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UBRAF thematic report: reducing sexual transmission

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Results

Working towards zero new infections, the UN set a 2015 target to halve sexual transmission of HIV, including among young people, men who have sex with men (MSM), and for transmission in the context of sex work. New infections, however, remain high among MSM and female sex workers, who, respectively, are 19 and 14 times more likely to be living with HIV than the general population. While prevalence among young people is generally declining, young people aged 15–24 still account for 35% of new infections in people aged 15 and older. This report provides an overview of achievements in 2012 and 2013 in three areas: young people, key populations, and combination prevention. Further elaboration can be found under other thematic areas.

1) Young people

UNAIDS provided new guidelines and evidence to reduce sexual transmission among youth. WHO provides recommendations for HIV testing, counselling and care services for adolescents. UNICEF modelled the impact and cost of implementing the HIV investment approach on adolescents. Findings from this undertaking showed two million new infections could be averted by 2020 by scaling up high-impact interventions, empowering youth-led organizations, addressing legislation and policy to enable delivery, and reducing the vulnerability of adolescents. The World Bank provided new evidence on the impact of cash transfers in HIV prevention for young people.

UNAIDS prioritized the improvement of sexual education and services for young people. UNESCO contributed to scaling up sexuality education in more than 75 countries, with 102 UNFPA country offices in 2013 also supporting comprehensive sexuality education. For example, in Ukraine, UNFPA supported the roll-out in eight regions of the 'Grow healthy' curriculum, which includes education for adolescents on preventing HIV and sexually transmitted infections (STI). UNESCO, with the UNAIDS Secretariat, UNFPA and WHO, advocated for stronger political commitment, resulting in the Eastern and Southern Africa ministerial commitment to comprehensive sexuality education and sexual and reproductive health (SRH) services for adolescents and young people.

2) Key populations

UNAIDS provided global leadership to reduce sexual transmission among key populations. The *Guidelines on HIV and STI prevention and treatment for sex workers*, and the accompanying *Sex worker implementation tool*, provide direction on how to effectively respond to the HIV epidemic among sex workers. Much work also focused on strengthening evidence. The World Bank, with UNFPA and UNDP, published two important studies, *The global HIV epidemics among sex workers* and *The global epidemics of HIV in men who have sex with men*, which highlight the efficiency of investing in reducing sexual transmission in key populations.

UNAIDS implemented innovative programmes to reduce sexual transmission among key populations. The International Labour Organization (ILO), with the Southern African Development Community (SADC) and the UNAIDS Secretariat, supported the implementation of an Economic Empowerment and HIV Vulnerability Programme along transport corridors in Malawi, Mozambique, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe, targeting young women from key populations. Preliminary findings show a strong correlation between economic empowerment and risk reduction, with a reported decrease in concurrent partnerships from 15% to 7% (women), and a 14% decrease in women reporting selling sex. The World Bank assisted the Nigerian Government in strengthening its female sex worker programme, including a mapping exercise involving more than

160 000 female sex workers. UNDP and UNFPA strengthened the capacity of key population organizations, including the Global Network of Sex Work Projects, the MSM Global Forum, the International Network of People who Use Drugs and transgender representatives, enabling them to engage in HIV policy dialogue, such as the sex worker guidelines described above. Recognizing the greater HIV burden in urban areas, UNDP and UNFPA supported 26 cities covering five regions to develop innovative municipal HIV action plans addressing the needs of key populations. These plans led to improved health service delivery, action to address stigma and discrimination and the establishment of more favourable legal frameworks.

3) Combination prevention and prevention technologies

Male and female condoms remain the most effective tool to stop HIV transmission. In 2012 and 2013, UNFPA was the largest supplier of female condoms (41 million) and the third largest of male condoms (1.75 billion). UNFPA helped countries manage the supply and build demand for condoms. Through the CONDOMIZE! campaign (allaboutcondoms.org, thecondomizecampaign.org), UNFPA advocated for increased condom access and demand, with a strong focus on community development, stressing the need to reprioritize condom use in HIV programming. Following the 17th International Conference on AIDS and STIs in Africa (ICASA 2013), five African countries requested support via CONDOMIZE!

The UN Commission on Life-Saving Commodities identified eight priority countries for female condoms and key actions to scale up male and female condoms. Country plans and a strategy to generate female condom demand were developed. In 2012, WHO pre-approved the Cupid female condom, which was subsequently included in the UNFPA procurement. In 2013, two new female condom products were considered for review by the WHO/UNFPA female condom technical review committee.

In 2012 and 2013, there was significant progress in scaling up voluntary male medical circumcision (VMMC); in Kenya, 116 311 VMMCs were performed in 2012 alone. WHO provided technical leadership, including guidelines for using devices, such as Prepex (prequalified in 2013), to safely scale up VMMC. World Bank efficiency studies in several countries estimated the potential cost and impact of scaling up VMMC. In Malawi, the World Bank directly funds VMMC services for adults and newborns, which will advance the country a quarter of the way towards its goal of 2.1 million adult VMMCs over five years.

WHO provided guidance on pre-exposure prophylaxis for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV. The WHO-UNAIDS HIV Vaccine Advisory Committee and the HIV Vaccine Advisory Committee (VAC) provided advice to WHO and UNAIDS to facilitate the development, evaluation and future access to HIV vaccines; it focused on developing an ethical framework for designing vaccine trials using antiretroviral drugs.

The ILO, with support from UNAIDS, launched the VCT@WORK Initiative, reaching out to workers with messages on prevention, stigma and discrimination. The objective of the initiative is to have five million workers uptake voluntary HIV counselling and testing by 2015. UN Cares reduced the impact of HIV on UN staff by supporting universal access to HIV benefits and services.

Constraints and challenges, and lessons learned

Reducing sexual transmission of HIV by 50% by 2015 requires a concerted effort to reach more key populations and young people with evidence-informed interventions. Stigma and discriminatory behaviours, particularly by healthcare service providers and law enforcement officials, remain significant barriers. Such barriers in accessing HIV and sexual and reproductive health services, including life-saving commodities, expose sexually active young people and key populations to increased HIV risk.

Legal environments in some countries hamper efforts to address the HIV prevention and health education needs of key populations, especially those countries with punitive laws on homosexuality, sex work, drug use and the age of consent.

The lack of focus on condom and lubricant programming as the centrepiece of HIV prevention continues to fuel the HIV epidemic for all populations, especially key populations. Condom accessibility remains a constant challenge in sub-Saharan African. In 2012, about 1.7 billion male condoms and 25 million female condoms were donated to the region, representing an annual supply of eight for every man aged 15–49, and one female condom for every eight women of reproductive health aged (15–49). Few countries budget to purchase condoms.

Limitations in the availability and quality of routine data on HIV incidence and mode of transmission pose a challenge in research. Despite recent improvements, the availability of rigorously gathered longitudinal data remains limited in many countries and regions. A better understanding and appreciation is required of the lives and needs of adolescents who engage in behaviours that put them at high risk of HIV.

HIV and comprehensive sexuality education is a necessary, long-term investment. A more careful analysis of the education sector's contribution to the epidemic response is needed in order to make the case for such investments. Any intervention in the education sector that is expected to reach thousands of schools, teachers and learners requires significant resources, but difficulties remain: in negotiating space for sexuality education in already overloaded curricula, for example, or in securing the necessary political, policy and community support.

VMMC has high HIV prevention potential, and one-off incentives may achieve critical uptake by men. To help scale up VMMC, the experience of implementing services must be documented and disseminated for cross-country learning. Countries need to understand the predicted VMMC impact on HIV prevention will materialize only if they are vigilant in meeting coverage targets.

Although at least five million VMMCs had been performed in 14 eastern and southern African countries by the end of 2013, the pace is too slow to reach targets of 80%. Improved leadership is required at national and subnational levels to overcome weak coordination and sometimes erratic donor funding. Gender and cultural barriers inhibit demand and a supportive environment, while capacity at management and service-delivery levels remains limited.

Key future interventions

1. Scaling up HIV service models, which improve reach and coverage of key populations, with proven high-impact interventions, including the sex work implementation tool.
2. Continue to help countries decide how to allocate HIV programme resources, consistent with the information available on key populations in their national epidemics.

3. Continue to provide evidence on the effectiveness of key population interventions.
4. Technical guidance and support to countries and the Global Fund in co-financing and structural approaches, including social protection initiatives.
5. Continued support to all regions for scale-up, curriculum review and teacher training, with closer attention to adolescent pregnancy, emphasizing girls' rights to return to school.
6. Continue to assist the scale-up of VMCC by prioritizing the allocation of resources by countries and strengthening monitoring and evaluation.
7. Develop implementation tools (similar to the sex work and HIV implementation tool, or SWIT) for men who have sex with men, transgender people and people who use drugs.
8. Further develop guidance and technical briefs for adolescent/under 18 key populations.
9. Strengthen the roll-out of the Urban Health and Justice Initiative.
10. Scale up advocacy for increased condom availability from domestic funding, resources for market research, and segmentation and demand-generation strategies to increase condom use.
11. Reinvigorate HIV and condom campaigns, including CONDOMIZE!, to raise HIV awareness and educate through entertainment by involving national champions and celebrities.

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