A Decade of Business Unusual

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

SUMMARY
East and Southern Africa (ESA) is home to 50 per cent of all people living with HIV. According to UNAIDS, of the 28 countries experiencing 75 per cent of new infections, 15 are in ESA. Preventing further infections in this region is, therefore, key to ending the global HIV and AIDS epidemic. While much has been done since 2010, current data show that the 2020 prevention targets will be missed, a situation exacerbated by the unprecedented public health crisis in the wake of the COVID-19 pandemic. It is therefore imperative that the reduction in sexually transmitted HIV infections be fast-tracked if countries in the region are to achieve the overarching global HIV targets agreed for 2030. In support of UNAIDS, the lead UN agency on the prevention of HIV/AIDS, UNFPA has drawn up a framework to guide HIV prevention for the next 10 years in the region. This Framework was developed in 2019/2020 by UNFPA ESARO following a broad participatory process that takes into account trends in new infections, the current state of the epidemic, programmatic responses to date, and sustainable methods of preventing and monitoring the sexual transmission of HIV.

It is an advocacy-driven, stakeholder-led, multi-sectoral, collaborative approach that is fully aligned with the priorities of the Global HIV Prevention Coalition (GPC) and existing and emerging normative guidance, including the UNFPA Strategic Plan 2018-2021 and the 2016-2021 UNAIDS strategy towards ending AIDS. The Framework has also benefited from the outcomes of ICPD 25.

The Framework sets out the priority commitments and actions to be taken by UNFPA offices to help countries in East and Southern Africa scale up the five HIV global prevention pillars. Within the UN Division of Labour, UNFPA is uniquely placed to take the lead on three of them, namely 1) adolescent girls, young women and their male partners; 2) key populations of sex workers, men who have sex with men, and transgender people; and 3) condom programming. Beyond this, UNFPA is also committed to contributing to integrated services for HIV, sexual and reproductive health and rights (SRHR) and sexual and gender-based violence (SGBV), including the two prevention pillars of voluntary medical male circumcision (VMMC) and the roll-out of pre-exposure prophylaxis (PrEP) in high-risk situations.

**EPIDEMIC OVERVIEW**

The driving forces behind the epidemic in East and Southern Africa are well documented. They include biological, socio-behavioural and structural factors that vary in weight according to location, population and individual circumstances, contributing to the high prevalence of generalized epidemics. Contributing factors include the preponderance of multiple, concurrent partnerships, including unprotected age-disparate and transactional sex; insufficient condom use; endemic STIs; and low levels of male circumcision. The situation is compounded by harmful socio-cultural practices and widespread SGBV that increase the risks for women. At the same time, cultural stigmatization and criminalization of transgender identity, same-sex relationships and sex work prevent at-risk populations from seeking testing and treatment. 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.

Given the complexity of causes and underlying conditions and the often highly-localized nature of the outbreaks, finding suitable metrics to measure success across countries and even within countries, remains a challenge. Currently, the most useful metric to determine when countries and regions can be said to have declining epidemics is the incidence-prevalence ratio\(^2\), which takes into account both incidence and improved lifespans of people living with HIV through treatment uptake.

While no countries in the region are fully on track to meet the 2020 prevention outcome targets, Botswana, Burundi, Eritrea, Eswatini, Ethiopia, Kenya, Rwanda, South Africa and Zimbabwe reached the 3 per cent incidence-prevalence ratio benchmark in 2019 – proof of the effects of successful programming. Comoros, DRC, Lesotho, Malawi, Namibia, Uganda, Tanzania and Zambia had estimated ratios between 3 and 4.99 per cent. In Angola, Mauritius, Mozambique and South Sudan, ratios were between 5 and 9.99 per cent. In Madagascar, where weak programming for key populations is contributing to a rise in new infections in the general adult population, it is over 10 per cent.

**PRIORITY ACTIONS, APPROACHES AND THEORY OF CHANGE**

Providing support for governments and key stakeholders to seek funding to strengthen three of the HIV prevention pillars is top of the list of UNFPA priorities, along with ensuring that they invest in proven strategies that are capable of being brought to scale. The emphasis is on sustainable, coordinated, practical, multi-layered and multi-sectoral combination approaches that are community-owned and that empower and engage beneficiaries at all stages. They also need to be flexible enough to incorporate new learning and technology and allow for robust monitoring and quality assurance to measure results and address bottlenecks. In line with General Assembly resolution 70/1 on the 2030 Agenda for Sustainable Development, it also supports the view that no one will be left behind and that the furthest behind will be reached first.

The theory of change presented on page 4 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 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 rights 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 to SRH, support to networks, as well as coordination and strengthening/sustaining political commitment and funding.

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\(^2\) When the incidence-prevalence ratio falls below the 3 per cent benchmark, UNAIDS considers country responses 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.
TABLE 7: THEORY OF CHANGE ON PREVENTION OF SEXUAL TRANSMISSION OF HIV

External Factors:
Evolving Epidemics - Stigma and Discrimination - Trends in Global/National Financing - Ongoing Marginalization - Poverty and Socioeconomic Inequalities

Outputs/Outcomes at Country Level

SRH Services in Humanitarian Contexts Integrate 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 Emphasise 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, 8]
Girls at Risk of Early Marriage Build Skills to Avoid Coercion and Access HIV Prevention [SRA 3, 5, 6]

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]
Improvements in Quality and Availability of Condoms and Lubricants [SRA 3, 4]
“Condomize” campaigns integrated with HIV testing and treatments [SRA 8]
Prevention and Treatment Services Packages for KPs Integrated in SRH [SRA 6, 8, 9]
Health 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]

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 (Inc. Total Market Approach)
Strengthen/improve procurement and supply chain management for Condoms/Lubricants
Strengthen 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 SRH/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

UNFPA HIV Strategic Outcomes
HIV Prevention Fully Integrated into SRHR Policies and Services
Rights of Young People and Key Populations to Knowledge, Services, and Freedom for Stigma, Coercion, Discrimination and Violence (GBV) Secured (including PLWHIV)

UNFPA Strategic Plan Goal (2018-2021)
Reduced Rate of New HIV Infections
Universal Access to SRH and Realised Reproductive Rights

UNFPA Strategic Plan Outcome 1: Every women, adolescent and youth everywhere has utilised integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence
ADOLESCENT GIRLS AND YOUNG WOMEN AND THEIR MALE PARTNERS

Except for Kenya and Lesotho, all countries in the region have lagged on this prevention pillar. UNAIDS has therefore drawn up an options menu that provides an overarching theory of change that can be adapted to different situations depending on gaps in programming. Based on this, UNFPA is committed to help countries develop integrated strategies for this cohort that include HIV testing and counselling, condom programming, SGBV services (incorporating intimate partner violence), and full SRHR support. UNFPA will play a key role in advocating for the removal of legal and policy barriers preventing adolescents from accessing comprehensive SRHR, HIV and SGBV services, while also addressing the cultural barriers of stigma and discrimination that prevent them from using these services. Additionally, UNFPA will support and empower adolescent girls and boys and young women to participate meaningfully in all levels of policy and programming designed for them. The focus will also be on ensuring appropriate messaging to boost demand for male and female condoms and support for all aspects of a successful condom roll-out plan (see condom programming below). UNFPA will advocate for the expansion of CSE in and out of schools and for sufficient government support to provide for adequate numbers of trained teachers and students and undertake and share the mapping of health services close to schools and colleges. Finally, UNFPA will promote social and economic asset-building as a strategy for keeping adolescent girls and young women in school, while also advocating for PrEP and ART, especially for adolescent girls and young women at higher risk.

KEY POPULATIONS

There is an urgent need to assist countries in tailoring effective responses to each identified priority population – including sex workers, men who have sex with men, and transgender populations. Programming for the latter lags furthest behind in all countries, with many lacking sufficient data upon which to base programming needs. Similarly, the widespread criminalization of homosexuality and sex work also need to be addressed through both legal and policy provisions to prevent stigma and discrimination and encourage the integration of services that include mental health and welfare services and support for alcohol and other substance abuse.

Priority actions include supporting the scale-up of the comprehensive package of HIV, SRH and SGBV services, while also contributing to resolving strategic information gaps and advocating for the roll-out of a standardized monitoring system across all implementing partners, as well as conducting bio-behavioural surveillance surveys as necessary.

UNFPA also supports the stepping up of expenditure of GFATM funds for key and vulnerable populations, providing technical support for related GFATM proposals and improving the quality and monitoring of programmes, while strengthening visibility around programming. 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, must be engaged and strengthened and clear action pathways mapped out within a robust theory of change.
CONDOM PROGRAMMING

Even though condoms remain the most reliable defence against HIV, other STIs and unwanted pregnancies, they are viewed as ‘old technology’, having been eclipsed by long-acting reversible contraceptives, particularly in adolescent girls. As a result, demand for condoms has stagnated since 2010, creating a crisis in many countries’ programming. To fix this, the GPC has prepared materials to support new condom programming modules to address the gaps between country strategies, work plans and resources, and improve the coordination of financing strategies at all programme levels. UNFPA specifically supports condom resources and undertakes to invest in the supply of male and female condoms and appropriate lubricants and to create demand through innovative SBCC that address the values and needs of diverse at-risk populations. In addition to the implementation and assessment of integrated, tailored condom programming, priority actions include investing in leadership and coordination at country level to strengthen stewardship for a total market approach based on sustainable domestic funding and more efficient public sector supply and distribution. UNFPA also commits to accurate monitoring and programme intelligence about where the main challenges lie; and persuading commercial actors to play a more prominent role in ensuring the sustainability of programmes. Support for social marketing organizations is key to achieving a total market approach, as is strengthening ‘last mile’ condom distribution to multiple community-appropriate outlets, with robust forecasting and assurance against stock-outs. To this end, the UNFPA also supports investments in gathering market data and the capacity to use data effectively to better address the barriers to condoms – including cultural and religious barriers – by taking a rights-based approach.

FURTHER UNFPA COMMITMENTS FOR HIV PREVENTION

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. 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.

Adult women aged 15 and above accounted for 60 per cent of new adult infections in ESA in 2019. While the focus on prevention has thus far been on young women (aged 15-24), UNFPA is advocating for more evidence to make the case for inclusion of adult women in the priority pillars for HIV prevention. In addition to promoting the use of female condoms as a prevention tool, UNFPA aims to advocate for increased investment in SRHR information and services; the provision of technical support to strengthen integration of HIV and SRHR for women; the reinvigoration of prong 1 and 2 of the PMTCT/
EMTCT strategy; technical support for laws, policies and programmes that address gender-based violence and intimate partner violence; and support for the effective involvement of men in SRHR issues, including family planning, antenatal and PMTCT services.

**People with disabilities** across all populations are particularly vulnerable, with girls and young women with disabilities ten times more likely to experience SGBV than those without disabilities, thus significantly increasing their risk of contracting HIV and other STIs.³ To this end UNFPA advocates 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), including advocating for better, more accessible facilities staffed by sufficiently knowledgeable and empathetic personnel, while actively discrediting the myth that people with disabilities have no need for CSE or SRHR.

Given that **integrated services** are key to successful combination prevention strategies, priority actions include: advocating for an enabling legal and policy environment that supports the integration of services and coordination at different levels across sectors; fostering a collaborative approach that includes all stakeholders; emphasizes critical linkages; and provides

³ UNFPA (2018) Young Persons with Disability: Global study on ending gender-based violence, and realising sexual and reproductive health and rights.
technical support for the development and costing of national SRHR, HIV and SGBV integration plans. Other priority support areas include training health care providers to be sensitive to the needs of diverse key and vulnerable populations and supporting integrated SRHR and other relevant services within the provisions for PrEP, VMMC and other specialized HIV services and treatment, including tuberculosis and malaria.

UNFPA also has a pivotal role to play in the inter-agency strategy to assist all people, and especially key populations, in humanitarian settings. In addition to contributing to the understanding of how countries can transition from crisis to peace and development, UNFPA undertakes to 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 workers. Also, UNFPA undertakes to provide support to reach women, girls and young people with HIV prevention integrated with life-saving SRH and SGBV services and information; and improving logistics efficiencies in crisis settings.

MONITORING

Robust monitoring and quality assurance are 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. The Framework will therefore 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 measure progress against specified core indicators, including inputs to the GPC HIV prevention monitoring and tracking tools.

CONCLUSION

The successes in some countries facing the heaviest epidemic burden inspire hope that HIV prevention is possible with the right combination of coordinated and layered approaches, and with sufficient multi-sectoral effort and resources. UNFPA is fully committed, through its new Framework for action in ESA and through consolidated partnerships, to contribute effectively to ending new HIV infections in the region by promoting collaborative, transparent and innovative solutions to programme gaps.
Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person’s potential is fulfilled.