Agenda item 5

UNAIDS/PCB (56)/CRP3

SURVEY ON THE GLOBAL AIDS STRATEGY 2026–2031

Summary of survey results

UNAIDS

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Executive summary

1. An online survey was conducted as part of stakeholder consultations for the development of the Global AIDS Strategy 2026–2031. The survey questionnaire centered on two primary themes: the barriers impeding progress towards current global targets and the priorities for the forthcoming strategy. Respondents to the survey were asked to identify the biggest barriers faced in 11 programme areas of the 2021-2026 Global AIDS Strategy, and they were asked to rank options for programming, financing and cross-cutting themes.

2. There were 5,809 respondents who answered at least the first question, and a completion rate of 44%. Respondents were highly diverse geographically, with 146 countries represented. There was strong civil society involvement, with community networks representing people living with HIV, key populations and other populations served by the HIV response accounted for 25% of the total respondents and national NGOs an additional 15%. More than one-third (35%) of respondents stated that they represented or identified as people living with HIV. Significant percentages of respondents identified as key populations. Government employees and health providers each accounted for 11% of respondents, and individuals working for international organizations comprised 24%.

3. A quantitative analysis of the responses to the multiple choice and ranking questions and a qualitative analysis of the responses to an open-ended question following broad conclusions on respondents' views of the HIV response:

Stigma and discrimination remain major barriers to HIV service access

4. Despite decades of awareness-raising on HIV and the current widespread availability of antiretroviral medicines that allow people living with HIV to protect their health and prevent transmission of the virus, stigma and discrimination was widely viewed as the biggest barrier to achieving the global goals of the AIDS response, and in particular to reaching global targets for widespread coverage of HIV services, including prevention, testing, treatment and care.

Progress on societal enablers has been limited by persistent social and cultural norms and prohibitive laws and policies

5. Three of the five most reported barriers to reaching current global goals and targets for the AIDS response reinforced the importance of societal enablers: (1) harmful social and cultural norms; (2) gender inequalities; and (3) prohibitive laws and policies.

Access to services is the top priority for reaching the goal to end AIDS

6. Despite the huge challenges presented by societal barriers, more than two-thirds (69%) of respondents stated that access to HIV services was the top priority for the AIDS response moving forward. Half stated that the top priority was HIV testing and treatment for people living with HIV, and another 19% ranked HIV prevention first.

These two areas were a much higher priority for respondents compared to efforts to reinforce rights and prevent violence, stigma and discrimination.

Integration and community leadership are important pathways to increasing service coverage

7. Lack of integration of HIV services into broader health services was a commonly reported barrier to services, and integration was the third most likely to receive the top ranking among seven potential priority action areas for the strategy. Integration was especially popular among government and technical partners who are struggling to maintain the delivery of HIV services in a period of decreasing availability of international resources. Civil society respondents were less likely to prioritize integration, and they were twice as likely as government respondents to state that community leadership was a top priority. Work on both of these pathways will need to reckon with a barrier to HIV service delivery identified by roughly one-third of respondents: lack of knowledge and information about those services.

Increasing domestic financing is viewed as critical to sustaining progress towards global goals

8. Lack of domestic funding was consistently identified as a barrier across all 11 programme areas. ‘Increasing domestic financing’ was also selected by more than half (53%) of respondents as the top financing priority for sustaining the global AIDS response. Calls for greater government ownership, commitment, financing and accountability in the HIV response were also common in the answers to the open-ended question on bold changes.

Introduction

9. UNAIDS has been tasked by its Programme Coordinating Board (PCB) to develop the Global AIDS Strategy 2026–2031, which will serve as a roadmap for continued global efforts to end AIDS and will inform the United Nations General Assembly High-Level Meeting on Ending AIDS, including its political declaration. This strategy represents a critical cornerstone in the global AIDS response, aiming to address persistent gaps and articulate a transformative approach to eliminating AIDS.

10. A fundamental aspect of the strategy's development is the inclusion of a diversity of stakeholders throughout the process. A variety of methods, including stakeholder consultations, were employed to capture key priorities and identify transformative changes required for the 2026–2031 period. An online survey was conducted as part of this process. The survey was anonymous and easy to access, enabling widespread participation of grassroots stakeholders beyond the representatives of constituencies invited to formal stakeholder consultations at national, regional and global levels.

11. The objectives of the survey were:

- Ensure broad engagement opportunities for stakeholders in the development of the Global AIDS Strategy.

- Collect insights on barriers, priorities, and critical actions necessary to achieve the goal of ending AIDS.

- Obtain stakeholder feedback on proposed strategic priorities and actions.

12. This report aims solely to present the findings of the global online survey and does not necessarily reflect the views of UNAIDS.

Design, methodology and limitations

13. The online questionnaire centered on two primary themes: the barriers impeding progress towards current global targets and the priorities for the forthcoming strategy. SurveyMonkey was chosen as the platform to host the questionnaire, given its user-friendly interface and the confidentiality it affords respondents. The survey was developed by UNAIDS in English. To enhance accessibility and promote diverse participation, the survey questionnaire was available in Chinese, English, Hindi, French, Portuguese, Russian, Spanish, Ukrainian and Vietnamese.

14. Survey respondents were recruited using a non-probability convenience sampling method. The minimum age for participation in the survey was set at 16 years old. To ensure broad global reach and inclusive participation, the survey link was disseminated online and shared with Geneva-based country missions, UNAIDS co-sponsors, and the NGO Delegation to the Programme Coordinating Board (PCB). Additionally, the UNAIDS communications team distributed the survey across all official channels, and Country Directors further shared it within their regional networks. Although not a representative sample with generalizable findings, the

sampling method facilitated rapid dissemination and enabled quantitative questions to be accessed by a large, geographically diverse cohort to provide valuable insight. The survey remained open to the public from April 3 to April 22.

15. Analysis of the quantitative data was primarily conducted using standard tools available in SurveyMonkey, including tools that facilitate comparisons of sub-populations of the survey respondents by region, occupation, sex/gender, age and group identity. When needed for additional analysis or more bespoke data presentation, the quantitative data was downloaded from SurveyMonkey and analyzed in MS Excel.

16. Analysis of the responses to the open-ended question at the end of the survey was conducted with the aid of an AI-driven tool. This tool was trained using a description of the results and general instructions[1], followed by specific questions that guided further investigation. To address ethical concerns around privacy when handling sensitive qualitative data, the tool was designed internally and specifically for the UNAIDS analysis rather than an open-source or publicly accessible system. No external or AI-generated data was used; the analysis was based solely on the original survey responses.

17. This research methodology presents certain limitations. The non-random, non-probability sampling method inherently limits the generalizability of the findings. The sample predominantly included individuals with prior engagement with UNAIDS and its partners, which may introduce sampling bias.

18. An additional potential limitation was the timeframe for data collection; an extended survey period might have allowed for greater participation. SurveyMonkey was not available in all countries, regions and languages, in part due to local or foreign access restrictions. Additionally, internet accessibility issues at the sub-national level in certain regions (e.g. rural areas of sub-Saharan Africa), along with language and literacy barriers, may have hindered broader demographic participation.

19. Other offline and hybrid consultations opportunities were made available to stakeholders at global, regional and national level. For a summary of the Global AIDS

[1] The AI tool was trained to categorize survey responses into predefined or dynamically identified categories. The prompts were: (i) organize responses based on demographic variables, geographical regions, or other criteria provided in the uploaded data; (ii) detect and highlight recurring themes, patterns, or ideas across the responses; (iii) surface emerging trends or unique perspectives within the responses; (iv) provide concise summaries of the uploaded data, including overarching insights and representative ideas; (v) deliver summaries tailored to specific user questions, offering clarity and focus on particular aspects of the survey data; (vi) analyze responses to identify gaps or overlooked areas in the HIV response; (vii) highlight responses that offer bold, creative solutions aligned with the GAS objectives; (viii) use reasoning and interpretation to propose actionable strategies and recommendations based on the extracted insights; (ix) ensure recommendations are relevant to ending AIDS as a public health threat by 2030 and sustaining the response beyond 2030; (x) represent key findings through visual summaries, such as graphs or charts, if possible; (xi) at the end of the response, please give the methodology of what actions you took to generate the response. Do not give what is ideal, only what you did.

Strategy consultation process please see: Global AIDS Strategy 2026-2031 | UNAIDS

20. AI-driven analysis has notable limitations. The tool may not have a nuanced understanding of context and therefore difficulties in interpreting subjective data. The AI model used may also perpetuate biases from training data.

Who responded?

21. There were 5,809 respondents who answered at least the first question. Most respondents did not answer every question. The overall completion rate was 44%, with 53% completing the barriers section of the survey, 47% completing the priorities section, 44% the section on cross-cutting issues and 28% the final question on bold changes (Figure 1) The following analyses of the demographics of the survey respondents are of the 3,061 who completed at least the barriers section.

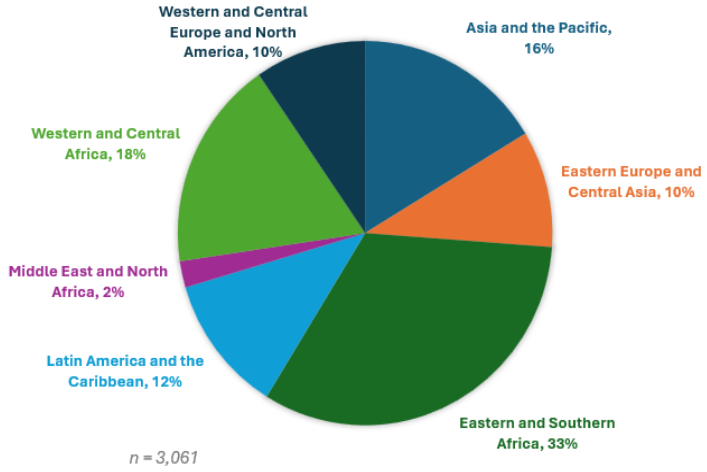
Figure 1. Survey completion

22. A nearly equal number of respondents identified themselves as female (1,456) and male (1,480), with each comprising 48% of total respondents and an additional 3% identifying themselves as trans or gender diverse.

23. Geographically the respondents showed a high degree of diversity, with 146 countries represented. About one third (33%) of respondents were from the region most affected by HIV, Eastern and Southern Africa, and 16% hailed from the world's most populous region, Asia and the Pacific (Figure 2). Just 6% of respondents were from the Middle East and North Africa, the region least affected by the AIDS pandemic.

24. Almost half of respondents (49%) worked on the HIV response on a national level and about a quarter (26%) identified themselves as province or district level, and 27% as global level. Two thirds (67%) dedicate all or most of their work to the HIV response.

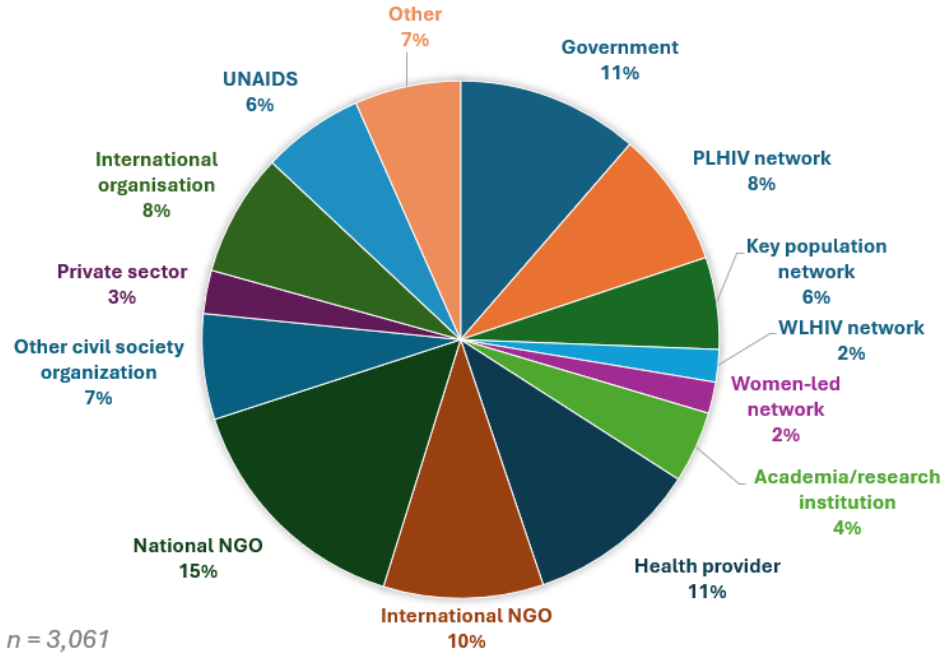
Figure 2. Survey respondents, by region



A wide range of stakeholders were contacted for the survey. Community networks representing people living with HIV, key populations[2] and other populations served by the HIV response accounted for 25% of the total respondents, and national NGOs an additional 15%, reflecting strong civil society involvement. Government employees and health providers each accounted for 11% of respondents, and individuals working for international organizations comprised 24%. Academia and the private sector comprised only 4% and 3%, respectively (Figure 3).

25. As well as their organization, respondents were asked to indicate which communities they represented or identified with. It was possible for respondents to select more than one community.

Figure 3. Survey respondents, by organization

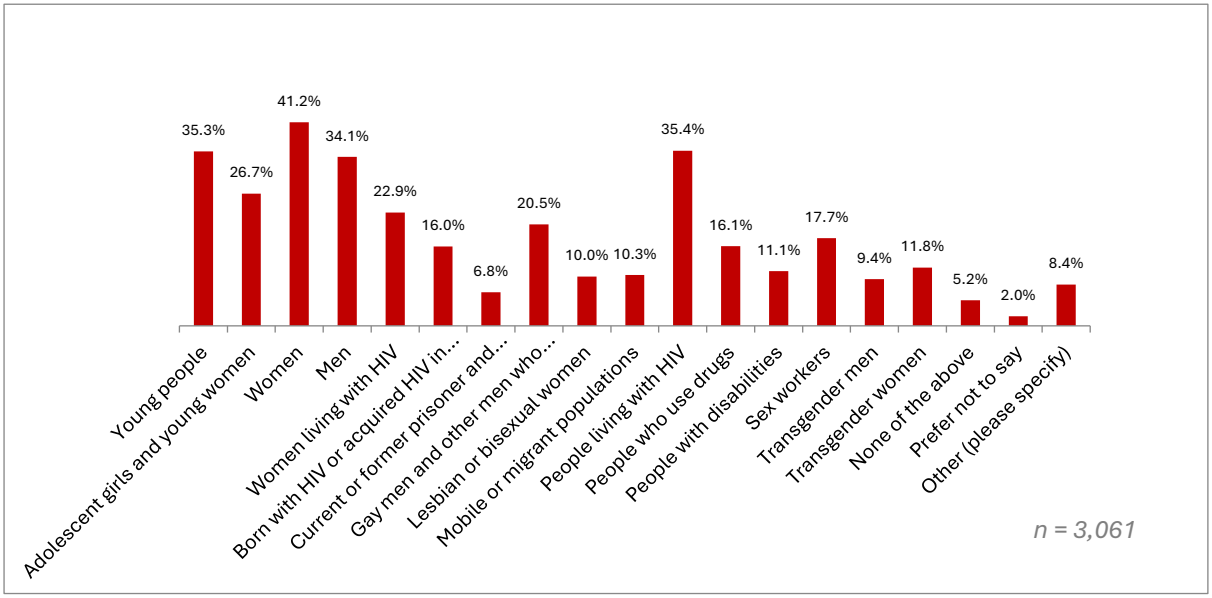


[2] Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with 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.

26. More than one-third (35%) of respondents stated that they represented or identified as people living with HIV. Significant percentages of respondents identified as key populations: gay men and other men who have sex with men at 21%, sex workers 18%, people who use drugs 16%, transgender women 12%, transgender men 9% and former and current prisoners 7%. Women (41%) and young people (35%) were highly represented, including more than a quarter (27%) who identified themselves as adolescent girls and young women (Figure 4).

27. Although 35% said they represented or identified as young people, only 7% of respondents were aged 25 or younger. More than half of respondents said they were over 40 years old.

Figure 4. Survey respondents, by identity and representation *(respondents could select all that apply to them)*



Survey results

Barriers to reaching the targets of 2021-2026 current Global AIDS Strategy

28. The Global AIDS Strategy for 2021-2026 features ambitious targets and commitments to be achieved in every country and community for all populations and age groups by 2025. These targets include very high coverage of HIV services, removing societal and legal impediments to an effective HIV response; and establishing robust and resilient systems to meet the needs of people.[3] As of mid-2025, significant gaps remained between these targets and the state of the AIDS responses of most countries.

[3] https://aidstargets2025.unaids.org/

29. Respondents to the survey were asked to identify the biggest barriers faced in 11 programme areas of the 2021-2026 Global AIDS Strategy. They could choose between one and three of the following barriers:

Unavailability of services and commodities	Weak or poor quality of services, delivery systems and commodities
Harmful social and cultural norms	Lack of integration of HIV services into broader health
Lack of meaningful community involvement	Inadequate human resources
Prohibitive laws and policies	Cost to the individual
Stigma and discrimination	Inadequate government resources/funding and commitment
Gender inequalities: e.g. violence against women and girls, economic status, etc.	Inadequate international resources/funding and commitment
Lack of knowledge and information about HIV services	

30. Some barriers were not included among the potential responses of some questions. For example, 'lack of integration' could not be chosen as a barrier to integration.

<u>Global responses</u>

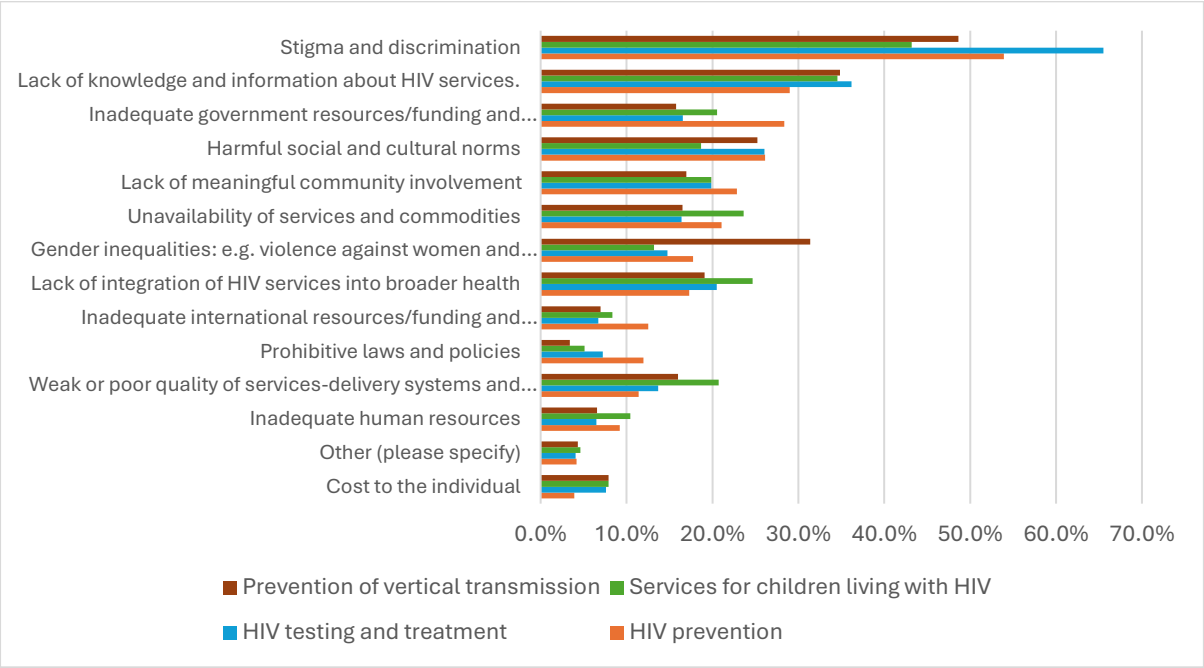
31. 'Stigma and discrimination' was the most commonly reported barrier reported in six areas of the response, including all four HIV service areas. More than half of respondents said that stigma and discrimination was a barrier to HIV prevention interventions (54%) and from knowing one's status, accessing treatment and adhering to it (66%); and just under half said it was a barrier to diagnosis, treatment and care for children living with HIV (43%) and prevention of vertical transmission (49%) (Figure 5).

32. 'Lack of knowledge and information about HIV services' was a commonly reported barrier to HIV services, reported by 37% as barrier to testing, treatment initiation and treatment adherence, by 35% as a barrier to services for children living with HIV, by 35% as a barrier to the prevention of vertical transmission, and by 29% as a barrier to HIV prevention.

33. 'Lack of integration of HIV services into broader health services' was selected by 21% of respondents as a barrier to testing, treatment initiation and treatment adherence, by 25% as a barrier to services for children living with HIV, by 20% as a

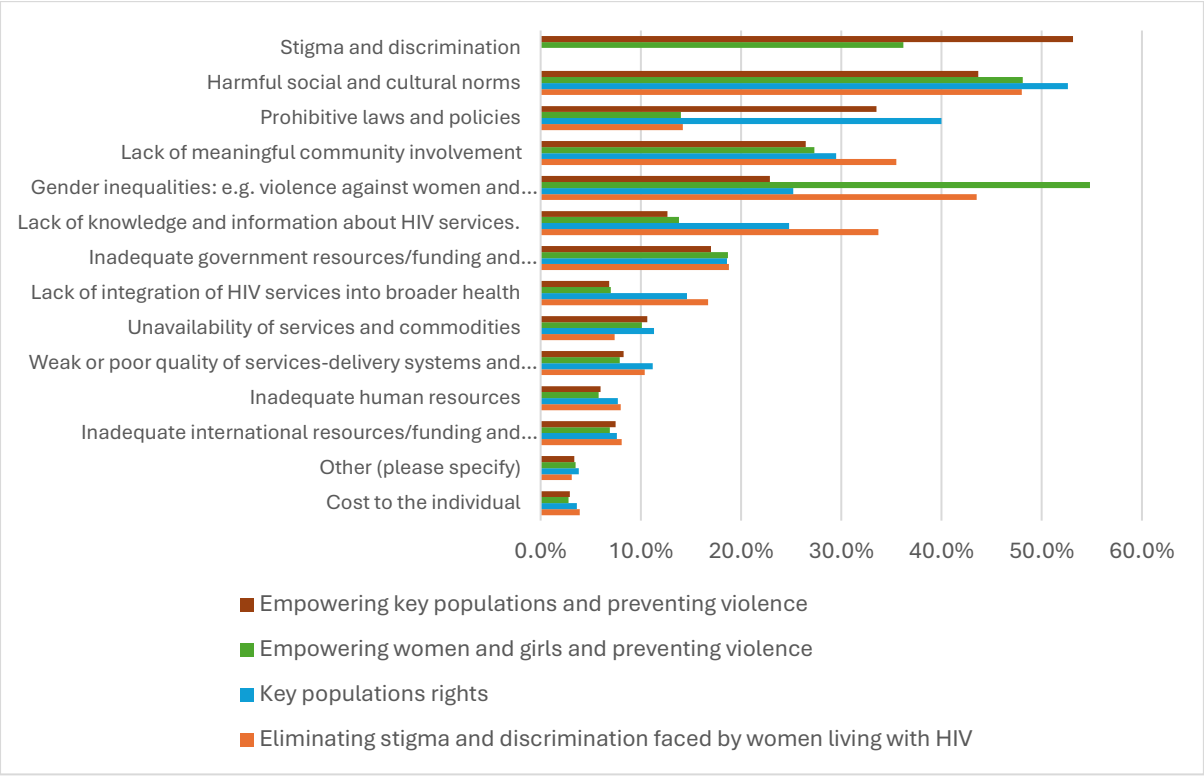
barrier to the prevention of vertical transmission, and by 17% as a barrier to HIV prevention.

Figure 5. Barriers to HIV services, all respondents



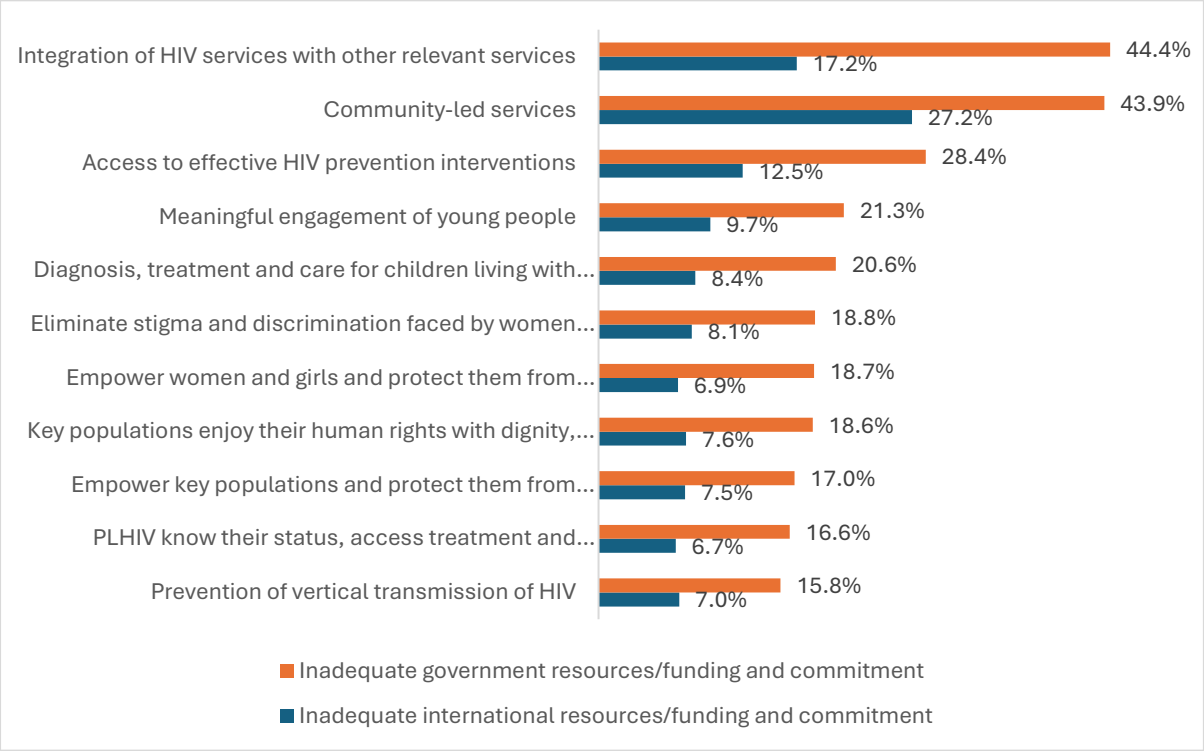
34. 'Harmful social and cultural norms', 'gender inequalities' and 'prohibitive laws and policies' were the most commonly reported barriers to progress on the societal enablers of the AIDS responses, such as eliminating stigma and discrimination, enjoying one's human rights, living with dignity, empower women and key populations, and preventing physical and/or sexual violence (Figure 6).

Figure 6. Barriers to progress on societal enablers, all respondents



35. Inadequate domestic funding was consistently identified as a barrier across all 11 programme areas, ranging from nearly half (44%) of respondents stating it was a barrier to community-led services and the integration of HIV services with other relevant services to 16% for the prevention of vertical transmission (16%). By comparison, despite the recent reductions in donor funding, inadequate international resources were much less likely to be identified as a barrier, ranging from 27% for community-led services to less than 7% for HIV testing and treatment (Figure 7).

Figure 7. Comparison of the percentage of respondents who identified inadequate domestic and international funding as a barrier to progress in 11 areas of the HIV response



Responses by region

36. Regional responses were similar to global responses, with stigma and discrimination almost always the most commonly reported barrier to HIV services. However, 'lack of knowledge and information about HIV services' was the top barrier to services for children living with HIV in the Middle East and North Africa (48.0% of respondents) and the top barrier to services to prevent vertical transmission in Eastern Europe and Central Asia (46.5% or respondents).

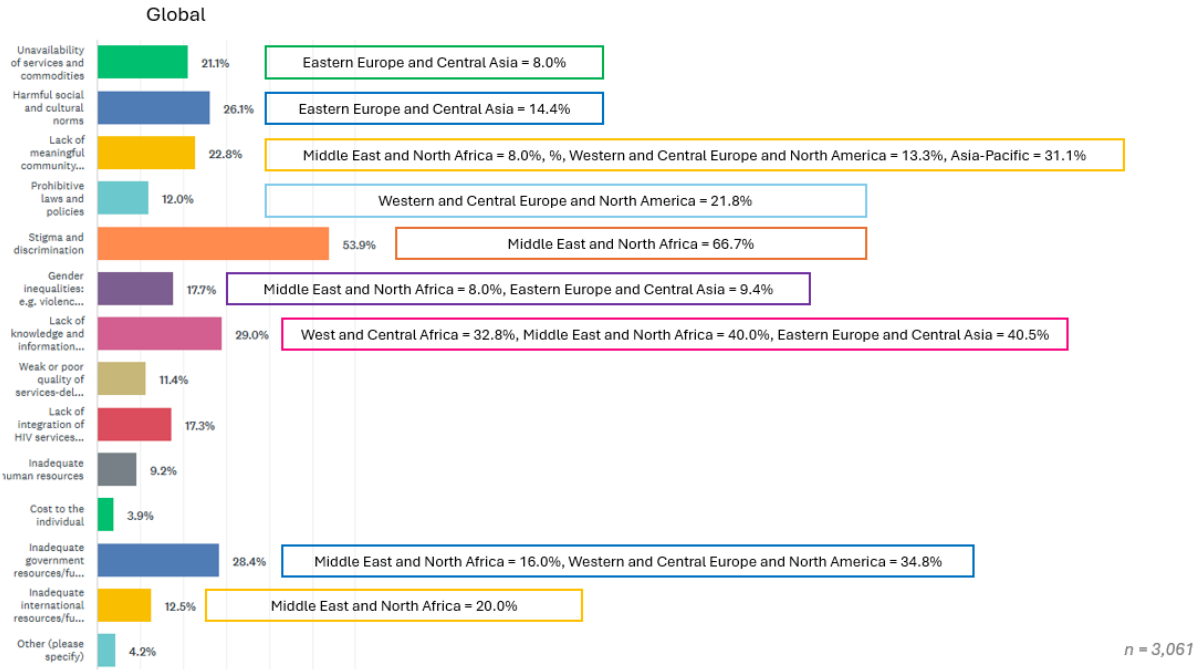
37. In Eastern and Southern Africa, 'lack of meaningful community involvement' was more frequently named as a barrier than the global average in two areas: efforts to eliminate stigma and discrimination for women living with HIV (41.0% vs 35.5% globally) and empowering women and girls and protecting them from violence (32.4% vs 27.3% globally).

38. In West and Central Africa, 'harmful social and cultural norms' were more frequently named as barriers than the global average in three areas: prevention of vertical transmission (29% vs 25% globally), empowering women and girls and protecting them from violence (53.0% vs 48.1% globally) and empowering key populations and protecting them from violence (49.8% vs 43.7% globally).

39. There were variations in regional reporting on the barriers to HIV prevention (Figure 8). These variations sometimes appeared to reflect regional differences in modes of transmission, social and cultural norms and legislation/policies that impact key

populations and other vulnerable and marginalized groups. Sometimes they did not. For example, 21.8% of respondents in Western and Central Europe and North America reported that prohibitive laws and policies were a barrier to HIV prevention, compared to 12.0% globally. In the Middle East and North Africa, 'gender inequalities' and 'lack of meaningful community involvement' were less frequently reported as a barrier, while 'lack of knowledge and information', 'stigma and discrimination' and 'inadequate international resources/funding' were more frequently reported. In Eastern Europe and Central Asia, 'unavailability of services and commodities' was rarely reported as a barrier (8.0% versus 21.1% globally), and 'lack of knowledge and information' was more frequently reported as a barrier (40.5% versus 29.0% globally).

Figure 8. Barriers to HIV prevention, global vs regional responses



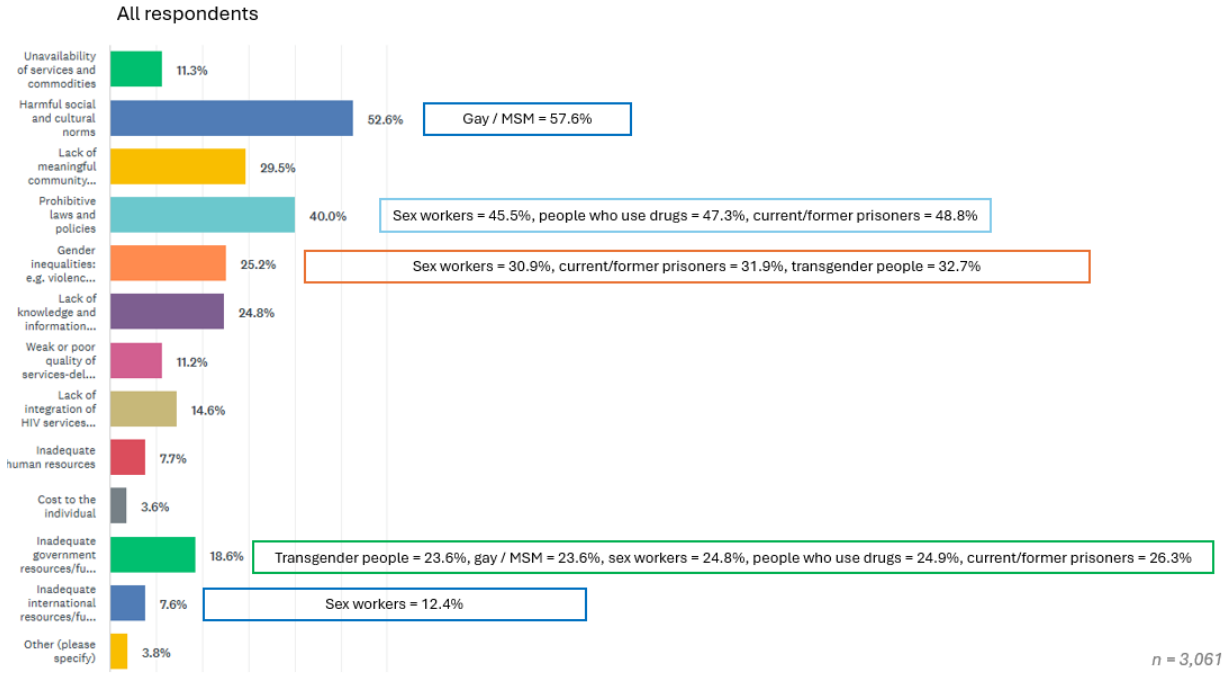
<u>Responses by sub-population</u>

40. Analysis of responses by sub-population revealed few differences in reported barriers to HIV prevention, compared to the global responses. There were a few small but notable differences in the barriers preventing people living with HIV from knowing their status, accessing treatment, and adhering to it. People living with HIV were more likely than government respondents to identify 'stigma and discrimination' and 'lack of meaningful community involvement', and less likely to report that 'unavailability of services and commodities' and 'harmful social and cultural norms' were barriers.

41. Analysis of the barriers preventing key populations from enjoying their human rights with dignity, equality and free from stigma and discrimination by sub-populations revealed some differences in their responses compared to all respondents. Three groups of key populations more frequently identified 'prohibitive laws and policies',

‘gender inequalities’ and ‘inadequate government resources/funding’ as barriers (Figure 9).

Figure 9. Barriers preventing key populations from enjoying their human rights with dignity, equality and free from stigma and discrimination, global vs key population responses



42. There were several differences in the responses of women and men on barriers. Across several areas of the HIV response, women were more likely than men to report that ‘gender inequalities’ and ‘lack of knowledge and information about HIV services’ were barriers, while men were more likely than women to report that ‘inadequate international resources/funding and commitment’ was a barrier (Figure 10).

Figure 10. Responses to questions on barriers, women vs men

Barrier	Area	% of women who selected the barrier	% of men who selected the barrier	Difference
Gender inequalities	Eliminating stigma and discrimination faced by women living with HIV	48.0%	38.8%	9.2%
	Rights and no stigma and discrimination for key populations	27.8%	22.4%	5.4%
	Empower women and girls and preventing violence	59.6%	50.1%	9.5%
	HIV prevention	21.5%	13.9%	7.7%
	Prevention of vertical transmission	35.0%	27.7%	7.3%
Lack of knowledge and information	Young people engagement	40.7%	33.7%	7.0%
	Prevention	32.1%	26.9%	5.2%
	Testing and treatment	39.8%	33.5%	6.3%
	Services for children living with HIV	38.6%	31.6%	7.0%
	Prevention of vertical transmission	38.0%	32.6%	5.4%
Inadequate international funding and commitment	Integration	14.1%	19.9%	-5.8%
	Young people engagement	6.8%	12.4%	-5.6%
	Prevention	9.3%	15.3%	-6.0%

Priorities for the new Global AIDS Strategy

Action areas

43. Survey respondents were presented with seven potential action areas for the next Global AIDS Strategy:

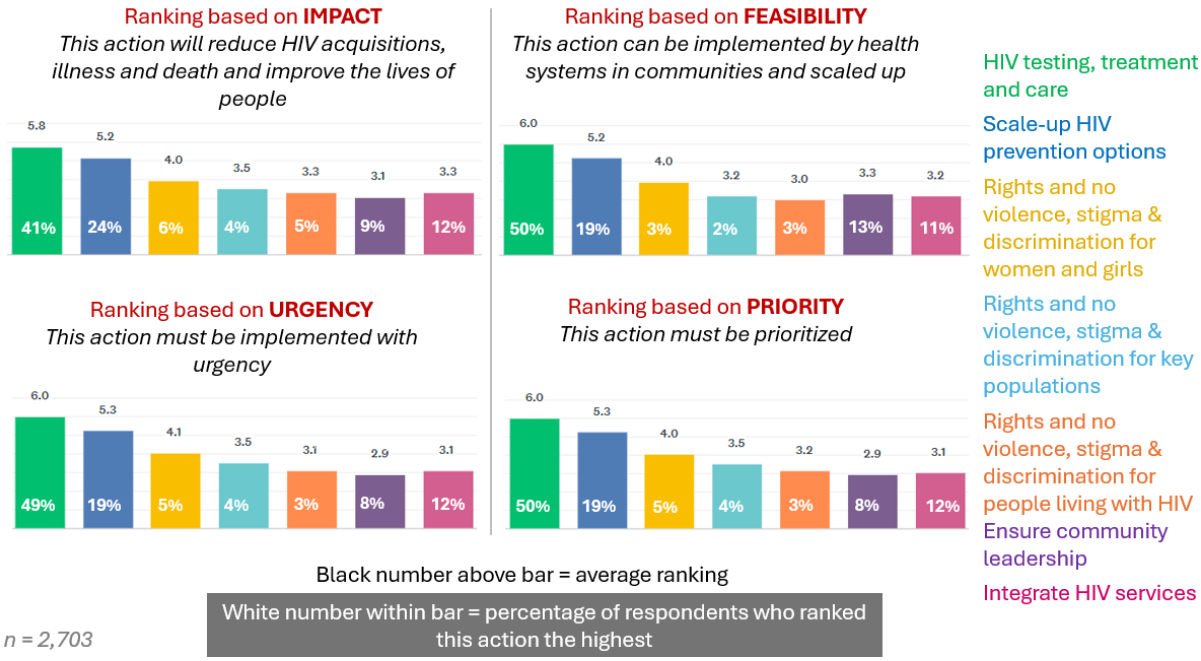
- Ensure available, accessible, acceptable and quality HIV testing, treatment and care
- Scale-up HIV prevention options that bring together biomedical (e.g., PrEP), structural, and behavioral interventions
- Women and girls, in all their diversity, enjoy human rights, equality and dignity free of stigma and discrimination and violence in the response to HIV
- Key populations affected by HIV enjoy human rights, equality and dignity, free of stigma and discrimination and violence
- People living with HIV enjoy human rights, equality and dignity, free of HIV-related stigma and discrimination and violence.
- Ensure community leadership in the HIV response
- Integrate HIV services with broader health systems and other sectors

44. Respondents were asked to rank these seven potential action areas across four domains:

- Impact (the most impactful to the least impactful)
- Feasibility (the most feasible to the least feasible)
- Urgency (the most urgent to the least urgent)
- Priority (the highest priority to the lowest priority)

45. HIV testing, treatment and care received the highest average ranking (the most impactful, the most feasible, the most urgent and the highest priority), followed by HIV prevention with the second highest average ranking (Figure 11). These two HIV service areas were also far more likely to be the top ranked action area than the other four action areas. For example, 50% of respondents stated that HIV testing, treatment and care was the top priority, and 24% stated that HIV prevention was the most impactful. This general pattern in the results was consistent across all regions and sub-populations.

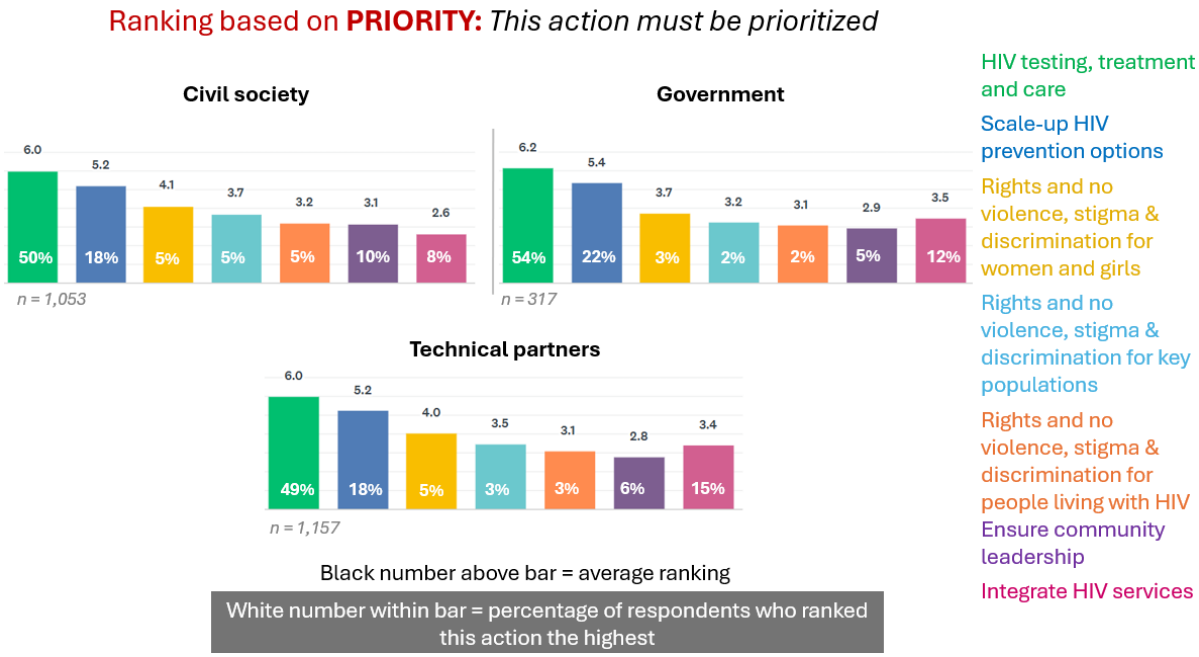
Figure 11. Rankings of seven potential action areas for the next Global AIDS Strategy, all respondents



46. Integration of HIV services was the third most likely to be ranked highest globally and across all regions. However, efforts to protect rights of and prevent violence faced by women and girls received the third highest average ranking globally and across all regions (including in Western and Central Europe and North America and in Eastern Europe and Central Asia, where it had an identical average ranking as efforts to the protect rights of and prevent violence faced by key populations).

47. Compared to regional responses, there was more variation in the rankings of priorities reported by civil society[4], government and technical partners[5]. Among civil society respondents, 'ensure community leadership' was the third most likely to be ranked the top priority. Government respondents rarely identified efforts to protect the rights of and prevent violence faced by various sub-populations as a top priority, and technical partners were the most likely to state that integration of HIV services was a top priority (Figure 12).

Figure 12. Rankings of seven potential action areas for the next Global AIDS Strategy, comparison of responses from civil society, government and technical partners



Sustainable financing

48. Survey respondents were told that sustainable financing of the HIV response will be essential for the Global AIDS Strategy 2026-2031. They were then asked to rank seven financing options from highest to lowest priority.

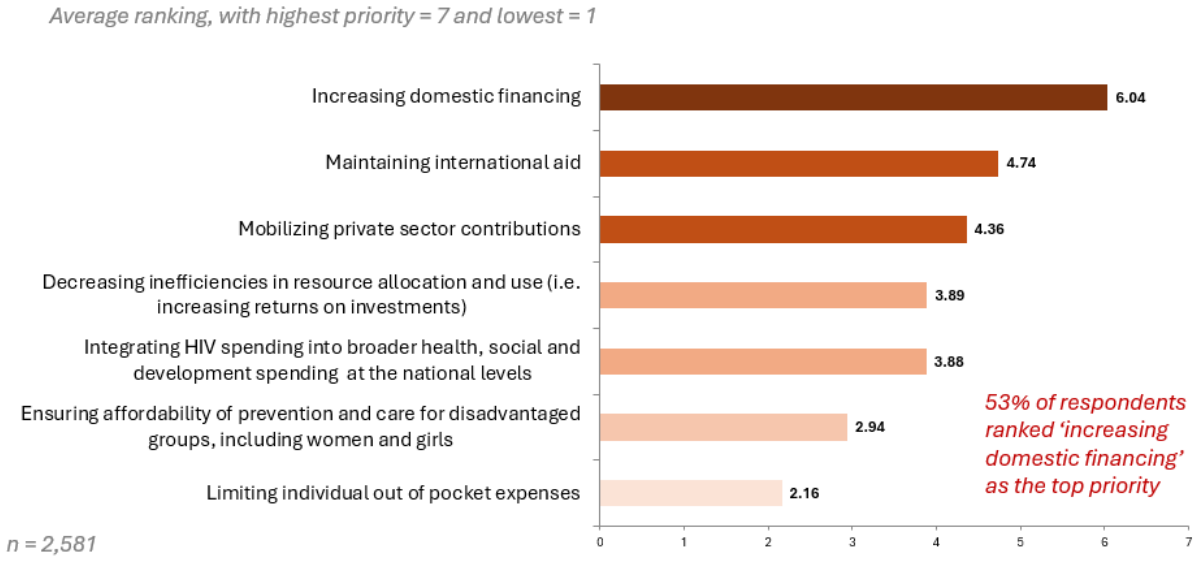
- Increasing domestic financing
- Maintaining international aid
- Mobilizing private sector contributions
- Decreasing inefficiencies in resource allocation and use (i.e. increasing returns on investments)

[4] Respondents who stated that their organization was a PLHIV or key population network, a national NGO or another civil society organization.
[5] Respondents who stated that their organization was UNAIDS, an international organization, an international NGO, academia/research institution, health provider or the private sector.

- Integrating HIV spending into broader health, social and development spending at the national levels
- Limiting individual out of pocket expenses
- Ensuring affordability of prevention and care for disadvantaged groups, including women and girls

49. Among all respondents, 'increasing domestic financing' had the highest average ranking by some distance, with 53% of respondents selecting it as the top priority (Figure 13). Maintaining international aid and mobilizing private sector contributions ranked second and third, respectively, and limiting out-of-pocket spending had the lowest average ranking, with just 2.5% of respondents naming it as the top priority.

Figure 13. Ranking of financing options for the AIDS responses, all respondents



50. The pattern of responses to this question was similar region to region and also among sub-populations, with one exception: in Eastern and Southern Africa, 'mobilizing private sector contributions' had the second highest average ranking.

Cross-cutting areas

51. Respondents were presented with four cross-cutting areas of the global AIDS response:

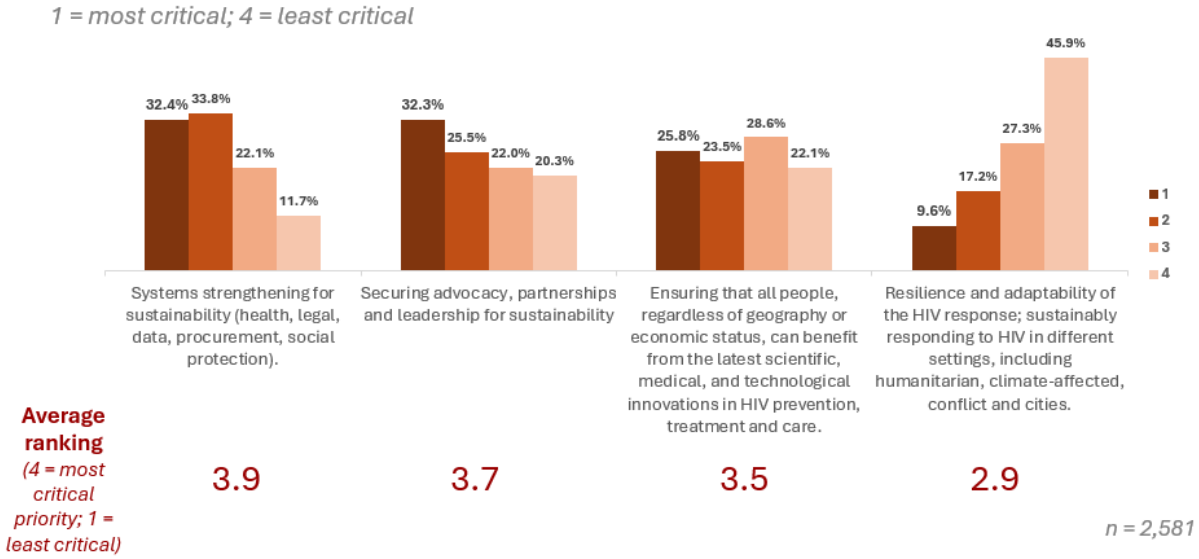
- Securing advocacy, partnerships and leadership for sustainability
- Systems strengthening for sustainability (health, legal, data, procurement, social protection).
- Ensuring that all people, regardless of geography or economic status, can benefit from the latest scientific, medical, and technological innovations in HIV prevention, treatment and care.

- Resilience and adaptability of the HIV response; sustainably responding to HIV in different settings, including humanitarian, climate-affected, conflict and cities.

52. They were asked to rank these areas from the most critical to the least critical to pursue in the next five years in order to make progress towards the 2030 goal of ending AIDS.

53. 'Systems strengthening for sustainability' received the highest average ranking, followed closely by 'securing advocacy, partnerships and leadership for sustainability' and 'ensuring that all people … can benefit from the latest … innovations' (Figure 14).

Figure 14. Ranking of cross-cutting areas to pursue in the next five years, all respondents



54. 'Advocacy, leadership and partnerships' was the top cross-cutting issue for respondents from West and Central Africa (average ranking of 4.0, with 40.9% ranking it highest) and Middle East and North Africa (average ranking of 4.3, with 57.4% ranking it highest); 'scientific, medical and technological innovations' was the top cross-cutting issue for Western and Central Europe and North America (average ranking of 3.8, with 40.3% ranking it highest); and all other regions chose 'systems strengthening for sustainability' as the top cross-cutting issue.

55. The rankings of people living with HIV and key populations were very close to the global results. While still ranking 'systems strengthening for sustainability' highest, civil society and government respondents were a little more likely to rank 'advocacy, leadership and partnerships' as the top cross-cutting issue, while technical partners placed more priority on scientific, medical and technological innovations than the global average.

Bold changes

56. The only open-ended question of the survey was: “Thinking forward and taking into consideration the current context of the HIV response, what bold change is needed to end AIDS as a public health threat by 2030 and sustaining the response beyond 2030?”

57. There were 1630 responses in eight languages, with a majority (74%) of the answers written in English. Non-English answers were translated using an online translation tool.

58. The AI tool that was used for the analysis of this question (see methodology section above) identified and categorized recurring themes and ideas from the survey responses and provided concise summaries. Ten common themes were identified by the AI tool. A manual spot check confirmed that eight of the themes were the subject of at least 200 responses:

Funding and financial sustainability	Integration and health system strengthening
Community involvement and empowerment	Stigma and discrimination
Government and policy support	Education and awareness
Innovations and technology	Human rights and equity

Funding and financial sustainability

59. Many responses highlight the importance of sustainable funding models. This includes increasing domestic funding, diversifying funding streams, and reducing dependency on international aid. Innovative financing mechanisms such as social impact bonds and public-private partnerships are suggested. Simultaneously, respondents stated that governments and donors need to make long-term resource commitments, ensuring predictable and sustainable financing.

> *“Increase domestic financing. Allocate more national budget to HIV response. Introduce health taxes or insurance schemes to fund HIV services. Gradually reduce donor dependency.”*

Integration and health systems strengthening

60. A common theme was the need to rethink and strengthen health systems. This includes building new ways to achieve desired health outcomes, integrating HIV services into broader health services, and ensuring universal and equitable access to new technologies such as affordable long-acting PrEP and future innovations like HIV vaccines or cures. There is also a call for decentralizing health systems and empowering communities to lead interventions.

“A bold and necessary change to end AIDS as a public health threat by 2030 is the full integration of HIV services into broader, people-centered health systems under the framework of Universal Health Coverage (UHC). This approach requires shifting from a disease-specific model to one that addresses the social determinants of health (...). By embedding HIV services into resilient, equitable health systems, this strategy not only accelerates progress toward ending AIDS but also ensures the response remains effective and sustainable well beyond 2030.”

Community involvement and empowerment

61. Active community involvement and patient-centered approaches are frequently mentioned. Empowering community-led organizations and networks of people living with HIV to lead prevention, treatment, and advocacy efforts is seen as essential. Enhancing participation in decision-making and ensuring that affected communities have a voice in policymaking and program design are highlighted.

Stigma and discrimination

62. Addressing stigma and discrimination is a repeated theme. Responses call for national anti-stigma campaigns, strengthening legal protections, and ensuring human rights for all, particularly vulnerable populations. Ending HIV-related stigma and discrimination is seen as crucial to empowering communities and promoting human rights.

Government and policy support

63. Many responses call for greater government commitment and accountability in the HIV response. This includes enhancing national governments' ownership of efforts to end the AIDS epidemic, reinforcing evidence-based practices, and ensuring progressive and accountable leadership at all levels. Domestic investments in HIV programs and prioritizing local health systems are also emphasized.

Education and awareness

64. There is a strong emphasis on integrating comprehensive sexuality education at all educational levels. Many responses highlight the need for massive media campaigns to decrease stigma and discrimination, increase awareness about HIV, and promote the availability of PEP and PrEP to the LGBTQ+ community. Promoting responsible sexuality education from an early age, including mobile clinic tours to reach rural areas and integrating HIV education into community programs, is considered important.

"More education and access to information is the solution. Prevention is always better than cure."

Innovation and technology

Ending AIDS will take courage—not just medically, but socially and politically. And the most powerful thing we can do is to make sure that those living with HIV are not just survivors, but leaders in shaping a future where no one is left behind.

65. There is a strong emphasis on harnessing technology and innovation to improve the HIV response. This includes utilizing digital health solutions, investing in research and development for innovative prevention methods, and leveraging telemedicine and mobile health apps. Responses call for the rapid scale-up of long-acting injectables for prevention and the use of data systems to track progress and inform timely action.

Human rights and equity

66. There is a call to eliminate laws that criminalize HIV, sex work, drug use, and sexual and gender diversity, as these laws are seen as fueling stigma and limiting access to services. Ensuring universal, free, and equitable access to comprehensive HIV prevention, diagnosis, treatment, and care is a recurring theme, including addressing economic and geographic barriers. Strengthening human rights interventions to ensure that communities view AIDS as something that can be overcome, and that creating new laws to guarantee the rights of people living with HIV, are also emphasized.

"The greatest priority should be investments in research and development in long lasting injectable ARVs. … Using the TRIPS agreement to make access to long lasting prevention and treatment technologies is the surest path to ending AIDS. "

Innovative ideas

67. Particularly innovative and bold ideas came about looking into youth engagement and leadership. There were clear calls to invest in youth leadership by equipping young people with skills, resources, and platforms to lead HIV interventions and advocacy in their communities but also to adapt services to be youth oriented. This includes age-appropriate, inclusive education, youth-friendly health services, and ensuring young people feel safe to access services, as well as involving youth in designing and implementing digital tools, outreach, and campaigns to spread awareness and fight stigma.

"The future of the HIV response must be radical in inclusivity and unwavering in its fight for health justice—because equity is non-negotiable in the journey to ending AIDS."

68. Similarly, the focus of new ideas was on community-centered approaches and recognizing community-led responses, both in public health infrastructure and local support systems.

Conclusions

69. The following broad conclusions on respondents' views of the HIV response were distilled from the data:

Stigma and discrimination remain major barriers to HIV service access

70. Despite decades of awareness-raising on HIV and the current widespread availability of antiretroviral medicines that allow people living with HIV to protect their health and prevent transmission of the virus, stigma and discrimination is widely viewed as the biggest barrier to achieving the global goals of the AIDS response, and in particular to reaching global targets for widespread coverage of HIV services, including prevention, testing, treatment and care. In addition, knowledge and awareness of available services was a commonly reported barrier to coverage targets. Conversely, few respondents identified out-of-pocket costs, human resource constraints and prohibitive laws and policies as barriers to HIV services.

Progress on societal enablers has been limited by persistent social and cultural norms and prohibitive laws and policies

71. Three of the five most reported barriers to reaching current global goals and targets for the AIDS response reinforced the importance of societal enablers: (1) harmful social and cultural norms; (2) gender inequalities; and (3) prohibitive laws and policies.

72. Harmful social and cultural norms were the top or second-most mentioned barrier to all areas relating to human rights and ending stigma, discrimination and violence, and they were also reported as a barrier by at least a quarter of respondents in four other areas.

73. Gender inequalities were the top barrier to empowering women and girls and protecting them from physical and/or sexual violence, and the second most reported barrier to eliminating stigma and discrimination faced by women living with HIV.

74. Although prohibitive laws and policies were rarely viewed as a barrier to HIV service scale-up, they were identified as one of the top barriers to empowering key populations and protecting them from physical and/or sexual violence.

Access to services is the top priority for reaching the goal to end AIDS

75. Despite the huge challenges presented by societal barriers, more than two-thirds (69%) of respondents stated that access to HIV services was the top priority for the AIDS response moving forward. Half stated that the top priority was HIV testing and treatment for people living with HIV, and another 19% ranked HIV prevention first. These two areas were a much higher priority for respondents compared to efforts to reinforce rights and prevent violence, stigma and discrimination.

Integration and community leadership are important pathways to increasing service coverage

76. Lack of integration of HIV services into broader health services was a commonly reported barrier to services. Among the seven potential priority action areas for the strategy, integration was third most likely to be ranked highest, and integration was especially popular among government and technical partners who are struggling to maintain the delivery of HIV services in a period of decreasing availability of international resources. Civil society respondents were less likely to prioritize integration, and they were twice as likely as government respondents to state that community leadership was a top priority. Integration and community engagement and involvement were also among the top themes raised by respondents in their answers to the open question on bold changes. Work on both of these pathways will need to reckon with a barrier to HIV service delivery identified by roughly one-third of respondents: lack of knowledge and information about those services.

Increasing domestic financing is viewed as critical to sustaining progress towards global goals

77. Amid rapid shifts in AIDS response financing, including deep cuts in donor funding from the United States and others, the theme of sustainable financing was touched upon in all sections of the survey. Lack of domestic funding was consistently identified as a barrier across all 11 programme areas. By comparison, despite the recent reductions in donor funding, inadequate international resources were much less likely to be identified as a barrier. ‘Increasing domestic financing’ was also selected by more than half (53%) of respondents as the top financing priority for sustaining the global AIDS response. Calls for greater government ownership, commitment, financing and accountability in the HIV response were also common in the answers to the open-ended question on bold changes.

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