

2020 Global HIV Policy Report:

Policy Barriers to HIV Progress

HIV Policy Lab



Introduction

Nearly forty years since the discovery and isolation of the human immunodeficiency virus (HIV), the science of HIV has never been better. Today, we have a better understanding of how the virus functions and how to test, treat, and prevent HIV infection. We have clear evidence on the biomedical, social, and structural drivers of new HIV infections and deaths, and new tools to halt them. Antiretroviral medicines (ARVs), for example, are available to save lives and to stop transmission—with new long-acting injectable forms shown just this month to be effective prevention for women.¹ We have clear evidence that differentiating delivery of HIV service delivery to meet the needs of people works, that self-testing helps reach populations poorly served by other methods, that healthcare user fees push people out of HIV care, that criminalization of key populations undermines access and drives HIV, and much more.²

Yet the translation of science into law and policy remains a drag on the AIDS response. Despite rapid scientific advances, the world will not achieve the 2020 global HIV goals. This reality stems from progress that is highly unequal. As shown in the UNAIDS 2020 Evidence Review, some countries and communities are seeing real success while others see little.³ Some countries have made remarkable use of HIV science—14 countries from throughout the world had attained the global target of at least 73% of all people living with HIV achieving viral suppression by 2019. AIDS deaths were cut in half in eastern and southern Africa. Others see growing epidemics and are far off track. New HIV infections have increased by 72% in Eastern Europe and Central Asia, 22% in the Middle East and North Africa and 21% in Latin America. Differences between countries are stark. While most in Eastern and Southern Africa have seen remarkable progress, in Madagascar and South Sudan less than half of people living with HIV know their status. In Angola a majority of people who know they are living with HIV are not accessing treatment. Viral load suppression levels in the United States are much lower than in the rest of the Western and Central Europe and North America region. The AIDS-related mortality rate in Haiti, a low-income country, declined by 52% between 2010 and 2019 and is now lower than that of Jamaica, an upper middle-income country where AIDS-related mortality increased by 7% over the same period. Stark differences exist, too, in populations within countries. Compared to the general population, the risk of acquiring HIV is on average about 26

times higher for gay men and other men who have sex with men, 29 times higher for people who inject drugs, 30 times higher for sex workers, and 13 times higher for transgender people than for adults in the general public.

This can, at least in part, be explained by the significant gap that remains between science and law/policy in much of the world. Laws and policies drive who has access to the benefits of science, how people living with and affected by HIV are treated, how health systems are structured, and how officials engage with communities.

This report presents the state of HIV policy in 2020 from the HIV Policy Lab—a collaborative project of academic, civil society, and multilateral organizations—which compiles and measures the HIV-related policy environment in countries around the world. Overall it shows that policy barriers exist throughout the world that undermine the quality of HIV treatment and prevention, undermine access to HIV treatment and prevention, and increase the vulnerability to HIV infection and AIDS death.

This report shows that:

- No country in the world has fully aligned its laws and policies with the best HIV science and core international recommendations. In fact, across all 194 UN member states, the median country has aligned just over half of policies tracked with international standards.
- On the whole, the regions and countries making the most progress have adopted many or most of the laws and policies recommended by evidence and international normative bodies. Every country, however, has laws and policies that would need to be updated to align with international recommendations.
- Many of those countries and regions that are furthest off track—those facing growing epidemics and rising death rates—have the fewest policies that align with current evidence.
- Many countries have not yet fully adopted up-to-date policies on some of the most critical new interventions, including differentiated service delivery and PrEP.

- Every country in the world has at least one law criminalizing same-sex sexual relations, sex work, drug use, or HIV exposure/transmission, often all four, despite evidence that criminalization is counterproductive.
- Countries are inconsistent in adopting recommended policies—the majority of countries do well in some policy categories but worse in others.
- The regions with the highest rates of policy adoption are Eastern and Southern Africa and Western and Central Europe and North America. The country with the highest rate of policy adoption is South Africa.
- In general, policy recommendations related to HIV clinical care and treatment are adopted at a much higher rate than policies related to testing and prevention, structural barriers, or health systems factors. Even so, quite a few countries still lag behind in adopting key clinical/treatment policies, including updating HIV treatment guidelines to include the latest first-line ART regimens.

In this report, readers will find data and analysis on the law and policy environment in each region of the world and every UN member state. 33 different specific laws and policies are tracked across countries, with the most up-to-date information publicly available. Rather than some unattainably high standard, these 33 indicators represent minimum policies that have been recommended by internationally-recognized normative authorities including WHO, UNAIDS, UNDP, the Global Commission on HIV and the Law, and others based on current science and evidence. It would be reasonable, therefore, to hope that governments would align on all 33 of these indicators, at minimum—even as these indicators are only a starting point and do not capture every policy that would ideally be needed for an optimal response.

This report presents country alignment in multiple ways. An overall evaluation of the country's laws and policies is shown for each country in Section 5, allowing countries to be compared on a scale from those that have adopted few to those that have adopted most of these policies. The 33 laws/policies are also grouped into four policy categories, showing the areas of policy where countries are most aligned and where they are least. Together with the answers for each specific policy question, these can provide a road map for public health officials, governments, civil society, and funders to prioritize law and policy changes to improve the AIDS response.

Policy is the indispensable mechanism by which governments bring effective, evidence-based interventions to scale to benefit all. That laws and policies do in fact affect

health outcomes in general, and HIV outcomes in particular, has been demonstrated by scholars analyzing the “legal determinants of health”—for example, showing that eliminating parental consent policies is linked to increased rates of HIV testing, countries with a constitutional right to health have better health outcomes, and that countries not criminalizing sex work have significantly lower HIV prevalence among sex workers.⁴ Today there are multiple mechanisms in place to disseminate science-based policy recommendations and support their adoption by national governments via technical guidance and fund implementation through UNAIDS, the World Health Organization (WHO), UNAIDS, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the US President's Emergency Plan for AIDS Relief (PEPFAR), etc.⁵

It would be tempting to think that, several decades into a truly global AIDS response, most countries have aligned their laws and policies with current science and evidence, and that the quality of implementation is what explains differences between countries. Data from the HIV Policy Lab shows this is not the case—that policy- and law-reform remain an essential task of the global AIDS response. Data also shows that countries have much to learn from each other.

Achieving an end to AIDS as a public health threat—the global goal set for 2030 by the UN General Assembly—will require more than good science and scaled up programs. It will require laws and policy aligned with that science. In 2020, the clear message from the HIV Policy Lab data is that there is much work to do to put us on that path.

About the Policy Lab

The HIV Policy Lab is a unique collaboration between academic, United Nations, and civil society organizations to track, measure, and improve the HIV-related law and policy environment in countries around the world. The HIV Policy Lab research and accountability platform systematically identifies and visualizes policies adopted by countries around the world and how those align with international norms. It is an open, living global public resource that draws information from legal documents, government reporting, and independent analyses to create data that can be compared across countries and across issues. The HIV Policy Lab seeks not just to document, but to improve the policy environment by partnering with governments, public health officials, financing agencies, and civil society groups to support learning across countries and science-based policy change. The Policy Lab also provides researchers with cross-national data on policies so we can learn more about the impacts and drivers of policy choices—recognizing that what works in a research setting might not work when taken to scale through policy-making. HIV-related laws and policies can have life and death consequences. We need to measure them, evaluate them, and change them to meet the evolving context on the path towards ending the global AIDS pandemic.

The HIV Policy Lab is produced by Georgetown University's O'Neill Institute and NHS Department of International Health with Talus Analytics, in partnership with UNAIDS, the Global Network of People Living with HIV, and a growing set of partners around the world, and with support from the PEPFAR.

At the HIV Policy Lab's online platform, users will find not only summaries and visualizations across 33 different policies, but also a growing reference library of policy documents. Users are invited to help update the database by sharing law and policy information with our team of analysts to help keep the site up to date.

**View the full HIV
Policy Lab platform at
hivpolicylab.org**

Methodology

The HIV Policy Lab includes a dataset, index, reference library, and research/accountability platform that rigorously tracks HIV-related law and policy in 194 countries. The dataset quantitatively represents the HIV-related law and policy environment in a given country for multiple years, enabling governments, civil society, funding agencies, and researchers to compare countries.

We draw on methods from policy surveillance—the systematic, scientific collection and analysis of laws of public health significance over time^{6,7}—and from comparative political and social science. The full methodology is described online at www.hivpolicylab.org/methods and in an article in *BMJ Global Health*.⁸

Fig. 1.1.

Policy indicators tracked by the HIV Policy lab, by policy category

POLICY CATEGORIES				
	Clinical/Treatment	Testing & Prevention	Structural	Health Systems
POLICY INDICATORS	Treatment Initiation	Self-testing	Same-sex sex non-criminalization	Task shifting
	Same-day treatment start	Partner notification/index testing	Sex work non-criminalization	Healthcare financing
	Treatment regimen	Compulsory testing	Drug use non-criminalization	Universal health coverage
	Differentiated service delivery	Age restrictions on testing and treatment	HIV exposure non-criminalization	User fees
	Viral load testing	PrEP	Non-discrimination protections	Access to medicines (TRIPS)
	Pediatric diagnosis and treatment	Harm reduction	National human rights institutions	Unique identifiers w/ data protections
	Migrant access to healthcare	Comprehensive sexuality education	Constitutional right to health	Data sharing
	Tuberculosis diagnosis	Prisoners prevention	Girls education	
			Gender-based violence	
		Civil society		

Indicators

The HIV Policy Lab rigorously tracks adoption of 33 key HIV-related laws and policy indicators. Sixteen of these policies are comprised of two or more sub-policies, for a total of 50 policies being tracked. These indicators are grouped into four categories: treatment, testing and prevention, structural barriers, and health systems factors.

HIV Policy Lab indicators were chosen after an extensive year-long global process that included review of international normative guidance and agreements along with a series of subject-specific, cross-sectoral focus groups and consultations with national policymakers, clinicians, researchers in social and biomedical science, international organizations, financing agencies, communities of people living with HIV, and other civil society groups. The HIV-related policy environment is made up of hundreds of specific policies—those chosen are intended as indicators representing this broader policy context. For each of the indicators, a coding schema was developed to translate information about the content of the laws and policies into data. A full list of scoring criteria for each indicator is available from the HIV Policy Lab codebook at www.hivpolicylab.org/codebook

Data Collection

Each observation in the HIV Policy Lab database represents the policy in a given country that corresponds to the indicator. The sources for every observation are publicly available and cited in the online database. We gather this data on national policies via several approaches. We collect a large number of primary sources and code the text of laws and policies, which are available in our reference library. Data also comes from formal reporting by governments to UNAIDS and the World Health Organization through the Global AIDS Monitoring framework.⁹ Information about policies is reported through the National Commitments and Policy Instrument (NCPI) and validated by UNAIDS and WHO. In addition, we conducted a meta-analysis of other published sources of information about policies in the public sphere including United Nations, NGO, and academic sources. A full list of sources is online. By collecting and coding data from multiple sources we are able to triangulate information, include the most up-to-date data available, and allow for a broader scope of analysis. A wide range of partners provided data for this report. You can find a full set of sources from NGO, government, and UN partners at <https://www.hivpolicylab.org/sources>

Fig. 1.2

HIV Policy Lab Policy Adoption Scoring System

Score	% of recommended policies adopted
VERY FEW	0—19%
FEW	20—39%
SOME	40—59%
MANY	60—79%
MOST	80—100%

Coding

Each policy is benchmarked against international normative instruments to enable us to interpret our code based on whether a policy is “adopted.” These benchmarks include guidance from UNAIDS, the World Health Organization, and international rights agreements. A full set of benchmarks is available in the full PDF download of the online codebook. For each policy area and overall, each country receives a HIV Policy Lab summary score. For all indicators for which there are data, the total of adopted (1) and partially adopted (0.5) is divided by the total number of indicators scored. Where data are missing for a given indicator, the numerator is reduced so that we are only scoring a country based on existing data.

This scoring metric assigns a categorical label based on the quantitative score to convey the degree to which countries’ policies are aligned with global norms, overall and in each of the four policy categories. We represent the degree of policy adoption using a five-level scale: *Very Few* indicates less than 20% of recommended policies have been adopted; *Few* indicates that 20-39% of recommended policies have been adopted; *Some* indicates that 40-59% of recommended policies have been adopted; *Many* indicates that 60-79% of recommended policies have been adopted; and *Most* indicates that 80% or more of recommended policies have been adopted. This same scale is used for regional policy adoption scores, which represent the average of the policy adoption scores for countries in that region.

Comparing National Policy Environments

The HIV Policy Lab collects information on national HIV-related laws and policies and codes whether, in a given year, a country has adopted each of 33 different policies that align with international standards set out by the World Health Organization, UNAIDS, international treaties and other international authorities. These are not aspirational, but instead represent a minimum floor for aligning policy with science. A policy environment based on the best evidence for an effective AIDS response would adopt all of these laws and policies and more. Section X of this report contains data on the policies of each UN member state, detailing whether the country has adopted, or partially adopted, these international standards on each specific policy.

The figures on the following pages summarize national HIV law and policy environments for each country—allowing for comparison of countries and regions. The “overall” bar in each figure shows the portion of these 33 policies that each country has adopted—placing them from the left hand side of our figures, representing environments where the none of these policies have been adopted, to the right where all have been. In addition national policy environments are shown for each of four policy categories—illustrating the reality that most countries have aligned a greater portion of policies in some areas than others. Figure 2.1 below shows a global summary of averages by region, with countries broken out on the pages that follow.

Fig. 2.1

Comparing the HIV policy environments across UNAIDS regions: Regional average policy adoption scores

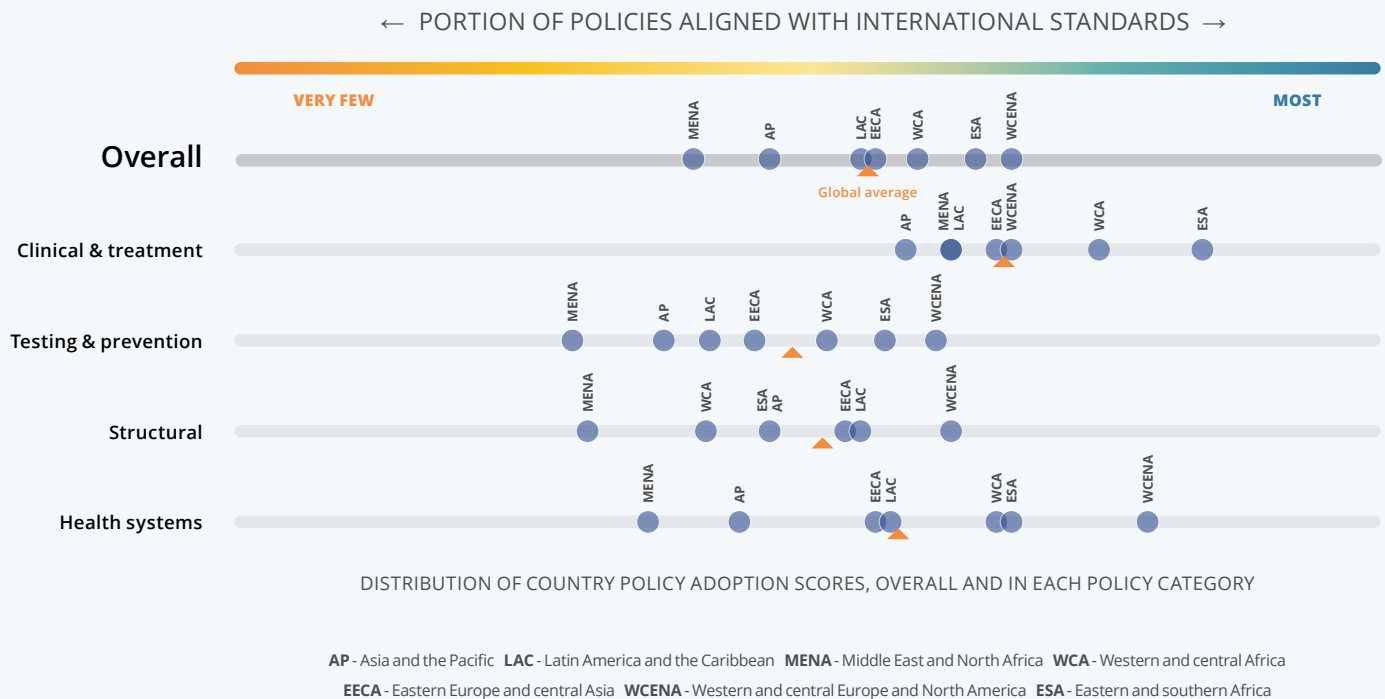


Figure 2.2

Comparing national HIV policy environments Asia and the Pacific region

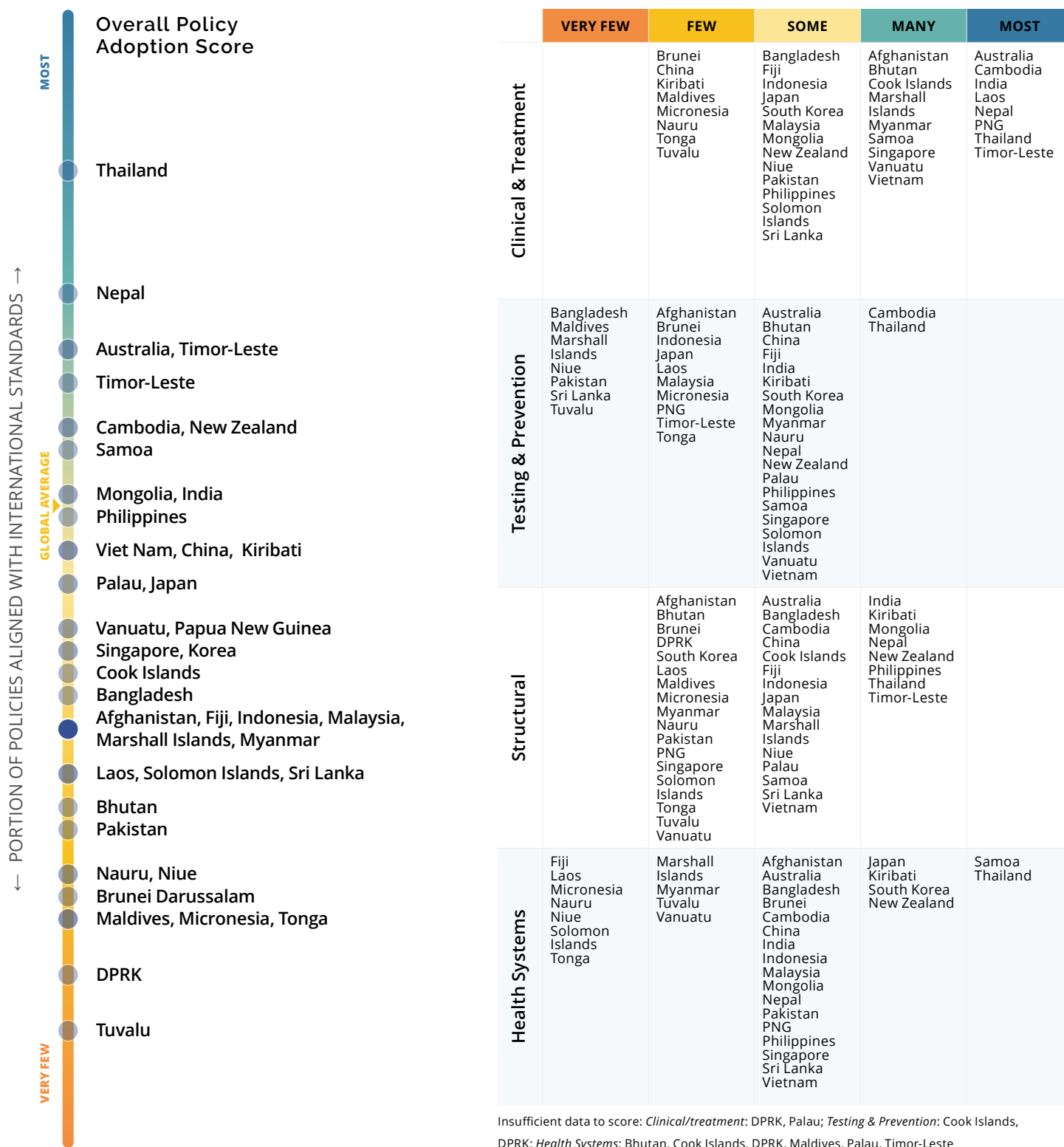


Figure 2.3

Comparing national HIV policy environments Eastern Europe and central Asia

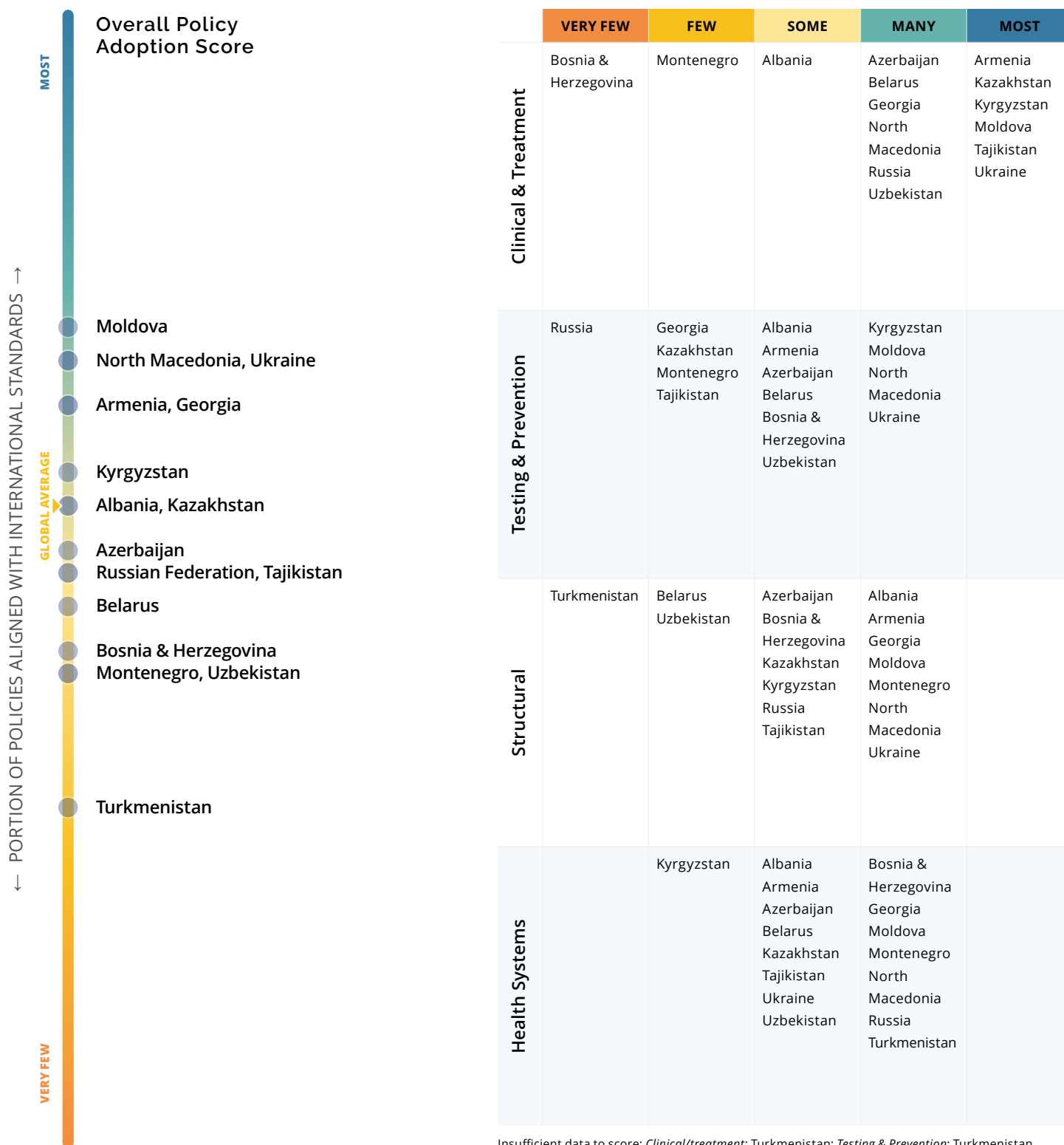


Figure 2.4

Comparing national HIV policy environments Eastern and Southern Africa

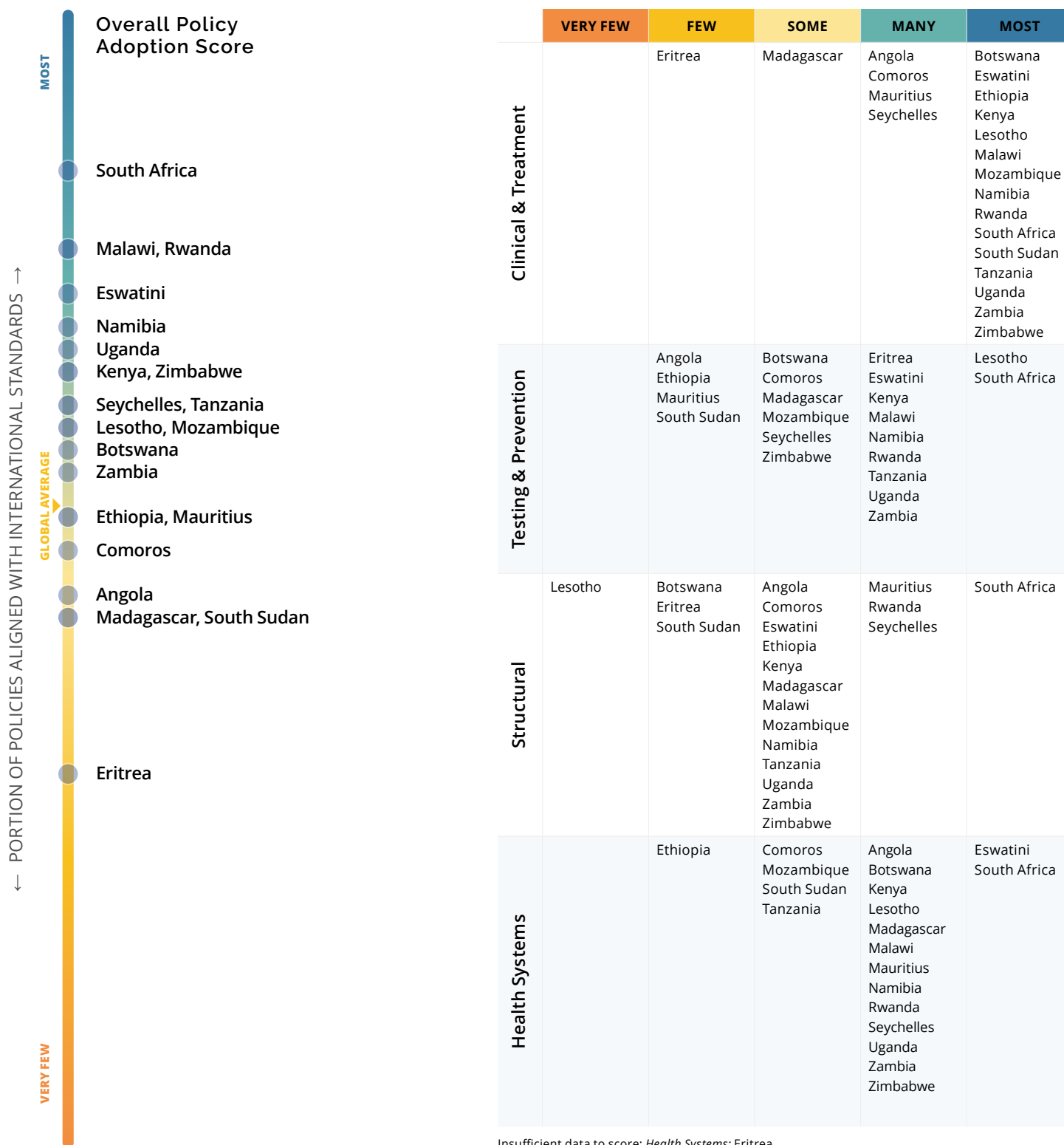


Figure 2.5

Comparing national HIV policy environments Latin America and the Caribbean

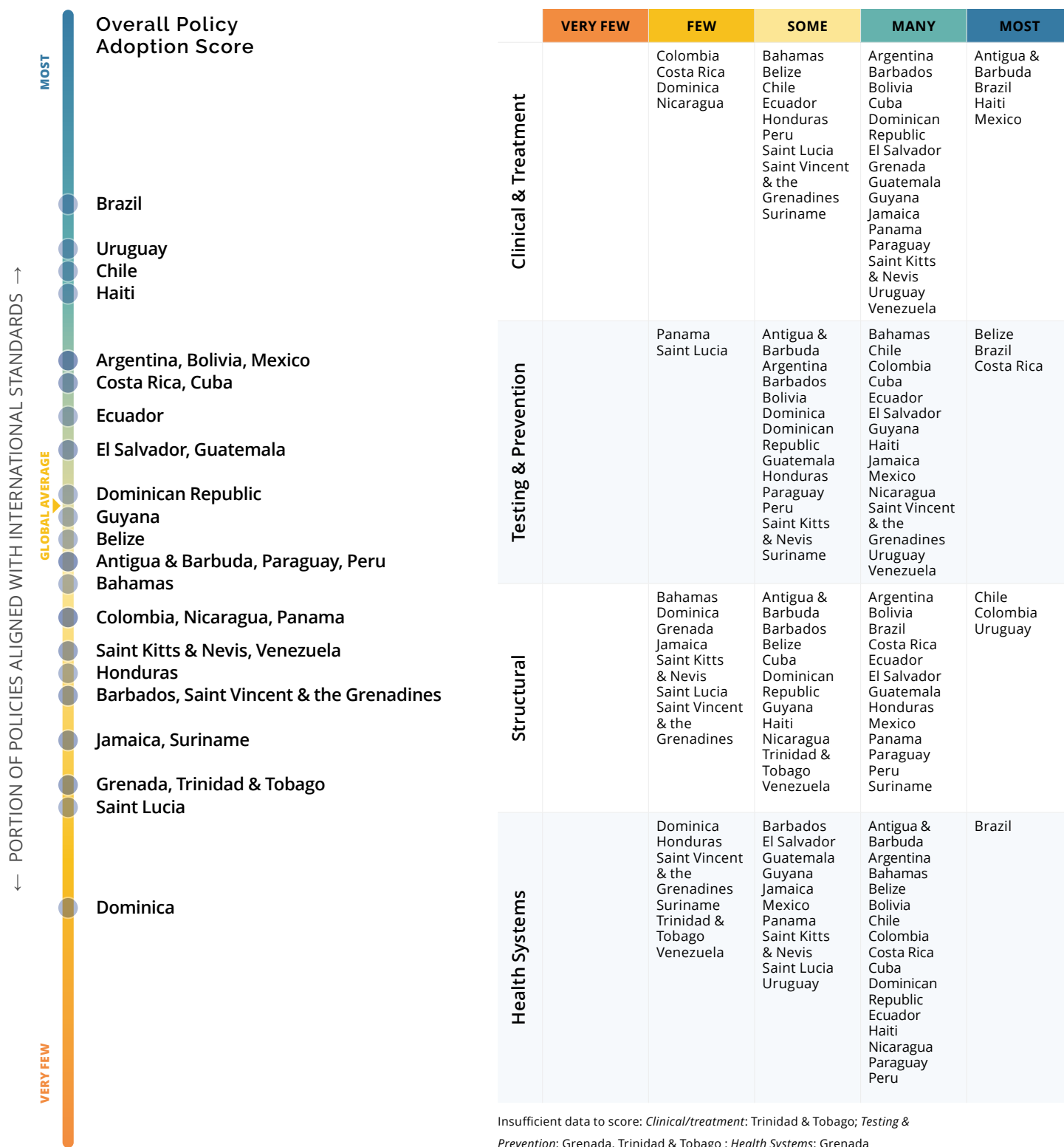


Figure 2.6

Comparing national HIV policy environments Middle East and North Africa

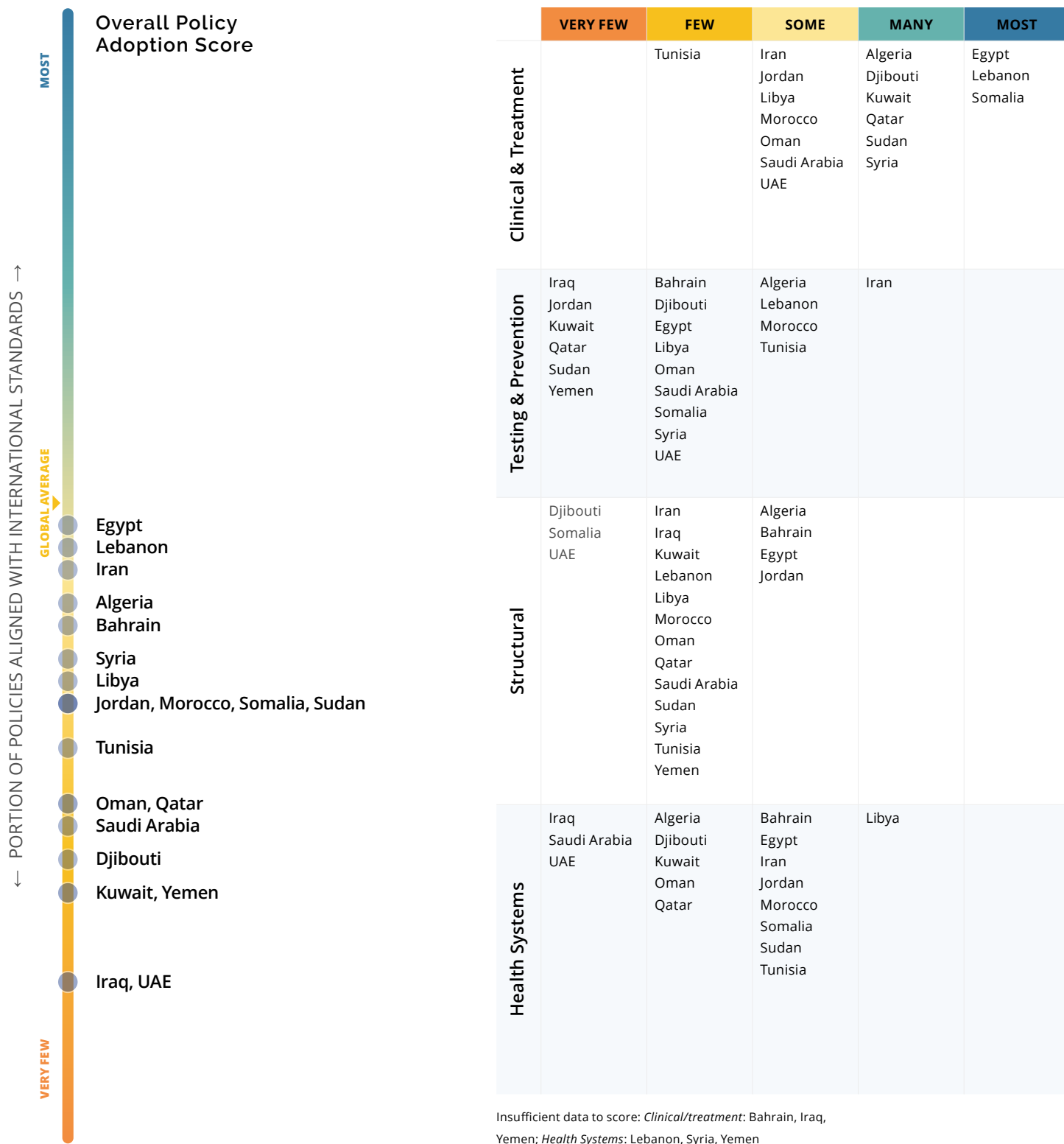
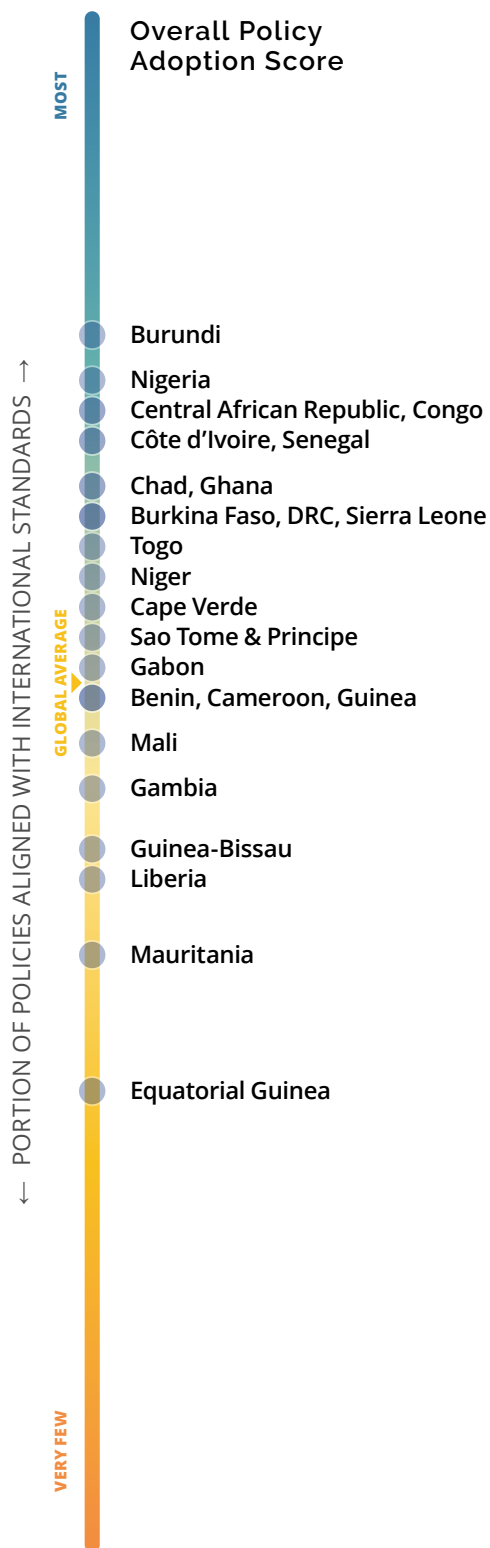


Figure 2.7

Comparing national HIV policy environments Western and central Africa

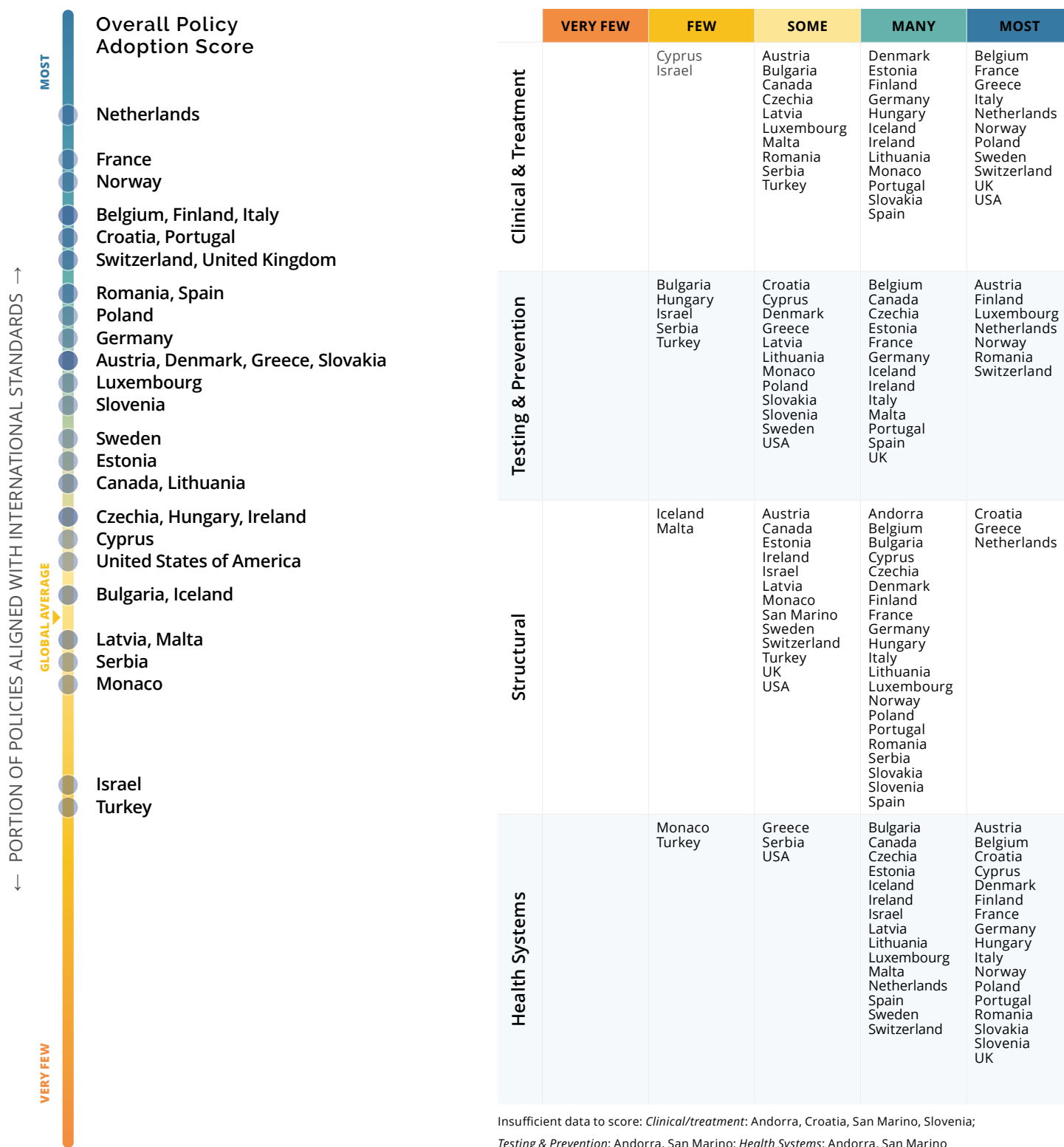


	VERY FEW	FEW	SOME	MANY	MOST
Clinical & Treatment			Cape Verde Equatorial Guinea Guinea Bissau Mauritania Sao Tome & Principe	Benin Cote d'Ivoire Ghana Guinea Mali Niger Senegal Togo	Burkina Faso Burundi Cameroon CAR Chad Congo DRC Gabon Gambia Liberia Sierra Leone
Testing & Prevention	Equatorial Guinea	Gabon Gambia Guinea Bissau Liberia Mauritania	Benin Burkina Faso Cameroon CAR Chad Cote d'Ivoire Ghana Guinea Mali Niger Senegal Sierra Leone	Burundi Congo DRC Sao Tome & Principe Togo	Nigeria
Structural		Cameroon Equatorial Guinea Gabon Gambia Guinea Liberia Mauritania Nigeria	Benin Burkina Faso Burundi CAR Chad Congo Cote d'Ivoire DRC Ghana Guinea Bissau Mali Niger Senegal Sierra Leone Togo	Cape Verde Sao Tome & Principe	
Health Systems		Liberia	Cameroon DRC Mali Nigeria Sao Tome & Principe Sierra Leone	Benin Burkina Faso Burundi Cape Verde Chad Congo Cote d'Ivoire Equatorial Guinea Gambia Guinea Guinea Bissau Mauritania Niger Senegal Togo	CAR Gabon Ghana

Insufficient data to score: *Testing & Prevention*: Cape Verde

Figure 2.8

Comparing national HIV policy environments Western and central Europe and North America



Key Trends

No country has adopted all the recommended policies

We find that no country in the world has fully aligned its policy environment with international standards on all 33 indicators. In fact, across all 194 UN member states, the median country in the world has aligned just over half (55%) its policies with international standards.

No country except South Africa has even adopted at least 80% of international standards—categorized as “Most” in our system—in all four policy categories we track. Instead, both overall and in each of the four policy categories, alignment varies widely.

Table 2.1
Countries that have adopted “Most” recommended policies in each policy category

Clinical and Treatment (n=59)	Testing and Prevention (n=10)	Structural (n=7)	Health Systems (n=25)	Overall (n=4)
Antigua and Barbuda	Austria	Chile	Austria	France
Armenia	Finland	Colombia	Belgium	Netherlands
Australia	Lesotho	Croatia	Brazil	Norway
Belgium	Luxembourg	Greece	Central African Republic	South Africa
Botswana	Netherlands	Netherlands	Croatia	
Brazil	Nigeria	South Africa	Cyprus	
Burkina Faso	Norway	Uruguay	Denmark	
Burundi	Romania		Eswatini	
Cambodia	South Africa		Finland	
Cameroon	Switzerland		France	
Central African Republic			Gabon	
Chad			Germany	
Congo, Republic of			Ghana	
DRC			Hungary	
Egypt			Italy	
Eswatini			Norway	
Ethiopia			Poland	
France			Portugal	
Gabon			Romania	
Gambia			Samoa	
Greece			Slovakia	
Haiti			Slovenia	
India			South Africa	
Italy			Thailand	
Kazakhstan			United Kingdom	
Kenya				
Kyrgyzstan				
Laos				
Lebanon				
Lesotho				
Liberia				
Malawi				
Mexico				
Moldova				
Mozambique				
Namibia				
Nepal				
Netherlands				
Nigeria				
Norway				
Papua New Guinea				
Poland				
Rwanda				
Sierra Leone				
Somalia				
South Africa				
South Sudan				
Sweden				
Switzerland				
Tajikistan				
Tanzania				
Thailand				
Timor-Leste				
Uganda				
Ukraine				
United Kingdom				
United States of America				
Zambia				
Zimbabwe				

Note: “Most” indicates at least 80% policies overall and in each policy category

Eastern and Southern Africa and Western and Central Europe and North America lead the world in policy progress

But there is great variation across and within regions

Of the seven UNAIDS regions, Eastern and Southern Africa (ESA) and Western and Central Europe and North America (WCENA) stand out for their strong policy adoption. They are the only regions to achieve an overall regional policy adoption score of *Many* policies adopted. (The regional policy adoption score is the average of the policy adoption scores for countries in that region.) There is a notable gap in policy adoption between these two regions and a group of middle-performing regions: Western and Central Africa (WCA), Latin America and the Caribbean (LAC), and Eastern Europe and Central Asia (EECA). Meanwhile, two regions—Asia and Pacific (AP) and the Middle East and North Africa (MENA)—have regional policy adoption averages below the global average across the board.

Furthermore, there is significant variation in policy adoption across countries, even among countries within the same region. And in every region, for every policy category, there are outliers—countries that stand out from the pack for their high or low rates of policy adoption. For a full breakdown comparing policy adoption scores for countries within each region, see Appendix A.

Eastern and Southern Africa (ESA)

Overall, 67% of countries in ESA have adopted *Many* (at least 60%) or *Most* (at least 80%) of the 33 policies tracked by the policy lab (see Fig 2.3). When it comes to both Clinical/Treatment and Testing and Prevention policies, ESA has the highest level of adoption of recommended policies of any region in the world. In particular, fully 100% of countries in the region for which we have data have adopted the “Treat All” recommendation for treatment initiation; 95% have routine viral load testing; 90% have same-day treatment start and have eliminated user fees for HIV services; and 85% have task shifting. ESA also leads the world in adopting self-testing and in offering PrEP to eligible populations.

That said, there are still a number of areas where policies are not well aligned with international standards. Only 40% of ESA countries allow 6-month dispensing of ARVs. Though 85% of countries have adopted the WHO-recommended first-line treatment regimen for adults, only 70% have done so for children. This is especially problematic in a context in which UNAIDS reports that in 2019 “the percentage of children with a suppressed viral load was only 40% (compared to 66% among adults).”¹⁰

Moreover, though the majority of countries in the region have high rates of adoption of treatment and prevention policies, there are still significant barriers. One-third

of countries do not have PrEP policies aligned with WHO recommendations. Roughly two-thirds do not allow adolescents to access HIV testing and/or treatment without parental consent, though UNAIDS continues to warn ESA countries of the need to increase testing among adolescents.¹¹ Even as countries in this region are rapidly scaling up index testing/partner notification strategies, more than 60% of countries have not put in place strong measures to protect the safety and confidentiality of PLHIV during the partner notification process. Fewer than half the countries have incorporated harm reduction into their national strategies. And ESA has one of the lowest rates of adoption of HIV prevention policies in for prisoners (condoms and needle/syringe exchange programs).

Finally, countries in ESA have the lowest levels of policy alignment with global guidelines in the Structural category—which includes issues of criminalization, gender, rights, and civil society. UNAIDS reports that roughly one quarter of new infections in ESA are among key populations and their sexual partners, “a reminder of the need for conducive laws and policies.”¹² Yet two-thirds of countries continue to criminalize same-sex sexual relations—making ESA the region among the least likely to align these policies with international recommendations, second only to MENA.

Western and Central Europe and North America (WCENA)

WCENA region has the highest average policy adoption score overall, but here too, there is room for improvement (see Fig 2.7). 64% of countries in the region have adopted *Many* of 33 policies, but that still reflects less than 80% adoption, while only 8% have adopted *Most* policies. Moreover, WCENA’s overall policy progress masks critical policy barriers that are still in place. For example, consistent with UNAIDS’ warnings about lack of access to HIV services for undocumented migrants,¹³ only 54% of WCENA countries allow all migrants, regardless of their immigration status, to access HIV services on par with citizens. Further, only 25% make primary healthcare available to all migrants under the same conditions as citizens. Nine countries in the region have not updated their treatment guidelines to include the latest WHO-recommended first-line regimen for adults, and 12 countries have not done so for children. Only 30% of countries allow task shifting. And while UNAIDS warns about the growing number of infections among young MSM,¹⁴ 72% of WCENA countries create obstacles to adolescents accessing HIV testing and/or treatment with policies requiring parental consent.

Western and Central Africa (WCA)

Overall, 40% of WCA countries have adopted *Many* or *Most* of the 33 recommended policies. (see Fig 2.6). The region’s average policy adoption score exceeds the global

average overall and in three of the four policy categories, with Structural policies as the exception. When it comes to Health System policies, WCA has a higher level of policy adoption than any other region apart from WCENA. In particular, all WCA countries for which we have data have allowed task shifting, more frequent adoption than any other region on this policy. It also has the highest rates of adoption for policies banning compulsory HIV testing and discrimination on the basis of HIV status.

However, substantial policy barriers remain, including in critical health system, testing, and prevention policies. For example, while only 20% of countries in WCA impose point-of-service user fees for HIV services, a full 63% impose fees for primary healthcare—which often drives PLHIV away from care. Only 9% of countries allow adolescents to access HIV testing and/or treatment without parental consent, only 25% make PrEP available to all populations at substantial risk, and only 36% include harm reduction in their national strategies.

When it comes to Structural policies, WCA's regional average policy adoption score just barely crosses the 40% mark, and a meager 8% of countries in the region have adopted *Many* or *Most* Structural policies. UNAIDS notes that key populations must “contend with hostile legal and social environments.”¹⁵ Though most countries have policies protecting people from discrimination on the basis of HIV status, only 4 countries protect people from discrimination on the basis of gender identity, and only 1 (Cape Verde) protects people on the basis of sexual orientation. 48% of countries criminalize same-sex sexual relations.

Latin America & the Caribbean (LAC)

Only 30% of countries in LAC have adopted *Many* or *Most* of the 33 recommended policies, indicating that substantial policy progress is needed (see Fig 2.4). As with most other regions, LAC countries Clinical/Treatment policies show the highest level of alignment with international recommendations, though the regional average is below the global average. Another relative bright spot is that LAC countries are more likely than much of the world to adopt Structural policies. In fact, this is only policy category in which LAC's regional average score is above the global average. The region as a whole has also made strong progress in ensuring sustainable financing for health systems. More than three-quarters of countries meet recommended benchmarks for public health system financing. Additionally, at least 20 countries have eliminated user fees for primary healthcare and HIV services, respectively.

In contrast, the region is most in need of improvement in Testing and Prevention, where the regional average policy adoption score is furthest below the global average. In particular, only 12% of countries allow HIV self-testing, only 22% allow adolescents to access testing and/or treatment

without parental consent, and only 20% of countries make PrEP available to eligible populations.

Eastern Europe and Central Asia (EECA)

EECA is one of only three regions where the HIV epidemic is growing and has a higher incidence-to-prevalence ratio than any other region. (see Fig 2.2). This makes the region's lag in adopting recommended Testing and Prevention policies all the more critical—only 9% of countries have adopted *Many* or *Most* recommended policies. In particular, none of the 13 countries allow adolescents to access testing and/or treatment without parental consent. On the other hand, 77% of countries still permit compulsory testing—the highest in the world. And though UNAIDS has called on EECA countries to increase access to HIV self-testing and PrEP,¹⁶ only two-thirds of the countries allow the former and less than one-third have PrEP policies aligned with WHO guidance.

Since 48% of new infections in the region are among people who inject drugs,¹⁷ it is an important sign of progress that 75% of countries incorporate harm reduction into their strategic plans and do not criminalize syringe possession. However, only 25% of countries make needle/syringe programs available in prisons and, like other regions, drugs remain heavily criminalized.

As with LAC, EECA countries are more likely than much of the world to adopt Structural policies, which is the only policy category in which its regional average score is above the global average. Nevertheless, UNAIDS notes the high levels of stigma and discrimination faced by LGBT people in the region, which manifest in policies.¹⁸ 69% of countries criminalize same-sex sexual relationships. Conversely, only 43% have laws protecting people from discrimination on the basis of sexual orientation, and 33% have non-discrimination protections based on gender orientation. Furthermore, countries in this region have often not adopted key Health Systems policies—the category where EECA's regional average falls farthest below the global average. In particular, none of the 13 countries for which we have data have adopted task shifting.

Asia and the Pacific (AP)

Countries in the AP region have, on average, the second lowest rate of policy adoption, suggesting significant attention to law and policy reform could be important for the AIDS response in the region. (see Fig 2.1). Clinical/Treatment policies are more likely to be aligned with global recommendations than other types of policies —yet comparatively speaking, AP's regional average policy adoption score in this category is the lowest in the world. Of particular concern, only 40% of AP countries have updated their treatment guidelines to align with current WHO

recommendations on first-line regimens for adults, and only 22% have done so for children.

When it comes to Structural policies, AP's regional average policy adoption score is only slightly below the global average—yet even here, only 20% of countries have adopted *Many* or *Most* of the recommended policies. Worse, for Testing and Prevention policies, the percentage of countries adopting *Many* or *Most* recommended policies is only 5%.

UNAIDS reports that 25% of new infections in the region are among young people,¹⁹ so it is notable that only 44% of countries allow adolescents to access testing and/or treatment without parental consent. While this is actually higher than other regions, more than half the countries in the region still present this policy barrier.

Rising number of infections among MSM are also a major concern,²⁰ making policy reform on Testing, Prevention, and Structural fronts urgent. For example, fewer than one quarter of AP countries make PrEP available to eligible populations. 42% of countries continue to criminalize same-sex sexual relations, and only 30% have laws in place that prohibit discrimination based on sexual orientation.

Middle East and North Africa (MENA)

In MENA, 0% countries have adopted *Many* or *Most* policies overall (see Fig 2.5). In every category except Clinical/Treatment, MENA has the lowest rate of policy adoption of any region. And even in when it comes to Clinical/Treatment policies, MENA's regional average policy adoption score is below the global average. UNAIDS reports that 43% of new infections in this region are occurring among people who inject drugs, and 23% are among MSM.²¹ So it is particularly troubling that only one-third of the countries for which we have data have incorporated harm reduction into their national strategies, while 82% criminalize syringe possession. So too, 80% of countries continue to criminalize same-sex sexual relations and none protect people from discrimination based on sexual orientation.

Many of the countries and regions making the most progress against HIV have high policy adoption, while many that are furthest off track have policy environments not aligned with international standards.

On the whole, the regions and countries making the most progress have adopted *Many* or *Most* of the laws and policies recommended by evidence and international normative bodies. For example, all of the fourteen countries in the world that had achieved the “90/90/90” goal of 73% viral suppression among all people as of 2019 had aligned *Many* or *Most* policies in the HIV Policy Lab. In the last decade, infections declined most significantly in Eastern and Southern Africa, where countries had among the highest policy adoption rates. Every country, however,

has laws and policies that would need to be updated to align with international recommendations.

On the other hand many of those countries and regions that are furthest off track—those facing growing epidemics and rising death rates—have the fewest policies that align with current evidence. Amidst progress in Eastern and Southern Africa, for example, South Sudan and Madagascar are seeing rising new infections while in Angola deaths have increased 36% over the last decade. These are also three of the countries in the region where the fewest policies are aligned with global standards. In Jamaica, where significantly fewer policies are aligned with international standards when compared with Haiti, AIDS deaths have increased this decade even as Haitian AIDS deaths have fallen by 52%. In the Middle East and North Africa, where less than one-third of people living with HIV were virally suppressed in 2020 and new infections have increased by 22%, the average policy adoption scores were also lowest.

The path between policy and HIV outcomes is as complex as the policy environment itself is. Therefore, significantly more work is needed to better understand how HIV-related law and policy environments drive HIV—a key goal of the HIV Policy Lab in the coming years. There are, nonetheless, good reasons to think that policy barriers are undermining the AIDS response in many countries.

Policy alignment within countries is uneven and contradictory

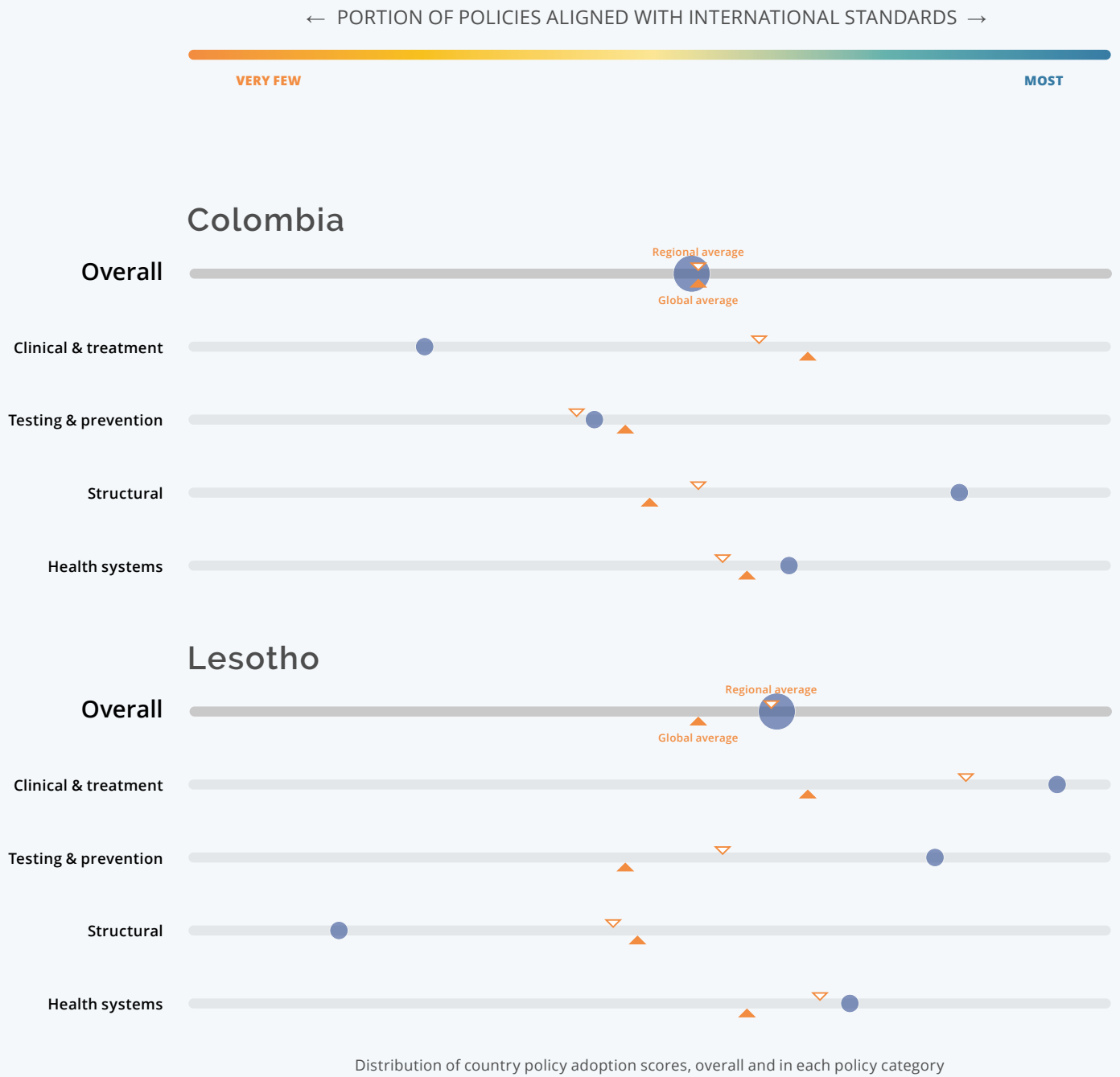
Countries tend to adopt aligned policies in some categories but not in others

It could be tempting to assume that countries likely to adopt recommended policies will to do so across the board—in other words, that countries either update their policies to align with global guidelines and scientific evidence or they do not.

The HIV Policy Lab shows that this is not the case. 106 countries have adopted *Most* policies in at least one policy category, but *Some*, *Few*, or *Very Few* policies in at least one of the other categories. This combination of strengths and weaknesses in different aspects of the policy environment is true across policy areas and across regions. For example, Lesotho has one of the world's highest rates of policy adoption for Clinical/Treatment policies, but one of the lowest rates of adoption for Structural policies. Colombia has the reverse policy environment, having adopted *Most* recommended Structural policies, but *Few* recommended Clinical/Treatment policies. (See Figs. 2.9-2.12 for examples. For a full report on each country's policy progress, see Section V).

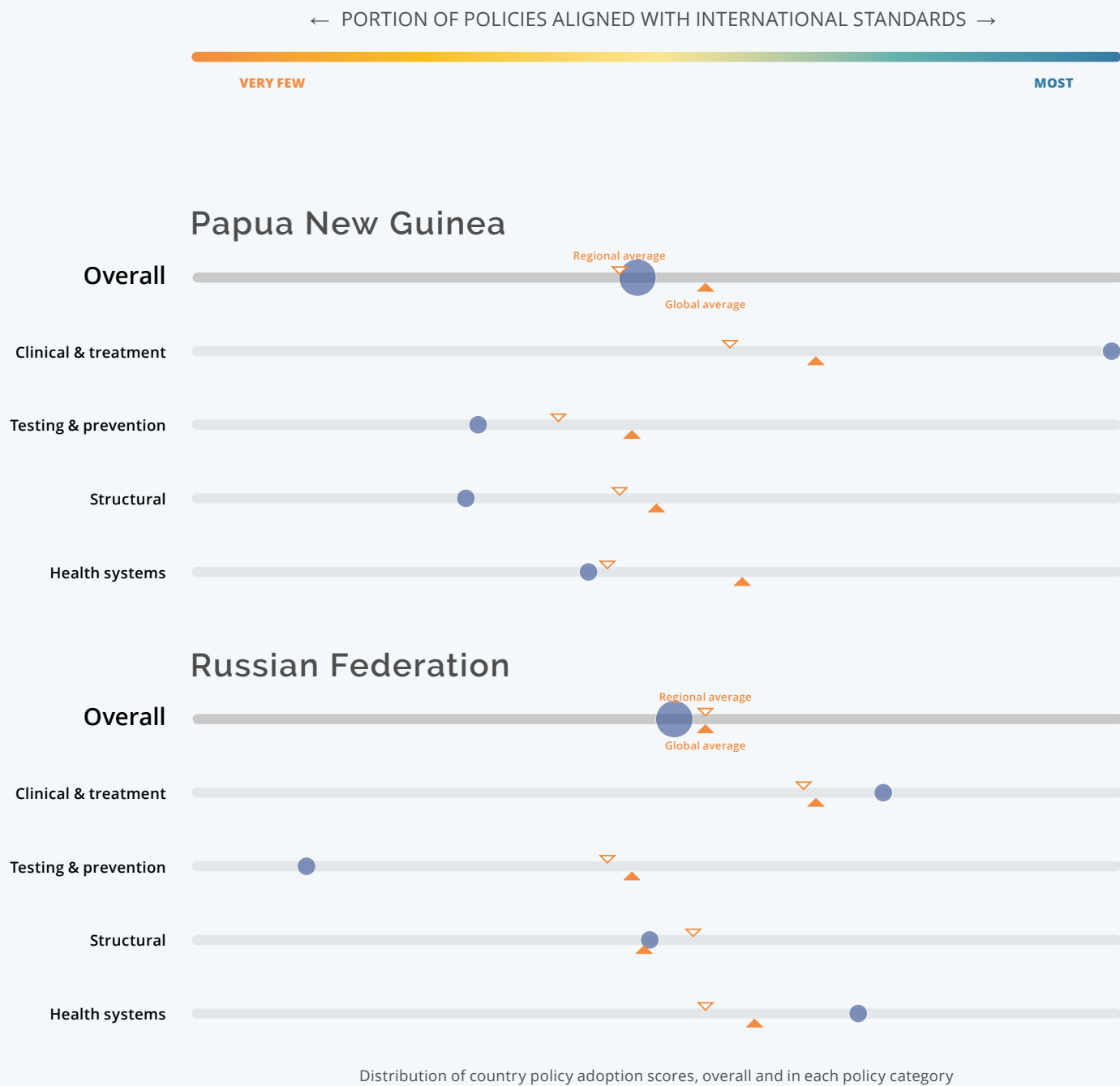
Figs. 2.9- 2.10

Overview of the HIV policy environment in Colombia, Lesotho, Papua New Guinea, & Russia



Figs. 2.11- 2.12

Overview of the HIV policy environment in
Colombia, Lesotho, Papua New Guinea, & Russia



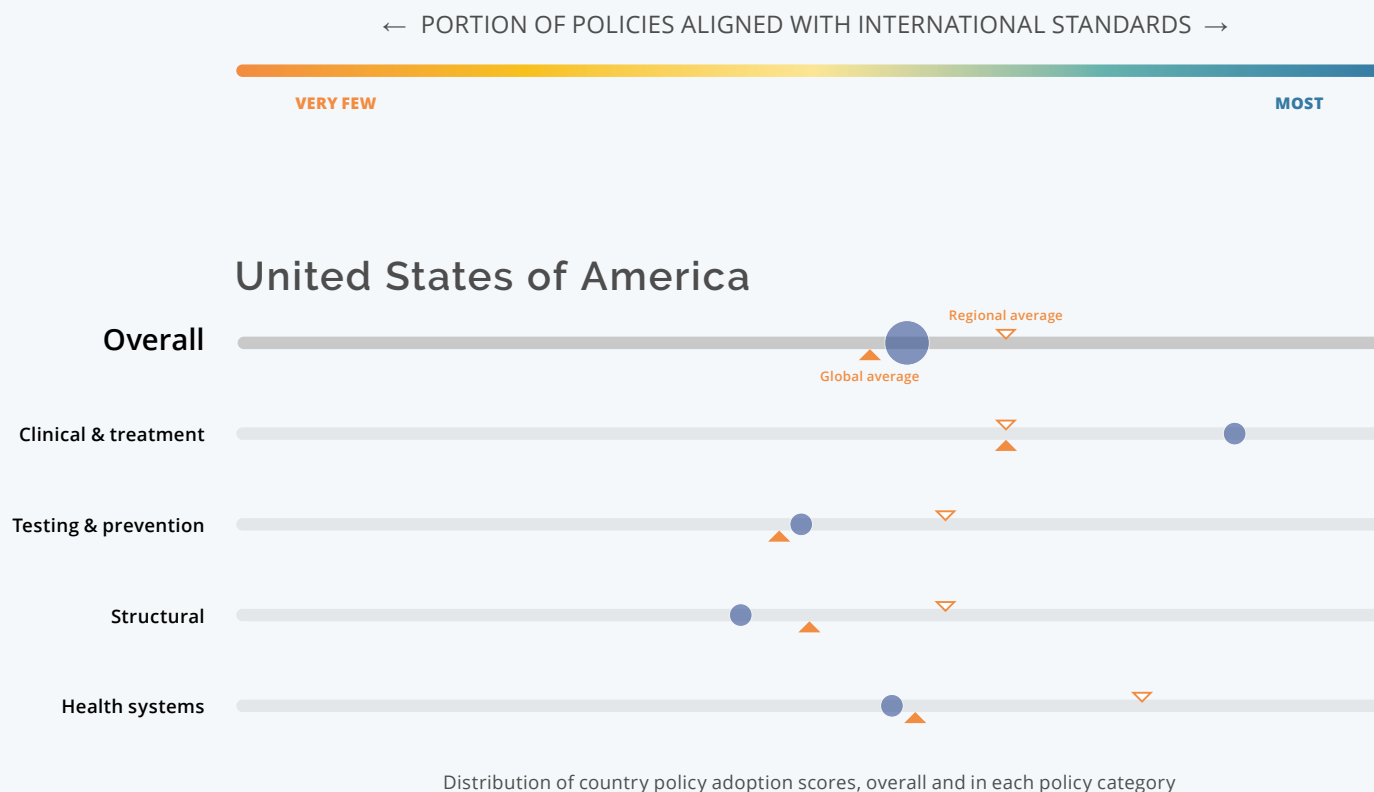
Countries often do not align policies even within a category

Inconsistent policy adoption is seen in the HIV Policy Lab data even for policies that are closely related. For example, 48 countries have adopted the latest WHO recommendations on first-line ARV treatment regimens for adults but not for children. At least 35 countries have adopted the “treat all” policy (which states that people living with HIV should start treatment as soon as they are diagnosed) but have not adopted the “same day start” policy (which allows people to actually receive their first dose of medications on the day they test positive). And there are 21 countries, including Australia, New Zealand, and the US, that have incorporated harm reduction (including needle and syringe exchange programs) into their national strategies, yet still criminalize syringe possession.

Occasionally, national governments may have opportunities to learn from policies endorsed in other contexts. For example, the US government encourages countries that receive funding from PEPFAR to adopt policies like differentiated service delivery (particularly 6-month dispensing) and task shifting that it has not yet adopted domestically. 21 countries receiving PEPFAR funding have higher policy adoption scores than does the US.

Fig. 2.13

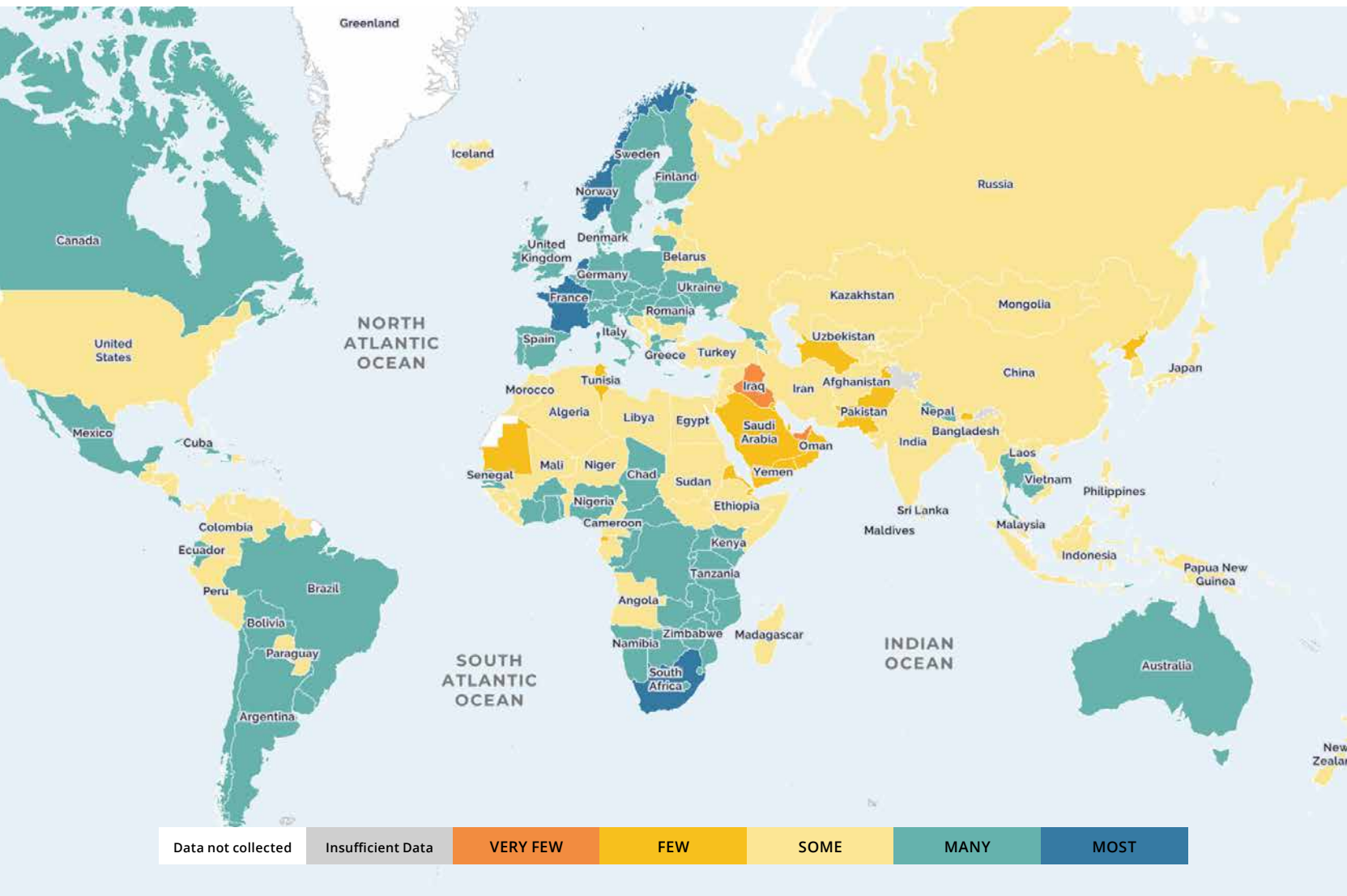
Overview of the HIV policy environment in the United States



This report finds that no country in the world has adopted all of the core HIV-related laws and policies tracked in the HIV Policy Lab. Every government has the opportunity to improve the HIV policy environment. There are important differences between policy areas and trends in adoption between countries—with technical support, advocacy, and law-reform efforts particularly needed in some areas. The 2020 Global HIV Policy Report shows several important trends.

Fig 3.1

Global overview of national HIV policy environments



Clinical/Treatment-related policies are adopted at a much higher rate than other policies

Adoption of HIV testing, prevention, and structural policies lag far behind

On the whole, countries are much more likely to have adopted recommended policies related to clinical care and treatment than testing, prevention, structural barriers and enablers, or health systems factors (see Fig. 3.1-3.5). 61% of countries have adopted *Many* or *Most* of the recommended Clinical/Treatment policies tracked, and more than 90% of countries have adopted at least *Some* of these policies. While better than other areas, these figures still show a substantial gap between what WHO, UNAIDS, and other normative agencies advise and what policies there actually are in key areas.

Countries have also adopted quite a few of the recommended Health Systems policies. Just under half of countries have adopted *Many* or *Most* of these policies. And while numerous studies of health system capacity focus on high-income countries, many low- and middle-income countries are leading the way on policy. Just over 70% of countries in Sub-Saharan Africa have adopted *Many* or *Most* recommended policies.

In contrast, Testing and Prevention policies are even less robustly adopted. Here, more countries have adopted *Few* or *Very few* of the recommended policies than have adopted *Many* or *Most*. And for policies linked to structural barriers and enablers, the number of countries in the two groups is about even.

Fig. 3.2

Global adoption of Clinical/Treatment policies

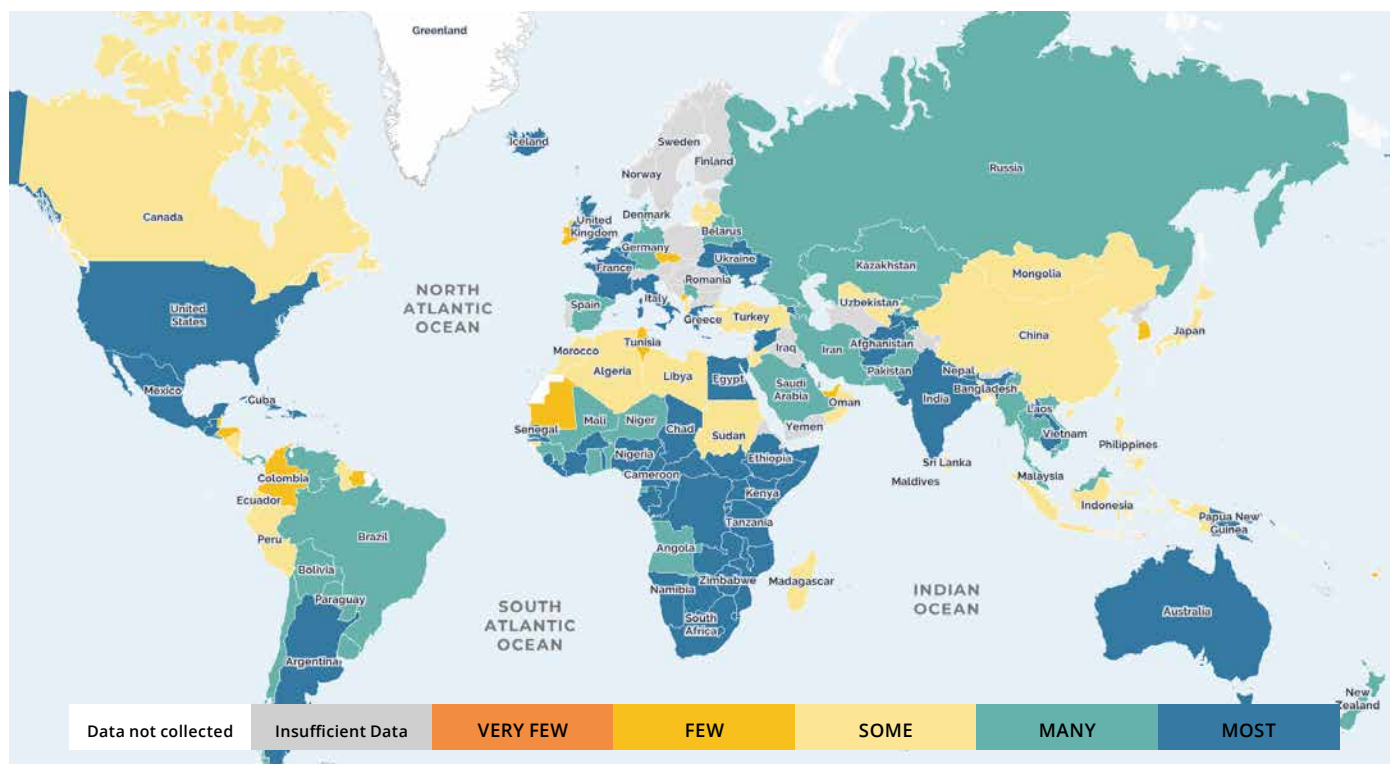


Fig. 3.3

Global adoption of Testing & Prevention policies

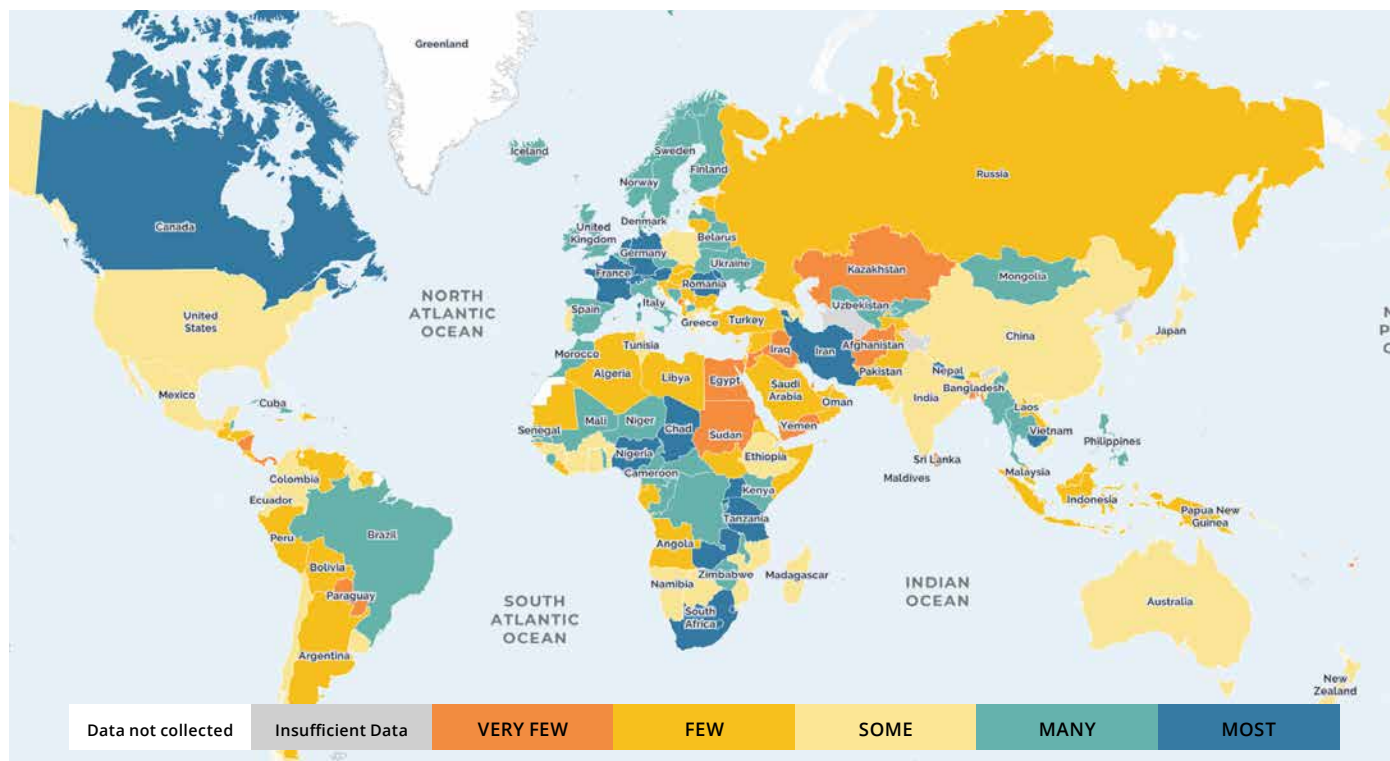


Fig. 3.4

Global adoption of Structural policies

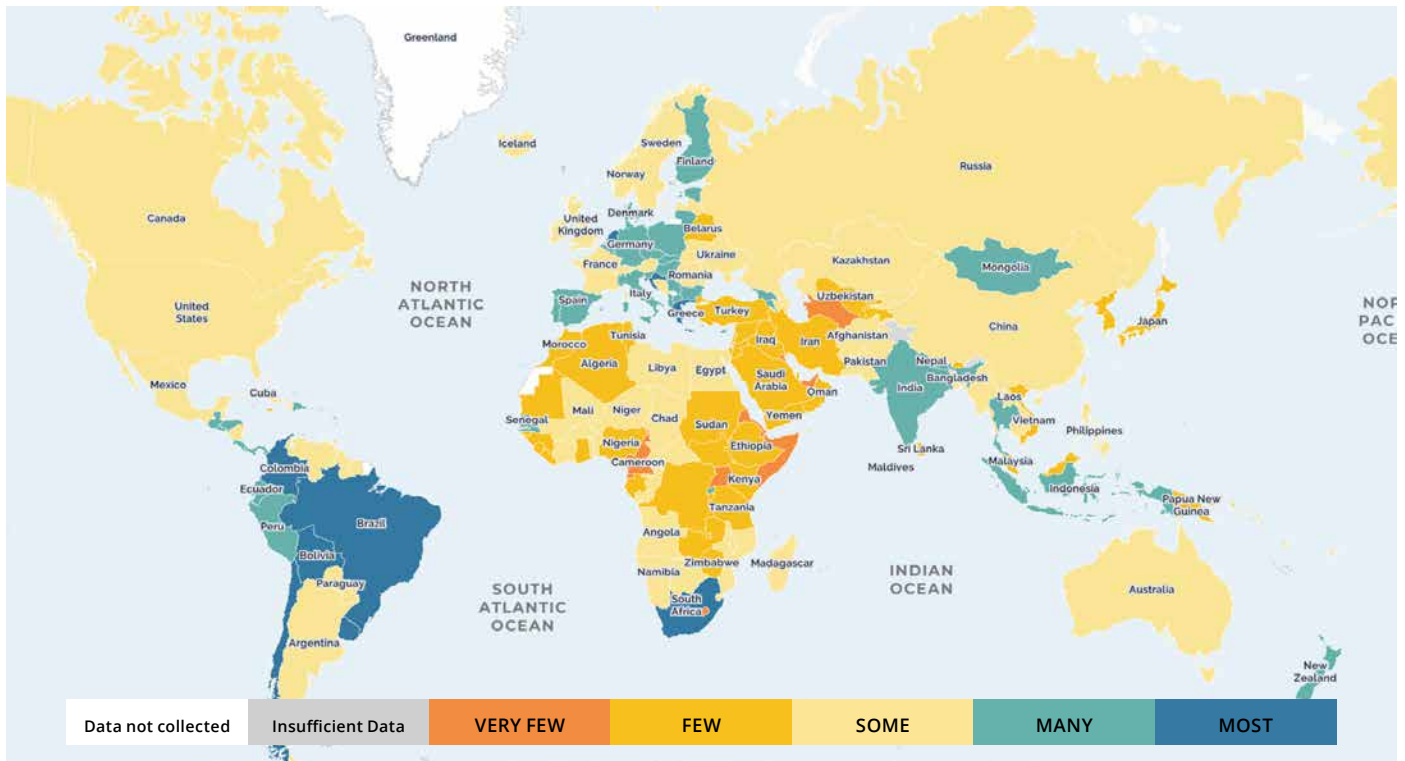


Fig. 3.5

Global adoption of Health Systems policies

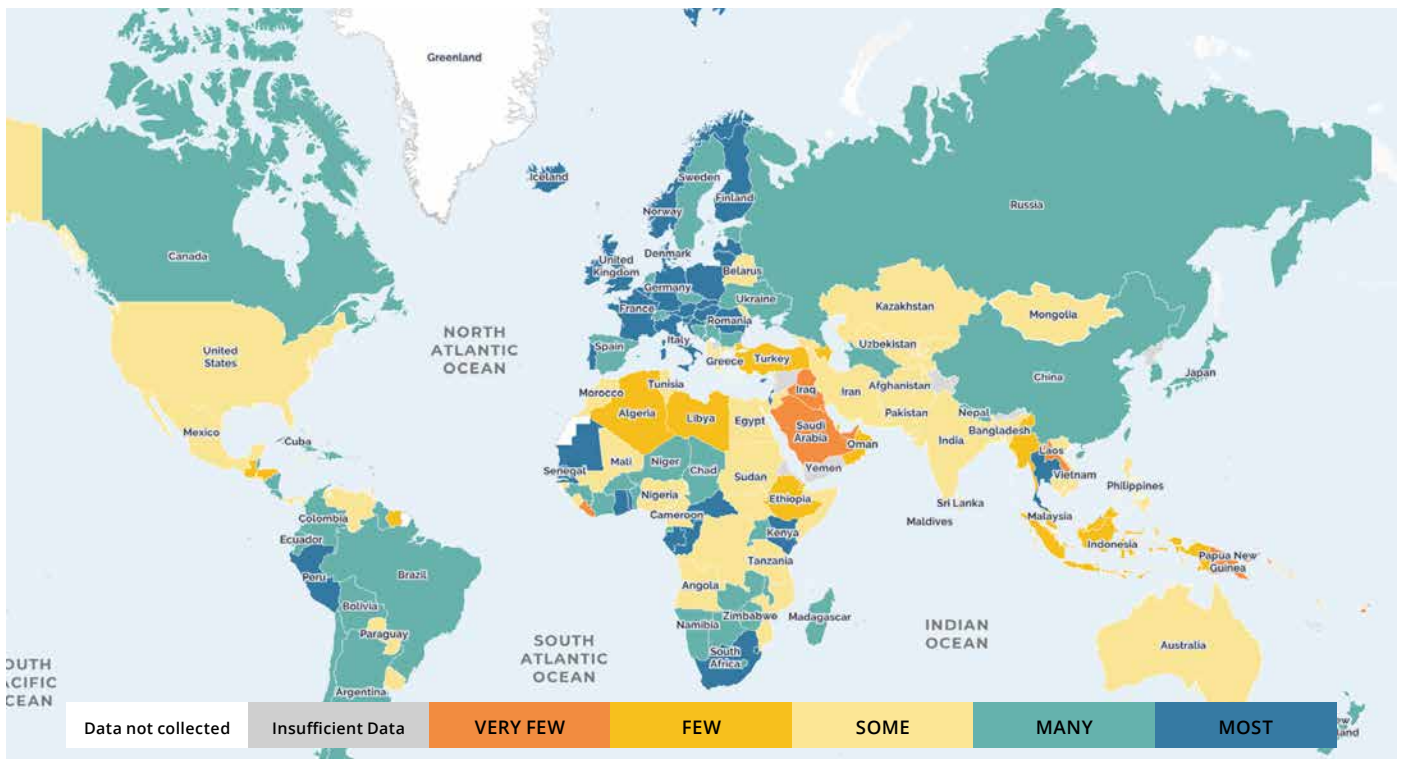


Fig. 3.6

Comparing policy adoption across policy categories

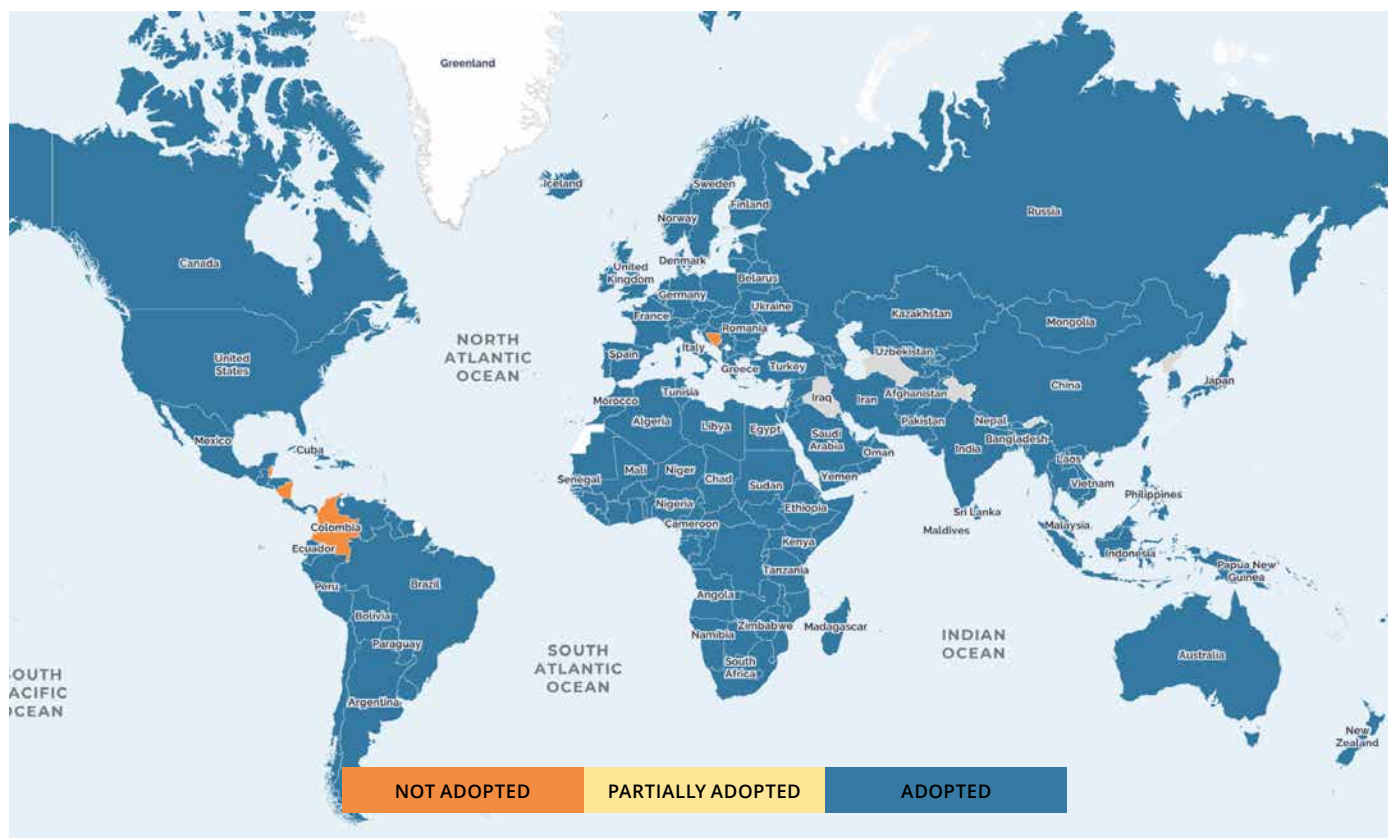
	% countries adopting <i>Many or Most</i> policies
Clinical/Treatment	61%
Testing & Prevention	24%
Structural	31%
Health Systems	49%
All Policies	37%

The progress made on Clinical/Treatment policies is a result of extraordinary work by WHO, UNAIDS, advocates, and financing agencies to develop and disseminate clinical guidelines and encourage governments to adopt them. The Treat All policy—which has been adopted by 185 countries—is a clear example of this.

Other successes are the Same Day Start policy, which has been adopted by 72% of countries, and the recommendation for annual viral load testing, which has been adopted by 88% of countries.

Fig 3.7

Do national policies align with global recommendations on treatment initiation (“treat all”)?



Policy Change Story: Treat All

Over the last decade, the evidence that PLHIV should begin treatment immediately, rather than waiting until they become immunocompromised, became clearer and clearer—both for individual health and to prevent HIV transmission. Aligning policy with that evidence, however, was no easy task. For one, it radically shifted the global AIDS response goal posts. For over a decade, the goal—the denominator of who needed HIV treatment in each country and globally—was a smaller subset of those living with HIV whose CD4 count made them eligible for treatment. Making all people living with HIV eligible for treatment increased that number substantially. In 2010, for example, 34 million people were living with HIV but only 14.2 million were estimated eligible for treatment.²² The 6.65 million people accessing treatment reflected nearly half the goal. Making all people eligible therefore had significant political and financial implications. Many governments were deeply concerned about the cost implications.

The WHO changed its guidance in step-wise fashion, advising countries to implement ART at CD4 counts below 350 cells/mm³ in 2009, below 500 cells/mm³ in 2013 and irrespective of CD4 count (Treat All) in 2015.

WHO guidance, of course, is not adopted by national governments automatically. Indeed the HIV Policy Lab shows major gaps between WHO recommendations and national policy. Yet, on treat all, that gap has largely been closed through the coordinated work of multilateral efforts, government, and civil society. Activists were a key element of movement. In multiple countries, people living with HIV and civil society worked hard to push government to rapidly update their guidelines and eliminate CD4 barriers, even before WHO guidance. And, in key places, they found willing partners in forward-looking public health officials eager to use the tools at hand to halt the AIDS pandemic. The influential US policy changed in 2012 to treatment for all regardless of CD4 count.²³ Both the governments of Malawi and Thailand, meanwhile, took note and adopted “Treat All” guidelines before WHO. Once the 2015 guidance was in place, WHO, along with the full UNAIDS Joint Program, moved rapidly to socialize countries with workshops and technical assistance across the world. The adoption of 90-90-90 targets at the UN High Level meeting that year set out clear benchmarks for countries, and the campaign for their adoption at national level had a major impact. Meanwhile, researchers not only compiled gold-standard evidence on the efficacy of immediate treatment, but they also compiled cost-benefit analyses. These studies helped governments see that, by preventing illness and new infections, the policy switch would be cost-effective or, in many contexts, cost-saving.²⁴ Finally, financing agencies including PEPFAR and the Global Fund ensured that resource-limited countries had sufficient fiscal space to make the shift.

Together, this “all hands on deck” approach to policy change worked. In 2016, adoption of treat all policies was relatively limited—with most countries still using CD4 500, 350, or sometimes even 200 as the threshold for eligibility. By 2020, however, only four countries in our dataset have not yet adopted treat all—the highest alignment of any single policy. This approach suggests that policy change can happen widely and rapidly when the various parts of the AIDS response align behind it—even policies with significant cost implications.

Fig 3.8

Do national policies align with global recommendations on same day start?

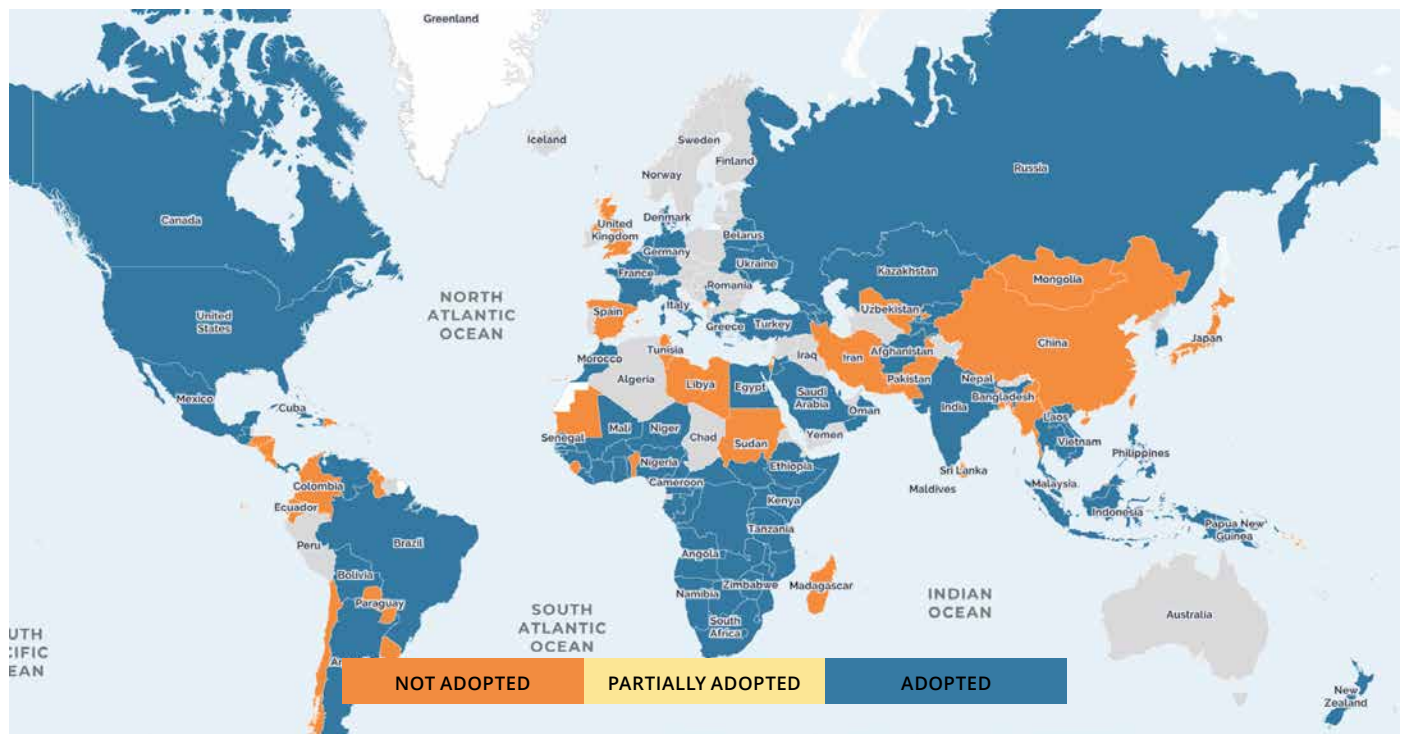
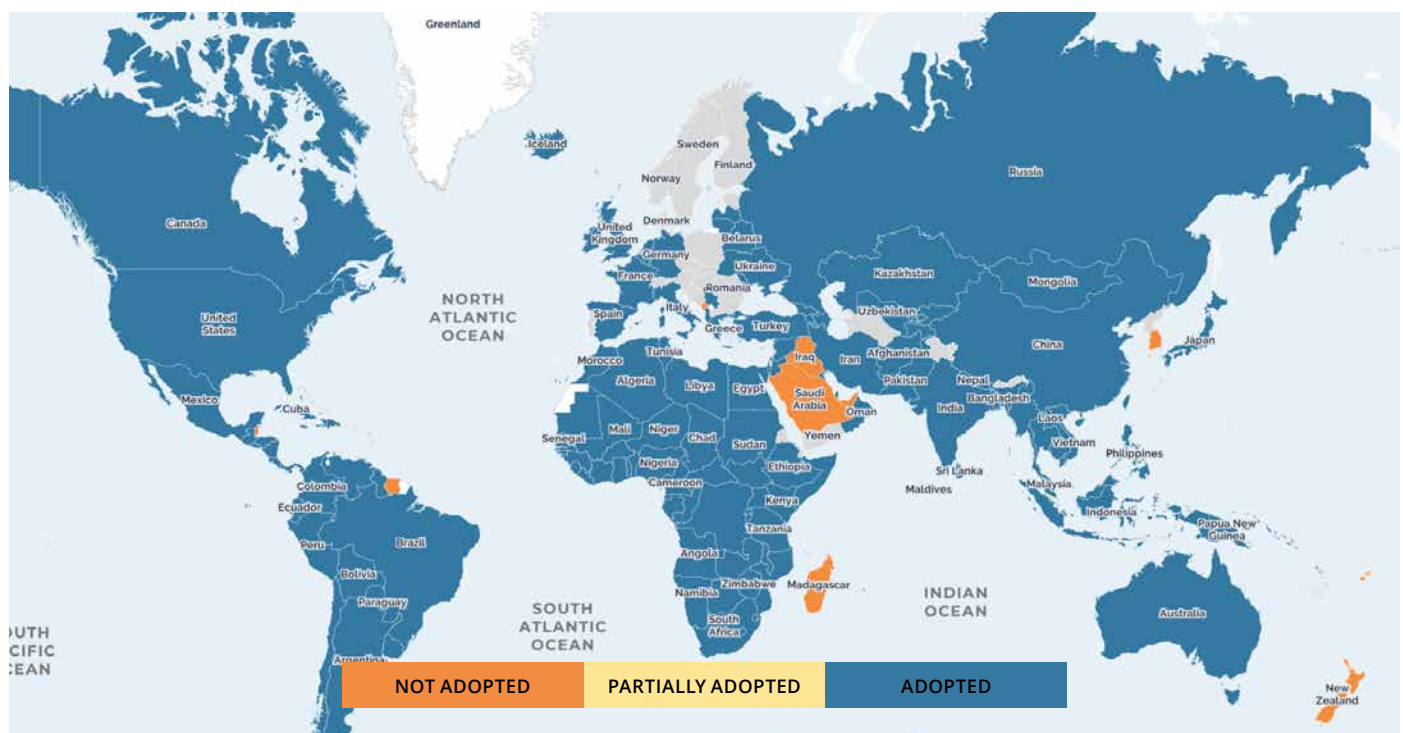


Fig 3.9

Do national policies align with global recommendations on viral load testing frequency?



There's still room for improvement on Clinical/ Treatment policies

But even within the Clinical/Treatment category, there is variation in policy adoption, and thus, room for progress. Two policy gaps are partially concerning. 43% of countries have not updated their HIV treatment guidelines to use Dolutegravir (DTG) in the first-line treatment regimen for adults. Meanwhile, only 62% of countries with data have adopted WHO recommendations on early infant diagnosis, and only one-third of countries have adopted the latest recommended first-line regimen for children.

Fig 3.10

Do national policies align with global recommendations on first-line regimens?

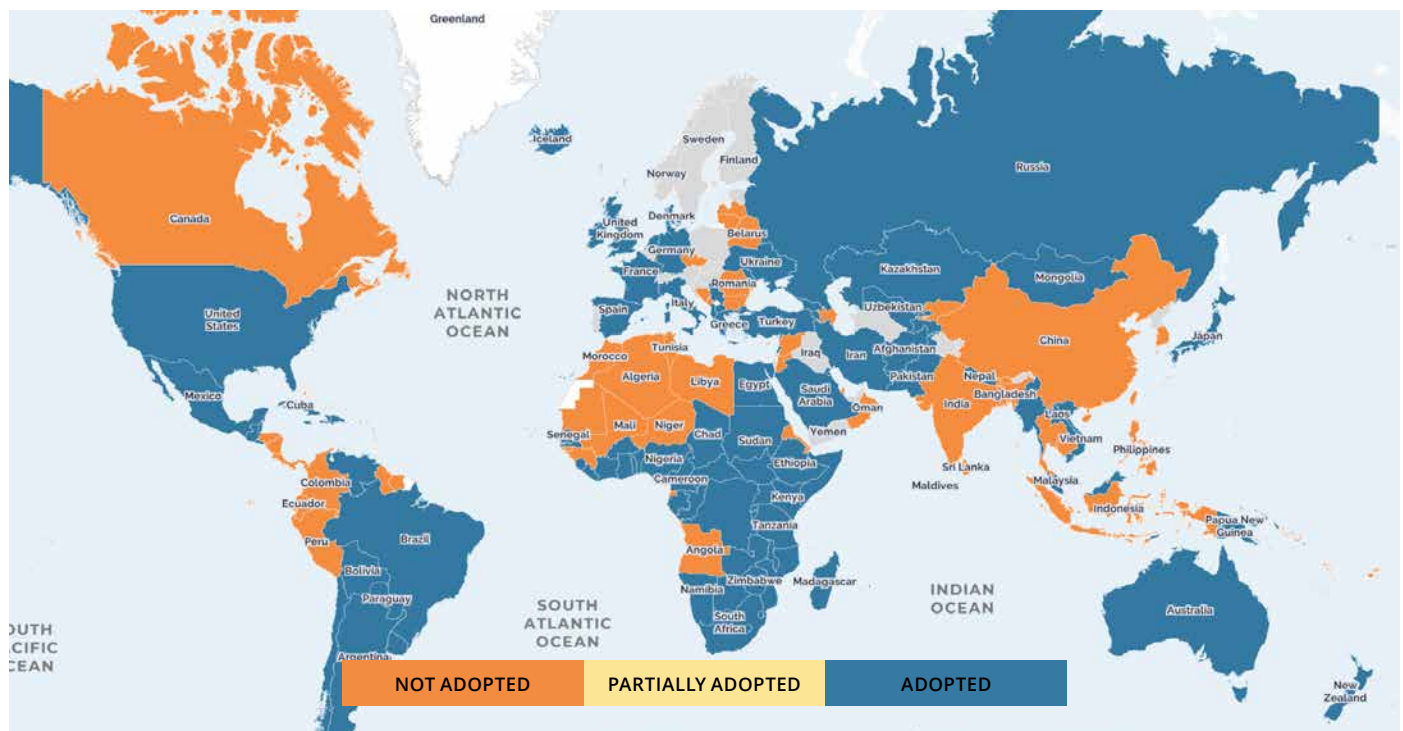
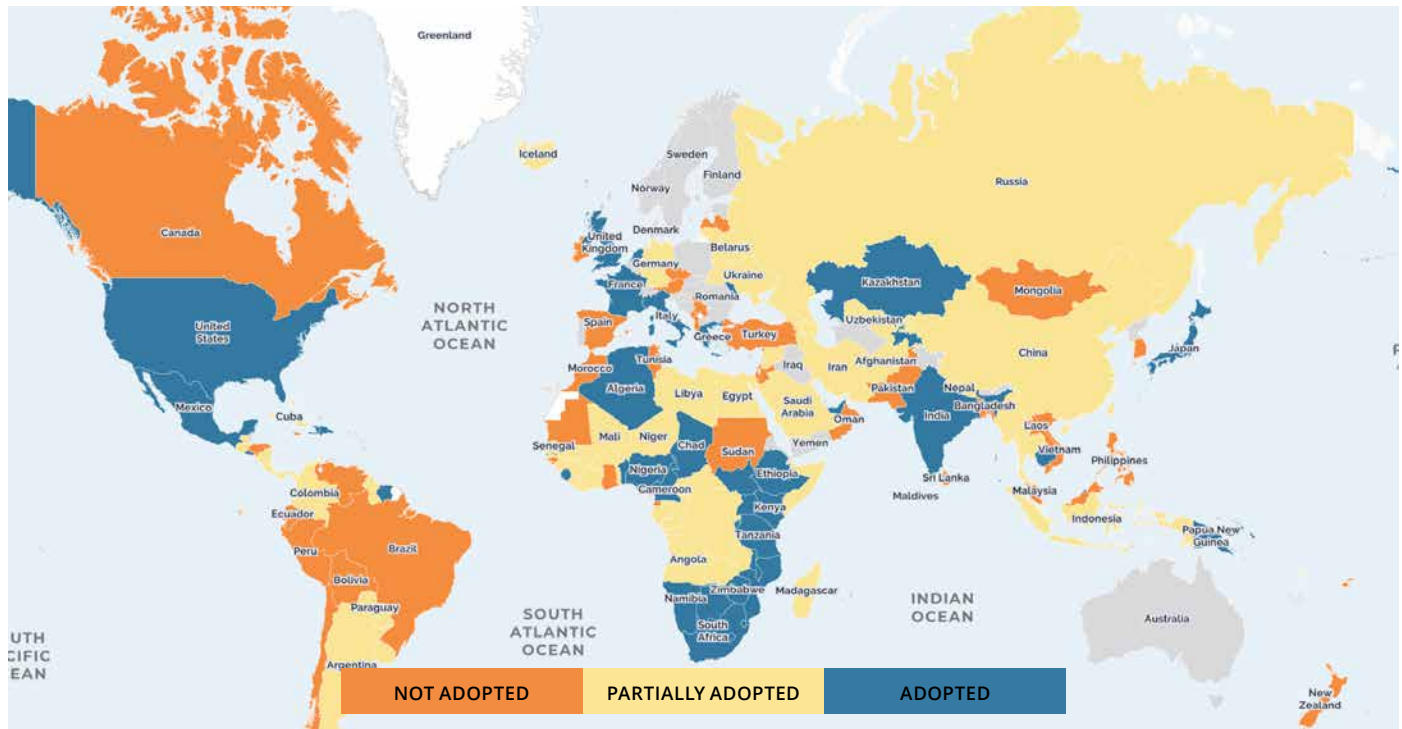


Fig 3.11

Do national policies align with global recommendations on pediatric testing and treatment?



Poor policies create barriers to implementing good policies

Furthermore, availability of high-quality clinical care does not necessarily mean that people living with HIV have access to that care. Even when a country has adopted *Many* or *Most* of the recommended Clinical/Treatment policies, the absence of good testing, prevention, service delivery, structural enablers, and health systems policies imposes barriers to people accessing the care that they need. In other words, the benefits of science and clinical care guidelines are directly inhibited when other laws and policies undermine access, affordability, and quality. Misaligned policies in one area should be understood as barriers to implementing good policies in others.

Differentiated service delivery: Care needs to be convenient

To keep PLHIV clinically stable on life-long HIV treatment, care needs to be convenient and enable them go about their lives. This means that accessing treatment needs to be simple. For example, rather than requiring people to travel to a clinic every month to wait in a queue/line-up to pick up their medications, people should be able to receive a multi-month supply of medications at a location convenient to

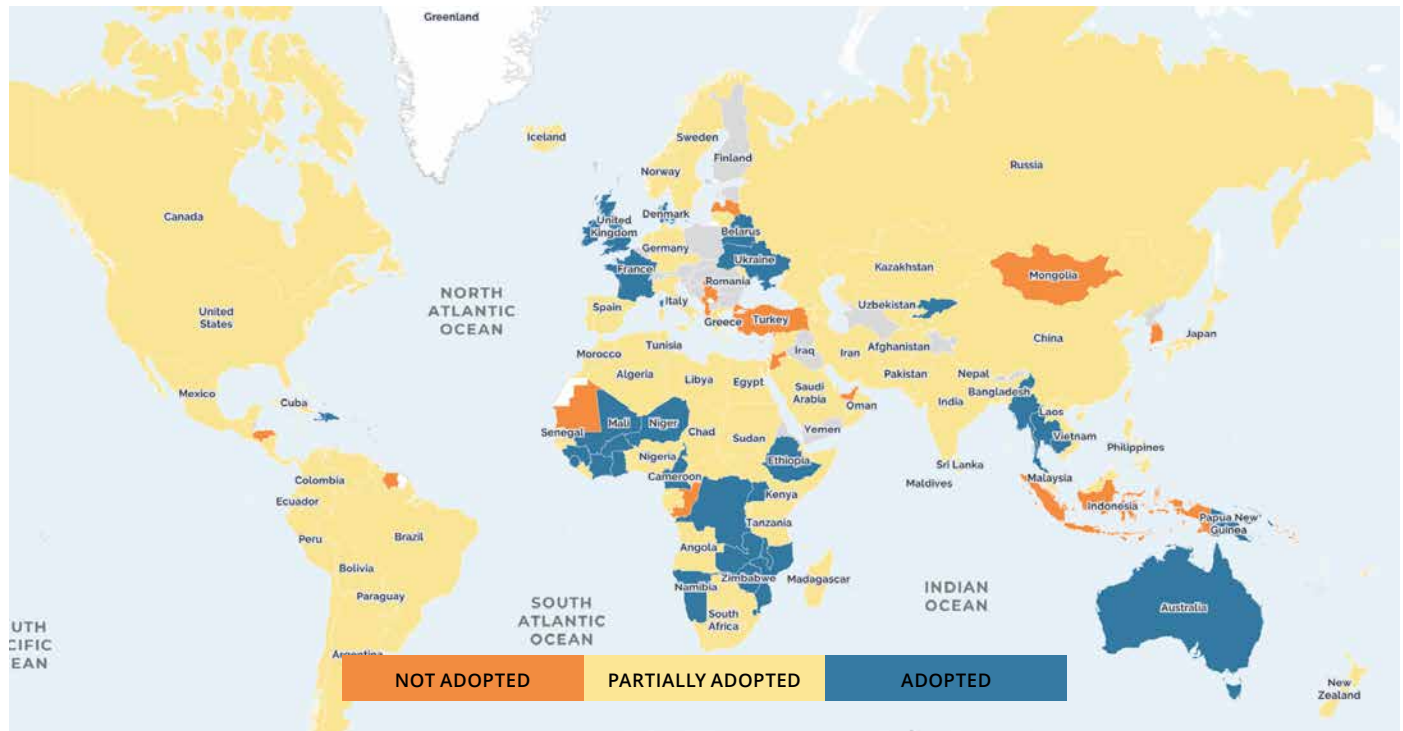
them – a community pick-up point, a peer-support group, or somewhere close to home. Differentiated service delivery (DSD), the policy shifts enabling services to be adapted to meet the needs of people, while also not unnecessarily burdened the healthcare system, is one of the most critical innovations in recent years.

More than 100 countries offer some form of DSD for HIV treatment for people who are clinically stable. Often, the frequency of clinical consultants with a trained health care worker is reduced while the location and timing of medication refills can happen in communities and with peers. DSD models, including facility- and community-based models, group, and individual models, often include extending refills of ART medications to 3 or 6 months. A range of models are being implemented, with more on this available from our partners at differentiatedservicedelivery.org

Despite the progress in policy adoption and implementation of DSD for HIV treatment, nearly 60 countries have no DSD policies in place. And progress varies significantly across regions. For example, all countries in ESA and 93% of countries in LAC have adopted some form of DSD. But 32% of countries in AP and 17% of countries in WCENA do not offer any form of DSD.

Fig 3.12

Do national policies align with global recommendations on **differentiated service delivery**?



In the midst of the COVID-19 pandemic, UNAIDS, WHO, advocates, and others have called on governments to provide multi-month dispensing of ART, reducing the need for PLHIV to visit health facilities just for a medication refill. At least 59 countries have 3-month dispensing. However, only 32 countries (20%) allow 6-month dispensing. While more than half of the countries providing 6-month dispensing are in sub-Saharan Africa, only 4 are in the WCENA region.

Policy Change Story: Expanding Differentiated Service Delivery in Times of Emergency

Contributed by

Anna GRIMSRUD, International AIDS Society

There are precedents for countries expanding DSD in times of crises like COVID-19. During the 2014 Ebola outbreak in Guinea, many health facilities closed down and “many clients faced restrictions in movement, resulting in a large proportion of the HIV cohort being lost to follow-up. A 6-month refill system, a facility-based individual model, was piloted and scaled up in response to this crisis.”²⁵ After the Ebola epidemic ended, this approach was further expanded and became national policy. Also during Ebola, “in Sierra Leone, peers started collecting and distributing ART refills to patients’ homes or from community meeting points. In response to conflict in the Central African Republic in 2015, patients were provided with 6-month refills distributed by lay healthcare workers from decentralized peripheral health facilities. More recently, in 2019 during armed conflict in the Cabo del Gado province of Mozambique, mobile clinics provided outreach and ART refills within communities.”²⁶

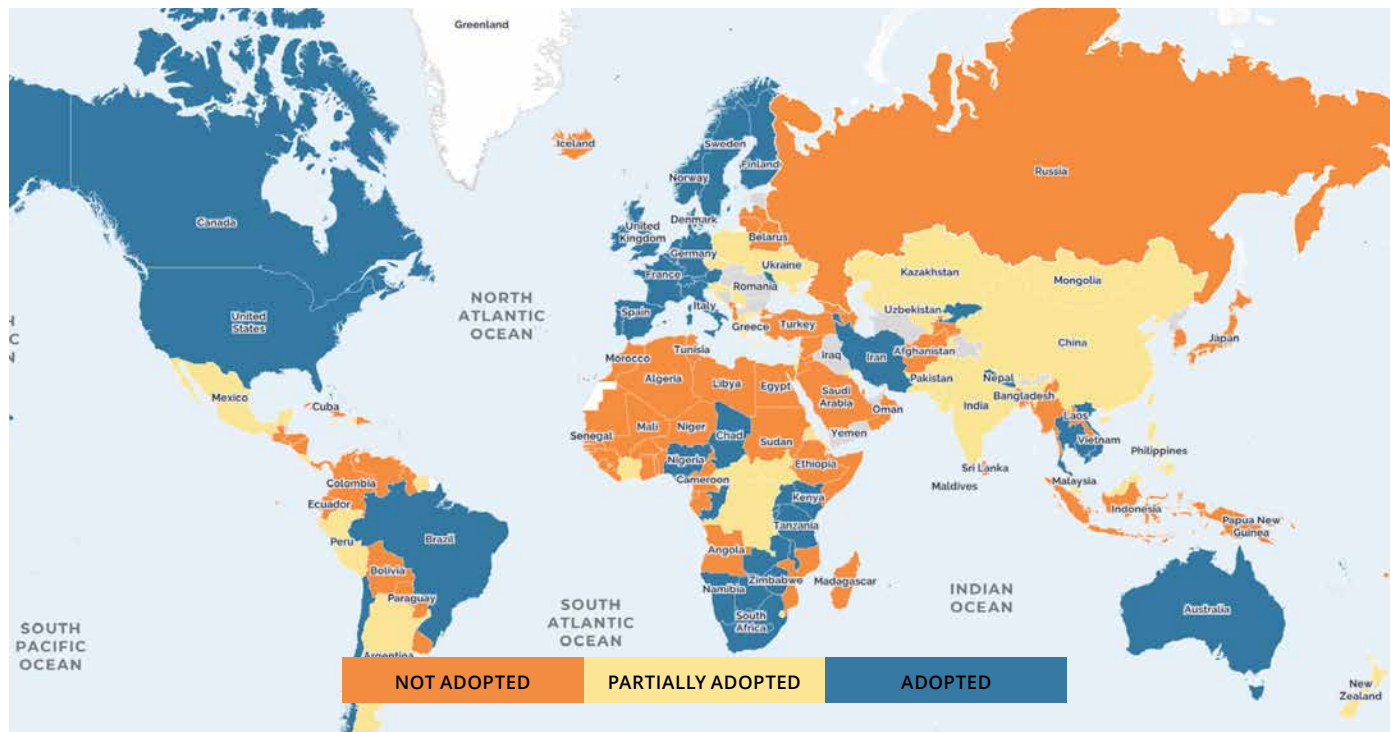
During COVID-19, a number of countries—including, but not limited to, Kenya, Malawi, and Thailand—extended ART refills or otherwise changed policies to increase who is eligible for multi-month dispensing and DSD models. This change in policy emphasized the importance of community-based models and worked to integrate and align refills of other medications, such as TB preventive therapy. Many of these adaptations made in response to COVID-19 are likely to enable improved outcomes, and they should be retained beyond the COVID-19 pandemic.

PrEP: Access to ARVs for prevention

Arguably, the most transformational, recent, scientific and policy innovation in HIV is the recognition that ARVs are a critical tool for prevention. When PLHIV are clinically stable on ART, their viral load is suppressed to the point where they no longer transmit HIV. And taking ARVs as pre-exposure prophylaxis (PrEP) can help prevent people from contracting the virus. WHO recommends that PrEP be offered to all individuals at substantial risk of HIV; eligible groups in most countries include men who have sex with men (MSM), sex workers, people whose partners are HIV+, and others depending on their individual situations. The HIV Policy Lab tracks if countries have made people at substantial risk of HIV eligible, and if at least one drug has received regulatory approval for use as PrEP.

Fig 3.13

Do national policies align with global recommendations on PrEP?



Only half of countries have adopted one or the other of these policies, and only 30% have adopted both these policies. Moreover, of the countries that do make PrEP available to eligible populations, less than one-third cover PrEP under their national health insurance scheme. In the other two-thirds of countries, people seeking PrEP may have to pay out-of-pocket, which may place the most effective prevention method we have out of reach of the individuals who need it most. Of course policy is only one piece of access, and more info on PrEP implementation can be found with our partners at PrEPWatch.org. The HIV

Policy Lab data gives substantial evidence to statements out of the Global HIV Prevention Coalition that law and policy gaps—and the lack of political will to close these gaps by adopting recommended, science-based policies—pose a major barrier to progress in HIV prevention.

Policy Change Story: PrEP in London and the UK

Contributed by

Gonçalo LOBO, IAPAC Regional Director, Fast-Track Cities, Europe

In 2018, Mayor Sadiq Khan committed to taking action on HIV by joining National Health Service (NHS) England, Public Health England, and the London Councils in signing London up to the Fast-Track Cities initiative. This commitment included the aim to end new HIV infections in London by 2030.

In the UK, HIV prevention was made the statutory responsibility of local government in 2013. Since then decisions by the London HIV Prevention Program and local government have been critically important in turning around the epidemic (which saw exponential growth between 2005 and 2013). In 2013, the London HIV Prevention Program represented a new strategic approach, with new investment and new prevention methods for London, including Do It London, which was the first large, London-wide HIV campaign since the 1980s. The campaign, launched in 2015, and delivers sexual health promotion outreach to gay men and other men who have sex with men (MSM) as well as other communities that are at increased risk of HIV exposure. Do It London was also the first official campaign to widely promote pre-exposure prophylaxis (PrEP). But policy on PrEP lagged far behind London's ambition. While NHS Scotland had provided PrEP since 2017, NHS England's policy did not and PrEP was only available without charge via clinical trials. Still, a substantial number of people – predominantly gay men and other MSM men – were able to access PrEP by maximizing use of the trial and through purchase in online pharmacies. Alongside other prevention methods, including treatment as prevention, this focus on PrEP access contributed to a 37% decline in new HIV diagnoses (40% among gay men and other MSM men) between 2015 and 2017.

In 2019, as he opened the Fast-Track Cities 2019 conference in London, Mayor Khan welcomed conference delegates to a Fast-Track City that had made some of the most significant progress towards ending its local HIV epidemic. However, he also stressed that more work remains to be done, even in a model Fast-Track City such as London, notably eliminating the persistent national policy barriers to more widely accessible PrEP. Activists had long demanded access for all through the NHS. Following on that Fast-Track City conference, and due to multi-stakeholder advocacy, NHS England changed its policy—expanding access to this prevention tool beyond the fraction of HIV-negative people at higher risk who had been granted access under the studies. The new policy, delayed under COVID, took effect 1 October after the Government announced it had allocated funds to local councils.

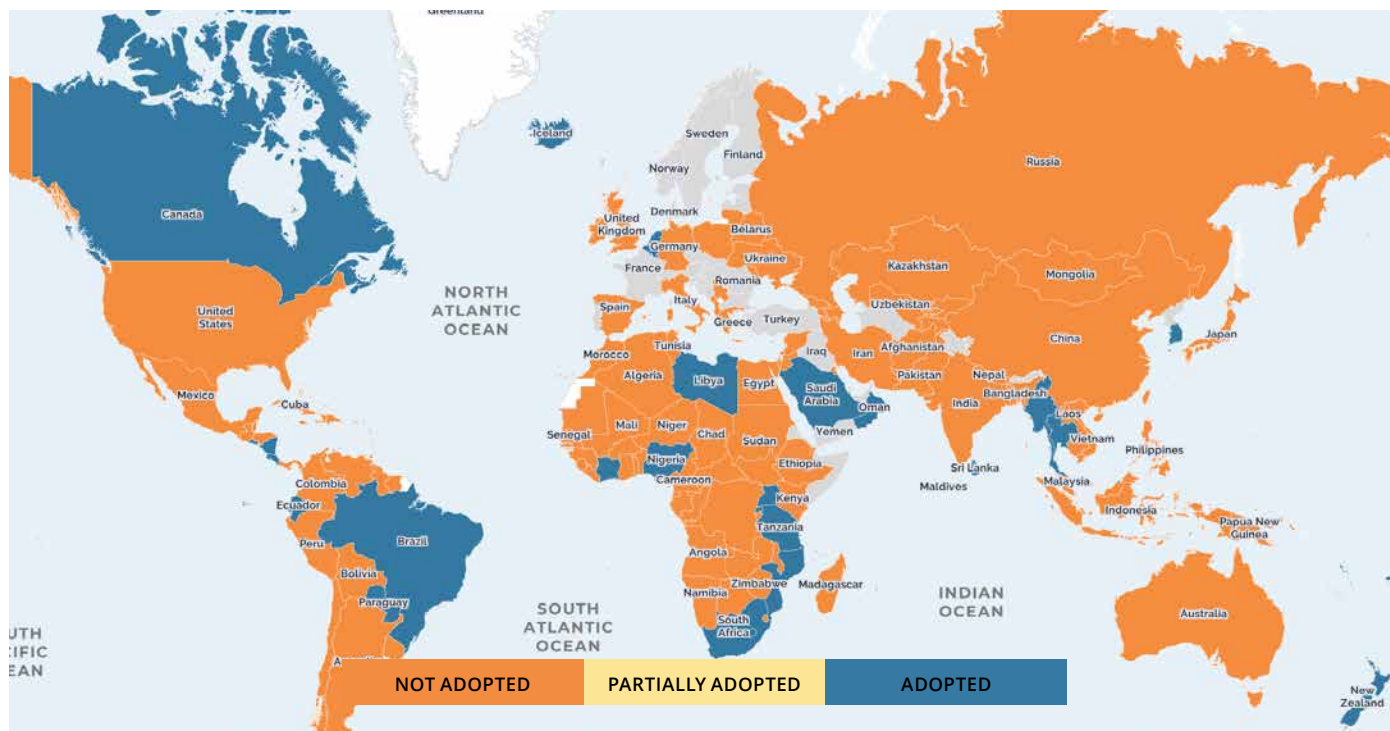
Age should not be an obstacle: access to HIV testing and treatment for adolescents

Adolescents represent a growing share of PLHIV. According to UNICEF, an estimated 170,000 young people between the ages of 10-19 were infected with HIV in 2019.²⁷ Data from ESA indicates that only 22% of people between the ages of 15-19 had received an HIV test in the last year.

UNAIDS, WHO, and the UN Special Rapporteur on the right to health recognize that policies requiring young people to get parental consent in order to learn their HIV status or access care are recognized as a major barrier to tackling the epidemic. Further, they recommend that mature adolescents should be able to consent to testing and treatment on their own. Yet only 26% of the countries have adopted this recommendation. This policy gap is particularly pressing in WCA, where only 9% of countries have adopted the policy.

Fig 3.14

Do national policies align with global recommendations on adolescent testing and treatment?



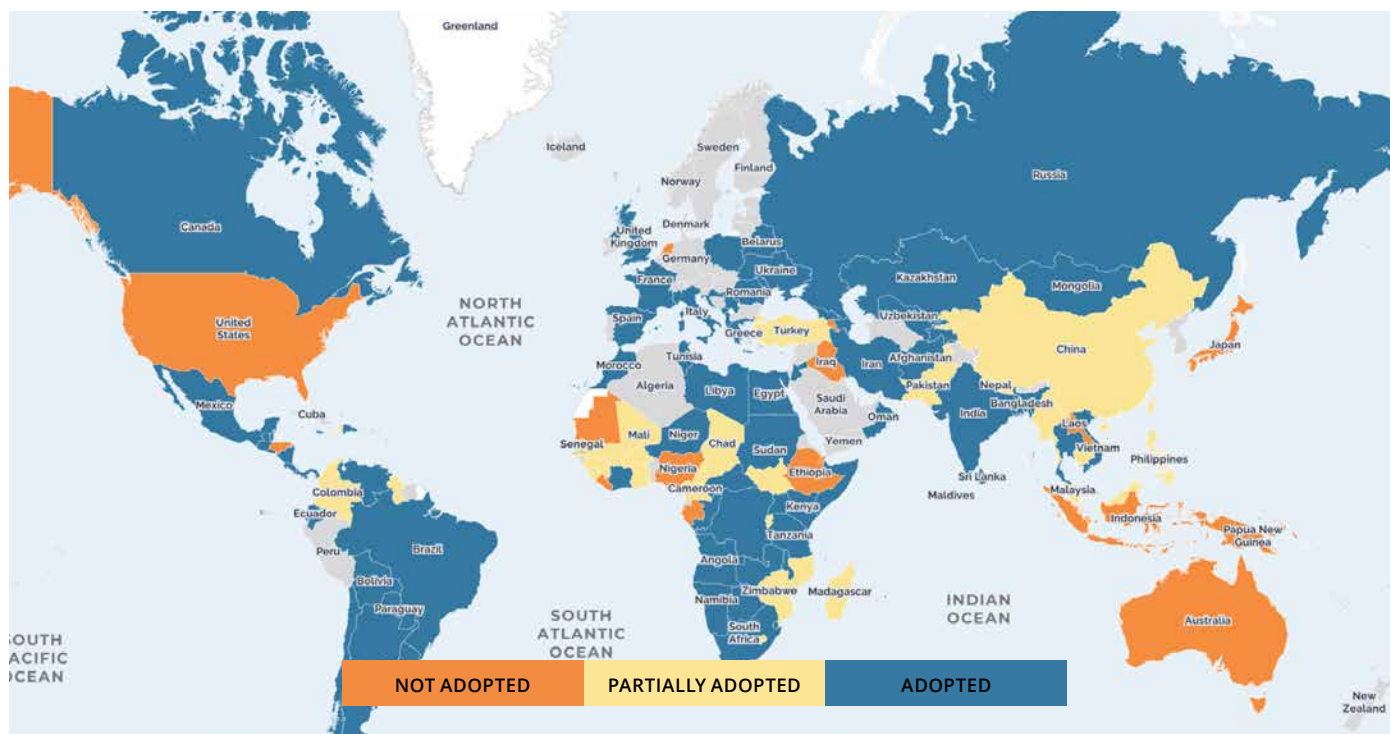
Eliminating user fees: Removing financial barriers to access

One bright spot is the elimination of user fees. Often written into policy as a condition of receiving World Bank funding in the 1980s and 1990s, extensive research has shown

that user fees are not a sustainable financing mechanism for health systems. More importantly, user fees create a significant barrier to accessing necessary healthcare, particularly among the poorest and most vulnerable.

Fig 3.15

Do national policies align with global recommendations on **user fees**?



That 83% of countries do not, as a matter of policy, impose user fees for HIV services, and just over two-thirds do not impose user fees for primary healthcare, are signs of progress. However, the fact that at least 37 countries still impose user fees for primary healthcare—including 22 countries which have eliminated user fees for HIV services—is a policy gap which much be addressed. While several countries in WCA, including Cameroon, have recently begun the process of removing user fees, this remains a particular challenge in that region.

Criminalization of same-sex sexual relations, sex work, drug use, and/or HIV exposure/transmission are counterproductive, yet all countries do it

UNAIDS new targets include eliminating punitive laws. Every country in the world has laws criminalizing one or more of these areas

Halting HIV mortality and infection requires reaching

individuals who are most at risk of HIV and the PLHIV who are least likely to know their status or be retained in treatment. Studies and normative guidance in HIV have long shown that criminal law is not effective in halting HIV. Indeed, criminalization is counterproductive, driving many of the people most vulnerable to HIV away from prevention, testing, and treatment services for fear that they will be reported to authorities, arrested, and/or prosecuted. For this reason, UNAIDS and the Global Commission on HIV and the Law recommend that governments abandon these four sets of criminalization policies.

UNAIDS's new targets include "Less than 10% of countries criminalize sex work, possession of small amounts of drugs, same-sex sexual behaviour, and HIV transmission, exposure or non-disclosure by 2025".

Yet our data show that not a single country in the world has laws that refrain from criminalizing all four activities. Only 5 countries refrain from criminalizing in law or arresting people for three of the four activities. If we look only at what is criminalized in law, this number increases to nine, and five of them are in LAC.

Non-criminalization of sex work and drug use have the lowest rates of policy adoption of any policies

Of the 33 recommended policies tracked in the HIV Policy Lab, sex work and drug use non-criminalization are the least frequently adopted.

Only six countries in the world refrain from criminalizing buying, selling, and organizing sex work under the letter of the law. Even here, though, sex workers can often face harassment and arrests on other charges. Only New Zealand has actively decriminalized sex work. A detailed look at sex work laws compiled by our partners at NSWP is online at www.nswp.org/sex-work-laws-map.

Similarly, only seven countries refrain from criminalizing opioid possession for personal consumption. As with sex work, criminalization of people who use drugs includes a complex set of legal measures and law enforcement policies. More information on that front is available from our partners IDPC at www.talkingdrugs.org/drug-decriminalisation.

Fig 3.16

Do national policies align with global recommendations on **not criminalizing sex work**?

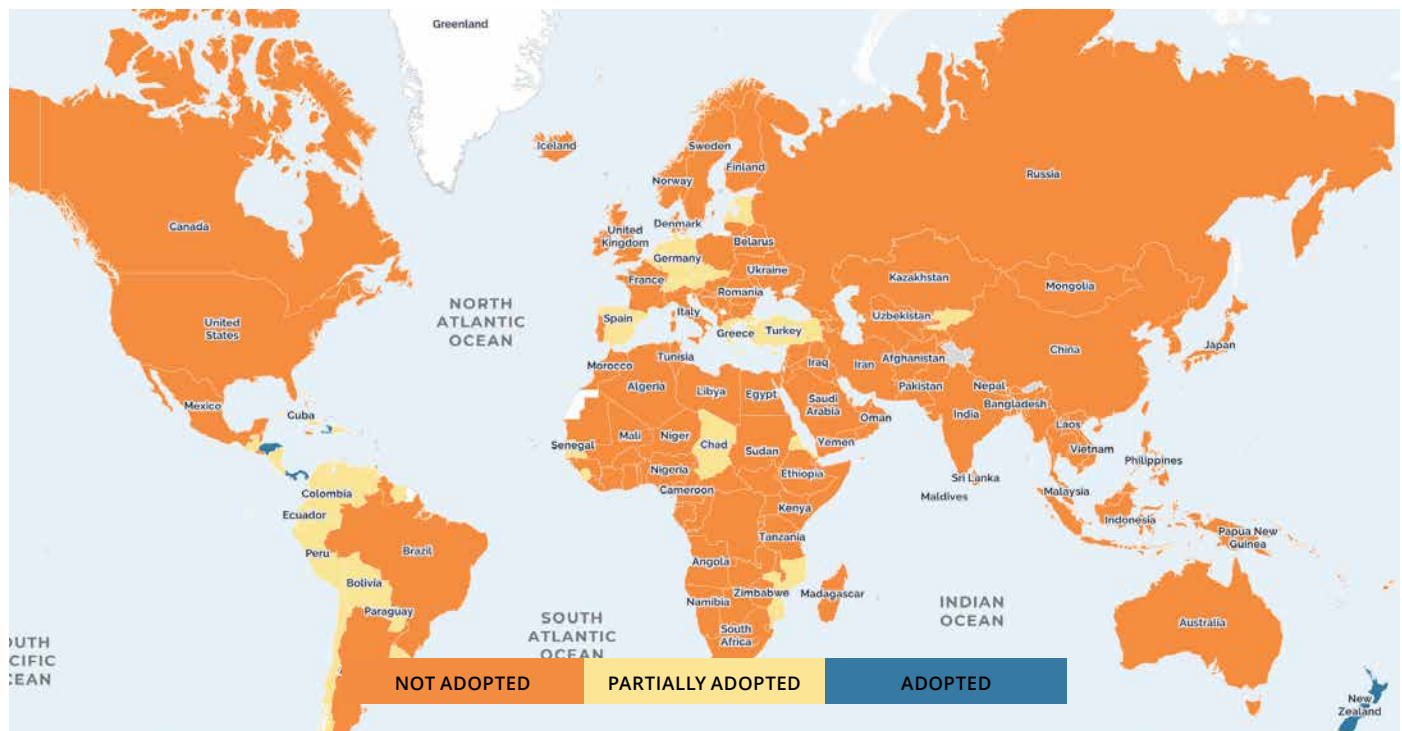
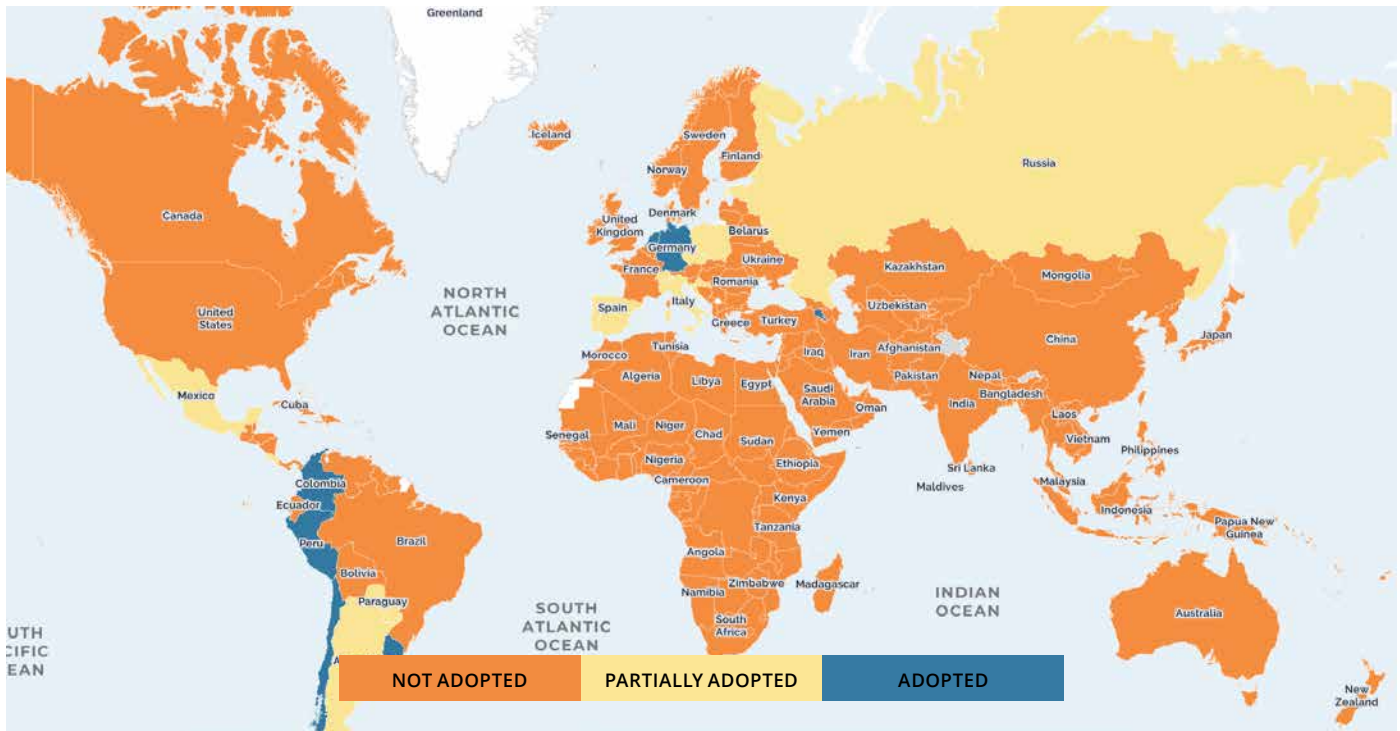


Fig 3.17

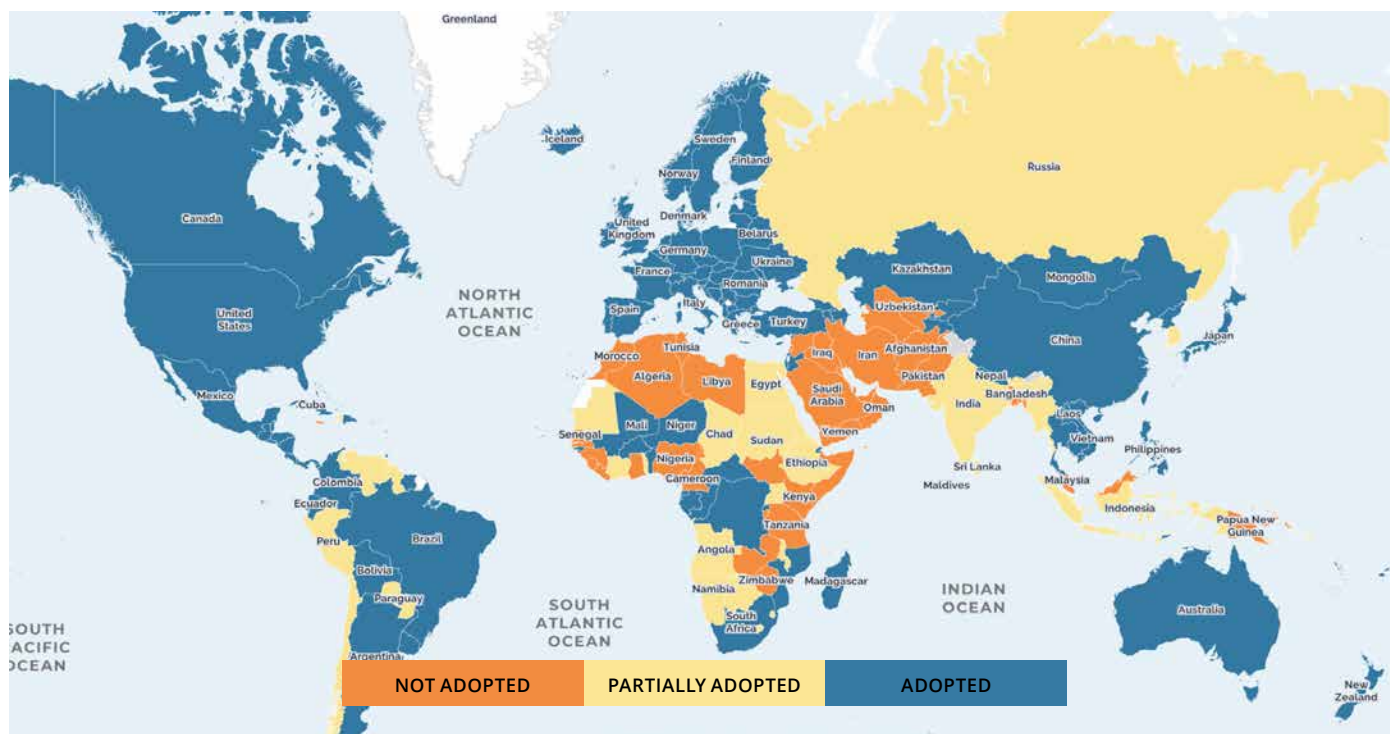
Do national policies align with global recommendations on **not criminalizing drug use**?



When it comes to non-criminalization of same-sex sexual relations and HIV exposure/transmission, more progress has been made. 64% of countries do not criminalize same-sex sexual relations in law; 74% do not arrested people for it (based on reports identified in the past few years, including those compiled by ILGA and UNAIDS). That said, the fact that more than one-third of countries in the world continue to criminalize same-sex sexual relations is a significant problem.

Fig 3.18

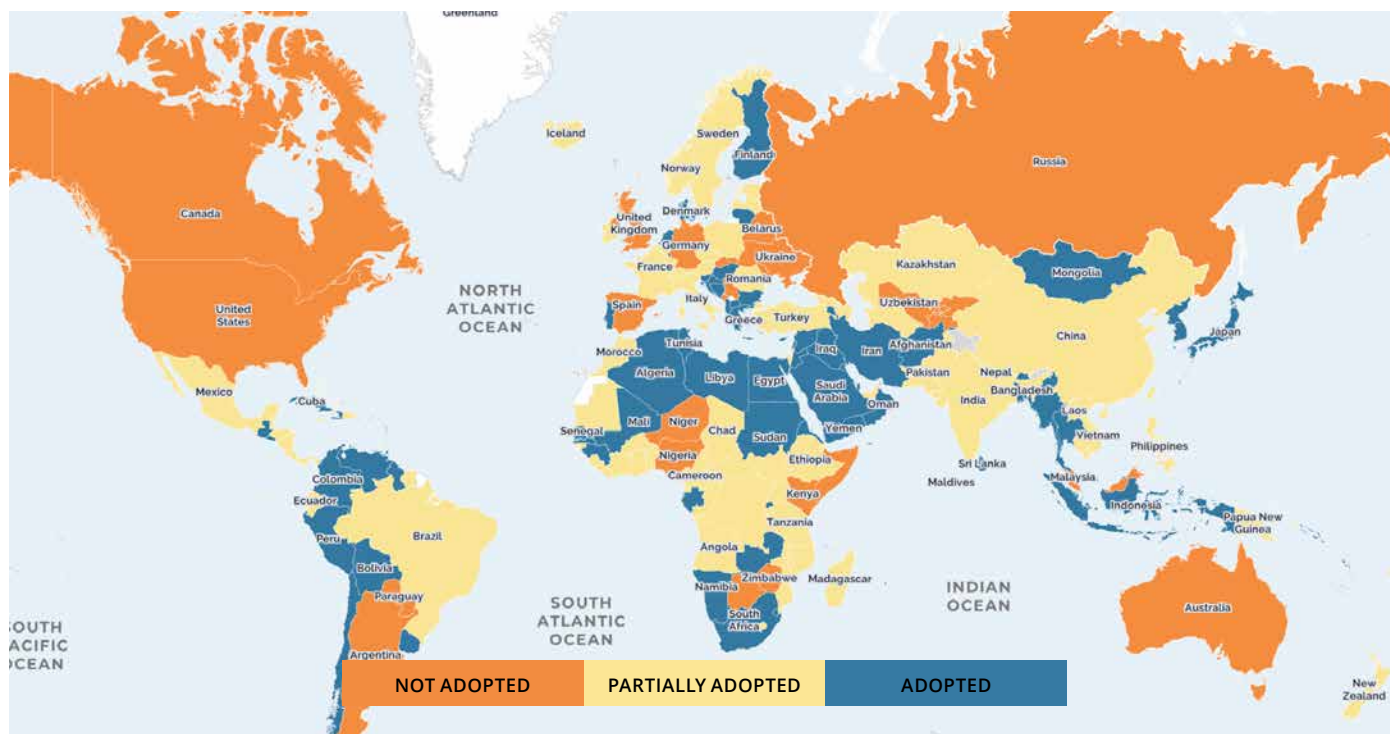
Do national policies align with global recommendations on not criminalizing same-sex sexual relations?



At least 40% of countries still criminalize HIV exposure/ transmission in law, which is particularly unhelpful in encouraging people to know their status. These are not just laws as written, since at least 25% of countries have a policy of arresting and/or prosecuting people for exposure/transmission, based on reports by the HIV Justice Network's Global HIV Criminalization Database (www.hivjustice.net/global-hiv-criminalisation-database) and by UNAIDS.

Fig 3.19

Do national policies align with global recommendations on **not criminalizing HIV exposure**?



The biggest take-away: Insufficient alignment of policies & science are still a major obstacle to ending AIDS

Over the past decade, the scientific evidence base for what kinds of policies we need to end AIDS has advanced rapidly. WHO, UNAIDS, and others have issued authoritative policy recommendations and guidelines for governments to update their policies accordingly. With all the attention, effort, and funding directed towards HIV, it may be tempting to assume that governments have aligned their policies with the science and adopted these recommendations—and that our failure to achieve the 90-90-90 targets is due primarily to problems and failures in implementing these policies.

The HIV Policy Lab shows conclusively that this is not the case. Poor policies are still a major barrier in the fight against HIV. Only 12% of countries in the world have adopted *Many* or *Most* of the 33 policies we track. Put differently, 87% of countries have adopted less than 60% of the recommended policies. No country has fully aligned with the best science. Though progress has been made on certain policies and in certain policy categories, the world still has a long way to go before we have the policies in place that we need to end AIDS.

Fig. 3.20

How many of the 33 recommended policies has each country adopted?

MOST 4 of 194 countries (2%)	MANY 68 of 194 countries (35%)	SOME 96 of 194 countries (50%)	FEW 22 of 194 countries (11%)	VERY FEW 2 of 194 countries (1%)
South Africa	Argentina	Afghanistan	Bhutan	Iraq
France	Armenia	Albania	Brunei	United Arab Emirates
Netherlands	Australia	Algeria	Democratic People's	
Norway	Austria	Angola	Republic of Korea	
	Belgium	Antigua and Barbuda	Djibouti	
	Bolivia	Azerbaijan	Dominica	
	Botswana	Bahamas	Equatorial Guinea	
	Brazil	Bahrain	Eritrea	
	Burkina Faso	Bangladesh	Kuwait	
	Burundi	Barbados	Maldives	
	Cambodia	Belarus	Mauritania	
	Canada	Belize	Micronesia,	
	Central African	Benin	Federated States of	
	Republic	Bosnia and	Nauru	
	Chad	Herzegovina	Niue	
	Chile	Bulgaria	Oman	
	Congo	Cameroon	Pakistan	
	Republic of	Cape Verde	Qatar	
	Costa Rica	China	Saudi Arabia	
	Croatia	Colombia	Tonga	
	Cuba	Comoros	Tunisia	
	Cyprus	Cook Islands	Turkmenistan	
	Czechia	Cote d'Ivoire	Tuvalu	
	Democratic Republic	Dominican Republic	Yemen	
	of the Congo	Egypt		
	Denmark	El Salvador		
	Ecuador	Ethiopia		
	Estonia	Fiji		
	Eswatini	Gabon		
	Finland	Gambia		
	Georgia	Grenada		
	Germany	Guatemala		
	Ghana	Guinea		
	Greece	Guinea Bissau		
	Haiti	Guyana		
	Hungary	Honduras		
	Ireland	Iceland		
	Italy	India		
	Kenya	Indonesia		
	Lesotho	Iran		
	Lithuania	Israel		
	Luxembourg	Jamaica		
	Malawi	Japan		
	Mexico	Jordan		
	Moldova	Kazakhstan		
	Mozambique	Kiribati		
	Namibia	Korea		
	Nepal	Republic of		
	Nigeria	Kyrgyzstan		

MOST 4 of 194 countries (2%)	MANY 68 of 194 countries (35%)	SOME 96 of 194 countries (50%)	FEW 22 of 194 countries (11%)	VERY FEW 2 of 194 countries (1%)
	North Macedonia	Laos		
	Poland	Latvia		
	Portugal	Lebanon		
	Romania	Liberia		
	Rwanda	Libya		
	Senegal	Madagascar		
	Seychelles	Malaysia		
	Slovakia	Mali		
	Slovenia	Malta		
	Spain	Marshall Islands		
	Sweden	Mauritius		
	Switzerland	Monaco		
	Tanzania, United	Mongolia		
	Republic of	Montenegro		
	Thailand	Morocco		
	Timor-Leste	Myanmar		
	Togo	New Zealand		
	Uganda	Nicaragua		
	Ukraine	Niger		
	United Kingdom	Palau		
	Uruguay	Panama		
	Zambia	Papua New Guinea		
	Zimbabwe	Paraguay		
		Peru		
		Philippines		
		Russia		
		Saint Kitts and Nevis		
		Saint Lucia		
		Saint Vincent and the Grenadines		
		Samoa		
		Sao Tome & Principe		
		Serbia		
		Republic of		
		Sierra Leone		
		Singapore		
		Solomon Islands		
		Somalia		
		South Sudan		
		Sri Lanka		
		Sudan		
		Suriname		
		Syria		
		Tajikistan		
		Trinidad and Tobago		
		Turkey		
		USA		
		Uzbekistan		
		Vanuatu		
		Venezuela		
		Vietnam		

Countries with insufficient data to score: Andorra, San Marino

Progress in the fight against HIV offers hope for COVID-19

Twenty years ago, ART and high-quality clinical care were available in high-income countries but not the rest of the world. This is no longer the case thanks to activism by the community of PLHIV and allies, the creation of new and more robust funding agencies, coordination by multilateral organizations, and concerted efforts by governments. Even as so much more needs to be done to halt the HIV pandemic, the magnitude of what has been achieved to close the access gap and tackle this virus without a cure or vaccine cannot be overstated. It proves that solidarity in pursuit of the human right to the highest attainable standard of health is not just a pipe dream—or it does not have to be.

As such, there are some key lessons from HIV and the HIV Policy Lab that have immediate application for the COVID response. Two in particular deserve highlighting in this 2020 report.

First, policies that respect human rights and empower communities work. Criminalization doesn't. An effective, sustainable pandemic response depends on building trust between public health officials and communities. It depends on making sure that people have the information and support they need to assess risks and make choices to protect themselves and the people around them. And it means empowering people to comply with public health measures over the long haul by ensuring that they can do so without sacrificing their livelihoods. Stigma, discrimination, and the use of criminal penalties or even violence to enforce public health measures is ineffective and undermines that essential trust. As described in this report, every country in the world has at laws that criminalize either gay sexual relations, drugs, sex work, or HIV exposure—often several of these. But many countries have made progress in eliminating punitive laws and policies on HIV. Today, for example, countries as diverse as Argentina, South Africa, Portugal, Rwanda, and Mongolia have relatively high rates of adoption in the “structural” area of HIV-related laws and policies. Each has policies not aligned with international standards, but fewer than most.

In the coming years, more work in this area is needed. As legal frameworks are established to respond to COVID-19, they should start from this base understanding and, wherever possible, lean giving people the support they need to comply with public health measures over the use

of criminal law to punish non-compliance. Meanwhile, the AIDS response and the COVID-19 response have opportunities for synergies in law reform that can help enshrine alternatives to criminalization for these and other diseases.

Second, unequal access to health technologies fuels pandemics, costing lives and hurting economies. Ensuring access to affordable health technologies in low- and middle-income countries must get better, not worse, than has been achieved on HIV.

Twenty years ago, policymakers in high-income countries insisted that it was not affordable or feasible to make life-saving HIV treatment available everywhere in the world. That argument was wrong then about HIV, and it is wrong now about COVID-19. From the vantage point of 2020, we can see that it also drove the expanding AIDS pandemic—had access come earlier and wider, millions of HIV infections could have been halted and the task still ahead would be far less daunting.

To expand access to HIV treatment, the global health community developed an entire infrastructure of financial, procurement, production, and distribution mechanisms. We must now leverage those mechanisms or create similar or better ones for COVID-19.

The use of TRIPS flexibilities for public health, outlined in the WTO Doha Declaration, is one such mechanism. As of 2020, at least 73 countries have incorporated TRIPS flexibilities (including compulsory licensing, parallel importation, and/or the least developed countries (LDC) extension) into national law, and at least 109 countries have utilized these flexibilities to procure affordable medicines (not just ARVs). The creation of a robust market for affordable, generic ARVs brought the price of AIDS drugs down by over 99%. Most often this has had less to do with the provisions that get high profile attention, like issuance of compulsory licenses, than with the leverage that open trade and generic production has given to governments and aid agencies like the Global Fund to negotiate with companies and procure technologies at an affordable rate. Yet far too often, these dynamics have been limited to HIV and not extended to other needs—from cancer to heart disease, and now to COVID-19. The technologies needed for COVID-19, including vaccines, testing, and hopefully an eventual, highly effective treatment, are different—the market dynamics are different. But the lessons of HIV in the use of policy to expand affordable access, including the extensive use of TRIPS flexibilities, the pooling of IP, and others remain important.

Policy Change Story: Why fixing South Africa's patent laws is necessary in the fight against HIV

Contributed by

Umunyana Rugege, SECTION 27

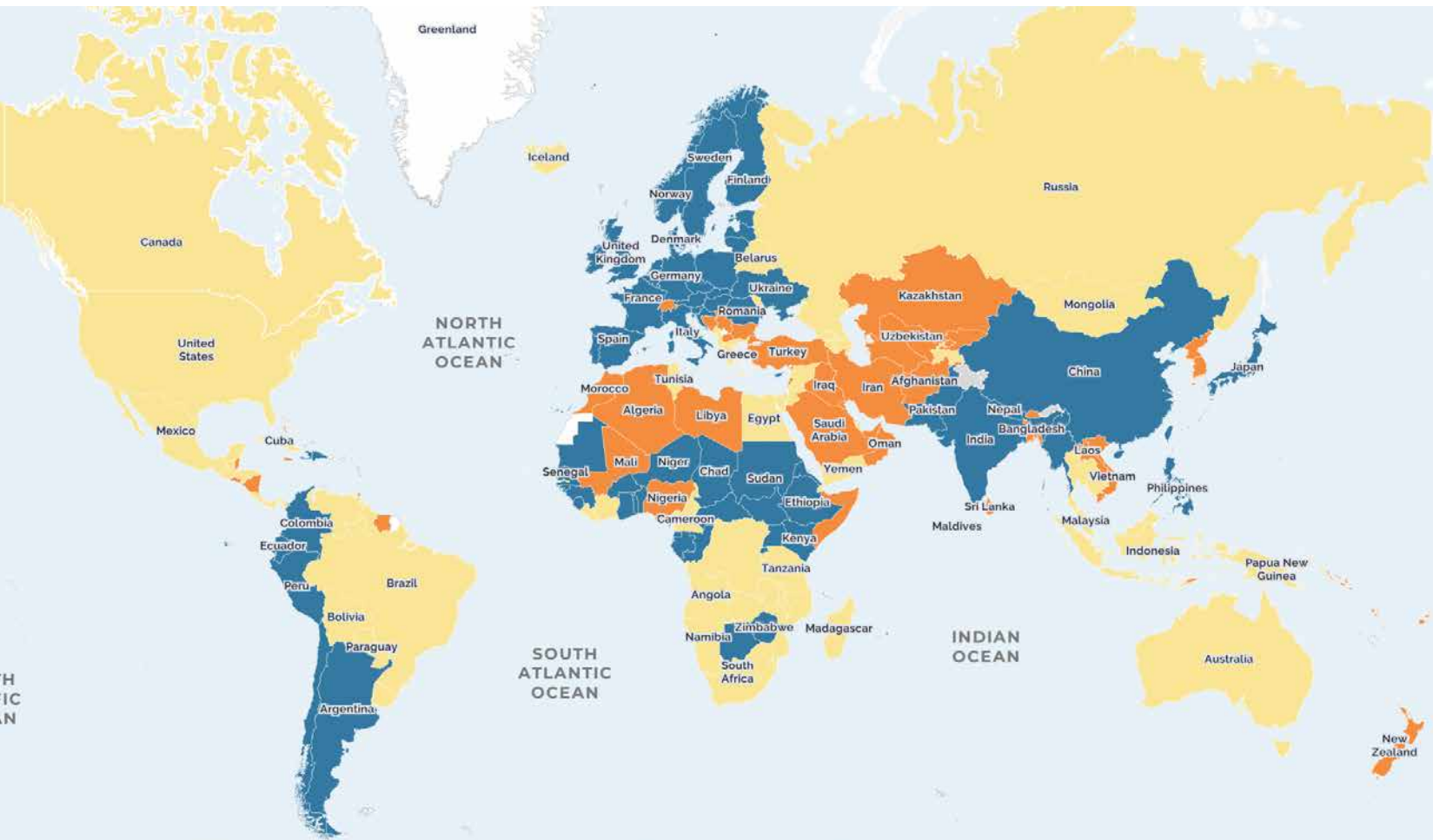
COVID-19 is a global health crisis and one that affects working-class and poor people disproportionately. People's lives are at stake. The world needs governments, multilateral institutions, and industry to take bold steps that prioritize the needs of vulnerable populations above profits and above nationalism. Sound familiar? We discussed this around the early 2000s, in relation to the HIV epidemic.

We have won many battles in the fight against HIV in South Africa over the past two decades. The court victory in the mother-to-child-transmission case enabled the state to expand this important intervention. Victories driven by activists, people living with HIV, unions, and others stopped the excessive pricing of HIV treatment by pharmaceutical companies using completion law. And now we are managing the largest HIV program in the world with the lowest costing drugs. But we still have not taken advantage of the opportunities in international trade law to deal effectively with monopolies across all disease areas. South Africa's patent law has not been changed since the 1970s. In the interim, we established a constitutional democracy that places obligations on the state to take necessary legislative and other measures to progressively realize the right to health. We know how patent laws and the lack of competition drives up prices of life-saving medicines, we learnt that lesson decades ago. Over at least the last decade, activists in South Africa have been pressing the government to reform the patent regime. A long policy process, which sought the input of a vast array of stakeholders from industry and civil society—and with the support of think tanks around the world—has resulted in a 2018 policy that properly balances intellectual property and public health. This was a victory for the movement for equitable access to affordable medicines. But more is needed.

The Fix the Patent Laws Coalition (FTPL), a group of over 40 organizations working to reform South Africa's patent laws has called for the urgent finalization of draft amendments to the Patents Act to ensure that the government has the tools to address all public health issues. This has been brought into stark relief during the COVID-19 pandemic. The urgency of finalizing this law reform process is more real than ever. However, this is just as important for addressing the HIV/AIDS epidemic. 7.6 million people are living with HIV in South Africa, that is roughly 13% of the population. That is 4.8 million women and 2.5 million men. Young women continue to bear the brunt of this epidemic and continue to face discrimination and stigma and also face poverty and the burden of unpaid care work. It is critical that second line treatment and new treatments are available in the public health sector. Exciting new research means that we may soon have an HIV prevention injection, which, if accessible, will be a major breakthrough for women in South Africa. Affordability is key, however, and that means we must ensure that the legal environment is able to be responsive to public health needs. As new drugs for HIV and TB come online and health technologies for COVID-19 become available, we must ensure that we meet the challenge in line with the constitutional right to access health care services.

The South African government has shown exemplary leadership on the world stage on matters of public health. For example, the government has proposed a coronavirus waiver of intellectual property at the World Trade Organization to ensure that developing and middle-income countries are not left behind while wealthy nations secure deals with pharmaceutical companies, and that monopolies do not stand in the way of widespread African access to COVID-19 vaccines. This is the kind of solidarity that helped turn the HIV epidemic around. Addressing intellectual property barriers in our domestic laws is absolutely critical to fight the COVID-19 pandemic and to address the pressing HIV and TB burden. This is why the Fix the Patent Laws Campaign has called on Minister Patel and President Ramaphosa to act with urgency to ensure that South Africa has an intellectual property regime that ensures equitable access to life-saving vaccines and medicines.

Fig 4.1: Do national policies align with global recommendations on [access to medicines \(TRIPS\)](#)?



Appendix A

Country Policy Adoption Scores

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Asia & Pacific (AP)					
Afghanistan	Many	Few	Few	Some	Some
Australia	Most	Some	Some	Some	Many
Bangladesh	Some	Very few	Some	Some	Some
Bhutan	Many	Some	Few	Null	Few
Brunei	Few	Few	Few	Some	Few
Cambodia	Most	Many	Some	Some	Many
China	Few	Some	Some	Some	Some
Cook Islands	Many	Null	Some	Null	Some
Democratic People's Republic of Korea	Null	Null	Few	Null	Few
Fiji	Some	Some	Some	Very Few	Some
India	Most	Some	Many	Some	Some
Indonesia	Some	Few	Some	Some	Some
Japan	Some	Few	Some	Many	Some
Kiribati	Few	Some	Many	Many	Some
Korea, Republic of	Some	Some	Few	Many	Some
Laos	Most	Few	Few	Very Few	Some
Malaysia	Some	Few	Some	Some	Some

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Maldives	Few	Very few	Few	Null	Few
Marshall Islands	Many	Very few	Some	Few	Some
Micronesia, Federated States of	Few	Few	Few	Very Few	Few
Mongolia	Some	Some	Many	Some	Some
Myanmar	Many	Some	Few	Few	Some
Nauru	Few	Some	Few	Very Few	Few
Nepal	Most	Some	Many	Some	Many
New Zealand	Some	Some	Many	Many	Some
Niue	Some	Very few	Some	Very Few	Few
Pakistan	Some	Very few	Few	Some	Few
Palau	Null	Some	Some	Null	Some
Papua New Guinea	Most	Few	Few	Some	Some
Philippines	Some	Some	Many	Some	Some
Samoa	Many	Some	Some	Most	Some
Singapore	Many	Some	Few	Some	Some
Solomon Islands	Some	Some	Few	Very Few	Some
Sri Lanka	Some	Very few	Some	Some	Some
Thailand	Most	Many	Many	Most	Many
Timor-Leste	Most	Few	Many	Null	Many
Tonga	Few	Few	Few	Very Few	Few
Tuvalu	Few	Very few	Few	Few	Few
Vanuatu	Many	Some	Few	Few	Some

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Vietnam	Many	Some	Some	Some	Some
Eastern Europe & Central Asia (EECA)					
Albania	Some	Some	Many	Some	Some
Armenia	Most	Some	Many	Some	Many
Azerbaijan	Many	Some	Some	Some	Some
Belarus	Many	Some	Few	Some	Some
Bosnia and Herzegovina	Very Few	Some	Some	Many	Some
Georgia	Many	Few	Many	Many	Many
Kazakhstan	Most	Few	Some	Some	Some
Kyrgyzstan	Most	Many	Some	Few	Some
Moldova	Most	Many	Many	Many	Many
Montenegro	Few	Few	Many	Many	Some
North Macedonia	Many	Many	Many	Many	Many
Russia	Many	Very few	Some	Many	Some
Tajikistan	Most	Few	Some	Some	Some
Turkmenistan	Null	Null	Very Few	Many	Few
Ukraine	Most	Many	Many	Some	Many
Uzbekistan	Many	Some	Few	Some	Some
Eastern & Southern Africa (ESA)					
Angola	Many	Few	Some	Many	Some
Botswana	Most	Some	Few	Many	Many
Comoros	Many	Some	Some	Some	Some

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Eritrea	Few	Many	Few	Null	Few
Eswatini	Most	Many	Some	Most	Many
Ethiopia	Most	Few	Some	Few	Some
Kenya	Most	Many	Some	Many	Many
Lesotho	Most	Most	Very Few	Many	Many
Madagascar	Some	Some	Some	Many	Some
Malawi	Most	Many	Some	Many	Many
Mauritius	Many	Few	Many	Many	Some
Mozambique	Most	Some	Some	Some	Many
Namibia	Most	Many	Some	Many	Many
Rwanda	Most	Many	Many	Many	Many
Seychelles	Many	Some	Many	Many	Many
South Africa	Most	Most	Most	Most	Most
South Sudan	Most	Few	Few	Some	Some
Tanzania, United Republic of	Most	Many	Some	Some	Many
Uganda	Most	Many	Some	Many	Many
Zambia	Most	Many	Some	Many	Many
Zimbabwe	Most	Some	Some	Many	Many
Latin America & the Caribbean (LAC)					
Antigua and Barbuda	Most	Few	Some	Many	Some
Argentina	Many	Few	Many	Many	Many
Bahamas	Some	Some	Few	Many	Some

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Barbados	Many	Few	Some	Some	Some
Belize	Some	Many	Some	Many	Some
Bolivia	Many	Few	Many	Many	Many
Brazil	Most	Many	Many	Most	Many
Chile	Some	Some	Most	Many	Many
Colombia	Few	Some	Most	Many	Some
Costa Rica	Few	Many	Many	Many	Many
Cuba	Many	Some	Some	Many	Many
Dominica	Few	Few	Few	Few	Few
Dominican Republic	Many	Few	Some	Many	Some
Ecuador	Some	Some	Many	Many	Many
El Salvador	Many	Some	Many	Some	Some
Grenada	Many	Null	Few	Null	Some
Guatemala	Many	Few	Many	Some	Some
Guyana	Many	Some	Some	Some	Some
Haiti	Most	Some	Some	Many	Many
Honduras	Some	Few	Many	Few	Some
Jamaica	Many	Some	Few	Some	Some
Mexico	Most	Some	Many	Some	Many
Nicaragua	Few	Some	Some	Many	Some
Panama	Many	Very few	Many	Some	Some
Paraguay	Many	Few	Many	Many	Some

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Peru	Some	Few	Many	Many	Some
Saint Kitts and Nevis	Many	Few	Few	Some	Some
Saint Lucia	Some	Very few	Few	Some	Some
Saint Vincent and the Grenadines	Some	Some	Few	Few	Some
Suriname	Some	Few	Many	Few	Some
Trinidad and Tobago	Null	Null	Some	Few	Some
Uruguay	Many	Some	Most	Some	Many
Venezuela	Many	Some	Some	Few	Some
Middle East & North Africa (MENA)					
Algeria	Many	Some	Some	Few	Some
Bahrain	Null	Few	Some	Some	Some
Djibouti	Many	Few	Very Few	Few	Few
Egypt	Most	Few	Some	Some	Some
Iran	Some	Many	Few	Some	Some
Iraq	Null	Very few	Few	Very Few	Very few
Jordan	Some	Very few	Some	Some	Some
Kuwait	Many	Very few	Few	Few	Few
Lebanon	Most	Some	Few	Null	Some
Libya	Some	Few	Few	Many	Some
Morocco	Some	Some	Few	Some	Some
Oman	Some	Few	Few	Few	Few
Qatar	Many	Very few	Few	Few	Few

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Saudi Arabia	Some	Few	Few	Very Few	Few
Somalia	Most	Few	Very Few	Some	Some
Sudan	Many	Very few	Few	Some	Some
Syria	Many	Few	Few	Null	Some
Tunisia	Few	Some	Few	Some	Few
United Arab Emirates	Some	Few	Very Few	Very Few	Very few
Yemen	Null	Very few	Few	Null	Few
Western & Central Africa (WCA)					
Benin	Many	Some	Some	Many	Some
Burkina Faso	Most	Some	Some	Many	Many
Burundi	Most	Many	Some	Many	Many
Cameroon	Most	Some	Few	Some	Some
Cape Verde	Some	Null	Many	Many	Some
Central African Republic	Most	Some	Some	Most	Many
Chad	Most	Some	Some	Many	Many
Congo, Republic of	Most	Many	Some	Many	Many
Cote d'Ivoire	Many	Some	Some	Many	Some
Democratic Republic of the Congo	Most	Many	Some	Some	Many
Equatorial Guinea	Some	Very few	Few	Many	Few
Gabon	Most	Few	Few	Most	Some
Gambia	Most	Few	Few	Many	Some
Ghana	Many	Some	Some	Most	Many

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Guinea	Many	Some	Few	Many	Some
Guinea Bissau	Some	Few	Some	Many	Some
Liberia	Most	Few	Few	Few	Some
Mali	Many	Some	Some	Some	Some
Mauritania	Some	Few	Few	Many	Few
Niger	Many	Some	Some	Many	Some
Nigeria	Most	Most	Few	Some	Many
Sao Tome and Principe	Some	Many	Many	Some	Some
Senegal	Many	Some	Some	Many	Many
Sierra Leone	Most	Some	Some	Some	Some
Togo	Many	Many	Some	Many	Many
Western and Central Europe & North America (WCENA)					
Andorra	Null	Null	Many	Null	Null
Austria	Some	Most	Some	Most	Many
Belgium	Most	Many	Many	Most	Many
Bulgaria	Some	Few	Many	Many	Some
Canada	Some	Many	Some	Many	Many
Croatia	Null	Some	Most	Most	Many
Cyprus	Few	Some	Many	Most	Many
Czechia	Some	Many	Many	Many	Many
Denmark	Many	Some	Many	Most	Many
Estonia	Many	Many	Some	Many	Many

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Finland	Many	Most	Many	Most	Many
France	Most	Many	Many	Most	Most
Germany	Many	Many	Many	Most	Many
Greece	Most	Some	Most	Some	Many
Hungary	Many	Few	Many	Most	Many
Iceland	Many	Many	Few	Many	Some
Ireland	Many	Many	Some	Many	Many
Israel	Few	Few	Some	Many	Some
Italy	Most	Many	Many	Most	Many
Latvia	Some	Some	Some	Many	Some
Lithuania	Many	Some	Many	Many	Many
Luxembourg	Some	Most	Many	Many	Many
Malta	Some	Many	Few	Many	Some
Monaco	Many	Some	Some	Few	Some
Netherlands	Most	Most	Most	Many	Most
Norway	Most	Most	Many	Most	Most
Poland	Most	Some	Many	Most	Many
Portugal	Many	Many	Many	Most	Many
Romania	Some	Most	Many	Most	Many
San Marino	Null	Null	Some	Null	Null
Serbia, Republic of	Some	Few	Many	Some	Some
Slovakia	Many	Some	Many	Most	Many

	Clinical/ Treatment Policy Adoption Score	Treatment & Prevention Policy Adoption Score	Structural Policy Adoption Score	Health Systems Policy Adoption Score	Overall Policy Adoption Score
Slovenia	Null	Some	Many	Most	Many
Spain	Many	Many	Many	Many	Many
Sweden	Most	Some	Some	Many	Many
Switzerland	Most	Most	Some	Many	Many
Turkey	Some	Few	Some	Few	Some
United Kingdom	Most	Many	Some	Most	Many
United States of America	Most	Some	Some	Some	Some

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policylab@georgetown.edu
hivpolicylab.org

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