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

Ensuring an equitable response to end the AIDS pandemic and accelerate progress for global health and the Sustainable Development Goals

Report of the Secretary-General*

Summary

As mandated in the Declaration of Commitment on HIV/AIDS, adopted by the General Assembly in its resolution S-26/2, and the Political Declarations on HIV and AIDS: Ending Inequalities and Getting on Track To End AIDS by 2030, adopted by the Assembly in its resolution 75/284 of 8 June 2021, the present report reviews progress towards realizing the commitments set out in the 2021 Political Declaration on HIV and AIDS in 2021–2022.

Through the global AIDS response, remarkable gains have been made towards achieving target 3.3 under Sustainable Development Goal 3, which is to end AIDS as a public health threat by 2030. The number of AIDS-related deaths has declined by 68 per cent since it peaked in 2004 and the number of new infections has declined by more than 50 per cent since 1996. The strongest progress was in regions with high burdens of HIV, across a range of income levels extending from high-income to middle- and low-income countries. This is a testament to the power of strong political commitment, global solidarity, evidence-driven strategies and mutually supportive partnerships between affected communities and public authorities. These gains and the health and community systems that are being strengthened are yielding wider health, economic and developmental dividends, which are accelerating progress towards 10 other Sustainable Development Goals.

The remarkable gains, however, are not reaching everyone, everywhere. Despite progress, AIDS, which claimed one life every minute in 2021, remains the fourth leading cause of death in Africa. Some earlier gains in action against HIV have stalled and the overall pace of progress in ending the AIDS pandemic is slowing, owing to faltering political will, funding constraints, fragile public health systems and a failure to confront the injustices and inequalities that fuel the pandemic.

* The present report was submitted late owing to delays in the approval process.

These inequalities include the disproportionate impact of the AIDS pandemic on women, especially adolescent girls and young women, in Eastern, Southern, West and Central Africa, the regions with the highest burden. HIV-related stigma, discrimination and violence remain alarmingly common. Many underperforming HIV programmes, which lack the services and enabling environments needed to turn the tide against AIDS, are in places where the pandemic is concentrated among key populations. Children living with HIV are still poorly served and large numbers of men are missing out on life-saving HIV testing and treatment services. Urgent action is needed to remove these barriers so that the world can achieve the HIV targets set out in the 2021 Political Declaration on HIV and AIDS and regain the momentum required to end the AIDS pandemic as a public health threat by 2030.

Underpinning the accomplishments to date in action against AIDS is a commitment to universality, equity and inclusiveness, principles that are at the heart of the Sustainable Development Goals and Our Common Agenda and crucial for achieving pandemic preparedness. Member States are urged to act with urgency to accelerate and enhance the global AIDS response and to consider the recommendations presented in this report on (a) addressing the gaps in HIV prevention, testing and treatment services and societal enablers; (b) ensuring adequate and equitable funding; (c) implementing evidence-based and data-driven programmes; (d) supporting community-led responses; (e) building on HIV models and resources for broader health and development outcomes; (f) achieving equitable access to medicines and other health technologies; and (g) enhancing global partnerships and solidarity.

I. Overview of progress towards ending the AIDS pandemic by 2030[1]

1. The progress of the global AIDS response has been remarkable. Through the global roll-out of HIV treatment, an estimated 16.5 million AIDS-related deaths were averted between 2001 and 2020,[2] while through increased condom use almost 120 million HIV infections have been averted since 1990.[3] The latest data from the Joint United Nations Programme on HIV/AIDS (UNAIDS) show that new HIV infections and AIDS-related deaths have continued to decrease, bringing the AIDS response closer to achieving target 3.3 under Sustainable Development Goal 3 of ending AIDS as a public health threat by 2030. These gains and the health and community systems that are being strengthened are also yielding wider health, economic and developmental dividends which are accelerating progress towards other Sustainable Development Goals. Persistent challenges remain, however, and renewed commitment and focus are needed to reach the populations and places that are still being left behind.

2. In the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, adopted by the General Assembly in its resolution 75/284 of 8 June 2021, Member States committed to achieving global targets that would put the world on course to reach the landmark goal of ending AIDS by 2030, as set forth in target 3.3 under Sustainable Development Goal 3. The core targets require a reduction of the number of annual global new HIV infections to fewer than 370,000 and the number of AIDS-related deaths to under 250,000 by 2025. Reaching those targets requires robust health programmes and purposeful actions to eliminate the inequalities that deprive people of their right to health. This focus on inequalities and people-centred actions echoes the emphasis placed in Our Common Agenda on inclusive, rights-based and equity-driven approaches to achieving the Sustainable Development Goals overall.

3. The estimated number of new HIV infections arising globally in 2021 (1.5 million (1.1–2.0 million)) was smaller than at any point since the late 1980s and almost one third (32 per cent) the number in 2010 (figure I). Progress is particularly strong in regions with the highest HIV burden: sub-Saharan Africa[4] has achieved a 44 per cent decline in annual new HIV infections since 2010, the steepest reduction in the world. Progress is slower in other regions, where most new infections affect key populations whose members are subjected to criminalization, violence and social exclusion, such as gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and people in prisons and other closed settings. Eastern Europe and Central Asia are experiencing steep increases in the

[1] Unless otherwise stated, data provided are epidemiological estimates of the Joint United Nations Programme on HIV/AIDS (UNAIDS) for 2022 and data reported by countries to UNAIDS through its annual Global AIDS Monitoring exercise.

[2] UNAIDS, "Global roll-out of HIV treatment has saved millions of lives", update (Geneva, 6 September 2021). Available at www.unaids.org/en/resources/presscentre/featurestories/2021/september/20210906_global-roll-out-hiv-treatment.

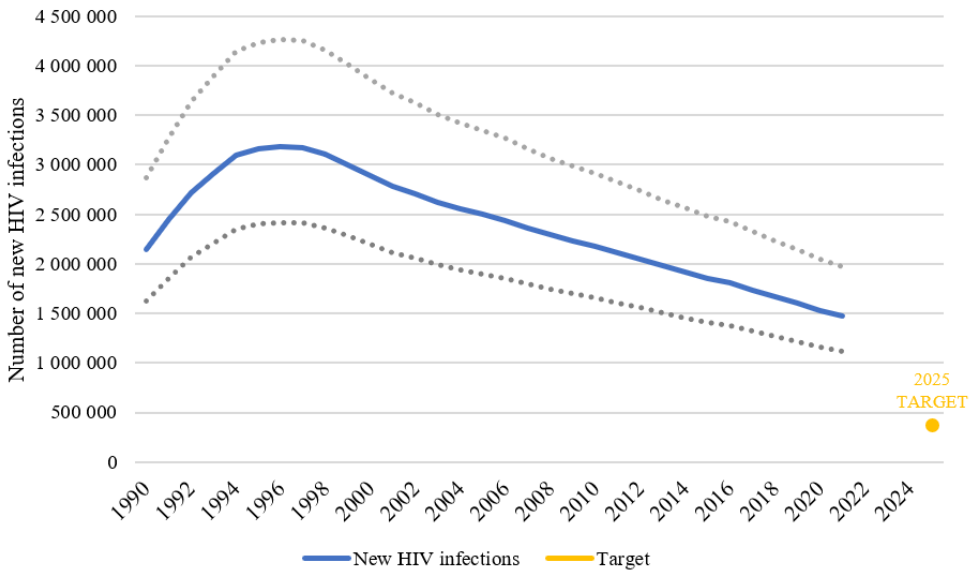
[3] John Stover and Yu Teng, "The impact of condom use on the HIV epidemic (version 2)", *Gates Open Research*, vol. 5, No. 91 (11 February 2022).

[4] The World Bank defines the sub-Saharan regions as including the following countries: Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Tonga, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

number of annual HIV infections (up 45 per cent since 2010), as are the Middle East and Northern Africa, while earlier declines in Latin America and the Caribbean have stalled. In Asia and the Pacific, while the number of new HIV infections has fallen steeply in many countries, there has been an alarming rise in the number of those infections in others.

4. Extensive provision of antiretroviral therapy to pregnant and breastfeeding women living with HIV continues to reduce new child infections, positively impacting women and children in sub-Saharan Africa who account for the majority of new vertical infections (about 85 per cent). The number of new vertical infections among children (aged 0–14 years) declined globally by 52 per cent since 2010, to 160,000 (110,000–230,000), the lowest figure since the 1980s. Sixteen countries and territories have succeeded in eliminating new HIV infections among children and several others are on course to reach the same goal in coming years.

Figure I
New HIV infections, global, 1990–2021, and 2025 target



Source: UNAIDS epidemiological estimates, 2022 (https://aidsinfo.unaids.org/).

5. However, the overall pace at which new infections are decreasing must accelerate to end the AIDS pandemic by 2030. Multiple factors, including stigma and discrimination and social, economic and gender inequalities, continue to put key populations everywhere and women and adolescent girls especially in sub-Saharan Africa at heightened risk of HIV infection. The last decade has seen considerable pushback which has reversed some of the key gains of the feminist and lesbian, gay, bisexual, transgender and intersex movements. While the coronavirus disease (COVID-19) pandemic exposed and intensified existing inequalities, it also highlighted the need for a diverse, enabled and active civil society.[5]

6. Provision of effective HIV treatment to increasing numbers of people living with HIV has reduced global AIDS-related deaths by 52 per cent since 2010 (from 1.4 million (1.1 million–1.8 million) to 650,000 (510,000–860,000) in 2021)

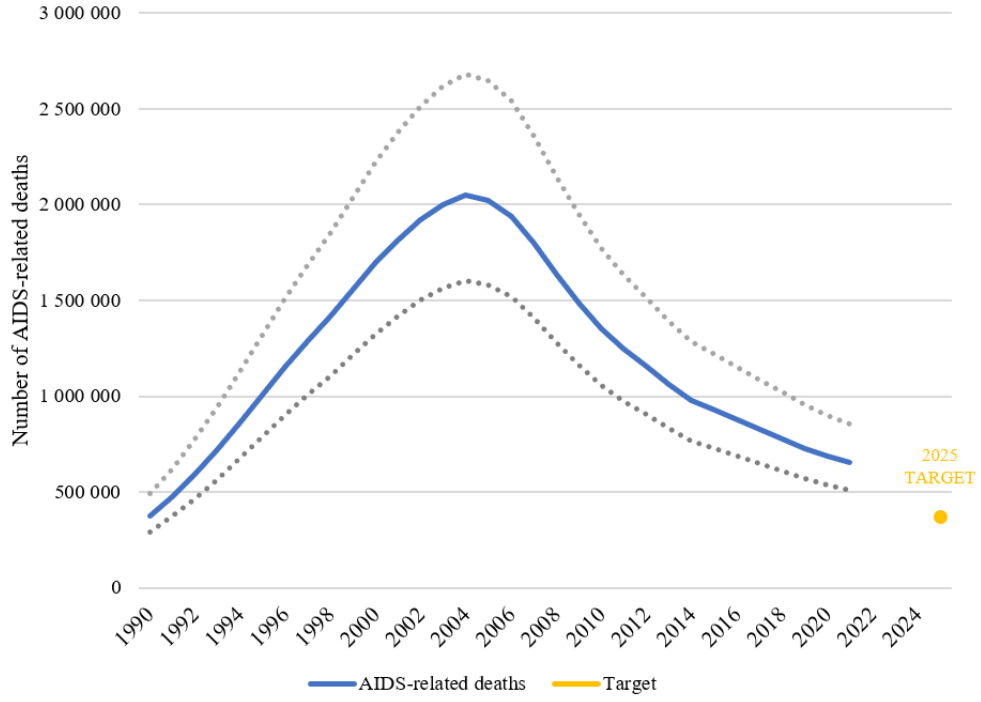
[5] CIVICUS, *2021 State of Civil Society Report*, overview (Johannesburg, South Africa, 2021). Available at https://civicus.org/state-of-civil-society-report-2021/wp-content/uploads/2021/05/CIVICUS-State-of-Civil-Society-Report-ENG-OVERVIEW.pdf.

(figure II). Driving that achievement is the massive expansion of antiretroviral therapy in sub-Saharan Africa and Asia and the Pacific. In 2021, the AIDS pandemic claimed fewer lives in those regions than at any point since the early 1990s.

7. Not everyone is benefiting from these gains, however. Even though the number of AIDS-related deaths among children (aged 0–14 years) were reduced by 59 per cent in 2010–2021, the pandemic still claimed the lives of 98,000 children (67,000–140,000) in 2021, owing largely to a failure to reach some 800,000 (640,000–990,000) children living with HIV to provide life-saving treatment. Success in reaching women living with HIV for testing and treatment reduced the numbers of adult women dying of AIDS-related causes to 240,000 (180,000–320,000) in 2021, almost 56 per cent fewer than in 2010. In the same period, AIDS-related deaths decreased by 45 per cent among adult men, of whom an estimated 320,000 (250,000–430,000) died in 2021.

8. These and other disparities mean that, despite the progress made, AIDS claimed one life every minute in 2021. Moreover, it remains the fourth leading cause of death in Africa. The reach of HIV testing and treatment services must increase so that all persons living with HIV are diagnosed, are rapidly linked to treatment and are able, through reduction of their viral loads to the requisite level, to protect their health and remove the chance of transmitting HIV. Equitable HIV testing and treatment are essential for achieving epidemic control.

Figure II
AIDS-related deaths, global, 1990–2021, and 2025 target



Source: UNAIDS epidemiological estimates, 2022 (https://aidsinfo.unaids.org/).

9. Policy and structural barriers continue to hinder access to HIV services. Some earlier gains in action against HIV have stalled or been reversed owing to faltering political will, funding constraints, fragile public health systems and a failure to confront the intersecting inequalities that fuel the AIDS pandemic. Even though domestic resources for HIV increased by 49 per cent during the last decade, a 2 per cent annual decrease was registered in 2021 and the vulnerable macroeconomic

situations in many countries challenge their ability to sustain an upward trend. Many underperforming HIV programmes are in places where the pandemic is concentrated among key populations, but which lack the services and enabling environments needed to turn the tide against AIDS. These obstacles must be removed if the world is to achieve the HIV targets for 2025 and target 3.3 under Sustainable Development Goal 3 by 2030.

10. Missing those targets will carry huge costs. Given current trends, at least 1.2 million people will acquire HIV in 2025 (three times the target) and millions of people living with HIV will require lifelong treatment and care, increasing the cost of HIV responses far into the future and putting further strain on health systems and communities. Unless gaps in testing and treatment are removed, some 460,000 people are projected to die of AIDS-related causes globally in 2025, a figure that is 80 per cent greater than the target.

11. Progress towards ending AIDS as a public health threat is linked integrally to broader efforts to end poverty and hunger, close inequality gaps, build resilient institutions and functional partnerships and build resilient and sustainable communities. Examples of the impact of the HIV response on other Sustainable Development Goals include a 67 per cent reduction in tuberculosis-related deaths among people living with HIV (Goal target indicator 3.3.2), prevention of vertical HIV transmission programmes as an important contributor to the reduction in child mortality since 2000 (Goal target 3.2),[6] and the translation of country capacity to monitor the HIV epidemic into COVID-19 pandemic preparedness (Goal target 17.18).[7]

II. Coverage and impact of HIV services

12. Achieving the targets set out in the 2021 Political Declaration on HIV and AIDS and the Global AIDS Strategy 2021–2026 will put countries on track to end AIDS by 2030 and will contribute to progress towards a range of other Sustainable Development Goals (figure III). The headline targets demand more than overall progress: they are to be achieved within all geographical settings, subpopulations and age groups.

[6] Jamie Perin and others, “Global, regional, and national causes of under-5 mortality in 2000–19: an updated systematic analysis with implications for the Sustainable Development Goals”, *Lancet Child and Adolescent Health*, vol. 6, No. 2 (February 2022), pp. 106–115.

[7] Wafaa M. El-Sadr, “What one pandemic can teach us in facing another”, *AIDS*, vol. 34, No. 12 (1 October 2020), pp. 1757–1759.

Figure III
The AIDS response advances at least 10 Sustainable Development Goals

A. Equitable access to HIV services and solutions

2025 target: 95 per cent of people at risk of HIV infection should have access to effective combination prevention options

13. Countries with diverse epidemics and development levels are combining proved prevention options, including HIV treatment as prevention, to achieve steep reductions in new HIV infections. They are focusing services to have maximum impact, integrating community-led interventions with public health programmes and reducing barriers (such as discriminatory laws and policies, gender and other inequalities, human rights violations and institutional weaknesses) which hold back progress. The 10 core actions outlined in the HIV 2025 prevention road map: getting on track to end AIDS as a public health threat by 2030[8] emphasize high-impact prevention programmes for key and priority populations, backed by actions to ensure wide availability of proved HIV prevention tools alongside new ones (such as vaginal, oral and long-acting injectable pre-exposure prophylaxis).

14. Diverse countries have reduced adult HIV infections markedly through combination prevention programmes, including Côte d'Ivoire and Zimbabwe, which reduced new HIV infections among adults by over 75 per cent and 70 per cent, respectively, in 2010–2021. Nonetheless, important HIV prevention services, particularly for key populations, are unevenly accessible or absent. For example, coverage reported in recent years of combination HIV prevention among gay men and other men who have sex with men and transgender people was low in every region.

15. Success in HIV prevention occurs when community-led organizations are closely engaged in providing the services, people are protected against violence and discrimination, and punitive laws and policies are absent or not enforced. While coverage and use of combination HIV prevention among sex workers are extensive in some countries, with eight countries in 2021 reporting above 95 per cent coverage

[8] Geneva, UNAIDS, 2022. Available at www.unaids.org/sites/default/files/media_asset/prevention-2025-roadmap_en.pdf.

of condom use at last sex, punitive approaches, human rights violations, discrimination and a shrinking civic space hinder HIV prevention options and services for key populations in many places. The coverage and use of combination HIV prevention among gay men and other men who have sex with men, for example, ranged from 27 per cent in Asia and the Pacific to 53 per cent in West and Central Africa.

16. Condoms are inexpensive and cost-effective HIV prevention method. Gaps persist, however, in their availability and use and gaps are widening in several countries owing to reduced investments in and defunding of social marketing programmes. Discrimination, social stigma and hostile policies further limit the potential of condoms to prevent new HIV infections, especially among key populations.

17. Voluntary medical male circumcision significantly reduces the risk among heterosexual males of acquiring HIV infection through sexual intercourse. Voluntary medical male circumcision can contribute greatly to population-level HIV prevention in the 15 priority countries where an additional 12 million procedures are recommended overall by 2025. Kenya has reached the 90 per cent coverage target and other countries (Ethiopia and the United Republic of Tanzania) are within reach of it.

18. Pre-exposure prophylaxis has a huge potential to reduce HIV infections among people who are at substantial risk of acquiring HIV, including key populations, and women and adolescent girls in Eastern and Southern Africa. High coverage and use of oral pre-exposure prophylaxis have already led to marked reductions in new HIV infections among gay men and other men who have sex with men in high-income settings (notably in Australia, the United Kingdom of Great Britain and Northern Ireland and some cities in the United States of America). Globally, the use of oral pre-exposure prophylaxis has continued to increase, with approximately 1.6 million people in 86 countries having received pre-exposure prophylaxis at least once in 2021 (almost twice as many as in 2020). While access and use have increased in some countries in Africa and Asia, progress is much slower in other regions. Multimonth dispensing, the use of virtual service platforms and bigger roles for community-led organizations can increase use of this powerful prevention tool.

19. The positive public health impact of comprehensive harm reduction, including through needle and syringe programmes, opioid agonist therapy and overdose treatment, is well established in the scientific literature. Harm reduction services were reported in 87 countries in 2021 but mostly on a small scale and often in the context of counterproductive law enforcement practices. Since 2017, only 18 of the 40 reporting countries have achieved the 90 per cent target on coverage of safe injecting practices. Coverage of opioid agonist therapy has remained low. In Asia and the Pacific and the regions of Eastern Europe and Central Asia, where injecting drug use is an important driver of national HIV epidemics, opioid agonist therapy reached less than 10 per cent of people who inject drugs.

20. The HIV-related needs of people in prisons and other closed settings continue to be neglected: in 2017–2022, only 7 countries had needle and syringe programmes and 27 provided opioid agonist therapy in prisons. Most of those programmes are small, with limited coverage. Much stronger political will is needed to apply a public health approach to drug use and dependence.

21. According to data of the United Nations Educational, Scientific and Cultural Organization (UNESCO), at least 85 per cent of 155 reporting countries have policies or laws for the provision of comprehensive sexuality education in schools.[9] However,

[9] UNESCO, *The Journey towards Comprehensive Sexuality Education: Global Status Report* (Paris, 2021).

owing to weaknesses in educational systems and resistance to curricula for comprehensive sexuality education in some places, those curricula are often taught poorly, leaving young people with incomplete and ambiguous information. Survey data from sub-Saharan Africa (2015–2020) show that only 38 per cent of youth (aged 15–24 years) had comprehensive knowledge about HIV.[10] The failure to provide young people with comprehensive sexuality education is denying them acquisition of the knowledge, attitudes and skills that can help them make sensible decisions about their sexual and reproductive lives and stay HIV-free.

2025 target: All pregnant and breastfeeding women living with HIV receive lifelong antiretroviral therapy, and 95 per cent of them are virally suppressed

22. Increased provision of antiretroviral therapy to pregnant and breastfeeding women living with HIV has reduced new HIV infections among children by half since 2010. About 81 per cent (63–97 per cent) of pregnant and breastfeeding women living with HIV were receiving antiretroviral therapy in 2021, up from 46 per cent in 2010.

23. Programmes for preventing vertical transmission of HIV, however, may be losing momentum, since their coverage has stagnated in recent years. This is especially worrisome in West and Central Africa, where programmes reached only 60 per cent (48–70 per cent) of pregnant or breastfeeding women living with HIV in 2021. Recovering momentum requires significant shifts in service delivery, including making integrated antenatal care and HIV services more accessible and convenient, especially for adolescent girls and young women who are stigmatized and marginalized. Programmes also need to become more effective in supporting women's efforts to learn their HIV status and start antiretroviral therapy, when needed.

2025 target: 34 million people on HIV treatment

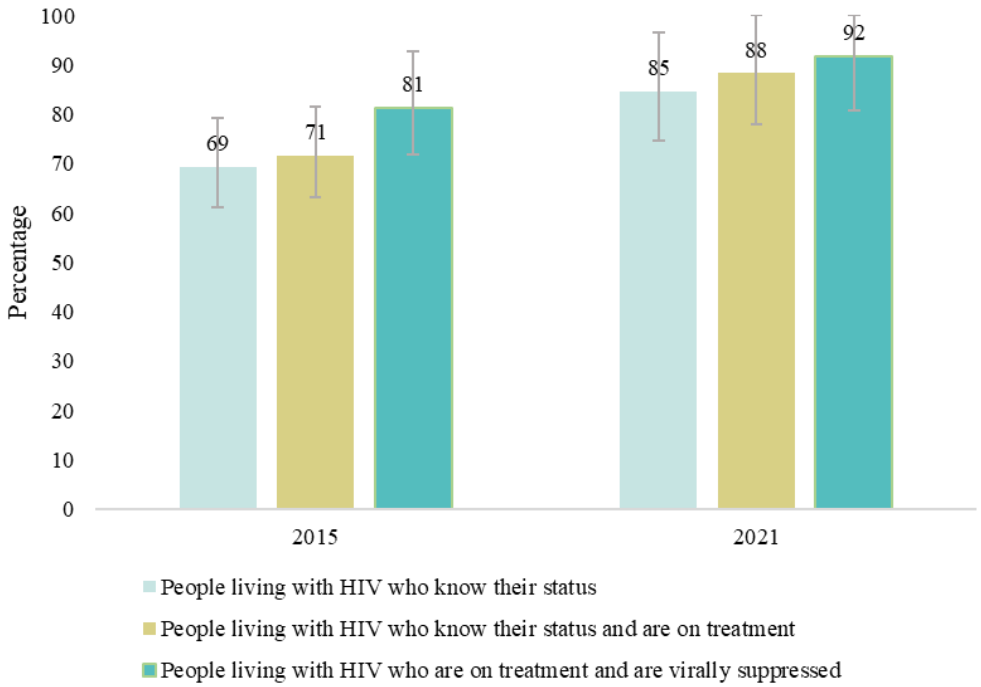
24. Two decades ago, life-saving HIV treatment was almost unobtainable in low- and middle-income countries. In 2021, 28.7 million people living with HIV, representing 75 per cent (66–85 per cent) of the global total, were receiving antiretroviral therapy. This ranks among the great public health achievements of recent times. An additional 1.5 million people received HIV treatment both in 2020 and in 2021. If that rate can be maintained, the global target of having 34 million people on HIV treatment by 2025 will be reached, making the 2030 goal achievable.

Achieve the 95–95–95 testing, treatment and viral suppression targets within all demographic groups and geographical settings

25. There were continued gains in diagnosing and treating people living with HIV in 2021. The available data show that at least 12 countries (9 in sub-Saharan Africa) achieved the 90–90–90 target, putting the 95–95–95 target within their reach. Globally, in 2021, approximately 85 per cent of people (75–97 per cent) living with HIV knew their HIV status, 88 per cent of them (78–98 per cent) were receiving HIV treatment and 92 per cent of people on treatment (81–>98 per cent) were virally suppressed, a marked improvement since 2015 (figure IV).

[10] USAID, Demographic and Health Surveys (DHS) Program STATcompiler database. Available at www.statcompiler.com.

Figure IV
Progress towards the 95–95–95 targets, global, 2015 and 2021



Source: UNAIDS special analysis, 2022.

26. Progress towards the 95–95–95 targets is especially advanced in sub-Saharan Africa, home to two thirds of all people living with HIV, and in high-income countries. Even though the HIV burden is much lower, treatment coverage lags notably in Eastern Europe and Central Asia, and in the Middle East and Northern Africa, where only about half of the people living with HIV received antiretroviral therapy in 2021. Asia and the Pacific and Latin America and the Caribbean were also below the global average for HIV treatment coverage and viral suppression.

27. The biggest remaining gap involves diagnosing people living with HIV and linking them swiftly to treatment and care services. Globally in 2021, almost 6 million people (5.2 million–6.7 million) were unaware that they were living with HIV and were therefore not receiving treatment. Conventional testing methods are missing these people. Use of a wider range of testing approaches and tools, including HIV self-testing, community-based methods and partner-testing approaches, can narrow this gap substantially.

28. HIV programmes generally perform well at linking people diagnosed with HIV to treatment services and enabling them to keep taking antiretrovirals. While most people who start antiretroviral therapy successfully suppress their viral loads to undetectable and therefore untransmittable levels (92 per cent in 2021), there is still room for improvement, as about 2.4 million people were estimated not to have been virally suppressed at their last viral load test. To close this gap, differentiated services to support people's needs and improve retention in care are needed.

29. Furthermore, not everyone is benefiting equally from the expanded provision of HIV testing and treatment. In countries collecting the relevant data, approximately 1 in 4 key population members are not aware of their HIV status.

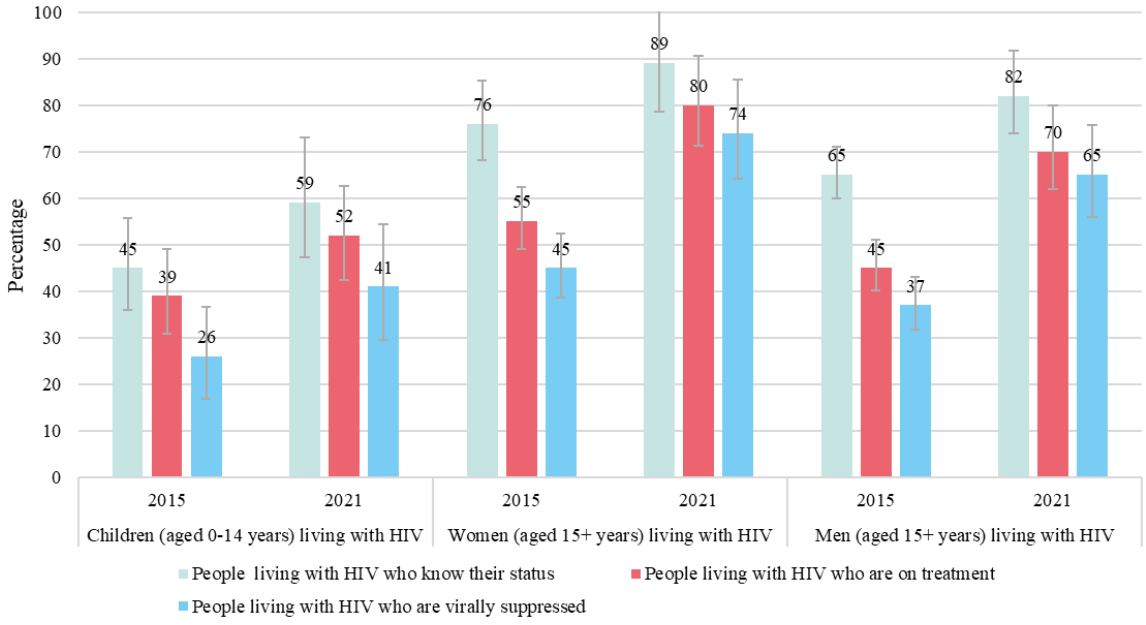
30. Other disparities require urgent action. Treatment coverage among children living with HIV remains far lower than coverage for adults, 52 per cent (42–65 per

cent) versus 76 per cent (67–87 per cent) in 2021 (figure V). This gap, which is widening, reflects partly the missed opportunities for diagnosing children living with HIV: more than 60 per cent of children not receiving HIV treatment are aged 5–14 years and were not diagnosed as infants. While wider adoption of point-of-care early infant diagnosis will help close this gap, additional efforts are needed to find the children living with HIV who were missed by infant testing. Moreover, the health outcomes of children who receive HIV treatment are worse than those of adults, owing partly to suboptimal paediatric HIV medicines and challenges related to care retention. Consequently, only 41 per cent of children living with HIV had suppressed viral loads in 2021, less than half the 2025 target of 86 per cent.

31. Men fare worse than women with respect to HIV testing and treatment and experience worse outcomes. This disparity has emerged in the past decade and is especially evident in sub-Saharan Africa. In 2021, 86 per cent (78–98 per cent) of adult men living with HIV in that region knew their HIV status, 74 per cent (67–84 per cent) were accessing treatment and 69 per cent (62–78 per cent) were virally suppressed, compared with, respectively, 92 per cent (84–>98 per cent), 83 per cent (76–93 per cent) and 77 per cent (70–86 per cent) of women. While harmful norms of masculinity explain those disparities partly, financial and other costs deter impoverished men from seeking health care. In addition, primary health-care services (including maternal care and childcare) are tailored to women of reproductive age and are suitable for providing them with HIV services. Similar entry points for men are not common.[11] Innovations for making HIV testing and treatment services more accessible to men are increasing, including workplace-based interventions, efforts to change social norms to increase service utilization, greater use of self-testing, flexible opening hours for clinics and provision of convenient HIV services at outpatient departments.

Figure V

HIV testing and treatment cascade, comparisons between children (aged 0–14 years), women (aged 15+ years) and men (aged 15+ years), global, 2015 and 2021



Source: UNAIDS special analysis, 2022.

[11] Morna Cornell and others, “HIV services in sub-Saharan Africa: the greatest gap is men”, *Lancet*, vol. 397, No. 10290 (5 June 2021), pp. 2130–2132.

32. Overcoming the remaining gaps in HIV testing and treatment is vital for breaking the cycle of HIV transmission and saving lives. Service delivery approaches must adapt to people's varied realities and needs and also focus on serving marginalized populations. The socioeconomic gaps in access to treatment, for example, are not being seen in countries where well-funded and well-managed treatment programmes focus on reaching the most vulnerable populations.

B. Breaking down barriers

2025 target: No more than 10 per cent of women, girls and people living with, at risk of and affected by HIV experience gender-based inequalities and sexual and gender-based violence

33. HIV programmes are most effective when people are free from violence, can make informed decisions on their sexual lives and can obtain the services and support that they need to stay healthy. Data from 156 countries indicate that an estimated 245 million women aged 15 years or over (10 per cent) who have ever been married or partnered experienced physical or sexual violence in the previous 12 months and that 641 million (26 per cent) have experienced such violence at least once in their lifetime.[12] Other survey data show that key populations, especially transgender people, sex workers and people who inject drugs, experience high levels of violence. Interventions focused on changing the social norms that perpetuate such violence must be implemented at a scale that ensures wide societal impact.

2025 target: Less than 10 per cent of countries have restrictive legal and policy frameworks which lead to the denial or limitation of access to services

34. Laws and policies that criminalize and permit the harassment of people living with HIV and key populations greatly increase the risk of HIV transmission and sabotage efforts to control the pandemic. A 2023 10-country study showed that HIV prevalence among gay men and other men who have sex with men was five times higher in countries that criminalize same-sex relationships than in non-criminalized settings.[13] Moreover, countries that have moved away from laws and policies that are harmful to people who use drugs and that have increased investment in harm reduction have reduced the number of new HIV infections and improved health outcomes.[14]

35. According to reporting of Member States during the 2022 UNAIDS Global AIDS Monitoring exercise, many countries continue to criminalize the use or possession of drugs, 153 countries criminalize some aspect of sex work, 67 countries

[12] See World Health Organization, *Violence Against Women Prevalence Estimates, 2018: Global, Regional and National Prevalence Estimates for Intimate Partner Violence against Women and Global and Regional Prevalence Estimates for Non-partner Sexual Violence against Women* (Geneva, 2021).

[13] Carrie E. Lyons and others, "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*, vol. 10, No. 3 (March 2023), pp. e186–e194.

[14] See UNAIDS, *Do No Harm: Health, Human Rights and the People Who Use Drugs* (Geneva, 2016), available at www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf; Global Commission on HIV and the Law, *Risks, Rights and Health* (New York, United Nations Development Programme, 2012) and the Supplement thereto (New York, UNDP, 2018); Kora DeBeck and others, "HIV and the criminalization of drug use among people who inject drugs: a systematic review", *Lancet HIV*, vol. 4, No. 8 (August 2017), pp. e357–e374; and Pieter Baker and others, "Policing practices and HIV risk among people who inject drugs: a systematic literature review", preprint with the Lancet, 12 June 2019.

criminalize consensual same-sex sexual relations, 20 countries criminalize transgender persons and 134 countries criminalize or otherwise prosecute HIV exposure, non-disclosure or transmission. There have been positive changes, however, with some countries repealing laws that criminalize consensual same-sex relations[15] and HIV transmission, exposure or non-disclosure.[16] Overall, however, the world must accelerate efforts to remove barriers to HIV prevention and treatment and the full realization of the right to health for all, without discrimination.

2025 target: less than 10 per cent of people living with, at risk of and affected by HIV experience stigma and discrimination

36. Discriminatory attitudes towards people living with HIV remain alarmingly common in all regions. Across 55 countries with recent survey data, a median of 59 per cent of people harboured discriminatory attitudes towards people living with HIV, suggesting that we are far from achieving the global targets on an enabling environment for the HIV response. In 11 countries, more than 75 per cent of those surveyed displayed discriminatory attitudes. Recent survey data show that more than 10 per cent of people living with HIV experienced stigma and discrimination in health-care settings in 16 of 22 countries. Members of key populations are especially affected: at least 38 per cent of countries with recent survey data reported that more than 10 per cent of respondents avoided health care owing to stigma and discrimination.

2025 target: 30 per cent of HIV testing and treatment services, 80 per cent of prevention services and 60 per cent of programmes to support the achievement of societal enablers are delivered by community-led organizations

37. The advantages of partnering with community-led organizations to deliver people-centred HIV services are increasingly recognized, including by both the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief. Progress towards the 30–80–60 targets is unclear, however, since few monitoring systems track the proportion of services and programmes delivered by community-led organizations.[17] Available research suggests that the work of community-led organizations is undermined by funding shortages, policy and regulatory hurdles, capacity constraints and crackdowns on civil society in many countries.

2025 target: 95 per cent of women and girls of reproductive age have their HIV and sexual and reproductive health service needs met

38. The ability to freely make decisions about one's sexual and reproductive health shapes women's prospects for living HIV-free lives. According to data from 64 countries, in 2022, a median 58 per cent of women (aged 15–49 years) who were in a union reported making their own informed decisions regarding sexual relations, contraceptive use and their own health. Decision-making power about one's own health care tends to be weakest among women and girls with the least education and lowest incomes.[18]

[15] UNAIDS and WHO, Laws and Policies Analytics data, 2021.

[16] UNAIDS, "HIV criminalization", human rights fact sheet (Geneva, 2021). Available at www.unaids.org/sites/default/files/media_asset/01-hiv-human-rights-factsheet-criminalization_en.pdf.

[17] UNAIDS and stakeholders are currently examining options for developing metrics for tracking progress towards the 30–80–60 targets.

[18] Demographic and Health Surveys, 2017–2021.

C. Well-resourced and integrated HIV responses

2025 target: Increase annual HIV investments in low- and middle-income countries to US$ 29 billion

39. Funding for HIV responses in low- and middle-income countries totalled US$ 21.4 billion in 2021, well below the target for 2025, with total resources for HIV programmes having dwindled slightly each year since 2017. While domestic sources accounted for 60 per cent of resources available for HIV responses in low- and middle-income countries in 2021, the earlier trend of marked increases has stalled. Several large bilateral donors have also scaled back their contributions. Were it not for stable bilateral financing from the United States of America, the largest single contributor to the global AIDS response, and Global Fund allocations, the shortfall would be considerably bigger.

2025 target: 90 per cent of people living with, at risk of and affected by HIV can access people-centred and context-specific integrated services for HIV and other health and social issues

40. Integration of tuberculosis and HIV services has expanded and services for HIV, syphilis, viral hepatitis and other sexually transmitted infections are also more functionally integrated with antenatal and postnatal services. In other areas, however, such as human papilloma virus vaccination coverage and cervical cancer screening and treatment, progress is too slow, especially in low-income countries. Further advances towards universal health coverage will add momentum to the integration of HIV services with a full range of health and social programmes that people need to protect their health and well-being. In many countries, while essential health benefit packages and national health insurance schemes have expanded service coverage, this has been primarily for HIV treatment, with less of a focus on HIV prevention and interventions for key and vulnerable populations. It is important to ensure that efforts to achieve universal health coverage include a focus on those populations. Some 90 per cent of essential health services can be delivered through primary health care.[19] At the high-level meeting, Member States can be encouraged to accelerate progress towards a truly universal health coverage, without discrimination, as well as to leverage universal health coverage platforms for accelerating progress towards Sustainable Development Goal 3, pandemic preparedness and broader sustainable development.

2025 targets: 90 per cent of people living with HIV receive preventive treatment for tuberculosis; reduce tuberculosis-related deaths among them by 80 per cent (against a 2010 baseline)

41. The annual number of people living with HIV who receive preventive treatment for tuberculosis rose from fewer than 30,000 in 2005 to 2.8 million in 2021. Between 2005 and the end of 2021, 16 million people living with HIV were initiated into tuberculosis preventive treatment. When measured against the 38 million people living with HIV, the target of 90 per cent is clearly not yet within reach.

42. Widening access to antiretroviral therapy and improvements in the integrated delivery of HIV-tuberculosis services have led to a steep drop in tuberculosis-related deaths among people living with HIV. There were an estimated 187,000 (158,000–218,000) tuberculosis-related deaths globally in 2021 among people living with HIV, a 67 per cent reduction since 2010. This suggests that the target of an 80 per cent reduction by 2025 may be within reach if the momentum achieved prior to the

[19] See www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

COVID-19 pandemic can be regained. Likely owing to failures in detecting and reporting tuberculosis among people with HIV, only 46 per cent of people living with HIV who developed tuberculosis in 2021 received antiretroviral therapy, the same level as in 2020.

2025 target: 45 per cent of people living with, at risk of or affected by HIV access at least one social benefit

43. Although social protection mechanisms have proliferated in many low- and middle-income countries over the past two decades, only about 47 per cent of the global population were effectively covered by at least one social protection benefit in 2020 and coverage in sub-Saharan Africa was at only 17 per cent.[20] Recent data indicate that social protection coverage among people living with, at risk of or affected by HIV is generally as low or lower than in the general population.[21] This insufficient coverage occurs despite strong evidence that well-funded and well-managed social protection programmes can help meet multiple needs of people who are impoverished and marginalized, including people living with, at risk of, or affected by HIV.[22]

2025 target: 90 people of people in humanitarian settings have access to integrated HIV services

44. The rapid growth in natural disasters and climate change-induced and/or conflict-related humanitarian emergencies is cause for great concern. In 2022, the number of people displaced by war, violence, persecution or human rights abuses exceeded 100 million for the first time.[23] A lack of available data hinders an up-to-date assessment of access to integrated HIV services among people in humanitarian settings. However, HIV funding requests to the Global Fund increasingly include programmes for both refugee and internally displaced persons, suggesting that this priority is receiving increased attention.[24]

III. Building blocks for success

45. The targets of the 2021 Political Declaration on HIV and AIDS and the goal of ending AIDS as a public health threat by 2030 can be achieved. A mere two decades ago, the AIDS pandemic seemed unstoppable. More than 2.5 million people were acquiring HIV and the pandemic was claiming 2 million lives per year. In parts of sub-Saharan Africa, the pandemic was reversing decades-long gains in life expectancy. Effective treatments were available only at prohibitive prices, limiting their use to the privileged few.

[20] International Labour Organization, *World Social Protection Report 2020–2022: Social Protection at the Crossroads – In Pursuit of a Better Future* (Geneva, 2021).

[21] David Chipanta and others, "Access to social protection by people living with, at risk of, or affected by HIV in Eswatini, Malawi, Tanzania, and Zambia: results from population-based HIV impact assessments", *AIDS and Behavior*, vol. 26, No. 9 (September 2022), pp. 3068–3078.

[22] International Labour Organization, *World Social Protection Report 2020–2022: Social Protection at the Crossroads – In Pursuit of a Better Future* (Geneva, 2021).

[23] Office of the United Nations High Commissioner for Refugees, "Global displacement hits another record, capping decade-long rising trend", UNHCR press release, 16 June 2022. Available at www.unhcr.org/en-us/news/press/2022/6/62a9d2b04/unhcr-global-displacement-hits-record-capping-decade-long-rising-trend.html.

[24] Dana McLaughlin, "Promoting the inclusion of displaced populations in HIV, TB, and malaria programs" (New York and Washington, D.C., United Nations Foundation, 24 January 2023). Available at https://unfoundation.org/what-we-do/issues/global-health/promoting-the-inclusion-of-displaced-populations-in-hiv-tb-and-malaria-programs/.

46. Today, almost 29 million people across the world are receiving life-saving treatment. AIDS-related deaths have declined by 68 per cent since they peaked in 2004 and options for preventing HIV infection have been combined to reduce new infections by more than 50 per cent since 1996. However, as those remarkable gains are not yet reaching everyone, everywhere, efforts to reach the finish line must be redoubled.

47. The history of AIDS shows how inequalities, stigma, discrimination, criminalization, punitive laws and human rights violations both fuel pandemics and upend the responses to them. That history also shows that HIV responses succeed when they are anchored in strong political leadership, have adequate resources, follow the evidence, use inclusive, rights-based and community-led approaches, and pursue equity. Governments and communities, supported by UNAIDS, have pioneered ways of working and have built health and community systems that have turned the tide against AIDS and are crucial for overcoming other existing and future pandemics. The upcoming high-level meetings on universal health coverage, tuberculosis and pandemic prevention, preparedness and response will offer a key opportunity to leverage and build on these principles and approaches, which echo the priorities set out in Our Common Agenda and provide potent lessons for accelerating achievement of the Sustainable Development Goals overall.

A. Strong political will and leadership on HIV

48. Strong political leadership has been the bedrock of successful HIV responses everywhere. It is the catalyst for investing adequately in HIV programmes, bringing about policies, laws and actions that uphold people's right to health and building trust and partnerships between Governments and communities. At a global level, the HIV response has been turned into a multisectoral undertaking which draws together the resources and efforts of diverse sectors. UNAIDS, a unique joint programme comprising 11 United Nations entities and a secretariat, exemplifies this partnership approach. Above all, countries with successful HIV responses have applied similar approaches at all levels. They have created multisectoral planning bodies and oversight systems and built partnerships with people living with HIV and their communities. This inclusive approach is a hallmark of successful AIDS responses and a reminder of the power of solidarity in the face of common dangers. Modern health systems include communities as partners with Governments in planning and delivering services, providing vital information derived from their lived realities and working together to solve problems and maintain accountability.

B. Adequate funding

49. Progress in action against AIDS is strongest in the countries and regions (particularly Eastern and Southern Africa) that invest sufficiently in their HIV responses. This has been achieved through a mix of increased domestic resources and strong global solidarity. Conversely, regions with the largest resource gaps, namely, Eastern Europe and Central Asia and the Middle East and Northern Africa, are making the least headway against their HIV epidemics.

50. Rising domestic investments since the early 2000s have powered the HIV response in low-and middle-income countries. Underpinning those investments has been the realization that delays and half-measures are ultimately much costlier than prompt, decisive action. Domestic resources for HIV, however, have declined by 2 per cent each year since 2020 and towering levels of debt stress public finances in many countries, thereby threatening those investments. Development assistance for HIV has

been, and will continue to be, vital, with the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria playing crucial roles. These are the largest funders of grants for health systems, with the Global Fund investing about US$ 1.5 billion and the President's Emergency Plan about US$ 1 billion per year to build the infrastructure and capacity of country health systems. The ripple effects of those investments are visible in other developmental outcomes, including falling child mortality rates, expanding tuberculosis screening and treatment and strengthened community systems.

C. Community engagement

51. HIV services tend to be more accessible and effective when community-led and other civil society organizations are closely engaged in planning, implementing and monitoring HIV programmes. It is owing largely to the activism propelled by those organizations that affordable HIV medicines and prevention tools are now the norm across most of the world. These organizations enrich the evidence base for effective action against HIV, uncover gaps and unfairness in programmes, expose discrimination and other human rights violations and campaign for legal and policy changes that can build health equity. Engaging with women civil society has also been critical to addressing gender gaps in access to prevention and treatment and data for various communities, including key populations. Thanks to the energizing roles of young people in civil society organizations, Governments and donors are increasingly recognizing the value of engaging youth in health and social initiatives.

52. In many countries, community-led organizations are leading HIV service providers for key and marginalized populations. Their resilience and adaptability proved crucial during the COVID-19 pandemic, when they kept core HIV services operating in dozens of countries and took on vital responsibilities related to the COVID-19 pandemic.[25] There is growing recognition of the leadership of those organizations in achieving the effective governance of health systems, including in universal health coverage initiatives and efforts to strengthen global health security and preparedness.

D. Resilient and accessible public and community health systems

53. Community-led interventions are most effective when they are an integral part of robust public health systems. Those systems collect and manage the strategic health information that guides HIV programmes; maintain the procurement and distribution of medicines, diagnostics and prevention tools; and run the health facilities that people rely on. The AIDS pandemic brought home the shortcomings of one-size-fits-all health models, which led to new strategies that seek to tailor services to the distinct needs of specific populations and places. HIV services were decentralized, becoming closer to the communities and allowing for services to reach underserved communities through the involvement of community health workers, peers and community networks. In Africa especially, the enlisting of lay staff and new cadres of community health workers has contributed to some of the biggest breakthroughs in action against HIV. Community health workers proved vital in action against the COVID-19 pandemic, delivering medications and other supplies to homes and keeping basic health services running. They will be crucial for managing future

[25] UNAIDS, "Community-led package services in response to COVID-19 in high-density settlements: resource needs" (Geneva, 2021).

pandemics and public health threats if trained and deployed in sufficient numbers, integrated with health systems and adequately paid and supported.[26]

E. Evidence-based, data-driven programmes that are equitable and effective

54. Accurate, trustworthy data have underpinned and guided progress of action against the AIDS pandemic. The global AIDS response has included the building of some of the most comprehensive data systems in the global health and development sphere, systems that were used in responses to the COVID-19 pandemic as well. Strong information systems that capture routine and granular data are increasingly valuable for understanding and enhancing the HIV response and directing limited resources towards high-priority places, populations and interventions. Those data are exposing the underlying disparities and inequalities that shape pandemics and skew their impact. They have revealed the elevated risk of HIV infection in sub-Saharan Africa among adolescent girls and young women, as well as gaps in testing and treatment coverage among men and boys, prompting corrective actions. Similar improvements are needed in the collection and analysis of data on key populations to better tailor HIV interventions to the realities of these important groups.

F. Scaling the use of proved tools and approaches for the biggest impact

55. Countries that have followed the evidence and used proved tools and methods on a wide scale have achieved steep reductions in new HIV infections. Programmes that address the needs of key populations have achieved steep reductions in new infections (including, in 2010–2021, a 60 per cent decline in Viet Nam and a 50 per cent decline in Sri Lanka). Estonia reduced its HIV incidence to almost zero by widening access to comprehensive harm reduction services, while in Côte d'Ivoire, early expansion of key population services and an increase in antiretroviral coverage contributed to a 75 per cent decline in new adult HIV infections in 2010–2021. Cambodia and Thailand reversed the course of their HIV epidemics in a few years by increasing condom use among sex workers and their clients. By ensuring that 95 per cent of pregnant women living with HIV were on treatment, Botswana has reduced its vertical transmission rates from 9.0 to 2.2 per cent since 2010. It is now the first high HIV burden country to be World Health Organization (WHO)-certified for achievement on the path to eliminating vertical HIV transmission.

G. Service integration and linkages

56. Global evidence shows that service integration can contribute to ending AIDS by 2030, while simultaneously supporting progress towards universal health coverage.[27] The integration of HIV and tuberculosis services has contributed to steep reductions in AIDS-related deaths, while the integration of HIV testing and treatment with maternal care and childcare has prevented almost 2.9 million HIV infections in pregnant women and children since 2000[28] and has been central to the massive

[26] Akalewold T. Gebremeskel and others, "Building resilient health systems in Africa beyond the COVID-19 pandemic response", *BMJ Global Health*, vol. 6, No. 6 (June 2021), p. e006108.

[27] Caroline A. Bulstra and others, "Integrating HIV services and other health services: a systematic review and meta-analysis", *PLoS Med*, vol. 18, No. 11 (9 November 2021), p. e1003836.

[28] United Nations Children's Fund (UNICEF), "Elimination of mother-to-child transmission" (New York, July 2022). Available at https://data.unicef.org/topic/hivaids/emtct/.

expansion of antiretroviral therapy coverage among women (and their male partners), especially in sub-Saharan Africa. Global pushback on human rights, including women's rights to bodily autonomy, calls for accelerated efforts to integrate sexual and reproductive health and rights and HIV services to reduce HIV infections among adolescent girls and young women and unintended pregnancies among women living with HIV, as well as maternal mortality, thus increasing the chance of meeting development goals, particularly Sustainable Development Goal target 3.7.[29]

57. These advantages can be exploited more fully, for example, through further integration of data, procurement and supply systems; the multi-use of clinical and laboratory platforms; and instituting more routine linkages and referrals among HIV, tuberculosis, family planning, cervical cancer, mental health, gender-based violence and social protection programmes. However, integration must be inclusive and serve efforts to reach those who are least likely to obtain the services and support they need. Deeper integration, including in the context of universal health coverage, must strengthen, rather than weaken, the emphasis on equity and human rights protections.

H. Equitable access to medicines and other health technologies

58. In the context of the COVID-19 pandemic response, a vital lesson from the HIV response has been revived, namely, that delays in ensuring affordable access to crucial health-care innovations cost lives. Some of the biggest breakthroughs in action against the AIDS pandemic have resulted from successful demands for affordable and equitable access to antiretroviral medicines and other HIV products. Steep price reductions, achieved, for example, through voluntary licensing deals, generic production and pooled procurement, made it possible to provide highly effective HIV medicines for free or at low cost in low-income and lower-middle-income countries. Similar demands have been carried over to other public health priorities (such as tuberculosis, cervical cancer and viral hepatitis). Affordability, however, remains an ongoing issue, including in upper-middle-income countries, which are often not eligible for price reductions and new products, such as long-acting injectable antiretrovirals. Moreover, the highly unequal access to COVID-19 vaccines and treatments underscores the urgent need for more equitable systems for the manufacture and distribution of essential health products.

IV. Recommendations

59. To put the world on track to end AIDS as a public health threat by 2030, accelerate progress towards the Sustainable Development Goals, achieve universal health coverage and address pandemics, Member States and stakeholders are encouraged to fully implement the recommendations below.

Recommendation 1: Take urgent action on inequalities to address gaps in HIV prevention, testing and treatment services and societal enablers

60. Member States are urged to address the social, structural and systemic factors that generate and perpetuate HIV-related inequalities, by:

(a) Reviewing progress towards the HIV prevention, testing and treatment targets in the 2021 Political Declaration to determine the HIV-related inequalities

[29] Luka Nkhoma, Doreen Chilolo Sitali and Joseph Mumba Zulu, "Integration of family planning into HIV services: a systematic review", *Annals of Medicine*, vol. 54, No. 1 (December 2022), pp. 393–403.

(including gender inequalities and inequalities faced by key populations) that hold back progress;

(b) Implementing strategies to remove the barriers (including stigma and discrimination), close the gaps (including between children and adults, and men and women), accelerate efforts to end AIDS in children and address the HIV-related needs of the populations that are being left behind;

(c) Delivering integrated services that prevent HIV among adolescents and young people in all their diversity, including quality, gender-responsive and age-appropriate comprehensive sexuality education, access to sexual and reproductive health and rights services, and interventions that transform harmful gender norms.

Recommendation 2: Ensure adequate, sustainable and equitable funding

61. Member States are urged to increase domestic and international donor allocations for the AIDS responses of low- and middle-income countries to enable funding to reach US$ 29 billion annually by 2025, including greater investments in HIV prevention and societal enablers, as set out in the 2021 Political Declaration, and to support sustainability through appropriate integration of HIV-related needs into broader health and development budgets.

Recommendation 3: Implement evidence-based and data-driven programmes

62. Member States are urged to enhance effective rights-based, people-centred HIV programmes by:

(a) Adapting integrated health data systems in order to identify gaps, barriers and solutions for achieving effective, integrated HIV services, including in humanitarian situations;

(b) Strengthening routine, granular and disaggregated data systems for differentiated delivery of services and to capture, analyse and monitor progress on reducing barriers that hinder access to and use of crucial HIV-related services.

Recommendation 4: Support community-led responses

63. Member States are urged to:

(a) Create and maintain safe, open and enabling environments in which people living with HIV, affected communities and the broader civil society can participate in decision-making, service delivery and progress monitoring for the AIDS response, for efforts to achieve universal health coverage and for pandemic prevention, preparedness and response;

(b) Adopt and implement laws and policies that enable the sustainable financing of people-centred, integrated community responses, including through social contracting, building on the resilience and innovation demonstrated by community-based health systems during the COVID-19 pandemic.

Recommendation 5: Build on HIV models and resources for broader health and development outcomes

64. Members States are urged to:

(a) Align their HIV models and responses more closely with the core functions of primary health care, namely, primary care services, community engagement and multisectoral policy and action;

(b) Apply the expertise, infrastructure, multisectoral model and rights-based approach of the HIV response across their health and other sectors, where appropriate, to achieve more rapid progress towards the Sustainable Development Goals;

(c) Draw on lessons from successful HIV responses to strengthen mechanisms for pandemic prevention, preparedness and response.

Recommendation 6: Promote equitable access to medicines and other health technologies

65. Member States are urged to ensure equitable and reliable access to affordable, high-quality HIV-related health products and technologies in all low- and middle-income countries by strengthening supply chain management systems and using the public health-related flexibilities of the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights, optimizing the use of voluntary licensing and technology transfers, catalysing regional manufacturing capacities and developing pooled purchasing mechanisms.

Recommendation 7: Enhance global partnerships and solidarity

66. Member States are urged to:

(a) Ensure that the UNAIDS 2022–2026 Unified Budget, Results and Accountability Framework (UBRAF)[30] is fully funded;

(b) Report progress to UNAIDS annually on their HIV epidemics and responses, using robust monitoring systems that identify gaps and inequalities in service coverage and outcomes;

(c) Adopt an inclusive and comprehensive approach to reviewing progress on the commitments set out in the 2021 Political Declaration, including at the 2023 Sustainable Development Goals Summit and the high-level meetings on universal health coverage, tuberculosis and pandemic prevention, preparedness and response, reflecting the multisectoral nature of efforts to end the AIDS pandemic by 2030.

Recommendation 8: Harness synergies between AIDS response, broader health and the Sustainable Development Goals

67. Member States are urged to give due consideration to the interlinkages between the AIDS response and efforts on tuberculosis, universal health coverage and pandemic prevention, preparedness and response, as well as other/broader Sustainable Development Goals, to inform the deliberations at the upcoming Sustainable Development Goals Summit and the high-level meetings on tuberculosis, universal health coverage and pandemic prevention, preparedness and response, including their outcome documents, in order to harness synergies and accelerate progress towards realizing the shared goals of ending AIDS and tuberculosis, achieving universal health coverage and addressing pandemics.

[30] See 2022–2026 UBRAF | Portal (unaids.org).