2 People with disabilities

Given the greater vulnerability of people with disabilities to HIV infection and violation of their sexual and reproductive health rights, context-specific responses tailored to their specific needs within an inclusive legal and policy environment are needed. This must address not just the immediate HIV- and SRHR-related needs of people with disabilities, but the much wider intersecting factors that people with disabilities frequently face of stigma and discrimination, gender, violence, poverty, and exclusion from educational and leisure activities and employment. This particularly applies to young people. In addition to relevant priority actions noted above, in ESA UNFPA will, in support of people with disabilities:

a) Advocate for a positive and inclusive legal and policy environment for the full rights of all people with disabilities in line with the Convention on the Rights of People with Disabilities (CRPD) and its optional protocols;\(^\text{124}\)

b) Advocate for a positive and inclusive legal and policy environment, ensuring that people with disabilities, particularly girls and young women, can realize their HIV-related and wider sexual and reproductive health rights.\(^\text{125}\) UNFPA will address both public sector services and all international agencies and civil society organizations providing services for HIV and wider SRHR needs of people with disabilities;

c) Promote the integration of people with disabilities into programming across all populations and settings;

d) Advocate for and support disability prevention and rehabilitation service providers and disabled persons’ organizations and networks to have supportive attitudes to the HIV- and wider SRH- and SGBV-related needs of people with disabilities, especially girls and young women;

e) Advocate for and support the accessibility of quality health services, including integrated HIV, SRHR and SGBV services for people with different disabilities;

f) Advocate for and support the development and use of accessible, comprehensive sexuality education and other materials in formats accessible to people with different disabilities, especially young people;

g) Advocate for and support the disaggregation of population data to include people with disabilities.

4.4.3 Integrated services

Although complex to measure, progress is in place in various countries towards integrating HIV, SRHR and SGBV services, and this needs to become a norm throughout the region with models appropriate to national and local needs. In ESA UNFPA will:

a) Advocate for an inclusive enabling legal and policy environment that supports integration of services and coordination at different levels across sectors;

b) Advocate and provide technical support for the adoption or adaptation and role out of appropriate models of integration to address local needs, with bi-directionality both across


\(^{125}\) The CRPD Article 25 a mandates states to: Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes
services and vertically from legal and policy provisions to community outreach;

c) Advocate for the inclusion of all relevant stakeholders as needed, from parliamentarians to change laws, through finance and line ministries to civil society at all levels, and with coordinated inputs from international and national development partners;

d) Advocate and provide support for person-centred, quality assured and sustainable service integration that promotes the involvement of male as well as female clients, and that emphasizes critical linkages such as for HIV prevention within FP services and for HIV with other STI services;

e) Provide technical support for the development and costing of national SRHR, HIV and SGBV integration plans to leverage national and international investment, with efficiency and cost-effectiveness studies to support advocacy for scale-up;

f) Advocate for the specific inclusion of mobile and migrant populations in integrated policies, planning and programming for HIV, SRH and SGBV, and for the scale-up of minimum service packages for delivery in key geographical and community locations;

g) Advocate and provide technical support for health care provider training, and the inclusion of training in pre-service curricula, for a comprehensive, people-centred rights-based package of integrated SRHR, HIV and other STIs and SGBV services, and for addressing the needs of diverse key and vulnerable populations, including adolescents sensitively;

h) Advocate and provide technical support for the development of standard curricula and training for community health care workers on an integrated package, ensuring robust monitoring and evaluation;

i) Advocate and support integrated SRHR and other relevant services within the provisions for PrEP, VMMC and other specialized HIV services and treatment, including wider concerns such as tuberculosis and malaria.

4.4.4 Innovation

As new information and evidence emerge on what works for HIV prevention with diverse populations and in different settings, UNFPA needs to keep abreast of innovative means of service delivery, programme support, communication and technologies. The unprecedented impact of COVID-19 on HIV prevention has made the need to innovate more urgent. In ESA, UNFPA will:

a) Advocate for and invest in innovative programming, communications and technologies;

b) Advocate for and provide technical assistance to countries to understand, share, implement and monitor emerging strategies for differentiated service delivery to address the integrated HIV prevention, SRHR and SGBV and wider needs of diverse adults and of key and vulnerable populations;

c) Advocate for, and support training for and use of, innovative technology to bring it to scale: e.g. social and digital media (such as dating sites for older adolescents and young adults); improved models of male and female condoms and lubricant; PrEP and ART; cash and social transfers for young people, especially girls; HIV self-test kits; new VMMC devices; and emerging proven microbicides.
4.4.5 Humanitarian settings

The guidance of the UNFPA Humanitarian Offices in Geneva and New York forms the basis for evolving agency action in humanitarian settings, together with updated inter-agency reproductive health kits, the inter-agency Minimum Standards for GBV Prevention and Response, and the updated Handbook for Coordinating GBV Interventions in Humanitarian Settings. In relation to HIV and STI prevention and FP, UNFPA in ESA will, as required in specific country settings:

a) Contribute to systematic plans in humanitarian settings agreed by the identified stakeholders according to designated roles and responsibilities;

b) Contribute to the understanding of the humanitarian and peace nexus, how resilience cuts across, and how countries can transition from humanitarian crisis to peace and development;

c) Take account of diverse, fragile contexts in the region, with 5 to 10-year timeframes within a longitudinal view to 2030 to ensure that people at risk are not left behind;

d) Provide advocacy and support for the inclusion of the most vulnerable and marginalized in the humanitarian response, including people with disabilities, those who are trafficked (especially girls and women), and those engaged in transactional sex and sex work;

e) Provide support to reach women, girls and young people in humanitarian settings with HIV prevention integrated with life-saving SRH and SGBV services and information;

f) Roll out the revised Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings with particular attention to the need for HIV prevention;

g) Increase field capacity for data analysis and information management in humanitarian situations;

h) Continue to build and strengthen key partnerships and regional and national advocacy for the HIV, SRHR and SGBV response in humanitarian crises, linked with wider inter-sectoral needs;

i) Support countries to achieve reliable HIV, STI and FP supply chain management in humanitarian settings as part of health systems strengthening;

j) Strengthen regional and national preparedness, including pre-positioning of humanitarian supplies and strengthening medical logistics capacities in relation to HIV, SRH and GBV;

k) Meet surge requests within 72 hours for major emergencies;

l) Contribute to and utilize cash-based programming models for integrated HIV prevention, SRH and SGBV services;

m) Advocate for mental health and psycho-social support.

5. **Monitoring the Framework**

Robust monitoring is essential to measure progress and to identify and respond to pitfalls, bottlenecks and other challenges to achieving activities, outputs and outcomes within the overarching theory of change. It is also critical to being able to assess and modify the theory of change itself as further information emerges. The framework will be monitored in line with the three cycles of UNFPA to 2021, 2025 and 2029, and with annual reporting at country and regional level to assess progress towards the cycle targets highlighted in section 1.4. Table 13 provides the core indicators against which progress will be measured and the data sources.

### TABLE 13: HIV PREVENTION INDICATORS AND DATA SOURCES

<table>
<thead>
<tr>
<th>Area of focus</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reduce new infections</td>
<td>% reduction in incidence</td>
</tr>
<tr>
<td>2</td>
<td>Adolescents girls and young women in high prevalence setting have access to comprehensive prevention services</td>
<td>% of high-incidence locations covered with comprehensive programmes for adolescent girls and young women</td>
</tr>
<tr>
<td>3</td>
<td>Sex Workers have access to comprehensive prevention services</td>
<td>% of sex workers who reported receiving at least two prevention services in the past three months</td>
</tr>
<tr>
<td>4</td>
<td>MSM have access to comprehensive prevention services</td>
<td>% of MSM who reported receiving at least two prevention services in the past three months</td>
</tr>
<tr>
<td>5</td>
<td>Transgender people have access to comprehensive prevention services</td>
<td>% of Transgender Persons who reported receiving at least two prevention services in the past three months</td>
</tr>
<tr>
<td>6</td>
<td>Access to condoms</td>
<td>% of condom distribution need met</td>
</tr>
<tr>
<td>7</td>
<td>Women of reproductive age in high prevalence settings</td>
<td>% of women who have their HIV prevention and SRH services met</td>
</tr>
<tr>
<td>8</td>
<td>Adoption of people centered and context specific integrated approaches</td>
<td>% of PLHIV and individuals at heightened risk of HIV infections linked to other health services they need for overall health and well-being.</td>
</tr>
</tbody>
</table>
UNFPA country offices will also assist countries to complete the various monitoring tools that the GPC has developed for priority settings. These include the Road Map Implementation Tracker that tracks response design, systems and operationalization; Country Scorecards to measure progress in outputs (coverage), outcomes and impacts; and Programme Assessment Checklists for the prevention pillars addressing programme design, implementation and quality. In particular, UNFPA will assist in assessing the achievement of programming with key populations, addressing the four core components of stewardship, implementation, scale and programme outcomes for condom programming and for adolescent girls and young women.
6. Conclusion

It is impossible to end the global HIV and AIDS epidemic without intensified, innovative, evidence-informed efforts, as well as political will, in East and Southern Africa where the outbreak is most severe. The successes in some countries facing the heaviest epidemic burdens inspire hope that HIV prevention is possible with the right combination of coordinated and layered approaches, and with sufficient multi-sectoral effort and resources. The country scorecards highlight where the most effort is needed to reach the prevention pillar targets and move all countries into the green zone on all indicators. UNFPA is fully committed, through its new framework for action in ESA and through consolidated partnerships, to contribute to reaching the 2030 targets in the region.
Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person’s potential is fulfilled.