Agenda item 5

UNAIDS/PCB (56)/25.14

ANNOTATED OUTLINE OF THE NEXT GLOBAL AIDS STRATEGY 2026–2031

UNAIDS

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Additional documents for this item:

Survey on the Global AIDS Strategy 2026-2031 (UNAIDS/PCB (56)CRP3);

Report of the multistakeholder consultation on the Global AIDS Strategy 2026-2031 (UNAIDS/PCB (56)CRP4)

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

145. *Recall* PCB decision point 6.2a from the 55th PCB meeting;

146. *Take note* of the annotated outline of the Global AIDS Strategy 2026-2031;

147. *Request* the Executive Director to present the Global AIDS Strategy 2026-2031, to be developed through an inclusive and transparent multistakeholder consultative process, to the 57th PCB meeting in December 2025 for consideration and adoption;

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

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Executive summary

Standing together to end AIDS

1. The 2026–2031 Global AIDS Strategy is being developed at a critical juncture, amid widening inequalities, converging global crises and shrinking fiscal space. Only five years remain to achieve the global goal to end AIDS. To succeed, the global HIV response must adapt to a challenging global context, confront the structural inequities that undermine access and accelerate the expansion of services in sustainable ways.

2. Important progress has been achieved under the current Global AIDS Strategy 2021–2026. However, the world is not on track to meet the 2025 targets. Large gaps in access to HIV treatment and prevention services persist within a rapidly evolving global context. Despite these challenges, a path to ending AIDS by 2030 remains open. This Strategy seeks to guide the world down that path.

3. Ending AIDS requires collective action. The response must be country-led and people-centred, with differentiated services that are delivered locally.

4. UNAIDS developed the draft annotated outline of the new Strategy 2026–2031 using a phased, evidence-based consultative approach. Throughout 2024 and the early months of 2025, the foundation of the new Strategy was laid along four work areas: (a) the mid-term review of the 2021–2026 Global AIDS Strategy; (b) the work of the Global Task Team on Targets for 2030; (c) support to countries to develop national sustainability roadmaps; and (d) multi-stakeholder consultations.

Mid-term review

5. The mid-term review highlighted important gains, especially in HIV treatment scale-up, as well as major gaps in HIV prevention access and insufficient progress against societal and structural barriers. Nearly one in four people living with HIV were not receiving HIV treatment in 2023 and the 1.3 million new HIV infections were more than triple the 2025 target. Funding gaps and societal barriers left children, women and girls, and key populations underserved. The review identified opportunities to expand access to new prevention technologies, secure sustainable financing, particularly in lower-income, high-burden settings, and integrate HIV within broader health and development agendas.

Proposed 2030 targets

6. With the 2025 global target deadlines approaching, the Global Task Team on Targets for 2030 recommended 16 top-line global targets and 50 second-tier targets that provide the “what” (desired outcomes), while the Strategy outlines the “how” (actions needed at different levels to achieve those outcomes). The targets aim to simplify accountability while addressing evolving challenges. A number of the targets that were in the 2021–2026 Global AIDS Strategy are recommended to be extended to 2030 because they have not yet been achieved by all countries and remain critical for ending AIDS as a public health threat by 2030 (for example the 95–95–95 targets).[1]

7. Achievement of the targets will bridge the gap in services and enabling environments and avert 2.9 million new HIV infections and 1.3 million AIDS-related deaths between 2025 and 2030, thus meeting the 2030 goal of ending AIDS as a public health threat (or “ending AIDS”, in short). That goal is defined as a 90% reduction in both the number of

[1] https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf

people newly acquiring HIV and the number of AIDS-related deaths compared with the 2010 estimates.

Sustainability roadmaps

8. In 2024, UNAIDS and partners started working closely with countries to begin the development of country HIV response sustainability roadmaps. The roadmaps ensure that sustainability is integrated into all aspects of HIV responses. That process, which is interlinked with other strategy and planning national instruments, has served as a timely input to the development of the new Strategy.

Multi-stakeholder consultations

9. Consultations of stakeholder groups took between March and May 2025 at country, regional and global levels. Representatives from nearly 100 national governments and 379 civil society organizations participated in consultation meetings and more than 3,000 stakeholders participated in an online survey. Participants were urged to focus on identifying priority actions to secure results in the next phase of the global HIV response.

10. A methodology using a prioritization matrix was used to assess and rank potential areas of focus based on agreed criteria such as urgency, impact, feasibility and alignment with strategic goals. The results of these exercises were synthesized into the strategic priorities and results areas presented in this outline.

Three priorities and eight results areas to build a sustainable response and end AIDS by 2030

11. The Strategy sets out three priorities and eight results areas that must be pursued with focus and urgency. Each results area includes a set of initial recommendations for all stakeholders to build a sustainable response and reach the 2030 goal of ending AIDS.

Priority 1: Sustain the response—country-led, resilient and ready for the future

12. Countries, both governments and communities, are at the forefront of leading their national HIV responses. As international funding declines, it is essential that domestic and donor investments focus on sustainable approaches that strengthen broader health systems, deliver integrated and people-centred services, and that programmes are developed and monitored on the basis of strong information systems and data.

- *Results area 1. Ensure sustainable financing for people-centred national and global HIV responses*
- *Results area 2. Integration of HIV interventions and HIV-related health and community systems with primary health care, broader health systems, and key non-health sectors*
- *Results area 3. Invest in essential information systems and data collection by sectors and communities*

Priority 2: People-focused—equity, dignity and access

13. The Strategy centres on people living with, affected by, or at risk of HIV. Ending AIDS requires ensuring they have access to quality services in environments free from stigma, discrimination, and violence. That demands addressing inequalities and protecting the rights of women and girls, men and boys, children, key populations and others affected or at risk of HIV, whatever their location and circumstances.

- *Results area 4. Scale up biomedical, structural, community and behavioural options for HIV prevention*
- *Results area 5. Ensure available, accessible, acceptable and quality HIV treatment and care for people living with HIV*
- *Results area 6. End stigma and discrimination and uphold human rights and gender equality in the HIV response*
- *Results area 7. Ensure equitable access to scientific, medical and technological innovations in HIV prevention, treatment and care*

Priority 3: Powering communities to lead

14. Communities of people living with, at risk of, and most affected by HIV must continue to lead the way to ending AIDS. They guide policy direction, deliver services and ensure mutual accountability.

- *Results area 8. Ensure community leadership in the HIV response across services and systems*

15. Initial recommendations for each results area have been proposed in this outline, which will inform the finalization of the Strategy.

Local, regional, and multilateral action to end AIDS

16. Services are primarily provided at local level. It is also often at that level where new productive partnerships have been developed with the private sector, philanthropies, faith-based organizations and others. These partnerships between communities, local authorities and the wider community at local level are critical for the success of the HIV response.

17. Regional organizations such as the African Union, the Caribbean Community or the Association of Southeast Asian Nations are critical actors for the sustainability of the global HIV response through their roles in pooling technical support and procurement, harmonizing public strategies, promoting national accountability, mobilizing shared resources, conducting research, disseminating information and other tasks which are performed more efficiently at scale.

18. The progress of the HIV response to date reflects the power of the global effort that has combined community activism and country leadership with the latest science and innovation. Targets, accountability and international standards for a rights-based, gender-transformative response to HIV are developed at the global level. Multilateral action is also necessary to ensure sustainable financing; advance normative guidance and international standards; convene actors in the global response towards collective action; increase access to new biomedical tools, such as long-acting injectables; and guide science and research.

19. Governments and communities lead national efforts, while regional and international partners provide coordination, guidance and technical support. No single actor can end this pandemic alone—but by standing together we can end AIDS by 2030.

Introduction and strategic foundations for the next Global AIDS Strategy

Progress, challenges and urgency in the global HIV response

20. The 2026–2031 Global AIDS Strategy is being developed at a critical juncture, amid widening inequalities, converging global crises and diminishing fiscal space. With only five years remaining to achieve the global goal to end AIDS as a public health threat by 2030 and sustain the response after the 2030 target date, this Strategy will be one of the most consequential strategies in the four decades of the global HIV response. To succeed, it must adapt to a challenging global context, confront the structural inequalities that undermine access to life-saving services and medicines, and accelerate the expansion of quality services in sustainable ways.

21. Midway through the current Global AIDS Strategy, in 2023, fewer people were acquiring HIV than at any point since the late 1980s. By 2024, almost 31 million people were receiving HIV treatment and AIDS-related deaths had been reduced to their lowest levels since the peak of 2004. This progress was made possible by decades of global solidarity and activism marshalled by people living with HIV, affected communities, civil society, health workers, scientists, researchers, governments and donors.

22. However, those gains were not arriving quickly enough to meet the 2025 targets. Of the 39.9 million people living with HIV in 2023, 9.3 million were not receiving life-saving antiretroviral therapy (ART) and an estimated 1.3 million people acquired HIV, more than triple the 2025 target of 370 000. Funding gaps and societal barriers were leaving many children, women and girls, and key populations[2] underserved. Those gaps persist within a rapidly evolving global context. Conflicts, economic inequalities and climate change shocks—the likes of which are unprecedented in the global HIV response—are fuelling instability and straining multilateral cooperation,

23. Despite these challenges, a path to ending AIDS by 2030 remains open. The tools and the knowledge to end AIDS prevention are at hand—and they include exciting new innovations. Sustainable financing options can be made available. Communities of people living with, at risk of, or affected by HIV stand ready to lead the way.
The next Strategy seeks to guide the world down that path. It offers a blueprint for achieving unity, sharpening focus and prioritization, building strong country ownership and securing continued global solidarity in the response to AIDS.

24. This annotated outline responds to the Programme Coordinating Board's December 2024 decision point 6.2a, which requested the UNAIDS Executive Director to "Present the annotated outline of the Global AIDS Strategy 2026–2031, to be developed through an inclusive and transparent multistakeholder consultative process, for consideration by the Programme Coordinating Board at the 56th PCB meeting in June 2025". It draws on the 2023 mid-term review,[3] the recommendations of the Global Task Team on Targets,[4] national HIV sustainability roadmaps, extensive stakeholder consultations

[2] 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. See: UNAIDS Strategy 2011–2015: getting to zero. Geneva: UNAIDS; 2010.

[3] The HIV estimates cited in this outline reflect the latest data published by UNAIDS in July 2024. The data will be updated, and some adjustments may be made to the full Strategy document (to be submitted to the PCB in December 2025) to reflect the new HIV estimates which are due in mid-2025.

[4] Recommended 2030 targets for HIV | UNAIDS.

(conducted in January to May 2025) and the April 2025 global survey. The outline previews the structure, priorities and draft results areas of the forthcoming Strategy.

Towards the next Global AIDS Strategy: Centering inequalities in vision, timelines and process

Vision for the next Global AIDS Strategy

25. The next Global AIDS Strategy will guide governments, communities, civil society, donors and other stakeholders through the next phase of the HIV response. It presents both a call to action and a shared commitment to redefine what is possible and to reimagine how we can achieve our collective goals by adapting to a changing global context and by tackling the inequalities that continue to drive the epidemic. The vision of the Strategy is rooted in today's realities and shaped by the urgency of now.

26. The process of developing the next Global AIDS Strategy had the following objectives:
    a) propose a focused set of priority transformative actions that can set the world on the correct path to end AIDS as a public health threat by 2030;
    b) build on the inequalities lens of the current Global AIDS Strategy and on the results already achieved to sustain and amplify gains;
    c) mobilize renewed and inclusive multisectoral actions from national, local, regional and global levels, institutions and stakeholders;
    d) secure the long-term financial, political and programmatic sustainability of the HIV response; and
    e) define a path towards a coordinated effort where HIV responses are developed in coherence with other relevant strategies, including universal health coverage and the recently adopted WHO Pandemic Agreement.

Timeline for the development of the Strategy annotated outline

27. UNAIDS has been developing the draft annotated outline of the new Strategy 2026–2031 using a phased, evidence-based consultative approach.

    Phase 1. Scoping and sourcing solutions (January to March 2025). Consultations on key thematic areas for the next Global AIDS Strategy to ensure clear problem identification and source solutions from numerous stakeholders to achieve progress towards the high-level goals and 2030 targets.

    Phase 2. Selection and prioritization (April to May 2025). Proposals emerging from the thematic areas and from a multistakeholder consultation (including with PCB stakeholders) held from March to May 2025 informed the development of an outline of the Strategy.

    Phase 3. Development of an outline and proposal for the PCB (June 2025). The PCB will consider and provide comments on the draft outline. The comments will inform the finalization of the framework and development of the final Strategy.

    After receiving feedback from the June PCB, the following phases will commence.

    Phase 4. Final writing and final consultations on the draft Strategy (September to October 2025). A second multistakeholder consultation (including with PCB stakeholders) will be held to finalize the Strategy for adoption. During this phase, the Strategy will be refined based on the proposed outline and a theory of change will be

developed. This will also be the phase when regional-specific roadmaps will be delineated, building on the regional and country consultations to date and the results areas.

Phase 5. PCB submission and approval (November to December 2025). The final Strategy will be shared with the PCB for adoption at its 57th meeting.

The Strategy will serve as a basis for the Political Declaration submitted for adoption at the 2026 High-Level Meeting on AIDS currently projected to take place at the United Nations (UN) General Assembly in June 2026.

28. To ensure that the Strategy is future-facing and adaptable, UNAIDS will continue in this next phase of its development to engage with voices from beyond the traditional AIDS sector—including from digital innovation spaces, social enterprises and social justice movements—to gather fresh perspectives on how to tackle systemic barriers.

Methodology and evidence base for the Strategy

29. Throughout 2024 and into the earlier part of 2025, UNAIDS laid the foundation for the development of the next Global AIDS Strategy through four streams of work: (a) the mid-term review of the 2021–2026 Global AIDS Strategy; (b) the establishment of an advisory Global Task Team on Targets for 2030; and (c) support to countries to develop national HIV sustainability roadmaps; and (4) multi-stakeholder consultations. This work has continued during the financial changes significantly of 2025 and it provides critical guidance for the development of the next Strategy.

30. The mid-term review highlighted major gains, especially in the expansion of access to HIV treatment, along with persistent inequalities in access to HIV prevention and insufficient progress in removing societal and structural barriers. It identified urgent opportunities to expand access to new prevention technologies, secure sustainable financing—particularly in lower-income, high-burden settings—and integrate HIV within broader health and development agendas. Those insights provided a basis for the wide-ranging consultations that are shaping the next Global AIDS Strategy.

31. In addition to the mid-term review, the priorities and results areas for the next Global AIDS Strategy are being informed by proposals from countries (e.g. through the development of the HIV sustainability roadmaps)5 and the findings of the recent online survey, which highlighted the main barriers and key priority areas for action.6

32. In recent months, the landscape of the HIV response has changed significantly, in terms of HIV-specific funding, the overall aid architecture and the emergence of innovations and technologies that offer exciting new opportunities.

33. The multi-stakeholder consultations took place in March and April. Representatives from nearly 100 national governments and 379 civil society organizations participated in consultation meetings, and more than 3,000 stakeholders participated in an online survey. Participants were urged to identify priority actions to secure results in the next phase.

34. To guide the consultations, a prioritization matrix was embedded in the official facilitation guide. This helped participants assess and rank potential areas of focus based on agreed criteria such as urgency, impact, feasibility and alignment with strategic goals. The use of the matrix supported structured dialogue and consensus-

[5] See Homepage - UNAIDS Sustainability Website

[6] A conference room paper with the results of the survey is available.

building across diverse stakeholder groups. The results of these exercises were then synthesized to identify the strategic priorities and results areas presented in this outline.

Table 1. Summary of consultation reach through in-depth regional, national government and community consultations (March to May 2025)

Regions	# National governments	# Civil society organizations
Asia-Pacific	18	96
Caribbean	10	10
Eastern Europe and central Asia	9	45
Eastern and southern Africa	15	90
Latin America	25	90
West, Central, Northern Africa	16	48

* Countries in the Middle East and North Africa are engaged through UNAIDS offices in eastern and southern Africa and western and central Africa.

35. Approximately 93 countries and 360 civil society organizations were consulted during this period. Consultations are still ongoing and will continue through to September.

Strategic continuity with new ambition

36. The current 2021–2026 Global AIDS Strategy framed the HIV response around inequalities, introduced the 95–95–95 treatment cascade targets and enhanced the focus on removing social and structural barriers. It outlined an ambitious vision with 12 priority areas, five cross-cutting aeras and over 80 targets to be reached by 2025.

37. The mid-term review of the current Global AIDS Strategy highlighted the continued relevance some of the targets already adopted by countries. The Global Task Team on Targets recommended extending a number of those targets to 2030.

38. The next Global AIDS Strategy 2026–2031 will build on the foundations of the current Strategy, including its focus on inequalities as a central driver of the HIV epidemic, while sharpening the focus and prioritization of outputs based on a theory of change.

39. The Strategy will provide a sharper results-driven framework that is organized around three priorities, eight results areas and 16 top-line measurable targets, with increased clarity and focus on actions that address the needs of people living with, at risk of, or affected by HIV. It deepens the emphasis on sustainability through country-led roadmaps, domestic financing and integration,7 while promoting innovation.

40. The Strategy will focus on several aspects of the HIV response.

[7] Integration of HIV into systems for health includes 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 within existing health systems. Systems integration is needed to ensure people affected by HIV have effective and equal access to the full range of medical and non-medical services they need to protect themselves against acquisition and to survive and thrive if they are living with HIV. See: https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf.

- **Sustainability**. This refers to a country's ability to evolve and maintain a robust national HIV response that can achieve and sustain epidemic control toward and beyond 2030. Sustainability includes financial, political and programmatic considerations.[8]
- **Focused actions and results** for HIV treatment and prevention and for meeting the needs of people living with, at risk of or affected by HIV. This demands addressing inequalities and protecting the rights of women and girls, men and boys, children, key populations and others affected or at risk of HIV, whatever their location and circumstances.
- **Targets**. The Strategy will present specific, time-bound targets for generating momentum, gathering new and existing stakeholders around shared goals, and enhancing accountability and transparency. It will recommit to existing 2030 goals, while adjusting to the shifts in the global context, including the changing donor landscape.
- **Innovation**. Leveraging new technologies and scientific innovations in HIV prevention (including long-acting pre-exposure prophylaxis), testing, treatment and data to enhance programme management and service delivery and contribute to sustainable and equitable access.
- **Regionalization.** Differentiating the HIV response according to the epidemiological priorities and various regional (structural, social, legal, political and economic) contexts.
- **Stakeholder engagement**. The changing environment calls for leadership from many stakeholders at global, national and sub-national levels, including cities, the private sector, foundations, faith-based organizations, regional institutions (e.g. the African Union), as well as communities, countries and multilateral partners.

Evidence base and key building blocks

Status of the epidemic: key findings from the mid-term review

41. The starting point of the Strategy development process is the state of the HIV epidemic and response as described in the mid-term review of the Global AIDS Strategy, 2021–2026. Under the current Strategy, fewer people acquired HIV in 2023 than at any point since the late 1980s. Almost 31 million people were receiving lifesaving ART, a landmark public health achievement that has reduced AIDS-related deaths by half since 2010, 1.3 million to 630 000 in 2023.

42. However, the gains are not arriving quickly enough to meet the 2025 targets. Of the 39.9 million people living with HIV in 2023, 9.3 million were not receiving ART and an estimated 1.3 million people acquired HIV, more than triple the 2025 target of 370 000. Funding gaps and societal barriers were leaving many

43. While the end of AIDS as a public health threat is within our grasp, the world is not on track to reach that goal by 2030. Several important trends can be observed. At the global level, new HIV acquisitions are declining more quickly among women than men, though HIV incidence among adolescent girls and young women (15–24 years) remains extraordinarily high in parts of eastern and southern Africa and western and central Africa. In 2023, an estimated 120 000 adolescent girls and young women acquired HIV in the former region and 36 000 did so in the latter.

44. The number of people acquiring HIV in 2023 was 39% lower globally than in 2010 and 59% lower in eastern and southern Africa. But over the same period, new HIV

[8] UNAIDS Sustainability Primer. Geneva: UNAIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/HIV%20response%20sustainability%20response%20primer_web.pdf).

infections increased in the Middle East and North Africa, eastern Europe and central Asia and Latin America, and major gaps and inequalities in service access persisted.

45. Across the world, funding for HIV responses is declining. This is holding back vital activities to address entrenched inequalities, enhance HIV prevention programmes, scale-up and support the critical work of communities, and remove hurdles that block access to HIV treatment. In addition, the global HIV response is being threatened by pushbacks against human rights, gender equality and civic space, along with faltering political will and financial support. Many countries also face major constraints, including humanitarian emergencies, restrictive fiscal conditions that inhibit public health spending, political volatility, and social inequalities that need to be considered.

46. Success requires acting with renewed urgency and prioritizing differentiated interventions that reflect the varying contexts and needs of different countries. As the mid-term review noted, whether the world succeeds in ending AIDS depends on the path leaders take in the coming years. The upcoming Global AIDS Strategy 2026–2031 will define such a path for collective action.

47. For more detailed findings from the mid-term review, please see the UNAIDS 2024 Global AIDS update—The urgency of now: AIDS at a crossroads.[9]

Setting the 2030 targets

48. Global AIDS targets are set every five years and the 2025 targets are approaching their deadline. The UNAIDS Joint Programme convened a high-level task team of leading experts in the HIV response to develop a set of evidence-informed targets for 2030. The process sought to generate consensus around key targets that will galvanize countries to significantly reduce new HIV infections and AIDS-related deaths by 2030; achieve sustainability of the HIV response beyond 2030; and estimate the potential impact of reaching the targets and the global resource needs for doing so across the 2026–2030 period.

49. The Global Task Team on Targets, co-chaired by Chewe Luo and Michel Kazatchkine, was composed of 33 experts from government, civil society and networks of people living with or affected by HIV, public health experts, and multilateral or bilateral donors, supported by a group of metric experts. The team began its work in March 2024 and completed its mandate in February 2025.[10] Comments and guidance received from PCB members, Cosponsors and civil society informed the team's work.

50. The proposed 2030 targets (see below) build on the 2025 targets and link with other pertinent strategies and targets from the broader UN system to support overall cohesion and coordination. They provide a balanced, measurable, evidence- and human rights-based framework for ending AIDS as a public health threat. The target-setting process has been a critical input for the next Global AIDS Strategy, which will describe in detail how the various targets and objectives can be achieved.

Accelerating sustainability

51. The next Strategy must position the world to achieve the targets of the HIV response by 2030 and sustain those accomplishments beyond that point. This will have to be done in a difficult context. Political, financial and programmatic sustainability must be

[9] Global AIDS update 2024—The urgency of now: AIDS at a crossroads. Geneva: UNAIDS; 2024 (https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024).
[10] For more information on the work of the Global Task Team, see: Recommended 2030 targets for HIV | UNAIDS

planned across immediate, medium and long-term horizons to build resilient, country-owned systems that can accelerate progress.

52. In 2024, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and partners worked closely with countries to develop country HIV response sustainability roadmaps. That process builds on regional and global partnerships to develop sustainable HIV action plans that are based on overarching, country-owned visions. It is intended to help guide countries transform their HIV responses for long-term sustainability by leveraging multisectoral collaboration and resources within their borders, with a critical role for communities.

53. Sixteen countries have already completed their sustainability roadmaps Part A, which entails defining their visions for the future and identifying the key transformations they will need to bring about for HIV responses that are sustainable in the longer term. Seventeen other countries have embarked on the same process and continue to work on advancing their roadmaps.[11] Several countries have already started the second part of the roadmap process, which entails putting their sustainability plans into operation ("Part B").

54. This work is more urgent than ever and has been accelerated. The roadmaps will help ensure that sustainability is integrated into all aspects of countries' HIV responses. They identify the transformations that are needed to adapt the responses to evolving epidemics and shifting political, social and financial environments. The overall process, which is linked with other strategy and planning national instruments, is serving as a timely input for the development of the next Global AIDS Strategy.

Together we stand to end AIDS: a sustainable, inclusive, multisectoral country-owned HIV response

Recommended global targets to end AIDS by 2030

55. Clear global targets are crucial for unifying the actions of diverse stakeholders. The 2030 targets provide the "what" (desired outcomes), while the Strategy outlines the "how" (actions needed at different levels to achieve them). By 2030, the strategy aims for significant reductions—reducing new HIV infections by 90% from 2010 and continued 5% decline per year after 2030; reducing AIDS-related deaths by 90% from 2010; and ensuring sustainability of HIV response after 2030. The draft of the Strategy proposes 16 top-line targets and 50 second-tier targets.[12] Those targets aim to simplify accountability while addressing evolving challenges. A key consideration during the development of the targets was to align HIV efforts with broader health and development agendas—including for tuberculosis, noncommunicable diseases and sexual and reproductive health—thereby advancing sustainability and integration.

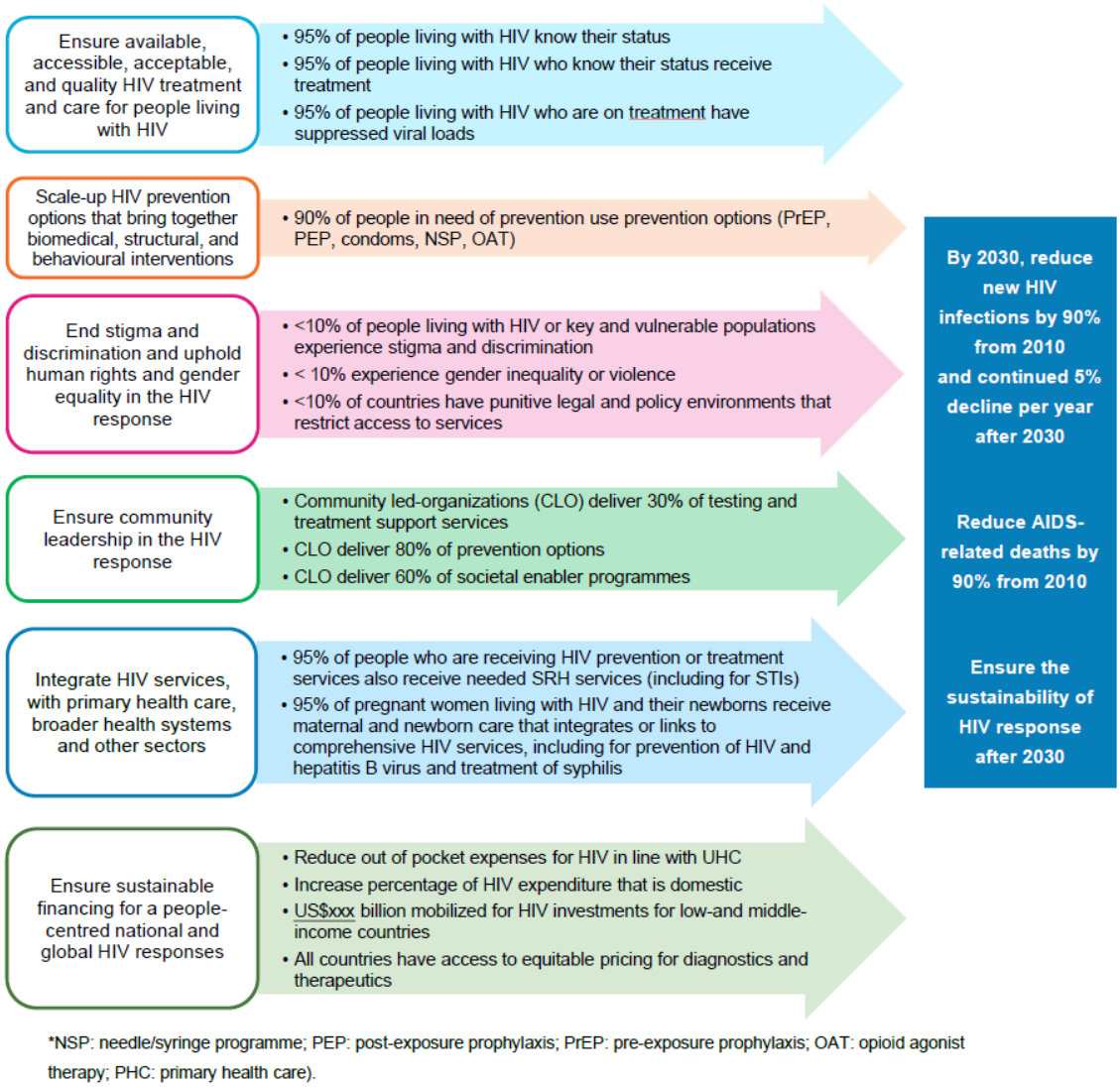
56. Some of the targets in the current Strategy are recommended to be extended to 2030 because they have not yet been achieved by all countries and remain critical for ending AIDS by 2030 (including the 95–95–95 targets, for example). The 16 top-line targets

[11] Sixteen countries have finalized Part A of their HIV Sustainability Roadmaps: Botswana, Eswatini, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, South Africa, Tajikistan, United Republic of Tanzania (including Zanzibar), Togo, Uganda, Viet Nam, Zambia and Zimbabwe. Seventeen additional countries are working on finalizing and endorsing Part A of their HIV sustainability roadmaps: Benin, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Dominican Republic, Ethiopia, Indonesia, Liberia, Mali, Nepal, Mozambique, Philippines, Rwanda, Thailand and Sierra Leone).

[12] https://www.unaids.org/en/recommended-2030-targets-for-hiv

recommended by the Task Team are organized into six priority areas (Figure 1). A further 50 second-tier targets indicate what is needed to achieve the top-line targets.

Figure 1. The 16 top-line targets for 2030



*NSP: needle/syringe programme; PEP: post-exposure prophylaxis; PrEP: pre-exposure prophylaxis; OAT: opioid agonist therapy; PHC: primary health care).

Ending AIDS: What meeting the 2030 targets can achieve and the resources needed

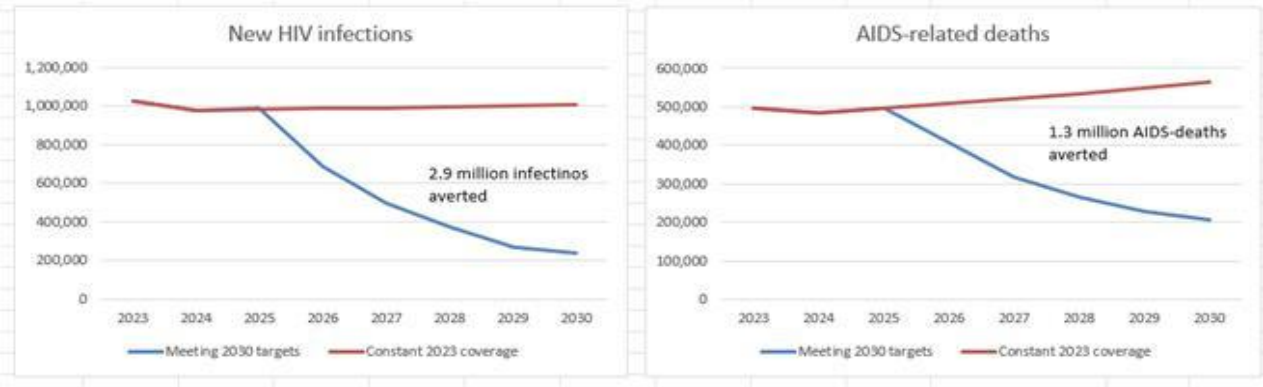
57. The Global AIDS Strategy is a call to action to ensure that, by 2030, almost 40 million people living with HIV are on HIV treatment, almost 20 million people are using antiretroviral-based HIV prevention, and those 60 million people can access discrimination-free HIV-related services.

58. Achieving the targets would be tantamount to reaching the 2030 goal of ending AIDS as a public health threat (or “ending AIDS”). That goal is defined as a 90% reduction against the 2010 benchmark in both the number of people newly acquiring HIV and the number of people dying of AIDS-related causes. Achieving the proposed 2030 targets would bring most countries in reach of this goal.[13]

[13] Global HIV target setting for 2030. Geneva: UNAIDS; 2025 (https://www.unaids.org/sites/default/files/2025-05/20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf).

59. As shown in Figure 2, achieving the targets would bridge the gap in services and enabling environments and avert 2.9 million new HIV infections and 1.3 million AIDS-related deaths between 2025 and 2030.

Figure 2. Projected number of new HIV infections and AIDS-related deaths averted by achieving the 2030 targets



Resource needs to end AIDS as a public health threat

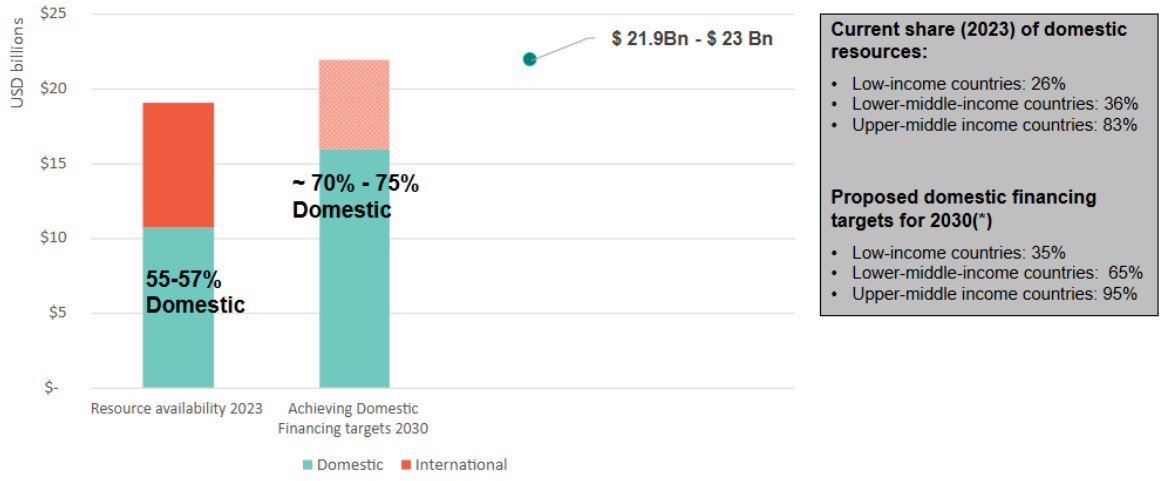
60. Preliminary estimates from UNAIDS indicate that achieving the global targets will require annual resources in 2030 ranging from US$ 21.9 billion to US$ 23 billion in low- and middle-income countries, down from the US$ 29.3 billion previously estimated. While a sensitivity range is presented for resource needs, actual needs may tend towards the lower bound. These new resource needs estimates are lower than the previous estimates from 2021 due to major cost efficiencies that have been achieved across the HIV response. There have been significant price reductions for antiretrovirals and for products used in opioid agonist therapy. In addition, the new estimates reflect more efficient and targeted service delivery, as well as a strong emphasis on prioritized approaches based on HIV risk.[14]

61. In 2023, about 59% of resources for HIV responses in low-and middle-income countries came from domestic sources. Excluding countries which were recently reclassified as high-income countries, the domestic share of HIV funding stood at 53–57% of the global HIV response in 2023 (see Figure 3). If countries meet the proposed domestic financing targets, it is estimated that the domestic share could increase to approximately two thirds of total HIV resource needs by 2030 (estimated at US$ 21.9–23 billion). This would leave a funding gap of approximately one third which would need to be filled by continued global solidarity.

62. Of the total annual HIV resource needs in 2030, approximately 20% would be in low-income countries, 34% in lower-middle-income countries and 46% in upper-middle income countries. Among all low- and middle-income countries, the (preliminary) estimated resource needs for HIV in 2030 are expected to be distributed programmatically as follows: 24% for prevention, 40% for testing and ART and 10% for societal enablers.

[14] The new estimates exclude upper-middle-income countries which the World Bank recently reclassified as high-income countries.

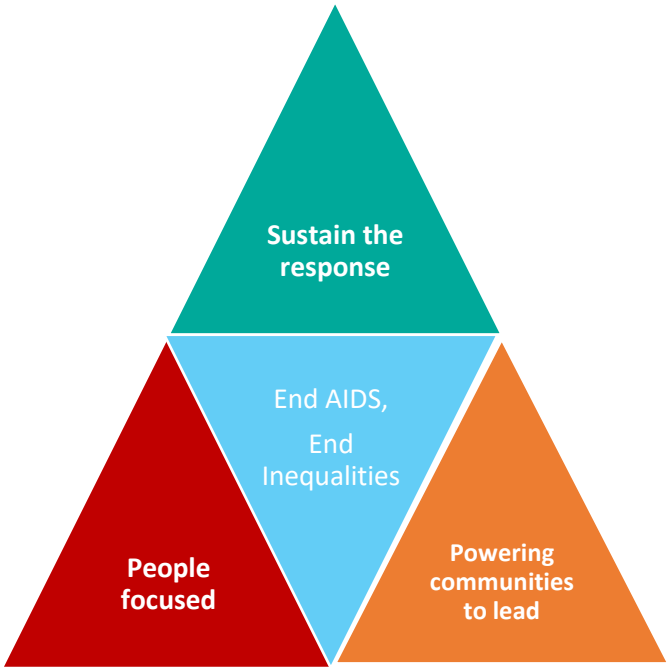
Figure 3. Estimated HIV resources available in low- and middle-income countries in 2023, estimated resource needs in 2030 and scenario in which domestic HIV financing targets are met



* The domestic financing targets reflect the average share of domestic resources across different income groups by 2030. Within each group—particularly among lower-middle-income and low-income countries—there is significant variation in disease burden, and fiscal capacity across countries. These targets aim to encourage greater domestic ownership at national level for a collective increase across each of the income groups.

Three priorities and eight results areas to build a sustainable response and end AIDS as a public health threat by 2030

63. Achieving the targets and the level of impact needed to end AIDS requires strategic choices to tackle the deep inequalities that drive and perpetuate the AIDS pandemic and to deliver effective HIV services to everyone who needs them. The next Global AIDS Strategy is designed to achieve and sustain those gains.



64. The Strategy sets out three priorities and eight results areas that must be pursued with focus and urgency.

Priority 1: Sustain the response—country-led, resilient and ready for the future. Countries, both governments and communities, are at the forefront of national HIV responses. As international funding declines, it is essential that domestic and donor investments focus on sustainable approaches that strengthen broader health systems, deliver integrated and people-centred services, and address the social and structural determinants of health for people living with, affected by, or at risk of HIV.

Priority 2: People-focused—equity, dignity, and access. The Strategy is people-centred. Ending AIDS requires that people can access quality HIV prevention, testing and treatment services in environments that are free of stigma, discrimination and violence. That demands reducing inequalities and upholding people's rights, including women and girls, men and boys, children, and key populations affected or at risk of HIV whatever their location and circumstances.

Priority 3: Powering communities to lead. Communities of people living with, at risk of and most affected by HIV must continue to lead the way to end AIDS. They guide policy direction, deliver services and ensure mutual accountability.

Eight results areas for ending AIDS

65. Through careful analysis of the findings and recommendations emerging from the consultation phase, including the multistakeholder consultation at the Programme Coordinating Board (PCB), the following eight results areas have emerged as the most impactful to support countries to sustainably end AIDS by 2030.

66. Six initial priority areas recommended through the targets work have been retained as results areas. Two additional results areas emerged from the consultations and evidence shared to date: one on rapid access to innovation and new technologies; and a second on strengthening sustainable data systems in countries and globally for greater efficiency in reaching all people in need of services and for accountability. The eight results areas are listed below.

    1. Ensure **sustainable financing** for people-centred national and global HIV responses.
    2. **Integration of HIV interventions** and HIV-related health and community systems with primary health care, broader health systems, and key non-health sectors
    3. Invest in **essential information systems and data collection by sectors and communities.**
    4. Scale-up biomedical, structural, community and behavioural options for **HIV prevention**.
    5. Ensure available, accessible, acceptable and quality **HIV treatment and care for** people living with HIV.
    6. End **stigma and discrimination** and uphold **human rights and gender equality in the HIV response.**
    7. **Ensure** equitable access to scientific, medical, and technological **innovations in HIV prevention, treatment and care**.
    8. Ensure **community leadership** in the HIV response across services and systems.

More details on these results areas and recommended actions are provided below.

Priority 1: Sustain the response: country-led, resilient and ready for the future

67. In a rapidly evolving global context, collaborative actions are needed to secure sustainable financing for the HIV response and make service delivery more efficient and effective.

68. Sustainable HIV responses will have to ensure that investments in impactful HIV responses simultaneously strengthen broader and integrated health and multisectoral systems. Financing and service delivery systems for healthcare and social protection must also reduce out-of-pocket expenditure and deliver accessible, acceptable and quality services to people living with, affected by, or at risk of HIV.

69. Domestic HIV investments will need to increase as external HIV resources decline. In many countries, national governments are already the primary source of funding for their national responses. Clear, incremental and self-reliant pathways to sustainable financing and a coherent national policy context are critical, but global solidarity will remain necessary.

70. People living with HIV, people affected by AIDS and people at risk of HIV need more than HIV and health services. Their health and well-being are affected by the conditions in which they are born, grow, live, work and age. When health and social protection systems are gender-responsive, inclusive and responsive to the needs of people living

with HIV, they can mitigate some the inequalities that drive the pandemic and undermine efforts to end it.

Results area 1. Ensure sustainable financing for people-centred global and national HIV responses

71. After years of steady decline, the sudden steep reduction in international funding for the HIV response in early 2025 has exposed the fragility of HIV financing across low- and middle-income countries. Tightened fiscal space for health and HIV programmes, exacerbated in many countries by high debt repayment obligations, has compounded the urgent need for increased domestic investments and stronger global solidarity to stabilize health investments. Greater multisectoral engagement on HIV, including with national ministries of finance, will be critical.

72. The cuts to donor funding are having cascading effects, including procurement delays; heightened risk of stock-outs for antiretroviral medicines; reductions in the availability of pre-exposure prophylaxis (PrEP) and community-led services; closures of projects focused on addressing stigma and discrimination and creating enabling legal environments; and critical gaps in financing for frontline health workers and HIV services. These effects extend beyond HIV and affect other health outcomes that depend on integrated service delivery.

73. The shocks highlight a structural overreliance on limited funding sources, as well as the urgent need for resilient, diversified financing mechanisms to protect and advance progress in HIV and other public health priorities. There is a significant dependency on international resources for HIV prevention in many regions. Current spending patterns for key populations do not reflect the disproportionately high rates of HIV acquisition among them. The latest estimates indicate that less than 3% of total HIV spending is allocated to prevention interventions among key populations, much less than the estimated average need of 20% of HIV resources for key populations prevention programmes by 2030.

74. Despite steady growth in domestic investment, international funding remains critical. The funding losses have exposed the fragility of some low- and middle-income countries' reliance on external financing for their HIV responses. By 2024, international HIV funding had declined by approximately 19% from its 2013 peak. HIV's share of total development assistance fell to 3.4% in 2022, reflecting shifts in spending priorities. Changes in the global financing architecture in 2025 threaten to reverse decades of progress and investment, jeopardizing the goal of ending AIDS.

75. There is a growing imperative for emerging economic powers to increase their contributions to global health and HIV financing, in line with their increasing economic influence. Domestic resource mobilization for HIV has been under strain for four consecutive years, however, a decline that began during the COVID-19 pandemic. Nonetheless, two-thirds of reporting countries have increased their domestic HIV spending over the past five years.

76. Innovative financing is needed to expand and sustain HIV responses, especially in resource-constrained settings. Debt swaps such as the Global Fund's "Debt2Health" initiative, convert sovereign debt into health investments, including for HIV, thereby unlocking new funding streams. Blended finance can also mobilize private and non-concessional capital by using concessional resources to reduce investment risk and channel funding to underserved areas.

77. Examples include the "IsDB Lives and Livelihoods Fund" and the GAVI Advance Market Commitment, which are relevant for diversifying HIV financing and incentivizing

antiretroviral manufacturing, respectively. Outcome-based models, like Rwanda's performance-based financing and South Africa's pay-for-performance HIV prevention for adolescent girls and young women, shift financial risk from donors and governments while promoting efficiency and innovation. Public and private insurance schemes can also integrate HIV services through pooled funding. While these approaches offer significant potential, their success depends on tailored technical support and achieving sufficient scale for impact.

Initial recommendations to ensure sustainable financing for people-centred global, regional and national HIV responses

a) **Countries that rely on international funding** should develop and implement multisectoral, country-led HIV sustainability roadmaps to sustain epidemic control beyond 2030. These roadmaps must define an inclusive and evolving division of financing responsibilities, across global, regional and national levels, to sustain people-centred HIV responses over time.

b) **Develop and promote an evolved HIV financing mix** to strengthen and incrementally transition to domestic financing, thereby reducing external aid dependence, by deploying a wide range of possible financing instruments and building self-reliance.

c) **Steadily increase domestic financing** for health and HIV through increased domestic revenue collection—including through increases in corporate and personal income tax rates, wealth taxes, reforms of preferential tax regimes, and measures to combat tax evasion and avoidance—and through reallocation of funds released by debt relief arrangements and improvements in the quality of tax administration and procurement systems.

d) **Establish diversified, innovative and blended financing instruments**, including ring-fenced health taxes, HIV levies and debt swaps, among other options.

e) **Increase direct development assistance** for health through accountable national systems, with context-specific investments that strengthen procurement and service delivery, engage civil society and improve the efficiency, sustainability and equity of the HIV response**.**

f) **Integrate HIV services in national health benefit** packages of universal health coverage systems, social protection and education schemes, social contracting mechanisms and public health insurance programmes to improve sustainability and access and reduce out-of-pocket payments.

g) **Secure greater accountability for country commitments** on domestic financing of health and HIV response (e.g. the Abuja Declaration, which committed countries in Africa to allocate at least 15% of their national budgets to health) with explicit tracking for HIV and community-led investments.

h) **Increased and sustained investments in societal enablers** as a necessary contribution to a rights-based approach.

Results area 2. Integration of HIV interventions and HIV-related health and community systems with primary health care, broader health systems, and key non-health sectors

78. Systems strengthening is fundamental to achieve sustainable HIV responses. Further strengthening of systems for health, especially in countries and settings where they are weak, is critical for the sustained availability and delivery of accessible, acceptable and quality HIV prevention, testing and treatment services.

79. Both immediate and longer-term actions are required to move away from fragmented and siloed donor-dependent systems. Integration implies a context-specific, evidence-driven alignment of multiple services, systems and/or sectors, with a focus on enhancing the timeliness, accessibility, equity and efficiency of efforts to address the diverse needs of individuals and communities.

80. Integration of HIV services and systems (including community systems) with countries' primary healthcare and broader health systems, as well as integration of HIV interventions with prioritized non-health sector programmes (such as education, social protection, justice, labour and humanitarian programmes) is imperative for the sustainable achievement of the Strategy's targets. Successful approaches to integration include phased, gradual integration that starts at the lower tiers of service delivery, such as primary care and community clinics or other settings, and that is guided by rapid needs assessments and analysis of country-specific HIV burdens and population health data.

81. Community systems (e.g. peer mobilizers) are also integral for effective, sustainable responses. Integration of these community systems with existing health and relevant non-health systems—and their ongoing strengthening—is needed to ensure that systems for health respond to people's needs and are resilient and sustainable.

82. Armed conflict, economic volatility and climate shocks are on the rise across the world, including in countries with high HIV prevalence. Nineteen countries with high HIV burden, mostly in sub-Saharan Africa, are among the 50 countries listed at the top of the 2024 Fragile States Index.[15] More than ever, HIV needs to be part of emergency preparedness and humanitarian response.

Initial recommendations for integration of HIV interventions and HIV-related health and community systems with primary health care, broader health systems, and key non-health sectors

a) **Strengthen the integration of HIV-focused systems and services into primary health care and broader public health systems** by aligning and focusing on core primary health care levers and functions, such as: workforces, laboratories, surveillance, health information, monitoring and evaluation, procurement and supply management, financing, and policies and governance to improve coordination, efficiency and sustainability of service delivery.

b) **Simplify HIV service delivery by reducing complexities and focusing on essential HIV care and prevention** services to improve, within primary health care and broader public health systems, the availability, accessibility, quality and efficiency of overall HIV care and other HIV services that are provided in a voluntary manner without discrimination or coercion.

c) **Formalize, institutionalize and integrate HIV-focused community systems and services** (see below) within primary health care and broader public health systems to ensure delivery of quality person- and community-centred, trusted and cost-effective HIV and broader health services.

d) **Strengthen collaboration, align policies and invest in co-financing across sectors for the integration of HIV into areas such** as social protection, education, justice and labour, to address societal barriers and structural drivers and enhance the effectiveness of HIV interventions. Invest in reforms and capacity-building for non-health sectors as part of integrated approaches and interventions.

[15] https://fragilestatesindex.org/global-data/

e) **Promote multi-sectoral programmatic coordination and strengthen the inclusion of key stakeholders** (such as legislators, local governments and community organizations) to realize the broader developmental benefits of HIV integration, ensuring sustained support and resource mobilization across sectors.

f) **Embed HIV in disaster preparedness plans and humanitarian responses** to ensure the delivery of services in times of crisis.

Results area 3. Invest in essential information systems and data collection by sectors and communities

83. Robust data information systems are a cornerstone of the HIV response. They are crucial for estimating HIV incidence, prevalence and mortality trends; for determining where and among whom HIV risk is high; for documenting how resources are spent; and for monitor programmatic responses to the epidemic by tracking progress and identifying gaps.

84. In monitoring the epidemic and response, a holistic approach is needed to bring multiple data sources to bear on: (a) efforts to understand the epidemic (including the costs of the response); (b) knowing the response; and (c) using those data to inform decisions.

85. Low- and middle-income countries' capacities to monitor their HIV epidemics and responses have depended heavily on external financing. It is important that countries build national HIV-related information and data systems that are integrated with other health and development measurement systems. In this context, community-led monitoring is important for accountability and for ensuring that quality HIV services are delivered.

86. HIV responses have invested significantly in collecting disaggregated data across geographies to inform relevant multisectoral programmes. Increased investments are needed in information systems that use those data, especially for key and vulnerable populations, to achieve greater efficiencies for HIV treatment and prevention.

87. New information technologies, in particular artificial intelligence (AI) tools, offer exciting opportunities for analysing, presenting and publicizing data. AI systems can analyse large datasets ("big data") to support deeper understandings of key trends which are not easily accessible to traditional data systems. Those data include social media, large household surveys, electronic health records, internet searches and metadata. However, as digital technologies become more integral to healthcare delivery and community engagement, the protection of privacy, confidentially and other digital rights must be a central concern in HIV programming.

Initial recommendations for investing in essential information systems and data collection by sectors and communities

a) **Invest and maintain robust routine data systems, including case surveillance** and civil registration data (including cause-of-death data) to provide strategic information across the HIV prevention and treatment cascades. Support national institutional capacities to manage HIV data as part of health and social data governance. That includes but is not limited to ownership and curatorship of data within and outside health facilities, privacy protection, data sharing and access by national governments, communities, international partners and other relevant stakeholders.

b) **Recognize and support the need for multiple and innovative data sources and systems to support the HIV response**. Comprehensive multi-disease and multi-behaviour household surveys can avoid "survey fatigue" in communities; support more

efficient use of financial and labour resources; allow for the collection of people-centred data; and reach people outside formal healthcare settings. Also important is the continued strengthening of civil registration systems and the use of digital technologies, including AI, to enhance data use and visualization.

c) **Ensure systematic differences between and within groups are measured to identify relevant inequalities**. Governments and the private sector will need to support the expansion of routine data systems beyond standard approaches to facilitate enriched data sets that include access to health and social services, socioeconomic status, education levels, employment and other granular details. Additional disaggregation of data will assist countries and communities to identify inequalities and inequities and develop countermeasures.

d) **Promote digital transformation and cross-border interoperability of health information systems.** It is essential to support integrated service delivery and responses, where feasible, shared electronic health and social records, while ensuring disaggregated data collection and analysis for evidence-based decision-making and improving systems and service delivery efficiencies at the highest standards of data privacy and protection. Use HIV data system improvements to strengthen other health and social data collection activities and transition towards integrated data systems, with a focus on sexual and reproductive health, tuberculosis and chronic disease data. Support the digitalization of electronic health and social data as well as moves towards making clinical, logistics, human resources, financing and community data more interoperable.

e) **Formalize collaboration between government-led and community-led structures,** ensuring mutual accountability and operational synergy. Promote the interoperability of health information systems while ensuring data are collected for evidence-based decision-making.

f) **Use information on expenditures in all data analyses to inform national planning, budgeting, efficiency improvement and policy development**. Disaggregated data on expenditures, costing and financing of transformative interventions in national HIV responses remain scarce. Further work is needed to integrate transformative actions and key indicators in national HIV programmes, strategies and plans and to ensure that those actions are costed and adequately resourced.

Priority 2: People focus: equity, dignity, and access

88. The new Strategy emphasizes that ending AIDS requires equitable, stigma- and violence-free access to tailored HIV prevention, testing and treatment services for all people living with, at risk of, or affected by HIV. Addressing inequalities and ensuring fair access to medicines and innovations are essential for success.

89. Consultations with the people served by the HIV response highlighted their unique challenges and differentiated needs. The Strategy offers a holistic approach for fulfilling those needs, including through enhanced access to differentiated health services and equitable education opportunities and social protection measures.

Results area 4. Scale up HIV prevention options that bring together biomedical, structural, community and behavioural interventions

90. Sustainability of the HIV response depends largely on accelerating progress in reducing new infections. Despite gains in some countries, the estimated 1.3 million new HIV infections in 2023 were more than triple the 2025 target of 370 000. This gap reflects unequal access to proven prevention tools.

91. Biomedical prevention—including oral and long-acting versions of PrEP—holds great promise. However, access remains limited among key and other priority populations. Interventions must be focused where the greatest impact is possible, sub-nationally and within sub-populations.

92. Behavioural and community-led strategies, HIV self-testing, peer outreach and comprehensive sexuality education are effective for a range of outcomes but are often underfunded and scarce. In addition, condom procurement has declined by one third and social marketing schemes have been steadily defunded over the past decade. Partly as a result, condom use is declining in several countries. HIV testing rates also remain low among some populations who are at high risk of acquiring HIV.

93. HIV prevention programmes for key populations must be scaled up and barriers such as persistent stigma and criminalization must be removed, not least in regions where rising numbers of people are acquiring HIV, such as eastern Europe and central Asia and the Middle East and North Africa. More culturally sensitive, male-targeted interventions that promote HIV testing, condom use, PrEP and health-seeking behaviours through sports clubs, places of worship and workplaces are needed.

94. There has been progress in integrating services for eliminating vertical transmission of HIV with sexual and reproductive health and rights programmes, but integrated services for HIV and sexual and reproductive health generally are not yet widespread (see results areas 2 and 6). Where prevention is embedded in broader sexual and reproductive health services and supported by community leadership, uptake and impact tend to be significantly higher.

95. Structural barriers, including gender-based violence and discrimination of populations specifically vulnerable to HIV acquisition, punitive laws and social stigma continue to undermine prevention efforts.

96. HIV prevention is underfunded globally and domestic investments in prevention are stagnant or shrinking in many low- and middle-income countries.

Initial recommendations to scale up comprehensive HIV prevention that bring together biomedical, structural, community and behavioural interventions[16]

a) Advance comprehensive, people-centred HIV prevention by scaling up access to **effective biomedical** tools (e.g. oral and long-acting injectable PrEP and the Dapivirine ring) within the broader framework of combination prevention and by prioritizing adolescent girls and young women and key populations, including in humanitarian settings. Services must be differentiated to population needs.

b) Strengthen adoption into national health policies of **differentiated service delivery** approaches to HIV prevention that include community-based systems that are aligned with the needs of sub-populations experiencing the largest gaps.

c) Reinvigorate total market approaches for **condoms and HIV self-testing**, while expanding self-care approaches to HIV prevention, including PrEP and post-exposure prophylaxis.

d) Ensure that prevention **options are systematically offered** in relevant healthcare settings as a standard of care, including during routine health care visits, sexual and

[16] The Global HIV Prevention Coalition, through its members and the country HIV Multisector Leadership Forum, will hold additional consultations to consolidate recommendations for a new approach to HIV prevention.

reproductive health consultations, maternal and child health, and in harm reduction settings (e.g. needle and syringe programmes and opioid agonist therapy clinics).

e) **Design and implement a new generation of integrated prevention access initiatives** that incorporate the complementary roles of pharmacies, community distribution networks and self-care options, thereby bringing HIV prevention closer to the people who need it.

f) **Improve demand for HIV prevention options** by applying a new approach to people-centered prevention communication that includes digital and peer-led outreach campaigns promoting the benefits of PrEP, post-exposure prophylaxis, condom use and harm reduction tools, with messaging that is tailored to specific key and other priority populations.

g) **Analyse granular data on epidemiology**, sub-populations and their prevention uptake, preferences and barriers (see results area 8), and use those data to develop differentiated prevention needs estimates and a new generation of country-led prevention responses (see results area 3).

h) **Address policies and societal barriers to accessing HIV prevention tools and services** and drive policy, legal and programmatic differentiated actions for key and other priority populations across the life-course to make informed choices about their own health (see results area 6).

i) **Protect the next generation** of young people by expanding quality comprehensive sexuality education and behavioural interventions that address their risk factors, and empower them, including by integrating gender-transformative components.

j) **Develop a scaled system of trusted access** to programmes for key populations in line with country contexts. That includes integrated models of support to community-based organizations to design programmes and deliver HIV prevention services.

k) **Integrate comprehensive HIV combination** prevention into national development priorities and establish multisectoral coordination mechanisms for more coherent, accountable and sustainable prevention systems.

Results area 5. Guarantee equitable access to available, accessible, acceptable and quality HIV testing, treatment and care

97. Millions of people living with HIV do not have access to HIV testing and treatment. Disparities in access to HIV testing and treatment coverage exist between regions, between adults and children, and between women and men.

98. Several countries have achieved steep reductions in their rates of vertical transmission of HIV. However, the rate of decline in HIV acquisition among children has slowed. Overall, a significant share of all new HIV infections—about one in 10—is due to vertical transmission.

99. Whereas about 86% of people living with HIV knew their HIV status and 77% were receiving HIV treatment respectively in 2023, only 66% of children with HIV had been diagnosed and 57% were receiving treatment. This mean that approximately 1.4 million children living with HIV were not receiving treatment in 2023, the majority of them in sub-Saharan Africa. Children accounted for 12% of all AIDS-related deaths, even though they constituted only 3% of people living with HIV.

100. Coverage of HIV testing, treatment and care services also tends to be lower among most key and priority populations than for the overall populations of people living with HIV. In sub-Saharan Africa, for example, available data suggest that treatment

coverage among key populations is significantly lower than among the overall population.

101. It is estimated that at least 1.8 million people have advanced HIV disease (or AIDS) due to late diagnosis of HIV, late initiation of ART or interrupted treatment.

102. In many countries, entrenched legal and societal barriers pose significant challenges for key populations in accessing necessary HIV services.

103. It is essential to meet the health needs of all people living with HIV across their life-course to reduce non-AIDS-related morbidity and mortality and achieve the best-possible health outcomes.

Initial recommendations to guarantee available, accessible, acceptable and quality HIV testing, treatment and care

a) Strengthen the adoption in national health policies of **differentiated service delivery** approaches to HIV testing and treatment that include primary health care providers and community-based systems. These should be aligned with the needs of the populations experiencing the largest gaps in testing and treatment and who are at high risk of AIDS-related mortality. Depending on the context, those populations would include children, pregnant and breastfeeding women, key populations, people living with HIV who have been lost to follow up, those with advanced HIV disease, older people living with HIV, and persons with comorbidities.

b) Accelerate the design and scale up **people-centered health services that integrate** HIV testing, treatment and care with services for co-infections and other infectious diseases (notably tuberculosis and viral hepatitis B and C), sexual and reproductive health, sexually transmitted infections, cervical cancer, maternal and child health, noncommunicable diseases and chronic diseases, mental health and gender-based violence.

c) **Invest in HIV literacy and service capacity strengthening** for healthcare providers and communities.

d) **Exploit new technologies and programme** innovations to optimize the decentralization and effectiveness of HIV testing, treatment and adherence support, such as HIV self-testing, long-acting and fixed-dose antiretroviral formulations, virtual outreach interventions, and the adoption of AI and digital health tools.

e) **Address laws and policies** that enable task shifting and community-led service delivery and remove legal and policy barriers to access to testing and treatment (see results area 6).

f) Ensure **availability and equitable access** in every context to optimal HIV testing and treatment medicines and products in line with global normative guidance.

g) Strengthen **national strategic information** systems to ensure quality and performance monitoring of HIV testing and treatment and to support evidence-based decision-making (see results area 3).

Results area 6. End stigma and discrimination and uphold human rights and gender equality in the HIV response

104. The AIDS pandemic is driven by entrenched inequalities and systemic human rights violations, many of which are sanctioned by laws that increase people's vulnerability, block their access to services and weaken HIV responses.

105. Stigma and discrimination are the most consistently reported barriers across all areas of the HIV response, particularly in healthcare, education, employment, community and humanitarian settings. Recent evidence shows that 13% of people living with HIV in 25 countries reported experiencing stigma in HIV-specific settings, compared to 25% in non-HIV healthcare settings.[17] HIV-related stigma and discrimination intersect with stigma and discrimination based on people's gender identity, race, disability, drug use and socioeconomic status. Youth, women and girls, and key populations experience intensified stigma and social exclusion, including internalized stigma.

106. Criminalization of key populations, their networks and organizations continues to be a significant barrier to service access. Sixty-three countries criminalized same-sex relations, and 13 countries criminalized gender identity in 2023. Punitive laws targeting drug use, sex work and HIV non-disclosure and transmission continue to undermine public health goals by deterring people from seeking care.

107. Gender-based violence, stigma, discrimination, harmful gender norms and gender inequality drive the AIDS pandemic among adolescent girls, women of all ages and key populations. Fifty-two per cent of people living with HIV in 2023 were women and girls. There is also a growing population of older people living with HIV.

108. The Strategy calls on countries recommit to the social and political rights that underpin the global response to HIV. That includes institutionalizing human rights and gender-transformative approaches that contain appropriate mechanisms for protection, redress and response across all relevant sectors, such as health, policing, education and more. Also needed are relevant and appropriate support and services that allow persons living with HIV to thrive in their national contexts.

Initial recommendations to end stigma and discrimination and uphold human rights and gender equality in the HIV response

a) **Address legal and policy barriers**, including punitive laws that impede access to HIV testing, treatment and prevention services, particularly for key populations and marginalized groups, and women and girls.

b) **Repeal discriminatory laws and practices** that increase women and girls' vulnerability to HIV and deter them from seeking HIV services and care, such as parental consent laws that restrict adolescents' access to HIV-related services.

c) **Develop and scale up implementation of policies and programmes to end HIV-related stigma, discrimination,** bullying (including cyber-bullying) and violence in health, education and other settings, while ensuring that policies and practices do not preclude access to education and employment based on HIV status. Institute workplace protections and support.

d) **Embed gender equality, human rights and community-led HIV-related differentiated services delivery** within universal health coverage arrangements, digital health strategies and national data systems through the development of minimum standards to transform health services into safe and inclusive spaces for all.

e) **Explicitly include key populations** in the definitions of vulnerable populations in national HIV strategies, especially in contexts where punitive laws and harmful social norms are contributing to low HIV service coverage.

f) **Institutionalize human rights** and incorporate anti-stigma training across relevant health, law enforcement and social care and education sectors, including gender and key population-specific modules.

[17] GNP+ 2024

g) **Integrate legal support and human rights mechanisms into HIV and health services, as well as in other sectors** such as prisons, including complaint channels, redress systems and legal literacy for people living with HIV, women and girls and key populations.

h) **Scale up financing and implementation of interventions that tackle human rights barriers and unequal gender norms**. Expand inclusive social protection and empower women and girls to enhance their access to HIV services and care. Support the leadership and participation of people living with, at risk of, or affected by HIV (including women and key populations) in the HIV response.

i) **Strengthen the capacities of legislators** and other political actors to participate in the response and collaborate effectively across health, education, social protection, justice and employment sectors.

j) **Secure, protect and respect civic space** for meaningful engagement and leadership of communities, networks and organizations of people living with HIV, women and girls, key and other priority populations in advocacy for human rights and gender-transformative approaches, policymaking, and policy monitoring.

Results area 7. Ensure equitable access to scientific, medical and technological innovations in HIV prevention, treatment and care

109. The slow roll-out of ART in the 1990s and 2000s led to millions of avoidable AIDS-related deaths and HIV infections. The world risks repeating history at this late stage of the HIV response. Decisive actions are required to ensure that all people benefit from the latest innovations in HIV prevention, testing, treatment and care.

110. The prices of key HIV products, especially antiretroviral medicines, are a decisive factor in countries' attempts to sustain their HIV responses with domestic financing. HIV commodities account for almost 30% of total annual HIV spending in low- and middle-income countries and up to 40% in upper-middle-income countries.

111. Price reductions for antiretroviral medicines and other HIV commodities, driven by activism and market-shaping efforts from international partners, have enabled many low- and middle-income countries to massively expand their HIV treatment programmes in the past two decades. The need for HIV treatment is so great, however, that approximately US$ 3 billion was spent on antiretroviral medicines in low- and middle-income countries annually in 2020–2022, according to procurement data received from 110 countries. Approximately US$ 2 billion of annual spending was on generic antiretroviral medicines.

112. Procurement prices still vary drastically across regions and country income groups. Middle-income and upper-middle-income countries generally pay higher prices for medical technologies, especially innovative products. This is particularly the case in Latin America and eastern Europe.

113. Encouragingly, though, average prices for antiretrovirals have decreased in recent years across all regions. These reductions are due partly to the use of pooled procurement mechanisms, economies of scale due to the growing numbers of people on ART, and the advocacy and other work of civil society organizations and multilateral institutions.

114. However, there are significant access barriers for new treatment and prevention products. Price reductions for antiretrovirals for HIV treatment and prevention, particularly long-acting formulations such as long-acting Cabotegravir and Lenacapavir, are crucial so these innovations can be made available to all who need them.

115. An overreliance on generic production that is concentrated in a few countries and on intercontinental supply chains was starkly exposed during the COVID-19 pandemic, when disruptions in global trade left many low- and middle-income countries struggling to procure essential HIV medicines. Those experiences reinforced political will in Africa and other regions to strengthen local manufacturing capacities.

116. In parallel, digital health, virtual interventions and AI represent exciting areas of innovation that can contribute to more equitable access to HIV services. These tools have the potential to expand access to prevention, testing and treatment—particularly in underserved and remote areas—by enabling virtual service delivery, strengthening surveillance systems and optimizing resource allocations. AI-driven tools could support personalized care, automate supply chain forecasting and guide integration with broader health services. Strategic investments and ethical frameworks are essential to ensure that these technologies are inclusive, community-informed and deployed in ways that reduce rather than reinforce existing inequalities.

Initial recommendations to ensure equitable access to scientific, medical and technological innovations in HIV prevention, treatment and care

a) Promote **financial sustainability** and **domestic investment** in HIV-related health products.

b) **Encourage health financing reforms** that increase domestic resource allocation to health products and strengthening of health supply chains, supported by strategic planning, high-level political commitment and evidence-based economic investment cases that maximize economic value. Develop evaluation frameworks to ensure efficient use of resources and long-term continuity of financing.

c) **Foster local and regional production** by investing in sustainable and geographically diversified regional manufacturing hubs and pooled procurement mechanisms to enhance supply chain resilience and reduce costs. Those changes should be complemented by efforts to promote local production of quality-assured HIV products.

d) **Promote legal frameworks** that enhance countries' capacities to manage intellectual property rights through using a public health lens, including by leveraging TRIPS flexibilities, implementing existing public health-oriented licensing arrangements, and enabling access to essential medicines for HIV prevention and treatment. Encourage transparent and inclusive transfers of technology to support those efforts.

e) **Prioritize market access strategies** that ensure all essential medicines and other health products, including long-acting and self-administered technologies, reach everyone who needs them, particularly underserved populations, and in all settings, including middle-income countries. Use advance purchasing mechanisms to support equitable access.

f) **Create and sustain demand for health technologies** by strengthening community-level awareness and demand for new HIV technologies through targeted education and demand-generation campaigns and by involving prospective users in product design and roll-out.

g) **Involve a wider set of stakeholders**—including low- and middle-income country governments, donors, legal experts, civil society and supply chain networks—in efforts to collectively address price barriers, legal hindrances and implementation bottlenecks. Advocate for more inclusive mechanisms to finance research and development to ensure that innovations reach those who need them the most and do so in affordable ways.

h) **Provide tailored technical assistance** to ensure countries have equitable and sustainable access to HIV-related health products. Where appropriate, countries should

have access to shared technical expertise and financial tools that reinforce national ownership and address local needs.

i) **Improve the transparency of markets for HIV-related health technologies**, by strengthening existing and strengthening platforms of prices of HIV-related products, providing countries with consistent and transparent information to engage in fair price negotiations. Transparency measures are also needed to ensure the quality of licenses of health products, by advancing analyses on the patent landscape of HIV-related health technologies

j) Encourage alternative mechanisms to **incentivize innovation** within the health sector, ensuring transparent coordination and sustainable financing of research and development of health technologies, promoting access to innovation for all, and pursuing alternative mechanisms to remunerate innovation in the health sector that are not dependent on the final prices of medical products.

k) **Leverage AI and digital health**. Integrate AI and digital health into the global HIV response through clear ethical and technical guidance, support for national implementation and strong community engagement.

l) **Encourage partnerships** with technology, finance and civil society actors, and promote virtual service models to overcome access barriers. Use AI to enhance integration with broader health systems, reduce disparities and create more agile, inclusive and effective programmes.

Priority 3 – Powered communities leading the HIV response

117. Communities are the heart of the HIV response and perform life-saving work. In moments of uncertainty, delay or political hesitation, communities have stepped forward to demand access to treatment, challenge stigma, shape policies and deliver services. From advocacy and resource mobilization to peer-led service delivery and community-led monitoring and research, community-led responses have identified gaps and pioneered innovative, context-specific solutions, including in challenging environments and crisis-affected areas. When new technologies such as long-acting PrEP, emerge, community-led responses devise innovative ways to create demand in communities and deliver services in acceptable and accessible ways.

118. In a context of political hesitation and setbacks, expanding community-led responses should be seen as an opportunity to continue transforming the HIV response from a top-down model to one rooted in solidarity, dignity, resilience and human rights.

Results area 8. Power communities to lead

119. Community-led advocacy, campaigning and engagement are essential for sustainable and effective HIV responses. That work generates urgency and reinforces accountability, qualities which institutional systems often struggle to maintain. Community advocates identify barriers, challenge harmful norms and co-create inclusive and impactful solutions. Community-led advocacy highlights the changes that can enhance the impact and efficiency of investments in treatment, prevention and care. Embracing and supporting community leadership is not only strategic; it is essential for ending the AIDS epidemic.

120. Community-led monitoring and research efforts complement other HIV surveillance systems by generating context-specific data which otherwise would go unnoticed, and which can be used to boost effectiveness. By powering communities to generate and analyse their data, we build local capacity and produce evidence to inform priorities and policy changes.

121. Expanding community-led service delivery is critical for reaching people and populations who are under-served by standard health systems. Communities are uniquely equipped to reach out to their peers and deliver prevention services for key populations and young people, provide treatment support for people living with HIV, promote self-care approaches, and support policies and programmes needed for effective national HIV responses. Because community-led service delivery is people-centred, it responds to people's diverse needs and can have an impact beyond HIV, including on broader health, social protection and inclusion, economic empowerment and education. Strong community-government partnerships to expand HIV service provision can have a massive impact.

122. Diverse and innovative financing of community-led responses is crucial. This is particularly true for settings with insufficient health staff and facilities, and where key and other priority populations face challenging social and legal environments. In the context of constrained resources, there is a valuable opportunity to modernize health systems by partnering with communities to deliver cost-effective, tailored and integrated interventions. Funding for community-led responses can be increased by promoting a combination of different funding models (e.g. social contracting, corporate social responsibility, social enterprises, etc.).

123. To break down barriers to community engagement, it is important to challenge traditional power dynamics and provide the populations who are most marginalized and underrepresented in the HIV epidemic—such as women and girls, key populations, and adolescents and youth—with capacity-strengthening, protection, mentoring and the means to participate fully in decision-making. Their voices and knowledge are often unheard and underestimated , which is to the detriment of HIV responses.

Initial recommendations to power community leadership in the HIV response

a) **Institutionalize community** engagement in coordination mechanisms and formally recognize the important roles of communities in achieving accountability in HIV responses.

b) **Reform policies and regulatory frameworks** that limit the ability of community-led organizations to participate in all aspects of HIV responses, particularly advocacy, engagement in decision-making, and service delivery, including treatment and prevention services.

c) **Adequately resource all** components of community responses to HIV, from advocacy to engagement in decision-making and accountability, service delivery and community-led monitoring and research.

d) **Enact effective social contracting** mechanisms that enable the financing of community-led responses from domestic resources and ensure those mechanisms are accessible to community-led entities such as youth-led organizations, women's networks and key population-led organizations.

e) **Sustain and scale up existing community-led service delivery systems**, including innovations such as digital services and campaigns, key population- or youth-friendly drop-in-centres, among others.

f) **Enable and resource community-led monitoring and research** and provide for their systematic inclusion in planning and decision-making processes that use data for programming and accountability.

g) **Support the capacity-strengthening, resilience and preparedness** of community-led organizations and service providers.

Local, regional and multilateral action to end AIDS

124. Ending AIDS requires sustained collective action. The HIV response must be country-led and people-centred, with services delivered locally. Governments and communities lead national efforts, while regional and international partners provide coordination, guidance and technical support. No single actor can end AIDS alone.

125. Greater recognition of the importance of sub-national levels of action will be key. Regional institutions and multilateral organizations and systems will also continue to play critical roles.

Where many are gathered: local action for greater impact

126. Services are primarily provided at local level. That is often also where productive new partnerships are developed with philanthropies, faith-based organizations, the private sector and others. Local-level partnerships between communities, local authorities and the wider community are vitally important.

127. Sub-national political units are increasingly important partners. In several countries, large cities are front-line providers of health and education services, which they deliver more or less autonomously from national institutions. Urban areas are capable of effecting rapid changes, while also offering unique comparative advantages for the HIV response due to existing infrastructure, institutions and forums for strengthened healthcare, economic growth, education, innovation and positive social change.

128. An estimated one quarter of all people with HIV live in 200 cities across the world. Key and other priority populations are often concentrated in urban or peri-urban areas or informal settlements, and face challenges in accessing HIV prevention, testing and treatment services due to stigmatizing and discriminatory attitudes or behaviours, or and the criminalization of specific behaviours. Local authorities are uniquely placed to address some of the challenges faced for example by people in prisons and other closed settings, sex workers, gay men and other men who have sex work men, people who use drugs, and other vulnerable populations in cities. City-level HIV commitment and planning can promote dialogue and coordination between different levels of government and help catalyse national legislative changes.

129. Some large cities also host significant refugee and migrant populations. When large-scale disasters strike, affected communities often converge on cities and towns in search of shelter and other support. The new Strategy therefore emphasizes the importance of including cities and municipalities as partners in the response to HIV.

<u>How local-level action can make a difference</u>

- Encourage leadership, coordination and dialogue between the different levels of government to address challenges faced in the HIV response, including by strengthening and integrating community systems into official health structures and disaster preparedness plans.
- Manage systems for strengthened data monitoring and reporting to better understand the differences in the HIV epidemic within cities and localities and to enhance local HIV responses.
- Guarantee equitable access to health services for people living with, at risk of, or affected by HIV, especially migrants, refugees and people in closed settings.

Better together: regionalism as a mechanism for maintaining momentum

130. The involvement of regional organizations such as the African Union, Africa Centres for Disease Control and Prevention, the Caribbean Community, and the Association of Southeast Asian Nations is important for the sustainability of the global HIV response. These entities can play powerful roles in pooling technical support and procurement, harmonizing public strategies, promoting national accountability, mobilizing shared resources, conducting research and disseminating information at scale.

131. Regional organizations also have critical roles in health and other emergencies, including through the promotion of common indicators, real-time reporting tools and data-sharing between humanitarian and health actors, including across borders, to facilitate continuity of vital health services.

132. The new Strategy recognizes that pandemics, conflicts and displacement make it necessary to integrate the HIV response into humanitarian interventions.

133. Regional organizations are uniquely placed to promote local production capacity for HIV medicines and other products, improve supply chain resilience and reduce dependency on international suppliers.

134. Innovative financing for regional responses is necessary to increase the sustainability of the global response. This can be done through mechanisms like community-based health insurance and regional health insurance schemes. Strengthening cross-border communication and information sharing is part of this response.

135. The new Strategy will include further guidance on the roles of regional organizations in supporting countries to end AIDS.

Shared responsibility, shared future for a global response to AIDS—inclusive multilateralism in a new era

136. The challenges of the HIV pandemic today require a response at all levels including global and multilateral support. The progress made in the global HIV response results from bringing together the activism and leadership of communities and countries with scientific innovations, shared expertise and global solidarity.

137. Advocacy, partnership and leadership are critical for the sustainability and resilience of the global response, especially in difficult periods. This includes reviving political commitments to the global HIV response, advancing inclusive and broad-ranging partnerships and revitalizing political and social leadership and accountability to keep the response on the international agenda.

138. Targets, accountability and international standards and commitment for a rights-based, gender-transformative and multisectoral response to HIV are developed by building partnerships and shared resolve at the global level.

139. Multilateral action is necessary to scale up access to essential biomedical tools like access to oral PrEP, long acting injectables, and the Dapivirine ring, prioritizing key populations, adolescent girls and young women, as well as young people, due to generational shifts. Investments in drug procurement and supply chain support are crucial, alongside innovative finance mechanisms for domestic production. Accelerating national approvals for new treatments, reducing costs through the use of generic varieties of key drugs remains essential.

140. Continued investment in research and development in both clinical and non-clinical interventions is vital to reach the 2030 goals, as well as to mitigate the impact of other

health crises. Breakthroughs like a possible cure for HIV are only possible through continued and coordinated sustainable financing for the global response.

141. Millions of people living with HIV are still directly dependent on international funding for access to treatment, prevention and psychosocial support. The new Strategy recognizes that the changing political context is undermining the sustainability of the global response, and it therefore will call on traditional and non-traditional partners to participate in the HIV response. It also recognizes that continued sustainable and equitable funding of the HIV response at community level is critical for achieving the goals of ending the pandemic by 2030, as well as for strengthening global health more broadly through investments in interventions that address the social and structural dimensions of the AIDS epidemic.

    The new Strategy offers the following recommendations for urgent multilateral action to increase the momentum towards ending AIDS as a public health threat by 2030 and building a sustainable response:

    a) **Provide a global framework for action**, ensuring accountability including target-setting and data monitoring of progress of the HIV response.

    b) **Ensure sustainable financing** for the global response by restoring disrupted financing streams to address the immediate needs of people living with, affected by, or at risk of HIV.

    c) **Advance normative guidance and international standards** for a rights-based, gender-transformative response to HIV.

    d) **Convene actors in the global response for collective action** to end AIDS as a public health threat, including communities of people living with, affected by, or at risk of HIV; philanthropies; the private sector; national governments; regional organizations; and multilateral entities.

    e) **Increase access to medicine** by addressing intellectual property and patent barriers to ensure affordability and increased access to new HIV treatments and diagnostics. Ensure that both existing and new HIV products remain widely available and accessible to overcome disparities.

    f) **Science and research**. Develop and invest in an international research agenda to accelerate the end of AIDS as a public health threat.

Conclusion

142. All Member States of the UN committed in 2015 to end the AIDS pandemic by 2030. Only five years remain until that deadline. Huge challenges stand in the way amid a rapidly evolving global context. Despite this, a narrow path remains open. The Global AIDS Strategy 2026–2031 is a roadmap for countries to adapt to the challenges and navigate that path to reach people with the life-saving services they need.

143. The Strategy features a concise set of targets for HIV treatment and prevention service coverage and the enabling environment that is needed to reach people living with, at risk of, or affected by HIV. The three priorities and eight results areas of the Strategy describe how these targets can be met: integration of HIV services within health and non-health sectors; steady increases in domestic investment supported by international financing; greater efficiency through better data; rapid and equitable access to scientific, medical and technological innovations; differentiated delivery of services to reach those in greatest need; and continued community leadership across services and systems.

144. The Strategy calls for a collective effort. The response must be people-centred, led by governments and communities at country level, and delivered by communities and authorities at the local level. Regional organizations must play a greater role in pooling resources and providing technical expertise. Global multilateral action is needed to set targets and monitor progress; coordinate research and provide normative guidance and international standards; increase access to new innovations; and mobilize and manage international financing. No community or country can end AIDS alone: we must stand together.

Proposed decision points

The Programme Coordinating Board is invited to:

145. *Recall* PCB decision point 6.2a from the 55th PCB meeting;

146. *Take note* of the annotated outline of the Global AIDS Strategy 2026-2031;

147. *Request* the Executive Director to present the Global AIDS Strategy 2026-2031, to be developed through an inclusive and transparent multistakeholder consultative process, to the 57th PCB meeting in December 2025 for consideration and adoption;

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