

# **End Inequalities. End AIDS. Global AIDS Strategy 2021- 2026**

**Data corrected version**

**Additional documents for this item:** N/A

**Action required at this meeting—the Programme Coordinating Board is invited to:**

*Adopt* the Global AIDS Strategy 2021-2026

**Cost implications for the implementation of the decisions:** none

End Inequalities. End AIDS. Global AIDS Strategy 2021–2026

2021

# END INEQUALITIES. END AIDS. GLOBAL AIDS STRATEGY 2021-2026



**Recalling that all aspects of UNAIDS work are directed by the following guiding principles:<sup>1</sup>**

- Aligned to national stakeholders' priorities;
- Based on the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection;
- Based on human rights and gender equality;
- Based on the best available scientific evidence and technical knowledge;
- Promoting comprehensive responses to AIDS that integrate prevention, treatment, care and support; and
- Based on the principle of nondiscrimination.

**UNAIDS is mandated, by ECOSOC Resolution 1994/24, to:**

- a) Provide global leadership in response to the epidemic;
- b) Achieve and promote global consensus on policy and programmatic approaches;
- c) Strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;
- d) Strengthen the capacity of national Governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;
- e) Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;
- f) Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

In fulfilling these objectives, the programme will collaborate with national Governments, intergovernmental organizations, non-governmental organizations, groups of people living with HIV/AIDS, and United Nations system organizations.<sup>2</sup>

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<sup>1</sup> [19th PCB - Decisions, recommendations and conclusions \(unaids.org\)](#)

<sup>2</sup> [ECOSOC Resolutions Establishing UNAIDS](#)

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## FOREWORD

Twenty years ago, as the AIDS pandemic rapidly spread across the world, the international community for the first time collectively set an ambitious target to halt and reverse the spread of HIV by 2015. When this was achieved, we set an even more ambitious goal in 2016—to end AIDS as a public health threat by 2030. The collective vision of UNAIDS underpins these targets: zero new HIV infections, zero discrimination, zero AIDS-related deaths.

Global solidarity and community resilience has saved millions of lives. But far more could have been done. Many of the inequalities that facilitated the spread of the AIDS pandemic are getting worse and continue to fan the spread of HIV in many parts of the world. COVID-19 has brought these inequalities to the forefront and exposed the fragility of the gains we have made. The resilience and experience of the HIV response in addressing inequalities that disproportionately affect the key populations and priority populations is critical to the once-in-a-generation opportunity to ‘build back better’ from COVID-19.

There is hope. The solutions exist. 40 years of experience in the HIV response has provided the evidence of what works. Some countries have reached control of their AIDS epidemics. We know how to end AIDS, and this is the Strategy to get us there.

**End Inequalities. End AIDS. Global AIDS Strategy 2021-2026** is a bold new approach to use an inequalities lens to close the gaps that are preventing progress towards ending AIDS. The Global AIDS Strategy aims to reduce these inequalities that drive the AIDS epidemic and prioritize people who are not yet accessing life-saving HIV services. The Strategy sets out evidence-based priority actions and bold targets to get every country and every community on-track to end AIDS as a public health threat by 2030.

Drawing on key lessons learned from the intersecting HIV and COVID-19 pandemics, the Strategy leverages the proven tools and approaches of the HIV response, identifying where, why and for whom the HIV response is not working. The Strategy outlines the strategic priorities and actions to be implemented by global, regional, country and community partners to get on-track to ending AIDS. It leverages four decades of experience of the HIV response, supporting governments, partners and communities to “build back better”, supporting systems for health to be more resilient and place people at the centre. This Strategy also outlines a new, bold call to action for the UNAIDS Joint Programme to advance our leadership role in the global HIV response and to implement the Strategy. And the Strategy demands that the HIV response is fully resourced and implemented with urgency and optimal efficiency.

This Strategy is the result of extensive analysis of HIV data and an inclusive process of consultation with member states, communities, and partners. I am deeply grateful to the thousands of participants from over 160 countries and partners who contributed to its development.

Let 2021 be a turning point in the history of ending AIDS. It has been forty years since the first AIDS cases were reported, twenty years since the historic United National General Assembly Special Session on AIDS and 25 years of UNAIDS. I call on the international community to rally behind the bold targets and commitments in this Strategy to end the inequalities that are preventing people from benefitting from HIV services and ensure that we get on track to ending AIDS by 2030. Let us rededicate ourselves to ensure that we put all our collective might towards ending AIDS and realizing the right to health for all.

Winnie Byanyima

## EXECUTIVE SUMMARY

1. The new Global AIDS Strategy (2021–2026) seeks to reduce the inequalities that drive the AIDS epidemic and put people at the centre to get the world on-track to end AIDS as a public health threat by 2030. Decades of experience and evidence from the HIV response show that intersecting inequalities are preventing progress towards ending AIDS.<sup>3</sup>
2. Developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS)<sup>4</sup> and to be adopted by the UNAIDS Programme Coordinating Board (PCB), this Strategy lays out a framework for transformative action to reduce these inequalities by 2025 and to get every country and every community on-track to end AIDS by 2030.<sup>5</sup> The Strategy uses an inequalities lens to identify, reduce and end inequalities that represent barriers to people living with and affected by HIV, countries and communities from ending AIDS.
3. The Strategy is being adopted during the Decade of Action to accelerate progress towards the Sustainable Development Goals (SDGs), and makes explicit contributions to advance goals and targets across the SDGs.<sup>6</sup>
4. The Strategy builds on an extensive review of the available evidence and a broad-based, inclusive, consultative process in which over 10,000 stakeholders from 160 countries participated. The results from the UNAIDS Fast-Track Strategy 2016–2021 informed the development of the new Strategy, including the Programme Coordinating Board (PCB) decision to develop the Global AIDS Strategy "by maintaining the critical pillars that have delivered results in the current Fast-Track Strategy, its ambition and the principles underpinning it to the end of 2025, but also enhance the current Strategy to prioritize critical areas that are lagging behind and need greater attention."
5. The Strategy keeps people at the centre and aims to unite countries, communities and partners across and beyond the HIV response to take prioritized actions to accelerate progress towards the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. The Strategy seeks to empower people with the programmes and resources they need to exercise their rights, protect themselves and thrive in the face of HIV.
6. Drawing on key lessons learned from the intersecting HIV and COVID-19 pandemics, the Strategy leverages proven tools and approaches of the HIV response. It identifies where, why and for whom the HIV response is not working. It outlines strategic directions and priority actions to be implemented by global, regional, country and community partners by 2025 to get the HIV response on-track to end AIDS by 2030.

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<sup>3</sup> Throughout the Strategy, the term "ending AIDS" is used to refer to the full term "ending AIDS as a public health threat by 2030", which is defined as a 90% reduction in new HIV infections and AIDS-related deaths by 2030, compared to a 2010 baseline.

<sup>4</sup> The use of UNAIDS in the Strategy refers to the Joint United Nations Programme on HIV/AIDS (UNAIDS).

<sup>5</sup> The Global AIDS Strategy covers the period 2021-2026, but features targets and commitments to be achieved by the end of 2025. This is to enable a review of these results and the development of the next Global AIDS Strategy in 2026, which will cover the period up to 2030.

<sup>6</sup> The 10 Sustainable Development Goals which are explicitly linked to this Strategy are SDG 1 No Poverty; SDG 2 Zero Hunger; SDG 3 Good Health and Well-Being; SDG 4 Quality Education; SDG 5 Gender Equality; SDG 8 Decent Work and Economic Growth; SDG 10 Reduced Inequalities; SDG 11 Sustainable Cities and Communities; SDG 16 Peace, Justice and Strong Institutions; and SDG 17 Partnerships for the Goals.



7. The Strategy also summarizes the role of the Joint United Nations Programme on HIV/AIDS in implementing the Strategy and its leadership role in coordinating the global HIV response.

### **Ending AIDS is possible, but a course correction is needed to make it a reality**

8. Forty years since the first cases of AIDS were identified and twenty-five years since UNAIDS was created, the world has proof of concept that ending AIDS as a public health threat by 2030 is possible with the knowledge and tools currently in-hand. With new diagnostics, prevention tools and treatment, we can move even faster until the day we have an HIV vaccine, and a functional cure.
9. Much progress has been made among some groups of people and in some parts of the world. A few countries have reached AIDS epidemic control, and others are close to doing so. By 2019, more than 40 countries had surpassed or were within reach of the key epidemiological milestone towards ending AIDS.<sup>7</sup> Millions of people living with HIV now enjoy long and healthy lives and the number of new HIV infections and AIDS-related deaths are on the decline. Of the 38 million people living with HIV, 26 million were accessing life-saving antiretroviral therapy (ART) as of June 2020. This treatment results in viral load suppression which prevents the spread of HIV.
10. Science continues to generate new technologies and mechanisms to advance HIV prevention, treatment, care and support, including progress towards an HIV vaccine and a functional cure. Innovative delivery strategies have enhanced the reach and impact of HIV services.
11. Despite the successes, AIDS remains an urgent global crisis. The world did not reach the 2020 Fast-Track prevention and treatment targets committed to in the 2015 UNAIDS Fast-Track Strategy and the 2016 United Nations Political Declaration on Ending AIDS. Most countries and communities are not on-track to end AIDS by 2030.
12. This was true before the COVID-19 pandemic, but the impact of that pandemic is making continued progress against HIV, including the need for more urgent action, more difficult. We must identify and address the factors that prevented us from reaching the 2020 targets. And we must do so while simultaneously safeguarding HIV programmes from the impact of COVID-19 and keeping people living with HIV and affected by HIV safe from COVID-19 and other imminent threats. When developing priority population groups for vaccines against COVID-19, the Strategy calls on countries to include all people living with HIV in the category of high-risk medical conditions.
13. Despite all our efforts, progress against HIV remains fragile in many countries and acutely inadequate among key populations<sup>8</sup> globally and among priority populations,

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<sup>7</sup> Defined as an HIV incidence:prevalence ratio of 3.0% or less, which 25 countries had achieved by 2019, including: Australia, Barbados, Botswana, Burkina Faso, Burundi, Cambodia, Côte d'Ivoire, Djibouti, Eritrea, Eswatini, Ethiopia, Gabon, Italy, Kenya, Nepal, Netherlands, Rwanda, Singapore, South Africa, Spain, Switzerland, Thailand, Trinidad & Tobago, Viet Nam, Zimbabwe. At the end of 2019, an additional 16 countries were on-track to reach a milestone of an incidence:prevalence ratio of 4.0% or lower, including: Cameroon, Dominican Republic, El Salvador, Guatemala, Haiti, Lesotho, Malawi, Morocco, Namibia, New Zealand, Niger, Peru, Senegal, Sri Lanka, Togo and Uganda.

<sup>8</sup> Key populations, or key populations at higher risk, 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. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

such as children and adolescent girls and young women in Sub-Saharan Africa. A range of social, economic, racial and gender inequalities,<sup>9</sup> social and legal environments that impede rather than enable the HIV response, and the infringement of human rights are slowing progress in the HIV response and across other health and development areas.

14. Inequalities exist not only between countries, but also within countries. Even in those countries that have achieved the 90–90–90 treatment targets, averages conceal the reality that too many people are still being left behind. The aggregate global and national averages, while reflecting positive trends, mask areas of continued concern—areas which, unless addressed, will prevent the world from ending AIDS.
15. In 2019, 1.7 million people newly acquired HIV infection. At the end of 2020, there were 12 million people living with HIV who are likely to die of AIDS-related causes if they do not receive treatment. Even though effective treatment exists, almost 700 000 people died of AIDS-related causes in 2019. The HIV response must refocus on how to extend life-saving services to all who need them, in every country and community.
16. For the majority of key populations and other priority populations, including millions of people living with HIV who are unaware of their HIV status or lack access to treatment, the benefits of scientific advances and HIV-related social and legal protection remain beyond reach. Key populations include people living with HIV, 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.<sup>1011</sup> In specific contexts, effective HIV responses must also focus on other priority populations, such as adolescent girls and young women in sub-Saharan Africa and 47% of children living with HIV globally who are not receiving access to treatment that will save their lives.

**Inequalities in the HIV response remain stark and persistent—they block progress toward ending AIDS.**

17. Decades of evidence and experience, synthesized in a comprehensive evidence review undertaken by UNAIDS in 2020,<sup>12</sup> show that inequalities are a key reason why the 2020 global targets were missed. The inequalities that underpin stigma, discrimination and HIV-related criminalization that enhance people’s vulnerability to acquire HIV and make people living with HIV more likely to die of AIDS-related illnesses.
18. The majority of people who are newly infected with HIV and who are not accessing life-saving HIV services belong to key populations and live in vulnerable contexts, where inadequate political will, funding and policies prevent their access to health care. Key populations and their sexual partners account for an estimated 62% of new infections globally and 99%, 97%, 96%, 89%, 98% and 77% of new infections in eastern European and central Asia, the Middle East and North Africa, western and central Europe and North America, Asia and the Pacific and Latin America, respectively.

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<sup>9</sup> Inequality refers to an imbalance or lack of equality. The term “inequalities” in this Strategy encompasses the many inequities (injustice or unfairness that can also lead to inequality), disparities and gaps in HIV vulnerability, service uptake and outcomes experienced in diverse settings and among the many populations living with or affected by HIV.

<sup>10</sup> See the glossary in Annex 4, where the definitions of these populations are provided.

<sup>11</sup> The term “key populations” is also used by some agencies to refer to populations other than the four listed above. For example, prisoners and other incarcerated people also are particularly vulnerable to HIV; they frequently lack adequate access to services, and some agencies may refer to them as a key population.

<sup>12</sup> Evidence review: Implementation of the 2016–2021 UNAIDS Strategy: on the Fast-Track to end AIDS. Available at [UNAIDS-2016-2021-Strategy-Evidence-review\\_en.pdf](#).

### **Disparities in access, HIV infections and AIDS-related deaths result from inequalities**

The gaps in HIV responses and resulting HIV infections and AIDS-related deaths lie upon fault lines of inequality. From its beginning, the HIV epidemic has represented an acute health inequality, affecting some key populations much more disproportionately. Inequalities illustrate why the HIV response is working for some people, but not for others. Structural inequalities and determinants of health: education, occupation, income, home and community all have direct impact on health and HIV outcomes. The lower someone's social and economic status, the poorer their health is likely to be. Societal forces, such as discrimination based on race, gender and sexual orientation, add to the stress level of certain population groups. Unequal gender norms that limit the agency and voice of women and girls, reduce their access to education and economic resources, and stifle their civic participation contribute to the higher HIV risk faced by women in settings with high HIV prevalence. Key populations: gay men and other men who have sex with men, sex workers, transgender people and people who use drugs, particularly those who inject drugs, are subject to discrimination, violence, and punitive legal and social environments, each of which contributes to HIV vulnerability. Some people with disabilities, older people living with HIV and migrants and internally displaced people are often disproportionately affected by HIV. While new HIV infections declined globally by 23% since between 2010 and 2019, new infections increased by more than 10% in over 30 countries. Young people (aged 15–24 years) represent about 17% of the global population, but accounted for and estimated 28% of new HIV infections in 2019. Adolescent girls and young women in high-burden countries with a high burden of HIV infection are twice as likely as their male peers their own age to acquire HIV infection. Key populations and their sexual partners comprised an estimated approximately 62% of all new HIV infections in 2019, but represent a small fraction of the world's population. Children living with HIV have poorer HIV treatment coverage than adults and comprise a higher proportion of AIDS-related deaths. The HIV burden on poorer households has increased, due in part to the difficulties poor people experience in obtaining the HIV services and social protection they need. To improve health and HIV outcomes, the Global AIDS Strategy calls for all policies and future practice to be assessed to determine whether they do not further stigmatise HIV diagnosis, perpetuate discrimination and exacerbate health inequalities.

19. The risk of acquiring HIV is 26 times higher among gay men and other men who have sex with men, 29 times higher among people who inject drugs, 30 times higher for sex workers, and 13 times higher for transgender people. Every week, about 4,500 young women aged 15–24 years acquire HIV. In sub-Saharan Africa, 5 in 6 new infections among adolescents aged 15–19 years are among girls. Young women are twice as likely to be living with HIV than men. Only 53% of children 0–14 years who are living with HIV have access to the HIV treatment that will save their lives.
20. A central reason why disparities in the HIV response remain so stark and persistent is that we have not successfully addressed the societal and structural factors that increase HIV vulnerability and diminish people's abilities to access and effectively benefit from HIV services. Recognizing the equal worth and dignity of every person is not only ethical, it is critical for ending AIDS. Equal access to HIV services and the full protection of human rights must be realized for all people.

### **The Global AIDS Strategy 2021–2026 is focused on reducing inequalities**

21. Building on the historic achievements of the HIV response and acknowledging the most pressing challenges and opportunities, this Strategy recognizes that key shifts are needed if the world is to end AIDS.
22. The Strategy places the SDGs that relate to the reduction of inequalities at the heart of its approach to guide and drive action in every country and community. The Strategy

outlines a comprehensive framework for transformative actions to confront these inequalities and, more broadly, respect, protect and fulfil human rights in the HIV response. By reducing the inequalities driving the AIDS epidemic, we can close the gaps for HIV prevention, testing, treatment and support by 2025 and put the world back on course to end AIDS by 2030.

23. The Strategy keeps people at the centre to ensure that they benefit from optimal standards in service planning and delivery, to remove social and structural barriers that prevent people from accessing HIV services, to empower communities to lead the way, to strengthen and adapt systems so they work for the people who are most acutely affected by inequalities, and to fully mobilize the resources needed to end AIDS.
24. The Strategy calls on national governments, development and financing partners, communities and the UNAIDS Joint Programme to identify and address these inequalities. Countries and communities everywhere must achieve the full range of targets and commitments outlined in the new Strategy—in all geographic areas and across all populations and age groups—to achieve the Three Zeros: zero new HIV infections, zero AIDS-related deaths and zero HIV-related discrimination.
25. If the targets and commitments in the Strategy are achieved, the number of people who newly acquire HIV will decrease from 1.7 million in 2019 to less than 370 000 by 2025, and the number of people dying from AIDS-related illnesses will decrease from 690 000 in 2019 to less than 250 000 in 2025.

### **HIV prevention receives unprecedented urgency and focus in the Strategy**

26. To realize the full potential of HIV prevention tools to prevent new HIV infections, the Strategy calls for the urgent strengthening and rapid scale-up of HIV combination prevention services that will have the greatest impact. The Strategy includes ambitious coverage targets for HIV prevention interventions and for all key populations and priority populations, and calls for total annual investments in prevention to increase to over US\$ 9.5 billion by 2025<sup>13</sup>. The Strategy also seeks to fulfil the potential of treatment as prevention, and it recommends the reallocation of finite resources away from less-effective HIV prevention approaches to those that are high-impact.
27. At the same time, the Strategy emphasizes the importance of avoiding artificial dichotomies in the HIV response between treatment and prevention, focusing instead on fully leveraging the synergies between combination prevention and treatment. If the underlying inequalities are addressed, including gender inequality, stigma and discrimination, both prevention and treatment outcomes will improve.

### **The Strategy calls for transformative results that demand ambition, speed and urgency in implementation**

28. Stakeholders across the HIV response will need to do more to ensure that their actions are strategic, smart and focused on outcomes. The Strategy prioritizes urgent implementation and scale-up of evidence-based tools, strategies and approaches that will turn incremental gains into transformative results. Maintaining and further scaling up existing tools and strategies will be essential.

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<sup>13</sup> Resource needs are explained in detail in Chapter 7.

**The Strategy should be implemented as a comprehensive package, but it requires differentiated responses that meet the needs of people, communities and countries in all their diversity, and that sustain progress in the HIV response**

29. The Strategy is designed to be implemented as a comprehensive package, with equal importance given to biomedical interventions, enabling environments, community-led responses and the strengthening and resilience of systems for health. The Strategy seeks to ensure progress is sustained and enhanced with respect to the care, quality of life and well-being of people living with HIV across the life course. It also aims to strengthen links to integrated services, such as those for other communicable diseases, sexual and reproductive health, mental health and noncommunicable diseases.

**Communities are at the forefront and must be fully empowered to play their crucial roles**

30. While communities are pivotal in the HIV response, the capacity of community-led responses, key populations and youth to contribute fully towards ending AIDS by 2030 is undermined by acute funding shortages, shrinking civic space in many countries and a lack of full engagement and integration in national responses. The Strategy outlines strategic actions to provide community-led and youth-led responses with the resources and support they need to fulfil their role and potential as key partners in the HIV response.

**The Strategy amplifies the broader benefits of the HIV response and ending AIDS**

31. A strong body of evidence shows that intersecting inequalities fuel the HIV epidemic and block progress towards ending AIDS. By reducing inequalities, we will be able to dramatically reduce new HIV infections and AIDS-related deaths. That, in turn, will contribute to a host of positive social and economic outcomes and accelerate progress towards sustainable development for all.

32. Investments in the HIV response have strengthened the functioning and resilience of systems for health across the world. The Strategy was developed while the COVID-19 pandemic disrupted many HIV services, exacerbating inequalities and undermining national economies. It therefore features actions that are needed to protect people living with or affected by HIV and the HIV response from current and future pandemics. Recognizing the pivotal role that the HIV infrastructure has played in helping diverse countries respond to COVID-19, the Strategy aims to leverage the HIV response to prepare for and respond to future pandemics, and enhance synergies with other global health and development movements.

**The Strategy's three related strategic priorities**

33. The Strategy builds on three interlinked strategic priorities:

- Strategic Priority 1: maximize equitable and equal access to HIV services and solutions;
- Strategic Priority 2: break down barriers to achieving HIV outcomes; and
- Strategic Priority 3: fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

34. Priority actions across 10 result areas and five cross-cutting issues are proposed to accelerate progress towards realizing the vision of zero new infections, zero discrimination and zero AIDS-related deaths. The 10 result areas include:

Result Area 1: Primary HIV prevention for key populations, adolescents and other priority populations, including adolescents and young women and men in locations with high HIV incidence

Result Area 2: Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being

Result Area 3: Tailored, integrated and differentiated vertical transmission and paediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence

Result Area 4: Fully recognized, empowered, resourced and integrated community-led HIV responses for a transformative and sustainable HIV response

Result Area 5: People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination

Result Area 6: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV

Result Area 7: Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS

Result Area 8: Fully funded and efficient HIV response implemented to achieve the 2025 targets

Result Area 9: Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive

Result Area 10: Fully prepared and resilient HIV response that protects people living with, at risk of, and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks

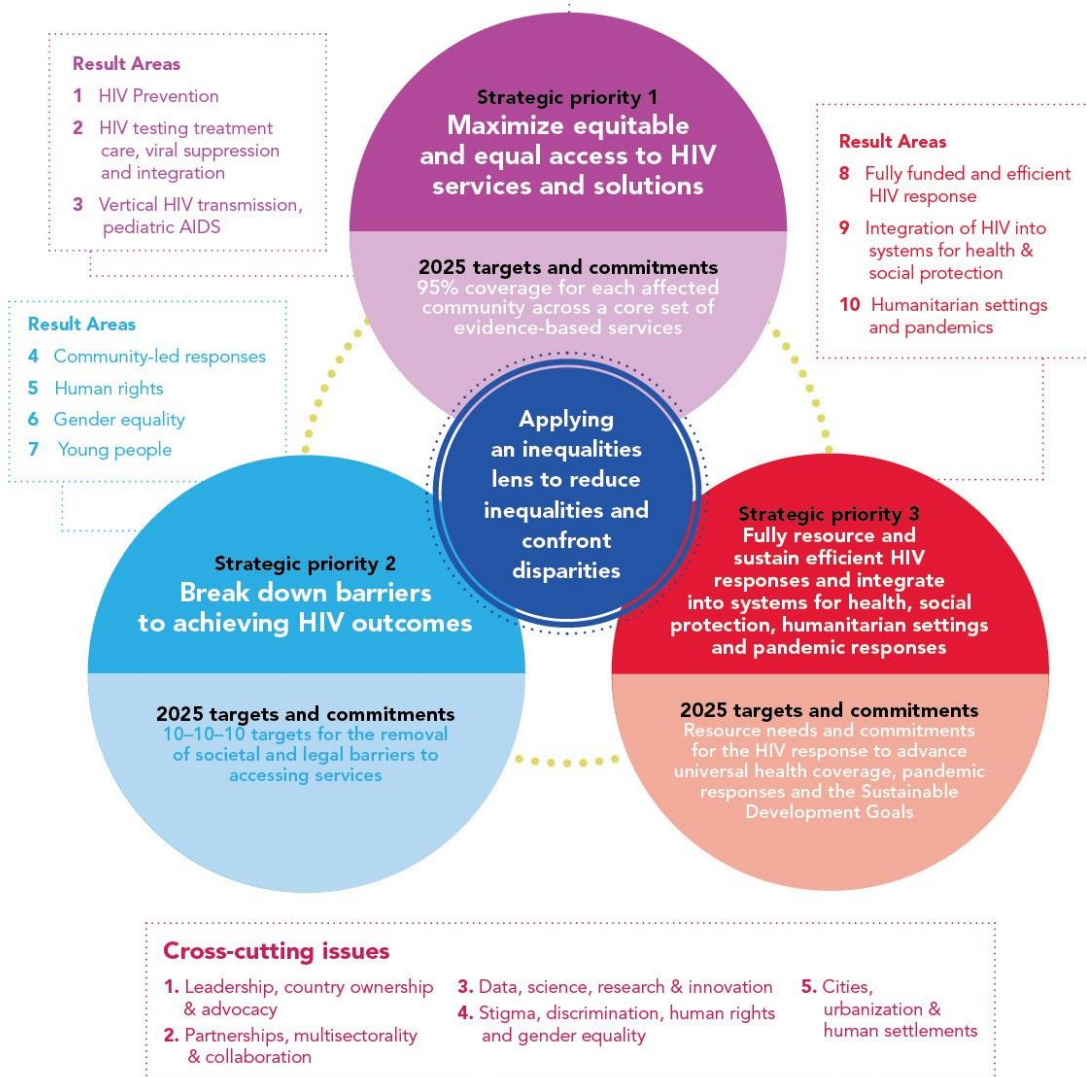
The cross-cutting issues include:

- i. Leadership, country ownership and advocacy: leaders at all levels must renew political commitment to, ensure sustained engagement with, and catalyze action from key and diverse stakeholders.
- ii. Partnerships, multisectorality and collaboration: partners at all levels must align strategic processes and enhance strategic collaboration to fully leverage and synergize the contributions to ending AIDS.
- iii. Data, science, research and innovation: data, science, research, and innovation are critically important across all areas of the Strategy to inform, guide and reduce HIV related inequalities and accelerate the development and use of HIV services and programmes.
- iv. Stigma, discrimination, human rights and gender equality: human rights and gender inequality barriers that slow progress in the HIV response and leave key populations and priority populations behind must be addressed and overcome in all areas of the Strategy.
- v. Cities, urbanization and human settlements: cities and human settlements as centres for economic growth, education, innovation, positive social change and sustainable development to close programmatic gaps in the HIV response.

# END INEQUALITIES. END AIDS. GLOBAL AIDS STRATEGY 2021-2026



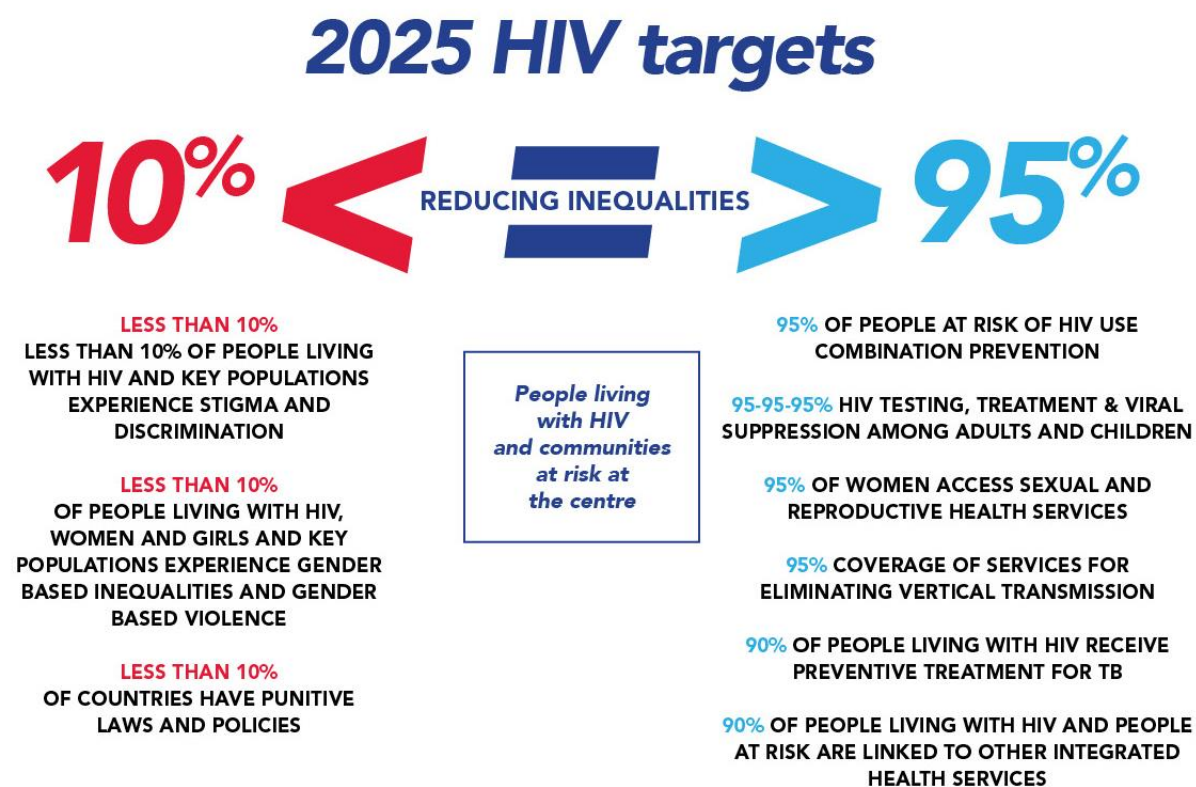
## End AIDS as a public health threat by 2030



## Ambitious targets and commitments for 2025 to put the world on course to end AIDS

35. The Strategy features ambitious, new targets and commitments<sup>14</sup> to be achieved in every country and community for all populations and age groups by 2025.<sup>15</sup>
36. The Strategy's three strategic priorities are reflected in the three categories of the targets and commitments: comprehensive, people-centred HIV services; breaking down barriers by removing societal and legal impediments to an effective HIV response; and robust and resilient systems to meet the needs of people.

## AMBITIOUS TARGETS AND COMMITMENTS FOR 2025



### Implementing the Strategy

37. To implement tailored and differentiated responses, individual regions and countries will need to adapt the Strategy in ways that respond to their epidemiological and economic circumstances, address key HIV-related inequalities, promote and protect human rights

<sup>14</sup> The full list of targets is detailed in Annex 1.

<sup>15</sup> The Global AIDS Strategy covers the period 2021–2026, and features targets and commitments to be achieved by the end of 2025. This is to enable a review of these results and the development of the next Global AIDS Strategy in 2026, which will cover the period up to 2030.



and drive progress towards ending AIDS by 2030. The Strategy includes profiles of seven regions, outlining priority actions to put regional HIV responses on-track.

38. Country ownership is emphasized as a sustainable driver of change in the HIV response, through diversified funding, service integration and by matching the response to national, subnational and community needs.
39. Achieving the goals and targets of the new Strategy will require annual HIV investments in low- and middle-income countries to rise to a peak of US\$ 29 billion by 2025. Upper-middle-income countries account for 51% of the total resource needs in the Strategy. The majority of resources are expected to come from domestic resources, while development partners must commit to sustainably funding remaining resource needs. The Strategy calls for sufficient resources to achieve these targets and commitments in order to change the dynamics of the epidemic and get on track to ending AIDS by 2030.
40. Chronic under-investment in the global HIV response has not only translated to millions of additional new HIV infections and AIDS-related deaths but also increased the global resource needs to reach the Strategy's targets and commitments. Significantly greater investments are needed in three areas:
  - i. HIV Prevention: an almost two-fold increase in resources for evidence-based combination prevention, from US\$5.3 billion per year in 2019 to US\$9.5 billion in 2025. Resources should also be reallocated from ineffective prevention methods to the evidence-based prevention programmes and interventions called for in the Strategy.
  - ii. HIV testing and treatment: investments must increase by 18%, from US\$8.3 billion in 2019 to US\$9.8 billion by 2025, but the number of people on treatment will increase by 35%, due to efficiency gains from the price reductions in commodities and costs to deliver the services. Reaching such treatment targets will contribute to additional reductions in new HIV infections, which will in turn lead to reductions in resource needs for testing and treatment from 2026–2030.
  - iii. Societal Enablers: investment in societal enablers must more than double to US\$3.1 billion in 2025 (representing 11% of total resources). These investments should focus on establishing the legislative and policy environment required to implement the Strategy. Societal enablers will need to be co-financed by the HIV response and non-health sectors.
41. As a joint programme, UNAIDS brings together the diversity and expertise of the UN system, Member States and civil society around a shared vision of ending AIDS and achieving the Three Zeroes. UNAIDS is a unique vehicle to drive transformation, incubate innovative multisectoral approaches and address the crosscutting challenges essential to implement this Strategy.
42. UNAIDS will work to catalyse the rapid implementation of the priority actions outlined in the Strategy. Upon adoption of the Strategy, UNAIDS will align its footprint, capacity, ways of working and resource mobilization efforts with the Strategy's strategic priorities and result areas. UNAIDS will measure its performance, contributions, and results against progress in country, regional and global HIV responses, with a specific focus on how it will work with countries and communities to reduce inequalities by 2025 to get the response on-track to ending AIDS by 2030.
43. In summary, the Strategy aims to unite countries, communities and partners across and beyond the HIV response to take prioritized actions that will accelerate progress towards the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. It

seeks to empower people with the programmes, knowledge and resources they need to claim their rights, protect themselves and thrive in the face of HIV. The Strategy identifies where, why and for whom the response is not working. Drawing on key lessons learned from the intersecting AIDS and COVID-19 pandemics, the Strategy leverages the proven tools and approaches of the HIV response. And it outlines strategic priorities and priority actions to get the HIV response on-track to end AIDS as a public health threat by 2030.

## CHAPTER 1: DECADE OF ACTION TO DELIVER THE SDGS: REDUCING INEQUALITIES AND CLOSING GAPS TO END AIDS AS A PUBLIC HEALTH THREAT

It is at the heart of the 2030 Agenda for Sustainable Development, our agreed blueprint for peace and prosperity on a healthy planet, captured in SDG 10: reduce inequality within and between countries.

*UN Secretary-General António Guterres* <sup>16</sup>

44. Over the last five years of the global HIV response, the seemingly impossible proved possible. During the implementation of the UNAIDS Fast-Track Strategy 2016–2021, some communities and countries experienced significant declines in HIV infections and AIDS-related deaths, even without an HIV vaccine or a cure. Dozens of countries took major strides towards achieving the 90–90–90 targets. By 2019, more than 40 countries were on-track to end AIDS as a public health threat by 2030. This progress was facilitated by scientific advances that delivered new technologies for HIV prevention and treatment, and new clarity on the optimal combination of services and delivery strategies. Also crucial was the compelling evidence regarding the value and necessity of removing laws and policies that discriminate or otherwise undermine human rights. The leadership by communities and people stepping forward to claim their right to health, reinforced by continued global solidarity, were also key drivers of this success.
45. Yet, despite the evidence that we can end AIDS, the HIV response is currently not on track to end AIDS by 2030, as envisioned in the SDGs. The AIDS epidemic remains a global crisis. Despite many successful government-funded and community-led prevention and treatment programmes, progress in reducing new HIV infections and in connecting more people living with HIV to treatment has slowed markedly in recent years in some countries and communities. In other countries and communities, the numbers of new HIV infections and AIDS-related deaths are rising. The AIDS epidemic remains dynamic, with evolving shifts and variations in epidemiological patterns and burdens of disease within, and among, a wide spectrum of communities, countries and regions.
46. An urgent, strategic course correction is needed to get the global HIV response back on-track. The Global AIDS Strategy 2021–2026 builds on lessons from the previous Strategy. It is guided by human rights principles, norms and standards, commitments to achieve gender equality, and approaches that put communities at the centre of the global response. The Strategy aims to address the specific factors that have slowed progress and caused the response to fail the people who are most vulnerable to HIV, especially those who are experiencing social, economic, racial and/or gender inequality.

### **Inequalities are driving the AIDS epidemic**

47. The world did not reach the 2020 Fast-Track targets because of worsening inequalities within and across countries. Gaps are widening between people and communities

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<sup>16</sup> [Secretary-General's Nelson Mandela Lecture: "Tackling the Inequality Pandemic: A New Social Contract for a New Era"; 18 July 2020.](#)

experiencing rapid declines in new HIV infections and AIDS-related deaths and those denied such improvements.

48. The rapid progress made in many countries and communities shows what can be achieved. However, the lack or slow pace of progress elsewhere reflects what happens when human rights, gender equality and communities are not placed at the centre of the HIV response.
49. Millions of people living with HIV and tens of millions of people at risk are still not able to benefit from HIV prevention and health-protecting and life-saving HIV treatment and care services. Inequalities affect not only the people who are excluded, they burden entire populations and societies. We cannot end AIDS without reducing these inequalities.
50. Inequalities mean that some people obtain immediate access to HIV prevention and treatment, while others must wait months or even years, with hundreds of thousands of people dying every year while waiting. Cutting-edge biomedical interventions and essential services reach only some people and some communities and countries. We cannot end AIDS unless we end these inequalities.
51. The AIDS and COVID-19 pandemics follow, and deepen, societal fault lines. Inequalities exacerbate vulnerability to infectious diseases and magnify the impact of pandemics. Within countries, structural inequalities and inadequate funding mean that cutting-edge biomedical interventions and essential social services frequently cannot be reached by people and communities who need them most. HIV programmes designed to deliver the benefits of scientific advances are often not tailored to the complex needs and realities of people who experience these multiple, often intersecting inequalities.
52. This is why the Global AIDS Strategy focuses on reaching the people and communities who are being left behind. It calls for understanding who and where these people and communities are, the patterns and causes of their vulnerability and marginalization, and why the efforts to date have not reached or not worked for them. It requires that we prioritize and scale up HIV programmes that put those people and communities at the centre of global, regional, national, subnational and community responses.
53. The inequalities blocking progress towards ending AIDS emerge when HIV intersects with complex fault lines across social, economic, legal and health systems. These inequalities operate along multiple axes, with some compounding others. They are often aggravated by laws and policies and are reflected in unequal HIV outcomes, discriminatory and oppressive practices, and violence.
54. Inequalities often express the ways in which health systems are designed, financed, organized and managed. Financial barriers cause health systems to fail poor people and low-income communities. The focus of many health services on curative interventions also diminishes attention and funding for preventive interventions that could help reduce inequalities in HIV and other health outcomes.
55. As a result of persisting inequalities, HIV responses work for some but not for others. HIV infections have declined among young women in many parts of the world, but adolescent girls and young women (aged 15–24 years) in sub-Saharan Africa are up to 5 times more likely to acquire HIV infection than their male peers.
56. Sexual and gender-based violence and harmful gender norms which no country in the world has ended, continue to be major drivers of the AIDS epidemic, with immediate and long-term consequences for individuals, families, communities and societies. HIV responses are also largely failing key populations.

57. Globally, men living with HIV are less likely to access HIV testing and treatment services than women living with HIV. In Europe and North America, even as cutting-edge technologies offer the means for ending the epidemic in some populations, many gay men and other men who have sex with men of different racial or ethnic minorities, transgender women, people who inject drugs and low-income people have been left behind. Inequalities are reflected in the deterioration and inaccessibility of health-care services for children, adolescents, young people and adults living with or affected by HIV in climate disasters and/or conflict settings, including refugees, internally displaced persons, returnees and asylum seekers, and vulnerable migrants. People living in informal settlements often lack access to essential services.

58. Children are being left behind. Only 53% of children living with HIV are accessing treatment. Without a voice in the response, they have an unequal opportunity to call for solutions to their needs.

59. While significant progress has been made against HIV in many high-burden countries, progress is fragile or lacking in many countries where HIV prevalence is lower. This is partly due to the diminished attention on HIV as the burden of noncommunicable diseases increases.

60. Evidence shows that the disparities in HIV service access, HIV incidence and AIDS-related mortality are the result of multiple, overlapping inequalities, and unequal access to education, employment and economic opportunities.

61. Renewed political and financial commitments are needed to scale up interventions that will address the different structural, financial and economic inequalities and transform

### **HIV and COVID-19**

From the start of the COVID-19 pandemic, UNAIDS has worked alongside people living with and affected by HIV across the world to manage its impacts. It also investigated how the experience of tackling HIV could help inform and guide effective, efficient, people-centred and sustainable COVID-19 responses. Decades of investment in the HIV response have created platforms that are proving useful against COVID-19—just as they were in responding to the 2014–2015 Ebola outbreak in western and central Africa.

Successful international efforts to respond to HIV have been rooted in innovation, respect for human rights and gender equality, community-based solutions and a commitment to leave no-one behind. Guidance on how to combat stigma and discrimination during COVID-19 also draws on 40 years of experience from the HIV response.

UNAIDS highlights several vital actions:

- Put gender equality at the centre of COVID-19 responses and show how governments can confront the gendered and discriminatory impacts of COVID-19.
- Protect the most vulnerable people, particularly those belonging to key populations who are at higher risk of HIV infection, to respond to human rights concerns in the evolving context of COVID-19.
- Leverage the experience and infrastructure of the HIV response to ensure a more robust response to both pandemics.

By heeding the lessons of the HIV response, the responses to COVID-19 and other pandemics can be people-centred, flexible, innovative, equitable and outcome-driven. By being smart and strategic, countries can leverage their HIV infrastructure to accelerate responses to COVID-19 and other pandemic threats to deliver on the promise of the 2030 Agenda for Sustainable Development for the health and well-being of all.

the harmful socio-cultural norms, gender-based inequalities and gender-based violence that continue to drive the AIDS epidemics.

### **Acting on inequalities that drive the AIDS epidemic delivers results.**

62. The HIV response has shown that when countries take legal, policy and programmatic measures to address inequalities, gaps in the response can be quickly reduced and overall progress towards ending AIDS accelerates.
63. Twenty years ago, when the international community first resolved to halt and reverse the AIDS epidemic, such outcomes were considered unrealistic.<sup>17</sup> Today, the rate of new HIV infections has declined fastest in some of the low-income countries most heavily affected by HIV.
64. In a diverse range of settings, the solidarity, ambition and innovations of the HIV response are saving lives.
65. Innovative service delivery, such as multimonth dispensing, and community leadership have sustained access to HIV services even during COVID-19 lockdowns.
66. Adolescent girls and young women in some settings in Africa are experiencing sharp reductions in their risk of acquiring HIV due to multisectoral HIV programmes that advance gender equality and focus on women and girls' health. They include sexual and reproductive health programmes, including contraception, education, comprehensive sexuality education, and economic empowerment.
67. Inequalities exist also between key populations in different countries and regions. In some settings, key populations have been able to maintain access to life-saving HIV services, such as pre-exposure prophylaxis (PrEP) and harm reduction, even during COVID-19 lockdowns. But elsewhere, key populations continue to face severe inequalities that limit their access to HIV services.
68. Political and financial commitments are needed to scale up interventions that will address the structural, financial and economic inequalities and transform the harmful sociocultural norms, gender-based inequalities and gender-based violence that drive the HIV epidemic.
69. The Strategy's inequalities lens shifts the focus to the people and communities who are still being left behind in HIV response. In implementing this Strategy, the HIV response will use differentiated approaches that are tailored to the needs of specific contexts, populations, and locations and prioritize the people and populations most in need.

Using an inequalities lens to accelerate progress towards ending AIDS: An inequalities lens requires an understanding of the nature and causes of inequalities in different locations and among different population groups, and how they interact with HIV. Focusing on where, why and for whom the HIV response is not working can help identify the additional or modified actions needed to achieve better and more equal programmatic outcomes. By using an inequalities lens, countries, communities, UNAIDS and partners can craft better evidence-based approaches to reduce or eliminate inequalities, identify where modifications in approaches are needed and strengthen efforts to monitor progress towards ending AIDS as a public health threat.

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<sup>17</sup> The Millennium Development Goals, adopted in September 2000, featured the MDG6 goal to halt and begin to reverse the spread of HIV by 2015; see [A/RES/55/2: United Nations Millennium Declaration](#).

## **Shifting to an inequalities lens will ensure that the global HIV response works for everyone and leaves no one behind**

70. Several key principles underpin the inequalities lens in the new Global AIDS Strategy.
- i. Prioritize actions that will reduce HIV-related inequalities and disparities in health outcomes. The Strategy will promote a new, urgent focus to close the gaps created by inequalities and reduce disparities in health outcomes for people living with and affected by HIV who are still not benefitting from HIV services.  
All people living with and affected by HIV should benefit from HIV prevention, testing, treatment, care and achieve viral load suppression, regardless of who they are and where they live. This includes new technologies such as adherence-friendly injectable antiretroviral regimens for treatment and prevention, point-of-care diagnostics for children, HIV self-tests or antiretroviral-containing vaginal rings for PrEP for women.
  - ii. Address intersecting structural and social inequalities and prioritize actions that may be difficult but are needed the most, rather than focus on easier actions that do not confront persistent inequalities.
  - iii. Act holistically to address the epidemiological, socioeconomic, cultural and legal determinants of HIV.  
Globally and in each country and community, comprehensive, integrated and targeted responses must ensure progress across all aspects of the HIV response.
  - iv. Recognize that tailored HIV responses are needed to tackle the intersecting inequalities that drive the AIDS epidemic.  
The approach of "know your epidemic, know your response" requires all countries and communities to refocus on understanding where, for whom and why the HIV response is working; who has been left behind and where; and which inequalities and patterns of vulnerability are causing these gaps. The HIV response must be shifted and finetuned. This includes developing tailored tools, prioritizing funding and actions to transform harmful social norms, reforming legal environments as required, and introducing supportive policy and programmatic frameworks.
  - v. Measure our success in reducing inequalities.  
We must build and refine national data collection and monitoring systems in a sustainable manner to better capture, analyze and monitor progress on reducing HIV-related inequalities.
71. The Strategy will promote the scale-up of proven HIV interventions to combat inequalities. Urgent efforts will focus on closing the gaps in HIV prevention, through tailored, scaled-up combination HIV prevention packages and services that can sharply reduce HIV infection rates among key populations and priority populations such as adolescent girls and young women in sub-Saharan Africa. The Strategy prioritizes service delivery models and funded community-led responses that can ensure access even when health facilities are inaccessible, macroeconomic policies that expand fiscal space for priority investments (including essential social protection), and partnerships that shift social norms and influence removal of punitive laws, policies and practices that perpetuate inequalities and otherwise undermine human rights.

## **Using an inequalities lens across the Strategy's Targets and Commitments, Strategic Priorities and Result Areas**

72. An inequalities lens that is rooted in human rights, gender equality and community-led responses is the key unifying feature of the new Strategy. It calls for bold, urgent action to ensure 95% coverage in all populations, age groups and geographic areas of essential, evidence-based HIV services, including combination prevention, prevention of

vertical transmission and sexual and reproductive health services, HIV testing, treatment, care and support.



73. The Strategy also includes targets for societal enablers: reducing to no more than 10% the proportion of people living with or affected by HIV who experience stigma and discrimination, or who experience gender-based inequalities and gender-based violence, and the number of countries which have punitive laws and policies in place. While no instance of discrimination, violence or human rights violation is tolerable, the Strategy includes these targets to focus attention on the unconscionable prevalence of these realities and to drive urgent progress towards their elimination.
74. The Strategy's vision for reducing inequalities and laying the foundation to reach the 2030 targets builds on its three Strategic Priorities:
  - maximize equitable and equal access to HIV services and solutions;
  - break down barriers to achieving HIV outcomes; and
  - fully resource efficient HIV responses and integrate HIV in systems for health, social protection, and humanitarian and pandemic responses.
75. The Strategy outlines strategic results for each of these interdependent, strategic priorities. For each Strategic Priority and Result Area, it explains how they advance progress towards the Three Zeros and link with the 10 relevant SDGs. It outlines clear, quantifiable targets and commitments for 2025, with a specific focus on ensuring that no population, community, country or region is left behind in the global effort to end AIDS.
76. For each Result Area, high-priority actions are proposed to guide policy makers and implementing partners. Those actions do not preclude the core, ongoing actions that constitute the standard package of HIV interventions, programmes, services and policies and which must also be undertaken as part of an effective, comprehensive and evidence-based HIV response.
77. Recognizing that no single actor or sector can, on their own, end the AIDS epidemic, the Strategy is designed for the global HIV response as a whole. It seeks to unite diverse stakeholders around a common goal and enable all stakeholders to determine how they can contribute to ending the AIDS epidemic. The Strategy provides a framework for countries to leverage their leadership and ownership of the response, and tailor national strategies in ways that reduce inequalities, strengthen the response and maximize public health impact. The Strategy specifically describes how the Joint Programme will contribute to the achievement of the strategic results and targets.

### **Reducing the inequalities that drive HIV can be an entry point for transformation across the 2030 Agenda for Sustainable Development**




78. Since the first cases of AIDS were reported 40 years ago, HIV has exposed structural inequalities and discrimination in societies across the world. HIV has had a disproportionate impact on communities that were already marginalized and disenfranchised—be it gay men and other men who have sex with men, young women and girls in sub-Saharan Africa, sex workers across the world, people who inject drugs, or people in prisons and other closed settings, seasonal and mobile labourers, and migrants. The COVID-19 pandemic is repeating this pattern and reinforcing inequalities. While the impact of COVID-19 is felt by all, the pandemic is particularly damaging to people who are most vulnerable and who already experience discrimination and exclusion.

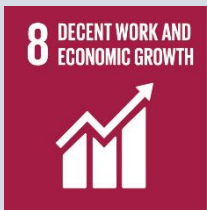


79. The world has met those realities with pioneering responses, which the Strategy seeks to leverage in order to promote healthier, more resilient and equal societies. There may be no vaccine or cure for inequalities, but it is possible to reduce them. Empowering the people and communities who are left behind can have a positive, transformative impact on all of society. Reducing inequalities within and among countries is one of the 17 SDGs (Goal 10). By reducing and ending inequalities that perpetuate and exacerbate the AIDS epidemic, transformative outcomes for society as a whole are set in motion.
80. Getting the HIV response on-track to end AIDS by 2030 will ensure achievement of the HIV specific target in the 2030 Agenda for Sustainable Development Goals (SDG 3.3), as well as accelerate gains towards at least 10 SDGs. Table 1 below outlines the synergies and linkages between the Strategy and the SDGs—how progress towards specific SDGs contributes to ending AIDS, and how gains in the HIV response accelerate progress towards achievements of these SDGs.
81. Putting inequalities at the heart of the Strategy will not only unblock progress towards ending AIDS. During this Decade of Action to deliver the SDGs, the Strategy will accelerate progress to reduce inequalities within and between countries, and to reach the furthest left behind first, as envisaged in the 2030 Agenda for Sustainable Development.



**Table 1: How the Strategy reduces inequalities that inhibit progress on HIV and select Sustainable Development Goals**

SDG	How select SDGs impact the HIV epidemic and response	How HIV affects progress towards this SDG	Illustrative examples of how the Strategy contributes to the SDGs
<p>SDG 1</p> 	<p>Poverty can exacerbate vulnerability to HIV and undermine people's capacity to mitigate its impact.</p>	<p>Countries and households disproportionately affected by HIV are more vulnerable to falling into and remaining in poverty, creating a cycle of vulnerability.</p>	<p>The Strategy prioritizes social protection interventions for people living with HIV, key populations and priority populations to reduce gender and income inequalities and eliminate social exclusion, and thereby diminish the risk of HIV due to poverty.</p>
<p>SDG 2</p> 	<p>Hunger, malnutrition, and food insecurity increase negative social risk management strategies and hinder ART initiation, adherence and efficacy, thereby hastening AIDS-related illnesses and death.</p>	<p>HIV weakens the immune system, impairing nutrient intake and absorption, undermines household food security by increasing stigma, reducing productivity, damaging livelihoods, and increasing morbidity and mortality.</p>	<p>The Strategy prioritizes integrated food and nutrition programming and social protection interventions to address the root causes of poverty and hunger by tackling structural deprivations, inequalities and vulnerabilities within communities and at scale, promoting robust national systems that are broad in their reach and inclusive across diverse population groups. Addressing food insecurity and malnutrition, keeping adults earning an income and keeping children in school, helps ensure the efficacy of HIV treatment.</p>



SDG	How select SDGs impact the HIV epidemic and response	How HIV affects progress towards this SDG	Illustrative examples of how the Strategy contributes to the SDGs
<p>SDG 3</p> 	<p>HIV prevention and treatment access is undermined when Universal Health Coverage is lacking, or when people do not have access to sexual and reproductive health services. Lack of access by people living with HIV to integrated care impact on health outcomes and quality of life.</p>	<p>People living with HIV are at increase risk of some non-communicable diseases, including mental health conditions. Women living with HIV are more likely to develop and die from cervical cancer than women not living with HIV.</p>	<p>The Strategy calls for HIV-sensitive Universal Health Coverage that is equitable, holistic and integrated with rights-based services for co-morbidities and other health issues experienced by people living with, at risk of or affected by HIV.</p> <p>Investing in HIV services strengthens health systems, including pandemic preparedness, as shown during the COVID-19 crisis, and helps reduce maternal and under 5 mortality for AIDS-related causes</p>
<p>SDG 4</p> 	<p>Globally, about 7 in 10 adolescent girls and young women have poor knowledge of HIV. Education is one of the best HIV prevention tools available. Each additional year of secondary schooling can lead to a reduction in the cumulative risk of HIV infection, in particular among adolescent girls and young women.</p>	<p>HIV-related illness impedes school attendance and learning, as does stigma and discrimination in school settings.</p>	<p>The Strategy pursues transformative change through quality education, including comprehensive sexuality education. The latter empowers young people with the knowledge and skills they need to take responsible and informed decisions regarding their health and well-being.</p> <p>Rights literacy can empower people living with HIV to become more active citizens who know and claim their rights beyond the right to health, inspiring others as they do so.</p>
<p>SDG 5</p> 	<p>Violence against women, denial of legal rights and women's limited participation in decision-making exacerbate vulnerability to HIV infection. Harmful gender norms also impact on men's health seeking behaviour.</p>	<p>HIV is a leading cause of death among women of reproductive age. Women living with HIV and women in key populations are more likely to experience gender-based violence.</p>	<p>The Strategy prioritizes resources for the empowerment of women and girls, guaranteeing their rights so that they can protect themselves from acquiring HIV, overcome stigma and gain greater access to HIV testing, treatment, care and support as well as to sexual and reproductive health services.</p> <p>Ensuring that adolescent girls and young women get an education and are economically empowered is a sound HIV prevention Strategy which also empowers those women and girls to lead transformative</p>

SDG	How select SDGs impact the HIV epidemic and response	How HIV affects progress towards this SDG	Illustrative examples of how the Strategy contributes to the SDGs
			<p>change in their communities. The Strategy also calls for reforms to ensure women's rights to land and other forms of property.</p> <p>Gender-transformative HIV programmes that involve women and girls along with men and boys can reduce gender-based violence, empower women and transform harmful gender norms, including those related to masculinity.</p>
<p>SDG 8</p> 	<p>Safe and secure work environments facilitate access to HIV services, including for workers in informal employment and migrants.</p>	<p>People living with HIV can experience unemployment rates three times higher than national unemployment rates.</p>	<p>The Strategy addresses HIV in the world of work by advocating for the protection of labour rights to ensure that people living with and affected by HIV enjoy full and productive employment, free from discrimination.</p>
<p>SDG 10</p> 	<p>HIV affects vulnerable and disempowered communities most severely. Social and economic exclusion and marginalization impacts on the ability of people to protect themselves from HIV.</p>	<p>HIV-related stigma and discrimination</p>	<p>The Strategy is centred on reducing and ending the inequalities that drive the AIDS epidemic, while simultaneously leveraging the HIV response as an entry point to drive transformative change across the SDGs by addressing inequalities.</p>
<p>SDG 11</p> 	<p>With rapid urbanization, many cities contend with growing AIDS epidemics. People living in slums often are at greater risk of acquiring HIV, partly due to poor access to basic services.</p>	<p>HIV particularly affects cities and urban areas, with 200 cities accounting for more than one quarter of the world's people living with HIV.</p>	<p>The Strategy advocates for city-led HIV responses at the local level to support positive social transformation by strengthening health and social systems to reach the most marginalized in society.</p> <p>As centres for economic growth, education, innovation, positive social change and sustainable development, cities are uniquely positioned to address complex multidimensional problems such as HIV through inclusive participation from diverse stakeholders.</p> <p>Local ownership and leadership in the HIV response ensure</p>

SDG	How select SDGs impact the HIV epidemic and response	How HIV affects progress towards this SDG	Illustrative examples of how the Strategy contributes to the SDGs
			greater substantive equality and helps to ensure health as a right for everyone.
<p>SDG 16</p> 	<p>Exclusion, stigma, discrimination, human rights violation, and violence fuel the AIDS epidemic among adults and children. Lack of access to justice impacts on the ability of people living with HIV and key populations to get redress for HIV-related human rights violations.</p>	<p>The HIV response, led by people living with and affected by HIV, has demanded access to justice and pioneered people-centred accountability mechanisms, yielding benefits that extend far beyond the HIV response.</p>	<p>The Strategy prioritizes participatory governance, including community-led responses, in order to drive more relevant, rights-based programmes and strengthen accountability for health and development.</p>
<p>SDG 17</p> 	<p>Partnerships and global solidarity are key elements of the HIV response and mobilizing domestic and international resources to meet the HIV-related resource needs is essential for ending AIDS as a public health threat by 2030.</p>	<p>Efforts to ensure the affordability of and access to HIV-related products and health technologies can benefit wider health and equity agendas, including for tuberculosis, hepatitis C and noncommunicable diseases. The HIV response has been at the forefront of innovating partnerships and placing communities at the centre.</p>	<p>The Strategy calls for mobilization of domestic and international investments in evidence based HIV-programmes. It also calls for enhanced global collective action to improve the affordability of and access to HIV commodities critical to ending the AIDS epidemic, including through promoting advocacy to leverage the use of Trade-Related Aspects of Intellectual Property Rights flexibilities, and optimizing the use of voluntary licensing and technology sharing mechanisms to meet public health objectives. The Strategy also calls for the strengthening of regional and interregional exchange and cooperation in science, research and innovation.</p>

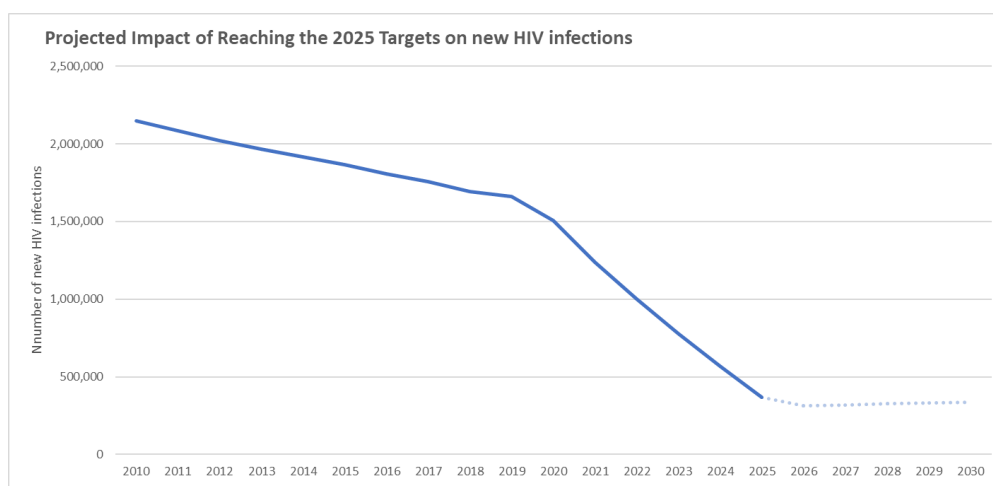
**Chapter 2: Achieving the vision of the Three Zeroes: modelled impact of delivering on the Strategy**

82. The failure to achieve the targets in the 2020 Fast-Track Strategy and the 2016 Political Declaration on Ending AIDS has had a tragic human cost: an additional 3.5 million people acquired HIV and an additional 820 000 people died of AIDS-related illnesses than would have been the case if the targets had been reached. As a result, millions

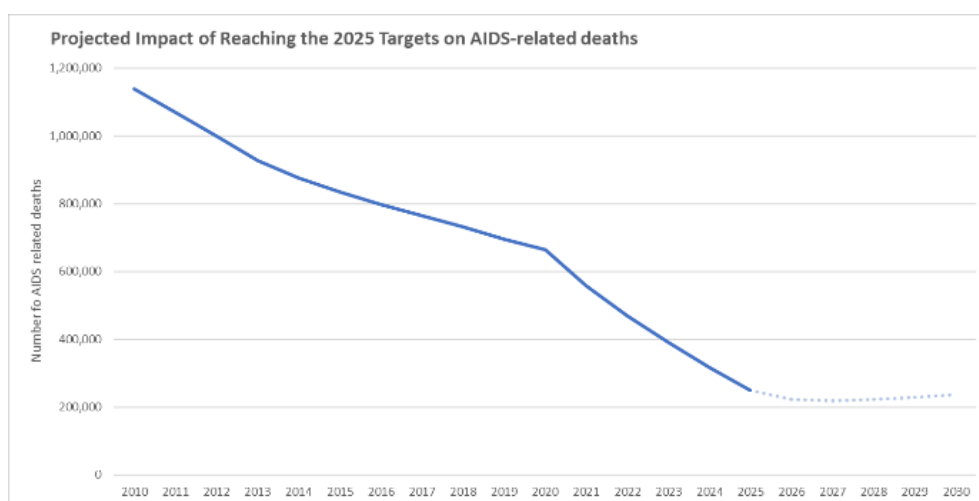
more people are living with HIV and tens of millions of people who are still at risk of HIV infection require targeted, comprehensive services.

- 83. The world can get on-track to end AIDS as a public health threat by 2030, which requires a 90% reduction in new infections and AIDS-related deaths (against the 2010 baseline). Achieving the full range of the 2025 targets in this Strategy in all geographic areas and across all populations will put every country and every community on-track to end AIDS.
- 84. Epidemic modelling shows that achieving the comprehensive 2025 targets will reduce annual HIV infections from an estimated 1.7 million in 2019 to less than 370 000 in 2025 and will reduce annual adult and children AIDS-related deaths, including tuberculosis (TB) deaths among people living with HIV, from an estimated 690 000 in 2019 to less than 250 000 in 2025. This degree of success in the HIV response will put the international community firmly on-track to end the AIDS epidemic in all settings and for all populations by 2030.

**Figure 1. Reaching the 2025 targets will reduce new HIV infections to under 370 000 in 2025<sup>18</sup>**

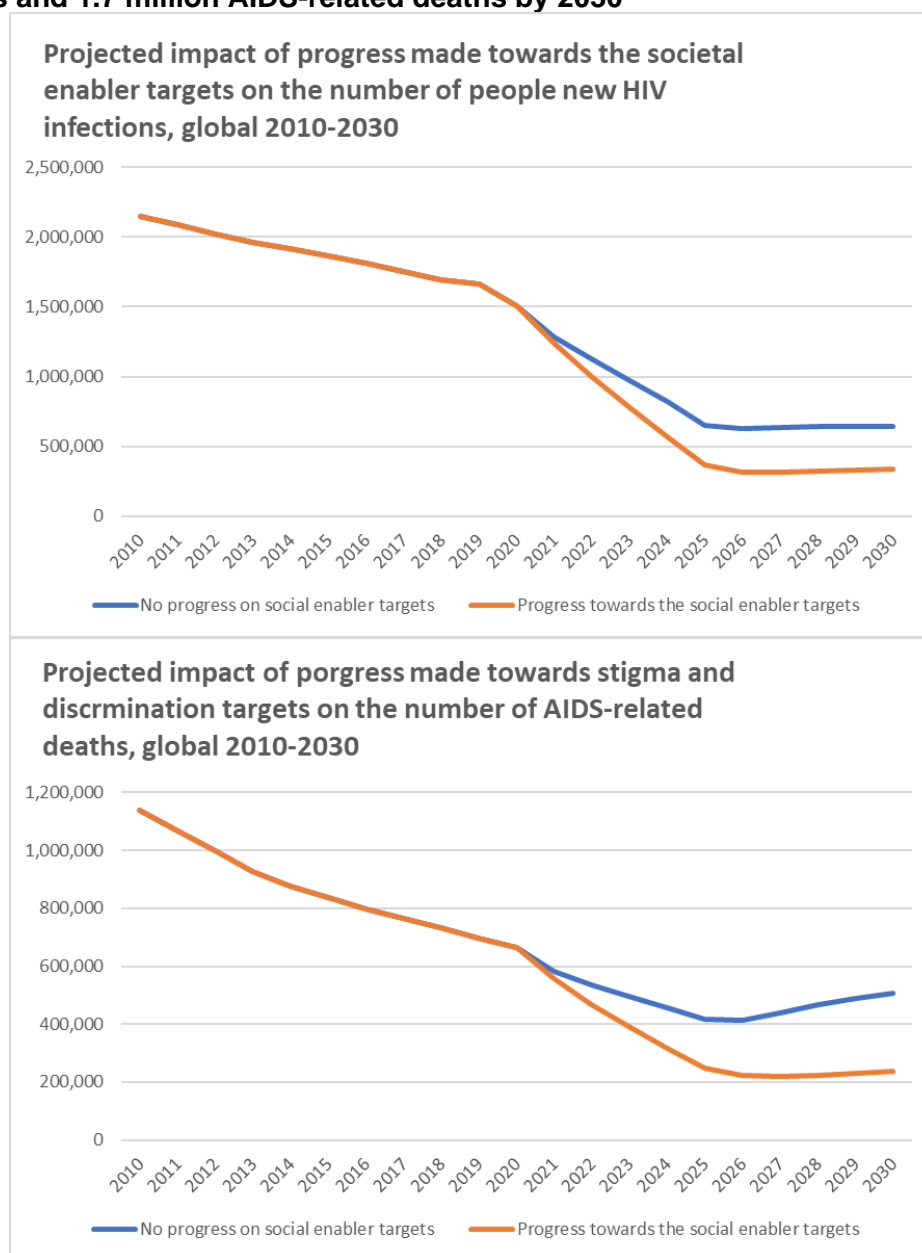


**Figure 2. Reaching the 2025 targets will reduce AIDS-related deaths to under 250 000 in 2025**



<sup>18</sup> The epidemiological impact between 2026–2030 assumes that the 2025 targets are met. The 2026–2030 epidemiological impact will be revisited closer to 2025, by which time it will be possible to assess programmatic achievements through 2025.

**Figure 3. Reaching the societal enabler targets will prevent 2.5 million new HIV infections and 1.7 million AIDS-related deaths by 2030**



85. Reaching the societal enabler targets in this Strategy is crucial. Modelling indicates that failure to reach the targets for stigma and discrimination, criminalization and gender equality will prevent the world from achieving the other ambitious targets in the Strategy and will lead to an additional 2.5 million new HIV infections and 1.7 million AIDS-related deaths between 2020 and 2030.

86. The full set of 2025 targets and commitments is provided in Annex 1. The resources required to achieve these results in low- and middle-income countries are discussed in greater detail in Chapter 7 and in Annex 2.

### CHAPTER 3: STRATEGIC PRIORITY 1: MAXIMIZE EQUITABLE AND EQUAL ACCESS TO HIV SERVICES AND SOLUTIONS

87. We have the potential and commitment to end AIDS. However, people-centred services remain limited. The lack of comprehensive, high-quality, rights-based, gender-

responsive, context-tailored services at the scale and intensity required have resulted in inequalities that slow global progress towards ending AIDS. Current HIV services are not always designed or tailored for the populations or age groups who are most affected by HIV, and they often fail to meet the needs of those populations. Stigma, discrimination and persistent gender inequalities leave many key populations and people from priority populations unreached and unserved. In addition, HIV services are often not complemented by broader rights-based, gender-sensitive access to age-tailored health care, sexual and reproductive health services, education (including comprehensive sexuality education both in and out of school), sustainable livelihoods, support systems and social protection.

88. This new people-centred Strategy calls for urgent action to link all individuals living with or at risk of HIV with the services they need. Recognizing that "one size does not fit all", the Strategy prioritizes the tailoring of differentiated service packages and service delivery approaches to the unique needs of people, communities and locations, using granular data to focus programmes most effectively.
89. To ensure sufficient service coverage, the new Strategy prioritizes actions to first benefit the people who are not being reached, such as key, priority and underserved populations. Tailored, combination HIV prevention packages must receive substantially greater prioritization—including scale-up of underutilized prevention approaches and community-led responses, such as comprehensive sexuality education, sexual and reproductive health (including contraception), harm reduction services, condoms, lubricants, PrEP and U=U,<sup>19</sup> and emerging prevention tools, such as antiretroviral containing vaginal rings. Prioritized actions are also required to close the gaps in access to treatment and care that undermine the benefits of ART.

<b>High-level 2025 targets<sup>20</sup></b>
<ul style="list-style-type: none"> <li>95% of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options.</li> </ul>
<ul style="list-style-type: none"> <li>95% of women of reproductive age have their HIV and sexual and reproductive health service needs met.</li> </ul>
<ul style="list-style-type: none"> <li>95% of pregnant and breastfeeding women living with HIV have suppressed viral loads.</li> </ul>
<ul style="list-style-type: none"> <li>95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding</li> </ul>
<ul style="list-style-type: none"> <li>75% of all children living with HIV have suppressed viral loads by 2023 (interim target)</li> </ul>
<ul style="list-style-type: none"> <li>95–95–95 testing and treatment targets are achieved <i>within all subpopulations, age groups and geographic settings</i>, including children living with HIV.<sup>21</sup></li> </ul>
<ul style="list-style-type: none"> <li>90% of people living with HIV receive preventive treatment for TB.</li> </ul>

<sup>19</sup> U=U, or Undetectable=Untransmittable is a scientifically proven concept which refers to people living with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking ART daily as prescribed, cannot sexually transmit the virus to others.

<sup>20</sup> These are the high-level, aggregated targets for this Strategic Priority. The complete set of targets and commitments are provided in Annex 1 and Annex2.

<sup>21</sup> 95% of people within the subpopulation who are living with HIV know their HIV status; 95% of people within the subpopulation who are living with HIV and who know their HIV status are on ART; 95% of people within the subpopulation who are on ART have suppressed viral loads.

- 90% 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.

**Result Area 1: Primary HIV prevention for key populations, adolescents and other priority populations, including adolescents and young women and men in locations with high HIV incidence**

90. HIV prevention efforts are not currently having the impact needed to end AIDS. The estimated 1.7 million people who newly acquired HIV in 2019 far exceeded the 2020 target of fewer than 500 000 new HIV infections. Insufficient resources and inadequate focus on preventing new HIV infections among key populations and their sexual partners and adolescent girls and young women in Sub-Saharan Africa are the biggest reasons for the slow progress.
91. The risk of HIV transmission among key populations and their sexual partners is the major contributor to new HIV infections globally and in every region outside of eastern and southern Africa. Although the likelihood of key populations acquiring HIV exceeds the risk among other populations, the gaps in HIV investment are disproportionately large for HIV prevention among key populations. HIV prevention efforts have also been slow to address how harmful alcohol or non-injecting drug use, such as “chem-sex” and the use of other stimulant drugs that affect sexual behaviours and increase risks of HIV acquisition.
92. HIV prevention efforts have also yet to fully engage the broader health sector as well as non-health sectors to address underlying inequalities and structural factors that contribute to HIV vulnerability. To close the gaps in HIV prevention, the urgent strengthening of tailored, high-impact, evidence- and rights-based combination HIV prevention, including the realization of the full potential of treatment as prevention, are key, transformative elements of the new Strategy.
93. The number of adolescent girls and young women who acquired HIV in 2019 (280 000) was nearly three times higher than the Fast-Track target for 2020 (100 000). In sub-Saharan Africa, high rates of HIV acquisition persist among adolescent girls and young women, stemming from multiple vulnerabilities such as harmful social norms and practices (i.e. female genital mutilation), sexual and gender-based violence, lack of access to education or completion of secondary school, poverty and age-disparate sex. Combination HIV prevention, including primary prevention, especially for young people, is also vital to eliminate vertical HIV transmission.
94. Political commitment and resources for evidence- and rights-based combination HIV prevention remains inadequate, and harmful social norms, stigma, discrimination and punitive laws still obstruct prevention efforts. Key populations continue to face these and other barriers to access HIV prevention services. Even though people in key populations are at a much greater risk of acquiring HIV, investments in HIV prevention for key populations are disproportionately low.
95. There are important opportunities to strengthen and transform HIV prevention efforts, including primary prevention, over the next five years and reduce the inequalities in access to HIV prevention. Marked progress in reducing new HIV infections has been made in diverse countries, including Cambodia, Estonia, South Africa, Thailand, Viet Nam and Zimbabwe. These and other countries that have achieved significant declines

in new HIV infections have mobilized strong political commitment, strategically targeted resources to high impact HIV prevention programmes, and supported community-led responses to HIV prevention.

96. The toolbox for combination HIV prevention continues to expand, with recent evidence validating the effectiveness of antiretroviral-containing vaginal rings and long-acting injectable antiretrovirals and PrEP. Drawing inspiration from the rapid development and deployment of vaccines to prevent COVID-19, the Strategy aims to minimize the delays between scientific discoveries of prevention breakthroughs and their implementation.
97. The Global HIV Prevention Coalition has helped mobilize global attention on HIV prevention, with all 28 of the Coalition's focus countries having adopted ambitious national HIV prevention targets. The Strategy builds on the efforts of the Global HIV Prevention Coalition to adequately resource, intensify and scale up effective and innovative prevention interventions as an urgent priority.
98. The new Strategy prioritizes the implementation and scale-up of evidence-informed, rights-based, community-led combination prevention packages that are tailored to address the diverse needs, circumstances and preferences of the populations who need effective prevention the most and that can yield the greatest programmatic impact.
99. Under the new Strategy, total annual spending on primary prevention should increase to US\$ 9.5 billion by 2025, with the aim of reaching the ambitious prevention targets for all populations.
100. While the priority populations for prevention efforts vary across local and community settings, the Strategy calls for focused efforts to reduce inequalities and close prevention gaps for key populations and for adolescent girls and young women in locations with high HIV incidence.
101. Countries need to ensure that population size estimates of key populations are updated to allow national programmes and implementation partners to invest in HIV services at a level that is commensurate with actual needs and track progress on reaching HIV prevention, testing and treatment 95-95-95 targets. The failure to provide HIV prevention, diagnosis and treatment interventions to key populations at scale will likely lead to failure in general epidemic control at the national level. The Strategy prioritizes actions to empower and meaningfully engage these and other priority and underserved populations, especially in decision-making regarding the HIV response.
102. Female genital schistosomiasis represents a risk for the acquisition of HIV infection in areas where schistosomiasis is endemic. Preventive treatment of schistosomiasis, with HIV prevention and the promotion of sexual and reproductive health is important to protect the health of women and girls.
103. **Priority actions to achieve targets and results**
  - a. *Optimally resource and rapidly scale-up access to combination HIV prevention for key populations through effective, layered HIV prevention programme packages that address the needs of key populations in line with agreed implementation tools and that include steps to ensure that national laws, policies and practices enable access to and uptake of high-impact service packages.*
  - b. *Expand and strengthen HIV prevention programmes for and with gay men and other men who have sex with men globally to reverse the trend of a growing number in new HIV infections including through rapid expansion of PrEP, U=U, condom and lubricant programming; sexual and reproductive health services;*



- violence prevention; community-led outreach; use of new communication technologies and empowerment.
- c. *Intensify and expand comprehensive programmes for and with sex workers* globally to address persistent gaps, including among the most affected sex workers in sub-Saharan Africa, through expanded community-led outreach, condom and lubricant programming; increased access to PrEP, sexual and reproductive health services; violence prevention, legal support and empowerment.
  - d. *Intensify and redouble efforts to scale up comprehensive harm reduction* for people who inject drugs in all settings, including needle-syringe programmes, opioid substitution therapy, medication used to block the effects of opioids overdose, and interventions for alcohol and noninjecting drug use, as well as prevention, diagnosis and treatment of TB and viral hepatitis, community-led outreach and psychosocial support.
  - e. *Intensify and expand comprehensive programmes for and with transgender people*, including condom and lubricant programming, increased access to PrEP, gender affirming health services, violence prevention, community-led outreach, empowerment and psychosocial support.
  - f. *Ensure universal access to comprehensive prevention in prisons and other closed settings* including voluntary HIV testing and treatment; harm reduction; prevention, diagnosis and treatment of TB and viral hepatitis; and related health services and psychosocial support.
  - g. *Address the multiple needs of adolescent girls and young women* by scaling up combination programme packages which link effective HIV prevention services with programmes that address HIV and sexual and reproductive health, including contraception, comprehensive sexuality education, prevention of schistosomiasis, sexually transmitted infections, gender-based violence and sociocultural gender norms, and which promote women's empowerment and meaningful engagement.
  - h. *Strengthen access to good-quality, gender-responsive, age-appropriate comprehensive sexuality education services*, both in and out of school, which address the realities of adolescents and young people in all their diversity, in line with international guidance, national laws, policies and context.
  - i. *Intensify outreach to young and adult men* and increase their access to and uptake of HIV prevention, testing and treatment programmes that are adapted to their needs, including voluntary male circumcision and male sexual, reproductive and other health-care services.
  - j. *Intensify the quality and coverage of HIV prevention among women, especially adolescent girls and young women, including in family planning and antenatal services.*
  - k. Where existing services fail to reach people, *provide alternative programmes and use creative approaches (including but not limited to virtual platforms) to reach key and priority populations*, and enable access to HIV, sexual and reproductive health and related prevention initiatives and services.
  - l. *Accelerate and facilitate consistent use of male and female condoms and lubricants* by priority populations, using demand-generation approaches that are adapted to the needs of new generations of young people.
  - m. *Maximize the benefits of the latest PrEP scientific advances* and urgently accelerate PrEP uptake for all people who are at substantial risk of HIV infection, including through simplified and differentiated approaches for delivery.
  - n. *End prevention inequalities by using granular data* to accurately estimate sizes of key populations and identify who is not receiving the HIV prevention services they need, and develop and implement focused strategic roadmaps in collaboration with

- affected communities to scale up combination prevention packages that are tailored to the needs of key populations and priority populations, including adolescents and young women and men in locations with high HIV incidence.
- o. *Update HIV behaviour change communications*, including to promote PrEP and U=U, and utilize internet-based and mobile applications that are relevant to young people and key populations to optimally expand the reach and impact of HIV services.
  - p. *Address the structural and age-related legal barriers faced by adolescents and young key populations*, ensure active participation of adolescent and young key populations in the development of community-led programmes, peer-led outreach and digital technology approaches to ensure adolescent and young key populations are reached with effective services early on.

**Result Area 2: Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being**

***Reducing inequalities in HIV testing and treatment services***

104. Remarkable gains have been made in the past five years in scaling up HIV testing and treatment services and in preventing AIDS-related deaths. Many countries have reached the 90–90–90 HIV testing and treatment targets<sup>22</sup> and more people than ever are accessing ART and achieving viral suppression. However, the impact of ART has been blunted by inequalities in HIV outcomes, including gaps in people's knowledge of their HIV status, the lack of timely treatment initiation and retention, and achieving and sustaining viral suppression.
105. Efforts to optimize the health and HIV prevention benefits of ART face several challenges. Inequalities in treatment access and outcomes arise when services do not specifically meet the needs of underserved populations who are not well served by mainstream health services. Many people who initiate ART achieve viral suppression, but some are not linked to care early enough or do not remain engaged in care. Differentiated approaches and support are often not in place to ensure quality and continuity of care. At the end of 2019, gaps across the testing and treatment cascade meant that an estimated 15.7 million people living with HIV globally did not have suppressed viral loads, which endangers their health and facilitates the further spread of HIV.
106. Adolescents and young people living with HIV are in particular need of tailored services that address their physical and mental health and well-being, and that support them as they transition to adult health services. Poor access to treatment experienced by young men compromises their own health and well-being and it contributes to high levels of new infections among adolescent girls and young women.
107. Stigma, discrimination, gender inequalities, age-of-consent laws that limit young people's access, punitive laws and policies, and a failure to address basic human needs limit many people's ability or willingness to access testing and treatment services or remain engaged in care.

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<sup>22</sup> The 90–90–90 targets aimed to ensure that by 2020: 90% of all people living with HIV know their HIV status, 90% of people with an HIV diagnosis receive ART and 90% of people receiving ART achieve viral suppression.

108. People in informal, humanitarian and fragile settings, people with disabilities, indigenous populations, migrant and mobile populations, key populations and other priority populations face unique challenges in accessing HIV testing, treatment and care.
109. Strong momentum already exists for addressing these many challenges. Nationally, 10 countries had attained the 73% target for HIV viral suppression by 2019.<sup>23</sup> Eswatini and Switzerland, for example, have exceeded the 95–95–95 targets for testing, treatment and viral suppression. Differentiated service delivery approaches, developed in many cases with or by communities to respond to their specific needs and circumstances, are now being taken up widely. The COVID-19 pandemic provides additional impetus for expedited roll-out to preserve service access during national or local lockdowns.
110. Scientific research continues to reveal ways to optimize treatment regimens. For example, two recent clinical trials found that monthly or two-monthly injections with cabotegravir and rilpivirine as long-acting formulations of antiretroviral medications are as effective as standard daily oral therapy. Future long-acting agents in trials have potential to improve treatment outcomes in low- and middle-income countries. Four large intervention trials have also validated service delivery strategies to reduce inequalities in testing and treatment uptake and outcomes among men and young people.
111. HIV self-testing has emerged as an important option for people who might otherwise avoid testing services due to stigma and discrimination. The rapid development of COVID-19 treatments and vaccines underscores the importance of science as a key pillar of every pandemic response.
112. Drawing on such momentum, the Strategy prioritizes actions to reduce inequalities in testing, treatment and care access and outcomes. It demands the achievement of 95–95–95 targets in all populations affected by the epidemic, and in all regions, countries and localities. This will require both political commitment and the strategic use of granular data to identify and address the specific testing and treatment needs of populations that are yet to experience the full health benefits of ART. Prioritized, population-focused and context-specific actions are urgently required to address gaps that diminish rates of viral suppression, including late diagnosis and loss to follow-up.

**113. Priority actions to achieve targets and results**

- a. *Reduce inequalities by using granular data* to identify and address the characteristics that lead to inequalities in testing, treatment and care access and outcomes.
- b. *Rapidly maximize the impact of affordable, effective HIV testing technologies and practices*, increase the uptake of differentiated HIV testing strategies where available (particularly HIV self-testing, community-led testing services, partner services and social network approaches) and strengthen the linkage of people who access testing services to HIV prevention and treatment services.
- c. *Complement the traditional facility-based, standalone HIV treatment service model* with innovative approaches, including those implemented during the COVID-19 pandemic, to expand services that are convenient so people can start, continue or resume treatment and achieve and sustain HIV viral suppression.
- d. *Remove legal, social and structural barriers* blocking uptake of testing and treatment, and ensure access to other relevant health and social services.

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<sup>23</sup> Achieving the 90–90–90 targets means that at least 73% of all people living with HIV achieve viral suppression.

- e. *Scale up and fully resource community-led service delivery and monitoring*, which has been proven to improve the HIV and wider health outcomes of people living with HIV.
- f. *Strengthen the capacity of the education sector to meet the needs of young people living with and affected by HIV*, including through scaling up access to school health and nutrition programmes, linkages to health and social protection services, and provision of good-quality comprehensive sexuality education.
- g. *Expand and promote equitable, affordable access to high-quality medicines*, health commodities, science, technology, innovations and solutions for people living with HIV, key populations and other priority populations.
- h. *Accelerate research and development for more effective HIV technologies*, including more effective treatment regimens and solutions, an HIV cure and an HIV vaccine, and invest further in implementation research to build the evidence base for the effective delivery and optimal impact of new technologies.
- i. *Address the impact of social and structural drivers of the AIDS epidemic*, including unequal gender norms and power dynamics, and human rights violations across HIV prevention, treatment and care efforts.

***Optimizing quality of life and well-being across the life-course, through integrated, people-centred services***

114. People-centred approaches enable individuals to receive the holistic, coordinated services they need in convenient, respectful and efficient ways. Integrating HIV and other health services is crucial to provide people-centred, outcomes-focused, coordinated care across the life-course. The populations most affected by inequalities in the HIV response are often least likely to receive integrated service packages that are designed to meet their needs. For example, young people living with or affected by HIV frequently have little or no access to services that are specifically designed to meet the needs of young people. Likewise, people living with HIV are at risk of accelerated aging, underscoring the need for services that can address multiple comorbidities.
115. Although many people could benefit from service integration, critical intersecting inequalities and integration gaps undermine HIV, health, well-being and quality-of-life outcomes for people living with HIV. For example, although TB is preventable and treatable, it is the leading cause of death among people living with HIV. Less than half of the estimated incident TB cases among people living with HIV are diagnosed and treated appropriately, and there is poor uptake of treatment regimens for latent TB infection.
116. Similarly, women living with HIV are six times more likely to experience invasive cervical cancer and are more likely than HIV-negative women to die of cervical cancer even when receiving ART. Yet services for prevention, screening and treatment of cervical cancer are insufficiently integrated with HIV services and typically are not available at scale. Mental health, treatment services for drug and substance use, and services for the prevention and treatment of hepatitis C are rarely integrated and linked with HIV services, notwithstanding the high prevalence of HIV among people who use drugs, particularly people who inject drugs. Linking HIV programmes with services for the prevention, testing and treatment of sexually transmitted infections is vital.
117. The Strategy prioritizes the context-specific integration of HIV with other health services and in primary health care, with particular attention to ensuring that the needs of key and priority populations are addressed. The Strategy outlines concrete, quantifiable targets to drive service integration, address inequalities, and promote holistic, people-centred

health services. With TB still accounting for roughly one in three deaths among people living with HIV, the Strategy calls for urgent attention to the unfinished agenda of addressing the twin epidemics of HIV and TB.

#### 118. Priority actions to achieve targets and results

- a. For people living with and at risk of HIV across the life course, *promote and intensify comprehensive, integrated health and social services, community engagement for peer support and addressing stigma and discrimination*, including linkages between HIV services and support services for other communicable and noncommunicable diseases, mental health, alcohol, drug use and substance dependence, and services for sexual and reproductive health, gender-based violence, harm reduction and mental health.
- b. *Expand rights-based community contact-tracing and scale up access to the latest technologies* for TB screening, diagnosis, treatment and prevention for people living with HIV and ensure optimal linkages to HIV care.
- c. *Scale up integrated services for HIV, syphilis, viral hepatitis, sexually transmitted infections and other infections* in antenatal and postnatal services and other settings, where needed.
- d. *Leverage both HIV and broader health investments to transform data recording and reporting systems* of vertical programmes and adapt integrated health data systems (including with other sectors such as social welfare and protection) to identify gaps, barriers and solutions to achieve effective integrated health services for people living with HIV and at risk of HIV.

#### Result Area 3: Tailored, integrated and differentiated vertical transmission and paediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence

119. One of the most glaring disparities in the HIV response is the failure to meet the needs of children living with or at risk of HIV. While 85% of pregnant women living with HIV were accessing HIV treatment services in 2019, only 53% of children living with HIV were doing so. Only 37% of children living with HIV were virally suppressed in 2019, compared to 60% of adults. An estimated 850 000 children living with HIV were not receiving treatment services, two-thirds of whom were aged five years and older—the result of many years of missed opportunities for prevention, diagnosis and treatment. Only 60% of HIV-exposed infants are tested by two months of age. Adoption and integration of new point-of-care diagnostic technologies can help close the testing gaps, but these have yet to be brought to scale in most settings.

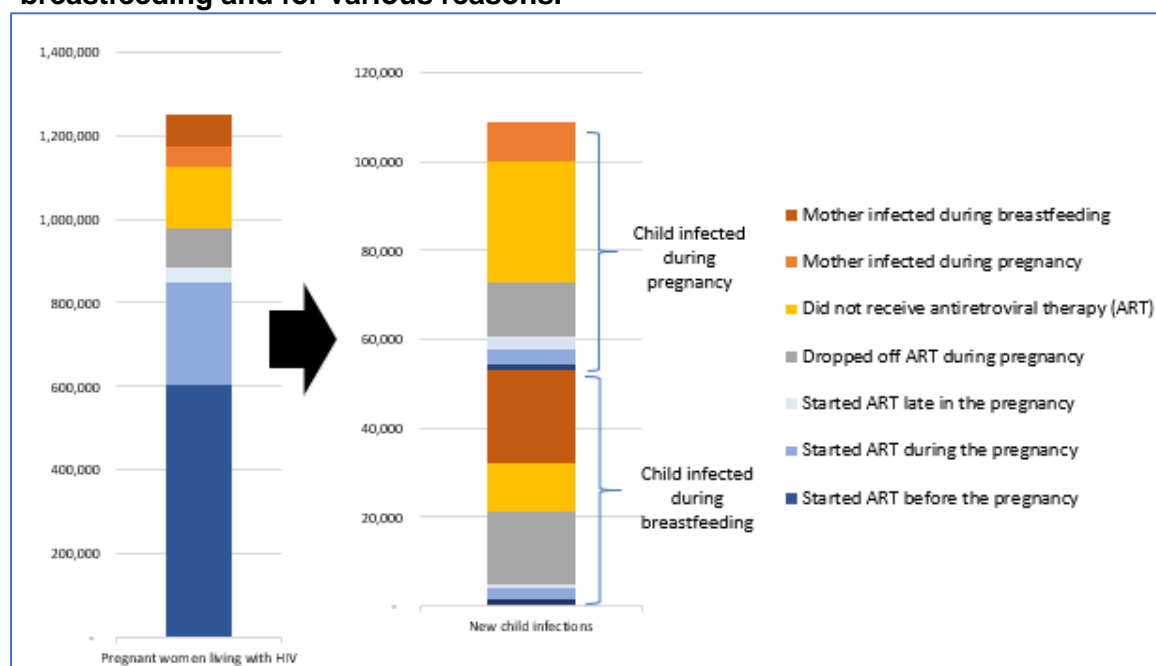
120. Development and uptake of optimal child-friendly HIV treatment lag far behind adults, leading to much poorer health outcomes. Although children accounted for 5% of people living with HIV in 2019, they represented 14% of all AIDS-related deaths. As they progress through childhood and into adolescence and early adulthood, children living with HIV often lack the psychosocial support, good parenting and prevention services they need to stay in HIV care.

121. Reductions in the number of children acquiring HIV constitute one of the most important achievements of the HIV response. Yet in 2019, there were 150 000 new HIV infections among children – far from the global 2020 target of 20 000 with declines in new child infections having slowed dramatically after 2016. Global coverage of ART among pregnant and breastfeeding women remains high (85% in 2019), but coverage expansion has also stagnated. There are many issues that require urgent attention to accelerate progress to eliminate vertical HIV transmission and to end paediatric AIDS.

- Some women living with HIV still do not access antenatal services during pregnancy and breastfeeding.
- Not all pregnant and breastfeeding women who access services for vertical HIV transmission, including ART, remain in treatment and care throughout pregnancy and breastfeeding.
- Women still acquire HIV during pregnancy and breastfeeding due to the lack of tailored combination HIV prevention, including PrEP for women at substantial risk for HIV. Repeat HIV testing during pregnancy and breastfeeding can help identify new infections and trigger acute interventions to prevent vertical HIV transmission.
- Women receiving ART who are pregnant or breastfeeding but not virally suppressed require additional interventions and support—being on ART is not sufficient to ensure optimal outcomes for women or children.

122. A range of socioeconomic and structural factors undermine the ability of many women, particularly women from key populations, to access and remain engaged in services. They include unequal power dynamics and gender norms, gender-based violence, poverty, user fees, and stigma and discrimination from health care workers, family members and the community. Identifying where new child infections are occurring will enable countries to take a targeted approach to eliminate vertical transmission of HIV (see figure below).

**Figure 4. New child infections can occur at any time during pregnancy and breastfeeding and for various reasons.**



123. Rapid strengthening of political commitment, global solidarity and dedicated funding will help close the inequalities gaps in HIV prevention and treatment for children. The world must build on and learn from key successes, including the proven ability of diverse countries to support women of all ages to achieve viral load suppression throughout pregnancy and breastfeeding.

124. Tailored strategies can improve service delivery and reduce inequalities in access to services, including the abolition of user fees, greater male involvement, peer mentoring, use of text messages for appointment reminders, clinic dashboards to track progress, integrated and differentiated service delivery and socioeconomic and psychological support. These strategies have proven effective in increasing treatment coverage,

retention and adherence among pregnant and breastfeeding women living with HIV and in encouraging caregivers to bring HIV-exposed children for testing and retesting, and to retain children living with HIV on optimal treatment.

125. Although still limited, antiretroviral regimens and formulations for children have improved, including approval in 2020 of a generic WHO-preferred, first-line, child-friendly dolutegravir-based HIV treatment for children under 20 kilograms. If the evolving needs of children living with HIV are met, programmes will be able to ensure a continuum of care as children grow and progress through adolescence, youth and into adulthood.
126. The Strategy prioritizes smarter programming to end vertical transmission and to reduce the inequalities that worsen outcomes for HIV-exposed infants and children living with HIV. Prioritized actions include an emphasis on linking and retaining all pregnant and breastfeeding women in a tailored continuum of testing, prevention and treatment services, and the urgent scale-up of efforts to find, diagnose and link children living with HIV to optimal child-friendly treatment.

**127. Priority actions to achieve targets and results**

- a. *Implement innovative tools and strategies* to find and diagnose all children living with HIV, including point-of-care early infant diagnostic platforms for HIV-exposed infants and rights-based index, family and household testing and self-testing to find older children and adolescents living with HIV not on treatment.
- b. *Prioritize rapid introduction and scale-up of access to the latest WHO-recommended, optimized, child-friendly HIV treatment* and achieve sustained viral load suppression.
- c. *Support transitioning of children through adolescence to adult care* and address their complex, multiple and changing needs, including peer adherence counselling and psychosocial support.
- d. *Use granular data to identify barriers and gaps and adapt tailored, effective approaches to national and subnational needs* in order to expand solutions across HIV prevention, treatment and care for children. Use tools such as the stacked bar analysis to identify and address when and where new child infections are occurring, and use age-disaggregated data to identify and close the gaps in HIV testing and treatment for children and adolescents.
- e. *Target adolescents and young people with a complete package of combination HIV prevention services* that is tailored to their evolving needs and is integrated with comprehensive sexuality education (both in and out of school), and with sexual and reproductive health (including contraception) and rights for people of reproductive potential, and with HIV treatment and care.
- f. *Reach, test and retain all pregnant and breastfeeding women living with HIV in integrated antenatal and HIV care* with optimized treatment regimens that achieve sustained viral load suppression through differentiated and community-led services that meet the needs of women in all their diversity.
- g. *Intensify provision of optimized, tailored prevention services for pregnant and breastfeeding women at risk of HIV, including PrEP.* Implement repeat HIV testing during pregnancy and breastfeeding per guidelines to identify women newly infected for rapid intervention with HIV treatment and prevention of vertical transmission.
- h. *Address stigma, discrimination and unequal gender norms* that prevent pregnant and breastfeeding women, especially adolescent girls, young women and key populations, from accessing HIV testing, prevention and treatment services for themselves and their children through differentiated support services. Those services include male, partner and extended family engagement; peer mentoring;

socioeconomic incentives; supported disclosure, psychosocial and mental health support and sensitization of healthcare workers.

- i. *Advance urgent progress towards validating eliminating vertical transmission* and validation of countries on the pathway to elimination of HIV, viral hepatitis and syphilis.

#### CHAPTER 4: STRATEGIC PRIORITY 2: BREAK DOWN BARRIERS TO ACHIEVING HIV OUTCOMES

128. A central reason why inequalities in the HIV response persist is that we have not successfully addressed the social and structural determinants that increase HIV vulnerability and diminish the ability of many people to access and effectively use HIV services.
129. Recognizing the equal worth and dignity of every person is not only an ethical imperative and an obligation arising from international human rights instruments, it is central for ending AIDS as a public health threat. SDG 3 cannot be achieved if stigma, discrimination, criminalization of key populations, violence, social exclusion and other human rights violations in the context of HIV are allowed to continue and if HIV-related inequalities persist. The evidence consistently shows that the criminalization of people living with HIV and key populations reduces service uptake and increases HIV incidence. Gender inequalities also increase the HIV vulnerability of women and girls, with women who experience intimate partner violence in high-prevalence settings more than 50% more likely to be living with HIV.
130. The effects of criminalization, stigma, discrimination, gender inequalities, gender-based violence and other human rights violations in the context of HIV are profound. However, recent years have seen important progress across diverse countries in implementing evidence-based programming to remove human rights barriers and promote substantive gender equality, respect and social inclusion. Over the next five years, the world must urgently apply lessons from those successes to expand investments and catalyze progress more broadly in reducing inequalities in the HIV response.
131. With its new targets for societal enablers, the Strategy demands that the same commitment and attention to technical detail that has characterized the HIV response's programmatic efforts be applied to the urgent business of addressing the social and structural factors that slow progress against AIDS. The Strategy prioritizes lessons from recent successes and applies them more broadly, especially in countries where inequalities are enabled by punitive legal and policy frameworks. Communities of people living with, affected by, or most at risk of HIV must be supported and effectively resourced to galvanize actions that can reduce inequalities in the response and to ensure that responses meet the needs of all people.



<b>High-level 2025 targets and commitments<sup>24</sup></b>
<ul style="list-style-type: none"> <li>• 30% of testing and treatment services<sup>25</sup> to be delivered by community-led organizations.<sup>26</sup></li> </ul>
<ul style="list-style-type: none"> <li>• 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations.</li> </ul>
<ul style="list-style-type: none"> <li>• 60% of the programmes support the achievement of societal enablers to be delivered by community-led organizations.</li> </ul>
<ul style="list-style-type: none"> <li>• Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services.</li> </ul>
<ul style="list-style-type: none"> <li>• Less than 10% of people living with HIV and key populations experience stigma and discrimination.</li> </ul>
<ul style="list-style-type: none"> <li>• Less than 10% of women, girls, people living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence.</li> </ul>

#### **Result Area 4: Fully recognized, empowered, resourced and integrated community-led HIV responses for a transformative and sustainable HIV response**

132. If we are to reduce HIV-related inequalities and get the response on-track to end AIDS by 2030, communities living with or affected by HIV must lead the way. Communities living with and affected by HIV have been the backbone of the HIV response at every level, from global to national to community. They advocate for effective action; they inform local, national, regional and international responses regarding communities' needs; and they plan, design and deliver services. They also advance the realization of human rights and gender equality, and support the accountability and monitoring of HIV responses. Communities give voice to people who are often excluded from decision-making processes. Effective community-led HIV responses must be adequately resourced and supported to enable communities to play their vital roles as equal, fully-integrated partners in national systems for health and social services.

133. Progress in recent years demonstrates the essential role of community-led HIV responses in global efforts to end AIDS. Communities have led efforts to identify and address key inequalities; expanded the evidence base for action to end AIDS as a public health treat; supported the planning and implementation of national HIV responses; identified key issues and gaps for national and multilateral governance and coordination bodies; expanded the reach, scale, quality and innovation of HIV services; and played a visible role as defenders of human rights. As of 2019, community and key population-led HIV prevention programmes that exceeded 80% coverage in many countries were among the most effective. With acute resource constraints, it is critical to prioritize HIV programmes that deliver optimal results in prevention, testing, linkages to treatment, treatment literacy and adherence support that are led by people living with HIV, key populations and women.

<sup>24</sup> These are the high-level, aggregated targets for this Strategic Priority. The complete set of targets and commitments in this Strategy are in Annex 1 and Annex 2.

<sup>25</sup> With 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 ARV (antiretroviral treatments).

<sup>26</sup> For an organization to be considered community-led, the majority (at least fifty percent plus 1) of governance, leadership, and staff comes from the community being served.

134. Social contracting, whereby governments partner with and procure services from civil society organizations, has emerged as a potentially powerful, though underutilized, option for reaching marginalized or hard-to-reach populations. Although the pivotal roles of communities are recognized in HIV governance, their meaningful engagement in national systems for health as leaders, decision-makers and partners remains limited.
135. As seen during COVID-19 pandemic, under-utilization of the potential of communities is compounded by an acute shortage of resources for community-led responses. Shrinking space for civil society in many countries, as well as persistent social and structural factors, exacerbate the pressures on community-led HIV responses and increase the risk of violence against organizations that serve key populations or other marginalized groups.
136. Reducing inequalities in the response will require the robust resourcing, engagement, capacity building and leadership of community-led responses. The false dichotomy between government-led health system responses and community-led health system responses must be transcended in national systems for health and social services, with communities fully integrated as essential partners in each and every aspect of the HIV response.

**137. Priority actions to achieve targets and results**

- a. *Fully implement the GIPA (Greater Involvement of People living with AIDS) principle* to put the leadership of people living with HIV at the centre of HIV responses, ensure that networks of people living with HIV and key populations are represented in decision-making bodies and can influence the decisions that affect their lives, and have access to technical support for community mobilization, strengthened organizational capacities, and leadership development.
- b. *Support community-led monitoring and research* and ensure that community-generated data is used to tailor responses to the needs of people living with HIV and key populations, including young key populations.
- c. *Scale up community-led service delivery* to ensure that the majority of HIV prevention programmes are led by key populations, women and young people, and that all HIV testing, treatment and care programmes include community-led elements.
- d. *Integrate community-led HIV responses into all national HIV responses.* Ensure urgent and adequate support for community-led responses at scale in all countries, especially those transitioning to domestic funding, in conflict zones and during humanitarian crises.
- e. *Mobilize funding for sustainable community-led responses,* ensuring financial support and equitable pay for community-led work and funding for activities led by networks of people living with HIV and key populations, including those led by women and young people.

**Result Area 5: People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination**

138. Stigma, discrimination and other human rights violations in the context of HIV both reflect and drive the inequalities that undermine HIV responses. Everyone, including people living with and affected by HIV, should enjoy human rights, equality and dignity.
139. The goal of zero discrimination still eludes the world. In 25 of 36 countries with recent data, more than 25% of people aged 15–49 years displayed discriminatory attitudes towards people living with HIV. Denial of health services to people living with HIV

remains distressingly common, and the prevalence and effects of discrimination are often especially acute for members of key populations, who face multiple, overlapping forms of discrimination. In humanitarian settings, people living with HIV, key populations and survivors of sexual and gender-based violence often experience social exclusion, mandatory HIV testing, stigma, and discrimination, as well as access barriers that are exacerbated by HIV criminalization laws and travel restrictions. In 2019, one in three women living with HIV reported to have experienced at least one form of discrimination related to their sexual and reproductive health in the previous 12 months.

140. Punitive laws, the absence of enabling laws and policies, and inadequate access to justice contribute to the inequalities that undermine HIV responses. At least 92 countries criminalize HIV exposure, nondisclosure and/or transmission, and 48 countries or territories continue to block people living with HIV from entry, stay or residence. Among countries reporting data to UNAIDS in 2019, 32 criminalized and/or prosecuted transgender persons, 69 criminalized same-sex sexual activity, 129 criminalized some aspect of sex work, and 111 criminalized the use or possession of drugs for personal use. The health and well-being of people living in prisons or other closed settings are routinely put at risk by punitive laws and policies, including denial of access to essential health services.
141. Efforts to anchor HIV responses in human rights principles and approaches, including the priority actions outlined below, can only be achieved through strong political leadership and the active engagement and leadership of community-led responses that are adequately resourced to advocate for, monitor and implement rights-based responses.
142. In working towards the goal of zero discrimination, important progress needs to be continued, accelerated, scaled up and funded. Stigmatizing attitudes have declined notably in numerous countries, and U=U has the potential to accelerate anti-stigma efforts. Since 2016, over 89 countries have reviewed and reformed punitive and discriminatory laws and policies in line with the recommendations of the Global Commission on HIV and the Law. The Global Fund's Breaking Down Barriers initiative has channeled critical new funding for initiatives to reduce human rights barriers to HIV, TB and malaria services. In a sign of important commitment to a human rights-based response, 18 countries have joined the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination. They have pledged to address HIV-related stigma and discrimination in health care, education, workplace, justice, individuals and communities and emergency and humanitarian settings.
143. This Strategy includes ambitious targets to sharply reduce the prevalence and impact of social and structural drivers. The Strategy seeks to ensure that, by 2025, less than 10% of countries have punitive legal and policy environments, less than 10% of people living with HIV and key populations experience stigma and discrimination, and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.
144. **Priority actions to achieve targets and results**
  - a. *End stigma and discrimination* that contributes to inequalities in the HIV response and affects people living with and affected by HIV, including adolescents and young people and key populations, women and girls and those experiencing multiple and intersecting forms of discrimination.
  - b. Contribute to reducing inequalities in the response by *accelerating and adequately resourcing interventions to end stigma and discrimination*, building on the efforts of the Global Partnership for action to eliminate all forms of HIV related stigma and

discrimination, and supporting community-led research and advocacy and implementation of the People Living with HIV Stigma Index.

- c. *Create an enabling legal environment by removing punitive and discriminatory laws and policies*, including laws that criminalize sex work, drug use or possession for personal use and consensual same-sex sexual relations, or that criminalize HIV exposure, nondisclosure or transmission. Introduce and enforce protective and enabling legislation and policies, and end the overuse of criminal and general laws to target people living with HIV and key populations.
- d. *Scale up and fund actions to reform public health and law enforcement practices* 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.
- e. *Ensure accountability for HIV-related human rights violations* by increasing meaningful access to justice and accountability for people living with or affected by HIV and key populations. This includes increasing collaboration among key stakeholders, supporting legal literacy programmes, increasing access to legal support and representation and supporting community monitoring for people living with or affected by HIV.
- f. *Prioritize advancing the rights* of people living with HIV, key populations and other people at risk of HIV by ensuring that all elements of the response—from provision of HIV services to research and monitoring—are rights-affirming and that they engage people living with HIV, key populations, young people and their communities. Ensure that digital health technologies and innovations advance the right to health and service access securely and without violating or undermining human rights.

## **Result Area 6: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV**

145. Gender inequality is a key driver of the AIDS epidemic. Unequal power dynamics between men and women and harmful gender norms increase the HIV vulnerability of women and girls in all their diversity, deprive them of voice and the ability to make decisions regarding their lives, reduce their ability to access services that meet their needs, increase their risks of violence or other harms, and hamper their ability to mitigate the impact of AIDS.
146. Women and girls account for 48% of new HIV infections worldwide and 59% of new infections in sub-Saharan Africa, and AIDS remains one of the leading causes of death for women aged 15–49 years globally. The epidemic's impact is especially pronounced among adolescent girls and young women. Women who belong to key populations, as well as women who are partners of key population members, experience alarmingly high risks of acquiring HIV and are less likely to access services.
147. Women and girls confront multiple, intersecting forms of violence, oppression, stigma and discrimination. National HIV strategies in at least 40 countries do not address the needs of women and girls in the context of HIV, and most countries lack a dedicated budget for activities to address women's HIV-related needs. Only about one third of young women in sub-Saharan Africa have accurate, comprehensive knowledge about HIV. Nearly one in three women worldwide have experienced physical and/or sexual violence by an intimate partner, nonpartner sexual violence or both in their lifetime. During displacement and times of crisis, the risk of gender-based violence significantly increases for women and girls.

148. Policy barriers, such as age-of-consent laws for accessing HIV testing or sexual and reproductive health services, as well as the social stigma associated with using those services, hinder adolescent girls from making decisions about their own sexual and reproductive health. Discriminatory laws and practices should be repealed, using the Convention on Elimination of All Forms of Discrimination Against Women as a monitoring tool to highlight violations of the rights of women living with and affected by HIV.
149. There has been important recent progress in identifying progress and creating strategic opportunities to develop HIV responses that work for women. Notable progress has been made in expanding women's access to HIV treatment, with 73% of women living with HIV receiving ART in 2019. New biomedical prevention tools, including antiretroviral-containing vaginal rings for PrEP for women, as well as oral and injectable PrEP, offer women increased options for making informed choices about their sexual lives and reproductive health. These biomedical innovations should be accompanied by evidence-based, gender-transformative community-led interventions that involve women and girls and men and boys in transforming unequal gender norms, attitudes and behaviours, and in increasing demand and up-take of HIV services.
150. A lack of education and economic opportunities and insufficient or nonexistent access to comprehensive sexuality education also increase women and girls' vulnerability to HIV. Research evidence confirms that completion of secondary education can help protect girls against HIV acquisition, while also yielding broader social and economic benefits. Comprehensive sexuality education helps improve young people's knowledge about HIV and counters misinformation about sexual and reproductive health. A growing body of data has validated numerous, intersectoral, gender-transformative interventions. Important, though still inadequate, investments by the Global Fund, the United States President's Emergency Plan for AIDS Relief (PEPFAR), UN Women, UNICEF and other partners are supporting the empowerment, mobilization and leadership of women living with HIV, women from key populations, and adolescent girls and young women.
151. The Strategy prioritizes substantially greater financing for women-led initiatives to transform unequal gender norms and reduce the gender-related inequalities and injustices that undermine HIV responses. Services must be adapted to be truly gender-responsive and holistic, and the HIV response must take concerted steps to ensure that women are served in all their diversity.
152. Achievement of this Result Area will support global efforts to achieve SDG Target 5.1 ("end all forms of discrimination against women and girls") and SDG Target 5.6 to "ensure universal access to sexual and reproductive health care."
- 153. Priority actions to achieve targets and results**
- a. *Scale up financing and implementation of gender-transformative, community-led innovations* to remove social and structural barriers that block gender equality. Transform unequal gender norms, engage women and girls and men and boys as gender equality advocates, tackle inequalities in the financing, design and delivery of health services, and increase demand and uptake of HIV prevention, treatment and care services.
  - b. *Support girls so they can complete quality secondary education.* Scale up social protection interventions to enroll and retain adolescent girls and young women in schools and to provide pathways for economic empowerment. Support policies and programmes that foster safe, inclusive school environments free of all forms of gender-based violence, stigma and discrimination.

- c. *Prevent and respond to gender-based violence and violence towards key populations* in the context of HIV. Adopt and enforce policy and legal frameworks, implement evidence-based interventions that prevent violence and HIV, integrate post-exposure prophylaxis into services for survivors of gender-based violence, and ensure that school environments are free from all forms of violence, including gender-based violence, stigma and discrimination, including through the implementation of the ILO Violence and Harassment Convention.
- d. *Conduct gender analysis* and collect and effectively use age-, sex- and gender-disaggregated data, to develop, implement and monitor national gender-transformative HIV policies, strategies, programmes, monitoring frameworks and budgets.
- e. *Promote gender equality through policies, programmes, results and budget allocations in the organizations and align with gender parity goals*, using tools such as Global Health 50/50, and in compliance with the ILO conventions on workplace gender equality standards and the UN System-wide Action Plan on Gender Equality and the Empowerment of Women (UN SWAP).
- f. *Prioritize people who are left behind* due to their gender, age, sexual orientation or gender identity or occupation. Ensure that women and girls who face intersecting forms of discrimination and violence (e.g. indigenous women, women with disabilities, women who use drugs, women in prison, female sex workers and transgender women) receive the tailored services and support they need, and ensure that they are meaningfully engaged in HIV-related decision-making. Ensure access to rights literacy and meaningful complaint and redress mechanisms for violations of their human rights in the context of HIV.
- g. *Promote women's economic empowerment* and their access to economic resources (including their rights to land, property and inheritance) and to labour markets and sustainable livelihoods. Redistribute the unpaid care work performed by women and girls in the context of HIV.
- h. *Repeal discriminatory laws and policies* that increase women and girls' vulnerability to HIV and address violations of their sexual and reproductive health and rights.
- i. *Invest in women-led responses* to HIV and in initiatives to support and build women's leadership—particularly networks of women and girls living with HIV, and women in key populations—in the design, budgeting, implementation and monitoring of the HIV response at regional, national, subnational and community levels.

### **Result Area 7: Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS**

154. At the forefront of every social movement are leaders of change who can envision new realities and who are determined to create the change they wish to see. More often than not, these pioneers are young people, as the #BlackLivesMatter and modern climate change movements show. The HIV response must leverage youth leadership to enable the radical changes needed to deliver on the Strategy.
155. In today's complex, unpredictable and fast-changing world, young peoples' roles in leading change are both crucial and under-utilized. The world is home to 1.8 billion young people, the largest generation of young people in history. Almost 90% of young people live in low- and middle-income countries, where they constitute a large proportion of the population.
156. Today's young people are adept at connecting across multiple digital platforms, using social media to crowdsource ideas across continents, initiating local groups and global

movements, and channeling and focusing people's desire to bring about social change. Keeping pace with technological change and using its advantages while mitigating its risks will be crucial for HIV responses. Young people are ideally equipped to take up these challenges. Facilitated by information technologies, new leadership models are emerging that are collaborative, networked and self-organizing. They can be deployed in the HIV response in ways that reflect young people's realities and realize their potential for leadership and social change.

157. The HIV response needs to reflect the fact that young people experience the world differently than the general adult population and have different needs. While steep reductions in new infections among young people have occurred in some countries, especially in eastern and southern Africa, the world missed the Fast-Track target on reducing HIV incidence among young people. Young people are also less likely than adults to know their HIV status, receive ART and achieve viral suppression. These disparities have been compounded during the COVID-19 pandemic.
158. It is important to invest in new generations of youth leadership to ensure the sustainability of the HIV response. This can be done by engaging and supporting young people in all their diversity, particularly those affected by HIV, to influence and lead HIV service delivery, decision-making, monitoring, accountability, research and advocacy. Young people must be empowered to play leadership roles in shaping new social norms around gender, sexuality, identity and consent.
159. Meaningful inclusion and empowerment of young people requires removing barriers to their participation in HIV-related decision-making spaces and processes. The Strategy aims to empower, support and celebrate young people as essential change agents in the global effort to end AIDS. COVID-19 underscores the transformative role that youth leadership can play in responding to a pandemic. Youth-led organizations have brought resilience and innovation to efforts to mitigate the colliding effects of the AIDS and COVID-19 pandemics.
160. Financial and programmatic support to youth leadership and youth-led initiatives is required to ensure the sustainability and impact of youth-led responses.

**161. Priority actions to achieve targets and results**

- a. *Scale up the meaningful engagement and leadership of young people in all HIV-related processes and decision-making spaces.*
- b. *Accelerate investments in youth leadership (particularly adolescent girls and young women and young key populations), capacity building and skills development at all levels in all aspects of the HIV response.*
- c. *Foster solutions and partnerships between youth-led organizations and governments, private sector, faith-based organizations, and other traditional and nontraditional partners to ensure sustainable investment in financing of programmes for young people.*
- d. *Strengthen access to high-quality, gender-responsive, age-appropriate comprehensive sexuality education programmes,<sup>27</sup> both in school and out of school, particularly for adolescent girls and young women and young key populations in settings with high HIV incidence.*
- e. *Support policies and programmes focused on increasing the enrolment and retention in secondary schools for adolescent girls and young key populations in*

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<sup>27</sup> Consistent with 2018 UN international technical guidance on sexuality education, co-published by UNESCO, UNFPA, WHO, UNICEF, UN Women and UNAIDS. [International technical guidance on sexuality education: an evidence-informed approach](#).

high-incidence locations, and provide linkages to social protection, “cash plus” initiatives, financial incentives, pathways to employment, and interventions to transform unequal gender norms and prevention of violence against adolescent girls and young women.

- f. *Remove legal and policy barriers*, including age-of-consent laws and policies, for adolescents and youth to access HIV services, and ensure access to other health and social services, including sexual and reproductive health services, condoms and other contraceptives, and commodities and wider health and social services relating to young people’s wellbeing.
- g. *Redesign HIV services to meet the needs of young people* and ensure adolescents and young people (particularly adolescent girls and young women and young key populations in settings with high HIV incidence) can access a full range of youth-centred and -led HIV services that holistically address their needs, including other health, protection and social services.
- h. *Ensure that the HIV response is integrated with COVID-19 pandemic recovery efforts as well as other emergencies and crises in humanitarian settings that benefit young people.*
- i. *Strengthen age-, sex-, gender- and population-disaggregated data and realtime evidence systems*, and enhance capacities to develop, monitor and analyse HIV-specific indicators across sectors.
- j. *Expand community-led outreach platforms for young people, including for young key populations, by combining peer-led outreach with new media solutions that are developed in collaboration with young innovators.*

## CHAPTER 5: STRATEGIC PRIORITY 3: FULLY RESOURCE AND SUSTAIN EFFICIENT HIV RESPONSES AND INTEGRATE THEM INTO SYSTEMS FOR HEALTH, SOCIAL PROTECTION, HUMANITARIAN SETTINGS AND PANDEMIC RESPONSES

162. Reducing inequalities will require systems that are robust, resilient and specifically designed to meet the needs of the people and communities most heavily affected by HIV. Ending AIDS demands a concerted push to ensure that every country develops a truly sustainable response which:

- receives sustainable, efficiently-used resourcing with equitable, evidence-based allocations that fully leverage technological innovations;
- leverages and supports the systems integration that is needed to ensure that people affected by HIV have effective and equal access to the full range of services (medical and nonmedical) they need to protect themselves against infection and to survive and thrive when living with HIV;
- is resilient enough to deliver services to all people when and where they need them, with systems that operate effectively in both normal and emergency conditions; and
- ensures a comprehensive, whole-of-system response that includes greater cooperation, coherence, coordination and complementarity among development and humanitarian actors.

High-level 2025 targets and commitments <sup>28</sup>
<ul style="list-style-type: none"> <li>• Increase global HIV investments to US\$ 29 billion per year by 2025.</li> </ul>
<ul style="list-style-type: none"> <li>• 45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.</li> </ul>






<sup>28</sup> These are the high-level, aggregated targets for this Strategic Priority. The complete set of targets and commitments in this Strategy are provided in Annex 1 and Annex 2.



<ul style="list-style-type: none"> <li>95% of people within humanitarian setting at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options.</li> </ul>
<ul style="list-style-type: none"> <li>90% of people in humanitarian settings have access to integrated TB, 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.</li> </ul>
<ul style="list-style-type: none"> <li>95% of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics including COVID-19.</li> </ul>

**Result Area 8: Fully funded and efficient HIV response implemented to achieve the 2025 targets**

163. The inequalities that are slowing progress in the HIV response have increased the resource needs for the global response and have underscored the urgent need for sustainable HIV financing. Additional resources will be needed to reduce inequalities, account for deficits resulting from the failure to achieve the Fast-Track targets, close service gaps resulting from the COVID-19 pandemic and to put the world on-track to end AIDS by 2030.

164. HIV must remain a priority for health systems and financing, including to support Universal Health Coverage and achievement of the relevant SDGs. In working to mobilize robust, sustainable financing, there are important opportunities that must be seized. In light of the demonstrated value of HIV infrastructure for national COVID-19 responses, the HIV response should showcase how HIV investments build capacity, strengthen programme infrastructure, support pandemic preparedness and create platforms to address other health conditions, including noncommunicable diseases.

165. Domestic financing accounts for approximately 56% of available financing for the global HIV response. Although domestic financing overall has not increased quickly enough, domestic HIV investments in 2015–2019 rose substantially in several countries. That trend, while promising, masks disparities in funding allocation. Domestic funding is mainly allocated to treatment services, while prevention programmes for key populations, adolescent girls and young women and programmes that address human rights barriers and structural inequalities are predominantly funded from international sources or are barely funded at all. The impact of domestic funding is further undermined in many countries by inefficiencies, including failure to allocate limited resources towards the most effective interventions or to focus resources strategically by location or population.

166. The negative economic impact of the COVID-19 pandemic has created additional challenges for many low- and middle-income countries to mobilize new domestic resources for their HIV responses. Declines in tax revenues and increases in government spending have resulted in higher debt and deficit levels, adding to existing unsustainable levels of debt in over 30 low-income countries. Several high burden countries now face the dual challenge of AIDS and COVID-19, while high levels of debt servicing significantly reduce their fiscal space to invest in their health and social sectors.

167. Financing for domestic HIV responses must leverage traditional and new partnerships to meet the challenging macrofiscal environment, resist a new era of austerity and identify a range of methods for mobilizing domestic and market resources. The Strategy calls for reforms that broaden the vision of financing for HIV and health financing to promote

sustainability through addressing the structural drivers of inequality, promoting progressive taxation and Universal Health Coverage, and increased social spending.

168. Maintaining global solidarity and international donor funding is critical to reach the targets and commitment in the Strategy. Overall international HIV assistance declined by nearly 10% from 2015 to 2019, with support from a few donors increasing while many others reduced their funding for HIV. Encouraging evidence of continued global solidarity in financing the HIV response can be found in the successful replenishment of the Global Fund in October 2019, the sustained and robust financial support of the United States of America for PEPFAR, and the important support for social spending provided by the World Bank.

169. The Strategy prioritizes transformative action in three areas to ensure that the HIV response is fully funded. Firstly, the Strategy underscores the importance of global solidarity and shared responsibility in mobilizing significant new resources to get the response on-track to end AIDS as a public health threat and to address the impact of COVID-19 on the HIV response. Secondly, it calls for urgent action to improve the equality and strategic impact of resource allocations to achieve sustainable solutions for underserved populations. Third, the Strategy prioritizes actions to focus finite resources on the settings, populations and game-changing approaches that will have the greatest impact.

#### 170. **Priority actions to achieve targets and results**

- a. *Mobilize the political leadership and global solidarity* needed to secure the resources needed to get the response on-track to end AIDS as a public health threat and to realize the right to health, by taking actions to:
  - i. enable increased efficiency, equitable and inclusive governance, policies and delivery platforms to achieve the Strategy's targets and sustain the gains made to date in the HIV response, and ensure affected communities and key populations are at the forefront of the decision-making processes;
  - ii. expand partnerships to address the structural and macroeconomic barriers to increased domestic public spending in HIV and in health as societal and economic priorities;
  - iii. maintain and increase donor funding, including for addressing the root causes of inequalities through community-led responses, particularly for low-income countries with limited fiscal ability, and for key population- and community-led responses, including in middle- and upper-middle income countries;
  - iv. mobilize political and advocacy support for the next Global Fund replenishment in 2022, and secure continued global solidarity for global, multilateral and bilateral, and domestic, funding for the AIDS response;
  - v. promote and increase the volume and predictability of long-term, direct funding for community-led responses, including through establishing funding earmarks across countries and public funding of community-led responses; and
  - vi. promote increased domestic and international investments in the public sector, management processes, greater transparency and accountability, and reset public-private partnerships towards equitable outcomes.
- b. *Maximize the impact of available resources* towards equitable and effective access and outcomes, by taking actions to:
  - i. strengthen the effectiveness, equality and efficiency of the HIV programmes, planning and implementation and embedding sustainable solutions;

- ii. focus resources on highly effective and efficient interventions for priority gaps and populations, including increased funding for scaling programmes for key populations and addressing structural drivers; and
  - iii. leverage appropriate technologies to reach people through differentiated approaches—tools that put services in the hands of people.
- c. *Develop and implement context-specific sustainability financing strategies (including multisectoral contributions to HIV responses) that ensure universal access and improved health outcomes, by taking actions to:*
- i. implement country-tailored financing frameworks that raise domestic revenues for the HIV response and social spending, increase the quality and coverage of HIV and health services, and improve resilience and sustainability of financing;
  - ii. ensure that financing, governance and social financing frameworks for Universal Health Coverage drive progress towards HIV targets, removing structural barriers and reducing inequalities; progress should be measured by the integration of the full range of HIV prevention, treatment and care services, reaching all populations with stigma free services, and public financing of community-led responses;
  - iii. abolish user fees for HIV-related and other health-care services, starting with the most marginalized populations, women, girls, people living with HIV, key populations and other priority populations;
  - iv. build on the platforms and structures of the HIV response to promote Universal Health Coverage that includes gender and other equity considerations beyond socioeconomic status and income towards realization of people's right to health;
  - v. shift towards progressive health financing that provides Universal Health Coverage for the full range of HIV services, inclusion in national schemes and general tax contributions for resource pooling, and shifts away from voluntary or contributory schemes that are linked to benefit entitlements; and
  - vi. implement transition strategies and plans that ensure sustainable financing, engage with communities, donors and partners to identify country-tailored solutions, and secure sustainable funding for programmes for key populations and community-led programmes.
- d. *Improve the collection and use of granular sex-, gender-, population- and age-disaggregated data to track funding for key populations, women and girls and other people underserved by the response, aiming to maximize impact and transparency, accountability and efficiency of resources and policy decisions.*

**Result Area 9: Integrated systems for health and social protection schemes that support wellness, livelihood and enabling environments for people living with, at risk of and affected by HIV to reduce inequalities and allow them to live and thrive**

***Integration of HIV into systems for health***

171. Existing health services often fail to address the HIV-related and other needs of people who need them most, due to discriminative attitudes or lack of sensitivity to the needs of key populations and priority populations and system capacity deficiencies. Dedicated HIV services do not always meet the broader health needs of people living with or affected by HIV.

172. When integrated service packages are tailored and delivered in ways that place people at the centre, they can help rapidly reduce inequalities in the HIV response as well as support Universal Health Coverage. People-centered systems for health must ensure that health and community systems, and social and structural enablers optimize the impact and sustainability of HIV programmes. This can be achieved through inclusive

governance structures that draw on community knowledge and perspectives. It also calls for a full range of health services to be integrated in primary health-care settings, with special consideration to acceptability for marginalized and other populations who experience stigma and discrimination.

173. Health systems must be transformed to be truly stigma- and discrimination-free. Key health system functions, including health information, procurement and supply chain management, human resource and financing, should be strengthened to support the effective delivery of HIV and integrated services, including access to quality medicines and other health commodities and technologies. Community-led responses, in particular, help to reduce HIV-related inequalities by enabling the tailoring of approaches to meet the needs of the people who need services the most. Communities are also essential to the effective governance of systems for health, with the efforts for primary health care and Universal Health Coverage highlighting inclusive governance as critical to ensuring effective and sustainable health systems. Attention to social and structural enablers helps to remove impediments to service uptake and quality, such as multidimensional stigma, discrimination, gender inequalities, sexual and gender-based violence, poverty, inadequate living conditions and insufficient investments in social protection and education focusing on poor girls and women.

#### 174. Priority actions to achieve targets and results

- a. *Integrate HIV into systems for health* and ensure that the integrated approaches are comprehensive, people-centred (with integrated and fully resourced community-led responses and systems) and gender-transformative and that they reduce inequalities and uphold people's right to health.
- b. *Build on experiences in the HIV response to transform health services* to be people-centered, rights-based and context-responsive, and systematically eliminate the multiple, intersecting forms of stigma and discrimination experienced by people when accessing services.
- c. *Strengthen health system capacity to deliver services*, including through improved human resources, procurement and supply management, monitoring and evaluation, governance and management to address the continuum of care needs of people living with HIV across their life course.
- d. *Enhance affordability of and access to HIV-related products and health technologies*<sup>29</sup> by leveraging the flexibilities of the Trade-Related Aspects of Intellectual Property Rights agreement and optimizing the use of voluntary licensing and technology-sharing mechanisms to meet public health objectives, promote generic competition, and accelerate market entry of new HIV-related health technologies;
- e. Improve the transparency of markets for HIV-related health technologies<sup>30</sup>;
- f. *Support efforts to overcome regulatory barriers* that delay market entry of HIV-related health technologies through market dynamics strategies, pooled procurement and strengthening of local and regional regulatory capacities;

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<sup>29</sup> HIV-related products and health technologies refer to generic and branded products, and health technologies, including HIV antiretrovirals and other essential commodities, including contraceptives, medicines for prophylaxis and treatment of coinfections and comorbidities (TB, viral hepatitis, STIs), laboratory diagnostics, including but not limited to rapid test kits, monitoring tools, viral load reagents and, equipment and consumables, and HIV prevention technologies, including male and female condoms and lubricants, voluntary medical male circumcision, PrEP and post-exposure prophylaxis, syringes and needles, and medication for prevention of drug overdose (naloxone) and opioid substitution therapy.

<sup>30</sup> In alignment with [WHA Resolution 72.8](#)

- g. *Support fair pricing negotiations* with pharmaceutical companies; strengthen cooperation and local capacity to develop, manufacture and deliver quality-assured affordable HIV-related products and health technologies, and enhance the reliability of drug procurement and supply systems and mechanisms for HIV-related technologies, including through promoting the development of regional markets, south-to-south collaboration and, cooperation with multilateral institutions in this area.
- h. *Support community-led responses and inclusive HIV and health governance* as a central Strategy to improve service provision. Integrate community-led responses to strengthen national systems for health and social services at all levels. Place emphasis on investments in community-led differentiated service delivery to ensure effective and equitable access that meets the context-specific needs of particular groups, places and individuals based on evidence of what works.
- i. *Strengthen the multisectorality of the HIV response, making it a whole-of-government and whole-of-society response* by advocating and supporting the alignment of HIV, health and other sector strategies, policies and practices for pro-poor and pro-vulnerable social protection and essential services, including education for girls.

### ***HIV-related social protection schemes and support***

175. Robust, people-centred social protection has a key role to play in reducing the intersecting inequalities that slow progress towards ending AIDS and enhancing the well-being, human dignity and productivity of households affected by HIV. Social protection reduces vulnerability, systematically removes barriers to service utilization and improves health, well-being, quality of life, enables food security and nutrition and social inclusion. All people living with and affected by HIV have an equal right to social protection, which must be mandated in national policy, legal and programmatic frameworks. These can include access to universal health services, social safety net transfers, insurance and pension benefits, and other state-facilitated systems that are available to the population.
176. Countries are failing to ensure ready access to the social protection that people living with and vulnerable to HIV infection need. Only 29% of the world's population has access to adequate social protection coverage; two thirds of children have no social protection coverage, and key populations are recognized as social protection beneficiaries in only 26 countries. Women and girls continue to bear the brunt of unpaid care work in the context of HIV.
177. Pandemics such as AIDS and COVID-19 highlight the pivotal role of social protection in addressing and mitigating the impact of health crises. Countries have expanded or started hundreds of new social assistance interventions in response to the COVID-19 pandemic and national expenditure levels for social protection have more than tripled. Many of these actions also help mitigate the impact of HIV and TB, reduce HIV risk and enhance access to HIV and TB services. In eastern and southern African countries, where health systems are fragile and overburdened, grassroots women's organizations have often filled gaps in formal services by helping to deliver antiretroviral and other medicines, sanitary pads, personal protective equipment, COVID-19 information, food, and cash support to individuals and families in need.
178. The Strategy calls for an intensified push to encourage meaningful, equitable investments by diverse sectors in inclusive, HIV-sensitive social protection safety nets and systems. This will strengthen and help sustain the HIV response, enhance access to HIV prevention and treatment programmes, contribute to delivering broad-based

benefits to society at large, and drive the development of health-inclusive social protection strategies and systems.

#### 179. Priority actions to achieve targets and results

- a. Conduct demand-driven assessments, operational research, monitoring and quality evaluations of existing social protection schemes and programmes, and ensure that they cover people living with and affected by HIV.
- b. Scale up intersectoral linkages to poverty reduction platforms and cofinancing for people living with HIV, key populations and priority populations to inclusive social protection programmes, including programmes that address the issue of unpaid care work performed by women and girls in the context of HIV.
- c. Create HIV-specific programming that leverages social protection tools and "cash-plus" options which have been shown to significantly improve HIV outcomes.
- d. Strengthen institutions and technical capacity to ensure that systems are fully equipped to link people at risk of HIV with social protection services, and to ensure that social protection responses address the needs of people living with HIV, key populations and other priority populations, including safety-net transfers that enable access to essential needs and improve their quality of life.
- e. Strengthen the capacity of communities affected by HIV to participate in the governance of social protection systems and deliver complementary community-led social protection services.
- f. *Ensure that existing social protection initiatives*, such as the social protection floors, address the needs of people living with, at risk of and affected by HIV.

### **Result Area 10: Fully prepared and resilient HIV response that protects people living with, at risk of and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks**

#### ***Humanitarian settings***

180. Reducing inequalities demands focused efforts to meet the needs of people who are most vulnerable and underserved, recognizing that people living with HIV and key populations in emergency and humanitarian settings are highly vulnerable to the socioeconomic impact of emergencies. They typically are least protected by national social safety nets and often experience multilayered inequalities which heighten their vulnerability. The Strategy calls for equal access to HIV services for people living with and affected by HIV in humanitarian emergencies (including refugees and internally displaced persons) and for ensuring that their health, food, nutrition, shelter and water basic needs are covered in humanitarian responses.
181. The magnitude and frequency of humanitarian emergencies are increasing, including complex crises, protracted conflicts, food insecurity, and climate change events. Conflict, disasters and displacement deplete health services, isolate communities and increase vulnerabilities, particularly among refugees, internally displaced persons, vulnerable migrants and key populations. Many countries facing ongoing humanitarian emergencies have weak health systems and governance, with poor delivery of basic HIV services.
182. Humanitarian situations often result in populations moving internally or across frontiers. Displacement can increase vulnerability and risk-taking and can interrupt HIV treatment. Even where treatment and other HIV services are available in humanitarian settings, people encounter multiple, practical barriers to accessing these services. Fearing

rejection or exclusion from host communities and health-care providers, displaced populations may avoid using available HIV services and commodities.

183. Women and girls in all their diversity are disproportionately affected by violence and other expressions of gender inequality in the context of humanitarian emergencies. Addressing HIV and conflict-related sexual violence in the context of humanitarian crises requires advance planning, coordinating and synergizing the activities of multiple actors and communities, meeting a multiplicity of health and service needs, and dealing with stigma and discrimination.

184. Efforts to address HIV in humanitarian settings can build on important, existing strengths and achievements. Clear guidelines and coordination mechanisms for addressing HIV in humanitarian settings exist. Important progress has been made in integrating HIV services in these settings, including among refugees and internally displaced people. A survey of 48 refugee hosting countries found that in 90% of countries refugees living with HIV have the right to access ART through national health systems, while refugees are receiving certain HIV services through Global Fund grants in 82% of countries. Despite these important achievements, the most vulnerable groups—including irregular migrants, key populations, unaccompanied minors and adolescents and children—often struggle to obtain meaningful access to HIV services in humanitarian settings.

**185. Priority actions to achieve targets and results**

- a. *Promote policy, frameworks and legislation that ensure national emergency response plans are tailored to specific contexts and that provide the initial minimum package and expansion to comprehensive HIV services to all people affected by humanitarian emergencies who are living with HIV or at risk of HIV, regardless of residency or legal status.*
- b. *Integrate refugees, internally displaced and other humanitarian affected populations into national HIV policy frameworks, programmes and funding proposals, reflecting their diverse needs, including support and scale-up of community-led responses and adapted service delivery.*
- c. *Using efforts tailored to the local context, intensify coordination and outreach to people in humanitarian settings to ensure HIV treatment continuation, through provision of the initial minimum package of HIV services (including combination prevention) and expanding to comprehensive services as soon as possible especially for key populations and young women and girls, in addition to essential life-saving services such as food, water and shelter during emergency responses.*
- d. *Strengthen actions to prevent and respond to gender-based violence and conflict-related sexual violence by adopting a multisectoral and survivor-centred approach.*
- e. *Resource community-led responses and scale up the engagement of communities in developing emergency preparedness plans at national and subnational levels and in providing outreach, peer support and linkages to HIV programmes.*
- f. *Ensure granular, targeted, and adapted HIV and related programming that is based on improved surveillance, localized assessment of risks and vulnerabilities, access to services and outcomes, and strengthened community-based monitoring systems.*
- g. *Leverage and continuously adapt existing data collection approaches to respond to different project needs, contexts or sectors in order to monitor and better support people living with HIV in fragile and humanitarian contexts.*

**COVID-19 and future pandemics**

186. Given the profound and continuing effects of the COVID-19 pandemic, urgent efforts will be needed to enable HIV services and broader responses to build back better, address

the vulnerabilities associated with COVID-19 (including increased incidence of gender-based violence), close pandemic-related deficits and gaps, and recover momentum. In addition, the HIV response must protect people living with and affected by HIV from future unexpected challenges, such as a resurgence of COVID-19, other pandemics and financial crises.

187. As AIDS and COVID-19 pandemics demonstrate, pandemic outbreaks are a perennial threat in an interconnected world. COVID-19 constitutes an emergency, a public health crisis and socioeconomic shock to the world. Even high-income and conflict- or emergency-free countries are experiencing serious difficulties in ensuring prevention, diagnosis and treatment, and in sustaining health services to the general population. The pandemic has had major effects on health and well-being, including alarming rises in the incidence of gender-based violence. The AIDS and COVID-19 pandemics underscore the need for the HIV response and systems for health to be resilient, adaptable, people-centred and prepared to respond to future pandemics.
188. Specific steps are needed to ensure that all people living with HIV, key populations and other people at risk of HIV are better protected in health emergencies (based on SDG indicator 3.d.1. International Health Regulations capacity and health emergency preparedness) and have access to health and other support services. Lessons from the HIV and COVID-19 responses should be used to strengthen preparedness. The COVID-19 pandemic has highlighted the fault lines of a deeply unequal world, where women in their diversity and traditionally marginalized groups experienced loss of livelihood, evictions and abuse. But it has also spurred rapid uptake of key HIV-related innovations, including HIV self-testing, multimonth dispensing of medicines and use of virtual platforms for support, counselling and information dissemination.
189. The most recent data indicates that people living with HIV are at increased risk for severe outcomes with COVID-19, including COVID-19 mortality, compared with people without HIV.
- 190. Priority actions to achieve targets and results**
- a. *Scale up investment* in adequately resourced, community-led emergency response infrastructure, and expand community-led responses to provide community outreach, information, and peer support during health emergencies and pandemic situations.
  - b. *Promote and ensure full access of effective, rights-based health emergency responses and pandemic prevention, diagnosis, treatment and care responses* by people living with HIV, at risk and affected by HIV.
  - c. *Ensure systematic engagement of HIV response in pandemic response infrastructure and arrangements*, leveraging national HIV strategic plans to guide key elements of pandemic preparedness planning.
  - d. *Protect and promote gender equality and human rights and to prevent and respond to gender-based violence*, with particular attention to people who are most marginalized and vulnerable to HIV in the context of pandemics and other shocks and crises.
  - e. *Use granular and real-time data* to identify barriers and gaps, and adapt effective approaches to ensure HIV programme continuity for people living with HIV, at risk and affected by HIV in health emergencies and pandemic situations.
  - f. *Include all people living with in the category of high-risk medical conditions when developing priority population groups for vaccines against COVID-19.*



## CHAPTER 6: CROSS-CUTTING ISSUES

191. The Strategy will reinforce, advance and effectively leverage five cross-cutting issues across all areas of the Strategy.

### **Leadership, country ownership and advocacy**

192. The COVID-19 pandemic and its impact on countries and communities afford governments and partners the opportunity to “build back better”—creating systems and approaches that are more resilient and that place people and communities at the centre. As leaders make political choices during the recovery from COVID-19, it is important that gains made in the HIV response are not just sustained but enhanced. Renewed political will and leadership is needed at every level to implement this Strategy in order to reduce inequalities by 2025 and accelerate progress towards ending the AIDS epidemic by 2030.

193. Strengthened leadership is needed to reinforce and advance the principles, targets and commitments in this Strategy as well as those made by all UN Member States in the 2030 Agenda for Sustainable Development and other political declarations.

194. The Strategy emphasizes country ownership. National governments must work in partnership with organizations led by and for people living with HIV, key populations, and other priority groups, affected communities, as well as with civil society organizations, the private sector, academia and international partners.

195. Working together, country-level partners should undertake a comprehensive analysis of HIV-related inequalities and advance urgent action to reduce inequalities and ensure that social structures, norms, laws and policies address the needs and protect the rights of people living with or at high risk of HIV. Political leadership and actions should focus, as a priority, on ensuring that people who are currently underserved have equitable access to acceptable, accessible and quality HIV services and related social and legal protection. The Strategy calls on countries to implement differentiated national, local and community HIV responses that are informed by data, local contexts, community engagement, social, legal and economic drivers, and vulnerabilities. Countries should monitor and report on progress annually through the Global AIDS Monitoring system.

196. In addition to mobilizing increased and sustained political commitment, the Strategy prioritizes the engagement and empowerment of people living with HIV, key populations and other priority groups in all their diversity. People living with HIV and key populations are key and indispensable decision makers for the HIV response.

197. Bold advocacy and communications will be critical to refocus the world’s attention on the urgent need to reduce inequalities by 2025 and ending AIDS as a public health threat by 2030. The Strategy seeks to harness the power of key influencers and the media to advance breakthrough progress on the underlying social, legal and structural barriers that impede gains towards HIV-related targets and commitments.

### **Partnerships, multisectorality and collaboration**

198. Reducing inequalities by 2025 and getting the HIV response on-track to end AIDS by 2030 are immense challenges that require strengthened partnerships and collaboration at all levels. The Strategy also requires the alignment of strategic processes and collaboration among global partners, including UNAIDS, the Global Fund, PEPFAR, Unitaids, the StopTB Partnership, the Medicines Patent Pool, the International Federation

of the Red Cross and Red Crescent Societies, GNP+, bilateral donors and private foundations, governments and communities.

199. The Strategy will ensure full alignment between global and national strategic processes, such as the Global AIDS Strategy, the Global Fund's post-2022 Strategy, PEPFAR's Country Operational Plans and its new Strategy, the strategies of UNAIDS Cosponsors (including campaigns to unlock societal enablers, such as Generation Equality), the UN Sustainable Development Cooperation Frameworks and the SDGs, as well as national HIV, health and development planning processes and mechanisms.
200. During the Decade of Action to deliver the SDGs, the Strategy calls for bold, inclusive, multisectoral approaches to HIV to reduce inequalities, protect human rights and strengthen collaboration and synergies between HIV-specific and broader health and development initiatives and systems at all levels. The Strategy will advance a whole-of-government, whole-of-society response to ending AIDS. The Strategy will strengthen inclusive, transparent, accountable and multisectoral country-level governance mechanisms to effectively support inclusive, multisectoral strategic partnerships, coordination and collaboration.
201. The Strategy prioritizes engaging, leveraging and synergizing the contributions of all relevant partners in every aspect of the HIV response.<sup>31</sup> The Strategy will also leverage and accelerate partnerships between the HIV response and other global and local movements for Universal Health Coverage, gender, human rights, nondiscrimination on the basis of sexual orientation and gender identities, economic justice, youth, anti-racism, ending violence against women, and climate change.
202. The Strategy will accelerate engagement with the private sector as a key provider of employment for people living with, at risk of or affected by HIV, and as a partner for mobilizing and accelerating expertise and systems to reduce inequalities, drive innovation and develop new technologies to accelerate progress to end AIDS as a public health threat, and as a complementary source of financial resources.
203. The Strategy places special emphasis on the role and contributions of faith-based organizations, religious leaders and faith communities. Their positions of trust at the heart of communities and their missions to serve communities equip them to provide services and support that extend beyond the reach of many conventional services and systems. The Strategy will leverage the distinctive and extensive contributions of faith-based organizations and faith communities in providing HIV services, care and support to the key populations and affected communities.
204. The Strategy will ensure alignment with the global health and development architecture, including through the Global Action Plan for Healthy Lives and Well-being for All.

#### **Data, science, research and innovation**

205. The Strategy can be effectively implemented only by leveraging the potential of data, science, research and innovation to guide the HIV response. Data is essential to identify

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<sup>31</sup> Including national governments, the UNAIDS Joint Programme and other relevant UN agencies and programmes, regional and subregional organizations, people living with, at risk of and affected by HIV, key populations, political and community leaders, parliamentarians, justice and law enforcement officials, communities, families, faith-based organizations, scientists, health professionals, donors, the philanthropic community, the workforce, the private sector, the media and civil society, including women's and community-led organizations, feminist groups, youth-led organizations, key population-led organizations, national human rights institutions and human rights defenders.

the ways in how and why the HIV response is working for some but failing others, inform strategic actions to reduce inequalities, and guide and accelerate implementation. Achieving the Strategy targets require using data to map the impediments to service access, including human rights barriers and inequalities, and to clearly identify the approaches, investments and tools that can close the gaps. The Strategy calls for tangible actions to remove barriers and translate scientific advances (in biomedical and clinical, social and behavioural, political and economic, and implementation sciences) into meaningful interventions that benefit all people equally. Global, regional and country-level data to assess progress will also become increasingly important.

206. The Strategy calls for improved collection, analysis and use of data to better inform AIDS epidemic responses, including through the greater use of community-generated and -owned data to monitor the affordability, availability, accessibility, acceptability and quality of the HIV response for different groups. The Strategy prioritizes collecting and effectively using timely granular data, in collaboration with communities and in rights-affirming ways, for location- and population-specific actions that reduce inequalities in HIV outcomes.
207. Continued innovation will be needed to develop new biomedical technologies and even more effective service delivery strategies to accelerate progress towards ending AIDS. Implementation of biomedical advances needs to be rights-based and occur as part of inclusive, community-led approaches. Greater investments are needed in the development of an HIV vaccine and a cure. Those efforts should draw inspiration and lessons from the unprecedented speed with which COVID-19 vaccines have been developed. A comparable spirit of innovation is required to inform and guide efforts to address the social and structural factors that increase HIV vulnerability and diminish access to and uptake of HIV services. Artificial intelligence and data science breakthroughs can be used to improve diagnostics and personalize HIV prevention and treatment options and services in ways that uphold human rights.
208. The Strategy also aims to embrace new partnerships with the information technology community to use the potential of digital and social innovations to connect people, share experiences through social media, access information, deliver services and support social movements to reduce HIV related inequalities. Across all such efforts, care will be needed to ensure that the innovations work for and not against vulnerable communities, and that they are used in accordance with human rights principles.

### **Human rights, gender equality and reduction of stigma and discrimination**

209. The Strategy renews and further underscores anchoring the HIV response in principles of human rights and gender equality, which must be consistently and explicitly reflected in all aspects of the response. Unless this vision is realized, it will be impossible to end AIDS by 2030.
210. The Strategy is informed by a central lesson from 40 years of responding to HIV: a human rights-based approach is essential to create enabling environments for successful HIV responses and to affirm the dignity of people living with, or vulnerable to, HIV. The Strategy highlights and builds on the obligations of all governments under international human rights law to reduce inequalities and ensure equal enjoyment of rights, including the right to health. It calls on all governments and partners to ground the response in a human rights approach.
211. The Strategy seeks to ensure that data and research on human rights in the context of HIV are used to inform the HIV response, and that challenges and gaps in current efforts to remove human rights barriers and end human rights violations are identified and

overcome. It also aims to ensure that the intersecting forms of HIV-related stigma and discrimination are addressed with evidence-based and adequately funded programmes, and that opportunities for greater integration of human rights in the HIV response are seized. The Strategy also makes explicit calls to maintain a bedrock of human rights principles such as confidentiality, privacy and informed consent.

212. Transforming harmful social norms, reducing gender-based discrimination and inequalities, advancing women's empowerment and fulfilling the sexual and reproductive health and rights of women and girls, men and boys in all their diversity (key populations) are crucial for reaching the SDGs and for achieving the targets and commitments in the Strategy. The Strategy calls for systematic efforts by all governments and partners to ensure the equal participation of women and girls, men and boys, in all their diversity, as making the decisions that shape the HIV response. In particular, the Strategy seeks to ensure that women and girls are empowered and supported in the realization of their full human rights.
213. The effects of social exclusion and marginalization are visible in the AIDS epidemic's disproportionate impact on laws, policies and social norms, frequently creating barriers for people to participate fully in the HIV response and benefit from the services and support they need. To end AIDS, societies need to be transformed to be inclusive, and to respect, protect and fulfil the rights of everyone.

#### **Cities, urbanization and human settlements**

214. Approximately 55% of the world's population currently lives in urban areas and that proportion is expected to increase to 68% by 2050. In most countries, cities account for a large and growing proportion of the national HIV burden; in some countries, a single city can account for up to 30% of the HIV burden. Risk and vulnerability to HIV is often higher in urban than in rural areas.
215. While the global HIV response has historically focused on national-level public sector actions, the Strategy highlights the centrality of cities and other human settlements in the HIV response. As centres for economic growth, education, innovation, positive social change and sustainable development, the Strategy underscores the role of cities and human settlements as being uniquely positioned to address complex multidimensional challenges such as HIV through inclusive participation from diverse stakeholders.
216. The Strategy calls on all partners to reinforce the leading roles of cities in addressing rights issues, reducing inequalities and social exclusion, and protecting against risks and vulnerabilities, while using the HIV response as a pathfinder in those efforts.

#### **CHAPTER 7: RESOURCES NEEDED TO ACHIEVE THE NEW STRATEGIC RESULTS AND TARGETS**

217. Moving forward, more resources will be needed to put the world on track to end AIDS by 2030. Achieving the goals and targets of the new Strategy requires that annual HIV investments in low- and middle-income countries rise to a peak of US\$ 29 billion (in constant 2019 dollars) by 2025. Closing resource gaps will be especially critical to accelerating progress in parts of the world where gains in the response are lagging, including West and Central Africa, the Middle East and North Africa and eastern Europe and central Asia. Although mobilizing the additional funding needed will encounter important challenges, especially in a world buffeted by the health and economic effects of COVID-19, summoning the political will and ingenuity needed to meet these challenges is critical to the future health and well-being of our world. Investing too little, too late will not only cause the AIDS epidemic to worsen and mean that ambitious

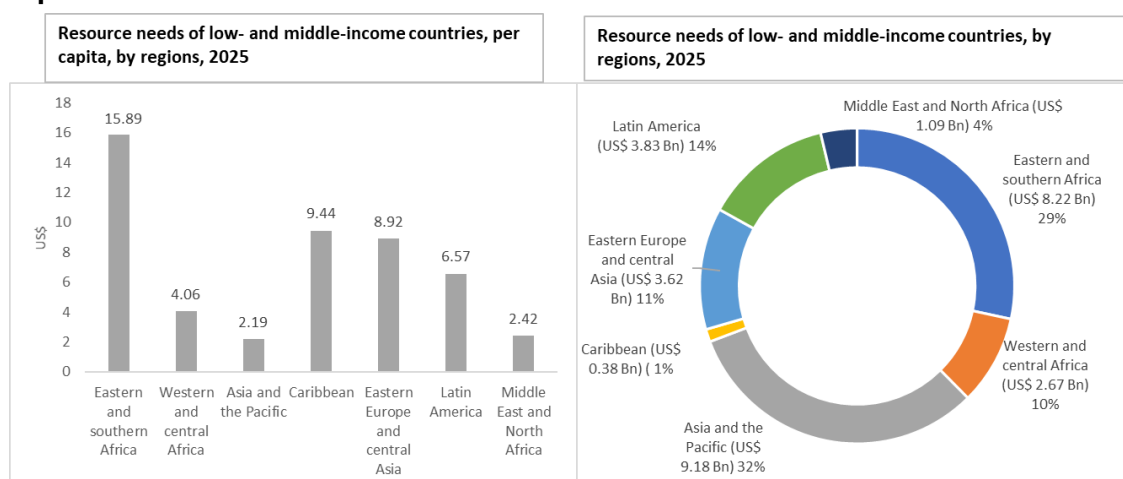
targets in the Strategy will not be met, but it will further add to the long-term costs of the HIV response. However, by fully funding the 2025 resource targets and using those resources to efficiently implement the Strategy, the year-on-year growth in resource needs can be halted after 2025.

218. During implementation of the Fast-Track Strategy, annual funding for HIV in low- and middle-income countries rose to an all-time high in 2017 but was about US\$ 4.2 billion short of the US\$ 26.2 billion annual target committed to in the 2016 Political Declaration on Ending AIDS. Like other aspects of the HIV response, resource mobilization efforts reflect the inequalities which this Strategy seeks to address. In settings where funding was sufficient and spent well, people living with and affected by HIV obtained the services they needed, leading to declines in new HIV infections and AIDS-related deaths. However, in too many countries and communities, resources remained inadequate, contributing to needless new HIV infections and AIDS-related deaths.
219. This Strategy provides a roadmap to enable the response to get ahead of the AIDS epidemic. It harnesses two key tactics to achieve a fully-resourced response: efficient and effective use of resources to reduce costs associated with a rapid expansion of the response; and mobilizing funding from national and international sources to support ready, equitable access to a comprehensive range of HIV programmes and services.
220. Focusing on addressing inequalities, the Strategy requires a shift in both allocation and volume of HIV investments to meet the specific needs of different countries and communities. To estimate the resources that will be needed to implement the Strategy, UNAIDS undertook a rigorous review of documented and anticipated service costs to project resources needed in 2021–2030 to end AIDS as a public health threat.

#### **Where resources will need to be spent**

221. As the epidemic has evolved, the allocation of resources among regions and income groupings has changed. The resource needs in upper-middle-income countries amount to 53% of the total resources required to achieve the results and targets outlined in the new Strategy. The majority of resource needs are concentrated in key geopolitical groupings—specifically, the BRICS (Brazil, Russian Federation, India, China and South Africa) represent 41% and three other countries from the MINT group (Mexico, Indonesia, and Nigeria) represent 9% of all resource needs.
222. Eastern and southern Africa has the largest per capita resource needs, reflecting its high HIV prevalence, and it accounts for 28% of total estimated resource needs by 2025. While Asia and the Pacific region has a lower disease burden and lower per-capita resource needs than eastern and southern Africa, the region nevertheless accounts for 32% of the total resource needs. Asia and the Pacific's substantial share of total resource needs stems from its much larger population, combined with unit costs which in many countries are higher than those in sub-Saharan Africa. Higher unit costs (e.g. for human resources and antiretroviral medicines) also contribute to the relatively high per capita resource needs in Latin America and in eastern Europe and central Asia.

**Figure 5. Breakdown of Peak Resource needs of US\$29 billion for the HIV response in 2025**



223. The resource needs projected for 2021–2030 reflect the total costs for HIV treatment, HIV prevention (taking into account the size of key populations and type of epidemic), commodities (diagnostics, antiretrovirals, condoms etc.) and service delivery. Resource needs for different countries reflect each country’s unique HIV-related needs. For example, the resource needs in China and India are shaped by the size of the populations in need of HIV prevention services. By contrast, countries with a higher burden of disease have higher aggregate costs for the provision of ART. Selected upper-middle-income countries have comparatively higher costs due to higher unit costs.

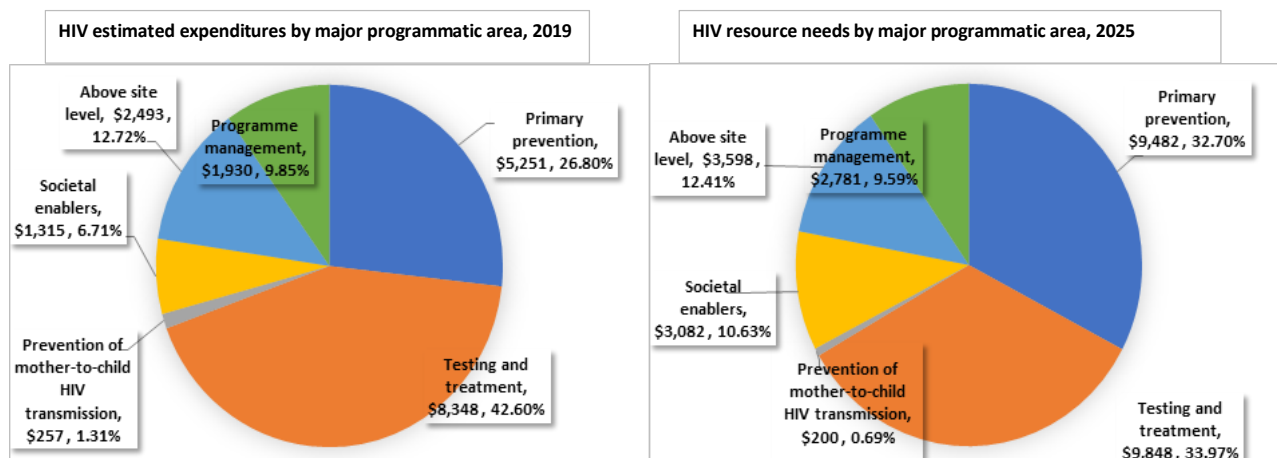
**Shifting spending to increase impact and reduce the cost of rapid scale-up of services and programmes**

224. This Strategy advances a prioritized, synergistic approach to rectify chronic under-funding and to cover the costs of reaching ambitious results by 2025. The imperative of identifying and eliminating HIV-related inequalities requires increased financial resources across every aspect of the HIV response. However, some areas require more rapid increases of resources than others, and the combination of priorities will differ significantly between countries and regions.

225. In many countries, investments in HIV have fallen short in recent years because the scale-up of some programme areas has been achieved at the expense of other areas. This Strategy explicitly calls for synergies that will only be available by achieving an effective, simultaneous scale-up of programmes and services, including across the range of HIV prevention, treatment and social enablers.

226. The HIV prevention targets in the Strategy include the rapid expansion of evidence-based, combination prevention options, which will require spending on primary HIV prevention to increase from US\$ 5.3 billion in 2019 to US\$ 9.5 billion by 2025. The Strategy opts against incremental progress and instead requires rapidly ramping up funding. This is necessary to catalyze swift gains in coverage for key populations and other populations who are at very high risk of HIV infection in order to achieve steep and sustained reductions in new HIV infections. A massive increase in spending on HIV prevention will enable urgent, transformational scale-up of HIV prevention services.

**Figure 6. Investment in HIV prevention should overtake investment in HIV testing and treatment by 2025**

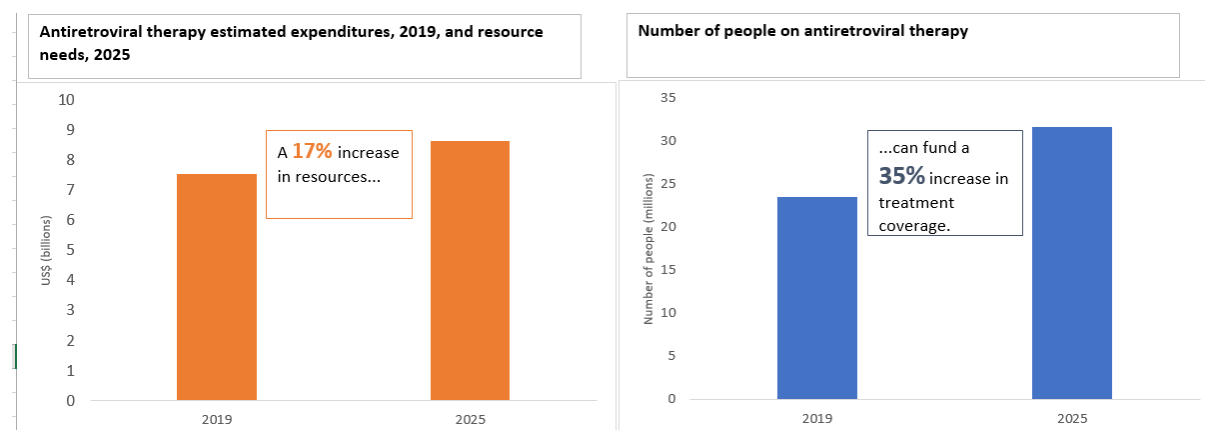


227. Alongside increased funding for combination HIV prevention, the Strategy targets the reallocation of approximately US\$ 1.15 billion in annual spending on HIV prevention services which are not optimally efficient, thereby optimizing the strategic mix of proven HIV interventions. This reallocation away from suboptimal approaches is essential to enable rapid scale-up for programmes to reach people and communities experiencing high rates of HIV transmission, such as key populations. The prevention-related resource needs in specific countries and subnational settings vary considerably, reflecting substantial differences in HIV disease burden, population size, the specific programmes needed to address the communities at greatest risk, unit costs and other variables.

228. In some countries with large numbers of people on ART, the percentage of overall HIV spending needed for prevention might be small even if the cost per person is adequate. In countries with lower treatment needs, a similar level of prevention spending per person may comprise a larger proportion of the total HIV spending.

229. Reducing the price of medicines and ART through the strategic use of TRIPS flexibilities and greater efficiency in procurement and supply management is a key achievable outcome of this Strategy. If fully implemented, the Strategy would increase the number of people receiving HIV treatment by 35% by 2025, but the treatment-related resource needs would rise by only 17% due to efficiency gains and projected reductions in unit costs (not including above-site costs and programme management, or the investment in societal enablers which are necessary to enhance the programme effectiveness).

**Figure 7. A 17% increase in investment in HIV treatment can result in a 35% increase in treatment coverage by 2025**



Source: UNAIDS financial estimates and projections, 2021.

Notes: the costs include only direct service delivery costs and commodities (antiretrovirals, diagnostics). These costs do not include above site costs, programme

230. Recent progress in preventing new HIV infections among children has helped minimize the cost of antiretroviral drugs to achieve the Strategy's target of eliminating vertical transmission. Initially, the cost of non-antiretroviral services to prevent vertical transmission of HIV will increase to overcome the persistent coverage and outcomes gaps which undermined the achievement of the elimination target by 2020. However, as countries get closer to eliminating vertical transmission and achieving the 95–95–95 treatment targets, the need for investments in standalone services for prevention vertical transmission will decline.

### Catalyzing essential investments by non-health sectors and societal enablers

231. Societal enablers are essential if HIV programmes are to be effective. Annual funding to improve the social enabling environment will need to reach US\$ 3.1 billion by 2025 if we are to end AIDS by 2030. In the expanded envelope for societal enablers, the largest investments are for legal literacy, programmes to reduce internalized stigma, gender equality programmes and legal services.

232. Efforts to end AIDS as a public health threat are integrally linked to broader efforts to end poverty and hunger, fulfill the right to health, and succeed across all the SDGs. UNAIDS' projections of the resources needed to meet the 2025 targets include important spending on key societal enablers. However, HIV budgets are unable on their own to address the many social and structural factors that affect success in the response, underscoring the need for strategic investments by sectors beyond health.

## CHAPTER 8: REGIONAL PROFILES

233. Renewed political will is needed to transform regional HIV responses and achieve the Three Zeroes. Within each region, countries in the vanguard should be leveraged to help spur gains in those where progress is lagging, to help accelerate country-level progress, adopt innovative approaches, and ensure comprehensive services for key populations.



## Asia and the Pacific

234. Earlier gains in the regional response in Asia and the Pacific are under threat, as many countries in the region experience new waves of HIV infection. In 2019, 98% of new HIV infections in the region were among key populations and their partners or clients, and one third of new infections were among young people.

235. The status of the response varies considerably. Several countries have experienced a decline in new HIV infections of more than 50% between 2010 and 2019, but new infections have fallen by only 12% across the region as a whole, far short of the Fast-Track targets. New HIV infections have increased between 17% and 207% in seven countries since 2010. Three countries (Maldives, Sri Lanka and Thailand) have been certified as having eliminated vertical transmission of HIV and syphilis, but substantial gaps in access to prevention services persist in many other parts of the region. Slow progress in the response underscores the failure to prioritize HIV prevention, bring services to scale and tailor approaches to address the needs of key populations.

236. Service scale-up has been insufficient to meet the needs of the 5.8 million people living with HIV in Asia and the Pacific. Regionally, one quarter of people living with HIV (and almost half of key population members living with HIV) do not know their HIV status and 40% are not receiving treatment. About 160 000 people die of AIDS-related causes annually in this region, and AIDS-related mortality has decreased by only 29% since 2010.

237. To close the gaps in its HIV response, Asia and the Pacific should build on and replicate more broadly the important AIDS leadership that is evident in some countries. That leadership has facilitated successful and diverse models of differentiated HIV service delivery, including HIV self-testing, multimonth dispensing of antiretroviral regimens and key population-led health services that bridge gaps in traditional programming. It has also increased adoption of innovative approaches such as telehealth, take-home opioid substitution therapy, needle-syringe services and PrEP services, and it has built highly multisectoral response that capitalize on the strengths of civil society and other partners.

### 238. **Priority actions include**

- a. *Renew and intensify the focus on key populations* in policies and programmes. Urgent, focused action is needed to bridge the significant prevention, testing and treatment service gaps for key populations, including adolescent and young key populations, through inclusive, youth-centered and gender-responsive approaches, adopting innovative strategies (including digital and virtual space interventions to reach unreached key populations), and enhancing civil society and community engagement.
- b. *Modernize HIV service delivery*. Priority must be given to scaling up combination prevention programmes for and led by key populations, including PrEP, self-testing, same-day ART and multimonth dispensing. Key population-led services must be prioritized, enabled and brought to scale. Adopting differentiated service delivery modalities involving nontraditional partners will allow for the integration of key population-led health services and reduce access barriers, tackle inequities, stigma and discrimination.
- c. *Eliminating the barriers to equitable programme coverage among the most marginalized communities will require countries to recognize and address overlapping vulnerabilities*. Concerted efforts are needed to address human rights issues in the context of HIV, promote gender equality and women's empowerment and eliminate stigma and discrimination against key populations and people living with HIV, to identify and overcome barriers to services (including economic barriers),

and to recognize and respond to gender-based violence against key populations and women and girls. Improving effectiveness and reducing inequalities also requires improved data disaggregation by age, gender, disability status, socioeconomic status and more. Law and policy reforms, including decriminalization of key populations, will be essential.

- d. *Mobilize sustainable domestic financing for prevention.* Domestic funding will be essential if HIV programmes are to be fully funded, including for key population-led and women- and youth-led health services under Universal Health Coverage. Domestic funding must cover expanded prevention programmes in order to achieve adequate national coverage among key populations in all settings.

## Eastern Europe and central Asia

239. Eastern Europe and central Asia is one of three regions in the world (along with Middle East, and North Africa and Latin America) where new HIV infections have risen since 2010. The annual number of new HIV infections in eastern Europe and central Asia increased by an estimated 72% from 2010 to 2019, making it the fastest growing epidemic in the world. Key populations and their sexual partners (including clients) accounted for the majority of new HIV infections (with an estimated 48% of new infections occurring among people who inject drugs). The HIV burden in the region is growing also among gay men and other men who have sex with men (with the most recent reported average HIV prevalence of 5.4%), among women and girls (with new infections rising by 71% in 2010–2019), and among middle-aged people. Unequal power dynamics and violence against women, especially among key populations and young women, threaten women’s ability to access HIV prevention, treatment and care services.
240. All countries in the region criminalize HIV transmission and nearly all of them also criminalize HIV exposure and nondisclosure of HIV status. Many countries criminalize key populations, especially people who inject drugs, gay men and other men who have sex with men, and sex workers. In some countries the evidence-based effective interventions for HIV prevention for people who use drugs, particularly people who inject drugs, are not being implemented or are being implemented at a low scale. Stigma and discrimination towards key populations and people living with HIV, including in health-care settings, persists. The withdrawal or reduction of external donor financing for HIV programmes in the region has challenged efforts to preserve and expand access to essential HIV services. Services provided by civil society and community-led organizations are rare. HIV services in prisons are typically lacking, with only two countries in the region having brought to scale a comprehensive HIV response in prison settings. Persons released from prisons where services are provided often experience service disruptions when they integrate into the community.
241. Prevention programmes are heavily dependent on donor financing and generally fail to achieve meaningful coverage. Regionally, an estimated 70% of people living with HIV knew their HIV status in 2019, 44% were receiving ART and 41% achieved viral suppression. AIDS-related deaths increased by 24% from 2010 to 2019, due primarily to late diagnosis and a failure to link many people with an HIV diagnosis with ART. TB morbidity and mortality remain high in eastern Europe and central Asia.
242. However, there are important signs of strengthened leadership which the region can build on to close the gaps in its HIV response. These include the roll-out of community-led PrEP services in Moldova, the launch of a plan by Ukraine to cover 80% of its HIV response through domestic resources by the end of 2020, and a number of countries that have either achieved or are on track to eliminate vertical transmission of HIV.

243. Implementing these priority actions will help ensure that the region is on-track to realize the Three Zeroes, which in turn would ensure that all children in the region are born free of HIV, all people on treatment (including key populations, women and girls and other vulnerable populations) achieve viral suppression and overall good health and well-being, key populations are economically empowered and socially included, stigma is eliminated and national responses are characterized by a spirit of innovation and the meaningful participation of all partners and stakeholders.

**244. Priority actions include**

- a. *Urgently expand access to combination HIV prevention*, including PrEP and harm reduction. This calls for focused steps to ensure a sound, seamless and sustainable transition of prevention programmes from donor to domestic funding. Gender-responsive harm reduction programmes for people (including adolescents and young people) who use stimulant drugs or other new psychoactive substances must be introduced and scaled up.
- b. *Close gaps in the testing and treatment cascade* by rolling out the treat-all approach fully, with particular attention to linkages to care and rapid initiation of treatment for all people with new or previous HIV diagnosis. Testing and treatment scale-up for key populations must be prioritized.
- c. *Institutionalize community-led services into national health care and HIV prevention systems*, ensuring that community-led services account for at least 30% of HIV service delivery.
- d. *Remove discriminatory and punitive laws, policies and structural barriers* (HIV transmission, exposure, barriers to treatment for migrants, laws criminalizing key populations, including adolescents and young people), strengthen the capacity of the judiciary to promote and protect human rights in the context of HIV, and reduce stigma in medical settings, legislative and educational institutions, and law enforcement practices.
- e. *Transform harmful gender norms and reduce gender-based violence*, including through the use of digital technologies to improve access to services for all in need.

**Eastern and southern Africa**

245. Eastern and southern Africa remains the region most heavily affected by HIV, accounting for approximately 55% of all people living with HIV and for two-thirds of all children living with HIV. Women comprised three in five new HIV infections among adults in the region in 2019, and adolescent girls and young women (aged 15–24 years) are up to 5 times more likely to acquire HIV than their male peers.

246. It is also the region where progress towards global AIDS targets is most evident. New HIV infections declined by 38% from 2010 to 2019, including a 63% reduction in the number of children newly infected with HIV, the sharpest reduction in any region. This means eastern and southern Africa reached the 2020 target for reductions in new HIV infections. Historic gains have also been made towards the 90–90–90 HIV testing and treatment targets: 87% of people living with HIV knew their HIV status in 2019, 72% received ART and 65% achieved viral suppression. Gains in preventing new HIV infections have continued, with coverage among pregnant and breastfeeding women exceeding 90% in 12 countries. Women and girls, particularly adolescent girls and young women, continue to bear the brunt of the epidemic in this region.

247. Political commitment remains strong across the region. Most countries have adopted ambitious targets for programme expansion and have increased domestic funding for

their HIV responses. Total financing for the response (estimated at US\$ 10.6 billion in 2017) exceeds the 2020 regional financing target by about US\$ 500 million.

248. However, the region also faces important challenges, and inequalities within and between countries in HIV responses persist. Some populations (including adolescent girls and young women, young and adult female sex workers (age 18+), people who inject drugs, gay men and other men who have sex with men, and transgender people, adolescent girls and young women and their male partners) are not benefiting equally from regional advances in the fight against HIV. Children have experienced much slower progress across the testing and treatment cascade than adults. Stigma in health-care settings and a lack of community involvement remain barriers to meaningful service access and robust service uptake. Structural barriers and unequal gender norms, including gender-based violence perpetuate inequities in access to essential HIV programmes.
249. The space for civil society organizations remains limited in many countries in the region, thus limiting their roles in HIV programmes. The response remains dependent on external resources for the majority of countries in the region, despite increases in domestic funding. This poses a threat to the long-term sustainability of the response. The COVID-19 pandemic has adversely affected national HIV programmes, including through service disruptions and economic challenges.
250. Ending AIDS as a public health threat will require translating political commitment into programmatic actions, including sustained efforts to scale up what works and focusing on settings where progress is slow and populations who are left behind. It will also require brave political leadership to lead transformative policy and programming on issues such as independent adolescent and youth access to health services, gender equality, and other inclusive changes. Countries such as Eswatini, Namibia and Zambia have shown tremendous leadership in advancing towards the 90–90–90 targets, with Eswatini already reaching 95–95–95 targets. South Africa has developed effective models of community involvement in designing, implementing and monitoring programmes using a people-centred approach. It is also funding the majority of its response from domestic sources, while Namibia has committed to spending one-quarter of its HIV budget on prevention.
251. A properly resourced and sustainable HIV response, embedded in a human rights-based approach, is the pathway to end AIDS as a public health threat in this region.
- 252. Priority actions include**
- a. *Significantly increase high-impact, evidence-based, people-centred combination HIV prevention for key populations and other priority populations, including adolescent girls, young women and young men in locations with high HIV incidence and prevalence.*
  - b. *Preserve the gains in testing, treatment and care in the current COVID-19 context and scale up services, especially for adolescents, youth, women and girls, key populations and other priority populations, and scale up prevention of vertical transmission and paediatric ART coverage in a stigma-free environment, using innovative models of service delivery.*
  - c. *Ensure sustainability of the HIV response with in-built resilience, leveraging system integration and tapping efficiency gains, with enhanced domestic funding, in order to fully fund the HIV response, and using technology, positioned within Universal Health Coverage.*
  - d. *Address social and structural barriers, including gender-based inequalities, unequal gender and social norms, and gender-based violence, and ensure an enabling*

environment based on human rights-based frameworks and protecting the human rights of key populations and priority populations.

- e. *Empower communities and place them at the centre* of all decisions affecting them and meaningfully involved in design, implementation and monitoring of programmes and of national systems for health.

## Western and central Africa

253. Although some progress is evident, the HIV response in western and central Africa is not advancing fast enough. New HIV infections declined by only 25% from 2010 to 2019—well short of the Fast-Track targets—and the incidence:prevalence ratio of 5% is well above the epidemic transition benchmark of 3%.

254. In 2019, key populations and their sexual partners accounted for an estimated 69% of new HIV infections, with women and girls representing 58% of new infections. Adolescent and girls are heavily affected, and violence against women and girls is pervasive. The region accounted for more than one third of new HIV infections among children globally in 2019. Early infant diagnosis and antiretroviral coverage for children remains inadequate. Nearly 1 in 3 people living with HIV did not know their HIV status, only 58% of people living with HIV obtained ART and only 45% of people living with HIV were virally suppressed in 2019. In many parts of the region, user fees for health services reduce service access and uptake.

255. COVID-19 has exacerbated the many vulnerabilities at play in this region, including protracted insecurity and conflict, rapid population growth, increasingly fragile states, already fragile financial and health systems, extreme poverty, food insecurity and environmental shocks. These intersecting vulnerabilities shape the regional political agenda and affect the allocation of finite resources. Gender inequalities, financial barriers to service access through user fees and other out-of-pocket costs, shrinking civic space for civil society, stigma and discrimination, and hostile legal and social environments for key populations and women and girls undermine efforts to respond effectively to HIV.

256. Across the region, renewed efforts to accelerate the HIV response hold promise. They include the new regional Strategy for HIV, TB, Hepatitis B & C and Sexual and Reproductive Health and Rights among Key Populations, adopted by the Economic Community of West African States (ECOWAS); the establishment of the Civil Society Institute for HIV and Health in West and Central Africa; and Cabo Verde's leadership on the elimination of vertical transmission of HIV.

### 257. Priority actions include

- a. *Reposition and empower communities as a central pillar* of the HIV multisectoral response.
- b. *Strengthen people-centred health systems* to deliver results for the most vulnerable. HIV responses must support the achievement of equitable, affordable, resilient health and community-led systems (including on health information); foster patient autonomy and rights-based quality services; promote decentralization and integration; scale up quality differentiated service delivery models; ensure sustainable commodity supplies; and ensure service continuity and neutrality during crises and conflict.
- c. *Close gaps in access to and uptake of services to prevent vertical transmission and paediatric HIV treatment.*

- d. *Promote an accountable, inclusive and sustainable HIV response.* It is urgent to revisit state ownership, leadership and responsibility vis-à-vis national HIV responses; increase focus on transboundary and regional dimensions of the epidemic; enhance participation and protect civic space (including online); reduce donor dependence and emphasize shared responsibility via increased investments in health; and enhance mutualization, coordination, adaptation and tracking of resources.
- e. *Revitalize multidimensional and integrated approaches.* Tackling multiple, intersecting inequalities and vulnerabilities and epidemics requires HIV responses to strengthen protection for social and financial risks and vulnerabilities; ensure access to education, and to child- and adolescent-friendly services, gender-based violence prevention and response, comprehensive sexual and reproductive health and rights services—all on the basis of human rights-based approaches; ensure the repeal of all punitive and stigmatizing laws and policies which fuel discrimination; and promote, protect and respect the human rights of all people in the region.

### **Middle East and North Africa**

258. Although the region of Middle East and North Africa has among the lowest HIV prevalence in the world, it is also home to one of the fastest growing epidemics. New HIV infections in the region have increased by 22% since 2010 and are concentrated among key populations and their sexual partners. Although AIDS-related deaths have declined by 16% among women since 2010, they have increased by 10% among men. The region lags behind in efforts to fully leverage the health benefits of HIV treatment: only 52% of people living with HIV knew their status in 2019, 38% of those living with HIV were accessing ART and only one third of people living with HIV were virally suppressed. Results were even poorer among pregnant women and children. Total resources available for the regional response amount to less than one fifth of the 2020 funding target.
259. These gaps reflect longstanding challenges across the region, including restrictive sociocultural norms mirrored in proscriptive laws and policies, widespread stigma and discrimination and sharp gender inequalities, as well as modest political leadership and minimal financial investment in HIV. Several countries in the region are facing humanitarian crises due to direct and indirect effects of conflict and instability. However, recent years have seen important advances in the regional response, including the emergence of coordinated community-led networks representing people living with HIV and key populations (e.g. MENA Human Rights Coalition); legal reforms (e.g. combatting stigma and discrimination in Iran and ending the mandatory HIV testing of foreigners in Sudan); innovations in services (among them PrEP in Morocco, HIV self-testing in Lebanon and opioid substitution therapy in Egypt); and developments in funding (e.g. increased domestic financing for HIV treatment in Algeria and in the Global Fund's Middle East Response Grant).
260. Because of its low HIV prevalence, it is wholly feasible for the Middle East and North Africa to move from aspiration to realization in the quest to end AIDS as a public health threat. This will require helping governments to commit to ending the epidemic, by positioning the HIV response in the broader context of the SDGs and by linking it to other priority issues, such as the COVID-19 response, youth engagement and gender equality.
261. These transformative steps will require innovative alliances, with community-led organizations and other new partners, to break the siloes characterizing the regional response to date. Such integration will allow new linkages between HIV and the broader efforts on Universal Health Coverage, social protection, sexual and reproductive health

and noncommunicable diseases, thereby weaving HIV into the fabric of development across the region.

## 262. Priority actions include

- a. *Scale up quality services.* The region needs to scale up equitable access to high-quality, innovative HIV combination prevention, testing and treatment, with a focus on key populations and other priority groups, and services for the elimination of vertical transmission of HIV and paediatric care, using integrated and differentiated service delivery models.
- b. *Leverage information to achieve transformative results.* The region needs better data, with a focus on key populations and priority populations, including enhanced epidemiological surveillance and biobehavioral studies, as well as improved strategic information for programme and policy design, more effective monitoring and evaluation, and more efficient resource mobilization and allocation.
- c. *Strengthen and empower community-led responses.* Building on a small but solid base, the region must do more to empower communities and enhance the leadership of people living with HIV and key populations, including capacity development, resource mobilization and the promotion of an open civic space.
- d. *Ground the response in human rights and gender equality.* The region needs to promote a gender-equality and rights-based response to ensure that no-one is left behind. This includes addressing gender-based violence, harmful social norms and practices, removing punitive laws, policies and practices (among them mandatory HIV testing), as well as promoting access to justice and eliminating stigma and discrimination.
- e. *Ensure preparedness for humanitarian emergencies and pandemics.* With the largest concentration of humanitarian crises in the world, the region must ensure that all affected people can access the full range of HIV prevention, testing and treatment services, and that these are fully represented in emergency, disaster and pandemic response plans.

## Latin America and the Caribbean

263. Between 2010 and 2019, new infections increased by 21% in Latin America but decreased by 29% in the Caribbean. Key populations are most affected. In 2019 in Latin America, an estimated 44% of new infections occurred among gay men and other men who have sex with men and 6% were among transgender women. In the Caribbean, key populations and their sexual partners or clients accounted for 60% of new infections. Overall, one quarter of new infections in 2019 in the Caribbean were among young people.

264. AIDS-related deaths declined by 8% in 2010–2019 in Latin America and by 37% in the Caribbean. Both regions lag behind the global averages in outcomes along the testing and treatment continuum. In Latin America in 2019, an estimated 77% of people living with HIV knew their HIV status, 60% were receiving ART and 53% were virally suppressed. In the Caribbean, 77% of people living with HIV knew their status, 63% were receiving treatment and 50% were virally suppressed. There were significant variations between countries.

265. The COVID19 pandemic has accentuated fundamental shortcomings in health systems, including financial, technical and human resources. The socioeconomic impact has been severe for key populations and it threatens the sustainability of national HIV responses in a region affected by the largest displacement of people in its history (Venezuela's migrant and refugee situation), systemic inequities and inequalities, political instability,

conservative backlashes, high levels of stigma and discrimination, as well as high rates of hate crimes, xenophobia and homophobia. In 2019, 88% of the countries in Latin America and 50% in the Caribbean had approved social protection strategies or policies and were implementing them, though only a few of those programmes were benefiting people living with HIV and key populations and priority populations.

266. Recent years have seen important signs of political leadership and commitment to the HIV response on which Latin America and the Caribbean can build. Twenty-one of the 24 countries in the region had by December 2020 implemented multimonth dispensing of antiretroviral medicines, including 13 countries that did so during the COVID19 pandemic. Seven countries and their territories (Anguilla, Antigua and Barbuda, Bermuda, the Cayman Islands, Cuba, Montserrat, and Saint Kitts and Nevis) have been certified as having eliminated vertical HIV transmission. In the Bahamas, Barbados, Brazil, Chile, Cuba, Dominican Republic, Ecuador, and Haiti, comprehensive prevention packages which include PrEP are offered through the public health system.

**267. Priority actions include**

- a. *Strengthen regional and national ownership and governance* to ensure a coordinated, coherent, cohesive, mutually accountable, effective and equitable multisectoral HIV response with active participation of community-led organizations, within a horizontal cooperation framework.
- b. *Within the framework of the SDGs and the Universal Health Coverage, promote equitable access* to effective, innovative and quality combination HIV prevention that includes PrEP, treatment optimization and care services (including comprehensive TB programmes), with a focus on key populations and priority populations (including indigenous populations, migrants, adolescent and youth), through active civil society engagement and social contracting initiatives.
- c. *Promote the adoption and implementation of HIV-related policies that remove structural barriers* and have positive impacts on people's lives.
- d. *Promote the repeal of harmful laws and policies* that criminalize people living with, and most affected by HIV, including in the context of same-sex relations and sex work.
- e. *Promote the enactment of protective legislation*, including but not limited to antidiscrimination and gender identity laws.
- f. *Strengthen regional and national political, technical and financial commitment to the elimination of vertical transmission of HIV and syphilis* and ending paediatric AIDS within a sexual and reproductive health and rights framework.
- g. *Enable, empower and fully resource gender-sensitive, innovative community-led responses* for a transformative and sustainable HIV response that upholds and protects the human rights of all people living with, affected by or vulnerable to HIV, including social protection programmes, targeting key populations and priority populations.
- h. *Strengthen strategic HIV and sexually transmitted infections planning, monitoring, evaluation and accountability* at all levels through improved monitoring mechanisms and information systems with a focus on key populations and locations, and through increased collection of granular, disaggregated data that cover social enablers and service integration.
- i. *Commit to implement evidence-informed and human rights-based national responses*, with efficient allocation of domestic resources and sustainable financing. Empowered, enabled, and funded civil society and communities of people living with HIV and key populations are crucial to ensuring that no-one is left behind.



## Western and central Europe and North America

268. The region of West and central Europe and North America has reached the benchmark incidence prevalence ratio of 3.0%, with high levels of ART coverage (81% of people living with HIV) and viral suppression (67% of people living with HIV). However, progress is uneven across and within the countries included in this regional grouping. Service access and uptake is frequently lower for people who inject drugs, migrant populations and racial and ethnic minority groups, due to stigma at the community level, structural discrimination and barriers to accessing health insurance and services (often due to migration status and xenophobia). Treatment cascade outcomes lag in some countries, most notably the United States of America, home to the largest epidemic in the regional grouping, and in central Europe, where the increase in new HIV infections is associated with high rates of late diagnosis and low treatment coverage and viral suppression. HIV responses in central Europe face important challenges, including limited political commitment, human rights violations, and antipathy towards lesbian, gay, bisexual, transgender and intersex populations and other key populations.

269. There are important signs of AIDS leadership across this regional grouping. Plans to end AIDS as a public health threat have been put in place in France, Germany, the Netherlands, Sweden, Switzerland, the United Kingdom and the United States, and in major cities across the region. PrEP coverage has increased, due to a combination of cost reductions, increased insurance coverage, communication campaigns, and dedicated services provision in countries such as Belgium, France, the United Kingdom and the United States. The Netherlands has put in place strategies to facilitate the early detection of new HIV infections.

270. Follow-through on ending AIDS as a public health threat in this regional grouping can generate important lessons to accelerate success against COVID-19 and future pandemics. This can also serve as a bridge to an overarching health policy for West and central Europe and North America. Success in high-income countries can inspire confidence in the feasibility of transformative gains against the epidemic in other regions.

### 271. Priority actions include

- a. *Increase domestic financing* for HIV and build strong political commitment for ending AIDS as a public health threat.
- b. *Develop and implement national plans* to end the epidemic, aligned to UNAIDS global targets for 2025 and 2030, and strengthen collaboration across countries to address inequities, close gaps and review progress.
- c. *Improve testing strategies*, including for viral load, especially for countries that are working to cover the “last mile” towards ending their epidemic.
- d. *Expand HIV prevention services*, including PrEP and harm reduction.
- e. *Improve quality of life of people living with HIV by overcoming stigma and discrimination in health care services*, by integrating care for coinfections and comorbidities management and mental health, and by supporting community-based services that reach key populations and priority populations.
- f. *Provide universal access for all, including key populations and migrants, to stigma-free quality HIV prevention, treatment and care services*, regardless of legal or insurance status, and ensure retention in care to achieve viral load suppression.
- g. *Provide equal access to and the continuation of HIV prevention, treatment and care services for people in closed settings*, including prisons and detention centres, long-term care facilities, and refugee and migrant camps.

- h. *Remove legal, regulatory and financial barriers* to affordable and easily accessed HIV prevention, including needle-syringe services, diagnostics and treatment, and reduce high out-of-pocket expenditure for people on ART and for those using PrEP.
- i. *Remove punitive and discriminatory laws and policies* that affect the HIV response for LGBTI communities, sex workers, people who inject drugs, people living with HIV and migrants.
- j. *Increase community engagement and leadership in local responses*, including through the engagement and leadership of young people.
- k. *Improve the quality and timeliness of data collection, reporting and use* to improve programme outcomes, inform resource allocations to maximize the return on investment, and use data disaggregation to expose and address inequities
- l. *Increase investments in HIV research*, with particular attention to priority research on long-acting antiretrovirals, HIV vaccines and cure.

## CHAPTER 9: THE UNITED NATIONS JOINT PROGRAMME ON HIV/AIDS: SUPPORTING A WHOLE-OF-GOVERNMENT AND WHOLE-OF-SOCIETY RESPONSE TO DELIVER ON THE GLOBAL AIDS STRATEGY

272. While this Strategy, “End Inequalities. End AIDS. Global AIDS Strategy 2021-2026” is a global Strategy developed by UNAIDS in accordance with its mandate from ECOSOC, this chapter describes specific roles and focus of the Joint United Nations Programme on HIV/AIDS – Cosponsors and Secretariat, in leading the coordination efforts of the global HIV response.

273. UNAIDS provides support and leadership, strategic intelligence and convening capacity towards ending AIDS as a public health threat by 2030 and advances the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

274. A champion and forerunner of UN reform, UNAIDS unites the efforts of 11 UN agencies as Joint Programme Cosponsors (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank) and the UNAIDS Secretariat. UNAIDS' mandate, as laid out in its founding Economic and Social Council (ECOSOC) resolution,<sup>32</sup> remains as relevant and important today as when it was drafted.

275. UNAIDS' work is grounded in the 2030 Agenda. During this Decade of Action to deliver the Global Goals, UNAIDS supports global collective action, based on the values and norms of the UN in accordance with the three pillars of the UN Charter: human rights, peace and security, and development. The health and human rights of people living with, at risk of and affected by HIV, who often are left farthest behind and who face exclusion, inequality and instability, remain at the forefront of the Joint Programme's work. UNAIDS' inclusive governance structure is an embodiment of the whole-of-society

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<sup>32</sup> UNAIDS' objectives, as specified in the ECOSOC Resolution 1994/24, are to:

- a) provide global leadership in response to the epidemic;
- b) achieve and promote global consensus on policy and programmatic approaches;
- c) strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;
- d) strengthen the capacity of national Governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;
- e) promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions; and
- f) advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

response to HIV, bringing to the table the voices of the people who are most affected by HIV.

276. The innovative model of the Joint Programme enables a multisectoral response to the multidimensional nature of the global AIDS epidemic and in support of the SDGs.
277. The Joint Programme is an integral part of the implementation of the Global AIDS Strategy. Building on the achievements and lessons from 40 years of the HIV response, as well as its 25 years of experience, UNAIDS leverages its collective competencies, skills and contributions to strategically support countries and communities to attain the new, bold and ambitious targets and commitments of the Strategy, and to implement prioritized actions that place people at the centre and reduce the inequalities that drive the AIDS epidemic.
278. As its specific contribution to the implementation of the Strategy, and working across the three strategic priority areas, UNAIDS will apply an inequalities lens and support countries and communities to identify and reduce inequalities, HIV-related human rights violations, injustice and exclusion that stand in the way of achieving equitable outcomes for people living with, at risk of, and affected by HIV in every country and every community, with a particular focus on low- and middle-income countries. It will inspire and support vital innovations, including the development of an HIV vaccine or cure and practical improvements that emerge from communities most impacted by the epidemic.
279. To close the gaps, save lives and ensure equitable HIV responses, UNAIDS will build on its strengths and sharpen its actions particularly in three areas: leadership, global public goods, and countries and communities.

## Leadership

280. The Joint Programme will provide vision and strategic guidance, and unite the efforts of governments and civil society, communities, the private sector and other global, regional and national partners to drive transformative progress on HIV. The Joint Programme will:
- a. *build political will to recognize and reduce inequalities* that underlie current gaps and shortcomings of the HIV response, and leverage ongoing learning from these efforts to understand and broadly apply what works;
  - b. *work with governments, communities and other partners* to translate political will into people-centred targets, investment and implementation, and inclusive governance platforms;
  - c. *foster and expand partnerships with the Global Fund, PEPFAR and other bilateral and multilateral partners* for collective leadership and alignment of actions and resources that can advance equitable policies and programmes and tailored responses that reach those furthest behind first;
  - d. *bolster the UNAIDS financing agenda* to drive visionary leadership towards equitable financing for HIV and health;
  - e. *serve as a trailblazer for transforming financing for health and development*, by pioneering and championing approaches that increase country ownership and empower communities;
  - f. *develop and enhance alliances with movements within and beyond HIV response*, building synergies to advance Universal Health Coverage, promoting human rights and gender equality, advancing equitable financing, and promoting sustainable development to reduce inequalities and inequities in the HIV response;
  - g. *contribute to the future architecture of global health* in the post-COVID era; and

- h. *Provide the UN system with a useful example of strategic coherence, reflecting national contexts and priorities, through its coordination, results-based focus, inclusive governance and country-level impact*

### **Global public goods**

281. The Joint Programme will provide leadership and accelerate action to create and ensure equitable distribution of global public goods critical for ending AIDS as a public health threat in the context of integrated SDG agenda. The Joint Programme will:

- a. *develop and support the implementation of normative guidance to drive transformative action to reduce inequalities* and ensure that all people living with and affected by HIV, as well as key populations and priority populations, including children and young people, and adolescent girls and young women are empowered and access affordable, high-quality, gender-responsive HIV and other services that are evidence- and rights-based;
- b. *advance inclusion to ensure whole-of-society responses* and assert the leadership of communities;
- c. *lead the world's most extensive data collection on the status of the AIDS epidemic, response and financing*, and publish authoritative and up-to-date strategic information and analyses to monitor progress and track gaps (including through more systematic community-led monitoring), and to strengthen the relevance of interventions and evidence for informed, impactful global, regional, national and local responses;
- d. *provide thought leadership and facilitate knowledge sharing* and of leveraging science, technology and innovation for impactful, cost-effective, inclusive and sustainable programming;
- e. *leverage partnerships to build financial capacity to access to unaffordable technologies and support under-financed public systems for health*, and to ensure the sustainability of inclusive, equitable, rights-based responses, with special attention on collaboration with the Global Fund, PEPFAR, Unitaid, the Stop TB Partnership, Gavi (the Vaccine Alliance) and the Medicines Patent Pool; and
- f. *explore alternative mechanisms to incentivize innovation within the health sector*, ensuring coordination and sustainable financing of research and development of health technologies, promoting access to innovation for all, and advance analyses on the patent landscape of HIV-related products and health technologies.

### **Countries and communities**

282. The Joint Programme will support countries and communities to use an inequalities lens to identify people who are still being left behind and to urgently reduce the inequalities, inequities and exclusion experienced by key populations, adolescent girls and young women, children and young people, and people in humanitarian or other extreme circumstances in the context of HIV. The Joint Programme will:

- a. *mobilize and support inclusive country leadership for equitable, sustainable HIV responses* that are integral to and integrated with national health and development efforts;
- b. *provide expertise and enhance capacity to generate, interrogate and utilize strategic information* to recognize and reduce HIV-related inequalities, and guide and support prioritization of programming and tailored service delivery, with a particular emphasis on reaching first the people who are furthest behind;

- c. *support countries and communities to develop, resource and implement inclusive, evidence-informed, people-centred, rights-based and gender-responsive strategies and plans;*
- d. *enhance technical capacity* to recognize the gaps and implement impactful, innovative approaches and tailored models of care that work also for people who are currently excluded and under-served;
- e. *convene, assert leadership and build capacity of communities to engage effectively in decision-making and implementation* of HIV responses and enhance community-led responses, championing the meaningful involvement of people living with HIV;
- f. *support countries to identify and prioritize national legal, regulatory and policy changes* that will have significant positive impact on HIV responses;
- g. *build on its partnerships with the Global Fund, PEPFAR and other health and development partners* to influence and ensure that resources are targeted where they address the most urgent gaps and inequalities, and deliver the greatest impact in the long-term, building national financial capacity and strengthening national systems to sustainably deliver effective, resilient, inclusive and equitable HIV responses that reduce inequalities and deliver transformative progress towards ending AIDS; and
- h. *demonstrate leadership in the UN Sustainable Development Cooperation Frameworks*, including through UNDP's integrator function, supporting UN Resident Coordinators and UN Country Teams on HIV and related issues, and contributing to the collective UN effort to support national SDG agendas.

### **Tackling inequalities in the work of the Joint Programme:**

283. Using the Strategy's inequality framework, UNAIDS will bring those elements together to strengthen and leverage its capacity to partner with governments and communities in order to reduce the inequalities driving the AIDS epidemic across all the strategic priorities and result areas of the Strategy.

284. With an urgent focus on mobilizing and enhancing expertise and resources at the country-level, UNAIDS will ensure it has the following capacities:

- a. **Using strategic information to identify the inequalities driving epidemic.** Knowing who we need to reach next to achieve impact, with a focus on those most in need, will require enhanced data systems and analysis that shifts from averages to specifics, and from aggregates to gaps. UNAIDS will support countries and communities to develop robust and sustainable information and surveillance systems that provide the required information and data in a timely and meaningful manner. Through the field and virtual presence of the Joint Programme, HIV programme managers will be encouraged to use data to transform their response and close the gaps leading to inequalities. UNAIDS will continue to compile data through the Global AIDS Monitoring reporting system and HIV estimates.
- b. **Convening and building political will to reduce inequalities.** Reducing inequalities requires UNAIDS to mobilize political will to advance bold, cross-sectoral action, with commitments and mobilization from governments, civil society, affected communities, faith-based organizations, the private sector and other sectors.
- c. **Providing technical capacity to reduce inequalities and support transformative HIV priority actions.** To support the shifts toward transformative, evidence-based prevention, accessible models of testing, treatment and care, and laws and policies that reduce inequalities and advance progress to ending AIDS, UNAIDS will ensure technical capacity is available to support planning and implementation and to enhance the efficiency and impact of HIV funding.

- d. **Identifying priorities for enhancing legal and policy environments to reduce HIV inequalities.** From revising clinical guidelines to regulations on HIV prevention technologies to punitive laws, UNAIDS will support enhancing laws and policies to reduce HIV-related inequalities.
- e. **Strengthening UNAIDS' contribution to capacity in the area of economics and financing to eliminate trade-offs that fuel HIV-related inequalities.** The need for sufficient funding and fiscal space to implement this Strategy requires UNAIDS to support the mobilization of full domestic and international funding for the HIV response, to work to make products and services more affordable and effective, to promote the removal of burdensome debt payments and to enhance the fiscal space needed to implement the Strategy.

### **Supporting the implementation of the Global AIDS Strategy**

285. To support the implementation of the Global AIDS Strategy, the Joint Programme will review and take steps to ensure that its operating model (i.e. its geographic and programmatic footprint, capacities and ways of working, resource mobilization Strategy, resource allocation principles and mechanisms, and results and accountability frameworks) remains aligned with the focus and priorities of the Strategy.
286. UNAIDS will translate the Strategy's three strategic priorities and its 10 result areas into a new UNAIDS Budget, Results and Accountability Framework (UBRAF). Evidence reviews and a detailed theory of change will highlight the areas where the Joint Programme's engagement is of critical importance and will inform prioritization of the UNAIDS' contributions and results for the UBRAF.
287. The new UBRAF will align with the global response targets to deliver prioritized UNAIDS support and articulate the collective role of UNAIDS, as well as the specific contributions of individual Cosponsors and the UNAIDS Secretariat in the implementation of the Strategy at global, regional and country levels. The updated monitoring and evaluation framework of the UBRAF will capture the Joint Programme's collective and entities' individual contributions towards global, regional and country-level progress in reducing inequalities, achieving the targets and closing the response gaps. The UBRAF will demonstrate the priorities for different funding levels and highlight different funding scenarios.
288. To deliver on the commitments reflected in the UBRAF, UNAIDS will strategically prioritize its programmatic focus and geographic footprint, based on a set of specific criteria that reflect the epidemic trends, persistent response gaps and inequalities, political and socioeconomic contexts, and capacities and needs in communities and countries, as well as the Joint Programme's global leadership role.
289. The UNAIDS Joint Programme will ensure it has a workforce with the right skills, performing the right functions, in the right locations, and which is enabled to deliver the best support to countries to achieve their goals. The UBRAF will guide the deployment of staff for the greatest impact on inequalities and on improving the health and well-being of people living with, at risk of or affected by HIV. Implementation of diversified support modalities and scale-up of virtual assistance will ensure flexibility and timely adjustment of programmatic and geographic focus, for the maximum impact and results for people.
290. The UNAIDS resource mobilization Strategy will align with the Joint Programme's priorities and commitments, to ensure funding is mobilized and allocated to deliver on the specific country-level, regional and global commitments and results.

291. UNAIDS will advance its joint work and collaborative action at country, regional and global levels with greater cohesion across all levels. Within their mandates, Cosponsors will further adapt to provide needs-based, demand-driven support to reduce the specific inequalities and gaps in the HIV response. The UNAIDS Division of Labour will be updated as needed to reflect the evolving contexts and demands. The UNAIDS Cosponsorship principles will guide the Cosponsoring agencies' engagement in supporting the implementation of the Global AIDS Strategy. The 2020 Quadrennial Comprehensive Policy Review will guide UNAIDS' activities for development and support to countries in the context of the UN Development System repositioning and efforts to work in an effective and impactful way across development, peace, humanitarian affairs and human rights.
292. The Joint Programme's accountability rests within the global HIV response and the UNAIDS PCB. UNAIDS will measure its performance, contributions and results against the progress towards achievement of the national, regional and global commitments and targets. It will also provide analysis of where adjustments are required in the responses of other actors and sectors. The extent to which, within the next five years, inequalities are reduced and response gaps are closed within countries and communities will serve as the ultimate measure of the Joint Programme's success.

[Annexes follow]

## ANNEXES

### Annex 1. Disaggregated 2025 targets and commitments

For the past 20 years, the HIV response has relied on concrete, time-bound targets to drive progress in addressing AIDS. With the aim of ensuring accountability and transparency in the response and of uniting diverse stakeholders around the shared goal of ending AIDS by 2030, the new Strategy outlines a series of new targets and commitment for 2025 to get the HIV response on-track to achieve the 2030 SDG target of ending AIDS as a public health threat. In addition to broad global targets, the Strategy demands achievement of ambitious targets in all populations and settings.

To develop the targets for 2025, UNAIDS worked with partners to review available evidence, including modelling to ascertain the specific actions needed to make the 2030 goal possible. As in prior target-setting exercises, this latest process used an investment framework to identify the level and allocation of resources required for achievement of the targets.

A series of technical consultations with experts and stakeholders was held across different domains of the response. These consultations reviewed evidence and determined what is currently working and needs to be continued, what is not working and needs to be changed, and which key gaps in the response need to be addressed. A team of epidemiological modelling experts was assembled to project the impact of various approaches and combinations of services.

#### ***95% of people at risk of HIV infection use appropriate, prioritized, person-centred and effective combination prevention options***

Intervention	Sex workers	Gay men and other men who have sex with men	People who inject drugs	Transgender people	Prisoners and others in closed settings
Condoms/lube use at last sex by people not taking PrEP and who have a nonregular partner whose HIV viral load status is not known to be undetectable (includes people who are known to be HIV-negative)	--	95%	95%	95%	--
Condom/lube use at last sex with a client or nonregular partner	90%	--	--	--	90%



PrEP use (by risk category)					
<i>Very high</i>	80%	50%	15%	50%	15%
<i>High</i>	15%	15%	5%	15%	5%
<i>Moderate and low</i>	0%	0%	0%	0%	0%
Sterile needles and syringes	--	--	90%	--	90%
Opioid substitution therapy among people who are opioid dependent	--	--	50%	--	--
STI screening and treatment	80%	80%	--	80%	--
Regular access to appropriate health system or community-led services	90%	90%	90%	90%	100%
Access to post-exposure prophylaxis (PEP) as part of package of risk assessment and support	90%	90%	90%	90%	90%

Intervention		Proposed benchmarks by stratum or geography		
	Risk by prioritization stratum	Very high	Moderate	Low
<b>All ages and genders</b>	Condoms/lube used at last sex by people not taking PrEP and who have a nonregular partner whose HIV viral load status is not known to be undetectable (includes those who are known to be HIV-negative)	95%	70%	50%
	PrEP use (by risk category)	50%	5%	0%
	STI screening and treatment	80%	10%	10%
<b>Adolescents and young people</b>	Comprehensive sexuality education in schools, in line with UN international technical guidance	90%	90%	90%

Strata based on geography alone		Very high (>3%)	High (1-3%)	Moderate (0.3-1%)	Low (<0.3%)
All ages and genders	Access to PEP (nonoccupational exposure) as part of package of risk assessment and support	90%	50%	5%	0%
	Access to PEP (nosocomial) as part of package of risk assessment and support	90%	80%	70%	50%
Adolescent girls and young women	Economic empowerment	20%	20%	0%	0%
Adolescent boys and men	Voluntary medical male circumcision	90% in 15 priority countries			
People within serodiscordant partnerships	Condoms/lubricant use at last sex by those not taking PrEP and who have a nonregular partner whose HIV viral load status is not known	95%			
	PrEP until HIV-positive partner has suppressed viral load	30%			
	PEP	100% after high-risk exposure			

Thresholds for the prioritization of HIV prevention methods

	Criterion	Very high	High	Moderate and low
Sex workers	National adult (15-49 years) HIV prevalence	>3%	>0.3%	<0.3%
Prisoners	National adult (15-49 years) HIV prevalence	>10%	>1%	<1%
Gay men and other men who have sex with men	UNAIDS analysis by country/region	Proportion of populations estimated to have incidence >3%	Proportion of populations estimated to have incidence 0.3-3%	Proportion of populations estimated to have incidence <0.3%
Transgender people	Mirrors gay men and other men who have sex with men (in absence of data)	Proportion of populations estimated to have incidence >3%	Proportion of populations estimated to have incidence 0.3-3%	Proportion of populations estimated to have incidence <0.3%

<b>People who inject drugs</b>	UNAIDS analysis by country/region	Low needle–syringe programme and opioid substitution therapy coverage	Some needle–syringe programme; some opioid substitution therapy	High needle–syringe programme coverage with adequate needles and syringes per person who injects drugs; opioid substitution therapy available	
	<b>Criterion</b>	<b>High and very high</b>		<b>Moderate</b>	<b>Low</b>
<b>Adolescent girls and young women</b>	Combination of [national or subnational incidence in women 15–24 years] AND [reported behaviour from DHS or other (>2 partners; or reported STI in previous 12 months)]	1–3% incidence AND high-risk reported behaviour	>3% incidence	0.3–<1% incidence and high-risk reported behaviour OR 1–3% incidence and low-risk reported behaviour	<0.3% incidence OR 0.3–<1% incidence and low-risk reported behaviour
<b>Adolescent boys and young men</b>	Combination of [national or subnational incidence in men 15–24 years] AND [reported behaviour from DHS or other (>2 partners; or reported STI in previous 12 months)]	1–3% incidence AND high-risk reported behaviour	>3% incidence	0.3–<1% incidence and high-risk reported behaviour OR 1–3% incidence and low-risk reported behaviour	<0.3% incidence OR 0.3–<1% incidence and low-risk reported behaviour
<b>Adults (aged 25 and older)</b>	Combination of [national or subnational incidence in adults 25–49 years] AND [reported behaviour from DHS or other (>2 partners; or reported STI in previous 12 months)]	1–3% incidence AND high-risk reported behaviour	>3% incidence	0.3–<1% incidence and high-risk reported behaviour OR 1–3% incidence and low-risk reported behaviour	<0.3% incidence OR 0.3–<1% incidence and low-risk reported behaviour
<b>Serodiscordant partnerships</b>	Estimated number of HIV-negative regular partners of someone newly starting on treatment	Risk stratification depends on choices within the partnership: choice of timing and regimen of antiretroviral therapy for the HIV-positive partner; choice of behavioural patterns (condoms, frequency of sex); choice of PrEP			

**95% of women of reproductive age have their HIV and sexual and reproductive health service needs met**

<b>Women of reproductive age in high HIV prevalence settings, within key populations and living with HIV</b>	95% have their HIV prevention and sexual and reproductive health service needs met
<b>Pregnant and breastfeeding women</b>	95% of pregnant women are tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible. In settings with high HIV burdens, pregnant and breastfeeding women with unknown HIV status or who previously tested HIV-negative should be retested during late pregnancy (third trimester) and in the post-partum period.

***95% of pregnant and breastfeeding women living with HIV have suppressed viral loads***

<b>Pregnant and breastfeeding women living with HIV</b>	90% of women living with HIV on antiretroviral therapy before their current pregnancy
	All pregnant women living with HIV are diagnosed and on antiretroviral therapy, and 95% achieve viral suppression before delivery
	All breastfeeding women living with HIV are diagnosed and on antiretroviral therapy, and 95% achieve viral suppression (to be measured at 6–12 months)

***95% of HIV-exposed children are tested at two months and after the cessation of breastfeeding***

<b>Children (aged 0–14 years)</b>	95% of HIV-exposed infants receive a virologic test and parents are provided with the results by age 2 months
	95% of HIV-exposed infants receive a virologic test and parents are provided with the results after cessation of breastfeeding
	95–95–95 testing and treatment targets achieved among children living with HIV

***95–95–95 testing and treatment targets achieved within all subpopulations and age groups***

95% of people within the subpopulation who are living with HIV know their HIV status
95% of people within the subpopulation who are living with HIV and know their HIV status are on antiretroviral therapy
95% of people within the subpopulation who are on antiretroviral therapy have suppressed viral loads

***90% 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 and gender-based violence, mental health and other services they need for their overall health and well-being***

<b>People living with HIV</b>	90% of patients entering care through HIV or TB services are referred for TB and HIV testing and treatment at one integrated, co-located or linked facility, depending on the national protocol
	90% of people living with HIV receive TB preventive treatment

	90% have access to integrated or linked services for HIV treatment and cardiovascular diseases, cervical cancer, mental health, diabetes diagnosis and treatment, education on healthy lifestyle counselling, smoking cessation advice and physical exercise
<b>Children (0–14 years)</b>	95% of HIV-exposed newborns and infants have access to integrated services for maternal and newborn care, including prevention of the triple vertical transmission of HIV, syphilis and hepatitis B virus
<b>Adolescent boys and young men (15–24 years)</b>	90% of adolescent boys and men (aged 15–59 years) have access to voluntary medical male circumcision integrated with a minimum package of services <a href="#">[1]</a> and multidisease screening <a href="#">[2]</a> within male-friendly health-care service delivery in 15 priority countries
<b>Adult men (25+)</b>	
<b>School-aged young girls (9–14 years)</b>	90% of school-aged young girls in priority countries have access to HPV vaccination, as well as female genital schistosomiasis ( <i>S. haematobium</i> ) screening and/or treatment in areas where it is endemic <a href="#">[3]</a>
<b>Adolescent girls and young women (15–24 years)</b>	90% have access to sexual and reproductive health services that integrate HIV prevention, testing and treatment services. These integrated services can include, as appropriate to meet the health needs of local population, HPV, cervical cancer and STI screening and treat, female genital schistosomiasis ( <i>S. haematobium</i> ) screening and/or treatment, intimate partner violence (IPV) programmes, sexual and gender-based violence (SGBV) programmes that include post-exposure prophylaxis (PEP), emergency contraception and psychological first aid. <a href="#">[4]</a>
<b>Adult women (25+ years)</b>	
<b>Pregnant and breastfeeding women</b>	95% have access to maternal and newborn care that integrates or links to comprehensive HIV services, including for prevention of the triple vertical transmission of HIV, syphilis and hepatitis B virus
<b>Gay men and other men who have sex with men</b>	90% have access to HIV services integrated with (or linked to) STI, mental health and IPV programmes, SGBV programmes that include PEP and psychological first aid
<b>Sex workers</b>	90% have access to HIV services integrated with (or linked to) STI, mental health and IPV programmes, SGBV programmes that include PEP and psychological first aid
<b>Transgender people</b>	90% of transgender people have access to HIV services integrated with or linked to STI, mental health, gender-affirming therapy, IPV programmes, and SGBV programmes that include PEP, emergency contraception and psychological first aid
<b>People who inject drugs</b>	90% have access to comprehensive harm reduction services integrating or linked to hepatitis C, HIV and mental health services
<b>People in prisons and other closed settings</b>	90% have access to integrated TB, hepatitis C and HIV services
<b>People on the move (migrants, refugees, those in humanitarian settings, etc.)</b>	90% have access to integrated TB, hepatitis C and HIV services, in addition to IPV programmes, SGBV programmes that include PEP, emergency contraception and psychological first aid. These integrated services should be person-centred and tailored to the humanitarian context, the place of settling and place of origin.

***Less than 10% of countries have punitive legal and policy environments that deny or limit access to services***

Less than 10% of countries criminalize sex work, possession of small amounts of drugs, same-sex sexual behaviour, and HIV transmission, exposure or nondisclosure by 2025

Less than 10% of countries lack mechanisms for people living with HIV and key populations to report abuse and discrimination and seek redress by 2025

Less than 10% of people living with HIV and key populations lack access to legal services by 2025

More than 90% of people living with HIV who experienced rights abuses have sought redress by 2025

***Less than 10% of people living with HIV and key populations experience stigma and discrimination***

Less than 10% of people living with HIV report internalized stigma by 2025

Less than 10% of people living with HIV report experiencing stigma and discrimination in health care and community settings by 2025

Less than 10% of key populations (i.e., gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs) report experiencing stigma and discrimination by 2025

Less than 10% of the general population reports discriminatory attitudes towards people living with HIV by 2025

Less than 10% of health workers report negative attitudes towards people living with HIV by 2025

Less than 10% of health workers report negative attitudes towards key populations by 2025

Less than 10% of law enforcement officers report negative attitudes towards key populations by 2025

***Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence***

Less than 10% of women and girls experience physical or sexual violence from an intimate partner by 2025

Less than 10% of key populations (i.e., gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs) experience physical or sexual violence by 2025

Less than 10% of people living with HIV experience physical or sexual violence by 2025

Less than 10% of people support inequitable gender norms by 2025

Greater than 90% of HIV services are gender-responsive by 2025

***Achieve SDG targets critical to the HIV response (i.e., 1, 2, 3, 4, 5, 8, 10, 11, 16 and 17) by 2030***

- [1] The minimum package of services delivered along with voluntary medical male circumcision includes safer sex education, condom promotion, the offer of HIV testing services and management of STIs.
- [2] Additional services such as diabetes, hypertension and/or TB screening, and malaria management. To be adjusted depending on the location.
- [3] Low- and middle-income countries with HPV and HIV coinfections.
- [4] For all subpopulations, PEP includes HIV testing and risk exposure assessment.

## Annex 2: Complementary targets produced during the Global AIDS Strategy development process

As part of the Global AIDS Strategy development process a comprehensive evidence review and consultations were undertaken to identify critical gaps and priority actions needed to get the HIV response on track to end AIDS as public health threat by 2030. Stakeholders identified additional targets in addition to the 2025 targets around the following areas: people-centred, integrated services; Covid-19 and future pandemics; and community-led responses.

### 90% of people living with HIV and people at risk are linked to people-centred and context-specific integrated services they need for overall health and well-being

People living with HIV	Reduce by 80% (from 2010 baseline) TB deaths among people living with HIV
Children (aged 0–14 years)	75% of all children living with HIV have suppressed viral loads by 2023 (interim target).
People on the move (migrants, refugees, those in humanitarian settings, etc.)	95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options. 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options.* 90% of people in humanitarian settings have access to integrated TB, hepatitis C and HIV services, in addition to programmes to address gender-based violence, including intimate-partner violence, that include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.
People living with, at risk of and affected by HIV	45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.
Covid-19 and other Global Pandemics	95% of people living with, at risk of and affected by HIV are better protected from health emergencies and pandemics including COVID-19.

**Commit to providing community-led responses with the resources and support they need to fulfil their role and potential as key partners in the HIV response**

30% of testing and treatment services to be delivered by community-led organizations, with focus on: enhanced access to testing, linkage to treatment, adherence and retention support, treatment literacy, and components of differentiated service delivery, e.g. distribution of ARV (antiretroviral treatments)<sup>33</sup>

80% of service delivery for HIV prevention programmes for key populations to be delivered by community-led organizations<sup>34</sup>

80% services for women, including prevention services for women at increased risk to acquire HIV, as well as programmes and services for access to HIV testing, linkage to treatment (ART), adherence and retention support, reduction/elimination of violence against women, reduction/elimination of HIV related stigma and discrimination among women, legal literacy and legal services specific for women-related issues, to be delivered by community-led organizations that are women-led.

60% of the programmes supporting the achievement of societal enablers, including programmes to reduce/eliminate HIV-related stigma and discrimination, advocacy to promote enabling legal environments, programmes for legal literacy and linkages to legal support, and reduction/elimination of gender-based violence, to be delivered by community-led organizations.

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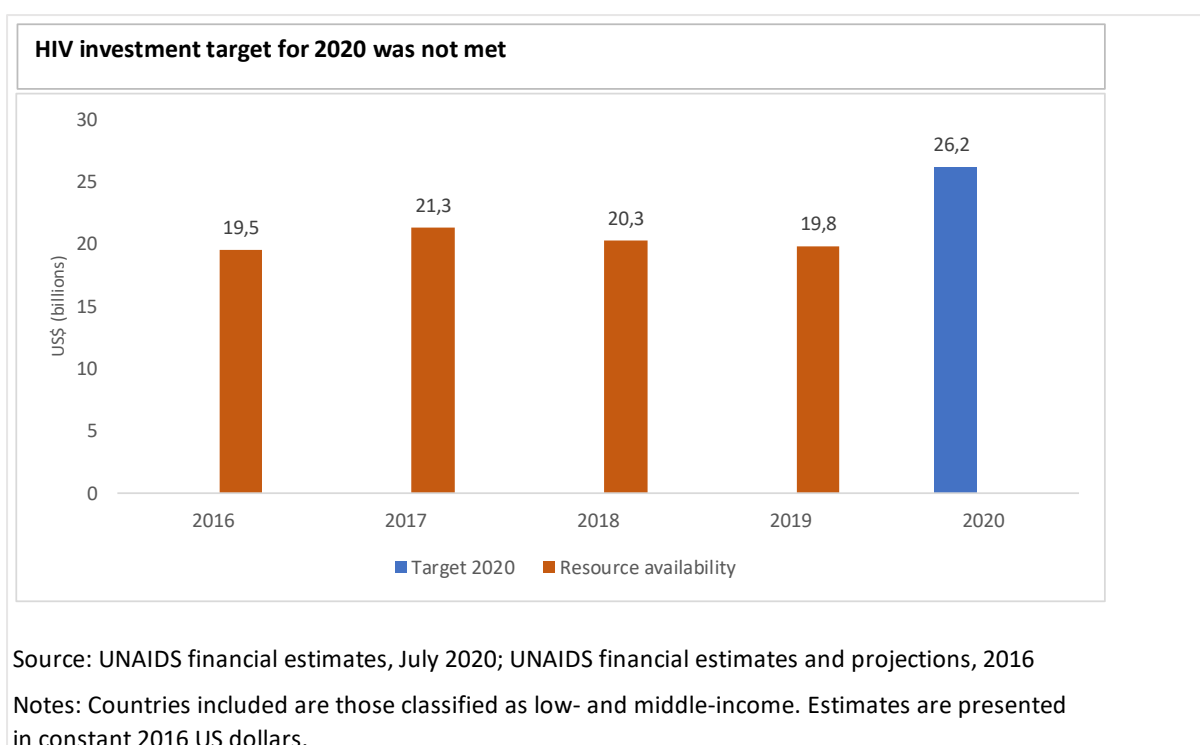
<sup>33</sup> With focus on enhanced access to HIV testing, linkage to treatment, adherence and retention support, treatment literacy, and components of differentiated service delivery, e.g. distribution of ARV (antiretroviral treatments).

<sup>34</sup> For an organization to be considered community-led, the majority (at least fifty percent plus 1) of governance, leadership, and staff comes from the community being served.



### Annex 3. Resource needs

In 2016, UN Member States committed to reach US\$ 26 billion by 2020 in annual investment in the HIV response by 2020 in low- and middle-income countries. Every year, HIV resources have fallen far short of these global targets. Increases in resources in these countries peaked in 2017, and started decreasing since 2018. The annual funding gap has continued to widen, with only US\$ 19.8 billion (in constant 2016 US dollars) available in 2019 (76% of the 2020 target). If the resource and programmatic targets had been met by 2020, overall resource needs for the global HIV response would have peaked in 2020, and then decreased to US\$ 25.6 billion in 2025 and US\$ 23.9 billion in 2030. However, the cost of investing too little, too late is reflected in new, larger resource needs to reach the new targets and commitments by 2025 and end AIDS by 2030.

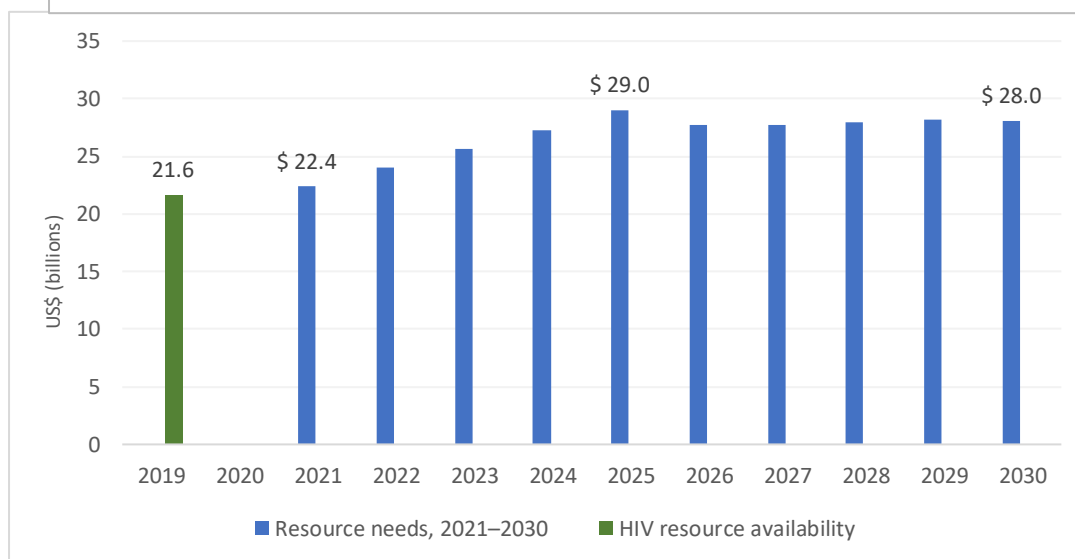


Chronic under-investment in the global HIV response has translated into millions of additional new HIV infections and AIDS-related deaths. This accounts for the increase in the global cost of reaching the targets and commitments in the Strategy to US\$ 29 billion in 2025 and the future annual cost of ending AIDS in low- and middle-income countries of US\$ 28 billion (in constant 2019 dollars) in 2030.

The lack of sufficient resources for HIV by 2020 has moved the peak of resource needs from 2020 to 2025. However, the long-term increase in resource needs can be halted by ensuring that all future investments in HIV are done through the optimized allocation of efficient services, with more ambitious programmatic targets and meaningful progress on societal enablers.

By contrast, if the resource needs in the Strategy are not fully and efficiently allocated, the long-term costs of ending AIDS will continue to increase.

**HIV estimated expenditures, 2019, and resource needs estimates in low- and middle-income countries, 2021–2030**

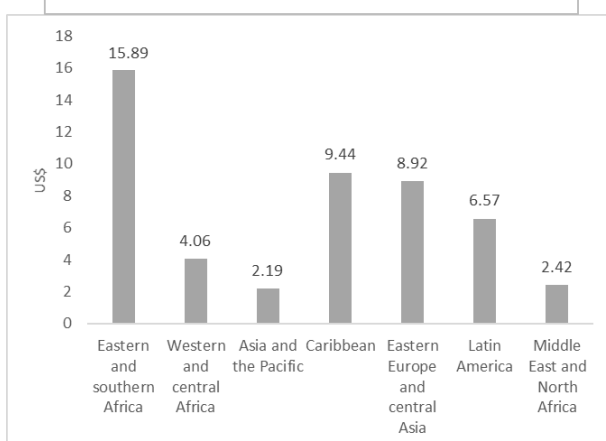


Source: UNAIDS financial estimates and projections, 2020 and 2021

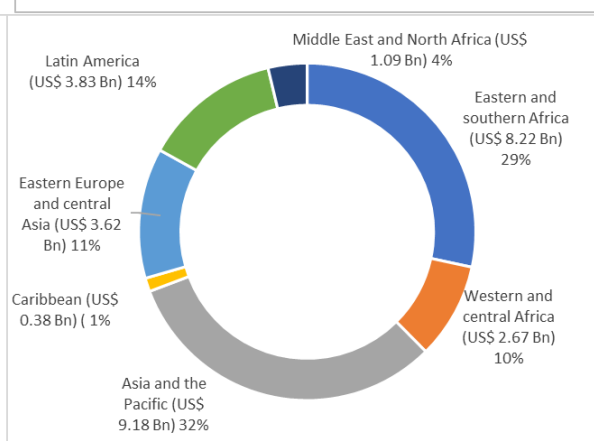
Notes: The estimated expenditures and the resource needs projections include countries recently classified as upper middle-income countries which were previously classified as high income. Estimates are presented in constant 2019 US dollars.

Compared to other regions, the high prevalence of HIV in eastern and southern Africa accounts for the high per capita resource needs (US\$ 15.8) in that region. In the Caribbean, Latin America and in eastern Europe and central Asia, higher unit costs for HIV services account for relatively high per-capita resource needs. Asia and the Pacific has the lowest per-capita resource needs, but the region’s large population (in particular in China and India) result in 32% of total resource needs in the Strategy.

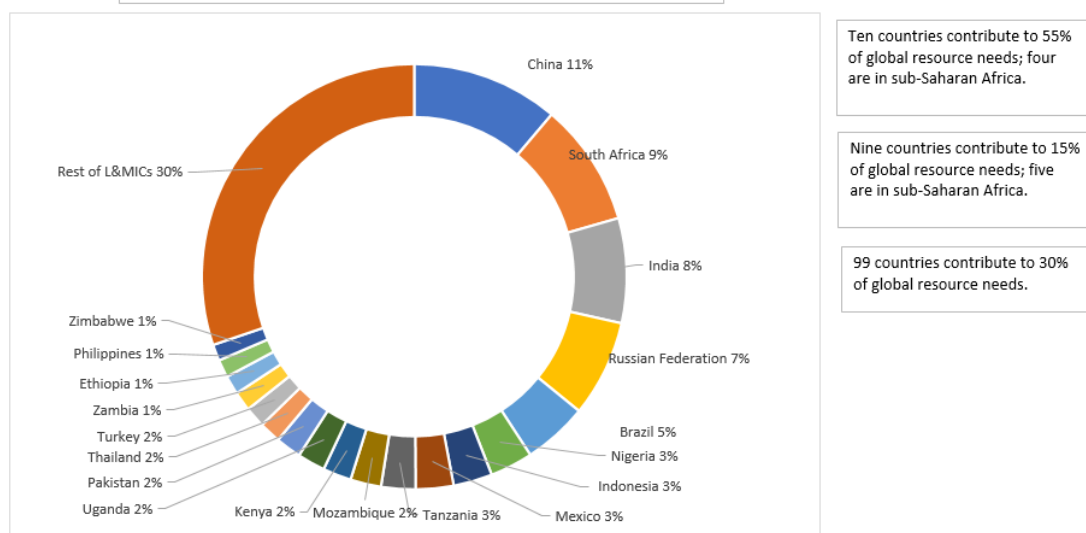
**Resource needs of low- and middle-income countries, per capita, by regions, 2025**



**Resource needs of low- and middle-income countries, by regions, 2025**



Share of global HIV resource needs in low and middle income countries by



Ten countries contribute to 55% of global resource needs; four are in sub-Saharan Africa.

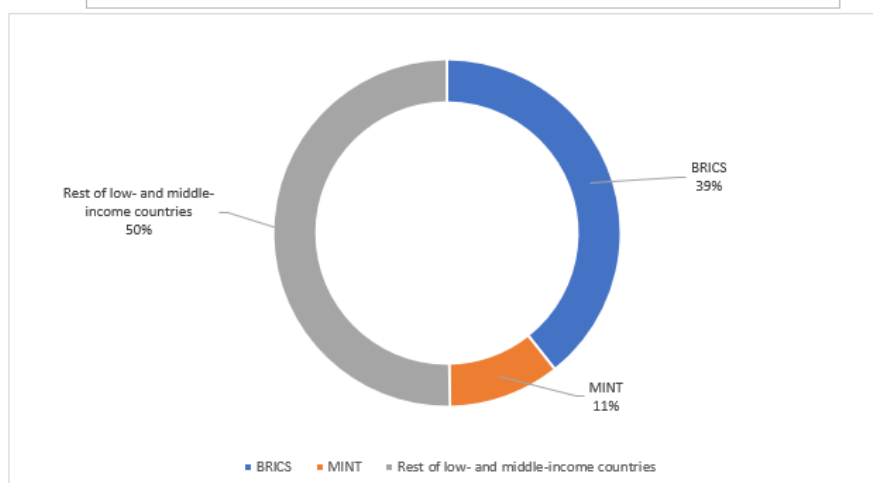
Nine countries contribute to 15% of global resource needs; five are in sub-Saharan Africa.

99 countries contribute to 30% of global resource needs.

Source: UNAIDS financial estimates and projections, resource needs modeling, 2021.

Ten countries account for more than half (55%) of total resource needs in low- and middle-income countries. The countries accounting for half of the needs include 4 countries in sub-Saharan Africa (Mozambique, Nigeria, Tanzania and South Africa), 6 upper-middle-income countries (Brazil, China, Indonesia, Mexico, Russian Federation and South Africa), and 7 of the 10 of the world’s most populous countries.

Percentage of the total HIV resource needs estimates by economic groupings of low- and middle-income countries, 2025

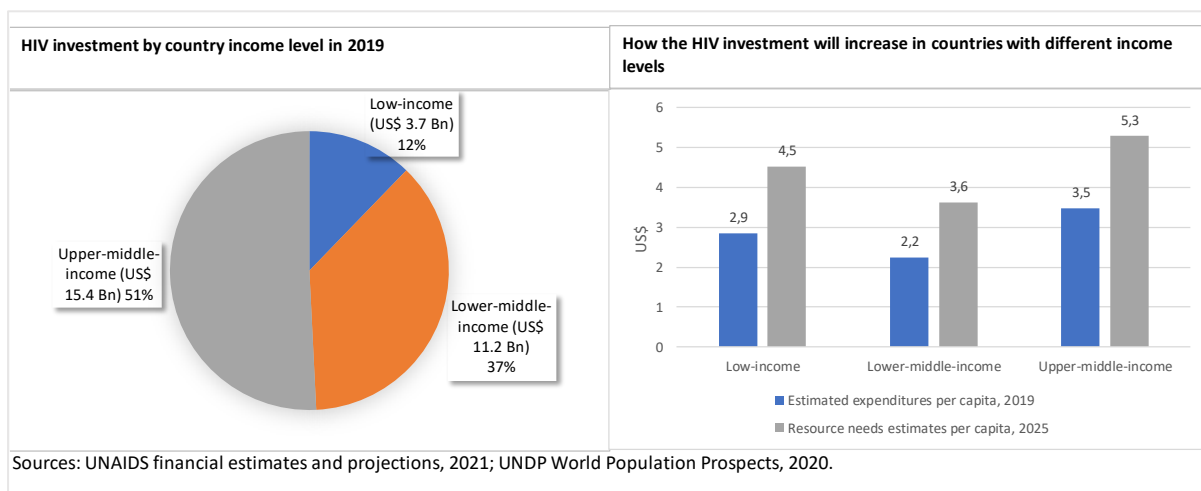


Source: UNAIDS financial estimates and projections, 2021.

Note: BRICS grouping includes Brazil, Russian Federation, India, China and South Africa; MINT grouping includes Mexico, Indonesia, Nigeria and Turkey.

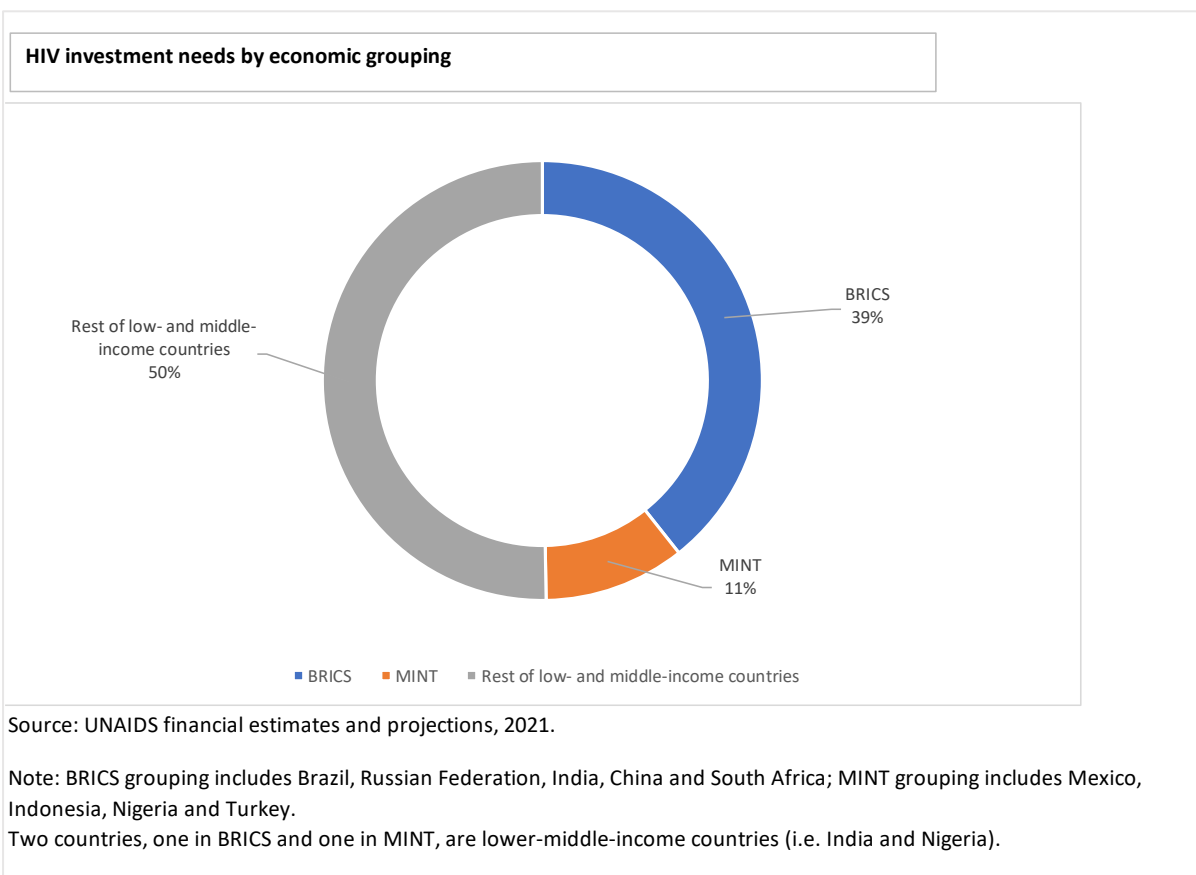
Two countries, one in BRICS and one in MINT, are lower-middle-income countries (i.e. India and Nigeria).

An additional 9 countries ranking below those 10 countries, account for 15% of the resource needs (including 5 in sub-Saharan Africa), while the remaining 99 other countries account for the 30% of total resource needs.

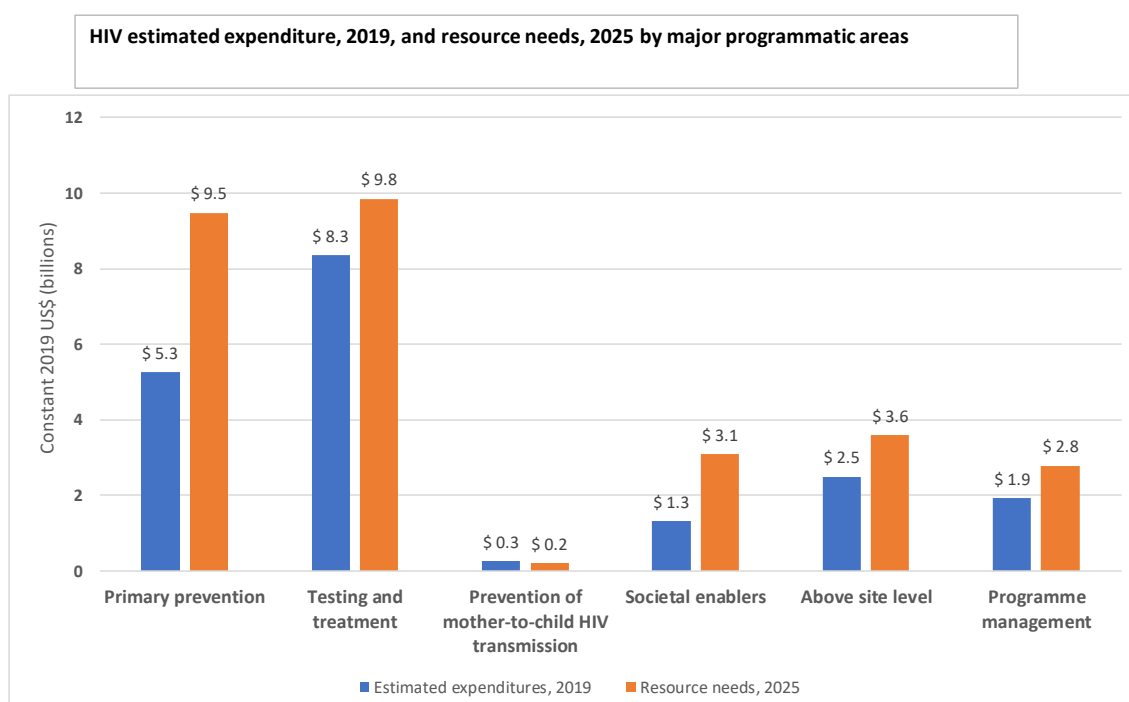


Upper-middle-income countries account for 53% of the total resource needs in the Strategy. The large proportion of resource needs in upper-middle-income countries reflects their higher unit costs, including higher human resource costs and costs of health technologies, including medication).

The largest per-capita gaps between estimated expenditures in 2019 and the 2025 resources needs are in upper-middle-income countries and low-income countries. Closing the resource gaps in upper-middle-income countries and lower-middle-income countries should primarily come from additional domestic resource allocations, with only some exceptions for high-burden countries that will continue to need significant international resources in order to meet the targets and commitments in the Strategy. By contrast, the majority of low-income countries require additional external support to close their resource gaps and meet the targets and commitments in the Strategy.



Key geopolitical groupings of emerging economies—specifically, the BRICS (Brazil, Russian Federation, India, China and South Africa) represent 41% and three countries from the MINT group (Mexico, Indonesia, and Nigeria) represent 9% of total resource needs in the Strategy, respectively. The majority of BRICS and MINT countries are already upper-middle-income, with the exceptions of India and Nigeria, which are classified as lower-middle-income countries.

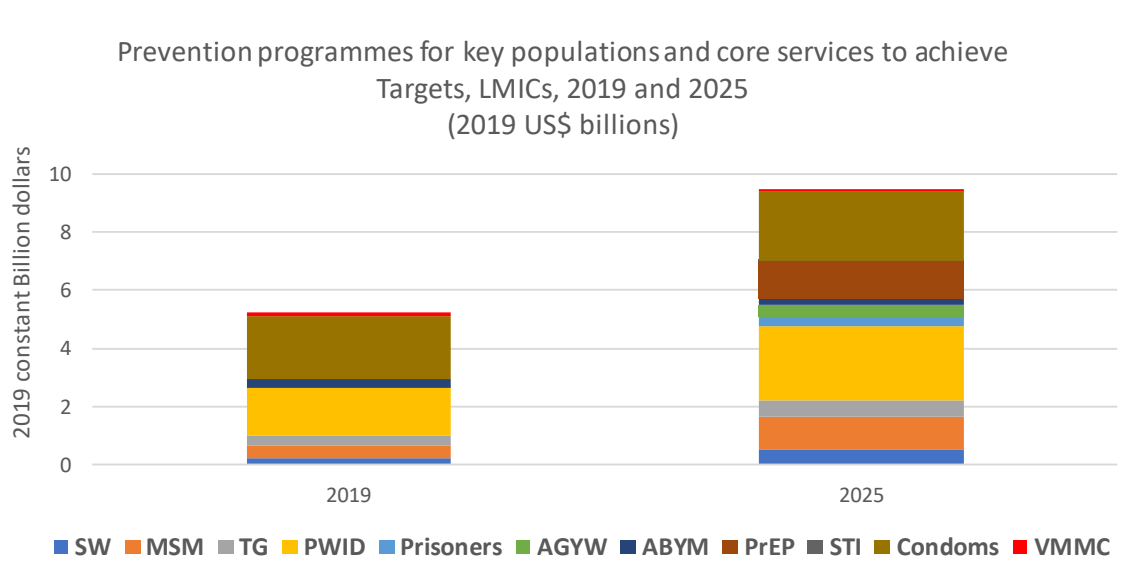


Source: UNAIDS financial estimates and projections, 2021.  
Note: The resource estimates are presented in constant 2019 US dollars.

Implementation of the Strategy requires substantially greater investments in evidence-based primary prevention services—an almost doubling from the estimated US\$ 5.3 billion in estimated expenditures in 2019 to US\$ 9.5 billion in 2025. A portion of this gap should be closed by reallocating HIV resources from ineffective prevention methods to the evidence-based prevention programmes and interventions called for in the Strategy.

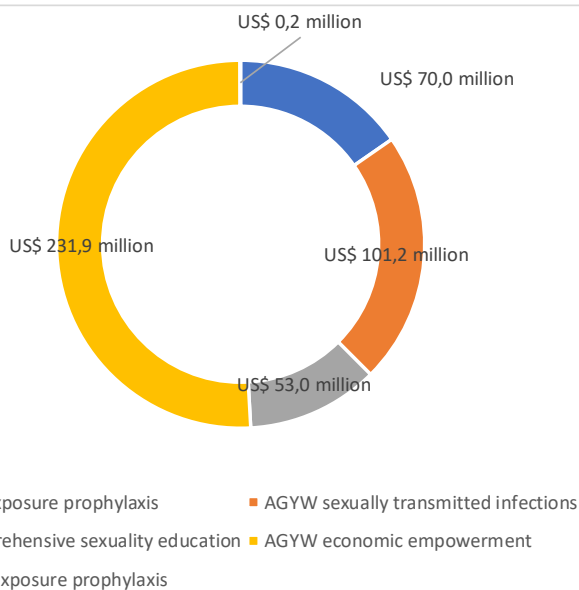
Investment in societal enablers must more than double, from US\$ 1.3 billion in 2019 to US\$ 3.1 billion in 2025, and grow to 11% of total resource needs. By contrast, while an additional US\$ 1.25 billion in resources are needed to close the gap between 2019 expenditures and 2025 resource needs for HIV testing and treatment, the proportion of total resources for HIV testing and treatment will reduce from 43% of estimated expenditures in 2019 to 34% of the 2025 resource needs. In absolute terms, this will increase the total expenditures for HIV testing and treatment from US\$ 8.3 billion in 2019 to US\$ 9.9 billion by 2025, and due to efficiency gains, more people can be on treatment.

There are also substantial gaps in investment in above-site-level activities (including procurement and supply chain management; health management information systems, surveillance and research; human resource for health; and laboratory system strengthening) and programme management activities (planning, coordinating and managing technical programmatic work, including administration and transaction costs for managing and disbursing funds).



Source: UNAIDS financial estimates and projections, 2021

**Half of HIV investments for adolescent girls and young women will be on economic empowerment by 2025**

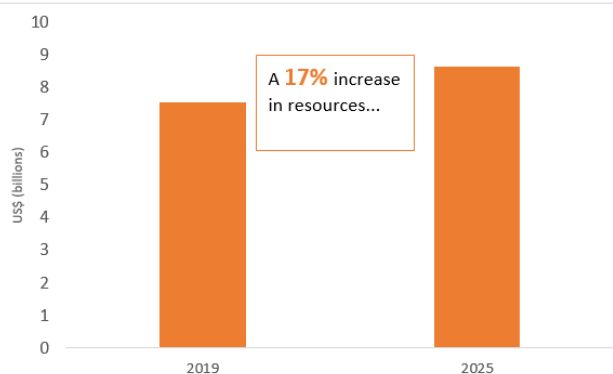


Source: UNAIDS financial estimates and projections, 2021.

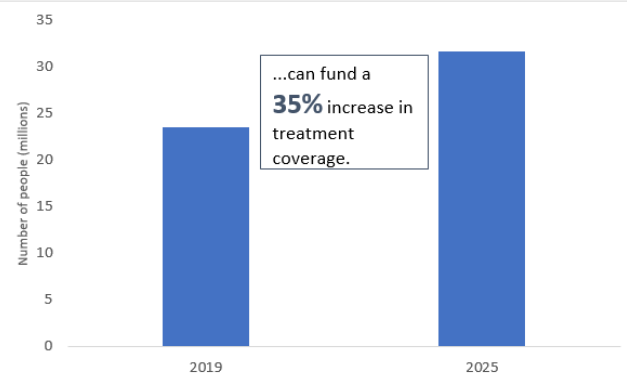
Much of the additional resource needs for evidence-based HIV prevention should be focused on key populations, which account for 60% of the total primary prevention resource needs in the Strategy (not including PrEP for key populations). Within interventions among key populations, a significant increase in resources is needed for combination harm reduction services for people who inject drugs. Greater resources are also needed for condom promotion, PrEP and interventions focused on adolescent girls and young women in high-prevalence settings.

Investing in combination HIV prevention for adolescent girls and young women is critical in high-burden countries in sub-Saharan Africa. More than half of the primary prevention resource needs for adolescent girls and young women should be targeted towards economic empowerment activities, reflecting the evidence that keeping girls in school and empowering them economically reduces their risk and vulnerability to HIV.

**Antiretroviral therapy estimated expenditures, 2019, and resource needs, 2025**



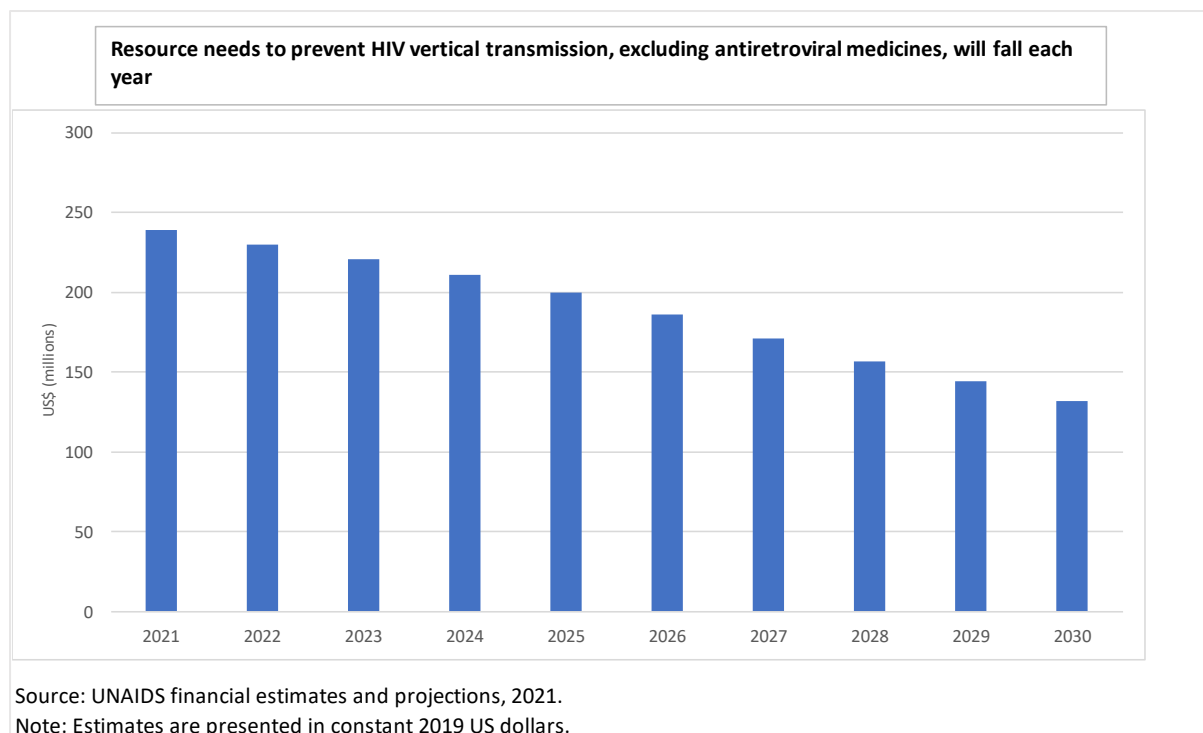
**Number of people on antiretroviral therapy**



Source: UNAIDS financial estimates and projections, 2021.

Notes: the costs include only direct service delivery costs and commodities (antiretrovirals, diagnostics). These costs do not include above site costs, programme

The Strategy calls for a modest 17% increase in resources for testing and treatment by 2025 because of reductions in the prices of commodities and forecasted reductions of costs to deliver the services. Together with the more effective use of these resources, this will enable a 35% increase in the number of people on treatment and enable the world to reach the 95–95–95 targets by 2025. Reaching such high treatment coverage levels will contribute to additional reductions in new HIV infections, which will in turn lead to reductions in resource needs for testing and treatment in 2026–2030.



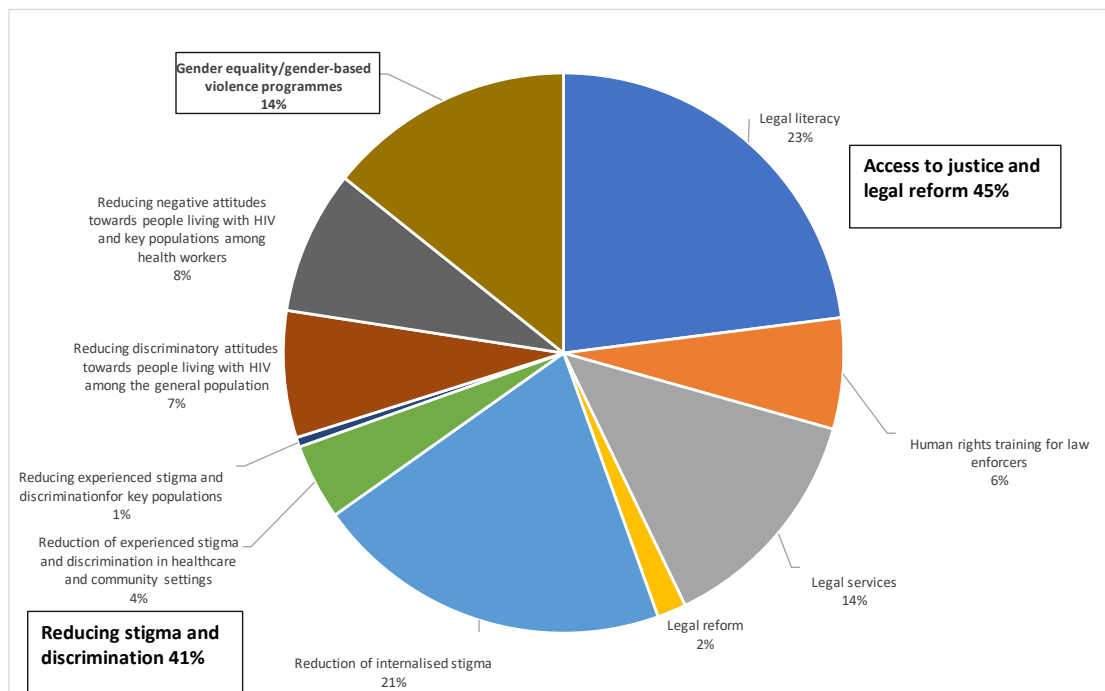
Antiretroviral therapy for all includes women, women of reproductive age and pregnant women, so related costs are included under overall cost for ART. The additional costs include mainly additional testing efforts as part of antenatal care, counselling, linkage to care and retention, contact tracing from partners, follow-up of the newborn, nutrition counselling including breast feeding, retesting of mothers, etc.

The high coverage of antiretroviral treatment for pregnant women living with HIV in high-prevalence countries has greatly reduced the number of children born with HIV and reduced resource needs for the prevention of vertical transmission. The acceleration of efforts to eliminate vertical transmission of HIV outlined in the Strategy would lead to further declines in nontreatment resource needs in this programme area.

The Strategy calls for much greater investments in societal enablers—reaching US\$ 3.1 billion in 2025— in order to enable access to and quality of services needed to end AIDS as a global public health threat by 2030. These investments should be focused on establishing the legislative and policy environment required to implement the Strategy, including the removal of legal and social barriers to HIV services, ending the criminalization of key populations at high risk of HIV infection, providing legal literacy training and legal aid to people living with HIV and key populations whose rights are violated, and contributing to efforts to achieve gender equality.



**Access to justice and legal reform will account for 45% of 2025 resource needs for an improved enabling environment**



Source: UNAIDS financial estimates and projections, 2021.

Note: The costs for the gender equality component were calculated based on the saved DALYs attributable to specific activities such as reduction of violence against women in the HIV burden of disease

## Annex 4. Glossary

### Combination HIV prevention

Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Combination HIV prevention also can be used to refer to an individual's Strategy for HIV prevention—combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices.

Combination prevention includes both primary prevention (focused on people who are HIV-negative) as well as prevention of onward transmission from people living with HIV.

*Source: UNAIDS Terminology guidelines 2015. Geneva: UNAIDS; 2015.*

#### Key features of combination prevention programmes

- Tailored to national and local needs and contexts.
- Combine biomedical, behavioural and structural interventions.
- Fully engage affected communities, promoting human rights and gender equality.
- Operate synergistically, consistently over time, on multiple levels—individual, family and society.
- Invest in decentralized and community responses and enhances coordination and management.
- Flexible—adapt to changing epidemic patterns and can rapidly deploy innovations.

*Sources:* Combination HIV prevention: tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections. Geneva: UNAIDS; 2010.

Combination prevention: addressing the urgent need to reinvigorate HIV prevention responses globally by scaling up and achieving synergies to halt and begin to reverse the spread of the AIDS epidemic. Geneva: UNAIDS; 2013 (UNAIDS/ PCB(30)/12.13).

### Comprehensive sexuality education

Comprehensive sexuality education (or CSE) is defined as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, nonjudgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision making, communication and risk reduction skills about many aspects of sexuality.”

*Source:* United Nations Educational, Scientific and Cultural Organization (UNESCO), UNAIDS, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and WHO. International technical guidance on sexuality education. Volume I. Paris: UNESCO; 2009.

Many different names are used, reflecting an emphasis on various aspects of CSE by different countries. As with all curricula, CSE must be delivered in accordance with national laws and policies.

#### Generic life skills

##### Essential topics

- Decision-making/assertiveness
- Communication/negotiation/refusal
- Human rights empowerment

### Desirable topics

- Acceptance, tolerance, empathy and nondiscrimination
- Other gender life-skills

## Sexual and reproductive health/ sexuality education

### Essential topics

- Human growth and development
- Sexual anatomy and physiology
- Family life, marriage, long-term commitment and interpersonal relationships
- Society, culture and sexuality: values, attitudes, social norms and the media in relation to sexuality
- Reproduction
- Gender equality and gender roles
- Sexual abuse/resisting unwanted or coerced sex
- Condoms
- Sexual behaviour (sexual practices, pleasure and feelings)
- Transmission and prevention of sexually transmitted infections

### Desirable topics

- Pregnancy and childbirth
- Contraception other than condoms
- Gender-based violence and harmful practices/rejecting violence
- Sexual diversity
- Sources for sexual and reproductive health services/seeking services
- Other content related to sexual and reproductive health/sexuality education

## HIV- and AIDS-related specific content

### Essential topics

- Transmission of HIV
- Prevention of HIV: practicing safer sex, including condom use
- Treatment of HIV

### Desirable topics

- HIV-related stigma and discrimination
- Sources of counselling and testing services/seeking counselling, treatment, care and support
- Other HIV and AIDS-related specific content

*Source:* Measuring the education sector response to HIV and AIDS—guidelines for the construction and use of core indicators. Paris: UNESCO; 2013.

UNESCO has developed a set of “essential” and “desirable” topics of a life skills-based HIV and SE programme: The essential topics are those that have the greatest direct impact on HIV prevention. Desirable topics are those that have an indirect impact on HIV prevention but that are important as part of an overall sexuality education programme.

## HIV-sensitive social protection

HIV-sensitive social protection enables people living with HIV and other vulnerable populations to be provided with services together with the rest of the population; this prevents the exclusion of equally needy groups. HIV-sensitive social protection is the preferred approach as it avoids the stigmatization that can be caused by focusing exclusively on HIV. Approaches to HIV-sensitive social protection include the following: financial protection through predictable transfers of cash, food or other commodities for those affected by HIV and those who are most vulnerable; access to affordable quality services, including treatment, health and education services; and policies, legislation and regulation to meet the needs (and uphold the rights) of the most vulnerable and excluded people.

*Source:* UNAIDS Terminology guidelines 2015. Geneva: UNAIDS; 2015.

## Key populations, or key populations at higher risk

Key populations, or key populations at higher risk, 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. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

*Source:* UNAIDS Strategy 2011–2015: getting to zero. Geneva: UNAIDS; 2010.

UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the four main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. The term “key populations” is also used by some agencies to refer to populations other than the four listed above. For example, prisoners and other incarcerated people also are particularly vulnerable to HIV; they frequently lack adequate access to services, and some agencies may refer to them as a key population. The term key populations at higher risk also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment. In addition to the four main key populations, this term includes people living with HIV, seronegative partners in serodiscordant couples and other specific populations that might be relevant in particular regions (such as young women in southern Africa, fishermen and women around some African lakes, long-distance truck drivers and mobile populations).

In addition, UNAIDS also uses the term priority populations to describe groups of people who in a specific geographical context (country or location) are important for the HIV response because they are at increased risk of acquiring HIV or disadvantaged when living with HIV, due to a range of societal, structural or personal circumstances. In addition to people living with HIV and the globally defined key populations that are important in all settings, countries may identify other priority populations for their national responses, if there is clear local evidence for increased risk of acquiring HIV, dying from AIDS or experiencing other negative HIV related health outcomes among other populations. In line with the country epidemiology of HIV, associated factors and inequalities, this may include populations such as adolescent girls, young women and their male partners in locations with high HIV incidence, sexual

partners of key populations, people on the move, people with disabilities, indigenous peoples, mine workers, as well as others in specific countries. However, in the vast majority of settings, key populations and people living with HIV are the most important priority populations for achieving global targets.

*Source:* UNAIDS Terminology guidelines 2015. Geneva: UNAIDS; 2015.

### Men who have sex with men

Men who have sex with men describes males who have sex with males (including young males), regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men. Gay can refer to same-sex sexual attraction, same-sex sexual behaviour and same-sex cultural identity.

*Source:* UNAIDS Terminology guidelines 2015. Geneva: UNAIDS; 2015.

### Transgender

Transgender is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender or otherwise gender nonconforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, transsexual or, in specific cultures, as hijra (India), kathoey (Thailand), waria (Indonesia) or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.

*Source:* Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

### Young People

Young people are people aged 15–24 as per the GARPR indicators.

*Source:* Global AIDS response progress reporting, 2015. Geneva: WHO; 2015 ([http://www.unaids.org/sites/default/files/media\\_asset/JC2702\\_GARPR2015guidelines\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2702_GARPR2015guidelines_en.pdf), accessed 25 September 2015).

WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.

*Source:* Adolescent development: a critical transition. In: WHO [website]. WHO; 2015 ([http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/dev/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/), accessed 25 September 2015).

## Annex 5. Abbreviations

ART	antiretroviral therapy
BRICS	Brazil, Russian Federation, India, China and South Africa
COVID-19	disease caused by the novel coronavirus SARS-CoV-2
CSE	comprehensive sexuality education
ECOSOC	UN Economic and Social Council
ECOWAS	Economic Community of West African States
GIPA	greater involvement of people living with HIV
MINT	Mexico, Indonesia, Nigeria and Turkey
PCB	Programme Coordinating Board of UNAIDS
PEPFAR	United States President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
SDG	Sustainable Development Goal
STI	sexually transmitted infections
TB	tuberculosis
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
U=U	Undetectable = Untransmittable
UBRAF	Unified Budget, Results and Accountability Framework
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UN SWAP	UN System-wide Action Plan on Gender Equality and the Empowerment of Women

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