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

Addressing inequality and preparing the next phase of the AIDS response

Report of the Secretary-General

Summary

This is a milestone year for the global AIDS response. The end of 2020 marks the deadline for targets agreed in 2016 by the General Assembly, in its resolution [70/266](#), to front-load investment, accelerate the response and end the epidemic by 2030.

The present report is also being issued while a new pandemic underscores the need for vigilance in tackling infectious diseases. The emergence of coronavirus disease (COVID-19) is in many ways a reminder of the early days of the HIV epidemic, when the world struggled to understand a new deadly virus. While an understanding of interactions between HIV, HIV-related immunodeficiencies and COVID-19 is emerging, there are concerns about the well-being of people living with HIV and key populations, including with regard to the possibility of severe disruption to HIV prevention, testing and treatment services.

Enormous progress has been made in fighting HIV over the past 20 years: globally, an estimated 24.5 million [21.5 million–25.5 million] people living with HIV were on treatment in mid-2019, and deaths from AIDS-related illness have steadily declined since 2004. A combination approach to HIV prevention, including behavioural, biomedical and structural approaches, has resulted in reductions in HIV infections in a variety of settings. The AIDS response has also strengthened health systems by supporting integrated service delivery and mobilizing community health workers, as well as by bolstering laboratory systems, health information systems, the procurement of medicine and supply chain management.

Nevertheless, progress is slowing, and the world is falling short of its 2020 targets, especially on HIV prevention. There are significant disparities in HIV service availability and uptake, both geographically and by subpopulation. Adolescent girls and young women continue to account for a disproportionately high number of HIV infections in sub-Saharan Africa, a disparity driven by gender inequality, violence,



food insecurity and the denial of access to sexual and reproductive health and rights. Large gaps in knowledge about HIV status and in antiretroviral therapy coverage among men and young people living with HIV contribute to HIV infections among women. In many countries, the criminalization and marginalization of key populations, including sex workers, people who inject drugs, prisoners, transgender people, gay men and other men who have sex with men, have blunted efforts to provide services to those who are most at risk. Treatment coverage among children living with HIV is lagging behind that for adults. Insufficient availability and inefficient use of financial resources threaten hard-won gains.

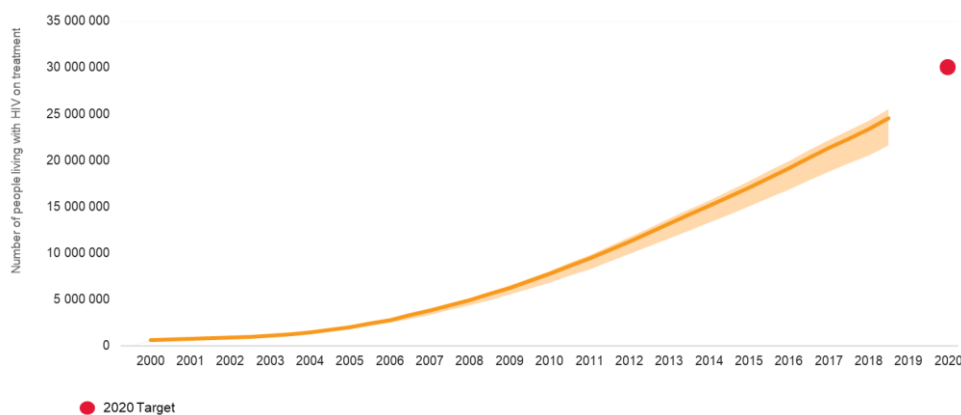
A decade of action is needed to achieve the 2030 Agenda for Sustainable Development. As part of this effort, the world must push to achieve the targets in resolution [70/266](#) and set a common agenda for the next phase of the disease response. As the seventy-fifth anniversary of the United Nations approaches, the largest joint United Nations programme, the Joint United Nations Programme on HIV/AIDS (UNAIDS), is working with Member States, civil society and other partners to review progress, calculate targets for 2025 and update the global strategy to achieve those targets. A strategic pivot to an intensified, people-centred approach could close the gap.

Member States are urged to consider the following recommendations: (a) address the inequality that lies at the heart of disparities in progress; (b) leverage the opportunities arising from the twenty-fifth anniversary of adoption of the Beijing Declaration and Platform for Action to address gender inequalities that contribute to the increased vulnerability of women and girls to HIV; (c) close the financing and leadership gap and deliver comprehensive and high-quality AIDS responses; and (d) engage in efforts to set ambitious 2025 targets and update the global AIDS response strategy.

I. State of the epidemic and response

1. Significant gains have been made since 2016, when the General Assembly agreed to “fast-track” the global AIDS response (see resolution 70/266, annex). Strong progress has been made towards the 90-90-90 testing and treatment targets: almost four out of five people (79 per cent) living with HIV know their status, 78 per cent of those living with HIV who know their HIV status are on treatment and 86 per cent of people who are on treatment are virally suppressed.¹ The number of people receiving life-saving antiretroviral therapy continues to rise. An estimated 24.5 million [21.5 million–25.5 million]² people living with HIV were on treatment globally in mid-2019, a figure that is more than triple the number in 2010 (see figure I).³

Figure I
Number of people living with HIV on treatment, globally, 2000 to mid-2019 and 2020 target



Source: Joint United Nations Programme on HIV/AIDS (UNAIDS) special analysis, 2019.

2. Fifteen countries have passed the 90-90-90 threshold of at least 73 per cent of people living with HIV being virally suppressed, including three countries with high HIV burdens: Botswana, Eswatini and Namibia.

3. Treatment scale-up has seen deaths from AIDS-related illness decline from a peak of 1.7 million [1.3 million–2.4 million] in 2004 to 770,000 [570,000–1,100,000] in 2018 (see figure II). Meanwhile, greater provision of antiretroviral therapy to pregnant women living with HIV has driven progress towards the elimination of mother-to-child transmission of HIV.

4. A combination approach to HIV prevention, including behavioural, biomedical and structural approaches, such as keeping girls in school, has resulted in steady reductions in HIV infections in a variety of settings. Condom use has increased in much of sub-Saharan Africa over the past decade and countries are gradually adopting pre-exposure prophylaxis (PrEP) as an additional HIV prevention option. More than

¹ The 90-90-90 targets are a call for 90 per cent of people living with HIV to know their HIV status, 90 per cent of people who know their HIV-positive status to be accessing treatment and 90 per cent of people on treatment to have suppressed viral loads by 2020.

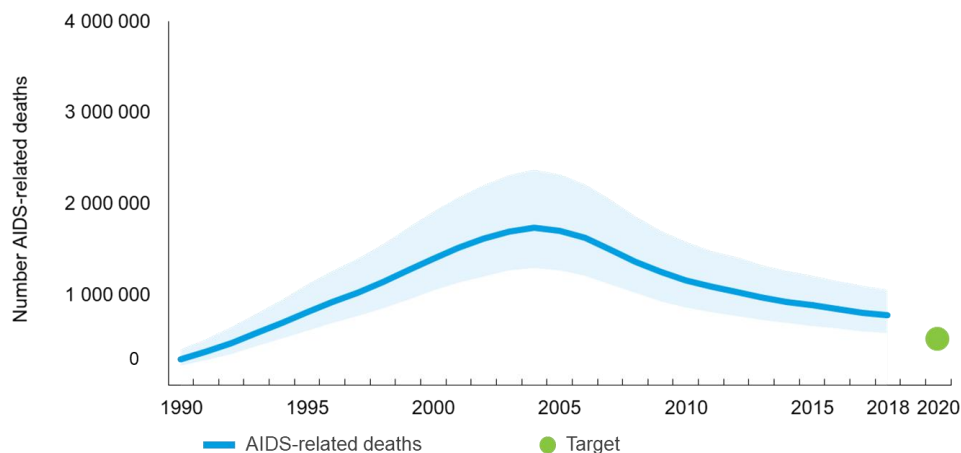
² Uncertainty bounds are calculated for each estimate. The bounds define the range within which the true value lies. Narrow bounds indicate that an estimate is precise, while wide bounds indicate greater uncertainty regarding the estimate.

³ Unless otherwise stated, data provided are Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates and country data reported to UNAIDS through its annual *Global AIDS Monitoring* reports.

300,000 people globally took PrEP at least once in 2018, with the greatest impact seen in cities in North America, Europe and Australia among gay men and other men who have sex with men. There have also been about 11 million voluntary medical male circumcisions performed in 15 priority countries since the beginning of 2016, including more than 4 million in 2018.

Figure II

Number of AIDS-related deaths, globally, 1990–2018 and 2020 target

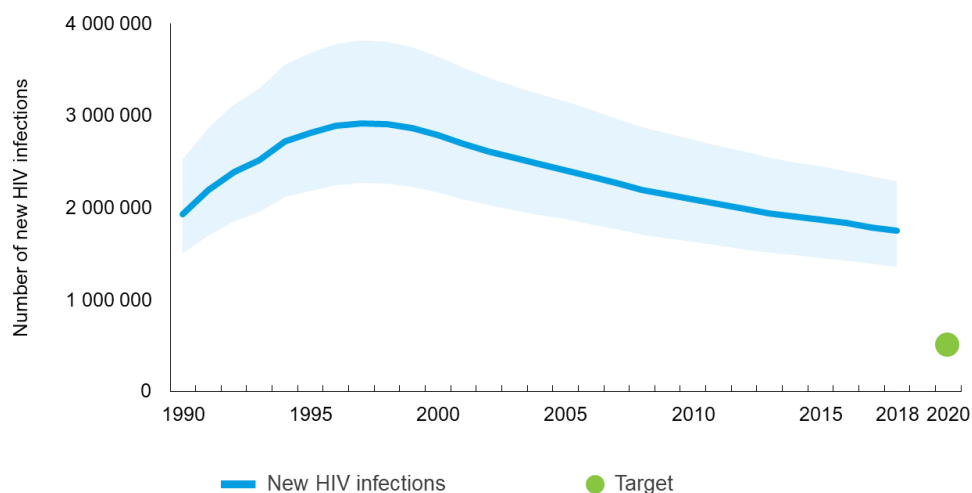


Source: UNAIDS 2019 estimates.

5. Nevertheless, progress in combating HIV is slowing globally and the 2020 targets have not yet been met. Gaps across the continuum of HIV testing and treatment services have left nearly half (47 per cent) of people living with HIV in 2018 with unsuppressed viral loads. Efforts to prevent HIV infections are far off track. There were 1.7 million [1.6 million–2.3 million] new infections in 2018, more than triple the 2020 target of fewer than 500,000 new infections (see figure III). About 160,000 [110,000–260,000] children (aged 0–14 years) acquired HIV globally in 2018, which is far off the targeted 95 per cent reduction by 2020.

Figure III

Number of new HIV infections, globally, 1990–2018 and 2020 target



Source: UNAIDS 2019 estimates.

6. Behind the global trends, there are significant disparities in progress, both geographically and by subpopulation. In East and Southern Africa, the regions hardest hit by HIV, firm global leadership and a combination of strong domestic and donor investment has seen the number of AIDS-related deaths decline by 44 per cent and new HIV infections decrease by 28 per cent since 2010. Nevertheless, the number of HIV infections and AIDS-related deaths is still increasing in some regions. Since 2010, for example, the annual number of new HIV infections has increased in Eastern Europe and Central Asia (29 per cent), the Middle East and North Africa (10 per cent) and Latin America (7 per cent).

II. Gaps and challenges

Inequality is limiting progress

7. Inequality lies at the heart of disparities in progress. Gaps in the provision of a comprehensive package of services are often largest for the people most in need. Those gaps arise from a collective failure to put human rights at the centre of the fight against HIV.

Women and girls

8. Women in high-prevalence settings (especially adolescent girls and young women), women in key populations (women who inject drugs, women sex workers, transgender women and women prisoners), the female sexual partners of men in key populations, and women and girls in humanitarian settings or on the move, continue to be at particular risk of HIV.

9. Gender power imbalances fuel the epidemic and play out across all facets of the AIDS response. They undermine women's ability to decide how, when and with whom to have sex or to negotiate for protected sex. They shape women's use of HIV services and other health services, and restrict their chances of leading lives free of violence and other human rights violations.

10. Women and girls continue to shoulder a disproportionate burden of the HIV epidemic. Globally, young women (aged 15–24) are twice as likely to be living with HIV than men of the same age, while 6,000 adolescent girls and young women became infected with HIV every week in 2018. In sub-Saharan Africa, adolescent girls (aged 10–19) accounted for 12 per cent of new HIV infections in 2018 despite making up just 5 per cent of the population. AIDS remains the leading cause of death for women of reproductive age worldwide.

11. The limited access of women and adolescent girls to comprehensive sexuality education and to sexual and reproductive health services seriously compromises their ability to protect their health and improve their well-being. They may be culturally expected or legally required to ask permission from their husband or other family members to gain access to sexual and reproductive health services or to take an HIV test. Even in the absence of legal barriers, they may not have the knowledge that they need to access those services or to negotiate for safer sexual practices with their partners.

12. Gender-based violence increases HIV risk and is a major barrier to services. Evidence from locations with high HIV prevalence in sub-Saharan Africa shows that intimate partner violence increases susceptibility to HIV and that violence, or the fear

of violence, is associated with reduced access to treatment, lower treatment adherence rates and lower rates of viral suppression among women and girls.^{4,5}

13. Recent evidence from a contraceptive trial in Eswatini, Kenya, South Africa and Zambia highlights the ongoing need for women-centred prevention approaches that combine biomedical, social and economic interventions. Despite regularly accessing health services that included HIV prevention options, women participating in the trial had a very high incidence of HIV (between 3.4 and 4.2 per cent) and the incidence among women younger than 25 years of age was even higher.⁶ These data underscore the need to tackle underlying gender dynamics that make it difficult for women to avoid acquiring HIV infection, as well as to strengthen the delivery of integrated services, particularly HIV services and family planning/contraception services.

14. Discrimination against women and girls in education systems and labour markets creates economic and social insecurity that undermines women's agency and heightens their risk of acquiring HIV.⁷ In many countries, girls are less likely to complete secondary education than boys and the quality of their education suffers owing to discrimination in schools. Women are also overrepresented in informal and unregulated sectors of the economy. Compounding those inequalities are the burdens of unpaid care and domestic work, unequal property and inheritance rights, and the limited financial autonomy that shape the lives of women and girls around the world.

15. Survival strategies for women living in poverty and women faced with limited livelihood opportunities also increase HIV risk. Economic need and insufficient access to nutritious food have been associated with higher rates of unsafe sexual behaviours among women, including transactional sex and unprotected sex with men who are not their primary partners.^{8,9} Hunger and food insecurity have also been found to be barriers to initiating and adhering to antiretroviral therapy.¹⁰

16. Punitive and discriminatory laws also often target women and people who do not adhere to prevailing conventions regarding sex, sexuality and gender. Some laws limit the sexual and reproductive choices of women and curb the agency of women living with HIV. Other laws criminalize people for their sexual identity or gender expression, for selling sexual services, for using illegal drugs, for transmitting HIV or for failing to disclose their HIV-positive status. Such laws and policies, and the stigmatization and discrimination that they encourage, prevent people from using the services that they need to protect their health and well-being.¹¹

⁴ Ying Li and others, "Intimate partner violence and HIV infection among women: a systematic review and meta-analysis", *Journal of the International AIDS Society*, vol. 17, No. 1 (January 2014).

⁵ Abigail M. Hatcher and others, "Intimate partner violence and engagement in HIV care and treatment among women: a systematic review and meta-analysis", *AIDS*, vol. 29, No. 16 (October 2015).

⁶ Evidence for Contraceptive Options and HIV Outcomes Trial Consortium, "HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: a randomized, multicentre, open-label trial", *The Lancet*, vol. 394, No. 10195 (July 2019).

⁷ UNAIDS, *Transactional Sex and HIV Risk: from Analysis to Action* (Geneva, UNAIDS and STRIVE, 2018).

⁸ Sophie J. S. Pascoe and others, "Poverty, food insufficiency and HIV infection and sexual behaviour among young rural Zimbabwean women", *Plos One*, vol. 10, No. 1 (2015).

⁹ Sheri D. Weiser and others, "Food insufficiency is associated with high-risk sexual behavior among women in Botswana and Swaziland", *Plos Medicine*, vol. 4, No. 10 (October 2007).

¹⁰ Elisabeth Chop and others, "Food insecurity, sexual risk behavior, and adherence to antiretroviral therapy among women living with HIV: a systematic review" *Health Care for Women International*, vol. 38, No. 9 (2017).

¹¹ UNAIDS, *We've Got the Power: Women, Adolescent Girls and the HIV Response* (Geneva, 2020).

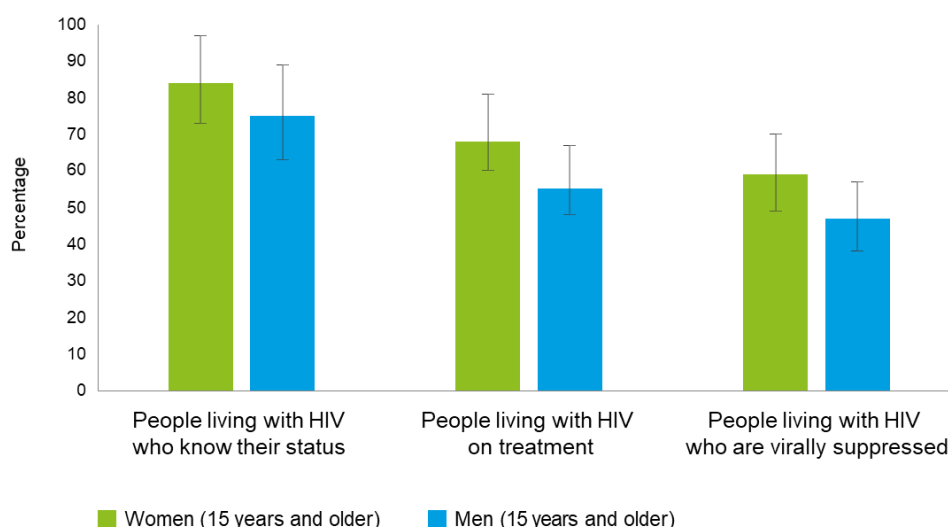
Men and young people

17. Gaps in knowledge of HIV status and treatment coverage are larger among men and young people living with HIV. Harmful gender norms, poor health-seeking behaviour and the relatively less frequent interaction of men with the health system compared with women result in men experiencing longer periods of time between infection and diagnosis, later initiation of treatment and lower rates of viral suppression (see figure IV). That in turn leads to poorer clinical outcomes and a greater likelihood of death from AIDS-related causes among men, as well as a greater risk of HIV infection among women.

18. In West and Central Africa, just 30 per cent [19–42 per cent] of adult men (aged 15 years and older) living with HIV were virally suppressed in 2018, and the same is true for only 50 per cent [42–59 per cent] of adult men in East and Southern Africa. Special efforts are needed to address the barriers faced by men living with HIV to know their HIV status and suppress their viral loads, both for their own health and to prevent HIV transmission to their sexual partners.

Figure IV

HIV testing and treatment cascade among adults aged 15 years and older, by sex, globally, 2018



Source: UNAIDS special analysis, 2019.

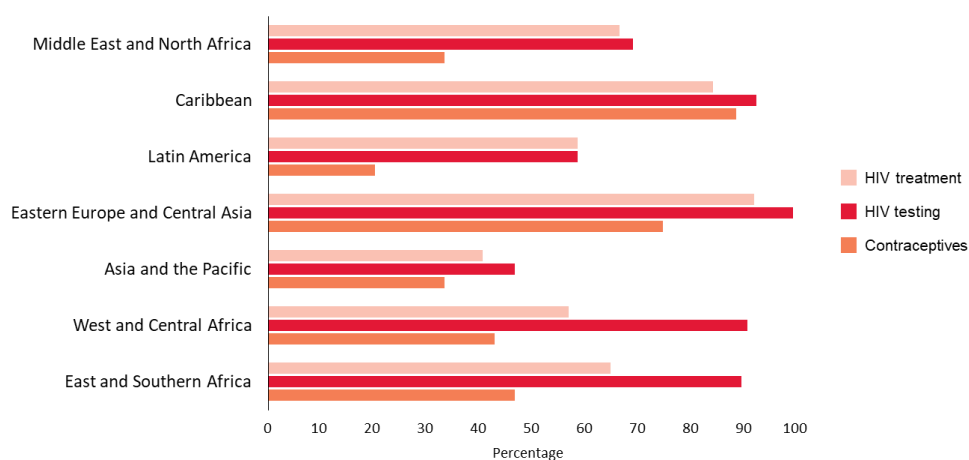
19. Young people's knowledge of HIV is alarmingly low in many regions. In countries with recently available survey data, just 23 per cent of young women (aged 15–24) and 29 per cent of young men (aged 15–24) have comprehensive and correct knowledge about HIV. Age-related legal restrictions deny many adolescents access to comprehensive sexuality education and youth-friendly services that can help them to make informed decisions about their sexuality, relationships and health. Even when sexuality education is available to young people, it often starts too late, excludes key learning topics, or is delivered by teachers who have not benefited from sufficient training and support.

20. Parental consent laws, as well as the criminalization of same-sex sexual relations and consensual sex among adolescents, further compound the stigma and health risks faced by adolescents and youth. A large proportion of countries, across all regions, restrict adolescents' access to HIV testing and treatment. In 2019, in 105 out of 142 countries, adolescents younger than 18 needed explicit parental consent to

take an HIV test,¹² and in 86 out of 138 reporting countries, they needed such consent to access HIV treatment and care (see figure V). In East and Southern Africa, knowledge of HIV status among young people living with HIV is far lower than that among adults: 66 per cent [62–71 per cent] of HIV-positive young women (aged 15–24) and 50 per cent [46–54 per cent] of HIV-positive young men (aged 15–24) know about their HIV status, compared with 82 per cent [71–93 per cent] of HIV-positive men (aged 15 and over) and 88 per cent [78–95 per cent] of HIV-positive women (aged 15 and over). In 2019, Namibia and the United Republic of Tanzania lowered the age for gaining access to HIV testing without parental consent to 14 years of age and 15 years of age, respectively.^{13,14}

Figure V

Percentage of reporting countries with laws requiring parental or guardian consent for adolescents to access contraceptives, HIV testing and HIV treatment, by region, 2017–2019



Source: UNAIDS National Commitments and Policies Instrument, 2017–2019, and other sources. See the UNAIDS publication *Power to the people* for details.

Key populations

21. Across the world there are key populations at high risk of HIV infection, including sex workers, people who inject drugs, prisoners, transgender people, and gay men and other men who have sex with men. Slower progress in providing key populations with services has resulted in the global distribution of new HIV infections crossing a notable threshold. UNAIDS 2018 epidemiological estimates show that 54 per cent of global infections were among members of key populations and their sexual partners (see figure VI). Gay men and other men who have sex with men accounted for more than half of new HIV infections in Western and Central Europe and North America, 40 per cent in Latin America and 30 per cent in Asia and the Pacific. People who inject drugs accounted for an estimated 41 per cent of new HIV infections in Eastern Europe and Central Asia, and for 37 per cent of new HIV infections in the Middle East and North Africa. Sex workers accounted for 14 per cent of new infections in West and Central Africa. Transgender women accounted for 5 per cent of new infections in the Caribbean and 4 per cent of new infections in Latin America, Western and Central Europe and North America. Even in East and Southern Africa, a region where HIV transmission

¹² 58 countries had consent restrictions for adolescents younger than 16 years of age; 47 countries had consent restrictions for adolescents younger than 18.

¹³ “14-year-olds can now consent to HIV testing”, *The Namibian*, 5 March 2019.

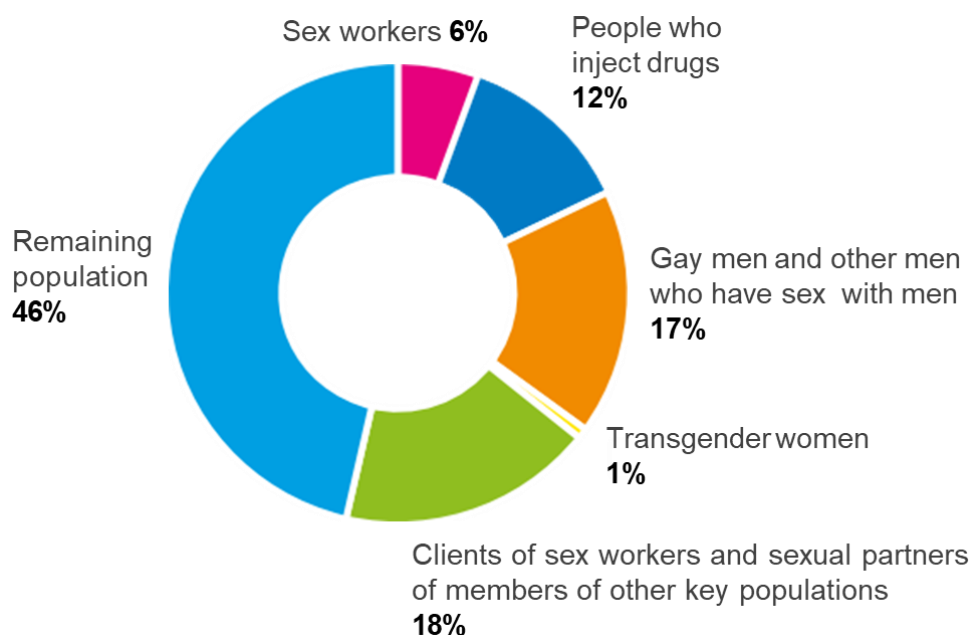
¹⁴ Xinhua, “Tanzania lowers HIV self-testing age to 15”, 13 November 2019.

occurs predominantly within the general population, 25 per cent of new infections were among members of key populations and their sexual partners.

22. An increasing proportion of the people not reached by HIV testing and treatment services belong to key populations. Survey data show that, on average, globally, more than one third of sex workers, gay men and other men who have sex with men, and transgender people do not know their HIV status, and that this proportion increases to approximately one half among people who inject drugs.¹⁵ These data may underestimate the knowledge gap, since surveys of key populations are typically conducted in areas where HIV testing services are available and therefore do not account for those who do not have access to testing.

Figure VI

Distribution of new HIV infections by population group, globally, 2018



Source: UNAIDS special analysis, 2019.

23. Failure to implement what is known to work, such as making comprehensive harm reduction available to all people who inject drugs, continues to slow progress. Similarly, criminalization, aggressive policing, harassment, violence and multiple levels of stigmatization and discrimination also have a negative impact on progress, violate the rights of key populations and deter them from accessing the services that they need. Discriminatory laws and policies that restrict the movement of people living with HIV or that target key populations' behaviours also result in substantial harm and the denial of HIV services. The effects on people's health, well-being and dignity are pernicious, especially in the context of the HIV epidemic. For example, transgender people may be subjected to discrimination in every sphere of life, including education and employment. Such exclusion drives people into livelihoods and personal behaviour that can be unhealthy and dangerous, placing them at high risk of substance misuse, violence and HIV infection.¹⁶

¹⁵ UNAIDS, *Global AIDS Monitoring 2019: Indicators for Monitoring the 2016 Political Declaration on Ending AIDS* (Geneva, 2018), see <https://aidsinfo.unaids.org/>.

¹⁶ UNAIDS, *Power to the people* (Geneva, 2019).

Children

24. Children and adolescents living with HIV generally have lower rates of HIV diagnosis, antiretroviral therapy initiation and viral suppression than other age groups. Nearly half (46 per cent) of all children living with HIV globally are not on treatment, and only 12 countries and territories have been validated by the World Health Organization as having eliminated mother-to-child transmission of HIV.

25. In too many infants, HIV is identified only when they present with HIV-related symptoms, which compromises their chances of survival and of a healthy childhood. Globally, in 2018, only 59 per cent [48–78 per cent] of HIV-exposed children were tested before two months of age and an estimated 100,000 [64,000–160,000] children (aged 0–14 years) died of AIDS-related causes.

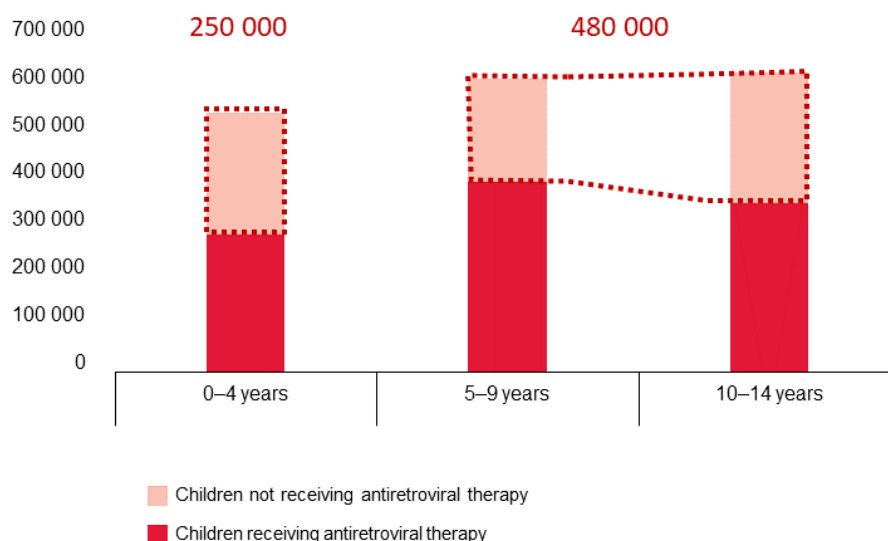
26. A major hindrance is the need for virological testing of HIV-exposed infants, which is often time-consuming and logistically challenging. It is estimated that more than 40 per cent of test results for HIV-exposed infants are never received by the caregiver, which contributes to a high rate of loss to follow-up, poor linkage between testing and treatment and high infant mortality.¹⁷

27. Coverage of early infant diagnosis in East and Southern Africa has improved dramatically in recent years and reached 68 per cent [56–91 per cent] in 2018. However, in West and Central Africa, just 27 per cent [21–39 per cent] of infants exposed to HIV were tested for HIV infection within eight weeks of birth.

28. As efforts to prevent vertical infections and test HIV-exposed infants improve, the paediatric treatment gap has shifted to older children living with HIV, whose infection as babies was not detected and yet who survived without treatment. There were 480,000 older children (aged 5–14) living with HIV not receiving antiretroviral therapy in 2018, compared with 250,000 infants and young children (aged 0–4) (see figure VII).

Figure VII

Number of children living with HIV receiving antiretroviral therapy, by age, globally, 2018



Source: UNAIDS epidemiological estimates, 2019.

¹⁷ Elizabeth Glaser Pediatric AIDS Foundation, “Point-of-care early infant HIV diagnosis: issue brief”, June 2018.

III. Joint United Nations Programme on HIV/AIDS is catalysing action

29. The establishment of UNAIDS in 1994 was a radical innovation in multi-agency collaboration during a health and development emergency. Following the adoption by the General Assembly of resolution [72/279](#) on the repositioning of the United Nations development system, in 2018, the secretariat of UNAIDS and its 11 co-sponsoring organizations have become active participants in United Nations reform processes. The United Nations Sustainable Development Cooperation Framework, for example, is guiding bottom-up efforts to help United Nations country teams to develop a common country analysis of HIV epidemics, the national response and United Nations support for that response.

30. A central tenet of the 2030 Agenda for Sustainable Development is the commitment to leave no one behind. UNAIDS continues to focus on putting people, in particular people living with HIV, key populations and people in situations of vulnerability or marginalization, at the centre of its efforts and tailoring its responses to country-level needs and priorities.

31. On the seventy-fifth anniversary of the United Nations, UNAIDS, which is the largest joint programme in the United Nations system, continues to catalyse action to combat the epidemic. The provision of support to countries for achieving the 90-90-90 targets is a priority for Joint United Nations Teams on AIDS at the regional and country levels, with the co-sponsoring organizations and the secretariat working together to ensure that:

- (a) The necessary policies and guidelines are developed, adopted and implemented;
- (b) Service delivery models are differentiated and diversified to better respond to clients' needs;
- (c) Approaches are in place to reach neglected communities;
- (d) Steps are taken to eliminate stigmatization and discrimination in health-care settings;
- (e) Space exists for communities and civil society to engage in policy and programme work, link people to services and support retention.

32. UNAIDS worked with 28 priority countries to fully operationalize the Global HIV Prevention Coalition and implement the HIV prevention 2020 road map. The Coalition is transforming national HIV prevention responses to more consistently align them with the five priority pillars of HIV prevention in countries with high HIV prevalence and, in countries with concentrated epidemics, to focus them on key populations.

33. The Joint Teams are also focusing on accelerating progress towards the elimination of mother-to-child transmission of HIV and the achievement of paediatric treatment targets. Their support to countries includes enabling them to review programmes, develop road maps and step up actions to achieve elimination.

34. With regard to the crucial gender dimension of the HIV epidemic, the Joint Teams are supporting efforts to integrate new science and knowledge into ensuring a gender-responsive approach to HIV and to improve the understanding and prevention of, and the response to, gender-based violence. For example, the gender assessment tool, which was first introduced in 2014, has been updated to reflect the commitments made in 2016 in the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, and to integrate new science and information (see resolution [70/266](#), annex).

35. The engagement and empowerment of young people continue to be a key focus for UNAIDS. It is supporting young people in implementing youth-led scorecards to track progress towards the targets of the Political Declaration on HIV and AIDS of 2016.

36. The elimination of stigma and discrimination continues to be an important component of UNAIDS work. In 2018, the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination was launched, with the United Nations Development Programme, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the UNAIDS secretariat and the Global Network of People Living with HIV as co-conveners. The Partnership is prioritizing actions in six settings (health-care, education, workplace, legal and justice, family and community, and emergency and humanitarian settings) and shifting the focus to countries by linking with the 20-country Breaking Down Barriers initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

37. The Joint Teams are also facilitating and supporting partnerships for mobilizing and effectively utilizing resources of the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR) and transitions to more sustainable sources of funding for AIDS responses.

IV. The way forward

38. A decade of action is needed to achieve the 2030 Agenda. As part of this concerted effort, a people-centred approach is required to achieve the targets in resolution [70/266](#), set a common agenda for the next phase of the disease response and end the epidemic by 2030.¹⁸ Addressing inequality in both access and outcomes, and maximizing synergies with efforts to achieve universal health coverage and other sustainable development targets and goals, are imperative to success.

39. The COVID-19 crisis is likely to have a profound and negative effect on sustainable development efforts. While an understanding of interactions between HIV, HIV-related immunodeficiencies and COVID-19 is emerging, there are concerns about the well-being of people living with HIV and key populations, including with regard to the possibility of severe disruption to HIV prevention, testing and treatment services. The differentiated impacts on segments of the population have to be fully taken into account, with due regard for disadvantaged groups in all societies and adherence to the highest human rights standards. Universal access to vaccines and treatment must be assured, with full respect for human rights and gender equality and without stigmatization.

Addressing gender inequalities in a milestone year for women's rights

40. The empowerment of women and girls and the fulfilment of their human rights is crucial for creating more just, equitable and prosperous societies. It will not be possible to put an end to the AIDS epidemic so long as women and girls are denied control of their bodies and their sexual and reproductive rights.

41. In 1995, in the Beijing Declaration and Platform for Action, Member States promised to create and maintain a non-discriminatory and gender-sensitive legal environment, eliminate legislative gaps that leave women and girls without their rights protected, and ensure effective recourse against gender-based discrimination. Nevertheless, discriminatory laws continue to affect some 2.5 billion women and girls

¹⁸ Ending the epidemic as a public health threat has been defined as reducing new HIV infections and AIDS-related deaths by 90 per cent compared with a 2010 baseline.

around the world. Transgender people are also criminalized in at least 19 countries.¹⁹ As the world marks 25 years since the adoption of the Beijing Declaration, renewed emphasis is needed on fast-tracking legal reform and enforcement, and on securing human rights and legal literacy for all women.

42. Gender inequities and power imbalances, which are rooted in harmful social norms and masculinities, have to be disrupted. Seismic shifts are needed at the legal, policy, institutional and societal levels to promote gender equality and human rights and to put an end to all forms of stigma and discrimination, as well as to the criminalization of key populations.

43. Access to women-centred sexual and reproductive health and rights, including improved integration of prevention, testing and treatment options for HIV and sexually transmitted infections within contraception services, is especially needed by women and adolescent girls in high-prevalence settings, female key populations (female sex workers, transgender women, women who inject drugs and incarcerated women) and female partners of members of key populations in all settings.

44. Education and economic independence both empower women and protect them from HIV. Staying in school has been shown to reduce HIV risk.²⁰ The provision of cash incentives to young people, especially girls, to stay in school longer and do better in their studies improves school attendance and performance, health, nutrition (especially for children) and empowerment, promotes safer sexual behaviour, delays sexual debut and reduces the number of adolescent pregnancies and early marriages and levels of monetary poverty.^{21,22,23} A three-year study in Eswatini found that the probability of becoming HIV-positive was 25 per cent lower for those who received financial incentives to stay in school than for those who did not receive them. Participants who both received financial incentives and were entered into a raffle if they remained free of sexually transmitted infections were 38 per cent less likely to acquire HIV.²⁴

45. Ending all forms of violence against women and girls is a key aspect of Sustainable Development Goal 5 on gender equality. The adoption and enforcement of zero-tolerance policies and laws is important for reducing gender-based violence, as are sustained social interventions that confront and reshape the norms and relations enabling such violence.

46. Transformative, community-based behavioural interventions to prevent intimate partner violence and reduce HIV risk have seen success, especially in Southern

¹⁹ UNAIDS, *We've Got the Power*.

²⁰ Jan-Walter De Neve and others, "Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment", *The Lancet: Global Health*, vol. 3, No. 8 (August 2015).

²¹ Francesca Bastagli and others, *Cash Transfers: What Does the Evidence Say – A Rigorous Review of Programme Impact and the Role of Design and Implementation Features* (London, Overseas Development Institute, 2016).

²² Ebenezer Owusu-Addo and Ruth Cross, "The impact of conditional cash transfers on child health in low- and middle-income countries: a systematic review", *International Journal of Public Health*, vol. 59, No. 4 (August 2014).

²³ Catherine Arnold, Tim Conway and Matthew Greenslade, *Cash Transfers: Evidence Paper – Policy Division 2011* (London, Department for International Development, 2011).

²⁴ M. Gorgens and others, "Sitakhela Likusasa impact evaluation: results of a cluster randomized control trial (CRCT) of financial incentives for HIV prevention among adolescent girls and young women (AGYW) in Eswatini", in International AIDS Society, *IAS 2019: Abstract Book* (2019).

Africa.^{25,26,27} Analyses of those interventions show that the meaningful involvement of both young women and young men, and due attention to wider social and structural conditions, are critical for success.²⁸

47. Pre-exposure prophylaxis is emerging as an empowering prevention option for women and girls who are at high risk of HIV infection. Countries in sub-Saharan Africa have begun rolling out PrEP for these women. Experience shows that community-level stigma and misconceptions, such as when PrEP use is associated with sexual promiscuity, can undermine the introduction of PrEP, especially among adolescents and young adults.^{29,30} Conversely, uptake is high when women and girls are provided with accurate information about PrEP, including compelling explanations of its benefits, and when PrEP is framed as an empowering prevention method and a positive life choice.^{31,32}

48. Engaging men and boys in supporting, promoting and respecting gender equality, women's sexual and reproductive health and rights and decision-making, and in opposing gender-based violence, is another important aspect.

Empowering young people

49. Comprehensive sexuality education lays a basic foundation for empowering young people, especially adolescent girls and young women, and those from other key populations and vulnerable communities, and forms an important component of HIV prevention by providing those persons with an understanding of their health rights and allowing them to make informed choices, to have safe, productive and fulfilling lives, and to enjoy mutually respectful relationships.

50. Comprehensive sexuality education can also close persistent knowledge gaps about HIV and lead to better health outcomes. Urgent action is also needed to prevent violence against children and adolescents and support survivors of violence, drawing on the evidence of what works.

51. Providing access to adolescent-friendly services for HIV testing and treatment is critical, including social support to help adolescents make informed decisions about their care and to address difficult issues, such as disclosure and peer pressure. Evidence from a study in South Africa shows that layering combinations of interventions improves treatment adherence among adolescents. Non-adherence to

²⁵ Andrew Gibbs, Jessica Jacobson and Alice Kerr Wilson, "A global comprehensive review of economic interventions to prevent intimate partner violence and HIV risk behaviours", *Global Health Action*, vol. 10, supp. No. 2 (2017).

²⁶ Eleanor Maticka-Tyndale and Jessica Penwell Barnett, "Peer-led interventions to reduce HIV risk of youth: a review", *Evaluation and Program Planning*, vol. 33, No. 2 (May 2010).

²⁷ Sandra I. McCoy, Rugare A. Kangwende and Nancy S. Padian, "Behavior change interventions to prevent HIV infection among women living in low- and middle-income countries: a systematic review", *AIDS and Behavior*, vol. 14, No. 3 (June 2010).

²⁸ Jenevieve Mannell and others, "Why interventions to prevent intimate partner violence and HIV have failed young women in southern Africa", *Journal of the International AIDS Society*, vol. 22, No. 8 (August 2019).

²⁹ K. Ortblad and others, "PrEP users perceive high community-level PrEP stigma in Kenya", in *International AIDS Society, IAS 2019: Abstract Book* (2019).

³⁰ Daisy Maria Machado, Alexandre Machado de Sant'Anna Carvalho and Rachel Riera, "Adolescent pre-exposure prophylaxis for HIV prevention: current perspectives", *Adolescent Health, Medicine and Therapeutics*, vol. 8 (2017).

³¹ Connie L. Celum and others, "HIV pre-exposure prophylaxis for adolescent girls and young women in Africa: from efficacy trials to delivery", *Journal of the International AIDS Society*, vol. 22, supp. No. 4 (July 2019).

³² Connie L. Celum and others, "Adherence 3 months after PrEP initiation among young African women" in a poster presented at the 2019 Conference on Retroviruses and Opportunistic Infections, Seattle, Washington, March 2019.

antiretroviral therapy stood at 18 per cent for adolescents (aged 10–19) living with HIV who received food security assistance, support from parents or caregivers and attended an HIV support group, compared with 54 per cent for adolescents who had none of those social protections.³³

52. Removal of age-of-consent barriers also improves service coverage. HIV testing among girls aged 15 to 18 is nearly 50 per cent higher in countries in which the age of consent is under 15 years, compared with countries where the age of consent is above the age of 16.³⁴

Reaching people most in need and delivering transformative results through comprehensive, multisectoral and community-led approaches

53. Experience has shown that the provision of services tailored by and for key and other affected populations, supported by structural changes that improve human rights protections, gender equality and socioeconomic conditions, is a winning formula across geographical, cultural and epidemic settings.

54. Getting on track to achieve a 90 per cent reduction in HIV infections by 2030 therefore requires making combinations of prevention options available and accessible in ways that are tailored to fit the different needs and realities of the people at highest risk of infection in different settings around the world. Offering a range of HIV testing options, including point-of-care early infant diagnosis, self-testing, community-based testing and index testing, results in earlier diagnosis, treatment initiation and viral suppression, which are important both for the health of people living with HIV and for efforts to prevent the spread of the virus.

55. The meaningful engagement and empowerment of communities is a crucial step. Among gay men and other men who have sex with men, community-led support has proven highly effective in promoting safer sex, popularizing the use of PrEP, advocating its use, increasing testing rates of HIV and sexually transmitted infections and supporting treatment adherence.^{35,36} Data also indicate that adolescents are less likely to drop out of care when they receive peer support; in East and Southern Africa, adolescents who received peer support had viral suppression rates seven times higher than the average regional rate.³⁷

56. As well as playing a critical role in service delivery, community organizations are at the vanguard of efforts to change laws that criminalize key populations and discriminate against people living with HIV. As the eyes and ears of the AIDS response, they play a critical role in holding decision makers to account and demanding political leadership.

³³ Lucie D. Cluver and others, “Achieving equity in HIV-treatment outcomes: can social protection improve adolescent ART-adherence in South Africa?”, *AIDS Care*, vol. 28, supp. No. 2 (2016).

³⁴ Britt McKinnon and Ashley Vandermorris, “National age of consent laws and adolescent HIV testing in sub-Saharan Africa: a propensity source-matched study”, *Bulletin of the World Health Organization*, vol. 97, No. 1 (January 2019).

³⁵ James Stannah and others, “HIV testing and engagement with the HIV treatment cascade among men who have sex with men in Africa: a systematic review and meta-analysis”, *The Lancet: HIV*, vol. 6, No. 11 (November 2019).

³⁶ Syliva Shangani and others, “Effectiveness of peer-led interventions to increase HIV testing among men who have sex with men: a systematic review and meta-analysis”, *AIDS Care*, vol. 29, No. 8 (2017).

³⁷ D. Mark and others, “The power of peers: multi-country analysis of adolescent viral suppression in sub-Saharan Africa”, 2018.

Maximizing the impact of investments in the HIV response

57. Since the early years of the AIDS response, a powerful combination of civil society activism and political leadership has mobilized levels of financial resources that are unprecedented for a public health issue: between 2000 and 2018, a total of \$168 billion (unadjusted for inflation) was invested in the AIDS response in sub-Saharan Africa alone.

58. These investments have done much more than prevent HIV infections and AIDS-related deaths. The AIDS response has advanced issues such as the right to health, gender equality and social protection, as well as addressing social norms, social exclusion and legal barriers to health and development. HIV funding has also contributed to the strengthening of wider health systems in many countries by providing training for health workers, strengthening health information and laboratory systems, improving procurement and supply chain management systems and building stronger community responses, including through mobilization of community health workers, task shifting and the promotion of a more integrated and people-centred service delivery.³⁸

59. In Zambia, for example, an HIV grant from the Global Fund has supported the integration of cervical cancer and HIV services, resulting in expanded access to and coverage of screening, early detection and the treatment of pre-cancerous lesions. The Global Fund encourages countries to address overarching health system weaknesses and build resilient and sustainable systems for health within the context of their applications for grants focused on ending HIV, tuberculosis and malaria.³⁹ According to an independent evaluation, \$5.8 billion in funding under the Global Fund's new funding model introduced in 2014 has been spent on resilient and sustainable systems for health, equating to 27 per cent of the Global Fund's total investment of \$21.4 billion.⁴⁰

60. PEPFAR, which is by far the largest bilateral provider of financing for AIDS responses in low- and middle-income countries, has invested over \$10 billion in strengthening health systems, including \$393 million in 2019 on an array of activities, such as supporting data systems and data use and strengthening laboratory and supply chain management systems.⁴¹ Those investments by the Global Fund and PEPFAR accelerate AIDS responses and the progress made towards universal health coverage, as well as helping countries to prepare for emerging threats to global health security.

61. Nevertheless, international and domestic investments in the AIDS response do not match global commitments. In 2016, the General Assembly agreed to a steady expansion of investment in the AIDS responses of low- and middle-income countries, increasing to at least \$26 billion by 2020, which is the amount required to reach the targets agreed upon in the Political Declaration on HIV and AIDS. An increase in the availability of financial resources for AIDS responses between 2016 and 2017 suggested that the world was making good on its commitment. Unfortunately, in 2018, investments in low- and middle-income countries decreased by \$900 million to \$19 billion (in constant 2016 United States dollars) (see figure VIII).

62. Additional efforts are also needed to improve impact through greater efficiency, innovation and integration. Notable progress has been made in some countries, but too often efforts remain episodic.

63. Progress made in combating the epidemic can be tracked closely with the amount invested in national AIDS responses and the effectiveness thereof. Where

³⁸ John Palen and others, "PEPFAR, health system strengthening, and promoting sustainability and country ownership", *Journal of Acquired Immune Deficiency Syndrome*, vol. 60, supp. No. 3 (August 2012).

³⁹ The Global Fund, "Building resilient and sustainable systems for health: information note", 23 August 2019.

⁴⁰ The Global Fund, "Technical Evaluation Reference Group: position paper – thematic review on resilient and sustainable systems for health", July 2019.

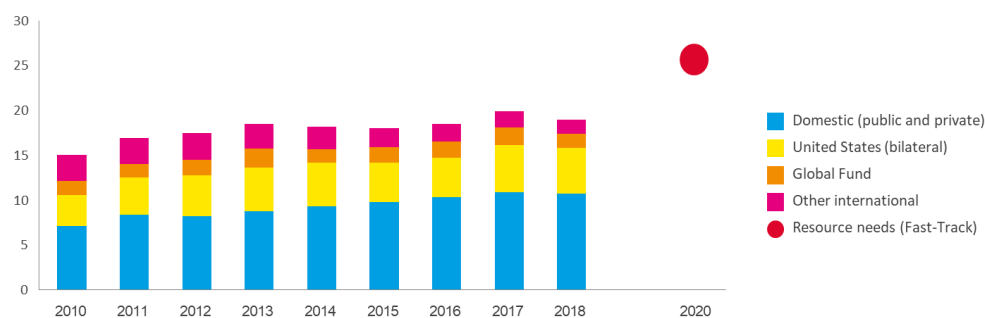
⁴¹ Data provided to UNAIDS by PEPFAR on 19 February 2020.

funding is available and utilized effectively, results are evident. For example, in East and Southern Africa, where expenditures per person living with HIV have been included in the region's 2020 resource needs estimates, reductions in HIV infections and AIDS-related deaths have been more rapid than in other regions.

Figure VIII

HIV resource availability in low- and middle-income countries, in constant 2016 United States dollars, by source of funding, 2010–2018 and 2020 target

(Billions of United States dollars)



Source: UNAIDS resource availability and needs estimates, 2019.

64. The encouraging international commitments made during the replenishment of the Global Fund for its 2020–2022 funding cycle and the extension of PEPFAR until at least 2023 provide hope that HIV investments can get back on track. However, these commitments alone are insufficient. A failure to dedicate the domestic and international resources required to reach the 2020 targets set by the General Assembly would severely threaten efforts to end the AIDS epidemic by 2030.

Preparing the next phase of the AIDS response

65. The global fight against HIV is far from won: more than 13 million people living with HIV are waiting for treatment and the number of new HIV infections each year is more than three times the 2020 target of fewer than 500,000. The international community must push forward with renewed energy, uniting behind a clear agenda for the next phase of the global AIDS response. In 2020, UNAIDS is working with Member States, civil society and other partners to review progress, calculate targets for 2025 and update the global AIDS response strategy in order to achieve those targets.

66. A process for developing 2025 targets was launched in mid-2018 under the guidance of the UNAIDS Programme Coordinating Board. Technical consultations have produced compelling results, including in-depth analyses of what is working and what is not working.

67. Greater attention has also been given to efforts to integrate the delivery of HIV services and other services needed by each population. For example, the integration of services relating to HIV and to sexual and reproductive health and rights can ensure that adolescent girls and young women are reached more efficiently by such services, while HIV and tuberculosis service integration is needed for many people living with HIV; and the integration of HIV services and opioid substitution therapy has been shown to improve HIV testing and treatment rates among people who inject drugs.

68. The new targets for 2025 will help to guide countries towards people-centred approaches. A revised UNAIDS strategy will map out the pathway to achieving the 2025 targets and ending the AIDS epidemic by 2030. The process for updating the strategy will be data-driven and consultative, involving ministries of health, finance and gender, parliamentarians and civil society, including people living with, at risk of and affected by HIV, young people, faith-based organizations, scientists and the private sector.

V. Recommendations

69. The following recommendations are made to Member States in order to help them build upon successes, address challenges that slow progress, achieve the 2020 targets and set an agenda for the next five years that guides the world towards ending the AIDS epidemic by 2030 and contributes to the achievement of universal health coverage and other targets and goals of the 2030 Agenda.

Recommendation 1: address inequality that lies at the heart of disparities in progress

70. Member States are urged to:

(a) Address the deep inequalities that are slowing progress in the fight against HIV, including harmful gender norms, economic inequality and discrimination in health-care, education, workplace, legal and justice, family and community, and emergency and humanitarian settings;

(b) Adopt people-centred HIV response strategies, including differentiated models of service delivery that provide high-quality combinations of prevention options, HIV testing and antiretroviral therapy at scale in ways that fit the different needs and realities of the people at highest risk of infection and people living with HIV and achieve coverage levels in line with global targets;

(c) Ensure that all young people, in particular girls, can stay in school, and that schools provide high-quality comprehensive education on health rights, incorporating issues of gender and violence;

(d) Redouble efforts to establish enabling legal and policy environments that eliminate the stigmatization and discrimination of people living with HIV and key and vulnerable populations and that enable health and HIV services to reach them, including the removal of restrictions to adolescents' access to essential health and HIV services. The Global Commission on HIV and the Law has set out in detail measures that should be undertaken to ensure effective and sustainable health responses that are consistent with universal human rights obligations.

Recommendation 2: leverage the opportunities arising from the twenty-fifth anniversary of the adoption of the Beijing Declaration and Platform for Action to address gender inequalities that contribute to the increased vulnerability of women and girls to HIV

71. Member States are urged to:

(a) Capitalize on the twenty-fifth anniversary of the adoption of the Beijing Declaration and Platform for Action to promote gender equality and ensure that a full understanding of the gender dimensions of HIV, as well as the social drivers and barriers to health for all women and girls, guides progress and reshapes practices, policies and institutions. The world needs a feminist approach to HIV that prioritizes gender equality, builds the empowerment of women and girls and transforms the health and development agenda for women and girls and all key populations;

(b) Ensure that women and girls everywhere can exercise their rights and are empowered to protect themselves against HIV and that all women and girls living with HIV have access to testing and treatment services that are responsive to their needs. Efforts to prevent gender-based violence should start early in order to enable girls and boys to question and challenge prevailing gender norms that justify violence against women. Interventions for preventing intimate partner violence and HIV must

also be developed jointly with young people and men in a genuinely participatory process of research, design and implementation;

(c) Accelerate the reform and enforcement of laws to uphold women's human rights, backed by adequate funding and strengthened institutions. Awareness-raising, community mobilization and legal literacy should accompany legislative changes. Women must know their rights, not least in relation to health and HIV, know how to seek redress and have access to legal aid and justice when their sexual and reproductive health and rights are violated;

(d) Improve the integration of sexual and reproductive health services, including contraception and testing, prevention and care options for HIV and sexually transmitted infections, and strengthen community-level prevention outreach for both women and men. There also remains an urgent need for a broader range of effective HIV prevention options and medical innovations for women, especially for adolescent girls and young women who are at high risk of HIV infection.

(e) Update policies and programmes involving men and boys to leverage all opportunities for undoing harmful masculinities, ending impunity and stopping gender-based violence.

Recommendation 3: close the financing and leadership gap and deliver comprehensive high-quality AIDS responses

72. Member States are urged to:

(a) Optimize resource allocation, close the funding gap and achieve the 2020 target of at least \$26 billion per year in overall financial investments in the AIDS responses of developing countries. Increased investments are needed in combination HIV prevention, testing, linkage and retention in care; in addressing co-morbidities and co-infections; and in social enablers, such as advocacy, community and political mobilization, community monitoring, public communication and outreach programmes that ensure that no one is left behind;

(b) Make sustainable investments in high-quality, differentiated and community-led services that respond to the lived experiences of people in need (including women and girls, key populations and people living with HIV) and recognize the key role of peer-to-peer counsellors, community health workers, door-to-door service providers, grass-roots activists and networks of people living with, at risk of and affected by HIV;

(c) Increase and sustain investment in the leadership, involvement and empowerment of communities of people living with, at risk of and affected by HIV. Communities are calling for legal and policy reforms that enable equitable access to prevention, treatment and social protection services, free from stigma, for all those who are in need.

Recommendation 4: engage in efforts to set ambitious 2025 targets and update the global AIDS response strategy

73. Member States are urged to renew their commitments to and accelerate the HIV response towards the shared goal of ending the AIDS epidemic by 2030, including by working with UNAIDS, civil society and other partners to establish ambitious, people-centred targets for 2025 and to update the global AIDS response strategy to achieve those targets.