Agenda item 4

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UNITED TOWARDS ENDING AIDS: THE GLOBAL AIDS STRATEGY FOR 2026–2031

UNAIDS

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Additional documents for this item:

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

- *Adopt* the Global AIDS Strategy 2026–2031

Cost implications for the implementation of the decisions: none

Recalling that all aspects of UNAIDS work are directed by the following guiding principles:[1]

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

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

a) Provide global leadership in response to the epidemic;

b) Achieve and promote global consensus on policy and programmatic approaches;

c) Strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;

d) Strengthen the capacity of national Governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;

e) Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;

f) Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

In fulfilling these objectives, the Programme will collaborate with national Governments, intergovernmental organizations, nongovernmental organizations, groups of people living with HIV/AIDS, and United Nations system organizations.[2]

[1] 19th PCB - Decisions, recommendations and conclusions (unaids.org)

[2] ECOSOC Resolutions Establishing UNAIDS

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Executive summary

1. The global HIV response is at a critical juncture. The world is closer than ever to ending AIDS as a public health threat, yet that progress is at dire risk of being lost amid converging crises, widespread volatility and deepening inequalities.[3]

2. The landscape of the HIV response has changed dramatically, marked by shifts in health and HIV-specific funding and the overall aid architecture, mounting fiscal pressures, and pushbacks against human rights. At the same time, the emergence of innovations and technologies offer exciting new opportunities.

3. A pathway for ending AIDS as a public health threat by 2030 exists—and it remains open. It requires that the global response adapts to this challenging context, confronts the structural inequities that undermine access, and accelerates the expansion of HIV and other essential services in sustainable ways.

4. The 2026–2031 Global AIDS Strategy presents a framework and actions for doing that––by working together to serve the needs of people affected by, at risk of, and living with HIV in this period of upheaval and uncertainty.

5. The Strategy keeps people at the centre and outlines strategic directions and priority actions that will enable them to exercise their rights, protect themselves and thrive in the face of the AIDS pandemic. It also summarizes the role of the Joint United Nations Programme on HIV/AIDS in implementing the Strategy and its leadership role in coordinating the global HIV response.

How was the Strategy developed?

6. The 2026–2031 Global AIDS Strategy is the product of extensive consultation with people living with, at risk of, and affected by HIV and with partners at multiple levels of society—from community workers, local organizations and the private sector, to national governments and bilateral and multilateral agencies. It considers the impact of a rapidly changing global health and development ecosystem, worsening inequalities and human rights violations, persistent stigma and discrimination, economic volatility and geopolitical uncertainty.

7. Development of the Global AIDS Strategy involved four streams of work: (a) the mid-term review of the 2021–2026 Global AIDS Strategy; (b) the development of 2030 global AIDS targets by an advisory Global Task Team on Targets for 2030;[4] (c) support to countries to develop national HIV sustainability roadmaps; and (d) multi-stakeholder consultations.

8. The mid-term review highlighted major gains, especially in the expansion of access to HIV treatment, but also showed persistent inequalities in access to HIV prevention and insufficient progress in removing societal and structural barriers. Those insights provided a basis for the wide-ranging consultations that shaped the Strategy.

[3] 2025 Global AIDS Update — AIDS, Crisis and the Power to Transform | UNAIDS

[4] For more information on the work of the Global Task Team, see: Recommended 2030 targets for HIV | UNAIDS

9. Consultations involved representatives from nearly 100 national governments and 379 civil society organizations participated in the meetings, while over 3,000 stakeholders also participated in an online survey. The consultations captured people's insights, needs and recommendations for achieving the goal of ending AIDS in a period of flux and uncertainty. Experts from academic and scientific institutions from across the world were engaged throughout the process as members of the Global Task Team on targets

What's new in the Global AIDS Strategy 2026–2031

10. The Global AIDS Strategy 2026–2031 links an emphasis on the rapid scale up of HIV services to building a response that can sustain its achievements into the future.

11. That entails moving from a predominantly intervention-centered approach to a people-centered one, and from a donor- and partner-led system to one that is country-owned and -led (including by communities and civil society) within a framework of shared responsibility.

12. The Strategy crystallizes a shift from an emergency, donor-driven HIV response to a sustainable, nationally led, rights-based and integrated approach that is embedded in resilient health and social systems. It emphasizes long-term domestic financing and the integration of HIV within Universal Health Coverage and primary health care and other platforms.

13. Clear actions are proposed across the Strategy's three core priorities and eight results areas, along with measurable targets, which countries can monitor, and an integrated approach for providing services within national health and social systems.

14. Priority 1 emphasizes domestic leadership, diversified financing and integration of HIV into Universal Health Care systems. It calls for fiscal innovation, multisectoral collaboration, integration into primary health care, and data governance that is grounded in equity and privacy.

15. Priority 2 focuses on integrated, differentiated and people-centred HIV services that ensure access to HIV prevention, testing, treatment and care for people living with, affected by, or at risk of HIV by combining biomedical tools and social behaviour change, and by pursuing local manufacturing of health commodities.

16. Priority 3 champions rights-based and gender-responsive approaches and community-led governance. Legal reform, resourcing of community-led organizations, and safeguarding are key.

Great progress shadowed by major threat

17. The 2026–2031 Global AIDS Strategy arrives at a moment of great opportunity and threat. Tremendous social, scientific and economic efforts have brought the world to the brink of ending AIDS as a public health threat. At the same time, public health is being deprioritized, conflict is increasing, and inequalities are forcing people apart.

18. During the period covered by the previous Strategy—covering the period from 2021 to 2025—fewer people acquired HIV in 2024 than at any point since the late 1980s, almost 32 million people were receiving HIV treatment and AIDS-related deaths had

been reduced to their lowest levels since the early 2000s.[5] Modelling indicates that the HIV response has saved 26.9 million lives.[6] [7]

19. That has been achieved through decades of global solidarity, political will and activism driven by people living with HIV, affected communities, civil society, health workers, scientists, researchers, governments and donors.

20. However, the progress is not occurring quickly enough to reach the targets set in the previous Strategy. Of the estimated 40.8 million people living with HIV in 2024, 9.2 million were not receiving antiretroviral therapy and an estimated 1.3 million people acquired HIV, more than triple the 2025 target of 370 000. Funding gaps and barriers that block access to prevention and treatment service still leave many people behind.

21. The Organisation for Economic Co-operation and Development forecasts that external health assistance will decline by 30–40% in 2025 compared with 2023. Many countries face economic uncertainty and fiscal restrictions that limit their spending on public health. Several are also contending with humanitarian emergencies, political volatility or armed conflict. All that is causing severe disruption to health services, including for HIV, in low- and middle-income countries.[8] Less funding also hinders efforts to address inequalities and scale up the vital work of communities.

22. Persistent inequalities and stigma exacerbate the situation, amid attacks on human rights and gender equality. HIV incidence among adolescent girls and young women (15–24 years) remains extraordinarily high in parts of sub-Saharan Africa. Members of key populations[9] everywhere are still at heightened risk of acquiring HIV yet face formidable obstacles when trying to protect themselves against the virus.

23. When governments defund HIV responses, it becomes more difficult for marginalized people to access the medicines and support they need to survive. When governments underfund community interventions that are on the frontline delivering services, people living with, affected by, or at risk of HIV populations suffer the consequences.

24. This context demands renewed urgency, revitalized solidarity and the prioritization of proven interventions and approaches that respond to the different conditions and needs in countries.

25. Despite the challenges, there is a clear path to ending AIDS by 2030. The tools and knowledge to end AIDS exist, and they include new, cutting-edge innovations. Resources can be reallocated to make sustainable financing of HIV responses a reality.

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[5] The HIV estimates cited here were published by UNAIDS in July 2025 and reflect data up to December 2024.

[6] AIDS, crisis and the power to transform: Global AIDS update 2025. Geneva: UNAIDS; 2025.

[7] The starting point of the Strategy development process was the status of the response to the HIV pandemic, as described in the mid-term review of the Global AIDS Strategy 2021–2026 and the 2024 Global AIDS Update. Since then, UNAIDS published the Global AIDS Update 2025, which presents a mixed picture of the HIV response and describes the initial impact of the funding cuts imposed in early 2025.

[8] https://www.oecd.org/en/publications/2025/06/cuts-in-official-development-assistance_e161f0c5/full-report.html

[9] 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, gay men and other 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.

The experiences and knowledge of communities of people living with, affected by, or at risk of HIV are available to guide and drive the responses forward. Collectively, the world has the means to end the pandemic. Needed most of all is a renewed sense of urgency, community, leadership and solidarity.

26. The Global AIDS Strategy 2026–2031 lays out a path for collective action over the next five years and beyond, even as the world shifts on its foundations. It is aimed at ensuring that, by 2030:

- 40 million people living with HIV are on HIV treatment and virally suppressed;
- 20 million people are using ART-based HIV prevention options; and
- all people can access discrimination-free HIV-related services.

Sustainability is the watchword

27. Sustainability is a recurring theme in the Strategy: the global HIV response must protect the gains made against the pandemic, extend those gains and ensure that they can endure.

28. Sustainability requires planning beyond the current emergencies by building health-care and social systems that are durable. Strengthened public health systems build resilience against HIV and other health threats.

29. That means having financing and service delivery systems for health care that deliver accessible and quality services to people living with, affected by, or at risk of HIV and that reduce out-of-pocket expenditures. It requires supporting communities so they can provide prompt and adequate support. And it demands addressing the structural inequalities that keep people from using life-saving services and receiving support.[10]

30. Finally, sustainability calls for strategic investments in national and local capacities, including flexible financing arrangements that respond to local priorities. Reliable funding alongside efficient and effective service delivery improves health outcomes, which generates secondary social, economic and political benefits. For that to happen, a range of entities, including those which might not traditionally be active in public health, have to work together across sectors and levels.

Three core priorities & eight results areas

31. The Global AIDS Strategy sets out three priorities and eight results areas, each entailing practical actions for achieving a successful and sustainable HIV response.

Priority 1: Country-led, resilient and ready for the future.

32. Governments and communities are at the forefront of national HIV responses. As international funding declines, domestic and donor investments must focus on sustainable approaches that strengthen broader health systems, deliver integrated and

[10] Centering Human Rights in Sustainable HIV Responses - UNAIDS Sustainability Website

people-centred services, and address the social and structural determinants of health for people living with, affected by, or at risk of HIV.

Results Area 1. Ensure financing for people-centered global and national HIV responses

Results Area 2. Integrate HIV interventions and HIV-related health and community systems with primary health care, broader health systems, and key non-health sector

Results Area 3. Invest in essential information systems and data collection in multiple sectors and including communities

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

33. The Strategy is people-centred. Ending AIDS demands that people can access quality sustainable HIV prevention, testing and treatment services in environments that are free of stigma, discrimination and violence. That requires reducing inequalities and upholding everyone's right to access HIV and other health services.

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

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

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 testing, prevention, treatment and care

Priority 3: Community leadership

34. Communities of people living with, at risk of and affected by HIV must continue to lead the way by shaping policies, delivering services and achieving accountability.

Results Area 8. Strengthen community leadership

35. Taken together, the priorities and results areas constitute a costed, measurable and focused agenda for ending AIDS by 2030 and sustaining national HIV responses into the future. At a time of global upheaval and uncertainty, they lay out a realistic path towards what would be an historic public health achievement: ending AIDS as a public health threat.

Renewed commitments and clear, realistic targets

36. The Strategy proposes 16 top-line targets, which are organized into six priority areas, and 50 second-tier targets.[11] These targets disaggregate the global response into distinct, manageable sections and serve to simplify accountability while addressing evolving challenges.

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

37. Some targets are maintained from the previous Strategy[12] because they have not yet been achieved by all countries and remain crucial. Those include the 95–95–95 targets which aim for 95% of all people living with HIV to know their HIV status; 95% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have viral suppression by 2025.[13]

38. Achievement of the targets is expected to avert 3.3 million new HIV infections and 1.4 million AIDS-related deaths between 2025 and 2030, effectively meeting the 2030 goal of ending AIDS as 90% reduction in new HIV infections and AIDS-related deaths compared with 2010. A further 5% reduction in new infections and deaths due to AIDS per year after 2030 would ensure the sustainability of that feat in countries and communities after 2030.

39. That goal can be achieved if people are able to access HIV treatment to live healthy lives and reduce onward transmission; if they can access other effective and appropriate prevention options; if stigma and discrimination is reduced; and if policies and laws that prevent them from accessing services are removed.

Partnerships for progress: local, regional and multilateral actions to end AIDS

40. In many countries, health and other key services are managed and provided at local levels. This allows for productive partnerships to be developed between communities, local authorities, service providers, philanthropies, faith-based organizations, the private sector and other actors. The Strategy presents recommendations for integrating the HIV-related activities of subnational political units.

41. Regional entities, including networks of civil society organizations, have critical roles. They are well-placed to harmonize public health strategies, pool technical support and procurement, promote national accountability, mobilize shared resources, promote local and regional production capacity for HIV-related products, conduct research, and disseminate information.

42. Multilateral action is necessary to generate and sustain political commitment, facilitate and coordinate action, advance normative guidance and international standards, achieve sustainable financing, and strengthen accountability. The Strategy therefore also features recommendations for regional and multilateral action.

43. A central theme in the Strategy, as well, is the understanding that AIDS pandemic cannot be overcome in isolation. HIV interventions must be integrated with other public health and development agendas and systems, including for sexual and reproductive health and rights, tuberculosis, viral hepatitis, noncommunicable diseases, mental health and social protection.

44. No single actor can end this pandemic alone: by standing together we can end AIDS by 2030.

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[12] Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. | UNAIDS

[13] Frescura L, Godfrey-Faussett P, Feizzadeh A, et al. Achieving the 95-95-95 targets for all: A pathway to ending AIDS. PLoS ONE. 2022;17(8):e0272405. https://doi.org/10.1371/journal.pone.0272405

The role of the Joint United Nations Progamme on HIV/AIDS

45. The Strategy recognizes that multilateral leadership on HIV, embodied in the Joint Programme, remains indispensable. As the context evolves, the Joint Programme will continue to provide the political leadership, convening power, data and accountability, and community engagement that has served the global HIV response for almost three decades.

46. Guided by the three priorities of the Global AIDS Strategy, the Joint Programme will tailor its support to country and regional contexts and work with governments, communities, civil society partners and other stakeholders (including regional institutions, the U.S. President's Emergency Plan for AIDS Relief, or PEPFAR, and the Global Fund) to enable countries to sustain their HIV responses and close the remaining gaps.

New estimates of resource needs

47. UNAIDS projections indicate that achieving the targets set out in the Strategy will require annual resources ranging from US$ 21.9 billion to US$ 23 billion in low- and middle-income countries by 2030. This is lower than the previous estimate of US$ 29.3 billion, due to price reductions and other savings achieved in recent years. The new estimate also reflects more efficient and targeted service delivery, as well as prioritized approaches based on HIV risk.

48. Most annual resource needs for HIV in 2030 will be in upper-middle-income countries (46%), with the remainder in lower-middle-income countries (34%) and low-income countries (20%).[14] [15] It is envisaged that low-income countries would fund about one third, lower-middle-income countries about two thirds, and upper-middle income countries almost the entirety of their HIV responses with domestic resources.

49. In 2024, HIV funding globally amounted to US$ 18.7 billion, with domestic funding accounting for 52% of that total. The Strategy recognizes, however, that the option of rapidly increasing domestic resources for HIV is not available to all countries, especially low-income countries, due to debt obligations, lack of fiscal space and slow economic growth. International resources will remain crucially important in some countries, including those affected by conflict.

United to end AIDS

50. The goal of ending the AIDS epidemic by 2030 as a public health threat is ambitious, but it is rooted in real achievements. Frontline workers and communities have shown that community-driven responses can slow the pandemic and reduce its worst impacts. Scientific innovation has delivered transformative treatments and diagnostics. For many years, global solidarity enabled countries to overcome resource limitations. The world

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

[15] Stover J, Mattur D, Siapka M et al. The impact and cost of reaching the UNAIDS global HIV targets. medRxiv. 2025. doi: https://doi.org/10.1101/2025.07.01.25330647.

has confronted the worst of the AIDS crisis and shown that grounding public health in science, solidarity and community leadership is both necessary and possible.

51. Yet the global response to HIV is now in great peril.

52. Even though over 40 million people are living with HIV and more than one million people newly acquire HIV each year, the commitment and solidarity that is needed to end the pandemic appears to be fraying. Access to key biomedical interventions like pre-exposure prophylaxis and antiretroviral therapy, vital data systems, and research and innovation are in jeopardy due to funding cuts. Prevention services have been disrupted, health workers have lost their jobs, and community-led organization are reducing or halting their HIV activities.

53. No community or country can end AIDS alone: we must stand together. The Global AIDS Strategy 2026–2031 provides a basis for revitalizing the collective determination and action that can end AIDS as a public health threat.

Introduction: It starts with people

54. The profound changes underway in the world are affecting the global response to HIV. Shrinking political and financial commitments for HIV and global health are resulting in a funding crisis that threatens almost 40 years of progress against the pandemic. How does a coalition of partners from across the world—from individuals navigating life with HIV to institutions delivering services and conducting cutting-edge research—manage such upheaval and uncertainty? How do we protect decades of hard-won gains in the face of daunting challenges? It starts with people.

55. The 2026–2031 Global AIDS Strategy is the product of extensive consultation with people living with, at risk of, and affected by HIV and partners at multiple levels of society—from community workers and local organizations to national governments and bilateral and multilateral agencies; to private sector and philanthropy; to researchers and programme implementers. The Strategy considers the impact of a rapidly changing global health and development ecosystem; deepening gender inequalities and human rights violations; growing economic challenges; persistent stigma and discrimination; and a host of other challenges.

56. This document emerged from a rich and extensive process that informed each target and strategic choice. These consultations also allowed participants to reconnect around a shared ambition to end AIDS as a public health threat by 2030, an ambition that is rooted in the desire to protect people's health and well-being.

57. The Strategy is divided into several sections. The first describes the current status of the global response to HIV and the consultation process that led to its recommendations. It includes the successes and failures and notes the opportunities for action. The second section covers the three priorities for action that emerged from the consultations. Each priority is divided into results areas or opportunities for progress. The third section lays out opportunities for partnerships at all levels of society to support and sustain the global response to HIV. A further section (Annex 1) describes regional priorities to realize the ambition to end the pandemic and sustain that progress into the future.

58. The Strategy recognizes both that the world is closer than ever to ending AIDS as a public health threat and that the progress achieved is at dire risk of being lost.[16] It proposes a framework and actions for working together to serve the needs of people living with, affected by, or at risk of HIV in a period of upheaval and uncertainty. The Strategy invites us to refocus urgently on how we can work together to navigate this unprecedented moment and continue to serve the people affected by and living with HIV and build a sustainable response for the future.

The current global HIV situation: Key findings from the mid-term review and 2025 data

59. The 2026–2031 Global AIDS Strategy arrives at a moment of great opportunity and threat. On one hand, tremendous social, scientific and economic efforts have brought the world to the brink of ending AIDS as a public health threat. People are learning.

[16] 2025 Global AIDS Update — AIDS, Crisis and the Power to Transform | UNAIDS

Communities are engaging. Science is working. But the gains are threatened by a volatile global political and economic climate in which public health is being deprioritized, conflict is increasing, and inequality is forcing people apart.

60. The evidence shows that investments in the global response to HIV are working.[17] During the period covered by the prior strategy—from 2021 to 2025—fewer people acquired HIV in 2024 than at any point since the late 1980s. Modelling indicates that HIV treatment has saved 26.9 million lives since 1995.[18]

61. However, the progress is not occurring quickly enough to reach the global targets set in the previous Strategy. Of the estimated 40.8 million people living with HIV in 2024, 9.2 million were not receiving antiretroviral therapy (ART) and an estimated 1.3 million people acquired HIV, more than triple the 2025 target of 370 000. Funding gaps and barriers that block access to prevention and treatment service still leave many people behind. Persistent inequalities and stigma exacerbate the situation. While the end of AIDS as a public health threat is within reach, we are not on track to reach that goal by 2030.

62. Several important trends underscore the urgency:

- At the global level, new HIV acquisitions are declining more quickly among women than men living with HIV, although 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. More than 210 000 adolescent girls and young women acquired HIV in 2024—an average of 570 new infections every day.
- Globally, 40% fewer people acquired HIV in 2024 than in 2010; eastern and southern Africa achieved a reduction of 56%. Yet over the same period, new HIV infections increased in the Middle East and North Africa (by 34%), Latin America (13%) and eastern Europe and central Asia (7%), and major gaps and inequalities in access to service access persisted, especially for key populations.
- The number of people dying of AIDS-related causes has fallen significantly, but the pandemic still claimed the lives of an estimated 630 000 people in 2024, 61% of whom lived in sub-Saharan Africa.
- Funding for HIV responses is diminishing across the world. According to the Organisation for Economic Co-operation and Development (OECD), external health assistance is projected to drop by 30% to 40% in 2025 compared with 2023, which will cause severe disruption to health services, including for HIV, in low- and middle-income countries.[19] Decreasing funding will also hinder efforts to address

[17] The starting point of the Strategy development process was the status of the response to the HIV pandemic, as described in the mid-term review of the Global AIDS Strategy 2021–2026 and the 2024 Global AIDS Update. Since then, UNAIDS published the Global AIDS Update 2025, which presents a mixed picture of the HIV response and describes the initial impact of the funding cuts imposed in early 2025.

[18] https://www.unaids.org/en/UNAIDS-global-AIDS-update-2025

[19] https://www.oecd.org/en/publications/2025/06/cuts-in-official-development-assistance_e161f0c5/full-report.html

inequalities, scale up and support the vital work of communities, and enhance access to HIV prevention and HIV treatment programmes.

63. In addition, the global HIV response is threatened by attacks on human rights and gender equality and is operating in shrinking civic space. Young women, key populations and other marginalized groups are more likely to be affected by these conditions, hence their heightened vulnerability to HIV. Stigma and discrimination also remain persistent challenges, obstructing access to services. Young people in many countries are less aware of HIV than previous generations who had benefitted from robustly funded programmes.

64. Many countries face major constraints, including economic uncertainty and fiscal restrictions that inhibit spending on public health, worsening humanitarian emergencies, political volatility and social inequalities, which have a direct impact on countries' abilities to respond to HIV.

65. Inequalities—highlighted in the previous Global AIDS Strategy—are worsening. Gender inequalities are being exacerbated by conflict, economic upheaval and lack of access to institutions and opportunities. People living with HIV, key populations,[20] and young women and girls remain excluded from key decision-making processes, which reduces their ability to contribute to the HIV response.

66. Sexual and gender-based violence prevent women and key populations, especially, from seeking and accessing relevant HIV and other essential services. There are also disparities in access to prevention, treatment and support services between various communities of people affected by HIV. When governments defund HIV responses, it becomes more difficult for people facing economic hardship to access the medicines and support they need to survive. When governments underfund community interventions that are on the frontline delivering services, key populations carry the costs. Government social protection systems that exclude people living with and affected by HIV perpetuate structural inequalities, undermine health outcomes, and weaken the resilience of communities.

67. Global tensions are rising, and the climate crisis is causing increasing harm, resulting in widespread displacement. Large institutional donors are shifting their priorities away from public health towards other priorities, and funding for health research and innovation is being redirected. All this is widening the gaps in the global HIV response.

68. This context demands renewed urgency and the prioritization of interventions and approaches that respond to the varying conditions and needs in countries. Success in ending AIDS as a public health threat will depend on the choices leaders make in the coming years. The Global AIDS Strategy 2026–2031 lays out a path for collective action over the next five years and beyond.

[20] 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, gay men and other 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.

69. The goal of ending the AIDS pandemic can be reached. At the end of 2024, almost 32 million people were receiving HIV treatment and AIDS-related deaths had been reduced to their lowest levels since the early 2000s.[21] That was achieved through decades of global solidarity, political will and activism driven by people living with HIV, affected communities, civil society, health workers, scientists, researchers, governments and donors.

70. Despite the challenges, there is a clear path to ending AIDS by 2030. The tools and knowledge to end AIDS exist, including cutting-edge innovations. Resources can be reallocated to make sustainable financing of HIV responses a reality. The experiences and knowledge of communities of people living with, at risk of, or affected by HIV are available to guide further advances. Collectively, the world has the means for ending the pandemic. Needed most of all is a renewed sense of urgency, community, political leadership and solidarity.

71. The Global AIDS Strategy 2026–2031 presents a new agenda to maintain the focus on our commitment to end AIDS as a public health threat by 2030 and to sustain national HIV responses beyond 2030, even as the world shifts on its foundations. To rise to the demands of this moment, the HIV response must confront the inequalities that undermine access to life-saving treatment and prevention services and medicines and accelerate the expansion of quality services in sustainable ways.

72. The Strategy is a call to action and a blueprint for achieving unity, sharpening focus and prioritization, building strong country ownership and securing continued global solidarity in the response to HIV. It will guide governments, communities, civil society, donors and other stakeholders through the next phase of the global HIV response.

Programmatic foundations for the Strategy

73. The Global AIDS Strategy 2026–2031 is aimed at ensuring that, by 2030:

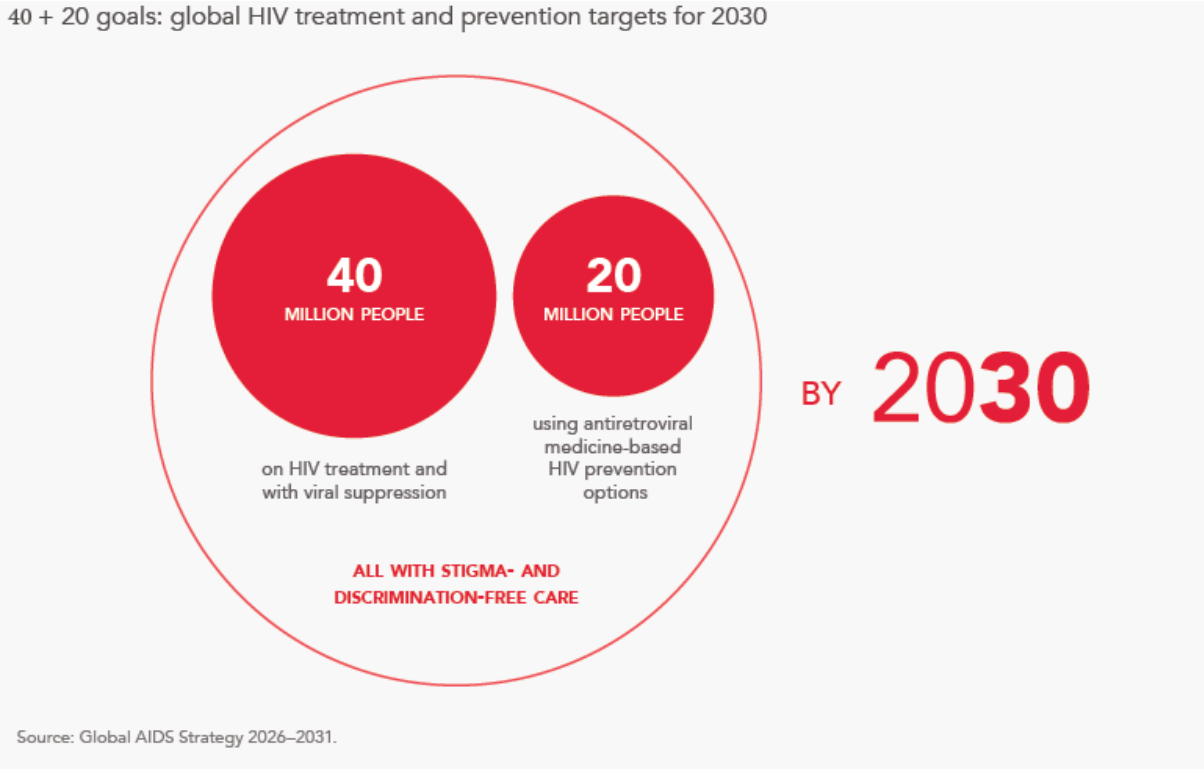
    - 40 million people living with HIV are on HIV treatment and virally suppressed.
    - 20 million people are using ART-based HIV prevention options; and
    - all people can access discrimination-free HIV-related services.

74. The Strategy therefore emphasizes the three pillars of the response—treatment, prevention and the provision of HIV services without stigma and discrimination—and it affirms that each must be pursued to achieve the goal of ending AIDS as a public health threat by 2030.[22]

[21] The HIV estimates cited here were published by UNAIDS in July 2025 and reflect data up to December 2024.

[22] As defined in the 2021–2026 Political Declaration On Ending AIDS (2021_political-declaration-on-hiv-and-aids_en.pdf) and reaffirmed in the recommended target for 2030 (https://www.unaids.org/en/recommended-2030-targets-for-hiv).

Figure 1. The foundations of the Global AIDS Strategy 2026–2031



75. Clear, shared global targets and a roadmap are needed to achieve that goal. The Strategy therefore identifies three priority areas, each of which entails sets of practical actions. The first section on the 2030 targets describes the "what" (the desired outcomes), while the second section outlines the "how" (the actions needed at different levels to achieve the outcomes).

76. The Strategy aims for significant reductions across various metrics: reducing new HIV infections by 90% compared with 2010 and a 5% decline per year after 2030; reducing AIDS-related deaths by 90% compared with 2010; and ensuring the sustainability of HIV responses by countries and communities after 2030.

77. The targets are shaped by a clear logic. The goal of ending AIDS as a public health threat can be achieved if people can access HIV treatment to live healthy lives and reduce onward transmission; if they can access other effective and appropriate prevention options; if stigma and discrimination is reduced; and if policies and laws that prevent people from accessing services are removed.

78. The Strategy proposes 16 top-line targets and 50 second-tier targets for 2030.[23] The targets disaggregate the global response into distinct, manageable sections. Some of

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

them are maintained from the previous Strategy[24] because they have not yet been achieved by all countries and remain crucial. They include the 95–95–95 targets which aim for 95% of all people living with HIV to know their HIV status; 95% of all people with diagnosed HIV infection to receive sustained ART, and 95% of all people receiving ART to have viral suppression by 2025.[25] As of December 2024, seven lower and middle-income countries—Botswana, Eswatini, Lesotho, Namibia, Rwanda, Zambia and Zimbabwe—had achieved the 95–95–95 targets. Those successes must be maintained and extended to countries where the targets have not been reached.

79. The AIDS pandemic cannot be overcome in isolation. HIV interventions must be integrated with other public health and development agendas and systems, including for sexual and reproductive health, tuberculosis, viral hepatitis, noncommunicable diseases, mental health and social protection. The purpose is to address people's multiple health and development needs, ensure their well-being across their lives, and make the HIV response more sustainable. Public health is a holistic endeavour.

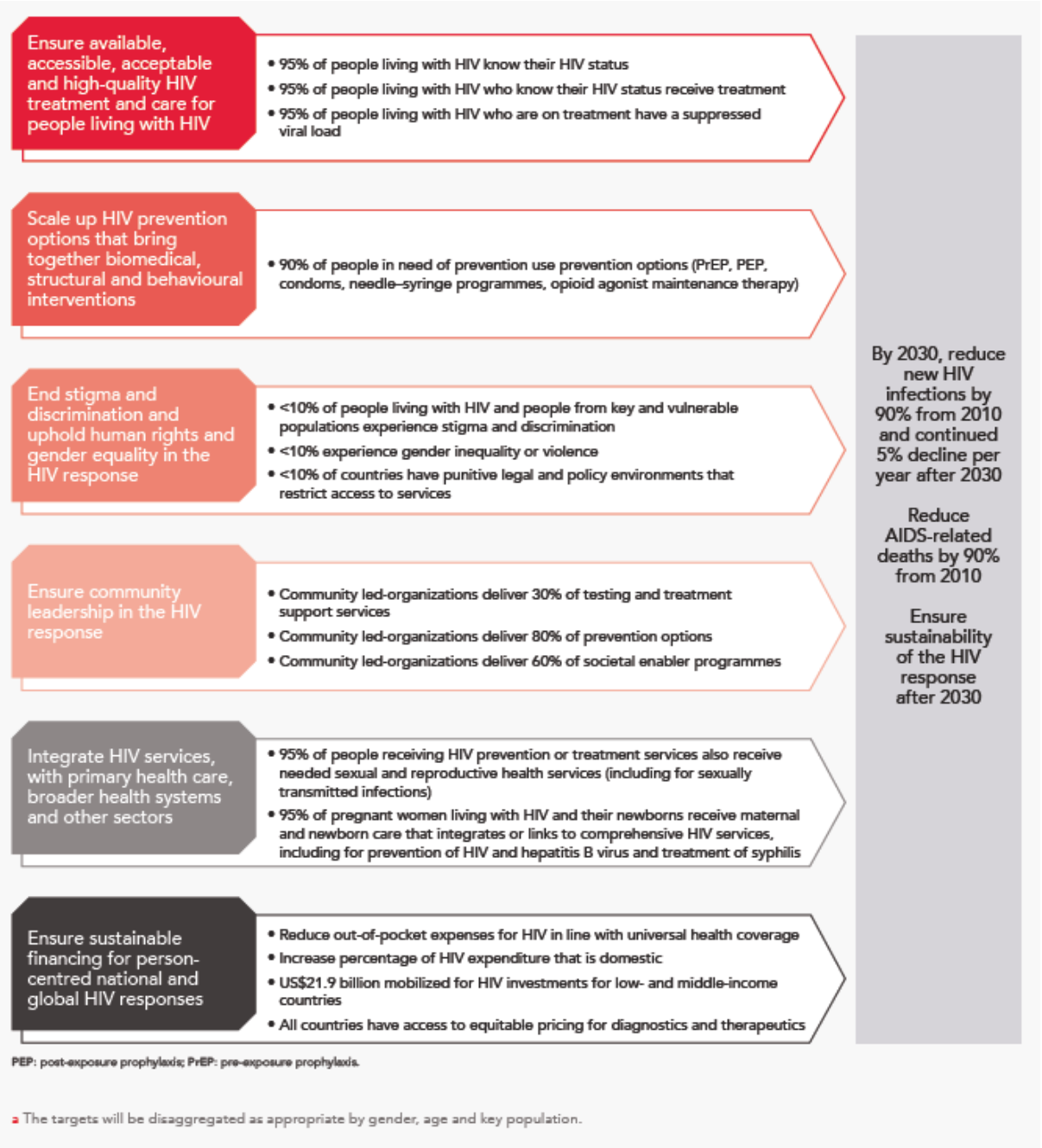
80. The 16 top-line targets are organized into six priority areas (Figure 2). Also recommended are 50 second-tier targets which countries should consider including in their national HIV strategies and programmes if they fail to reach the 16 top-line targets.[26]

[24] Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. | UNAIDS

[25] Frescura L, Godfrey-Faussett P, Feizzadeh A, et al. Achieving the 95-95-95 targets for all: A pathway to ending AIDS. PLoS ONE. 2022;17(8):e0272405. https://doi.org/10.1371/journal.pone.0272405

[26] 20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf

Figure 2. The 16 top-line targets to end AIDS as a public health threat by 2030 and ensure sustainability of the HIV response after 2030*



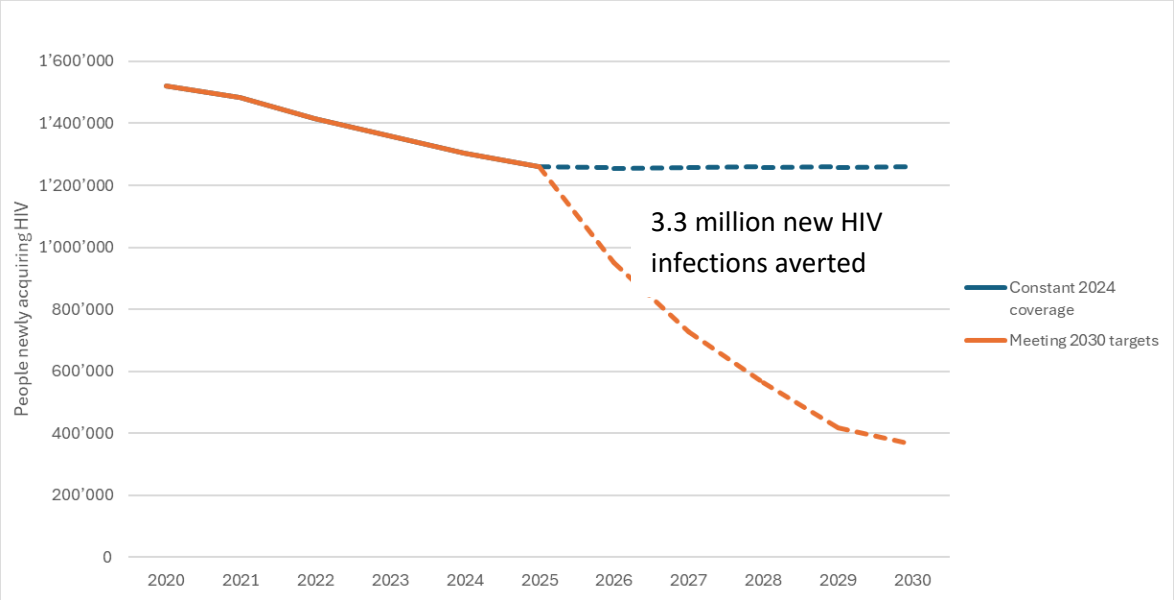
PEP: post-exposure prophylaxis; PrEP: pre-exposure prophylaxis.

a The targets will be disaggregated as appropriate by gender, age and key population.

81. Achieving the targets will put most countries in reach of the goal of ending AIDS as a public health threat (or “ending AIDS”) by 2030. 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.[27]

82. Figures 3 and 4 illustrate the impact of achieving the targets: between 2025 and 2030, 3.3 million new HIV infections and 1.4 million AIDS-related deaths would be averted.

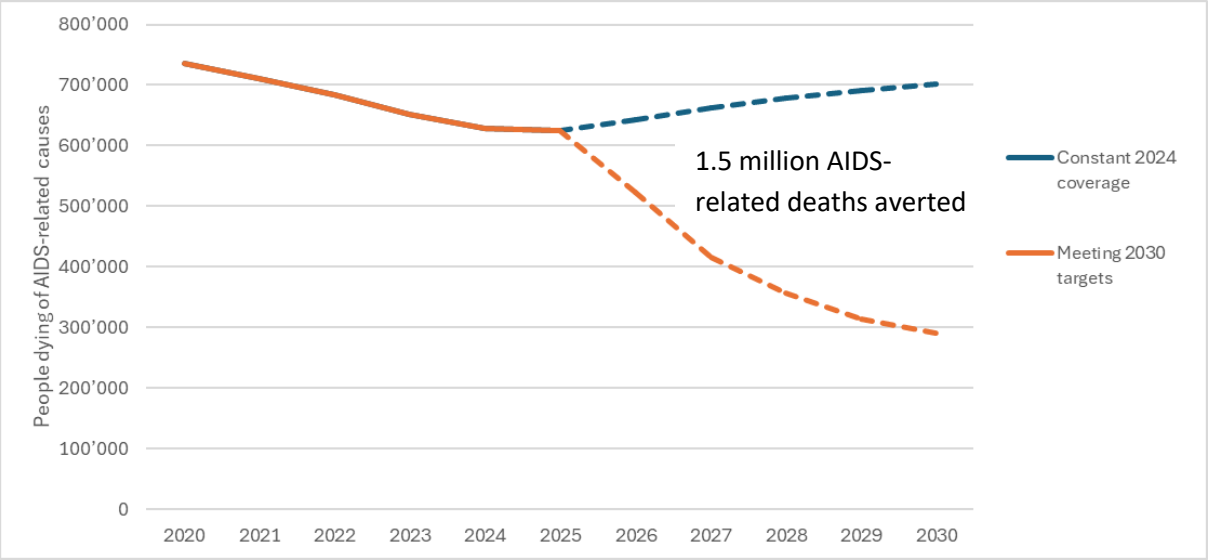
Figure 3. Potential new HIV infections averted if 2030 HIV targets are met, global 2020–2024 estimates and 2025–2030 projections



Source: 2025 UNAIDS epidemiological estimates and Goals Projections

[27] 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).

Figure 4. AIDS-related deaths averted if 2030 HIV targets are met, global 2020–2024 estimates and 2025–2030 projections



Source: 2025 UNAIDS epidemiological estimates and Goals Projections

Funding the global response to HIV

83. UNAIDS projections indicate that achieving the targets set out in the Strategy will require annual resources ranging from US$ 21.9 billion to US$ 23 billion in low- and middle-income countries by 2030.[28] This is up to US$ 7.4 billion less than the previous estimate of US$ 29.3 billion, due to price reductions and other savings that were achieved in recent years. In addition, the new estimate reflects more efficient and targeted service delivery, as well as prioritized approaches based on HIV risk.

84. Most annual resource needs for HIV in 2030 will be in upper-middle-income countries (46%), with the remainder in lower-middle-income countries (34%) and low-income countries (20%).[29] [30] It is estimated that low-income countries would fund about 35%, lower-middle-income countries about 65%, and upper-middle income countries about 95% of their HIV responses with domestic resources. 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. The deep inequalities that drive and sustain the AIDS pandemic must also be addressed to ensure that services are delivered effectively to everyone who needs them. Cost reductions without addressing

[28] Stover J, Mattur D, Siapka M et al. The impact and cost of reaching the UNAIDS global HIV targets. medRxiv. 2025. doi: https://doi.org/10.1101/2025.07.01.25330647

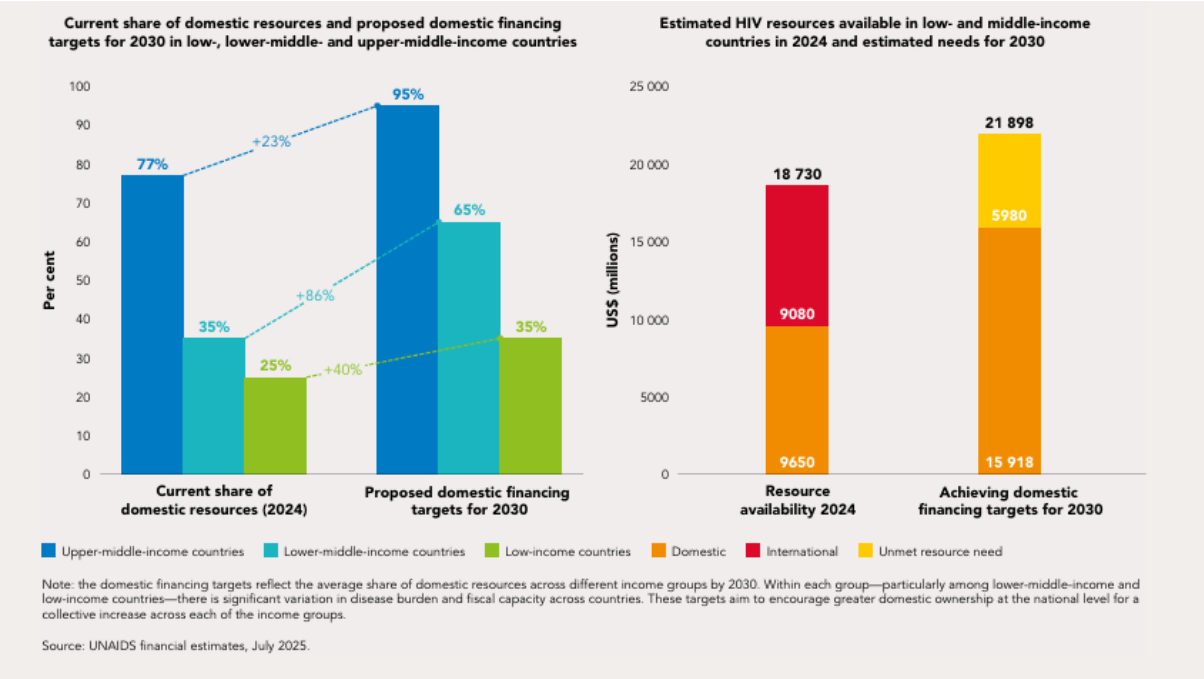
[29] The new estimates exclude the upper-middle-income countries which the World Bank recently reclassified as high-income countries.

[30] Stover J, Mattur D, Siapka M et al. The impact and cost of reaching the UNAIDS global HIV targets. medRxiv. 2025. doi: https://doi.org/10.1101/2025.07.01.25330647.

structural barriers to equal access to medications and services would only entrench inequalities.

85. In 2024, HIV funding globally amounted to US$ 18.7 billion, with domestic funding accounting for 52% of that total.[31] However, the option of rapidly increasing domestic resources for HIV is not available to all countries, especially low-income countries. The World Bank has projected that at least 29 countries will experience a reduction in per capita government expenditure until at least 2028 due to debt obligations, lack of fiscal space and slow economic growth.[32] International resources must be made available, especially in countries affected by conflict.

Figure 5. 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



Note: 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 the national level for a collective increase across each of the income groups.

Source: UNAIDS financial estimates, July 2025.

[31] The estimate excludes the upper-middle-income countries which were reclassified recently as high-income countries.

[32] Kurowsky C, Schmidt M. Evans DB, et al. Government health spending outlook–projections through 2028: diverging fiscal pressures, even constraints. Washington DC: World Bank; 2024 (https://documents1.worldbank.org/curated/en/099110524145099363/pdf/P506692116ebcb0e188b4175eb4c560cb5.pdf).

Mapping the shift: Three priorities, eight results areas to end AIDS as a public health threat by 2030 and sustain the response

86. The Strategy sets out three priority areas (Figure 6) and eight results areas (Figure 7). The actions must be sustainable, people-focused and must empower communities to lead.

    a) **Priority 1: Country-led, resilient and ready for the future**. Governments and communities are at the forefront of national HIV responses. As international funding declines, domestic and donor investments should 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.

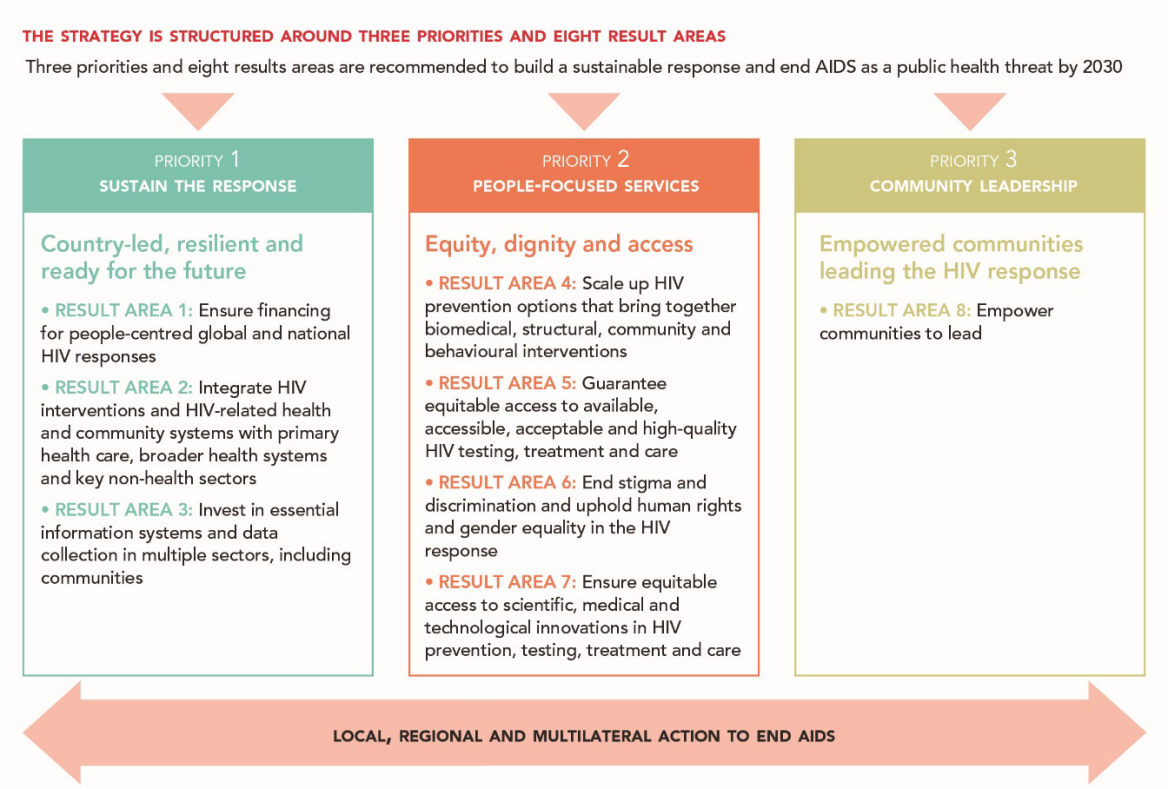
    b) **Priority 2: People-focused services—equity, dignity, and access**. The Strategy is people centred. Ending AIDS requires that people can access quality sustainable HIV prevention, testing and treatment services in environments that are free of stigma, discrimination and violence. That demands reducing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

    c) **Priority 3: Community leadership**. Communities of people living with, affected by, or at risk of HIV must continue to lead the way by shaping policies, delivering services and achieving accountability.

Figure 6. Three priorities to end AIDS as a public health threat by 2030 and sustain the response

87. Consultations with communities and other partners engaged in the global HIV response identified eight results areas or actions that will have the greatest potential to support countries to sustainably end AIDS by 2030. Those results areas were defined during the consultations for the Strategy, including the multistakeholder consultation requested by the Programme Coordinating Board (PCB).

Figure 7. Priorities and results areas for achieving a sustainable response to end AIDS as a public health threat by 2030

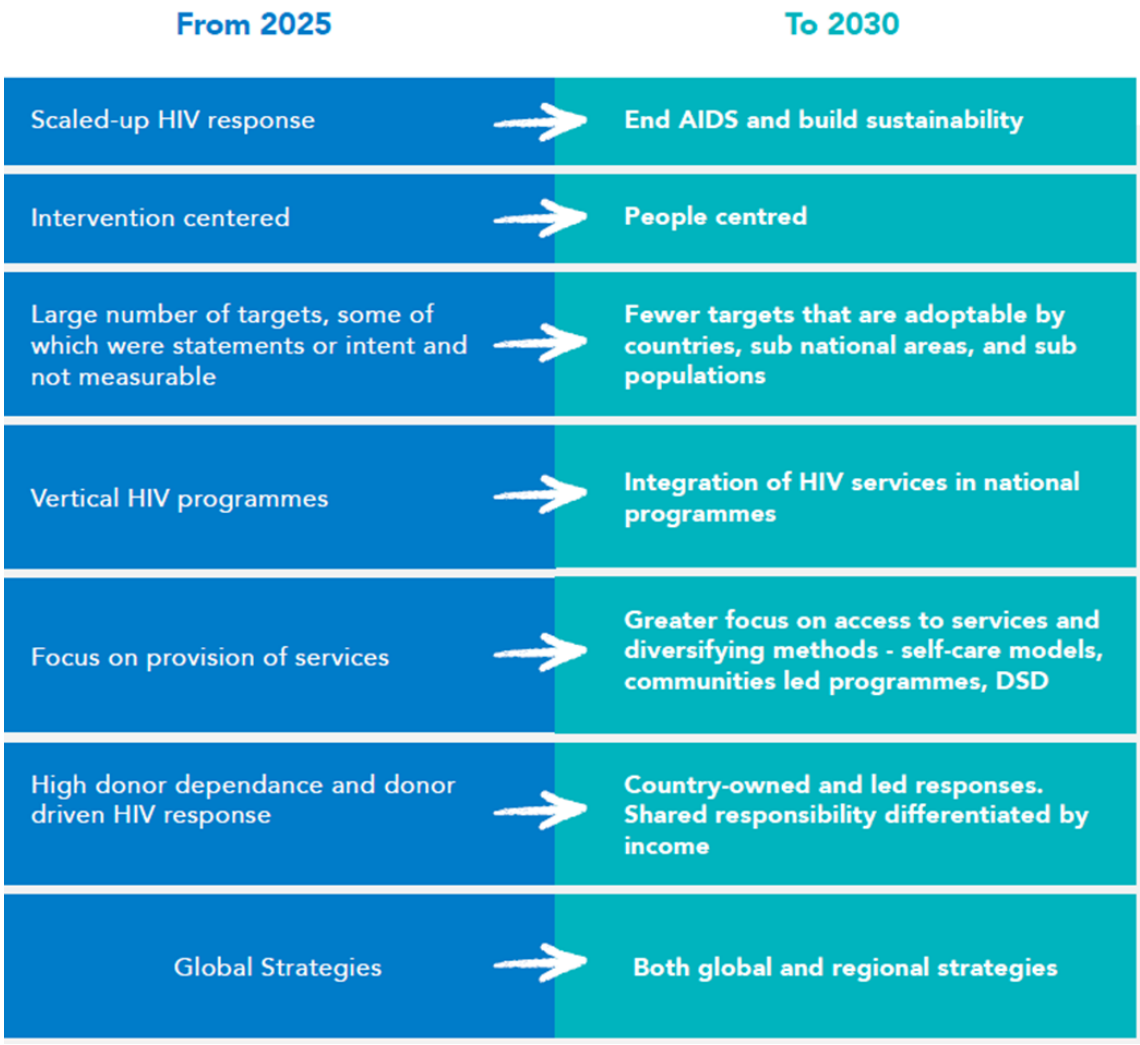


88. Taken together, the priorities and results areas constitute a costed, measurable and focused agenda for ending AIDS by 2030 and sustaining national HIV responses into the future. At a time of global upheaval and uncertainty, they lay out a realistic path towards achieving one of the most ambitious public health goals of our time.

What's new in the Global AIDS Strategy?

89. The Global AIDS Strategy 2026–2031 proposes a shift in focus from rapid scale up of HIV services to moving towards ending AIDS and building sustainability into the future. It also entails moving from a predominantly intervention-centered approach to a people-centered one, and from a donor- and partner-led system to one that is country-owned and -led (including by communities and civil society) within a framework of shared responsibility. The Strategy presents a reduced number of measurable targets which countries can monitor, along with an integrated approach for providing services within national systems.

Figure 8. Key shifts between the previous Global AIDS Strategy and the new Strategy



Theory of change: The path to 2030

90. The Strategy responds to an extraordinary period for global public health. Mounting fiscal pressures, overlapping crises and pushbacks against human rights threaten hard-won progress. Its theory of change (Annex 4) articulates the strategic shifts that are required to sustain gains, accelerate progress and adapt to changing conditions.

91. The theory of change crystallizes a shift from an emergency, donor-driven HIV response to a sustainable, nationally led, rights-based[33] and integrated approach that is

[33] A human rights-based approach is a conceptual framework for the process of human development normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities that lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress and often result in groups of people being left behind. References to this approach can be found in: the Global AIDS Strategy 2021–2026; HRC 56/22 (2024, consensus), which calls for human rights-based approaches in data systems and policy design; and HRC 54/16 (2023 consensus), which recognizes that a human rights-based approach is needed for the elimination of preventable maternal mortality and morbidity.

embedded within resilient national, subnational and community health and social systems. It emphasizes stronger country ownership, community leadership, long-term domestic financing, and integration of HIV within Universal Health Coverage (UHC) and primary health care platforms. It proposes concrete actions for strengthening country systems across the three priorities and the results areas.

92. It also acknowledges the progress achieved under the previous Global AIDS Strategy (2021–2026), ensuring that new ambitions build on proven success, particularly in viral suppression, community leadership and gender equality. The next strategic period builds on these achievements to complete the unfinished agenda, with renewed focus on sustainability, equity, and rights.

93. **Priority 1** emphasizes domestic leadership, diversified financing and integration of HIV into UHC systems. It calls for fiscal innovation, multisectoral collaboration, integration into primary health care, and data governance that is grounded in equity and privacy.

94. **Priority 2** focuses on integrated, differentiated and people-centred HIV services that ensure access to HIV prevention, testing, treatment and care for people living with, affected by or at risk of HIV by combining biomedical tools and social behaviour change, and by pursuing local manufacturing of health commodities.

95. **Priority 3** champions rights-based and gender-responsive approaches and community-led governance. Legal reform, resourcing of community-led organizations, and safeguarding are key.

96. The priorities encompass the essential building blocks of the HIV response: sustainable financing; integration into primary health care; affordable access to medicines and technologies; robust information systems; differentiated and people-centred testing, treatment, and care services; access to prevention options such as pre-exposure prophylaxis (PrEP) and condoms; enabling legal and policy environments; and investment in community-led actions and programmes.

97. The Strategy envisions achievement of the global AIDS targets by 2030—including the 95–95–95 cascade and a 90% reduction in new HIV infections and AIDS-related deaths—as the core, quantitative measures of success. The numerical targets are supported by broader strategic outputs: access to HIV prevention, testing, treatment, and care tools; the adoption of enabling laws and policies; increased domestic financing; and the full integration of HIV responses, including linkages to co-morbidities such as tuberculosis and viral hepatitis within resilient national, subnational and community health and social systems.

98. Central to this vision is the commitment to reduce the deep inequalities that continue to increase HIV risk and undermine access to services, particularly for women, girls, young people and key populations. Together, these quantitative targets and qualitative goals capture the holistic vision of ending AIDS as a public health threat and advancing equity, inclusion and sustainability.

Priority Action 1: A country-led, resilient and "future ready" global response

99. Sustainability was a recurring theme in the consultations that informed the Strategy. A sustainable global response has to protect the gains made against the pandemic, extend those gains and ensure that they will endure. This will have to be done despite a steep decline in international funding for HIV programmes in low- and middle-income countries.

100. Sustainability requires planning beyond the current emergencies by strengthening health-care and social systems that are durable and that can be deployed alongside other public health instruments. Investments in impactful responses need to simultaneously strengthen broader and integrated health and multisectoral systems. That means having financing and service delivery systems for health care and social protection that reduce out-of-pocket expenditures (grounded in evidence from health economics and long-term value analyses) and that deliver accessible, acceptable and quality services to people living with, affected by, or at risk of HIV. Strengthened public health systems build resilience against HIV and other health threats.

101. Sustainability also requires strengthening communities so that they can provide prompt and adequate support. It requires addressing the human rights and social contexts that lead to stigma and discrimination and that discourage people living with, affected by, or at risk of HIV from using services and seeking support.[34] When health and social protection systems are inclusive and gender-transformative and serve the needs of people living with HIV, they can mitigate some of the inequalities that fuel the pandemic and undermine the response. Addressing gender inequalities is central to community strengthening. Social protection can reduce vulnerability, remove barriers to service access and improve people's health, well-being, quality of life, enable food security and nutrition and social inclusion.

102. Finally, sustainability calls for strategic investments in national and local capacities, including flexible financing arrangements that respond to local priorities. Reliable funding alongside efficient and effective service delivery improves health outcomes, which generates secondary social, economic and political benefits. That requires actors—including those who might not traditionally be active in public health—working together across sectors and levels.

103. Making the HIV response sustainable[35] beyond 2030 demands major transformations. One such change is the accelerated integration of the HIV response into broader health systems, while incorporating community leadership and interventions. Another change involves increased domestic resource mobilization and investments for health and HIV.

104. Overall, the goal of a sustainable response is a country-led, resilient, inclusive and "future ready" HIV response. The country-led aspect requires being responsive to

[34] Centering Human Rights in Sustainable HIV Responses - UNAIDS Sustainability Website

[35] Sustainability is defined as a country's ability to have and use, in an enabling environment, people-centered, human rights and gender equality-based systems for health and equity, empowered and capable institutions and community-led organizations, and adequate, equitably distributed resources to reach and sustain the end of AIDS as a public health threat by 2030 and beyond, upholding the right to health for all. See: HIV response sustainability primer | UNAIDS.

distinctive local contexts and meaningfully engaging communities. Resilience means being adaptable to changing social, economic and political realities. Inclusivity requires that all populations, regardless of their gender, legal, socioeconomic and political status are engaged meaningfully in decision-making that affects them. Being “future ready” entails maintaining awareness of changes in the socioeconomic and political realms that might affect the HIV response.

105. The Strategy proposes the following results areas as action points.

Results Area 1. Ensure financing for people-centered global and national HIV responses

106. Sustainable financing is essential for a people-centred HIV response. In many countries, national governments are already the primary source of funding for their responses to HIV and must continue to be supported by global solidarity. National governments require support to conduct policymaking processes that deliver clear, incremental and pathways to sustainable financing. Local financing alternatives exist and are increasingly important for community-led responses. They include partnerships with private sector actors, religious institutions, traditional authorities, indigenous governance structures, community-led networks and organizations, and other local actors.

107. While two-thirds of countries reporting to UNAIDS have increased their domestic HIV spending in the past five years, domestic resource mobilization for HIV has been under strain for four consecutive years, a decline that began during the COVID-19 pandemic.[36] In addition to reduced international assistance, many low- and middle-income countries are saddled with burdensome debt repayments and limited fiscal space, which reduces their capacity to fund health and HIV programmes.

108. Meanwhile, cuts in donor funding are disrupting HIV programmes and causing critical gaps in financing for frontline health workers and HIV services. The impact includes procurement delays and stock-outs of diagnostics, antiretroviral (ARV) medicines, including for PrEP, and other prevention commodities. Also affected are community-led interventions, with projects addressing stigma and discrimination, gender inequalities and the creation of enabling legal environments being forced to shut down. The effects extend beyond HIV and are putting entire public health systems under strain, which also reduces the prospects for integrated service delivery.

109. Multilateral action therefore remains imperative, particularly for securing adequate financing. Inequalities in incomes and access to resources is also on the rise, with some of those inequalities keenly felt in health and social protection systems. Sustainable multilateral action can alleviate these disparities.

110. Data compiled by UNAIDS indicate that the United States (U.S.) Government, the Global Fund and other development entities collectively financed more than 90% of HIV responses in at least nine countries[37] and 60% of the HIV response in sub-Saharan

[36] See: https://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports

[37] Ethiopia, Haiti, Liberia, Malawi, Mozambique, Nigeria, South Sudan, United Republic of Tanzania, Zimbabwe.

Africa as a whole. Despite increased domestic HIV funding, the HIV responses of some countries have remained highly reliant on external support.

111. The rapid decrease in funding has exposed the fragility of HIV responses that are highly reliant on external financing. While the share of official development assistance going to public health held steady between 2010 and 2022, the share going to HIV programmes almost halved, from 6% to 3.4%. The funding cuts announced in early 2025 followed an almost 6% decline in official development assistance for HIV since a peak in 2013. That decline would have been even steeper had it not been for strong support from the Global Fund and the U.S. Government. However, in early 2025, a great deal of U.S. funding for HIV was either terminated or suspended. Changes in the global financing architecture in 2025 threaten to reverse decades of progress and investment, jeopardizing the entire HIV response.

112. Many HIV programmes, especially those focused on prevention, are struggling to cope with the impact of sudden, major reductions in donor funding. Upper-middle-income countries are capable of varying degrees of resilience. Some may be able to absorb reductions in donor funding due to stronger domestic financing capacities, but several will struggle to fill gaps in critical areas such as HIV prevention and societal enablers, where domestic investment has historically been limited. These realities underscore the need to diversify funding sources while also making them more resilient.

113. HIV prevention programmes in particular continue to be underfunded, as do programmes focused on societal barriers, including gender inequality. Not enough resources are dedicated to key populations, despite the disproportionately high rates of HIV within these groups. Latest estimates show that less than 3% of total HIV spending is allocated to prevention interventions among key populations, far less than the estimated 20% that is needed by 2030. A lack reliable funding for programmes that serve these populations undermines the entire HIV response.

114. Innovative and diversified financing is needed to expand and sustain HIV responses. Debt swaps such as the Global Fund's "Debt2Health" initiative, for example, can be used to convert sovereign debt into health investments, including for HIV, thereby unlocking new funding streams. Blended finance can also mobilize multilateral, public and non-concessional capital from national, regional and global development banks, development finance institutions and private actors by using concessional resources to reduce investment risk and channel funding to underserved areas.

115. Examples such as the "Lives and Livelihoods Fund"[38] support the case for diversifying HIV financing and incentivizing ARV manufacturing, respectively. Outcome-based models—such as Rwanda's performance-based financing and the pay-for-performance HIV prevention scheme for adolescent girls and young women in South Africa—support the work of donors and governments, while promoting efficiency and innovation. In Guatemala, the issuance of US$ 800 million in ESG (Environmental, Social and Governance) bonds prompted strong investor interest, with potential benefit for the National Programme for the Prevention and Control of STIs and HIV/AIDS as an eligible expenditure.[39] Public and private insurance schemes can also integrate HIV services through pooled funding. While these approaches have significant potential, their impact depends on tailored technical support, community involvement, and a rights-based approach that counteracts stigma and discrimination.

Social impact bonds

Social impact bonds are an innovative funding model which is being tested in low- and middle-income countries. The bonds are investments towards social goals, and they are realized when the targeted outcome of an intervention is achieved. In South Africa, a pilot social impact bond scheme launched in 2023 to reduce vertical transmission of HIV showed potential for aligning financial incentives with health outcomes. Although these bonds are not necessarily scalable models of intervention, they can serve as sources of bridge funding.

Source: Elendu C, Amaechi DC, Elendu TC, et al. Shaping sustainable paths for HIV/AIDS funding: a review and reminder. Ann Med Surg (Lond). 2025 Feb 27;87(3):1415-1445. doi: 10.1097/MS9.0000000000002976.

116. **Actions required** to ensure financing for people-centered global and national HIV responses include:

a) **Ensure alignment and full integration in the design, costing and budgeting of national HIV plans.** This includes alignment of funding sources (including external funding sources) with national strategies and plans, improved efficiency, transparency and strong accountability mechanisms.

b) **Develop and promote an advanced HIV response funding model to incrementally transition the HIV response to domestic financing and into integrated health systems**, by deploying a range of financing instruments:

- **Grow domestic revenue for health and HIV** through increased domestic revenue collection (e.g. increases in corporate, wealth and personal income tax rates, reforms to preferential tax regimes, and measures to combat tax evasion and avoidance); increased budget allocations to health and HIV; reallocation of funds released through debt relief arrangements; and tax administration and procurement improvements.
- **Establish and operationalize diversified, innovative and blended financing instruments for HIV programmes**—including ring-fenced health taxes, HIV levies, debt swaps, loans and social bonds—through joint financing platforms

[38] Lives and Livelihoods Fund | IsDB

[39] See: https://www.minfin.gob.gt/images/archivos/dcp/Repu%CC%81blica%20de%20Guatemala%20-%20Marco%20de%20Financiamiento%20Sostenible%202024%20vF.pdf

that involve governments, development banks, donors, civil society and the private sector.

- **Integrate HIV financing** into public health and multisectoral budgets, and into emerging instruments such as health insurance schemes and mechanisms.
- **Radically increase development assistance for health and HIV** that is channelled through country systems, in order to build lasting capacity to respond to HIV.

c) **Integrate HIV services**, including community-led service delivery and community-led monitoring, in national health insurance schemes and benefit packages of UHC systems; social protection and education schemes; social contracting mechanisms; and public and private sector health insurance programmes.

d) **Eliminate user fees and reduce out-of-pocket expenses** for HIV-related and other essential health services, prioritizing marginalized populations, including women, girls, people living with HIV and key populations.

e) **Establish large, pooled funding mechanisms** at national or subnational levels that combine domestic budgets, social health insurance and donor contributions to improve efficiency, sustainability and equity of the HIV response.

f) **Develop and implement multisectoral, rights-based country-led HIV sustainability roadmaps** to sustain epidemic control beyond 2030,[40] and converge those endeavours with national health system reforms and health financing efforts. The roadmaps must define an inclusive and evolving division of financing responsibilities across global, regional and national levels to sustain people-centred HIV responses and equity over time.

g) **Improve public financial management systems and secure full accountability** for country commitments on domestic financing for health and the HIV response with explicit resource tracking for HIV and community-led investments.

h) **Prioritize efficiencies, value for money and integration reforms** that ensure the best impact and results for investments.

i) **Leverage regional organizations and South-South learning** and cooperation platforms to strengthen accountability, pool resources (including for community-led organizations) and support predictable financing for regional and national community-led and other civil society organizations.

j) **Community leadership for services delivery and accountability is at the core of successful and sustainable national responses**. This needs to be reflected and monitored in the dedicated and long-term allocations in national budgets.

Results Area 2. Integrate HIV interventions and HIV-related health and community systems with primary health care, broader health systems, and key non-health sectors

117. The next phase of the HIV response demands a transformative shift that moves beyond vertical programmes toward fully integrated, resilient and people-centred systems. As

[40] Homepage - UNAIDS Sustainability Website

countries work to sustain achievements and close gaps, it is essential that they integrate HIV interventions and HIV-related health and community systems with primary health care,[41] broader health systems and key non-health sectors.

118. Integration can leverage the proven strengths of HIV responses—including its multi-sectorality, innovation, government and community leadership, accountability mechanisms, rights-based approaches and gender responsiveness—to accelerate progress toward UHC and sustainable development. It can enable more coherent service delivery platforms to address multiple health and non-health needs of people and communities; maximize resource efficiencies; and enhance health and development other outcomes by addressing people's needs more comprehensively. Strengthened primary health care that incorporates multisectoral actions and community engagement to promote health equity and well-being can further enhance HIV responses. By embedding HIV deeper in the broader arena of health and development, countries can lay foundations for a more inclusive, sustainable and "future ready" response that protects and advances gains for generations to come.

119. The Global AIDS Strategy recommends both immediate and longer-term actions 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. It also includes strengthening clinical and social systems for health, ensuring their availability to all sectors of society in the face of continuously widening inequalities.

120. HIV services and HIV-focused systems (including community systems) must be strategically integrated with countries' primary health care and broader health systems, taking into consideration the local contexts. HIV interventions should be integrated also with prioritized non-health sector programmes—such as education, social protection, empowerment and equality programmes, justice, labour and humanitarian interventions—to address structural determinants of HIV risk and to remove societal and structural barriers that hinder access to services. Such integration is essential for inclusive, equitable and effective HIV responses, while accelerating progress toward achieving broader health and development goals.

121. Successful integration starts locally—at primary health care facilities and community clinics—and expands gradually, based on rapid needs assessments and country-specific data on HIV burdens and population health and social factors.

122. Equally important are strong community systems, including peer support networks, community mobilizers, and community outreach workers who deliver services and conduct community-led monitoring. They play key roles in reaching people, fostering demand, delivering services and ensuring accountability. Integrating community workforce and systems with health and relevant non-health systems, while strengthening their capacity and leadership, helps ensure that systems for health respond to people's needs and are resilient and sustainable.

[41] Operational Framework for Primary Health Care

123. Integration can also enhance responses to external shocks such as conflicts, economic upheavals or climate disasters. These shocks are occurring more frequently, including in countries with high HIV prevalence, and they intensify the vulnerability of people living with and affected by HIV, especially women and girls, who may be exposed to gender-based violence. Nineteen countries with high HIV burdens, mostly in sub-Saharan Africa, are among the 50 countries listed at the top of the 2024 Fragile States Index.[42] More than ever, HIV needs to be part of emergency preparedness and humanitarian response.

124. **Actions required** for integration of HIV interventions and of HIV-related health and community systems with primary health care, broader health systems and key non-health sectors include:

    a) **Ensure strong political leadership, strategic and cross-programmatic commitment**, as well as clear operational mechanisms for integrating HIV into primary health care[43] and broader systems for health. This should be tailored to each country's epidemiological context, level of HIV burden and system capacities, and it should be reinforced with effective change management, emergency preparedness, strengthened system resilience and adaptability.

    b) **Strengthen the integration of HIV-focused services and systems—including community-led service delivery and monitoring—with primary health care and broader public health systems.** This can be done by aligning and focusing on core strategic and operational levers of a primary health care and public health functions, including: primary health care workforces; medicines and other health products; procurement and supply management; laboratory systems; health information and surveillance systems; monitoring and evaluation; digital technologies for health; financing; and policies and governance. Doing so can improve the coordination, efficiency and sustainability of people-centred and local, context-responsive service delivery.

    c) **Simplify HIV service delivery by focusing on essential HIV testing, treatment, 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 including self-care options. Services should be provided voluntarily, using a gender-sensitive and human rights-based approach, without discrimination or coercion.

    d) **Formalize, institutionalize and integrate HIV-focused community systems and services within primary health care and broader public health systems**. This should be done to recognize and include community health workers and other community workforces—including peer navigators, people living with HIV and key population networks and groups—as part of national and local health systems, with remunerated, formalized roles and protections. Doing so can ensure the delivery of quality person- and community-centred, trusted and cost-effective HIV and broader health services. Investment in community leadership builds local ownership and ensures that programmes are responsive to the lived realities and multiple health

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

[43] Operational Framework for Primary Health Care, WHO, 2020

and other needs of people living HIV and of key and other vulnerable populations (see Results Area 8).

e) **Strengthen collaboration, align policies and invest in co-financing across sectors** for the integration of HIV with social protection, education, justice and labour. This is important to address societal barriers and structural drivers and to enhance the effectiveness of HIV interventions, especially for people living with HIV and key populations. Invest in reforms and capacity-building for non-health sectors as part of integrated approaches and interventions. This includes the co-design of policies and service delivery protocols with intended beneficiaries.

f) **Promote multisectoral programmatic coordination and broaden the inclusion of key stakeholders** (such as legislators, local governments, community organizations and the private sector) to realize the broader developmental benefits of HIV integration. This can foster sustained support and resource mobilization across sectors, guided by health economics evidence to prioritize cost-effective interventions.

g) **Embed a human rights-based approach** in the integration of HIV services with general health care, using specific programmatic efforts to build stigma-free, gender-transformative, youth-responsive and key population-appropriate services, and embedding community-led structures within general systems in order to ensure availability, accessibility, acceptability and quality of HIV services.

h) **Embed HIV into security and disaster preparedness and response plans and humanitarian responses** and ensure implementation of those plans for continuity and delivery of services in times of crisis, including with sexual and reproductive health and rights services for victims of gender-based and sexual violence. These activities should include networks of people living with, affected by, or at risk of HIV in the development and implementation of national disaster preparedness and humanitarian response frameworks.

i) **Implement robust accountability systems and metrics** to measure the outcomes and effectiveness of integration of HIV-focused services and systems in primary health care, broader health systems and key non-health sectors. These monitoring systems will guide the integration process and provide valuable insights to inform and improve success in reaching the desired outcomes of integration. In addition, it is important to demonstrate, promote and track the developmental benefits of HIV integration by systematically generating and communicating evidence on how integrated HIV responses contribute to education, gender equality, labour and social protection goals.

j) **Strengthen global health security and country resilience and responses to global pandemics** by building on lessons from the HIV response—for example, regarding the importance of data-driven and evidence-informed responses, global solidarity, multisectoral actions, respect for human rights, strong national coordination, and community engagement.

Results Area 3. Invest in essential information systems and data collection in multiple sectors and including communities

125. HIV responses have been based on robust and timely data systems that inform planning and coordination. The resilience of these systems proved especially critical during other health emergencies, such as COVID-19 and Mpox. Strengthened HIV data systems potentially enhance public health monitoring more broadly, as these systems can be deployed across various health priorities. Continued investments in data systems are therefore of vital importance. In addition, capacities must be maintained for accurate estimations of HIV incidence, prevalence and mortality trends; for determining where and among whom HIV and incidence risk is high; for documenting how resources are allocated; and for monitoring programmes, tracking progress and identifying gaps.

126. Robust data systems incorporate multiple data sources, rely on timely collection of data at both subnational and national levels, and require secure data storage and capable analysis. The choice of data sources must enable programme managers to understand the epidemic and response (including the costs of the response), in order to conduct effective programme planning.

127. Increased investments are needed in information systems, especially for key and vulnerable populations. Existing global data on inequalities and structural drivers of HIV, for example, are not used widely enough to fully understand and respond to the effects of those inequalities on HIV vulnerability and risk.

128. To enhance the sustainability of the global response in the face reduced financing, countries should further integrate national HIV information and data systems with other health and development information systems, including data on the structural drivers of HIV vulnerability. Data from community-led efforts can guide service improvements and should be routinely included in data systems and used in national strategic plans. Community-led monitoring also increases accountability and quality of service provision.[44] [45] Communities must retain ownership and oversight over the data used in the HIV response, and the data must be managed in accordance with the highest standards of safety and care, while respecting the rights of the individuals whose data have been collected.

129. New information technologies, in particular artificial intelligence (AI) tools, may offer opportunities for analysing, presenting and publicizing data. If designed properly and safely, these systems can be used to identify cost-effective interventions and to understand the wider impact of integrated HIV testing, prevention, and treatment and care strategies. Such analyses can draw on social media, large household surveys, electronic health records, internet searches and other metadata. However, these tools cannot replace effective information and data gathering systems. As digital technologies become more integral to health-care delivery and community

[44] Ayala G, Sprague L, van der Merwe LL-A, et al. Peer- and community-led responses to HIV: a scoping review. PLoS One. 2021;16(12):e0260555.

[45] Caswell G, Dubula V, Baptiste S, et al. The continuing role of communities affected by HIV in sustained engagement in health and rights. J Int AIDS Soc. 2021;24(Suppl 3):e25724.

engagement, the protection of privacy, confidentially and other digital rights must be a central concern in HIV programming.[46]

130. **Actions required** to invest in essential information systems and data collection in multiple sectors include:

    a) **Governance.** Invest in and maintain robust routine data systems with effective data governance and stewardship, including ensuring confidentiality. Establish technical requirements for all digital health initiatives (including donor-funded ones) to align with national health information exchange architectures. Support national institutional capacities to manage HIV data as part of health and social data governance, including ownership and curating of data within and outside health facilities; privacy protection; data sharing; and access by governments, communities, international partners and other relevant stakeholders. Within data governance policies, include child-specific and community-informed data governance frameworks that address consent, privacy and protection from harm in digital health interventions. Ensure all digital tools serving minors undergo child rights impact assessments and incorporate age-appropriate design principles that protect privacy while enabling access to essential HIV services. Data policies must protect key populations, especially those who face increased risk due to criminalization.

    b) **Sources.** Recognize and support strategic and innovative data sources and systems to guide the HIV response with a special focus on reporting on the global targets that are most important for ending AIDS. Those include routine data systems that provide critical strategic information on epidemic patterns and across the HIV testing, treatment and prevention cascades, including measuring population-level viral suppression. Person-centred monitoring systems require establishing or strengthening electronic medical records based on nationally available unique identification.

        - Comprehensive, multi-disease, bio-behavioural household surveys can reach people outside formal health-care settings and yield a clearer understanding of how HIV affects various populations. Integrating surveys across development areas reduces “survey fatigue” in communities and enables more efficient use of financial and labour resources.
        - Continued strengthening of case surveillance and civil registration systems (including cause of death data) is important to transition toward real-time data.
        - Models can be used to estimate difficult-to-measure indicators and inform programme decisions on the potential impact of different interventions (including the estimated populations in need of prevention options).

    c) **Integration.** The interoperability of health information systems must be advanced. It is important to support integrated service delivery and responses, where feasible, along with shared electronic health and social records. This should be done while ensuring that disaggregated data collection and analysis are used for evidence-based decision-making and for improving systems and service delivery efficiencies,

[46] Ratevosian J, Reid M, Ni Z, et al. Reimagining HIV prevention with artificial intelligence. Lancet HIV. 2025:S2352-3018(25)00158-4.

and that the highest standards of data privacy and protection are observed. HIV data systems and other health and social data collection activities should ensure bi-directional learning and transition towards integrated data systems. The digitalization of electronic health and social data should also incorporate clinical, logistics, human resources, financing and community data, making them more interoperable. Where feasible and useful, cross-border data sharing can inform strengthening programmes.

d) **Inequalities.** Data sources should include characteristics that allow for disaggregated analysis to identify relevant inequalities. Governments (and the private sector) should support routine data systems to compile and protect data that offer insight into the circumstances and other characteristics of people being left behind. In addition, information systems need to capture data on access and barriers to health and social services, socioeconomic status, education levels, employment and other details. Analysis of disaggregated data will assist countries and communities to identify and monitor inequalities across key dimensions—including gender, age and relevant social and economic factors—and to take corrective actions. Combining those data with information on policies and laws can reveal human rights violations and their impact on access to services and point to countermeasures.

e) **Community-led monitoring.** Collaboration between government- and community-led monitoring structures should be formalized for mutual accountability and operational synergy. Promote the interoperability of these systems while ensuring data are collected and used for evidence-based decision-making.

f) **Finance.** Information on expenditures should be used to to inform national planning, budgeting, efficiency improvement and policy development. Disaggregated data on expenditures, costing and financing of interventions in national HIV responses remain scarce. Further work is needed to compile the costs of integrated transformative actions from national HIV programmes so strategies and plans can be costed and adequately resourced.

g) **Data use.** Health workers' digital capacities should be strengthened through systematic training programmes and ongoing support mechanisms. Digital competency frameworks must be developed for HIV service providers, digital health training can can be integrated into pre-service curricula, and mentorship programmes can be established to support health workers to use digital tools effectively for clinical decision-making, patient management and data-driven quality improvement. The careful use of digital technologies, including AI, to enhance data use and visualization should also be promoted.

h) **Estimates.** A new paradigm for routine HIV prevention needs estimates should be introduced through annual modelling of the number of people in need of HIV prevention. Estimates for different key and priority populations, as well as for different HIV prevention tools, should be developed. These country-specific estimates offer a basis for setting, implementing and measuring progress against annual national and sub-national prevention targets. They also enable simplified tracking of progress based on routine data (see Results Area 4) and the development of tailored prevention approaches.

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

> *"In the past 10 years, a lot has improved in provision of HIV-related services for people in prisons. But a big gap still remains in provision of equivalent services for people in prisons and in the community… As a person with lived experience in prison and now leading an NGO in Ukraine focusing on prison health, I can assert that a lot still needs to be done by governments and international community in close collaboration with people with lived experiences in prisons to ensure that limitation of freedom does not become a limitation of the right to health."*
>
> - Anon (Ukraine)

131. Ending AIDS entails reducing inequalities, halting violations of human rights, and doing away with the stigma, discrimination and violence that makes it difficult for people to access prevention, testing and treatment services. Such a holistic approach is also a more sustainable one, since it addresses the underlying factor that fuel the pandemic and undermine HIV responses. The Strategy maps such an approach, which includes enhanced access to differentiated health services and to equitable education opportunities and social protection measures.

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

132. The sustainability of the global response demands quicker reductions in new infections faster. Despite significant gains in several countries, the estimated 1.3 million new HIV infections in 2024 were more than triple the 2025 target of 370 000. Access to and use of proven HIV prevention tools remains inadequate and unequal.

133. Successful HIV prevention involves a mix of biomedical, behavioural and structural interventions. Biomedical prevention, including oral and long-acting versions of PrEP and holistic testing approaches, is vital. Oral PrEP is an important prevention option for people from key populations and their sex partners, and for adolescent girls and women in settings where HIV incidence is high. It remains one of the most effective biomedical interventions within the lifetime of this Global Strategy that has been effectively scaled-up in several cities worldwide. Access has increased but remains low, due to legal and policy barriers, under-investment in delivering PREP through community-led organizations to the people who need it the most, and other factors.

134. Long-acting, injectable HIV prevention products that replace multi-dose oral PrEP with six-monthly injections are a highly promising addition to HIV prevention, especially for women who struggle to negotiate condom use with male partners, as well as sex workers, gay men and other men who have sex with men, transgender people, and people who find it difficult to adhere to oral PrEP.

135. Six-monthly injections of long-acting injectable HIV prevention have been shown to be exceptionally effective at preventing HIV acquisition in clinical trials, with 100% efficacy among adolescent girls and young women in the PURPOSE 1 trial in South Africa and Uganda and 96% efficacy among cisgender men and transgender men and women in the PURPOSE 2 trial in Argentina, Brazil, Mexico, Peru, South Africa, Thailand and the United States of America. This long-acting PrEP option is safe and well-tolerated,

including during pregnancy.[47] By providing six months of continuous HIV protection, it can address some of the adherence and continuation challenges associated with oral PrEP.

136. Extensive use of condoms among populations who are at moderate risk of HIV, including young people, is a cornerstone of HIV prevention and epidemic models show it must be sustained to achieve 2030 targets. However, condom procurement has decreased by one third and social marketing schemes have been steadily defunded over the last decade.[48] As a result, condom use is declining in several countries. HIV testing is another important prevention tool, yet testing rates are decreasing and they remain low among key populations who are at high risk of acquiring HIV.

137. Behavioural and community-led strategies such as HIV self-testing, peer outreach and comprehensive sexuality education are complimentary and an essential part of the implementation of biomedical intervention and have proved reliable and effective for preventing new HIV infections. As set out in the International technical guidance on sexuality education,[49] many different names are used for comprehensive sexuality education, reflecting an emphasis on various aspects of comprehensive sexuality education by different countries. Persistent discrimination, as well as gender and other social inequalities, continue to impede access to prevention tools and services, underscoring the need for stronger efforts to address those structural barriers.

138. Prevention of sexual transmission of HIV is closely linked to efforts to avoid unintentional pregnancies and acquisition of other sexually transmitted infections. Despite marked progress in integrating services for eliminating vertical transmission of HIV with sexual and reproductive health services, the integration is not yet widespread enough (see Results Areas 2 & 6). Service uptake and impact tends to be higher when HIV prevention is embedded in broader sexual and reproductive health services and supported by community leadership.

139. The estimated 14 million people who inject drugs around the world continue to be left behind in HIV programmes, with women who inject drugs especially neglected.[50] Harm reduction programmes are almost entirely absent for people in prisons and other closed settings, despite ample evidence of injecting drug use. Between 2017 and 2024, only nine of 133 countries reported that needle-syringe programmes in prisons were operating. A comprehensive package of evidence-based interventions for HIV prevention, treatment and care are needed for people who inject drugs, including needle and syringe programmes, opioid agonist maintenance therapy, HIV testing and counselling, ART, preventing and treating sexually transmitted infections, condom

[47] Bekker LG, Das M, Abdool Karim, Q, et al. Twice-yearly lenacapavir or daily F/TAF for HIV prevention in cisgender women. N Engl J Med. 2024;391:1179-1192.

[48] Global AIDS Update 2024. Geneva: UNAIDS; 2024.

[49] International technical guidance on sexuality education. Volume I. Paris: UNESCO; 2009.

[50] World drug report 2024. Vienna: United Nations Office on Drugs and Crime; 2024 (https://www.unodc.org/unodc/en/data-and-analysis/world-drugreport-2024.html).

programmes, preventing and treating viral hepatitis and preventing, diagnosing and treating tuberculosis.[51]

140. HIV prevention programmes developed on concert with people living with HIV and key populations must be scaled up, and barriers such as stigma and criminalization of HIV and of people living with HIV and key populations must be removed. This is particularly urgent in regions where there are rising numbers of people acquiring HIV, such as eastern Europe and central Asia, Latin America and the Middle East and North Africa. More culturally sensitive, youth-led and targeted interventions that promote HIV testing, condom use, PrEP and health-seeking behaviours in social settings and workplaces are urgently needed.

141. Structural barriers—including punitive laws, age-related legal restrictions, gender-based violence, harmful gender norms and inequalities and discrimination against populations who are at high risk of acquiring HIV—must be addressed.

142. Overall, HIV prevention remains underfunded, making it difficult for the global response to reduce new infections to the low levels that are required to end AIDS. Domestic investments in prevention are either stagnant and shrinking in many low- and middle-income countries, exposing them to potential upsurges in new infections.

143. **Actions required** to scale up comprehensive HIV prevention that bring together biomedical, structural, community and behavioural interventions include:[52]

    a) **Advance comprehensive, people-centered HIV prevention, and scale up the availability of an optimal mix of prevention options,** including daily and long-acting PrEP, post-exposure prophylaxis, condoms and lubricants, and other services for specific populations, such as needles, syringes and opioid agonist therapy for people who inject drugs, and voluntary medical male circumcision for men in settings with high HIV incidence.

    b) **Rapidly introduce and scale up equitable access to PrEP options** to provide at least 20 million person-years of PrEP globally in 2030. Achieving widespread use of PrEP rapidly will require a mix of approaches and removing access barriers. Oral PrEP is now low in cost (about US$ 3 per person per month for generic versions) and scale up should continue through public, private and community channels. Highly effective, long-acting injectable PrEP should be introduced rapidly. Affordable prices for all low- and middle-income countries will be required to make long-acting options cost-effective and viable.

    c) **Reinvigorate total market approaches for condoms**, reverse declines in condom use caused by programmatic disruptions over the past decade and increase condom access among people left behind. Public investment in condom

[51] WHO, UNODC, INPUD Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs, 2023. https://www.who.int/publications/i/item/9789240071858.

[52] 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.

programmes can focus on free distribution and subsidized sales through social enterprises for lower-income groups, young people and key populations.

d) **Expand self-care in HIV prevention** by making self-care products such as condoms, self-tests, clean needles, post-exposure prophylaxis and, in some contexts, PrEP more widely available without requiring users to access formal health care provision. That requires increasing the number of access points offering self-care for HIV prevention (e.g. pharmacies, dispensers, physical and online shops). New products such as monthly oral PrEP, which may become available before 2030, could be added to the self-care agenda once they are confirmed safe and effective.

e) **Increase 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. Messaging should be developed with the involvement of people living with HIV and key and other priority populations, including young people, while engaging users around prevention choices and norms and strengthening health literacy, including on U=U.

f) **Develop sustainable prevention programme models for locations with high HIV incidence in sub-Saharan Africa**, particularly for young and adult women and men at higher risk of HIV. This will require stronger integration with existing service platforms such as sexual and reproductive health services and with comprehensive sexuality education through the education sector. Other sectors such as mining, tourism, agriculture and uniformed services can contribute resources from their budgets to prevention activities. Community outreach programmes addressing demand and HIV-related social and gender norms can be integrated into other community health programmes or, in areas with highest HIV incidence, can be implemented as country-owned programmes through local civil society rather than as donor projects.

g) **Expand culturally sensitive, male-targeted interventions that promote HIV testing, condom use, PrEP and health-seeking behaviours** through sports clubs, places of worship, prisons and workplaces. Reassess the role of voluntary medical male circumcision in light of countries' epidemiological situations; if found to be cost-effective, the intervention should be integrated into domestically financed health service provision.

h) **Develop a scaled-up system of trusted access to programmes for key populations in line with country contexts.** HIV prevention programmes for key populations should be co-designed by them and scaled up through a country-specific approach that combines community-led outreach and non-stigmatizing, non-judgmental service delivery. Barriers such as age-of-access restrictions, punitive laws and stigma must be removed. Integrated models of support are needed for community-led and -based organizations to design programmes and deliver HIV prevention services (see Results Areas 6 & 8).

i) **Strengthen and scale up comprehensive harm reduction services for people who inject drugs by ensuring equitable access to a full package of evidence-based interventions including needle and syringe programmes, opioid**

agonist therapy, HIV testing, condoms and lubricants, PrEP and PEP delivered through community-led, non-stigmatizing, and rights-affirming models. Remove legal, policy, and structural barriers that impede access, including punitive laws and restrictions on possession of injecting equipment, and expand differentiated and self-care approaches.

j) **Institutionalize differentiated HIV prevention delivery within national policies** and ensure that prevention options are routinely offered as standard of care in relevant health settings, including sexual and reproductive health, maternal and child health, and harm reduction services.

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

144. People living with HIV who receive treatment and achieve viral suppression have similar life expectancy as those without HIV and cannot transmit the virus to their partners. With appropriate prevention measures, transmission to infants can also be prevented. The U=U message (Undetectable = Untransmissible) is critical and is relevant across the HIV response.

145. However, millions of people still lack access to HIV testing and treatment. Disparities in access are evident between and within regions, and between adults and children, women and men, and members of key populations and the general population.[53] For example, although several countries have achieved steep reductions in the rates of vertical transmission of HIV, significant numbers of children living with HIV are undiagnosed and are not receiving HIV treatment. Children (0–14 years) accounted for 12% of all AIDS-related deaths in 2024 even though they constituted only 3% of people living with HIV. Knowing that someone is living with HIV is the first step to effective treatment; inadequate investment in testing compromises the entire HIV response.

146. In addition, a persistently large proportion (25–40%) of people have advanced HIV disease (or AIDS) at diagnosis or when starting treatment.[54] [55] This trend is evident across all regions and has changed little in the past decade—a reminder of the constant need to monitor, adjust and improve treatment programmes.

147. Funding losses are causing service interruptions (e.g. due to stockouts of ARVs and other medicines or staffing shortages) which are destabilizing treatment and care programmes. Treatment interruptions jeopardize the health of people living with HIV, increase the risk of transmission of HIV (and/or tuberculosis) to other people, and add strain to health systems. They contribute to increased HIV acquisition and AIDS-related morbidity and mortality, resulting in long-term human and economic costs and

[53] Stevens O, Sabin K, Anderson RL, et al. Population size, HIV prevalence, and antiretroviral therapy coverage among key populations in sub-Saharan Africa: collation and synthesis of survey data, 2010–23. Lancet Glob Health. 2024 Sep;12(9):e1400-e1412. doi: 10.1016/S2214-109X(24)00236-5.

[54] De Waal R, Wools-Kaloustian K, Brazier E, et al. Global trends in CD4 count measurement and distribution at first antiretroviral treatment initiation. Clin Infect Dis. 2024:ciae548 (https://doi.org/10.1093/cid/ciae548).

[55] Kitenge MK, Fatti G, Eshun-Wilson I, et al. Prevalence and trends of advanced HIV disease among antiretroviral therapy-naïve and antiretroviral therapy-experienced patients in South Africa between 2010–2021: a systematic review and meta-analysis. BMC Infect Dis. 2023;23(1):549 (https://doi.org/10.1186/s12879-023-08521-4).

consequences. In the absence of a cure for HIV, millions of people will continue to need HIV treatment for many decades to come.

148. It is vitally important to adress the multiple health needs of people living with HIV. The well-integrated delivery of HIV and non-HIV health services can reduce morbidity and mortality, including from comorbidities and coinfections such as tuberculosis, viral hepatitis, other sexually transmitted infections, non-communicable diseases, mental health and substance use conditions, and help achieve long-term well-being.

149. **Actions required** to guarantee available, accessible, acceptable and quality HIV testing, treatment and care include:

    a) **Deliver HIV treatment to 40 million people by 2030** through stigma- and discrimination-free services.

    b) **Strengthen the adoption in national health policies of differentiated service delivery approaches** to HIV testing, treatment and care that include primary health care providers and community-led services. 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 to ensure achievement of the 95–95–95 targets across all population groups. Depending on the context, those populations would include children, adolescents, pregnant and breastfeeding women, mothers, 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 and coinfections.

    c) **Accelerate the design and scale up people-centered health services, within primary health care systems and community settings**, that integrate HIV testing, treatment and care with services for maternal and child health, sexual and reproductive health, coinfections and other communicable and non-communicable disease (notably tuberculosis, viral hepatitis B and C, sexually transmitted infections, cervical cancer and other cancers, mental health, and substance use conditions), as well as gender-based violence services (including for intimate partner violence).

    d) **Involve people living with HIV and key population networks in the design, delivery and monitoring of integrated HIV services** especially where HIV intersects with sexual and reproductive health, non-communicable diseases, mental health and gender-based violence.

    e) **Invest in tailored HIV literacy and service capacity strengthening** for health-care providers and communities, including on the benefits of early diagnosis, U=U, viral suppression, and long-term care of people living with HIV, as well as on challenges related to advanced HIV disease, ageing with HIV, and stigma and discrimination.

    f) **Ensure the availability of and equitable access** to accurate, high-quality HIV testing and treatment products worldwide, in accordance with global health standards and normative guidance.

    g) **Deploy new technologies and programme innovations** to optimize the decentralization and effectiveness of HIV testing, treatment and adherence support,

such as holistic HIV testing for acute and chronic infections, accurate HIV self-testing, long-acting and fixed-dose ARV formulations, virtual outreach interventions, and the adoption of AI and digital health tools.

h) **Advance and support legal and policy reforms** that enable task shifting and community-led service delivery, and urgently repeal or amend punitive laws and policies that criminalize, penalize, stigmatize, or otherwise create barriers to access for HIV testing, treatment, prevention and care (see Results Area 6).

i) **Strengthen national information systems** to monitor the quality and performance of HIV testing and treatment services, identify barriers to access, and integrate health economics data to support evidence-based decision-making.

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

150. The HIV pandemic is fuelled by entrenched inequalities and systemic human rights violations, many of which are facilitated by laws, policies, social and gender norms and practices that increase vulnerability, block access to services and undermine the HIV response.[56] [57] Those conditions especially affect members of key populations, women, girls and gender-diverse people, increasing their exposure to risks and deterring them from seeking and receiving prevention, treatment, care or community support.

151. Addressing intersecting inequalities is therefore vital for ending AIDS as a public health threat by 2030. Human rights and gender equality must be fully integrated and operationalized at every level of the Strategy, ensuring that all people, in all their diversity, can realize their rights and live free from stigma and discrimination.[58]

152. Stigma and discrimination are the most consistently reported barriers across the HIV response and occur in health care, education, employment and humanitarian settings, as well as in households and communities. Recent evidence shows that 13% of people living with HIV in 25 countries reported experiencing stigma in HIV-specific settings and 25% had similar experiences in non-HIV healthcare settings.[59]

153. HIV-related stigma and discrimination intersect with stigma and discrimination based on people's gender identity, race, disability, drug use, age, social norms, gender norms and socioeconomic status. Youth, women and girls, and key populations experience intensified stigma and social exclusion. Additionally, people living with HIV may

[56] Lyons CE, Twahirwa Rwema JO, Makofane K, et al. Associations between punitive policies and legal barriers to consensual same-sex sexual acts and HIV among gay men and other men who have sex with men in sub-Saharan Africa: a multicountry, respondent-driven sampling survey. Lancet HIV. 2023;10(3):e186–e194.

[57] Kuchukhidze S, Boily M, Niangoran S, et al. Community-level HIV stigma and discrimination's impact on HIV testing, treatment uptake, and viral suppression in 33 African countries: a pooled analysis of 76 nationally representative surveys (2000–2022). Abstract OAF1106LB. Presented at AIDS 2024, 22–26 July 2024, Munich, Germany.

[58] Human Rights Council resolution on HIV and human rights adopted on 12 July 2024 (A/HRC/RES/56/20) calls on Member States to address discriminatory attitudes and punitive laws and policies that prevent access to health services, which include criminalization of key populations. Member States should remove legal barriers to ensure access to non-stigmatizing services.

[59] People Living with HIV Stigma Index 2.0 global report: Hear us out–measuring HIV-related stigma and discrimination. Amsterdam: Global Network of People living with HIV; 2023.

experience internalized stigma, marked by negative judgements about themselves and their prospects.

154. Criminalization of HIV transmission, non-disclosure, and exposure, as well as laws targeting people living with HIV, key populations, and their networks and organizations, significantly hinder access to HIV services. Sixty-four countries criminalize same-sex relations, and 14 countries criminalize gender identity—including transgender and non-binary identities. Laws criminalizing drug use, sex work and HIV non-disclosure and transmission also deter people from seeking care and isolate them from their communities, ultimately undermining public health. Additionally, some countries have prosecuted individuals for breastfeeding while living with HIV, further restricting the rights of people living with HIV.

Criminalization undermines HIV responses

Research indicates that criminalization undermines HIV outcomes. In countries criminalizing same-sex sexual acts, people living with HIV were 11% less likely to know their status and 8% less likely to be virally suppressed, compared with countries lacking such laws. The criminalization of sex work was associated with 10% lower knowledge of HIV status and 6% lower viral suppression, while the criminalization of drug use was associated with 14% lower knowledge of HIV status and 14% lower viral suppression levels. Countries criminalizing all three areas had the worst outcomes.

Source: Kavanagh MM, Agbla SC, Joy M, et al. Law, criminalization and HIV in the world: have countries that criminalize achieved more or less successful pandemic response? BMJ Glob Health. 2021 Aug;6(8):e006315. doi: 10.1136/bmjgh-2021-006315.

155. Gender-based violence, stigma, discrimination, harmful gender norms and gender inequality continue to fuel the AIDS pandemic among adolescent girls and women, gender-diverse people and key populations. Violence against people living with HIV discourages them from seeking HIV services and support and intensifies their social vulnerability and alienation. There is an ongoing, urgent need to transform gender relations, eliminate gender-based and other violence, and ensure that everyone can access the prevention, treatment and care services they need.

156. Gender inequalities and intersecting forms of discrimination also limit access to education, health services and social protection, while reinforcing power imbalances that increase vulnerability to HIV and HIV-related stigma.

157. Inequalities also affect the growing population of older people living with HIV, which faces compounded vulnerabilities, including age-related discrimination that intersects with HIV-related stigma. Ensuring that ageing people living with HIV have access to appropriate health services, social protection and human rights protections requires targeted policy and programmatic attention.

158. The Strategy calls on countries to reaffirm and fulfil their commitment to the social, economic and political rights that are fundamental for an effective and equitable global response to HIV. That includes institutionalizing human rights and gender-transformative approaches that include appropriate mechanisms for protection,

redress, promotion and accountability across all sectors, such as health, justice and security, employment, education. Only through inclusive, rights-centered action can the goals of this Strategy be realized and sustained.

159. **Actions required** to end stigma and discrimination and uphold human rights and gender equality in the HIV response include:

    a) **Ensure that all people can access stigma- and discrimination-free services** and 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. Introduce workplace protections and support, including peer support.

    b) **Address legal and policy barriers**, including the criminalization of people living with HIV and punitive laws that impede access to HIV testing, treatment and prevention services, particularly for key populations and marginalized groups, and women and girls. This includes removing HIV-specific criminal laws, as well as other laws that criminalize same-sex sexual acts, sex work and drug use; transforming harmful gender norms that limit the ability of women and girls to participate fully in social and political life; and protecting civic space.

    c) **Repeal discriminatory laws and practices** that increase women’s and girls' HIV-related stigma and vulnerability, and that deter them from accessing HIV services and care. Those include parental consent laws that restrict adolescents' access to HIV-related services; laws that limit women's autonomy and decision-making regarding their health; and the lack of legal protection against gender-based violence and discrimination.

    d) **Embed gender equality, human rights and community-led HIV-related differentiated services delivery** within UHC 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, and ensure access to high-quality prevention testing, treatment and care services across populations.

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

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

    g) **Integrate legal support and human rights protections into HIV and health services and other settings such as prisons.** Ensure that the mechanisms include complaint channels, redress procedures and legal literacy for people living with HIV, women and girls, and key populations.

    h) **Scale up financing and implementation of interventions that address 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.

Address coercive, neglectful and disrespectful practices related to their sexual and reproductive health and rights.

i) **Secure, protect, respect and promote civic space** to facilitate meaningful leadership and engagement of communities, networks and organizations of people living with HIV, women and girls, and key and priority populations. This should enable their participation in advocacy for human rights and gender-transformative approaches, policymaking and policy monitoring, with priority given to ensuring universal access to high-quality testing and continuity of care across populations and include removal of travel restrictions affecting people living with HIV.

j) **Strengthen the capacities of legislators** and other political actors to participate in the HIV response, promote non-discrimination, human rights and gender equality, and collaborate effectively across the health, education, social protection, faith, justice and employment sectors.

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

160. Science has always been a critical element in the global response to HIV. Social and clinical sciences have contributed to interventions that have slowed the pandemic and that provide life-saving treatment to tens of millions of people. They are also laying a basis for the possible development of a vaccine or cure that could definitively end the pandemic. Together with implementation science, this research is crucially important and requires continued funding.

161. The initially delayed and slow provision of ART in the 1990s and 2000s underscored the importance of pairing well-funded scientific and clinical interventions with broader social and political action. Despite the existence of life-saving treatment, political choices and systemic barriers severely limited access and led to millions of avoidable AIDS-related deaths and HIV infections. Decisive action is required to prevent this from happening again and to ensure that all people benefit from the latest innovations in HIV prevention, testing, treatment and care.

ARV prices still vary widely

In 2024, the lowest price for the WHO-recommended first-line HIV treatment for adults (TDF/3TC/DTG) was US$ 37 per person per year. The cost of the WHO-recommended first-line treatment for children was about US$ 30. However, those are subsidized prices. Drug manufacturers generally stipulate which countries are eligible for subsidies. As a result, ARV prices vary considerably between countries and regions.

Source: MSF Access (2024) https://msfaccess.org/antiretroviral-prices-2023

162. One of the most significant achievements of the global response to HIV has been the reduction of prices for ARVs. Those reductions are due partly to the political will of national governments, advocacy and other pressure from civil society organizations and multilateral institutions, competition from generic manufacturers, the use of pooled procurement mechanisms, and the effects of economies of scale. Lower ARV prices

enable wider access to HIV treatment, reduce the overall financial cost of the response and allow for savings to be allocated to other elements of the response.

163. Pricing transparency and health economics evaluations are important for assessing cost efficiencies, achieving programme sustainability, ensuring the availability of quality-assured health products, and pursuing greater equity. Quality diagnostics, ARVs and other HIV-related products must be accessible and affordable everywhere.

164. Despite the progress made in reducing ARV prices, the scale of need for HIV treatment is so great that treatment programmes still require large budget expenditures. Procurement prices also vary drastically across regions and country income groups. Middle-income and upper-middle-income countries are often excluded from subsidy schemes and donor programmes, which leaves them paying pay higher prices for health commodities and technologies, especially new innovations. Overall, HIV products account for almost 30% of total annual HIV spending in low-and middle-income countries and up to 40% in upper-middle-income countries.[60]

165. Equitable and affordable pricing for innovations such as long-acting ARVs are also crucially important for the HIV response. The same holds for future innovations, including the possible development of a vaccine or cure for HIV. The push to reduce the prices of medicines and other health products must include new innovations.

166. The production and distribution of less expensive, generic versions of ARVs enabled the major expansion of treatment access. However, the concentration of generic manufacturing in a few countries and a reliance on intercontinental supply chains carry risks, as seen during the COVID-19 pandemic when many low- and middle-income struggled to access medicines and other health products. Those experiences have reinforced the political will, especially in Africa, to strengthen local and/or regional manufacturing capacities.

167. The inequalities that stand in the way of equitable access to HIV and other essential health products can be addressed. For example, developments in digital health, virtual interventions and AI can be harnessed, especially in underserved and remote areas, to enable virtual services, strengthen health monitoring systems and optimize resource allocations. These tools could also support personalized care, automated supply chain forecasting and guide the integration of the HIV response with broader health services.

168. However, deployment of such tools must occur with attention to the vulnerabilities that people living with or affected by HIV face regarding confidentiality and data security. Strong safeguards are needed to prevent the exposure of sensitive health information, which could aggravate discrimination, criminalization and violence. Strategic investments and rigorous ethical frameworks are essential to ensure that these technologies are used in safe, inclusive, community-informed ways that reduce rather than reinforce existing inequalities.

169. **Actions required** for equitable access to scientific, medical and technological innovations include:

[60] AIDS, crisis and the power to transform: Global AIDS update 2025. Geneva: UNAIDS; 2025.

a) **Promote reforms to strengthen supply chains of health products** through strategic planning, improved quantification and forecasting, and encourage, strong political commitment, and encourage the adoption of health technology assessment frameworks.[61] Apply health economics principles to health product management to enhance efficiency, transparency and sustainability in the delivery of HIV testing, prevention, treatment and care services.

b) **Prioritize market access strategies** that ensure essential medicines and other health products—including assured quality diagnostics, long-acting and self-administered technologies—reach everyone who needs them, particularly underserved populations, in all settings, including middle-income countries. Leverage advanced purchasing mechanisms and market-shaping tools to support equitable access of health products, reduce new infections, improve timely HIV case detection and treatment continuity. Strengthen community-level demand through targeted education, campaigns and inclusive product design that involve prospective users (including community-led organisations) in product design and roll-out.

c) **Promote equitable access to quality-assured health technologies** for HIV and related co-infections and co-morbidities—including medicines, diagnostics, vaccines and other essential products—through tailored technical assistance. Maximize the health and economic impact and equitable allocation of quality-assured products to diagnose, prevent and treat HIV, its co-infections and co-morbidities, with quality assurance upheld irrespective of whether funding comes from domestic sources or international donors.

d) **Improve the transparency of markets for HIV-related health technologies**, by strengthening existing platforms and creating new ones for publicizing production costs and prices of HIV-related products through global/regional and national mechanisms, thus providing consistent and transparent information for fair price negotiations. Transparency measures are also needed to improve the quality of licenses of health products, by advancing analyses on the patent landscape of HIV-related health technologies.

e) **Promote balanced legal frameworks** that enhance countries' capacities to manage intellectual property rights through using a public health lens, including through the strategic use of existing flexibilities under the World Trade Organization (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS agreement). This includes enabling access to essential health products for diagnosing, preventing and treating HIV, as well as its co-infections and co-morbidities. In addition, encourage transparent, timely, unhindered and non-exclusive voluntary licensing agreements with unequivocal public health-oriented terms and conditions to enable the technology transfer, development, and manufacturing, on mutually agreed terms, and supply to a wide range of countries.

f) **Foster local and/or regional pharmaceutical production** by investing in sustainable and geographically diversified regional manufacturing hubs and pooled procurement mechanisms to enhance supply chain resilience and reduce costs.

[61] https://www.who.int/health-topics/health-technology-assessment#tab=tab_1

Those changes should be complemented by efforts to promote local /or regional production of quality-assured HIV products.

g) **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 do not depend on the final prices of medical products.

h) **Leverage AI and digital health** for HIV prevention, testing, treatment and care, using clear ethical and human rights-based principles**,** with appropriate technical guidance, strong governance frameworks and community engagement. Prioritize applications such as personalized care, virtual service delivery, automated supply chain forecasting, epidemic modelling and integration with broader health systems. Safeguard digital rights, confidentiality and data security to protect people living with or affected by HIV. Ensure digital readiness through WHO and International Telecommunications Union maturity assessments,[62] clear governance and accountability, equity safeguards (e.g. accessibility, digital literacy for health workers and communities), and universal design to include persons with disabilities, older adults and marginalized groups.

i) **Encourage partnerships with governments, donors, legal experts, civil society including networks of people living with, affected by or at risk of HIV, private sector and supply chain networks** to address price and legal barriers and implementation challenges. Advocate for inclusive and transparent mechanisms to coordinate and finance research and development, ensuring that innovations reach those most in need affordably and equitably.

j) **Address the digital divide** systematically by investing in connectivity infrastructure, affordable devices, primary data systems and digital literacy programmes as prerequisites for digital health equity. Ensure that digital health strategies explicitly address barriers faced by marginalized populations, including persons with disabilities, elderly populations, rural communities and those with limited connectivity or digital literacy. Design hybrid service delivery models that combine digital and traditional approaches to ensure no one is left behind.

[62] WHO Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021(https://www.who.int/docs/default-source/documents/gs4dhdaa2a9f352b0445bafbc79ca799dce4d.pdf).

Digital health and artificial intelligence in the global AIDS response: Priorities for 2026–2031

Artificial intelligence (AI) and digital health have the potential to increase agility, efficiency, equity and sustainability in the HIV response. The challenge is to unlock AI's transformative possibilities, while safeguarding rights, community trust and long-term sustainability.

Where AI holds promise

- **Predictive and operational gains**. AI could enable dynamic, context-sensitive risk profiling, epidemic forecasting, financing optimization and supply chain "control towers" that provide real-time insights for prevention, service delivery and resource allocation. Digitization replacing paper systems has the potential to ease burdens on overstretched health workforces and improve data quality.
- **Protections for equity and trust.** The HIV response is rooted in protecting marginalized and criminalized populations. AI introduces risks of data misuse, surveillance and algorithmic bias. Without meaningful community engagement and strong safeguards (e.g. privacy, de-identification, encryption and non-discrimination procedures), these tools could deepen inequities and erode trust.
- **Financing and delivery.** AI investments have the potential to generate measurable returns, strengthen health systems, and catalyze efficiencies. Yet, fragmented financing and unclear roles are barriers. A coherent investment framework, aligned with national HIV strategies and supported by pooled resources, could help realize the desired benefits.
- **Infrastructure and capacity**. Scaling AI requires sustainable, regionally designed infrastructure and clarity on data storage, governance and ownership. Building institutional readiness and capacity among policymakers, health workers and communities is important to achieve meaningful engagement and accountability.

Actions for 2026–2030

1. **Put people and rights at the centre**. Anchor all AI applications in dignity, privacy and safety; invest in HIV specific safeguards; and apply existing human rights frameworks where AI accountability is evolving.
2. **Institutionalize community engagement**. Facilitate the participation of people living with HIV and key populations in co-designing, implementing and evaluating AI deployment.
3. **Develop a tiered investment framework**. Position AI as a strategic necessity; build an evidence-based Investment case; and mobilize complementary financing across donors, governments, and private partners.
4. **Co-develop sustainable infrastructure**. Clarify governance and access, and leverage regional partnerships to build resilient, sovereign digital foundations.
5. **Strengthen data quality and integration**. Improve interoperability; invest in robust epidemiological data, programmes and financing; mitigate risks associated with poor-quality data; and ensure human involvement in oversight where automation falls short.

AI has the potential to help make the HIV response smarter, faster and more equitable—if innovation is balanced with rights, trust and investments that leave no community behind.

Pooled procurement for health products in a transitioning global health architecture

If countries meet the Global AIDS Strategy targets, domestic financing for HIV could potentially rise from 52% in 2024 to over two-thirds by 2030. While positive, this shift risks market fragmentation, potentially leading to higher prices, weakened supplier competition and stockouts—especially for low-volume products and in middle-income countries facing tiered pricing and intellectual property barriers. A blend of global and regionally anchored pooled procurement models can safeguard affordability, quality and innovation—thus complementing Results Area 7 actions for strengthening supply chains, fostering regional manufacturing hubs, and applying health economics principles.

Main challenges to effective pooled procurement mechanisms

- **Financing & foreign exchange.** Late payments, reluctance to prepay and currency volatility undermine supplier confidence.
- **Market fragmentation.** Uncoordinated domestic procurement erodes scale, potentially harming paediatric and low-volume products.
- **Regulatory barriers.** Misaligned laws, import restrictions and divergent standards delay access.
- **Capacity gaps.** Weak forecasting and limited visibility of health product supplies lead to stockouts and wastage.
- **Local production exclusion.** Regional manufacturers face prequalification hurdles and lack predictable demand to justify investments.

Policy and implementation options

- **Strengthen regional platforms.** Support the development of regional pooled mechanisms with clear governance, robust demand consolidation, and regulatory harmonization (e.g. WHO prequalification).
- **Secure financing for stable procurement.** Mobilize new financing instruments, support from development banks and donors for pre-financing, guarantees and foreign exchange hedging to ensure timely supplier payments and procurement stability.
- **Adopt a lifecycle approach.** When possible, transition mature products such as first-line ARVs to national systems, and retain pooled channels for paediatric, niche and innovative products (e.g. long-acting ARVs).
- **Quality adherence.** Apply WHO prequalification standards and aim for the lowest sustainable price, guided by health economics evaluations to sustain competition and affordability.
- **Improve data & forecasting.** Strengthen national data systems and build national capacity for robust forecasting to align procurement with anticipated demand.
- **Plan and sequence transitions.** Develop annual, country-owned transition plans linking financing reforms, legal adjustments and supply chain strengthening.
- **Support local manufacturing.** Combine pooled demand with technical assistance and risk-sharing to integrate compliant regional producers into supply chains.
- **Monitor & adapt.** Establish a market health scorecard to track price trends, supplier diversity and risks of stock disruption.

Priority 3: Community leadership in the HIV response

170. Communities constitute the third pillar of the Global AIDS Strategy and are central to its success. They are the heart of the HIV response and perform life-saving work. Networks and groups of people living with and affected by HIV—including networks of women, young people and key populations—have played vital roles since the start of the pandemic. They have mobilized 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, communities have identified gaps and pioneered innovative, context-specific solutions, including in challenging environments and crisis-affected areas. The Global Strategy cannot succeed without a concerted effort to support community-led responses, including people living with HIV, women-led, youth-led and key population-led networks.

171. Communities also create demand for health products by organizing people living with or affected by HIV into networks and by holding donors, governments and multilateral agencies accountable. When new technologies such as long-acting PrEP are developed, community-led organizations work to build demand and deliver services in acceptable and accessible ways. Especially in a context of political hesitation and funding setbacks, strengthened community-led responses are an opportunity to continue transforming the HIV response from a top-down model to one rooted in solidarity, dignity, resilience, human rights and gender equality.

Results Area 8. Strengthen community leadership

172. Community-led advocacy, campaigning and engagement are essential for sustainable and effective HIV responses. Those actions generate urgency and build accountability. Community advocates identify barriers, challenge harmful norms and co-create inclusive and impactful solutions. Community-led advocacy also highlights 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.

173. Community-led monitoring and research efforts complement other HIV surveillance systems by generating context-specific data which otherwise would go unnoticed. Understanding the social dimensions of HIV—including gender and other inequalities, and stigma and discrimination—allows for identifying interventions that are timely, socially appropriate and context-suited. Involving women-led networks in community-led efforts is critical for addressing gender inequalities. The empowerment of community-led organizations to generate and analyse the data they collect builds local capacity and produces evidence to inform improvements in policies and programmes.

174. Expanded community-led service delivery is critical for reaching people who are under-served by conventional health systems. Communities are uniquely equipped to deliver prevention services for people living with HIV, key populations and young people, provide treatment support and promote self-care approaches. Because community service delivery is people centred, it can respond to people's holistic needs and bring benefits beyond HIV, including for broader health, social protection and inclusion, economic empowerment and education. Strong community-government partnerships to

expand HIV service provision can have a massive impact on an effective, efficient and sustainable HIV response.

175. Diverse and innovative financing for community-led interventions is crucial, especially in settings with health staffing and facility shortages, and where key and other marginalized populations face social and legal hindrances. In the context of resource constraints, 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 enterprise, etc.).

176. Empowering marginalized, underrepresented and under-served populations is essential for a successful HIV response. That can be done by creating and safeguarding spaces and opportunities for participating in decision-making, and by providing training, mentoring and other capacity-strengthening support. The impact of such interventions goes beyond the HIV response by addressing human rights disparities and strengthening the civic space more broadly.

177. **Actions required** for community leadership in the HIV response include:

- **Institutionalize and formally designate community** representation (including of people living with HIV, key populations, women and young people) in coordination and decision-making mechanisms at all levels of the response, including HIV financing mechanisms.
- **Formally recognize and institutionalise the important roles of communities** in co-developing policy guidance, targets and accountability frameworks at all levels in HIV responses.
- **Reform laws, policies and regulations** 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 testing, treatment and prevention services. That includes support to safeguard civic spaces and to track the status of civic space and community participation in HIV planning and decision-making at national, regional and global levels.
- **Adequately resource all components of community responses**, from advocacy to engagement in decision-making and accountability, service delivery and community-led monitoring and research.
- **Enact effective social contracting mechanisms** that enable predictable, long-term and flexible financing of community-led responses through domestic resources and that ensure those mechanisms are accessible to community-led entities such as youth-led organizations, women’s networks and key population organizations.
- **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, by establishing minimum domestic allocation thresholds to ensure consistent and equitable funding for these approaches.

- **Enable and resource community-led monitoring and research** and provide for their systematic inclusion in planning and decision-making processes, using data for programming and accountability. Community-led research should assess both the effectiveness and cost-efficiency of HIV interventions to strengthen programme sustainability.
- **Support youth leadership** in the HIV response by increasing predictable and flexible youth-responsive funding, ensuring meaningful youth engagement in decision-making, and supporting intergenerational and peer collaboration and mentorship models that intentionally build successive generations of leaders.
- **Support the capacity-strengthening, resilience and preparedness** of community-led organizations, particularly those which represent and serve under-represented and under-served populations. That includes addressing human rights-, age- and gender-related barriers, and providing for legal literacy, resource mobilization and political engagement.
- **Support community engagement in the sustainability planning** processes and support the integration of community services and advocacy as part of national systems, including the establishment or expansion of social contracting.

Partnerships for progress: local, regional and multilateral actions to end AIDS

178. 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.

179. Subnational levels of government, including municipalities and federal units, are increasingly important to governance systems. In some countries, these levels of government have independent budget allocations for health and are the primary providers of certain health services. Greater recognition of the importance of subnational levels of action is needed.

Local action for greater impact

180. In many countries, key services, including health and education, are managed and provided at local levels. This allows for productive partnerships to be developed between communities, local authorities, service providers, philanthropies, faith-based organizations, the private sector and other actors.

181. Key and other priority populations are often concentrated in urban or peri-urban areas or informal settlements: in some countries, cities are home to large proportions of people living with HIV.[63] Some cities also host significant refugee and migrant populations. City authorities therefore are well-placed to address people's HIV-related risks and needs, and can promote dialogue, policy action and coordination across different levels of government. Indigenous nations can also be an important link to providing services to populations that may be reluctant to seek help from states. The

[63] Ending AIDS, Ending Inequalities: Fast-Track Cities. Geneva: UNAIDS; 2021.

Strategy therefore emphasizes the importance of including cities, municipalities and other local level authorities as partners in the response to HIV.

182. **Recommendations** for subnational political units include:

- **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 in official health structures and disaster preparedness plans.
- **Manage systems for strengthened data monitoring and reporting** to better understand the epidemic trends and patterns in 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.

Regionalism and the global response to HIV

183. Regional organizations can play vital 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. The value of regional coordination was shown during the COVID-19 pandemic, when African countries collaborated to rapidly procure and distribute testing kits, disseminate critical health information, and mitigate the pandemic's impact.

184. Regional institutions and multilateral organizations and systems play critical roles in the global HIV response. The African Union, for example, has taken the lead in coordinating regional HIV efforts, including developing a framework to integrate HIV responses with broader strategies for tuberculosis and COVID-19. This coordination allows the region to pool resources and strengthen its collective bargaining power with the global pharmaceutical industry.

185. Pandemics, conflicts and displacement make it necessary to integrate the HIV response into humanitarian interventions. The potential for regional coordination was demonstrated during the COVID-19 pandemic, when African countries collaborated to rapidly procure and distribute testing kits, disseminate critical health information, and mitigate some of the worst outcomes experienced elsewhere.

186. The involvement of regional organizations such as the African Union, Africa CDC, the Caribbean Community (CARICOM), the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA), the Andean Health Organization (Organismo Andino de Salud – Convenio Hipólito Unánue-ORAS-CONHU), and the Association of Southeast Asian Nations is therefore important for sustaining 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.

187. Emerging leadership of regional networks of people living with HIV and key population coalitions also play critical roles in policy development and coordination. Community-led regional bodies should be recognized as partners and decision-makers in regional planning and accountability.

Regional coordination

The Southern Africa Development Community (SADC) launched its Strategy for Sexual and Reproductive Health and Rights in 2019. The Strategy facilitates regional coordination for improving the sexual and reproductive health rights and includes a scorecard which presents a model of service integration across sectors and contexts, including humanitarian settings. It also considers the economic and developmental context of each Member State and seeks to ensure that policy actions contribute to improving the quality of life of all affected persons.

Source: Southern Africa Development Community. Strategy for sexual and reproductive health and rights in the SADC region. Gaborone: SADC; 2019.

188. Regional organizations are also best placed to promote local and regional production capacity for HIV medicines and other products, and to improve supply chain and procurement systems resilience, which reduce dependency on international suppliers. Strengthened cross-border communication and information sharing, along with moves towards lowering trade barriers, are positive steps in that direction. Financing instruments at the regional level that allow for channelling resources to community networks and organizations could also strengthen their leadership and roles.

Inclusive multilateralism and the global response to HIV

189. Multilateral action remains a vital part of the response. Global coordination across institutions allows for shared goals, clear agendas and effective distribution of resources and tasks across the various elements of the response.

190. A multilateral response also sets clear targets, provides global mechanisms of accountability and commits to international standards. Multilateral action is important for reviving and sustaining political commitment; advancing inclusive and broad-ranging partnerships; and strengthening accountability to keep the response high on the agenda. It is also necessary to scale up access to essential biomedical tools such as access to oral PrEP, long acting injectables and the dapivirine ring, prioritizing key populations, adolescent girls and young women, and young people. Investments in diagnostics, drug procurement and supply chain support are crucial, alongside innovative finance mechanisms for domestic production. Accelerating national approvals for new treatments and reducing costs by using generic varieties of key drugs remain essential.

191. Ongoing research and development for clinical and non-clinical interventions is vital for ending AIDS and for responding to other health crises. It requires sustained, coordinated multilateral financing, as well as collaboration across institutions and disciplines. This is best achieved through multilateral coordination.

192. Millions of people living with HIV are directly dependent on multilateral mechanisms for access to HIV treatment, prevention and psychosocial support. Traditional and non-traditional partners must participate in the HIV response, especially at the community level. Continued sustainable and equitable funding of the HIV response 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.

193. **Recommendations** for multilateral action include:

- **Convene and support multistakeholder collective action** at global and regional levels, including leadership of communities of people living with, affected by, or at risk of HIV; philanthropies; the private sector; national governments; regional organizations and multilateral entities.
- **Provide global and regional frameworks for action** to ensure accountability, including through setting targets and monitoring indicators to track progress in the HIV response.
- **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.
- **Advance normative guidance and international standards** for a rights-based, gender-transformative response to HIV.
- **Promote legal, policy and social change** that protects rights, addresses inequalities and ensures communities are empowered as full partners in the HIV response.
- **Increase access to HIV-related diagnostics and medicines** by addressing intellectual property and patent barriers to ensure affordability, without discouraging innovation and investment in research and development. Ensure that both existing and new HIV products remain widely available and accessible in order to account for disparities in capacity across various regions.
- **Develop and invest in an international science research agenda** to accelerate the end of AIDS as a public health threat.

Role of the Joint United Nations Progamme on HIV/AIDS (UNAIDS) in supporting implementation of the Global AIDS Strategy

194. Implementation of the Global AIDS Strategy requires that the Joint Programme perform critical functions to support countries. The Joint Progamme will support the implementation of the Global AIDS Strategy by focusing on the overarching priority of supporting governments and communities to lead sustainable, inclusive, multisectoral national HIV responses in a fast-evolving context.

195. Multilateral leadership on HIV, embodied in the Joint Programme, remains indispensable. As the context evolves, the Joint Programme will continue to provide the political leadership, convening power, data and accountability, and community engagement that countries need to sustain their HIV responses and close the

remaining gaps, thereby contributing to overall strengthened global health security and country resilience.

196. Recognizing the varied HIV epidemics, capacities, structural barriers and needs, the Joint Programme will tailor support to country and regional contexts. Guided by the three priorities of the Global AIDS Strategy, it will work with governments, communities (including country and regional networks of people living with HIV, key populations, youth and women), other civil society partners, and other stakeholders (including regional institutions, the U.S. President's Emergency Plan for AIDS Relief, or PEPFAR, and the Global Fund) to promote cross-country and inter-regional action to accelerate delivery and increase impact.

197. The Global AIDS Strategy recommends the following actions from the Joint Programme.

Priority 1: A country-led, resilient and "future ready" HIV response

- Engage and mobilize political leaders and other key stakeholders—including via high-level global, regional and country platforms—to uphold and advance political commitments and investments for sustainable, inclusive multisectoral national HIV responses supported by the Joint Programme's mutual accountability mechanisms. *(RA 3)*
- Convene and coordinate accelerated efforts with national programmes, communities, PEPFAR, the Global Fund and other partners to advance sustainability through the development, implementation and monitoring of key metrics of the HIV sustainability roadmaps (encompassing political, programmatic and financial aspects) with integrated programme delivery models and diversified financing for maximum impact. *(RA 1)*
- Advocate for, guide and support sustainable and equitable national HIV responses through the mobilization of increased domestic HIV financing, HIV-sensitive social protection for people living with, affected by and at risk of HIV, and advocacy for continued global solidarity. *(RA 1)*
- Provide policy guidance, advocacy and technical support for the integration of HIV interventions and systems with broader health and key non-health systems to build resilient, sustainable HIV responses and support global health security. *(RA 2)*
- Support countries to generate and analyse multisectoral data to improve their HIV responses. *(RA 3)*
- Lead and disseminate reporting on progress towards implementation of the Global AIDS Strategy. *(RA 3)*
- Identify and address inequalities, including through community-led HIV monitoring, capacity building of countries for integrated strategic information systems, and monitoring financial flows, pricing and procurement to strengthen transparency, accountability and efficiency, and to drive advocacy and sustainable HIV financing at global, regional and national levels. *(RA 3)*
- Guide and support enhancement and use of more integrated HIV and broader health and key other sectors' information systems to monitor, analyse to inform

evidence-based decisions and improve achieve more sustainable HIV and other services. *(RA 3)*

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

- Provide policy guidance and support to countries to adopt, implement and monitor national policies, tools and targets for combination HIV prevention, including accelerating uptake of innovations, for and with key populations, and other groups at higher risk of HIV infection. *(RA 4)*
- Convene communities, governments and other partners to advance HIV prevention and reduce barriers hindering a more effective HIV response. *(RA 4)*
- Provide policy, advocacy and technical support to countries to adopt or update and implement national policies and programmes that are aligned with the latest global guidance for effective access to quality HIV testing, treatment, care and integrated services, including for common co-morbidities and co-infections. *(RA 5)*
- Provide technical, policy and advocacy support to countries for scaled-up actions to uphold human rights, address stigma and discrimination, and advance gender equality for a more effective HIV response. *(RA 6)*
- Provide technical, policy and advocacy support to countries with scaled-up actions for equitable access to innovations, including HIV testing, treatment and prevention products, and for the scale-up of new technologies such as transformations in digital health. *(RA 7)*

Priority 3: Community leadership in the HIV response

- Support the leadership and meaningful engagement of communities of people living with HIV, key populations, adolescent girls and young women, and foster strong partnerships with governments and other stakeholders to strengthen community leadership as part of community and public health and social support systems for effective, inclusive and sustainable HIV responses. *(RA 8)*
- Provide advocacy, policy and technical support to countries to consolidate or expand the leadership HIV communities, including community-led HIV responses. *(RA 8)*

United to end AIDS

198. The goal of "ending the AIDS epidemic by 2030 as a public health threat" is ambitious, but it is grounded in real achievements. Frontline workers and communities have shown that community-driven responses can slow the pandemic and reduce its worst impacts. Scientific innovation has delivered transformative treatments and diagnostics. For many years, global solidarity enabled countries to overcome resource limitations. The world has confronted the worst of the AIDS crisis and demonstrated that grounding public health in solidarity and community leadership is both necessary and possible.

199. The lessons apply beyond HIV, as well. Community health workers in many countries who had been trained to provide non-clinical support for people living with HIV became the backbone of the response to the COVID-19 pandemic and MPox outbreaks[64] [65] in low- and middle-income countries. Integrated treatment protocols that combine clinical and non-clinical interventions have mitigated the impact of diseases like malaria and tuberculosis. Innovations in science and technology—including in public health data systems and transnational collaboration on data collection, storage and processing—have introduced new standards for data systems in public health. The HIV response has strengthened humanity's capacity to confront and overcome public health challenges.

200. The global response to HIV is now in great peril, however. Over 40 million people are living with HIV and more than one million people acquire HIV each year. Yet the commitment and solidarity that is needed to end the pandemic appears to be fraying. Access to key biomedical interventions like PrEP and ART, vital data systems, and research and innovation are in jeopardy due to funding cuts. Prevention services have been disrupted, health workers have lost their jobs, and community-led organization are reducing or halting their HIV activities.

201. No community or country can end AIDS alone: we must stand together. The Global AIDS Strategy seeks to revitalize the collective determination and action that has brought the world closer than ever to ending AIDS as a public health threat. It calls for renewed commitment to the ambition of reaching that goal.

[Annexes follow]

[64] Collins C, Isbell MT, Karim QA, et al. Leveraging the HIV response to strengthen pandemic preparedness. PLOS Glob Public Health. 2023 Jan 24;3(1):e0001511. doi: 10.1371/journal.pgph.0001511.

[65] 2025_global-council-inequality-report_en.pdf

Annex 1: Regional contexts for the global response

Alongside the priorities and results areas for the global response are a set of regionally specific priorities, which were developed in consultation with local partners. Annex 1 summarizes the regional specificities and situates them within the broader global response. In each region a range of stakeholders, including governments, civil society, communities, development partners and other key actors, will need to be engaged.

** Unless otherwise indicated, the data cited below are from the 2025 Global AIDS Update report.*[66]

Asia-Pacific

Overview

Asia and the Pacific continues to have the world's second-largest HIV epidemic, with an estimated 6.9 million people living with HIV and 300 000 new infections in 2024—nearly a quarter of all new infections worldwide.

Despite a 17% decrease in new infections and 53% decline in AIDS-related deaths since 2010, progress is uneven, with some countries experiencing growing epidemics. Some of the fastest-growing HIV epidemics are in this region (e.g. in Afghanistan, Fiji, Pakistan, Papua New Guinea and the Philippines). The region has a growing HIV prevention crisis. PrEP uptake is low and coverage of prevention services among key populations is far below the global targets. Treatment gaps persist: only 79% of people living with HIV knew their status, 69% were on treatment, and 66% had suppressed viral loads in 2024. Stigma, discrimination and various structural barriers continue to hinder access to services, especially for key populations and young people. Legal and policy reforms are needed to unlock access to HIV and related services.

While domestic financing has increased, many countries still rely heavily on external support, particularly for HIV prevention. Since 2010, external funding for HIV programmes has decreased by 54%, dropping from its peak of US$ 1.45 billion in 2011 to US$ 581 million in 2024. In the same period, the contribution of domestic resources rose by 92%. By 2024, about 82% of HIV funding was being sourced domestically, up from 54% in 2011. However, if China, India and Thailand are excluded from these calculations, the domestic share of HIV funding drops to 49%—highlighting the continued reliance on external support in many countries in the region.

[66] AIDS, crisis and the power to transform: Global AIDS update 2025. Geneva: UNAIDS; 2025.

The ongoing disruptions to external funding for HIV responses will affect HIV programmes across the region, including in the 10 countries where PEPFAR provided technical assistance or programme support. HIV prevention is likely to experience the biggest repercussions: data reported to Global AIDS Monitoring show that 11 of 16 countries in the region rely on international sources for more than 75% of their prevention financing.

Achieving an AIDS-free future requires adequate funding, overcoming systemic barriers, transforming societal attitudes, and championing community-led initiatives as the foundation of an inclusive, rights-based HIV response. Empowered, well-funded communities are essential for the region's HIV response: social contracting and continued donor funding will be critical for sustaining community-led responses in the region.

Priority 1: Country-led HIV response and ready for the future

- **Achieve sustainability** across the programmatic, political and financial dimensions of HIV responses, guided by country-owned planning, inclusive governance and multisectoral engagement. *(RA 1)*
- Steadily **increase domestic financing for health and HIV**, with particular attention to financing HIV prevention and key populations programming and develop and implement an evolved international and domestic financing mix. *(RA 1)*
- **Integrate HIV services and health technologies,** including for HIV prevention, in national health benefit packages of UHC systems, social protection and public health insurance programmes mechanisms to improve sustainability and access and to reduce out-of-pocket payments. *(RA 1)*
- I**ntegrate HIV services with broader health systems**, including primary health care, sexual and reproductive health, mental health, and harm reduction. *(RA 2,3)*
- Leverage **community systems,** through increased domestic investment, social contracting and strategic partnerships. *(RA 1)*
- Achieve **resilient health systems**—including infrastructure, workforces, access to medicines and diagnostics—through coordinated multisectoral action. *(RA 2)*
- Integrate **data systems** to enhance reach, quality of services, efficiency, confidentiality and data-sharing capabilities. Data systems should be sustainable, support evidence-based decision-making and include inputs from community-led monitoring to reinforce accountability. *(RA3)*
- **Institutionalize financial data systems** to routinely generate evidence on costing, expenditures and efficiency to inform decision-making. *(RA 3)*

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

- Scale up equitable access to effective HIV **combination prevention and harm reduction options**, with an emphasis on PrEP for key populations and groups of people who are most left behind. *(RA 4)*
- Expand access to innovative and **differentiated HIV service delivery** by supporting the scale-up and institutionalization of self-testing, mobile outreach, telehealth and long-acting PrEP within national systems and community-led services. *(RA 4)*

- Improve **HIV literacy** through digital platforms and culturally tailored education for youth and key populations. *(RA 4)*
- Support **early treatment initiation** and equitable access to optimal ARVs—including for children, adolescents and pregnant women—to improve adherence and maximize the benefits of U=U and "treatment as prevention". *(RA 5)*
- Accelerate **elimination of vertical transmission** of HIV through integrated services that leverage the global Triple Elimination Initiative, ensuring universal access to antenatal testing, timely treatment of pregnant women living with HIV, and follow-up care for exposed infants. *(RA 4, RA 5)*
- Ensure **equitable prices and access for HIV drugs** and diagnostics across countries, including innovative HIV prevention commodities. *(RA 5)*
- Advance **legal and policy reforms and address social and structural barriers**—including stigma, discrimination and gender-based violence—to improve access to HIV and related services. *(RA 6)*

Priority 3: Community leadership

- **Strengthen and institutionalize** community leadership through capacity-building, formal roles in governance and sustainable mechanisms for participation. *(RA 8)*
- **Support community-led service delivery** by expanding access to testing, prevention and treatment through trusted, culturally appropriate approaches. *(RA 8)*
- **Strengthen community capacity and accountability**, using digital tools, data systems and inclusive planning processes. *(RA 8)*

The Caribbean

The Caribbean has made progress in its HIV response since 2010. The annual number of new HIV infections declined by 21% between 2010 and 2024. Four countries (Cuba, Dominican Republic, Haiti, and Jamaica) accounted for almost 85% of all new HIV infections in the region in 2024, with Haiti alone representing 38%. Young people (aged 15–24 years) accounted for 25% of new infections in the region, in part due to limited access to youth–friendly prevention services.

Eleven of the 18 countries or territories globally that have been validated for eliminating vertical transmission of HIV and/or syphilis are in the Caribbean,[67] demonstrating the region's strong maternal health programme.

Average HIV prevalence among adults (15-49 years) in the Caribbean in 2024 was 1.2%, among the highest in the world outside sub-Saharan Africa. The epidemic disproportionately affects marginalized populations, including sex workers, transgender individuals, gay and other men who have sex with men, indigenous communities, and people living in poverty.

The number of AIDS-related deaths in the region has fallen by 62% since 2010, with treatment coverage expanding considerably: an estimated 85% of people living with HIV knew their HIV status, 74% were receiving ART, and 66% had suppressed viral loads in 2024. Treatment coverage was 79% among women living with HIV and aged 15 years, but 71% among their male peers.

HIV programmes in the Caribbean rely heavily on external aid, which accounts for more than 66% of HIV funding. Almost 100% of the Haiti's HIV response is donor-funded, while the Dominican Republic finances 60% of its HIV response with domestic resources.

Disruptions to donor funding—particularly from PEPFAR and other bilateral sources—are straining HIV programmes, especially prevention services for key populations. Many countries in the region have large debt burdens and face economic difficulties which, in some cases, are compounded by political instability, leading to reductions in social and health public spending. These economic pressures underscore the importance of sustained global solidarity and innovative funding strategies to support comprehensive HIV responses in the region.

Priority 1: Country-led HIV response and ready for the future

- **Ensure financial sustainability** through implementation of sustainability roadmaps, diversified resource mobilization and private sector engagement. Strengthen sub-regional capacity through the Pan-Caribbean Partnership against HIV/AIDS (PANCAP) and maintain global solidarity with countries that rely on external support. *(RA 1)*
- **Strengthen climate-resilient health systems** to ensure continuity of HIV services in disaster-prone areas. *(RA 2)*

[67] Cuba (2015); Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Montserrat, Saint Kitts and Nevis (2017); Dominica (2020); Belize (2023); Jamaica, Saint Vincent and the Grenadines (2024).

- **Strengthen data systems** and analysis to produce real-time, disaggregated HIV data—integrating HIV estimates, modelling, population size estimates and behavioural surveillance—that can be used to guide targeted programming. *(RA 3)*
- **Invest in data innovations** to support modelling, estimates, real-time monitoring and small sample estimation. *(RA3)*

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

- **Expand combination prevention coverage** with an emphasis on high-impact interventions, including affordable access to innovative long-acting PrEP and increased condom and lubricant promotion, ensuring equitable delivery through community-led and decentralized services. *(RA 5)*
- **Scale up uptake and access to innovation**, including the most efficacious treatment regimens and long-acting ARVs for treatment and HIV prevention.
- **Integrate HIV services within broader health and community systems**—including sexual and reproductive health, viral hepatitis, sexually transmitted infections, non-communicable diseases, maternal and child health, and primary care—while investing in stronger laboratory systems and diagnostics, self-testing and combined tests for multiple illnesses. *(RA 2, RA 3, RA 4, RA 5)*
- **Invest to strengthen laboratory systems and diagnostics**, including strengthening point-of-care diagnostics, viral load monitoring, self-testing for HIV and other sexually transmitted infections, and/or multiplexing to address concurrent needs.
- **Enhance comprehensive services for young people**, including sexuality education, sexual and reproductive health services, revitalized youth involvement and youth-led campaigns in educational institutions with community-led design and monitoring. *(RA 8)*
- **Eliminate vertical transmission of HIV** by integrating testing and treatment into antenatal care and by leveraging the Triple Elimination Initiative. *(RA 4, RA 5)*
- **Strengthen community-based support systems**, including community-led follow-up, peer support programmes for HIV-positive mothers, motivational messaging, safe treatment spaces, and enhanced redress mechanisms with appropriate referral systems. *(RA 4, RA 5)*
- **Reduce stigma and discrimination** through strengthened anti-discrimination policies, zero workplace discrimination, integrated gender-responsive sexual and reproductive health and rights policy frameworks, and comprehensive policy integration. *(RA 6)*
- **Invest in innovations in procurement mechanisms and regional cooperation** to improve equitable access to medicines and other health products (e.g. using the PAHO Strategic Fund).

Priority 3: Community leadership

- **Enhance social contracting implementation** and promotion to institutionalize community-led responses with sustainable financing mechanisms. *(RA 8)*
- **Strengthen community networks and leadership** of people living with HIV and key and affected populations through capacity building, community development

approaches, and improved gender sensitivity among community leaders and stakeholders.

- **Strengthen community-led monitoring and evaluation** systems to ensure accountability and effectiveness of HIV response initiatives at the community level. *(RA 3, RA 8)*
- **Integrate youth-centred approaches** in sexual and reproductive health and HIV prevention policies with community-led design and monitoring, prioritizing high HIV incidence countries. *(RA 8)*

Eastern and southern Africa

An estimated 490 000 people acquired HIV in 2024 in eastern and southern Africa, a region that is home to an estimated 21.1 million people living with HIV, a little over half of the global total. Yet the region has made remarkable progress against the pandemic. Annual new HIV infections have declined by 56% since 2010, from 1.1 million to 490 000 in 2024. Several countries have achieved significant reductions in vertical transmission of HIV, with coverage of prevention of vertical transmission services exceeding 95% in 10 countries.

The number of AIDS-related deaths decreased by 59%, from 630 000 to 260 000 in the same period, thanks to major expansions of testing and treatment programmes. In 2024, 93% of people living with HIV knew their HIV status, among them 91% were on HIV treatment and 95% of those on treatment had a suppressed viral load.

The current funding cuts, however, threaten these gains. There are also significant inequities across populations, with testing and treatment coverage low among children and adolescents. Moreover, the progress is inconsistent across the region. While most countries with large HIV epidemics have achieved steep declines in new HIV infections, some countries with smaller epidemics, especially in the Indian Ocean islands, are experiencing increases. Adolescent girls and young women (aged 15–24 years) continue to be at disproportionate risk for HIV. They accounted for 28% of new HIV infections in the region in 2024 and were three times more likely to acquire HIV than their male counterparts. Members of key populations lack consistent access to HIV prevention services and are at elevated risk of acquiring HIV. Funding cuts, including reductions in support from PEPFAR, have disrupted essential programmes in some countries, especially for marginalized groups.

Community-led organizations are best placed to provide HIV treatment and prevention services to their peers in ways that are acceptable and accessible. Recent funding trends have exposed the dependency of community systems on international aid, highlighting the urgent need to strengthen their resilience by expanding access to domestic resources, including through social contracting and other sustainable financing mechanisms.

HIV services are also being disrupted by conflict, climate change shocks and displacement. In 2023–2024, the region had more than 28.9 million internally displaced people and 6.4 million refugees. Ethiopia’s health system is under strain due to droughts, landslides and conflict, while treatment programmes in Malawi and Mozambique have been severely disrupted by extreme weather events. Effective HIV response in humanitarian settings are needed to address those challenges.

Total resources allocated to HIV responses in the region amounted to US$ 9.3 billion in 2024, a 6% decline since 2020. Approximately 34% of the funding was sourced domestically, though that proportion decreases to 20% if South Africa is excluded. This underscores the region’s continued reliance on external donors such as PEPFAR and the Global Fund. HIV treatment remains relatively well-funded, but investment in HIV prevention interventions is low, with only 8% of HIV funding allocated to prevention in Kenya, 10% in Namibia and South Africa, and 12% in Uganda, for example.

Many countries in the region are grappling with low economic growth and unsustainable debt, which limits the fiscal space to offset donor reductions. The current financial landscape puts vital areas of the response at risk, notably prevention, social enablers and community-led services. There is an urgent need for greater domestic ownership, innovative financing and long-term sustainability planning. Several countries have developed HIV response sustainability roadmaps that emphasize national ownership, integration of HIV services into broader health systems, and increased domestic resource mobilization.

Priority 1: Country-led HIV response and ready for the future

- **Leverage domestic and international resources** to strengthen sustainable funding mechanisms for long-term HIV response investments. *(RA 1)*
- Accelerate the development of **HIV sustainability roadmaps**. *(RA1)*
- **Accelerate progress toward UHC through integrated service delivery,** including in humanitarian settings. *(RA 2)*
- **Integrate** HIV services into national health systems, including UHC schemes. *(RA2)*
- **Strengthen national data systems** to generate disaggregated evidence for targeted HIV programming. *(RA 3)*
- **Improve** cross-border data integrations, referrals and data systems.
- **Build community-owned and led data systems**, including disaggregated tracking of progress toward 95–95–95 and 30–80–60 targets. *(RA3)*

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

- **Implement context-specific HIV prevention strategies** and ensure sustained access to quality testing, treatment and care for all, including children, adolescents and key populations. *(RA 2)*
- **Support and scale community-led service**s, including differentiated service **delivery** models, to expand access and improve health outcomes. *(RA 8)*
- **Implement HIV-related human rights-based decriminalization** models that reduce legal barriers and protect the rights of people living with HIV and key populations. *(RA 6)*
- **Develop tailored and youth-centred strategies** that address vulnerabilities and barriers to HIV prevention, testing, treatment and other sexually transmitted infection services. *(RA 4, RA 5)*
- **Advance gender equality in the HIV response** by removing barriers, reducing vulnerabilities and empowering women to exercise their right to health free from stigma, discrimination and violence. *(RA 6)*

Priority 3: Community leadership

- **Promote inclusive engagement and leadership of communities** in the HIV response. *(RA 8)*
- **Leverage and convene communities** to strengthen the leadership and ownership of people living with HIV in decision-making and HIV interventions. *(RA 4, R 5 & RA 6)*

- **Invest in community-led services and research** to strengthen locally owned HIV prevention strategies. *(RA 8)*
- **Establish and strengthen social contracting mechanisms** for effective delivery of community-led HIV interventions. *(RA 8)*
- **Scale up and integrate community-led monitoring** into government data systems to ensure accountability and impact tracking.

Eastern Europe and central Asia

AIDS-related deaths and new HIV infections have increased in eastern Europe and central Asia, by 48% and 7%, respectively. There were an estimated 130 000 new HIV infections in the region in 2024 and an estimated 2.1 million people were living with HIV. Testing and treatment cascades lag other regions: in 2024, 72% of people living with HIV knew their status, 51% were on treatment, and 43% had a suppressed viral load, which reflects gaps in testing, timely linkage, retention and treatment coverage.

The epidemic is fuelled by persistent inequities in access to services for key populations amid punitive laws and stigma and the criminalization of key populations. Prevention coverage is inadequate: in 2023, only 57% of sex workers, 54% of transgender people, 52% of people who inject drugs, and 34% of gay men and other men who have sex with men accessed at least two prevention services in the previous three months. Sexual transmission of HIV appears to be increasing, including among gay men and other men who have sex with men, and among people who inject drugs and sex workers and their partners.

The HIV response proceeds in the context of the war in Ukraine, other armed conflicts and political unrest and it is contending with shrinking civic space, disrupted continuity of care and inadequate access to services for key populations, migrants and refugees. Community-led services and community-led monitoring are insufficiently institutionalized and financed. The region is increasingly connected with neighbouring regions through migration, trade, labour flows and social ties, dynamics that have implications for health-care systems, HIV transmission patterns and demands on public health infrastructure.

Domestic spending on HIV must be aligned more closely with actual needs. Despite significant investment in ART, current spending is projected to cover treatment for only 60% of people diagnosed with HIV infection by 2030. There are also wide differences in ART costs, which range from US$ 120 per person per year in Armenia to US$ 6,778 in Serbia. Even with fully optimized spending, treatment coverage is expected to reach only 80%, highlighting the urgent need for more effective allocation of HIV resources in the region.

Most countries fund ARV medicines through domestic resources, but prevention services, community outreach and human rights-based activities continue to rely heavily on external donors, particularly the Global Fund and the U.S. Government. This funding model is increasingly unsustainable, especially as donor priorities shift. The region's growing HIV epidemic calls for HIV sustainability plans and actions that emphasize enabling legal environments; prioritize expanded prevention and treatment coverage, especially for people from key populations; facilitate and support community-led interventions; and boost domestic funding.

Priority 1: Country-led HIV response and ready for the future

- **Ensure sustainable HIV financing** with allocative-efficiency solutions by deploying strategic analysis, using multi-source financing models to ensure domestic investment toward the Strategy targets, and reducing unit costs. *(RA 1)*
- **Institutionalize social contracting** and establish contingency or emergency financing to sustain essential services during crises and donor shifts. *(RA 1)*

- **Integrate HIV in humanitarian and emergency preparedness and responses**, and include HIV in national contingency plans, needs assessments and humanitarian appeals. *(RA 2)*
- **Enable cross-border referrals** and recognition of medical records for **migrants and refugees**; guarantee uninterrupted access to ART and prevention regardless of legal status; and secure supply chains for HIV and sexual and reproductive health commodities. *(RA 2)*
- **Strengthen integrated information systems** and close data gaps for decision-making (especially for key populations); institutionalize community-led monitoring by integrating those data into national monitoring and evaluation and review processes. *(RA 3)*
- **Expand the use of digital platforms, telemedicine** and cross-border online services to strengthen patient navigation, continuity of care, and access to prevention and treatment, especially for migrants and refugees. *(RA 3)*
- **Integrate HIV and harm-reduction services into prison healthcare** with full parity to civilian systems, ensuring access to ART, PrEP, mental health care and peer support; and integrate HIV services in closed settings, including prisons and detention, into national health governance and UHC systems.
- **Optimize procurement and fast-track registration** and register essential HIV medicines and diagnostics at national level to ensure continued availability after donor phase-outs. Simplify and harmonize procurement procedures for HIV-related commodities, including pooled procurement models and regional collaboration.

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

- **Scale up combination prevention options** including long-acting PrEP and post-exposure prophylaxis and adapt regulatory mechanisms to accelerate adoption of innovations*. (RA 4)*
- **Optimize people-centred testing** and HIV service delivery (e.g. self-testing, community delivery, peer navigation, web-outreach) and strengthen treatment outcomes (U=U) within integrated packages of HIV, tuberculosis, sexual and reproductive health and mental health services. Institutionalize stigma-free care in health settings. *(RA 5)*
- Embed **gender-based violence preventio**n and survivor support across HIV programmes and strengthen women-led networks. *(RA 6)*
- **Protect civic space** and **advance legal reforms** towards the Global AIDS Strategy targets (e.g. decriminalization and repeal of punitive HIV laws) through coordinated advocacy, partnerships, legal literacy, rapid-response mechanisms and legal aid (including reforms that ban mandatory notification by health-care workers and non-consensual disclosure of HIV information to non-health authorities, including law enforcement).
- **Integrate HIV prevention, stigma reduction and sexual and reproductive health education** into formal and informal education systems, with strong involvement of communities and youth networks.

Priority 3: Community leadership

- **Institutionalize, finance and embed community-led responses** and -led monitoring with skilled community workforces, prioritizing youth- and women-led networks and the meaningful participation of communities in the design, delivery and accountability of programmes. *(RA 8 / RA 3)*
- **Build and retain community workforces** (e.g. peers, counsellors, outreach) with measures to prevent burnout and support their well-being; expand leadership, financing and participation in governance for youth- and women-led groups. *(RA 8 / RA3)*
- **Establish contingency financing** to sustain community-led services in crises and donor support shifts. *(RA 1, RA 6, RA 8)*

Latin America

Latin America is one of three regions in the world where the annual number of new HIV infections increased between 2010 and 2024: from an estimated 110 000 to 120 000. The annual number of AIDS-related deaths decreased by 31% from 2010 to 2024 in the regional overall. Those trends differ for men and women: AIDS-related deaths declined by 44% among men but increased by 6% among women.

Testing and treatment coverage is generally high among adults but is much lower for children. Approximately 86% of adults living with HIV knew their serostatus in 2024, 71% were receiving ART, and 66% had viral suppression. Only 56% of children living with HIV had been diagnosed, and 44% were receiving ART.

More than a quarter of new HIV infections (26%) occurred among young people (aged 15–24 years), with young men accounted for three quarters of new HIV infections. The epidemic disproportionately affects marginalized populations, including gay and other men who have sex with men, sex workers, transgender people, indigenous communities, and people living in poverty. Chagas disease remains a concern and is being addressed alongside the triple elimination of HIV, syphilis, and hepatitis B. This integrated disease control approach leverages existing systems for communicable disease management and generates synergies that also benefit the HIV response.

Average prices of ARV medicines in the region decreased from US$ 203 per person per year in 2020 to US$ 148 in 2023 but are still more than twice as high as in eastern and southern Africa, for example. Centralized procurement and the use of mechanisms such as the Pan American Health Organization Revolving Fund have reduced prices (including for hepatitis C medicines). Despite participating in trials, Latin American countries were not included from voluntary licensing arrangements that would grant access to more affordable prices for the long-acting ARVs.

Domestic resources funded 96% of the region's HIV response in 2024. However, seven of 15 countries reported allocating less than 10% of their total HIV resources to HIV prevention. Given the context of low economic growth, complex political situations, fiscal constraints associated with high debt levels, migrant flows, and the impact of extreme climate events, it is crucial to ensure sustainable financing for the HIV response, including through domestic funding, innovative financing and global solidarity.

Priority 1: Country-led HIV response and ready for the future

- **Ensure sustainability** across programmatic, political and financial dimensions through country-owned planning, inclusive governance, leadership of regional coordinating bodies, and multisectoral engagement, including successful transition to domestic financing via sustainability roadmaps and strategies. *(RA 1)*
- **Integrate HIV services** within broader health systems, including primary health care, sexual and reproductive health and mental health services, and with community and private sector-led systems. *(RA 2,3)*
- **Institutionalize the utilization of programme, epidemiological and financial data** for an evidence-informed HIV response. *(RA 3)*

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

- **Increase access to and uptake of combination prevention**, including affordable long-acting PrEP. *(RA 4)*
- **Improve HIV-service delivery and treatment outcomes** through diversified testing options, community-based care, peer support systems and access to innovative health technologies and optimized service delivery. *(RA 5)*
- **Increase commitment and efforts to reduce HIV-related stigma and discrimination** by developing and implementing laws and policies that guarantee and protect the rights of people living with HIV and of key and vulnerable populations, including indigenous peoples and migrants. *(RA 5)*
- **Guarantee human rights and equitable access** to HIV prevention, treatment and care services for indigenous populations, migrants and communities experiencing humanitarian crises, through culturally appropriate, conflict-sensitive programming and strengthened protection mechanisms. *(RA 2)*

Priority 3: Community leadership

- **Strengthen community-led responses** with sustainable financing and institutionalized social contracting mechanisms. *(RA 8)*
- **Enhance community leadership, capacity and representation** of people living with and affected by HIV in national, regional and global health and development policy and programming decision-making processes. *(RA 8)*

Middle East and North Africa

The HIV response in the Middle East and North Africa remains a long way from achieving the 2025 and 2030 targets. New HIV infections increased by 94% between 2010 and 2024, from 12 000 to 23 000 annually. Annual numbers of AIDS-related deaths decreased by only 6% in the same period. HIV treatment coverage in the region is the lowest in the world, with only 48% of people living with HIV receiving ART in 2024. Treatment coverage is even lower among children with HIV, at 35%. Except for Saudi Arabia, all countries in the region are far from reaching the 95–95–95 targets.

Given the very low HIV prevalence in the region, new infections can be reduced rapidly if countries take appropriate and effective actions that meet the needs of the populations most at risk of HIV. However, even when they exist, HIV services are missing many of the people who are most at risk for HIV infection. Intense stigma and discrimination marginalize people from key populations and deter them from seeking HIV-related health services. Strong social taboos, punitive laws and affordability barriers also restrict access, as do out-of-pocket expenses, which are among the highest in the world.

Total resources available for HIV in the region amounted to US$ 120 million in 2024, which left a 71% gap to meet the 2025 target. The region's HIV response is affected by extensive sociopolitical, economic and humanitarian crises. In Sudan, almost 15 million people need health assistance, but 70% of health facilities are not operating in hard-to-reach areas. Financial support from the Global Fund has enabled the replenishment of stocks of ARV medicines and re-enrolment in treatment of approximately 4,000 people living with HIV who dropped out of care due to civil war in that country. Protracted and complex humanitarian challenges skew development financing across the region at the expense of investments in the health and HIV responses.

With an overall HIV burden that is still comparatively low, countries in the region can end AIDS as a public health threat. But doing so will require stronger political commitment, increased funding—including support for community-led and other civil society organizations that serve the needs of people living with, at risk of or affected by HIV—and reduced legal and social barriers.

Priority 1: Country-led HIV response and ready for the future

- **Increase sustainable HIV financing** with allocative-efficiency solutions: deploy strategic analysis, multi-source financing models to ensure domestic investment toward the Global AIDS Strategy targets; support development and implementation of sustainability roadmaps that include integrated community-led responses and innovative solutions for prevention, optimized treatment and social protection. *(RA 1)*
- **Reduce out-of-pocket expenditures** for HIV-related services.
- **Integrate HIV in humanitarian and emergency preparedness and responses**, including HIV in national contingency plans, needs assessments and humanitarian appeals. Coordinate cross-border service platforms, ensuring sexual and reproductive health and HIV commodities and supply chains. *(RA 2)*

- **Leverage data** to achieve transformative results with a focus on key populations and priority populations, including enhanced epidemiological surveillance and bio-behavioural studies, as well as improved strategic information for programme and policy design, more effective monitoring and evaluation, and more efficient resource mobilization and allocation. *(RA 3)*
- **Integrate HIV services in humanitarian and conflict responses**.

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

- **Scale up combination prevention** options, including long-acting PrEP, and adjust regulatory mechanisms to accelerate the adoption of innovations. *(RA 4)*
- **Optimize people-centred HIV service delivery** (e.g. self-testing, community delivery, peer navigation, web-outreach) and strengthen treatment outcomes (U=U) within integrated packages of HIV, tuberculosis, sexual and reproductive health and mental health services. Institutionalize stigma-free care in health settings. *(RA 5)*
- **Scale up programmes to eliminate paediatric HIV transmission** across the region.
- Scale up **HIV testing, treatment and care services for children, people from key populations and young people** and reduce the societal and structural barriers that limit their access to needed services. *(RA5)*
- **Embed gender-based violence prevention and survivor support** across HIV programmes and strengthen women-led networks. *(RA 6)*
- **Protect civic space and advance legal reforms** (e.g. decriminalization and the repeal of punitive HIV laws) through coordinated advocacy and partnerships, legal literacy and legal aid. *(RA 7)*

Priority 3: Community leadership

- **Institutionalize, finance and embed community-led responses** and community-led monitoring with skilled community workforces, prioritizing key population-led networks and the meaningful participation of communities in the design, delivery and accountability of programmes. *(RA 8/RA 3)*
- **Establish contingency financing** to sustain community-led services in crises and during sudden shifts in donor support. *(RA 1, RA 6, RA 8)*

Western and central Africa

The HIV epidemic in western and central Africa remains a major public health challenge. In 2024, an estimated 160 000 new infections occurred in the region, which is home to 5.2 million people living with HIV. Between 2010 and 2024, the number of AIDS–related deaths decreased by 60%.

The expansion of differentiated services for HIV testing, treatment and support services has yielded noticeable progress, with 81% of people living with HIV knowing their status, 94% of the latter receiving ART and 92% of people on treatment having a suppressed viral load. The number of adults (15 years and older) receiving HIV treatment has more than doubled since 2015. However, a little over half (56%) of pregnant women living with HIV received ARV medicines to prevent vertical transmission in 2024 and only 37% of children living with HIV were receiving treatment. Paediatric HIV is therefore a top priority in the region. A combination of strong political commitment, technical expertise and community mobilization is needed to continue progress towards preventing vertical transmission of HIV.

Stigma, discrimination and restrictive legal environments hinder access to services and undermine community-led responses; they must be addressed. In addition, humanitarian crises, political instability and underfunded health systems threaten the sustainability of HIV responses and the continuity of services. The comparative weakness of health systems in several countries poses a challenge for the further integration of HIV services into national health systems.

The region's dependence on external funding for HIV programmes is also challenge for the sustainability of the HIV response. Increased focus on domestic resource mobilization is needed to reduce this dependency and strengthen long-term sustainability. Domestic HIV funding constituted only 29% of total HIV resources in the region in 2024, and it has declined since 2018. In addition, about half of the cost of HIV care is financed through out-of-pocket expending; affordability is therefore also a major problem.

HIV prevention programmes and societal enabler programmes especially require increases in domestic spending. Even though over one third of new HIV infections occur among members of key populations and their sex partners, only about 1% of total HIV resources is allocated to prevention interventions for people from those populations. Renewed advocacy for increased investments is needed urgently to promote a rights-based HIV response, with a focus on scaling up prevention, ending gender inequalities and stopping HIV-related stigma and discrimination.

Priority 1: Country-led HIV response and ready for the future

- **Mobilize and increase domestic financing** and diversify sources (e.g. taxes, private sector, local authorities). *(RA 1)*
- **Institutionalize HIV sustainability roadmaps** and plans within national frameworks (e.g. health strategies, national development strategies, UHC, etc.). *(RA 1)*
- **Strengthen health systems and gradually integrate HIV into UHC**, primary health care systems and private sector health-care provision, including for sexual and

reproductive health, non-communicable diseases (including mental health) and co-morbidities. *(RA 2)*

- **Integrate non-formal health services (communities)** into systems for eliminating vertical transmission of HIV, syphilis and viral hepatitis. *(RA 2)*
- **Support the establishment of local service networks** linking public, community and private services, with dedicated resources, including financial resources, to define interventions, implement and monitor and evaluate interventions. *(RA 2)*
- **Advance the integration** of HIV, sexual and reproductive health, and gender-based violence services in health emergency responses, emergency preparedness and humanitarian response through advocacy, coordination, capacity building and knowledge exchanges. *(RA 2)*
- **Collect, validate and analyse programme, epidemiological community and financial data** for an evidence-informed HIV response. *(RA 3)*
- **Develop local and population-based data** on new infections to guide prevention interventions, including differentiated service delivery, in priority areas. *(RA 3*
- **Expand community-led HIV monitoring**. *(RA 3)*

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

- **Ensure the development and implementation of local plans to accelerate combination prevention**, incorporating the latest technologies (e.g. long-acting, injectable PrEP) and condoms in priority areas, with the leadership of representatives of vulnerable groups and key populations. *(RA 4)*
- **Ensure access to effective prevention tools** (e.g. condoms and PrEP, including long-acting versions) and quality treatment. *(RA 4)*
- **Implement triple elimination guidance** using data-driven, tailored approaches to scale up and sustain vertical transmission programmes. *(RA 4)*
- **Strengthen comprehensive sexuality education** that is tailored to young people, by leveraging regional cooperation agendas. *(RA 4)*
- **Ensure the development and sustainability of key population organizations** and **organizations of young people/adolescents, girls and women** involved in HIV prevention and sexual and reproductive health. *(RA 4)*
- **Accelerate the implementation of differentiated testing and treatment services**, with emphasis on community services. (*RA 5)*
- **Integrate human rights and gender training** into the curricula of health professionals to ensure that services, including primary health services, are **free from stigma and discrimination**, especially for young and vulnerable groups. *(RA 5)*
- **Promote the creation and integration of community health centres**, managed by local actors and community organizations. *(RA 5)*
- **Support health literacy interventions by community organizations** to foster informed demand for services, particularly among adolescents, girls and women. *(RA 5)*

- **Conduct public awareness and communication campaigns** in collaboration with new media to add urgency to the HIV response and reduce HIV-related stigma, including by highlighting the experiences of children and adolescents living with HIV, their families and partners. *(RA 6)*
- **Empower (national) human rights institutions to address legal and policy barriers** that prevent people living with, at risk of or affected by HIV from accessing the services they need. Address the criminalization of key populations as a necessary step for their meaningful inclusion and access to services. *(RA 6)*
- **Leverage health technologies and digital innovations** to improve efficiencies, reduce costs and strengthen delivery and accountability systems, including telemedicine/telehealth and AI tools, etc. *(RA 7)*
- **Support regional pharmaceutical production** via regional hubs (ECOWAS, CEMAC, African Union). *(RA 7)*
- **Digitize HIV medical follow-up,** including to improve continuity of care in remote areas. *(RA 7)*

Priority 3: Community leadership

- **Strengthen community structures** (e.g. local health centers, mobile clinics, rural testing units) led by local actors to deliver context-adapted HIV services.
- **Introduce financial support mechanisms**, including social contracting, especially for organizations led by people living with HIV and young people.
- Actively **involve community leaders** and people living with HIV, including adolescents and young people living with HIV and key populations in the design, implementation and evaluation of programmes.
- **Set up integrated networks of community health services**, combining biomedical, behavioural and structural interventions.
- **Build local capacity** through trainer-of-trainers programmes and professionalization of community health workers, ensuring sustainable skill transfers.
- **Support legal literacy** for key populations in restrictive or hostile settings and train community leaders and peer educators as human rights defenders. *(RA 8)*
- **Establish rapid response mechanisms** for legal or political crises. *(RA 8, RA 6)*
- **Promote safe spaces and psychosocial support** for people who are marginalized and/or affected by stigma, discrimination or violence. *(RA 6*)

Western and central Europe and North America

There has been a 14% decrease in the annual numbers of new HIV infections and a 48% decrease in AIDS-related deaths in western and central Europe and North America since 2010. In many of the countries in this region, national responses are highly advanced and have unique access to the latest scientific and other innovations. The HIV response is often implemented by local authorities (particularly cities and large municipalities), which have access to considerable funding, health infrastructure, staffing and other resources. This reflects longstanding investments in public health infrastructure.

However, HIV prevalence among key populations remains significantly higher than among the general population. Despite data showing ongoing progress in HIV prevention, several factors—including stigma, discrimination and the criminalization of key populations—-continue to cause health disparities and compromise the health and well-being of people from marginalized communities.

Without accelerated scale-up of prevention and treatment coverage, there may be an estimated 49 000 new HIV infections and 2.5 million people living with HIV in the western and central Europe and north America region in 2030. The average age of people living with HIV is also rising, with the proportion of older adults (55 years and over) projected to increase from 18% in 2010 to 47% in 2030. Adolescent boys and men account for about 76% of all people living with HIV in this region.

Priority 1: Country-led HIV response and ready for the future

- **Strengthen political and community leadership** by ensuring the involvement of different stakeholders and partners, including from civil society, in policy formulation and decision-making, and by recognizing the role of civil society in reaching key populations with services. *(RA 1)*
- **Increase funding** and ensure the adequate and equitable allocation of resources at local and regional levels; enhance funding for person-centred HIV approaches to reduce disparities and improve health outcomes for people living, affected by or at risk of HIV. *(RA 1)*
- **Strengthen health systems**, including primary health care and maternal and child health systems, to ensure HIV is integrated into broader national and regional health planning. Develop and implement national strategies on HIV, sexual health, sexually transmitted infections and viral hepatitis. *(RA 2)*
- **Ensure integrated, person-centred, and long-term care** that addresses the full scope of physical, mental health and social needs of diverse populations *(RA2).*
- **Strengthen coordinated case management** involving pharmacists, nurses and community-led service providers. *(RA 2)*
- **Integrate social support** as a key component of HIV care to improve outcomes and reduce health disparities and ensure access to social protection services as part of comprehensive care.
- **Improve data systems** to track service quality and responsiveness, monitor service engagement and retention, especially for key and underserved populations, by setting

equity-driven benchmarks and targets and by promoting community-led monitoring to address data gaps. *(RA 3)*

- **Improve monitoring and disaggregated data collection** to inform decision-making, optimize resource allocation and support the development of targeted monitoring programmes to address the unmet needs of marginalized groups (e.g. women, sex workers, transgender persons, and undocumented migrants). *(RA 3*)

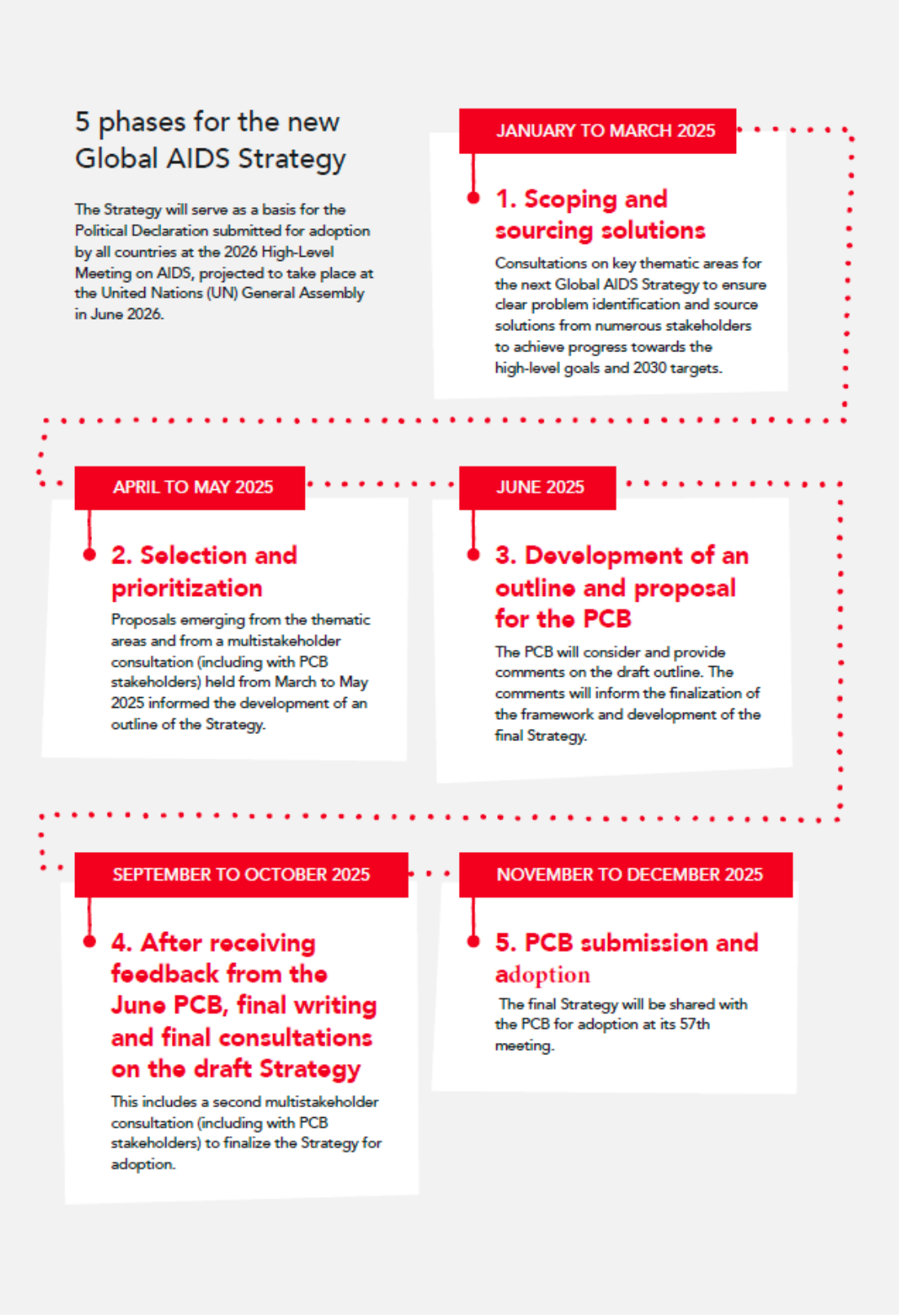
Priority 2: People-focused services—equity, dignity and access

- **Scale up HIV testing** among key populations, migrants and refugees by removing barriers to access, incentivizing early diagnosis, and facilitating self-testing to reduce internal stigma. *(RA 4)*
- **Strengthen primary prevention** and improve access to condoms, PrEP, post-exposure prophylaxis and ART as part of combination prevention programmes by increasing funding and scaling up services for all populations at higher risk of HIV infection. (*RA 4)*
- **Increase access and adherence to treatment** and improve the management of HIV coinfections and comorbidities by advancing research into new and accessible medicines for HIV treatment, and removing legal barriers so under-served populations, including migrants and refugees, have access to health care. *(RA 5)*
- **Address intersecting forms of stigma and discrimination**, especially in health-care settings. (*RA 6)*
- **Use digital tools and inclusive testing practices** to enhance prevention and early diagnosis, including by promoting digital health innovations to support care and prevention; addressing digital exclusion to ensure equitable access to digital tools; and expanding and normalizing opt-out HIV testing, especially in antenatal care, to support early diagnosis. *(RA 7)*
- **Design long-term care services** that are responsive to the lived realities of key populations and under-served communities and treat comorbidities as a health emergency, with early, routine, and integrated screening.
- **Address the broader social determinants of health** that affect people living with HIV and key and affected populations.
- **Protect civic space and advance legal reforms** (e.g. decriminalization and the repeal of punitive HIV laws) through coordinated advocacy and partnerships, legal literacy and legal aid.

Priority 3: Community leadership

- **Increase community engagement and leadership** in local responses, including through the engagement and leadership of young people.
- **Integrate community responses** in national HIV strategies and service delivery, particularly through social contracting.
- **Ensure communities are treated as equal partners** in the planning and delivery of care.
- **Provide sustainable and predictable funding** for community-led initiatives.

Annex 2: Phases of the development of the Global Strategy



Major milestones in the development of the Strategy

- **Developing the targets.** Throughout 2024 and in early 2025, UNAIDS laid the foundation for the development of the next Global AIDS Strategy. This involved four streams of work: (a) the mid-term review of the 2021–2026 Global AIDS Strategy; (b) the development of 2030 global AIDS targets by an advisory Global Task Team on Targets for 2030;[68] (c) support to countries to develop national HIV sustainability roadmaps; and (d) multi-stakeholder consultations. The work continued despite the mounting financial challenges in 2025.
- **Identifying what worked.** The mid-term review highlighted major gains, especially in the expansion of access to HIV treatment, but also showed persistent inequalities in access to HIV prevention and insufficient progress in removing societal and structural barriers. It identified major opportunities to expand access to new prevention technologies, secure sustainable financing (particularly in lower-income, high-burden settings), integrate HIV treatment and prevention services in broader health and development agendas, and address inequalities. Those insights provided a basis for the wide-ranging consultations that have shaped the Global AIDS Strategy 2026–2031.
- **Getting inputs from others.** In addition to the mid-term review, the priorities and results areas for the next Strategy were informed by inputs from countries (e.g. through the development of the HIV sustainability roadmaps)[69] and findings of a recent online survey, as well as national AIDS plans and assessments, which highlighted the main barriers and key priority areas for action.[70]
- **Responding to changing conditions**. Since 2024, the landscape of the HIV response has changed significantly, marked by shifts in HIV-specific funding, the overall aid architecture and the emergence of innovations and technologies that offer exciting new opportunities. The HIV funding ecosystem was particularly affected by changing multilateral priorities in early 2025. The Global AIDS Update 2025 documents these changes along with the latest data on the HIV epidemic and response.[71]
- **Gathering further inputs**. Multi-stakeholder consultations took place in March, April and October 2025. Representatives from nearly 100 national governments and 379 civil society organizations participated in the meetings, and more than 3,000 stakeholders participated in an online survey. Participants were asked to identify priority actions.
- **Ensuring a sound scientific basis.** Experts from academic and scientific institutions from across the world were engaged throughout the process as members of the Global Task Team on targets and through a dedicated consultation which was held during the International AIDS Conference in Kigali in July 2025, as well as through participation in thematic groups. The evidence base for the Strategy is also outlined in the mid-term review of the 2021–2026 Global AIDS Strategy (published in July 2024) and in the Global AIDS Update 2025, each of which is fully referenced.

[68] For more information on the work of the Global Task Team, see: Recommended 2030 targets for HIV | UNAIDS

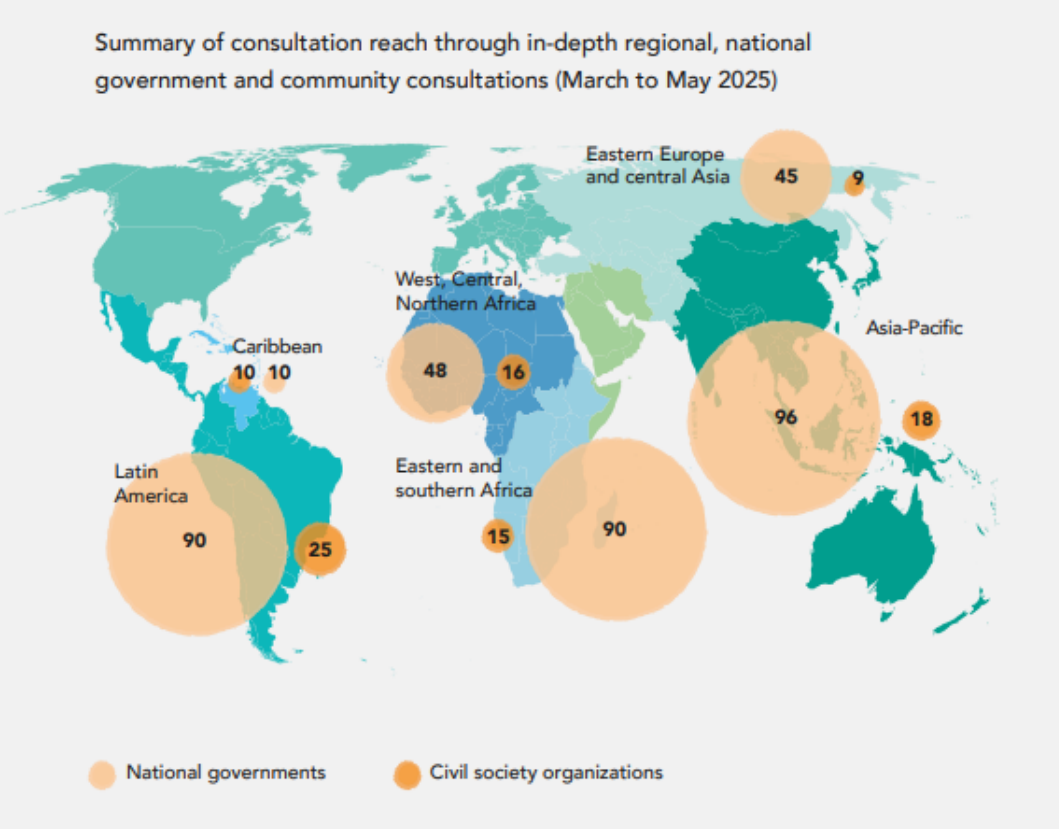
[69] See: Homepage - UNAIDS Sustainability Website

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

[71] Global AIDS Update 2025—AIDS, crisis the power to transform. Geneva: UNAIDS; 2025

- **Prioritization.** To guide the consultations, a prioritization matrix was embedded in the official facilitation guide. This enabled participants to 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 dialogues and consensus-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.

Figure 9. Participation in Global AIDS Strategy consultations



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

** Approximately 93 country governments and 360 civil society organizations were consulted during this period. Consultations continued subsequently.

Annex 3: Glossary

Combination HIV prevention

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

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

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

Key features of combination prevention programmes

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

Sources:

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

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

Comprehensive sexuality education

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

Source: International technical guidance on sexuality education. Volume I. Paris: UNESCO; 2009.

Comprehensive sexuality education is referred to differently across countries, Many different names are used, reflecting an emphasis on various aspects of CSE by different countries. As with all curricula, CSE must be delivered in accordance with national laws and policies.

Generic life skills

Essential topics	▸ Decision-making/assertiveness ▸ Communication/negotiation/refusal ▸ Human rights empowerment
Desirable topics	▸ Acceptance, tolerance, empathy and nondiscrimination ▸ Other gender life-skills

Sexual and reproductive health/sexuality education

Essential topics

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

Desirable topics

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

HIV- and AIDS-related specific content

Essential topics

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

Desirable topics

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

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

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

HIV-sensitive social protection

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

Source: UNAIDS terminology guidelines 2015. Geneva: UNAIDS; 2015 (https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf).

Key populations or key populations at higher risk

Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or transmit it and whose engagement is critically important for a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

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

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

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

However, in the vast majority of settings, key populations and people living with HIV are the most important priority populations for achieving global targets.

Source: UNAIDS Terminology guidelines 2015. Geneva: UNAIDS; 2015. Available at https://www.unaids.org/sites/default/files/ media_asset/2015_terminology_guidelines_en.pdf.

Men who have sex with men

Men who have sex with men describes males who have sex with males (including young males), regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men. Gay can refer to same-sex sexual attraction, same-sex sexual behaviour and same-sex cultural identity.
Source: UNAIDS Terminology guidelines 2015. Geneva: UNAIDS; 2015. Available at *https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf*.

Transgender

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

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

Young people

Young people are people aged 15–24 years (as per the Global AIDS Response Progress Reporting System indicators).

Source: Global AIDS response progress reporting, 2015. Geneva: WHO; 2015 (http://www.unaids.org/sites/default/files/ media_ asset/JC2702_GARPR2015guidelines_en.pdf, accessed 25 September 2015).

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

Source: Adolescent development: a critical transition. In: WHO [website]. WHO; 2015 (http://www.who.int/maternal_ child_adolescent/topics/adolescence/dev/en/, accessed 25 September 2015).

Annex 4: Theory of change

The framework below outlines in greater detail the theory of change referred to on page 20 of the Strategy.

GOAL: End AIDS as a public health threat by 2030 (90% reduction in new infections and deaths from 2010 levels; sustainable, equitable, resilient response)						
	Priority topline narrative	**Outputs (what must be done/delivered)**	**Outcomes (what changes)**	**16 Targets (destination by 2030)**[72] [73]	**Risks**	**Mitigation**
Priority 1: Country-led sustainability responses	Country-led HIV responses with secure, diversified long-term financing; HIV fully integrated within broader health and social systems; equitable access to innovation and strong data governance for resilience.	Increase alignment in costing and budgeting designs at national level. Increase domestic revenue mobilization (levies, debt swaps, health taxes). Create innovative financing instruments and embed budget accountability and HIV-sensitive budget tracking. Integrate HIV with PHC/UHC packages; strengthen multisectoral platforms (education, social	Long-term & diversified HIV financing secured. HIV responses embedded in quality, efficient, and resilient PHC. Equitable access to innovations ensured. Strong data & info systems drive accountability. Affordable, timely access to medicines and innovations is secured.	Increase percentage of HIV expenditure that is domestically sourced so domestic resources account for 35% of the HIV response in low-income countries, 65% in lower-middle-income countries and 95% in upper-middle income countries. Reduce out-of-pocket expenses for HIV, in line with UHC. US$ 21.9 billion mobilized for HIV investments in low-and middle-income countries. 95% of people who are receiving HIV prevention or treatment services also receive needed SRH services (including for STIs). 95% of pregnant women living with HIV and their newborns receive	Declining donor funding; weak domestic mobilization; institutional inertia; underfunded PHC; fragmented data systems; privacy and AI risks. Delayed information on epidemic resurgence. Dependence on donor-funded data systems. Weak integration of community monitoring. Privacy and digital rights risks. Unregulated or unethical use of AI and data governance, without sufficient safeguards for	Expand fiscal space (progressive taxes, levies, debt swaps). Engage emerging economies in financing. Strengthen budget accountability. Develop innovative financing instruments. Embed integration in health/UHC plans. Ensure PHC integration explicitly includes community-based service delivery platforms. Strengthen PHC infrastructure and workforce incentives. Mobilize resources for data systems.

[72] Note: NSP (needle/syringe programme); PEP (post-exposure prophylaxis); PHC (primary health care); PrEP (pre-exposure prophylaxis); OAT (opioid agonist therapy); STI (sexually transmitted infections); UHC (Universal Health Coverage); SRH (sexual and reproductive health); HBV (Hepatitis B vaccine). Source: Recommendations of the Global Task Team for Setting 2030 HIV Targets. Geneva: UNAIDS; 2025.

[73] The targets will be disaggregated, as appropriate, by gender, age and key population.

GOAL: End AIDS as a public health threat by 2030 (90% reduction in new infections and deaths from 2010 levels; sustainable, equitable, resilient response)						
	Priority topline narrative	**Outputs (what must be done/delivered)**	**Outcomes (what changes)**	**16 Targets (destination by 2030)**[72 73]	**Risks**	**Mitigation**
		protection, justice, labour). Invest in routine surveillance, civil registration and vital statistics, and interoperable digital health information systems with privacy and data protections. Strengthen national and community data-use capacity to drive adaptive learning and programme improvement. Develop national HIV sustainability roadmaps. Integrate adolescent- and youth-friendly and community ART. Ensure gender- and rights-sensitive digital applications.		maternal and newborn care that integrates or links to comprehensive HIV services, including for prevention of HIV and hepatitis B virus and treatment of syphilis. Complementary systems indicators (see targets recommendations).	privacy equity and human rights.	Integrate community-led monitoring and digital safeguards. Address digital-readiness gaps through maturity assessments and digital literacy programmes to ensure equitable access to digital health interventions. Strengthen AI/digital regulatory capacity.
Priority 2: Coverage & quality HIV service	Expand equitable access to HIV treatment and prevention so everyone who needs	Scale up differentiated & integrated HIV services.	People living with HIV access quality treatment and care; viral	95% of people living with HIV know their HIV status; 95–95–95 cascade achieved. 90% prevention coverage	Funding shortfalls PHC gaps, stockouts	Increase domestic/innovative financing. Increase financing and prevention budgets.

GOAL: End AIDS as a public health threat by 2030 (90% reduction in new infections and deaths from 2010 levels; sustainable, equitable, resilient response)						
	Priority topline narrative	**Outputs (what must be done/delivered)**	**Outcomes (what changes)**	**16 Targets (destination by 2030)**[72 73]	**Risks**	**Mitigation**
	the services can receive them.	Expand access to HIV prevention options (PrEP, PEP condoms, NSP, OAT, CSE). Strengthen provider & community literacy/capacity; reduce stigma. Support local manufacturing, pooled procurement, market-shaping activities. Integrate adolescent/youth-friendly and community ART. Ensure digital applications are gender- and rights-sensitive.	suppression increases. People at risk use effective prevention; HIV incidence decreases. Services are more differentiated, integrated and inclusive. Countries routinely use real-time data and learning to adapt and improve HIV service delivery models.	<10% stigma/discrimination <10% punitive laws	Stigma, weak SRH/HIV integration, punitive laws.	Strengthen PHC and health workforces. Regional procurement coordination. Reform punitive laws. Integrate SRH & HIV. Promote social and behaviour change campaigns. Support generics and pricing reforms. Strengthen AI/digital regulatory capacity.
Priority 3: Equity & Community	Advance human rights, gender equality, and community leadership so that services are accessible, acceptable and sustained.	Repeal discriminatory laws; enact enabling laws. Scale anti-stigma & gender-based violence programmes.	Communities empowered & resourced to lead responses. Stigma & discrimination reduced and civic space protected.	Community-led organizations deliver 30% of testing and treatment support services. Community-led organizations deliver 80% of prevention options Community-led organizations deliver 60% of societal enabler programmes.	Pushback against gender equality and LGBTIQ+ rights. Harmful gender norms and persistent gender-based violence. Insufficient financing for rights and anti-stigma interventions.	Build advocacy coalitions. Institutionalize legal empowerment and gender-transformative policies. Resource anti-stigma, gender-based violence and legal support programmes. Engage leaders/influencers to shift harmful norms.

GOAL: End AIDS as a public health threat by 2030 (90% reduction in new infections and deaths from 2010 levels; sustainable, equitable, resilient response)						
	Priority topline narrative	**Outputs (what must be done/delivered)**	**Outcomes (what changes)**	**16 Targets (destination by 2030)**[72] [73]	**Risks**	**Mitigation**
		Institutionalize gender-transformative, rights-based approaches. Resource community-led responses through social contracting co-design and community-driven innovation (including community health worker-led and digital self-care platforms.	Human rights & gender equality upheld.	(Note the community-led monitoring target in the remaining 50 targets)	Shrinking civic space and restrictive NGO laws. Weak recognition of community-led roles. Limited capacity and funding for community organizations.	Reform laws/regulations to enable community-led service delivery. Institutionalize social contracting mechanisms. Provide capacity strengthening and safeguarding support. Formal recognition of community-led monitoring and innovation, enabling scale up of local learning systems and adaptive tools.
Assumptions	🕐 Political commitment at global and national levels remains strong. 🕐 New HIV prevention and treatment innovations are accessible and equitably scaled. 🕐 Rights-based approaches remain central to national and global HIV responses. 🕐 Civil society and community-led organizations have legal space, resources, and capacity to operate and lead, with rapid mitigation where restrictions arise.					