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Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS

Addressing inequalities and getting back on track to end AIDS by 2030

Report of the Secretary-General

Summary

The present report, submitted pursuant to General Assembly resolution 70/266, provides information on progress achieved towards the commitments made in the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. There has been intensive action and progress against HIV in some places and population groups, while inaction in other places has allowed HIV epidemics to expand and deaths to mount. Six years after the General Assembly set an ambitious global goal to end AIDS by 2030, momentum is being lost. The global targets for 2020, agreed to in 2016 in the Political Declaration on HIV/AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, were missed. The stark contrast of successes in some areas and failures in others confirms that HIV remains a pandemic of inequalities. Getting back on track will require urgent, transformative action to reduce and end inequalities, as well as increased domestic and international investment in HIV, health, social protection, humanitarian responses and pandemic preparedness and control systems. Member States and all stakeholders are encouraged to adopt the recommendations in the present report, including the full set of 2025 targets, to re-energize progress towards ending AIDS and achieving the Sustainable Development Goals during the decade of action for the Goals.

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I. Introduction

1. Twenty years ago, the United Nations General Assembly convened its first-ever special session to address a pandemic that was causing death and devastation on a tremendous scale, overwhelming communities and health systems. AIDS was an unprecedented global challenge, and it was met with global solidarity and action. An innovative joint United Nations approach engaged all countries and the most affected communities in decision-making and service delivery. Life-saving medicines and health technologies that had been available in high-income countries began to reach people in the low-income and middle-income countries hardest hit by the virus.

2. Deaths from AIDS-related causes peaked in 2004 and have since fallen by 60 per cent. The annual number of new HIV infections has declined by more than one-third since 2001, including a 68 per cent reduction in vertical transmission of HIV to children. Stigma and discriminatory actions based on fear, racism, homophobia and denialism have been steadily replaced by science, compassion and rights-based approaches.

3. This progress reflects how the ideals on which the United Nations was founded upon 75 years ago have been turned into reality when the international community acts in solidarity against a global threat to health, development and security. Global action against HIV has been embedded within the 2030 Agenda for Sustainable Development, reflecting that health and well-being require more than health services – they require education, sustainable livelihoods, human rights, gender equality, community engagement and the forging of diverse partnerships. The Joint United Nations Programme on HIV/AIDS (UNAIDS), which draws on the experience and contributions of 11 United Nations system co-sponsors, exemplifies this approach. Twenty-five years after its creation, UNAIDS continues to refine its unique model in line with the 2030 Agenda and the reforms of the United Nations development system.

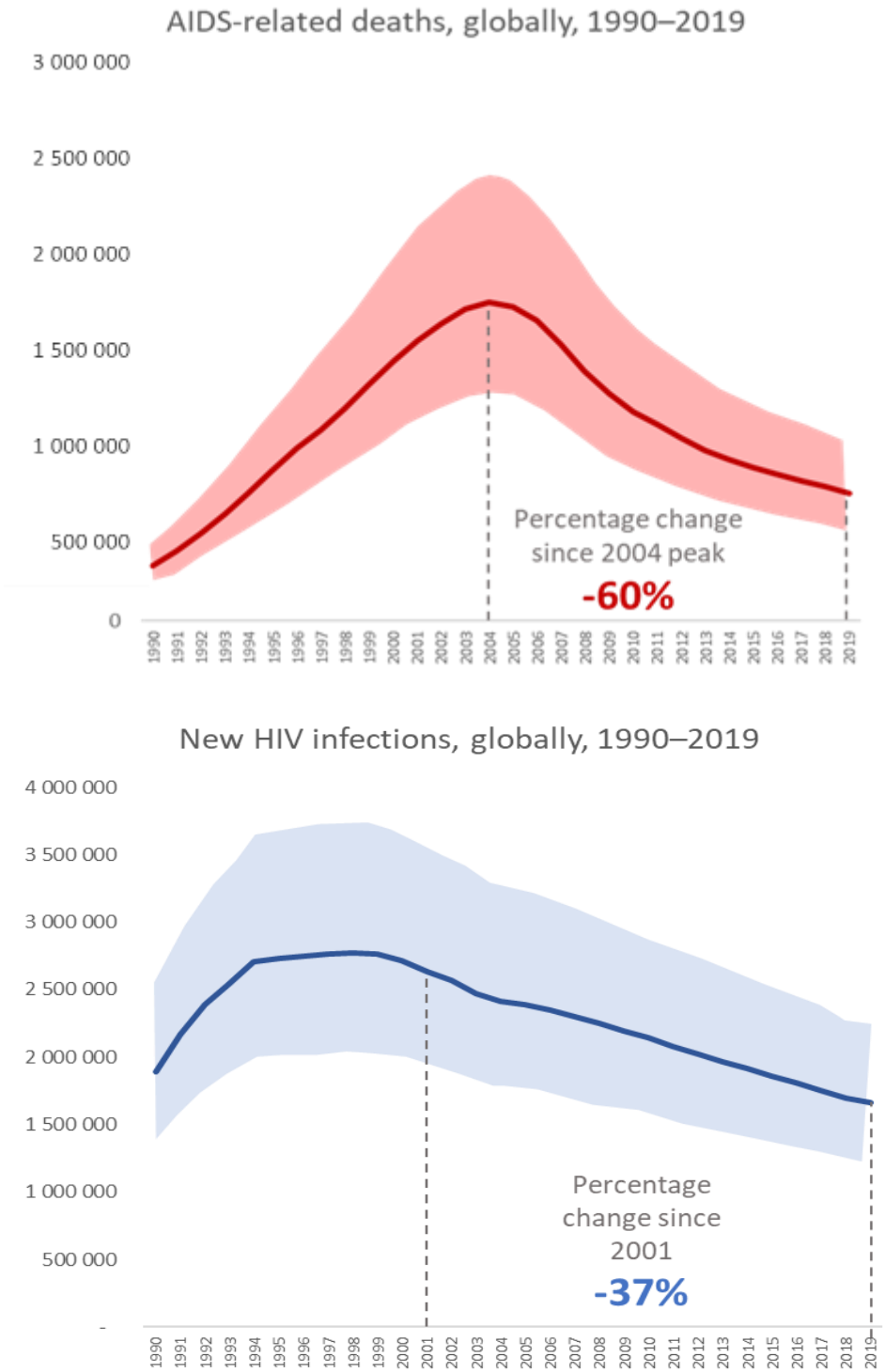
4. But the journey is far from over. There has been intensive action and progress against HIV in some places and population groups, while inaction in other places has allowed HIV epidemics to expand and deaths to mount. Of particular concern is inattention to the needs of key populations,[1] who continue to be marginalized and criminalized for their gender identities, sexual orientation, livelihoods, dependencies or simply for living with HIV. Gender inequality and gender-based violence leave women and adolescent girls particularly vulnerable to HIV, especially in high-burden settings. Children living with HIV are much less likely to receive treatment than adults, and their health outcomes are worse owing to suboptimal paediatric medication. The pandemic caused by the coronavirus disease (COVID-19) has placed enormous additional pressures on HIV responses, health systems and the people in need of services. Six years after the General Assembly set an ambitious global goal to end AIDS by 2030,[2] momentum is being lost. The global targets for 2020, which were agreed to in 2016 in the Political Declaration on HIV/AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, were missed.

[1] Key populations, or key populations at higher risk of HIV, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups.

[2] "Ending AIDS" and "ending AIDS as a public health threat by 2030" are defined as a 90 per cent reduction in annual HIV infections and AIDS-related deaths by 2030, compared to a 2010 baseline.

Figure I

Progress achieved since the 2001 United Nations General Assembly Special Session on HIV/AIDS



Source: Joint United Nations Programme on HIV/AIDS (UNAIDS).

5. The stark contrast of successes in some areas and failures in others confirms that HIV remains a pandemic of inequalities. The global AIDS community and UNAIDS have used an inequalities lens to develop a bold new strategy, with new targets that are ambitious, granular and tailored to reach the furthest behind first.[3] The upcoming high-level meeting of the General Assembly on HIV and AIDS, which will be held from 8 to 10 June 2021, provides a critical opportunity to advance this strategy, which includes new, ambitious global targets for 2025. Achieving these targets will require urgent, transformative action to reduce and end inequalities, as well as increased domestic and international investment in HIV, health, social protection, humanitarian responses and pandemic preparedness and control systems.

6. This pivotal moment for the global AIDS response comes as the COVID-19 pandemic upends both the global economy and our day-to-day life. The COVID-19 pandemic is overwhelming even the most sophisticated health systems, worsening gender inequalities and gender-based violence, threatening the education of a generation of young people, and disrupting HIV prevention, diagnosis and treatment initiation. At the same time, the COVID-19 pandemic has highlighted the agility of the HIV response and the many spill-over benefits of HIV investments in health and development. Community-led service delivery pioneered by the HIV response is helping to overcome the extraordinary obstacles created by the COVID-19 pandemic.

7. Some may argue that the world cannot afford to end AIDS during these difficult times. Such short-sighted approach was exactly what left the world so vulnerable to COVID-19. Countries can no longer afford to under-invest in pandemic preparedness and responses. The evidence and lessons learned from the HIV response show that investing too little, too late merely leads to millions of additional people requiring services, greater risk and uncertainty, and higher future costs.

8. Member States and all stakeholders are encouraged to adopt the recommendations within this report, including the full set of 2025 targets, to re-energize progress towards ending AIDS and achieving the Sustainable Development Goals during this decade of action for the Goals.

II. Successes and lessons from five years of “fast-track”

9. Five years ago, the General Assembly committed to “fast-track” the HIV response by making bold commitments and setting ambitious targets for 2020 (see resolution 70/266, annex). In 2016, the Political Declaration on HIV/AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 created an agenda to put the world on track to ending AIDS as a public health threat within 15 years, as called for in the 2030 Agenda.

10. Dozens of countries across different regions, economic and epidemic settings have achieved or are on track to achieve many of these commitments. A common thread among them is political leadership on AIDS, strong community engagement, rights-based and multisectoral approaches, and consistent use of scientific evidence to guide concerted action.

11. Expanded access to HIV services continues to generate health and development benefits, with innovations in diagnostics, therapeutics and service delivery techniques improving the impact, effectiveness and efficiency of HIV services. HIV investments and responses have also strengthened the functioning and resilience of health systems.

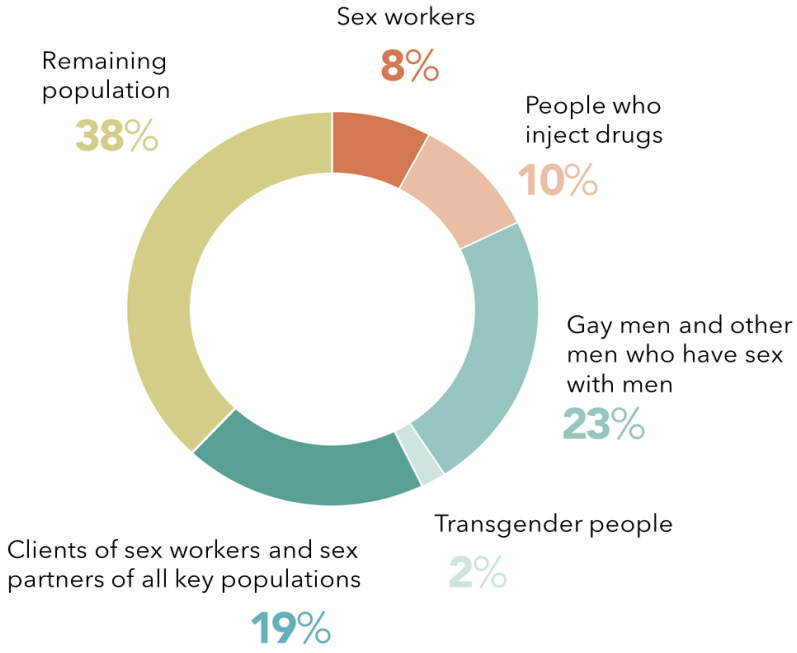
[3] “End Inequalities, End AIDS”. Global AIDS Strategy 2021–2026. Approved by the UNAIDS Programme Coordinating Board on 24–25 March 2021.

12. Deaths due to AIDS-related causes declined by 39 per cent from 2010 to 2019, and at least 26 countries are on track to achieve a 90 per cent reduction in AIDS-related mortality by 2030, including nine countries in eastern and southern Africa. Nevertheless, the staggering 690,000 AIDS-related deaths in 2019 far exceeds the 2020 target of reducing mortality to less than 500,000.

13. New HIV infections have been reduced by 23 per cent since 2010. Twenty-three countries were on track to achieve a 90 per cent reduction by 2030. However, the 1.7 million infections that occurred in 2019 are more than three times higher than the global target of less than 500,000 new infections in 2020. The 280,000 young women newly infected in 2019 was nearly three times greater than the 2020 target of fewer than 100,000. An estimated 150,000 new HIV infections among children (aged 0–14) occurred in 2019, compared to a 2020 target of less than 20,000.

14. Key populations continue to be left behind. HIV infections among gay men and other men who have sex with men increased by 25 per cent between 2010 and 2019, and annual infections among sex workers, people who inject drugs and transgender people have barely changed. Key populations and their sexual partners accounted for 62 per cent of all new infections worldwide in 2019.

Figure II
Distribution of new HIV infections by population, globally, 2019



Source: UNAIDS.

Progress on HIV service delivery

15. The 90–90–90 targets[4] called for HIV testing and treatment to be accessed by the vast majority of people living with HIV by 2020. Achieving the targets result in a minimum of 73 per cent of people living with HIV having suppressed viral loads, which keeps them healthy and prevents further spread of the virus. At the end of 2019,

[4] The targets called for 90 per cent of people living with HIV to know their HIV status, 90 per cent of people who know their HIV-positive status to be accessing treatment and 90 per cent of people on treatment to have suppressed viral loads.

14 countries in three regions had achieved 73 per cent viral suppression, with Eswatini and Switzerland remarkably surpassing 95–95–95.

16. Globally, at the end of 2019, 81 per cent of people living with HIV knew their HIV status, over two thirds were accessing antiretroviral therapy, and 59 per cent were virally suppressed. By June 2020 an estimated 26 million people living with HIV were accessing treatment – a number that has more than tripled since 2010, but still fell short of the 30 million target for 2020.

17. New HIV infections among children fell by more than half from 2010 to 2019, progress largely reflecting the increased provision of antiretroviral therapy to pregnant and breastfeeding women living with HIV. However, efforts to eliminate vertical HIV transmission have slowed in recent years. Treatment coverage among children living with HIV (53 per cent in 2019) is well below the coverage for adults (68 per cent) – a global failure to provide life-sustaining treatment and care to 840,000 children. More than half are older children who went undiagnosed as infants.

18. More than 15 million men and boys across 15 priority countries have been voluntarily and medically circumcised since 2016, against a target of 25 million young men by 2020. The introduction of pre-exposure prophylaxis (PrEP) to the HIV prevention toolbox has contributed to steeper reductions in HIV infections in several cities in North America, Europe and Australia among gay men and other men who have sex with men. The number of people reported to have received PrEP at least once in the previous year has increased dramatically, from fewer than 2,000 in 2016 to more than 590,000 in 2019.

19. However, progress on combination HIV prevention remains far too slow. Coverage in 2019 across the key pillars of combination prevention fell substantially short of global targets. Young people's comprehensive knowledge of HIV remains markedly lower than the 90 per cent target for 2020, and condom use by young women and young men has declined in several countries in sub-Saharan Africa. Key populations in dozens of countries are unable to access HIV prevention services. The scale up of PrEP has been concentrated in just a few countries, and global coverage is still short of the 2020 target of 3 million receiving PrEP. Comprehensive harm reduction for people who use drugs is absent or insufficient in all but a handful of countries.

20. Many poorly performing HIV responses are in settings where epidemics are heavily concentrated among key populations who disproportionately experience stigmatization, social marginalization and criminalization that blocks their ability to access services.

21. Gender inequality, underpinned by harmful gender norms, gives license to gender-based violence and limits the decision-making power of women and girls. The resulting lack of agency undermines the ability of women and girls to refuse unwanted sex, negotiate safer sex, mitigate HIV risk and access HIV and sexual and reproductive health services.

22. Poverty and food insecurity have been linked with increased risk behaviours among women and have disproportionate health, economic and social impacts among people living with HIV. Among people living with HIV at lower income levels, food insecurity and the difficulties of affording transport and other expenses related to health care contribute to later treatment initiation, lower treatment adherence and higher rates of AIDS-related mortality.

Insufficient resources

23. Failure to reach the service coverage targets for 2020 is in part due to chronic under-investment. In 2019, $19.8 billion (constant 2016 United States dollars) was available for the HIV response in low-income and middle-income countries – nearly 30 per cent short of the $ 26 billion per annum that Member States agreed to mobilize by 2020. Domestic investments in HIV responses in low-income and middle-income

countries have grown by 50 per cent since 2010, peaking in 2017 and then declining by 2 per cent in the following two years (in real terms, adjusted for inflation). Donor support to these countries increased by just 7 per cent between 2010 and 2019, with the United States bilateral contributions through its President's Emergency Plan for AIDS relief (PEPFAR) programme accounting for the majority of this increase.

Taking AIDS out of isolation

24. Scale-up of antiretroviral therapy and improvements in the integrated delivery of HIV and tuberculosis services has reduced tuberculosis-related deaths among people living with HIV by 63 per cent globally between 2010 and 2019, approaching the 2020 target of 75 per cent. While there has been considerable scale up of preventive therapy for tuberculosis among people living with HIV in recent years, tuberculosis remains the leading cause of death among people living with HIV. In 2019, half of people living with HIV who were newly enrolled in antiretroviral therapy did not receive preventative therapy for tuberculosis, and many others already on HIV treatment have not received it either.

25. Hepatitis C coinfection with HIV is reported across all key populations, especially among people who inject drugs. Direct-acting antiviral medicines have revolutionized the treatment and cure of hepatitis C infection. Steep price reductions for diagnostics and therapeutics have coincided with an acceleration of their use, including among people living with HIV.

26. Cervical cancer is the fourth leading cause of cancer deaths among women worldwide, and women living with HIV are about six times more likely to develop cervical cancer than their HIV-negative peers. This risk is linked to the human papillomavirus, a common but preventable infection. High human papillomavirus vaccination coverage of girls – combined with dramatically scaled up cervical cancer screening and treatment – is a cost-effective approach to the elimination of cervical cancer, including among women and girls living with HIV. However, of the 118 million women who have received the human papillomavirus vaccine to date, only 1.4 million (1 per cent) are in low-income and middle-income countries.

Impact of COVID-19

27. The COVID-19 pandemic has exposed the inadequacy of investments in public health, the persistence of profound economic and social inequalities and the fragility of many key global systems and approaches. Health systems are being overwhelmed, and COVID-19-related restrictions have a disproportionate impact on low-income households, women and girls, people living with HIV and key populations.

28. HIV services and commodity supply chains have been disrupted by the COVID-19 pandemic, with many countries reporting dips in new HIV diagnoses and treatment initiations in 2020 and early 2021. Modelling indicates that the impact of the COVID-19 pandemic on the HIV response could result in 123,000 to 293,000 additional HIV infections and 69,000 to 148,000 additional AIDS-related deaths globally.

29. At the same time, the COVID-19 pandemic has highlighted the agility of the HIV response and how HIV investments improve health systems. The use of HIV resources to train health-care workers and strengthen clinical, laboratory and disease surveillance infrastructure has enhanced overall pandemic preparedness and resilience. HIV experts, systems and resources were quickly mobilized in response to the COVID-19 pandemic. As of early 2021, the Global Fund has channelled nearly $1 billion in financial resources to COVID-19 responses of low-income and middle-income countries. UNAIDS co-sponsoring agencies are leveraging their experience and resources to support governments and civil society to provide personal protective equipment and livelihood support to vulnerable populations, and to address human

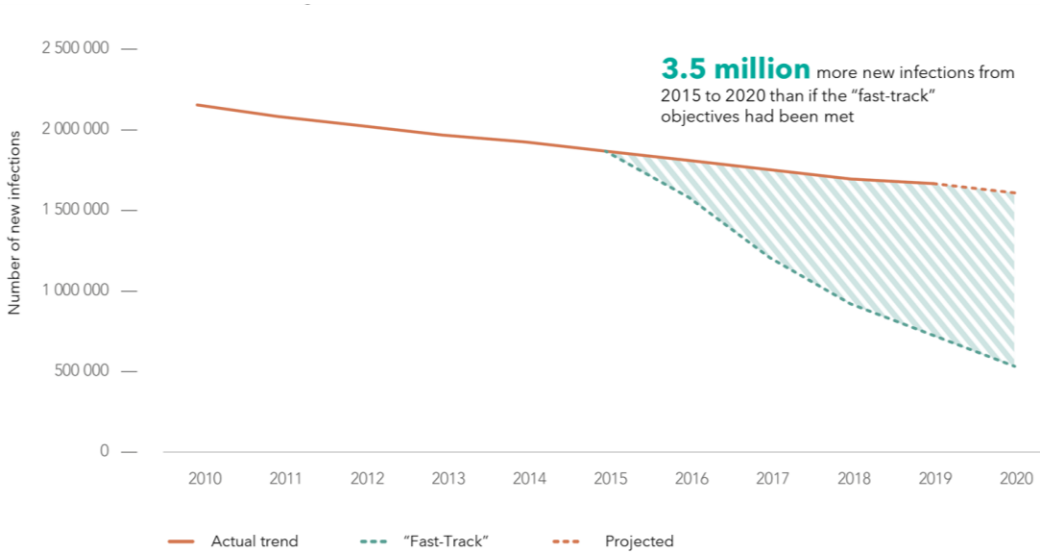
rights issues related to the movement restrictions and confinement resulting from the COVID-19 pandemic. HIV-related policy and service delivery innovations – especially the active engagement of affected communities – continue to support HIV and wider health service delivery in the face of extraordinary impediments.

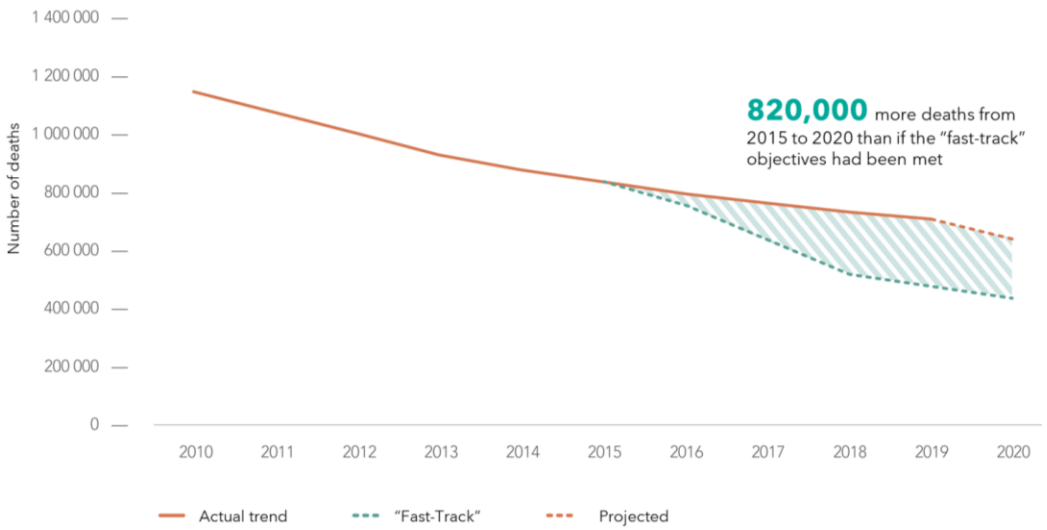
The human cost of coming up short

30. Overall progress has fallen far short of global commitments, hindered by insufficient attention to societal and structural issues and under-investment in comprehensive HIV prevention. The people being left behind are those disproportionately experiencing the impact of gender inequality, HIV-related stigma, social marginalization and criminalization. As a result, none of the global targets for 2020 have been met, and the funding gap for the HIV response in low-income and middle-income countries is widening.

31. Falling short has come at a tragic human cost: since 2016, an additional 3.5 million people acquired HIV and an additional 820,000 people died of AIDS-related deaths because the world did not achieve the 2020 targets (see figure III). Millions of additional people living with HIV now require life-long antiretroviral therapy, increasing the cost of the HIV response moving forward, further straining fragile health systems, and further burdening the lives of people, communities and countries.

Figure III
New HIV infections and AIDS-related deaths globally, actual trend compared to what would have been achieved if 2020 targets had been reached





Source: Special analysis by Avenir Health using UNAIDS epidemiological estimates, 2020 (see https://aidsinfo.unaids.org/).

III. 2025 targets: where we need to go

32. It is imperative to break out of an increasingly costly and unsustainable cycle of achieving some progress against HIV, but ultimately not enough to bring about an end to the pandemic. A course correction is urgently needed.

33. UNAIDS worked with a wide range of partners over two years to determine what is needed to get the HIV response back on track. This process produced an integrated set of ambitious targets for 2025 (see figure IV). These targets – adopted by the UNAIDS Programme Coordinating Board in March 2021 as part of the Global AIDS Strategy – highlight the different needs of different subpopulations.

Figure IV
HIV targets for 2025

Impact goals	Reduce annual new HIV infections to under 370,000	
	Reduce annual new AIDS-related deaths to under 250,000	
Access to HIV services and solutions	**Breaking down barriers**	**Fully resourcing and sustaining efficient and integrated HIV responses**
95 per cent of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options.	30 per cent of testing and treatment services to be delivered by community-led organizations.[a]	Increase global HIV investments to $ 29 billion per year by 2025.
95 per cent of women of reproductive age have their HIV and sexual and reproductive health service needs met.	80 per cent of service delivery for HIV prevention programmes for key populations and women to be delivered by community, key population and women-led organizations.	45 per cent of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.
95 per cent of pregnant and breastfeeding women living with HIV have suppressed viral loads.	60 per cent of the programmes support the achievement of societal enablers to be delivered by community-led organizations.	95 per cent of people within humanitarian setting at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options.
95 per cent of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding.	Less than 10 per cent of countries have punitive legal and policy environments that lead to the denial or limitation of access to services.	90 per cent of people in humanitarian settings have access to integrated tuberculosis, hepatitis C and HIV services, in addition to programmes to address gender-based violence (including intimate-partner violence), which include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.
75 per cent of all children living with HIV have suppressed viral loads by 2023 (interim target)	Less than 10 per cent of people living with HIV and key populations experience stigma and discrimination.	95 per cent of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics, including COVID-19.
95–95–95 testing and treatment targets are achieved within all subpopulations, age groups and geographic settings, including children living with HIV.	Less than 10 per cent of women, girls, people living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence.	
90 per cent of people living with HIV receive preventive treatment for tuberculosis.		

90 per cent of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, noncommunicable diseases, sexual health and gender-based violence, mental health, drug and substance use, and other services they need for their overall health and well-being.		

Source: End Inequalities, End AIDS. Global AIDS Strategy 2021–2026. UNAIDS, March 2021.

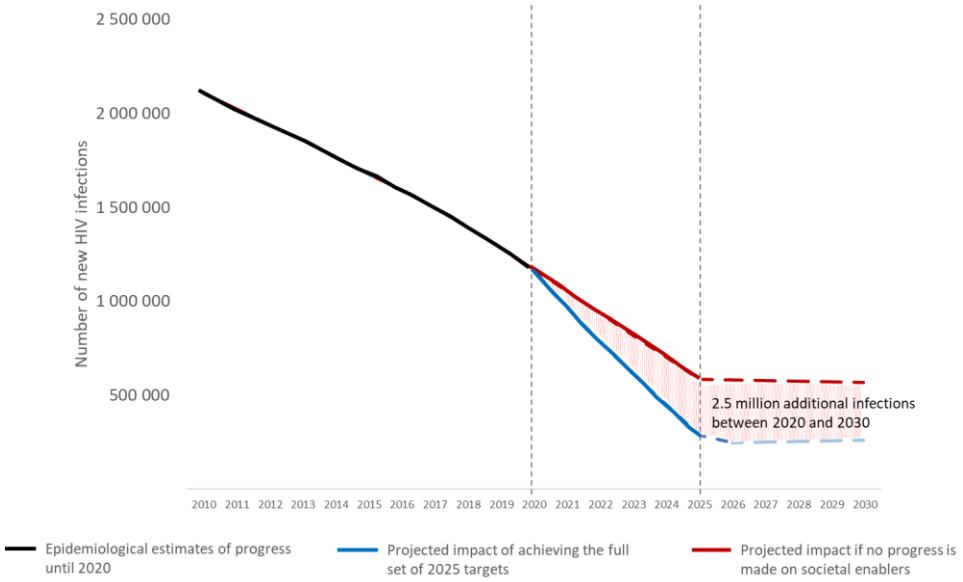
[a] With a focus on enhanced access to HIV testing, linkage to treatment, adherence and retention support, treatment literacy, and components of differentiated service delivery, e.g. distribution of antiretroviral medicines.

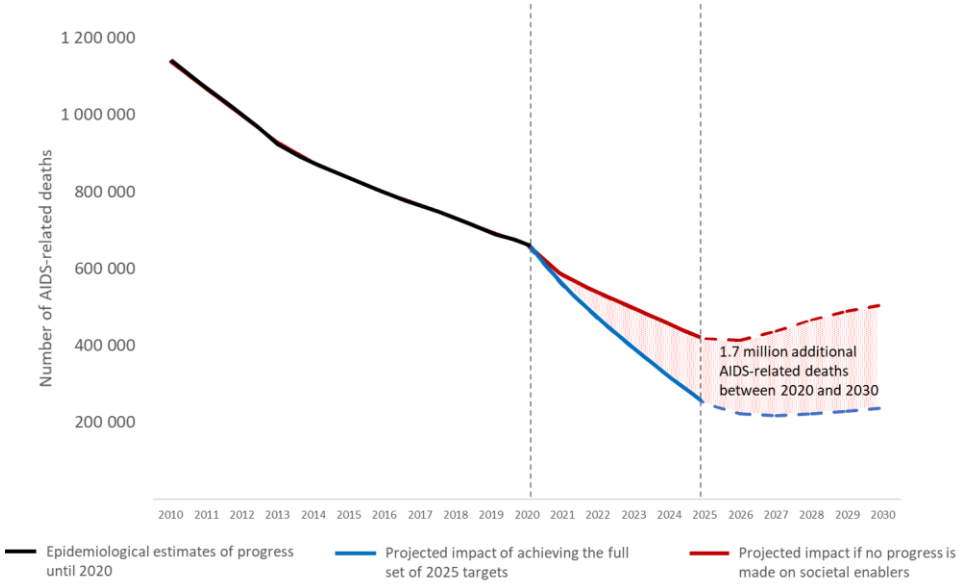
34. The individual targets reinforce each other within a carefully crafted holistic set. Countries cannot pick and choose among them. Reaching the societal enabler targets is essential to achieving other targets. Modelling on the negative impact of stigma and discrimination, criminalization of key populations and gender inequality shows that a failure to address these barriers would undermine efforts to reach the HIV service targets, leading to an additional 1.7 million AIDS-related deaths between 2020 and 2030, and an additional 2.5 million new HIV infections over the same period.

35. If every country and community achieve the full range of targets in all geographic areas and across all populations, the annual number of people newly infected with HIV will be reduced to less than 370,000 by 2025, and the annual number of people dying from AIDS-related illnesses would be reduced to less than 250,000 in 2025 (Figure V), putting the global AIDS response on-track to end AIDS by 2030.

Figure V

HIV infections and AIDS-related deaths estimated through 2020, and modelled predictions related to progress towards 2025 targets, with and without societal enablers, 2021–2030





Source: UNAIDS and Avenir Health.

IV. Using an inequalities lens to accelerate progress

36. Inequalities are the key reason why the 2020 global targets were missed. Inequalities exist along multiple demographics – including gender, age, ethnicity, sexual orientation, income level, HIV status and migrant status – with one form of inequality compounding others. They are often codified within laws and policies, and manifested through discriminatory practices, unequal access to health care and other services, violence and poorer HIV outcomes.

37. By ending inequalities, transformative outcomes are achieved for people living with HIV, communities and countries. Empowering adolescent girls and young women and addressing gender-based violence is an evidence-based HIV prevention strategy. Reforming punitive laws and improving rights literacy empowers people living with and affected by HIV to claim their rights and benefit from HIV services. Social protection supports HIV service delivery, supports broader health outcomes and keeps children in school. Investing in infrastructure for HIV services creates stronger health systems that are more resilient to health crises such as the COVID-19 pandemic.

38. The lessons from the countries, cities and communities that successfully fast-tracked their HIV responses over the last five years are at the heart of the UNAIDS Global AIDS Strategy 2021–2026.

Re-energizing combination HIV prevention

39. Scarce HIV resources are too often wasted on HIV prevention measures that are not evidence-based, lack focus and have little or no impact. Tailored, high-impact HIV prevention must be prioritized within a comprehensive continuum of HIV services.

40. Preventing HIV in high-burden settings requires addressing the multi-layered needs of adolescent girls and young women, who in sub-Saharan Africa are 2.6 times more at risk of HIV infection than their male peers. HIV prevention services must be delivered alongside efforts to deliver sexual and reproductive health and rights, to provide a quality secondary education that includes comprehensive sexuality education, to address gender-based violence and negative sociocultural gender norms, and to empower women and girls.

Pre-exposure prophylaxis (PrEP) – including new injectable formulations and vaginal rings – must be easily accessible by women at substantial risk of infection.

41. Key populations and their sexual partners need access to multiple HIV prevention options that address their changing needs. The triple prevention that condoms offer against HIV, sexually transmitted infections and unwanted pregnancy is unrivalled among all other prevention options. However, PrEP is a critical additional HIV prevention option when key populations and their sexual partners are unable to negotiate consistent condom use.

42. Evidence from multiple countries confirms that combinations of HIV prevention services for transgender people and gay men and other men who have sex with men – including condoms, PrEP and viral suppression – should be provided within an environment that fully respects lesbian, gay, bisexual, transgender, intersex and queer rights.

43. The positive public health impact of comprehensive harm reduction – including needle and syringe distribution, opioid substitution therapy and overdose treatment – is well established in the scientific literature. Legal and policy environments that eschew the punishment and criminalization of drug use and take a public health approach to drug dependence is critical to providing comprehensive harm reduction services that sharply reduce new HIV infections and enhance adherence to HIV treatment among people who use drugs.

44. In areas with high HIV prevalence, voluntary medical male circumcision, reduces heterosexual male vulnerability to sexually transmitted HIV infection and greatly contributes to population-level HIV prevention efforts.

45. HIV testing and treatment remain critical components of combination prevention. The fact that people living with HIV on effective HIV treatment and with an undetectable viral load cannot transmit HIV sexually (known as U = U) transforms the lives of people living with HIV, liberating them from the stigma associated with living with the virus.

Differentiated approaches to HIV testing and treatment

46. Gaps in knowledge of HIV status, antiretroviral therapy coverage and viral load suppression among people living with HIV are limiting the effectiveness of combination prevention and slowing the reduction in AIDS-related morbidity and mortality. These gaps are particularly large among children, young people, adult men and key populations. Closing these gaps requires addressing the varying needs of each subpopulation and ensuring accessibility, acceptability, affordability and quality services.

47. Differentiated HIV testing strategies – including community-led testing, index testing and self-testing – should be tailored to local epidemics and the needs of individual populations at high risk of HIV infection. Initiation of antiretroviral therapy should be offered to all people living with HIV immediately following diagnosis. Differentiated care models – including simplification, task shifting, decentralization and peer-based services – put people at the centre, facilitate more effective allocation of resources, reach underserved subpopulation, and improve quality of care and life.

48. A critical component of differentiated care is the multi-month dispensing of antiretroviral medicines for people living with HIV who are clinically stable, reducing clinic visits and saving countless hours for both patients and health systems. The COVID-19 pandemic crisis has highlighted the effectiveness of dispensing three-to-six-month supplies and accelerated the adoption of this modality by treatment programmes.

49. Viral load testing is a critical tool to detect treatment nonadherence or treatment failure. Point-of-care viral load testing platforms can deliver results quickly, improving efforts to manage virological failure, particularly in the context of community outreach services for rural and other hard-to-reach populations.

50. New antiretroviral medications for adults and children, such as fixed-dose formulations containing dolutegravir, have reduced side effects, increased viral load suppression and strengthened protection against drug resistance. New long-acting regimens are promising and need to be made more affordable and rolled out to all countries as quickly as possible.

Eliminating vertical HIV transmission and ending paediatric AIDS

51. Multiple factors account for recent slow progress towards the goal of eliminating vertical transmission of HIV, viral hepatitis and syphilis. In countries with low rates of antenatal care uptake, many women cannot access HIV and sexual and reproductive health services. In countries with high HIV burden and high coverage of HIV treatment among pregnant and breastfeeding women, challenges arise in diagnosing women who acquire HIV in late pregnancy and during breastfeeding, and in retaining women in treatment throughout pregnancy and breastfeeding. Social and structural factors, including harmful gender norms, undermine women's access to services.

52. Multiple strategies – such as male involvement, mentoring and other social support, and service integration and differentiation – have proven effective in increasing treatment coverage and adherence among pregnant and breastfeeding women living with HIV. Innovative tools and strategies, such as point-of-care early infant diagnostic platforms and family and household testing approaches, are essential to consistently link all children living with HIV to treatment.

53. While treatments for children have improved in recent years, the availability of WHO-recommended regimens remains limited. More work is needed to develop and roll out optimized paediatric regimens, as well as to support the evolving needs of children on HIV treatment and ensure a continuum of care as they progress through adolescence and into adulthood.

Communities at the forefront

54. Communities living with, at risk of, and affected by HIV are the backbone of the HIV response. Initiatives led by people living with HIV, women, key populations, young people and other affected communities have identified and addressed key inequalities and service gaps; advocated for the rights of their constituents; vastly expanded the evidence base for effective action against HIV; supported the planning, coordination and implementation of national responses and donor programmes; and expanded the reach, scale and quality of health services. Communities have stepped forward in the face of the COVID-19 pandemic to provide information and personal protective equipment to vulnerable and marginalized communities, and to preserve the delivery of key HIV services. Communities also offer a critical interface within efforts to strengthen primary health care.

55. An effective HIV response adequately resources and supports community-led responses. Implementation of the "Greater Involvement of People Living with HIV/AIDS" principle[5] ensures the effective and meaningful participation of people living with HIV in the decision-making that affects their lives. Community organizations and their networks require sustainable funding and technical support to fulfil their critical roles. Social contracting – whereby governments partner with and

[5] The "Greater Involvement of People Living with HIV/AIDS" is a principle that aims to realize the rights and responsibilities of people living with HIV, including their right to participation in decision-making processes that affect their lives.

procure services from civil society – has emerged as a potentially powerful, if still under-utilized, option for reaching marginalized populations.

Breaking down barriers to achieving HIV outcomes

56. The Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination is working with a wide-range of partners to advance the central role of human rights and freedom from discrimination in reaching the end of AIDS as a public health threat.

57. Evidence confirms that the completion of secondary education helps protect girls against HIV acquisition, while yielding broader social and economic benefits. Comprehensive, multisectoral approaches that include health-care interventions, keeping girls in school, social protection and community-based empowerment activities address the multiple drivers that fuel gender inequality and the HIV risks faced by adolescent girls and young women.

58. Removal of punitive laws and policies – including those that criminalize sex work, gender identity, sexual orientation, drug use, consensual same-sex relations, HIV exposure, non-disclosure or transmission – facilitates HIV service delivery and reduces HIV risk. Severe criminal penalties for same-sex sexual relations have been associated with a 4.7 times higher risk of HIV infection compared with settings that lack such penalties. In 10 countries in sub-Saharan Africa, repressive laws regarding sex work are linked to increased HIV prevalence. There is overwhelming evidence correlating the criminalization of drug use with increased risk of HIV transmission.

59. The removal of consent laws that require spousal or parental permission to access sexual and reproductive health and HIV prevention, testing and treatment services has been shown to improve health-seeking behaviours. Similarly, removing laws and policies that prevent schools from teaching age-appropriate comprehensive sexuality education empower young people to protect themselves from HIV, sexually transmitted infections, unwanted pregnancy and gender-based and sexual violence.

60. Effective efforts to achieve an end to HIV-related stigma and discrimination include community-led research and advocacy using the People Living with HIV Stigma Index, as well as addressing stigma and discrimination in the health and education sector, workplaces, housing and other settings. Sensitization training for health-care workers has been shown to reduce HIV-related discriminatory attitudes and practices in health-care settings. Review and reform of law enforcement practices is needed to ensure they support rather than impede the HIV response, including the removal of discriminatory, arbitrary or violent practices and compulsory testing, treatment or detention, and ending HIV-related travel restrictions and mandatory testing. Legal education and legal aid help people living with HIV to claim their rights and obtain legal redress when their rights are violated.

Fully resourcing efficient HIV responses

61. The funding mobilized for HIV over the past decades has saved millions of lives, strengthened the health systems and improved the socioeconomic development in dozens of countries. The huge cadres of community health workers, enhanced health information and laboratory systems, strengthened procurement and supply chain management systems, and revived community health systems are unique contributions of the HIV response which are now also playing important roles in the response to the COVID-19 pandemic.

62. However, HIV investments in recent years have fallen far short of what is needed to end the AIDS pandemic by 2030. Significant new domestic and donor resources are needed to get the HIV response on track. Achieving the targets requires

that annual HIV investments in low-income and middle-income countries rise to a peak of $29 billion by 2025.

63. Resources should be focused on highly effective and efficient interventions that aim to reach the populations in greatest need and close current service gaps. For example, the rapid expansion of evidence-based prevention options – particularly for key populations and other populations at very high risk of HIV infection – will require spending on primary HIV prevention to increase from $5.3 billion in 2019 to $9.5 billion by 2025.

64. Increasing the number of people living with HIV on treatment by 35 per cent by 2025, in line with the 95–95–95 targets, will increase treatment-related resource needs by just 17 per cent if efficiencies can be gained, such as through reductions in the prices of antiretroviral medications and reduced service delivery costs.

65. Annual funding to improve the societal enabling environment has to reach $3.1 billion by 2025, including substantial increases in investments for legal literacy and HIV-related legal services, programmes to reduce HIV-related stigma and discrimination, and programmes to promote gender equality.

66. Progressive integration of HIV-related services into universal health care financing and social spending is critical to building sustainable and equitable financing solutions, and debt relief can create additional fiscal space for HIV responses. Greater collection and use of granular, gender- and age-disaggregated data and data that track funding for key populations, women and girls and those underserved by the response is needed to maximize the impact, transparency, accountability and efficiency of resources and policy decisions, while data analytics and technology advances need to be further leveraged to support efforts to boost the efficiency, scope, equity and efficacy of interventions.

67. Reaching these resource targets and using resources efficiently will also halt the year-on-year growth in resource needs for HIV in low- and middle-income countries by 2025.

Integrating HIV in systems for health and social protection

68. Accelerated movement towards universal health coverage can help health systems achieve the highest possible standards of health and well-being for all people. It is estimated that approximately 8.6 million deaths per year in low-income and middle-income countries (including almost 300,000 among people living with HIV) could be attributed to the less-than ideal functioning of health systems.

69. The integration of services is a critical approach to providing people-centred, holistic and coordinated services that are convenient, respectful and efficient. People living with and at risk of HIV require linkages between HIV services and the full range of services they need to stay healthy, including services for other communicable and noncommunicable diseases, mental health conditions, harm reduction, alcohol and drug dependence, sexual and reproductive health and gender-based violence, and critical supportive services such as social protection and education. The inclusion of HIV services within universal health care benefits packages facilitates service integration.

70. Further reductions in tuberculosis cases and deaths among people living with HIV can be achieved by expanding rights-based community contact-tracing and scaling up access to the latest technologies for tuberculosis screening, diagnosis, treatment and prevention and ensuring optimal linkages to HIV testing and treatment for people diagnosed with tuberculosis.

71. Scale up of integrated services for HIV, syphilis, viral hepatitis, sexually transmitted infections and other infections are needed in antenatal and postnatal services and other settings. High human papillomavirus vaccination coverage and

dramatically scaled up cancer screening and treatment are needed to address the high prevalence of cervical cancer among women living with HIV.

72. Data recording and reporting systems of vertical disease programmes need to be more consistently integrated into health data systems and with other sectors such as social welfare and protection.

Strengthening health security and capacity for pandemic and other emergency responses

73. The COVID-19 pandemic has revealed the fault lines of a deeply unequal world where women and key populations experience loss of livelihood, evictions and abuse. It has also exposed the dangers of under-investment in public health and pandemic preparedness.

74. The COVID-19 pandemic has also illustrated the importance of leveraging the HIV response in preparing for future pandemics, spurring rapid uptake of key HIV-related innovations, including robust health information systems, self-testing technologies, multi-month dispensing of medicines and use of virtual platforms for support, counselling and information dissemination.

75. The most successful responses to HIV and COVID-19 demonstrate that robust, adaptable and people-centred health systems that receive unwavering government support and engage communities are more resilient to the immense challenges of pandemics. Given the profound and continuing effects of COVID-19, urgent efforts are needed to enable HIV services and broader communicable disease responses to rapidly rebound, as well as to better prepare for future challenges, such as the risk of resurgence of COVID-19 and other emerging pandemics and health emergencies.

76. Epidemic monitoring and health information systems require further strengthening, including building real-time data gathering and decision-making capacities that respond more rapidly to disease outbreaks.

77. In humanitarian settings, health systems are particularly under-resourced, leading to deficient delivery of basic health services. Crisis-affected populations – including refugees, internally displaced people, migrants and other people on the move – often face obstacles to access HIV services, including legal restrictions in transit or countries of destination. People living with HIV and other key populations are some of the most vulnerable to the socioeconomic impact of emergencies.

78. Addressing those challenges requires national emergency response plans tailored to specific contexts and that provide the standard minimum package of HIV services to all people affected by humanitarian emergencies, regardless of residency or legal status.

A joint United Nations approach to ending AIDS

79. The unique role of the United Nations and the diverse expertise of 11 co-sponsoring United Nations entities and the UNAIDS secretariat make the Joint United Nations Programme on HIV/AIDS (UNAIDS) a critical partner as the world advances towards the goal of ending AIDS by 2030.

80. Since its establishment 25 years ago, UNAIDS has galvanized political leadership and global solidarity against AIDS, mobilized and guided the use of domestic and donor resources, supported national HIV programmes and strengthened partnerships among government, civil society, academia and the private sector, promoted and supported the critical role of people living with HIV and other affected communities in the HIV response, and tracked progress against global targets and commitments.

81. UNAIDS continues to leverage its mandate, collective competencies, skills and resources to strategically support all countries and communities to set and attain new

and ambitious global targets and commitments. For example, the Education Plus initiative co-led by UNAIDS, the United Nations Educational Scientific and Cultural Organization, the United Nations Population Fund, the United Nations Children Fund and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) is championing the rights of girls in sub-Saharan Africa to education as both an entry point for HIV prevention and a strategy for addressing social and structural factors that perpetuate inequalities.

82. The joint programme model has highlighted the importance of a multisectoral, multi-disciplinary approach, inclusive governance, country-level prioritization of investments, and emphasizing results for people through more coherent and integrated approaches. The inclusion of civil society members representing people living with HIV and key affected populations on the UNAIDS Programme Coordinating Board has enriched the dialogue between Member States and affected populations and provides a model for how United Nations governance systems can be more inclusive and accountable.

V. Recommendations

83. In order to advance the decade of action for the Sustainable Development Goals, get the world on track to end AIDS as a public health threat by 2030 and accelerate progress towards the Sustainable Development Goals, Member States and all stakeholders are encouraged to urgently implement the recommendations below.

Recommendation 1

84. Member States are urged to reduce and end the acute and intersecting inequalities that are obstructing progress to end AIDS by :

(a) Committing to achieve the holistic set of 2025 targets that address inequalities and will reduce annual new HIV infections to under 370,000 and annual AIDS-related deaths to under 250,000 by 2025;

(b) Establishing epidemiological, behavioural and programmatic monitoring and evaluation systems that provide the granular data needed to reach the populations that are currently being left behind;

(c) Establishing policy and programmatic frameworks that protect the rights of people living with, at risk of and affected by HIV throughout their life course in healthcare, education, workplace, housing, legal and justice systems, humanitarian emergency situations, community and family settings;

(d) Prioritizing funding and actions that bring to scale proven innovative solutions for impact, based on the best available scientific evidence and technical knowledge, as well as in research and development of more effective HIV prevention and treatment methods, including an HIV vaccine and a functional cure for HIV.

Recommendation 2

85. Member States are urged to prioritize HIV prevention and ensure that 95 per cent of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options by 2025 by:

(a) Increasing national leadership and resource allocation for proven HIV combination prevention, including condom promotion and distribution, pre-exposure prophylaxis, voluntary male medical circumcision, harm reduction, enabling legal and policy environments and comprehensive sexuality education;

(b) Meeting the diverse HIV prevention needs of key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings and all people living with HIV;

(c) Delivering integrated services that prevent HIV and unintended pregnancy among adolescent girls and women, including economic empowerment, protection and promotion of their sexual and reproductive health and rights, and interventions that transform unequal gender norms;

(d) Strengthening the role of the education sector as an entry point for HIV prevention, testing and treatment, and ending stigma and discrimination, in addition to its role in addressing the social and structural factors that perpetuate inequalities and increase HIV risk;

(e) Providing access to quality, gender-responsive and age-appropriate comprehensive sexuality education, both in and out of school, that addresses the realities faced by adolescents and young people in all their diversity;

(f) Removing parental and spousal consent requirements for sexual and reproductive health services, and HIV prevention, testing and treatment services.

Recommendation 3

86. Member States are urged to close gaps in HIV testing, treatment and viral suppression that are limiting the impact of HIV responses, and achieve by 2025 the 95–95–95 testing and treatment targets within all subpopulations, age groups and geographic settings, including children living with HIV by:

(a) Establishing differentiated HIV testing strategies that utilize multiple effective HIV testing technologies and approaches, including HIV self-testing, and rapidly link newly diagnosed people to treatment;

(b) Using differentiated service delivery models for testing and treatment, including community-led and community-based services that overcome challenges such as those created by the COVID-19 pandemic by delivering treatment to the people in greatest need where they are;

(c) Achieving equitable and reliable access to affordable, high-quality medicines, health commodities and technologies by accelerating their development and market entry, reducing costs, strengthening local development, manufacturing and distribution capacity, including through aligning trade rules and public health objectives under a human rights framework, as well as encouraging the development of regional markets;

(d) Expanding access to the latest technologies for tuberculosis prevention, screening, diagnosis and treatment, ensuring that 90 per cent of people living with HIV receive preventive treatment for tuberculosis by 2025.

Recommendation 4

87. Member States are urged to eliminate vertical HIV transmission and end paediatric AIDS by:

(a) Identifying and addressing gaps in the continuum of services for preventing HIV infection among pregnant and breastfeeding women, diagnosing and treating pregnant and breastfeeding women living with HIV, and preventing vertical transmission of HIV to children;

(b) Ensuring by 2025 that 95 per cent of pregnant women are tested for HIV, syphilis and hepatitis B, that 95 per cent pregnant and breastfeeding women in high

HIV burden settings are re-tested during late pregnancy and in the post-partum period, and that all pregnant and breastfeeding women living with HIV are on life-long antiretroviral therapy, with 95 per cent achieving viral suppression before delivery;

(c) Testing, by 2025, 95 per cent of HIV-exposed children by two months of age and after the cessation of breastfeeding, and ensuring that children living with HIV are provided treatment regimens and formulas optimized to their needs;

(d) Finding undiagnosed older children and providing all adolescents living with HIV with a continuum of treatment, care and social protection proven to improve health outcomes as they grow and progress through youth and into adulthood.

Recommendation 5

88. Member States are urged to put gender equality and the human rights of women and girls in all their diversity at the forefront of efforts to mitigate the risk and impact of HIV by:

(a) Fulfilling the right to education of girls and young women, economically empowering women through skills trainings and employment opportunities, scaling up social protection interventions for girls and young women, and engaging men and boys in intensified efforts to confront unequal socio-cultural gender norms and undo harmful masculinities;

(b) Providing tailored services to prevent gender-based and sexual violence, including interventions that address multiple and intersecting forms of discrimination and violence faced by women living with HIV, indigenous women, women with disabilities, transgender women, sex workers, migrant women and other marginalized populations;

(c) Ensuring, by 2025, that 95 per cent of women of reproductive age have their HIV and sexual and reproductive health service needs met;

(d) Reducing to no more than 10 per cent the number of women, girls, people living with HIV and key populations who experience gender-based inequalities and gender-based violence by 2025.

Recommendation 6

89. Member States are urged to implement the Greater Involvement of People Living with HIV/AIDS principle and empower communities of people living with HIV, women, adolescents and young people and key populations to play their critical HIV response roles by:

(a) Ensuring their global, regional, national and sub-national networks are included in decision-making and provided with sufficient technical and financial support;

(b) Revising, adopting and implementing laws and policies that enable the sustainable financing of people-centred, community-led HIV service delivery, including through social contracting and other public funding mechanisms;

(c) Supporting community-led monitoring and research, and ensuring that community-generated data are used to tailor responses to protect the rights and meet the needs of people living with HIV and other key populations;

(d) Greatly increasing the proportion of HIV services delivered by community-, key population- and women-led organizations, including ensuring that 30 per cent of testing and treatment services are delivered by community-led organizations by 2025.

Recommendation 7

90. Member States are urged to respect, protect and fulfil the human rights of people living with, at risk of and affected by HIV and ensure by 2025 that less than 10 per cent of people living with HIV and key populations experience stigma and discrimination by:

(a) Removing punitive and discriminatory laws, policies and practices that block effective responses to HIV – including those that criminalize sex work, gender identity, sexual orientation, drug use, consensual same-sex relations, HIV exposure, non-disclosure or transmission, and those that impose HIV-related travel restrictions and mandatory testing – with the aim of ensuring that less than 10 per cent of countries have punitive legal and policy environments that lead to the denial or limitation of access to services by 2025;

(b) Adopting and enforcing legislation, policies and practices that realize the rights to health, education, food and nutrition support, housing, employment, and social protection, and that prevent the use of criminal and general laws to discriminate against people living with HIV and key populations;

(c) Expanding investment in societal enablers in low-income and middle-income countries to $ 3.1 billion by 2025 and accelerating interventions to end stigma and discrimination;

(d) Ensuring accountability for HIV-related human rights violations by securing access to justice for people living with or affected by HIV and key populations through the establishment of legal literacy programmes, increasing their access to legal support and representation, and expanding sensitization training for health-care workers and other duty bearers.

Recommendation 8

91. Member States are urged to enhance global solidarity to close the HIV response resource gap and increase annual HIV investments in low- and middle-income countries to $29 billion by 2025 by:

(a) Mobilizing additional domestic resources for HIV investments through a wide range of mechanisms, including public-private partnerships, debt cancellation and restructuring, and progressive integration of HIV response financing within domestic financing systems for health, social protection, emergency responses and pandemic responses;

(b) Complementing domestic resources through greater South-South, North-South and triangular cooperation and renewed commitments from bilateral and multilateral donors – including through the Global Fund to Fight AIDS, Tuberculosis and Malaria – to fund remaining resource needs, especially for HIV responses in countries with limited fiscal ability, with due attention to the financing of services for key populations and community-led responses.

Recommendation 9

92. Member States are urged to accelerate progress towards universal health coverage and strong primary health care systems, build forward better and fairer from COVID-19 and humanitarian crises, and strengthen global health security and future pandemic preparedness by:

(a) Investing in robust, resilient, equitable, and publicly-funded health and social systems that provide 90 per cent of people living with HIV and people at risk with people-centred and context-specific integrated services for HIV and other communicable diseases, noncommunicable diseases, sexual health and gender-based

violence, mental health, alcohol and drug dependence, and other services they need for their overall health and well-being by 2025;

(b) Utilizing the experience, expertise, infrastructure and multisectoral coordination of HIV actions across diverse sectors such as health, education, law and justice, economics, finance, trade, information, social protection and health as well as among development, humanitarian and peace-building actions;

(c) Building on the resilience and innovation demonstrated by community systems during the COVID-19 pandemic in reaching affected communities with essential health services, including multi-month dispensing of antiretroviral medicines and other lifesaving medications, COVID-19 testing and other health and social services;

(d) Increasing the availability of essential medicines and health technologies and ensuring their fair allocation among and within countries through pooled procurement mechanisms, voluntary licensing, financial incentives and the full use of the Trade-Related Aspects of Intellectual Property Rights flexibilities.

Recommendation 10

93. Member States are urged to leverage the 25 years of experience, expertise and mandate of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in building multisectoral, multi-stakeholder and rights-based collaborative action to end AIDS and deliver health for all as global public good by:

(a) Fully resourcing the UNAIDS Joint Programme and supporting its efforts to refine and reinforce its unique operating model so that it can continue to lead global efforts against AIDS and to remain a pathfinder for the United Nations reform;

(b) Reporting progress to UNAIDS annually on national HIV epidemics and responses, using robust monitoring systems that identify inequality gaps in service coverage and HIV response outcomes, to inform the General Assembly, the Economic and Social Council and the high-level political forum on sustainable development.

94. Looking forward, Member States should consider a holistic and comprehensive approach to reviewing progress on the commitments made in 2021, including the achievement of the agreed 2025 global targets, at relevant future high-level meetings, such as the high-level meeting on Universal Health Coverage in 2023, reflecting the multisectoral nature of efforts to end the AIDS pandemic by 2030.