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

Tackling inequalities to end the AIDS pandemic

Report of the Secretary-General

Summary

The AIDS pandemic is responsible for more than 13,000 deaths every week, a crisis that is undermining efforts to achieve global health goals. It is also colliding with the coronavirus disease (COVID-19) pandemic as underlying inequalities limit access to health services, and insufficient investment leaves the world dangerously underprepared to confront the pandemics of today and tomorrow.

The General Assembly responded to this urgent situation in 2021 by adopting the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, which focuses on inequalities. One year later, Joint United Nations Programme on HIV/AIDS (UNAIDS) data show that HIV infections and AIDS-related deaths are not declining fast enough to end the pandemic by 2030. A failure to reach the 2025 targets in the Declaration would result in 7.7 million AIDS-related deaths during the current decade.

Measures to slow the spread of the COVID-19 virus and the significant additional strain the new pandemic has placed on health systems have disrupted HIV services. In many countries, however, the challenges of COVID-19 have also led to a positive acceleration of differentiated service delivery, including community-based and community-led services. It is critical to maintain this momentum, and to prioritize the removal of societal barriers to services and the empowerment of communities in greatest need of services. Depending on the place and context, these populations include women and girls, gay men and other men who have sex with men, transgender people, sex workers, people who use drugs, prisoners, migrants, refugees and other displaced persons. A common resource gap across nearly all regions is funding for HIV prevention among key populations at higher risk of HIV infection.

The urgent need to address the societal barriers faced by these populations is expressed through the 10-10-10 societal enabler targets of the 2021 Political Declaration. Progress within this fundamental pillar of the AIDS response has been



slow. In most countries, criminal laws against key populations and people living with HIV continue to restrict their access to services. HIV-related stigma and discrimination and violence remain alarmingly high, and gender inequality continues to deny women and girls their fundamental human rights.

Member States are urged to take urgent action against the challenges that are slowing progress towards global targets and consider the recommendations within the present report on (a) HIV prevention and societal enablers; (b) community-led responses; (c) equitable access to medicines, vaccines and health technologies; (d) sustainable financing for the AIDS response and wider pandemic prevention, preparedness and response; (e) people-centred data systems and (f) strengthening global partnerships.

I. Inequalities limiting progress towards ending AIDS by 2030¹

1. The AIDS pandemic is responsible for more than 13,000 deaths every week, undermining efforts to achieve global health targets and the Sustainable Development Goals. An estimated 1.5 million new HIV infections and 680,000 deaths from AIDS-related causes occurred in 2020.
2. The AIDS pandemic is also colliding with the coronavirus disease (COVID-19) pandemic as the world fails to address the underlying barriers to equitable access to health services and remains dangerously underprepared and underresourced to confront the pandemics of today and tomorrow.
3. The successes, challenges and lessons learned from the responses to both pandemics were reviewed in detail by the General Assembly at its high-level meeting on HIV and AIDS, held from 8 to 10 June 2021. The Assembly adopted the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. This bold Declaration commits States Members of the United Nations to urgent and transformative action to end social, economic, racial and gender inequalities, as well as restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, and to achieve targets that will reduce annual new HIV infections to under 370,000 and annual AIDS-related deaths to under 250,000 by 2025.
4. The focus of the Declaration on inequalities is consistent with Our Common Agenda for inclusive, rights-based approaches to stopping COVID-19 and other pandemics, strengthening social protection for the most vulnerable and achieving the Sustainable Development Goals through a decade of action.
5. One year after the Declaration was adopted, Joint United Nations Programme on HIV/AIDS (UNAIDS) data show that HIV infections and AIDS-related deaths are not falling fast enough. The annual number of new infections among adults globally remains largely stable, and total new infections declined by just 31 per cent between 2010 and 2020. There was a 47 per cent decline in AIDS-related mortality between 2010 and 2020 (see figure I).
6. Progress is uneven geographically. The most affected regions – sub-Saharan Africa and the Caribbean – have achieved the strongest reductions since 2010, followed by Asia and the Pacific and Western and Central Europe and North America. By contrast, during the past decade little progress has been achieved in Latin America and the Middle East and North Africa, and HIV infections and AIDS-related deaths rose dramatically in Eastern Europe and Central Asia.
7. Progress is also uneven among different populations within countries. The prevalence of HIV is generally higher in urban areas, while the availability of HIV services is generally lower in rural areas, underscoring the importance of collecting granular data to identify gaps in service coverage within individual countries.
8. Gender inequality and gender-based violence contribute to the elevated risk of HIV infection faced by women and girls, with adolescent girls and young women particularly affected. In sub-Saharan Africa, more than 6 in 10 new HIV infections in 2020 were among women and girls, with adolescent girls and young women (aged 15–24 years) accounting for 25 per cent of HIV infections in 2020, despite representing just 10 per cent of the population.

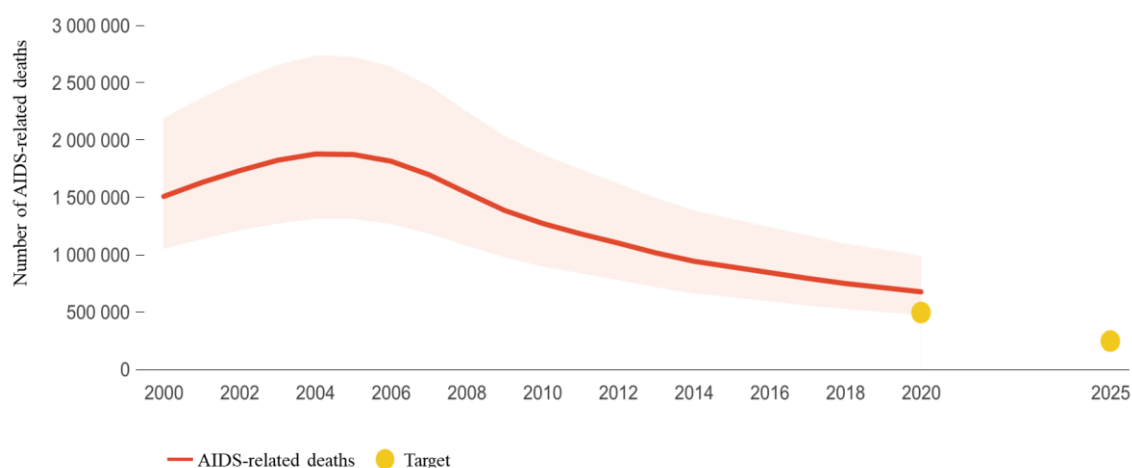
¹ Unless otherwise stated, data provided are Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates and country data reported to UNAIDS through its annual Global AIDS Monitoring exercise.

9. Key populations, including sex workers, people who inject drugs, prisoners, transgender people and gay men and other men who have sex with men, are at heightened risk of HIV and other life-threatening infections due to their marginalized status in society, the discrimination and violence they experience and the laws, policies and practices aimed at punishing them.

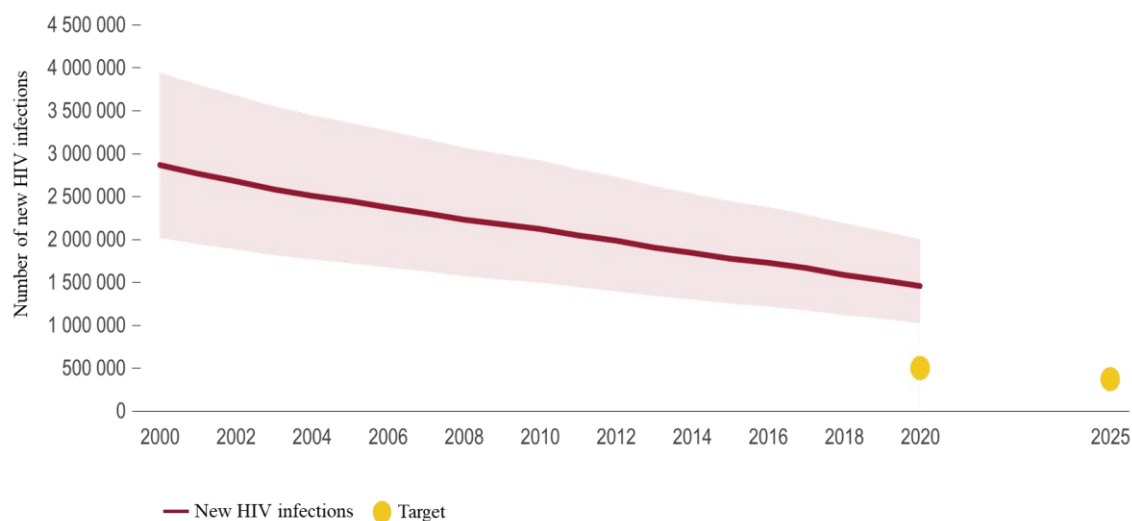
Figure I

New HIV infections and AIDS-related deaths, globally, 2000–2020, and 2020 and 2025 targets

AIDS-related deaths



HIV infections



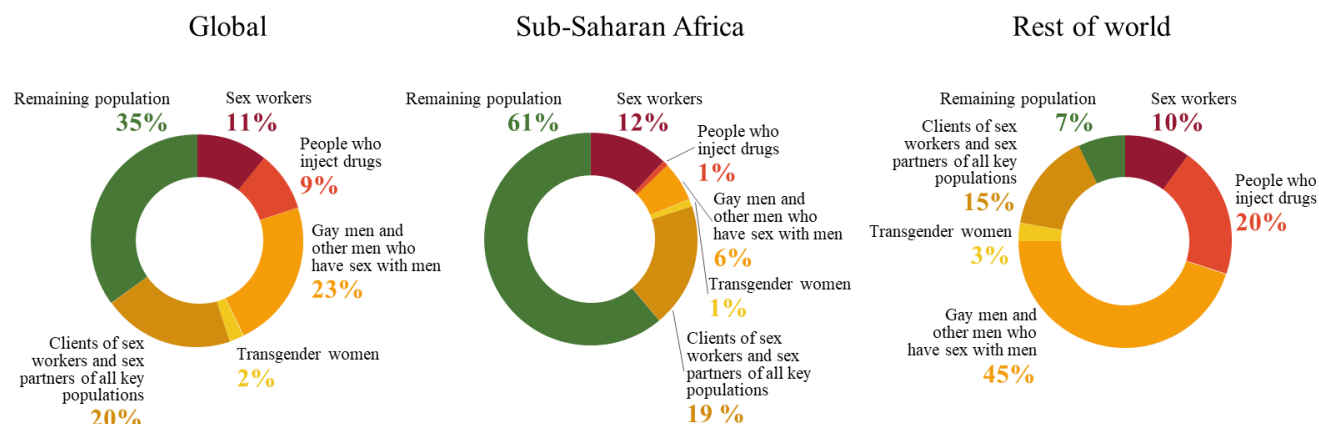
Source: Joint United Nations Programme on HIV/AIDS epidemiological estimates, 2021.

10. People who inject drugs are at 35 times greater risk of acquiring HIV infection than people who do not inject drugs; transgender women are at 34 times greater risk of acquiring HIV than other adults; female sex workers are at 26 times greater risk of acquiring HIV than other adult women; and gay men and other men who have sex with men are at 25 times greater risk of acquiring HIV than heterosexual adult men. Overall, key populations and their sexual partners accounted for 65 per cent of HIV infections worldwide in 2020 and 93 per cent of infections outside of sub-Saharan Africa (see figure II).

11. Social and structural barriers stand between these highly affected populations and the services they need to protect their health. Removing those barriers is needed to achieve global targets for 2025 and to change the current trajectory of infections and deaths. A failure to do so will result in 7.7 million AIDS-related deaths during the current decade.

Figure II

Distribution of HIV infection by population, 2020



Source: Joint United Nations Programme on HIV/AIDS special analysis, 2021.

II. Expanding HIV service coverage

12. The AIDS pandemic response is multisectoral and deeply interconnected with efforts to strengthen health systems and other public services, respond to COVID-19, prepare for future pandemics and achieve most of the Sustainable Development Goals.

A. HIV testing and treatment

13. The global roll-out of HIV testing and treatment has averted an estimated 16.6 million AIDS-related deaths over the past two decades. At least 19 countries achieved progress in line with the HIV testing and treatment targets for 2020.² This diverse range of countries demonstrates that ambitious targets can be achieved across cultures, socioeconomic development levels and epidemic settings.

14. Member States pledged in the 2021 Political Declaration to achieve the 95-95-95 testing, treatment and viral suppression targets within all demographics, groups and geographic settings by 2025, including among children and adolescents.³

15. At the end of 2020, across all countries, an estimated 84 per cent of the 37.7 million people living with HIV globally knew their HIV status, 87 per cent of people living with HIV who knew their HIV status were accessing antiretroviral

² The following countries reported to UNAIDS that they had achieved viral load suppression for at least 73 per cent of all people living with HIV in the country by the end of 2020: Botswana, Burundi, Cambodia, Croatia, Eswatini, Kenya, Lesotho, Malawi, Namibia, Norway, Qatar, Rwanda, Slovenia, Switzerland, Thailand, Uganda, Uruguay, Zambia and Zimbabwe.

³ The 95-95-95 targets are: 95 per cent of people living with HIV know their HIV status, 95 per cent of people who know their HIV-positive status are accessing treatment and 95 per cent of people on treatment have suppressed viral loads. Full achievement of these targets is equivalent to 86 per cent of all people living with HIV having suppressed viral loads.

therapy and 90 per cent of people on treatment were virally suppressed. At the end of June 2021, there were 28.2 million people living with HIV on treatment globally.

16. Gaps in testing and treatment tend to be larger among vulnerable and marginalized populations and those who are less likely to access health services. The gaps among children, young people, men and key populations living with HIV are particularly notable.

B. Ending AIDS among mothers and children

17. Efforts to provide HIV testing within antenatal settings and to achieve viral suppression through antiretroviral therapy before pregnant women living with HIV deliver their babies have greatly improved health outcomes for mothers living with HIV and reduced HIV infection among children by more than half (54 per cent) between 2010 and 2020.

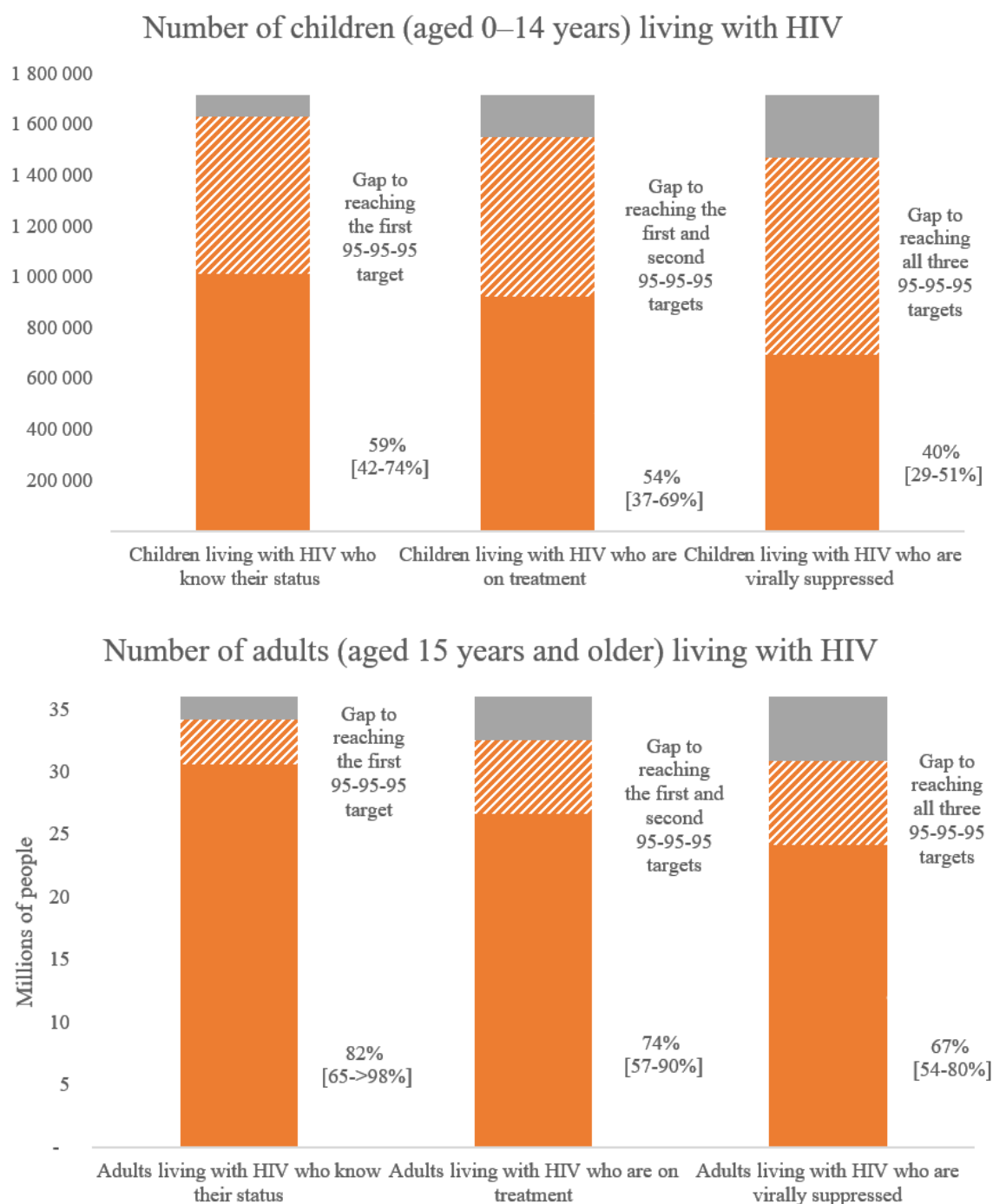
18. HIV testing and treatment coverage among pregnant women living with HIV is higher than the global average. An estimated 85 per cent globally were receiving antiretroviral therapy in 2020 to prevent vertical transmission and stay healthy. However, treatment gaps continue to be large within many countries in West and Central Africa, which is home to more than half (57 per cent) of pregnant women with HIV who are not receiving antiretroviral therapy. Substandard public health systems, the ongoing imposition of user fees for basic health services, and persistent stigma and discrimination (including self-stigma), especially towards key populations, are among the main hindrances these women encounter.

19. Six countries in sub-Saharan Africa accounted for nearly two thirds of children acquiring HIV in 2020. Eliminating vertical HIV transmission to children requires improvements in several areas. Integrated antenatal care and HIV services must be affordable, accessible, welcoming and suitable, especially for adolescent girls and women from key populations who are stigmatized, marginalized and subjected to discrimination, and they must ensure that women living with HIV are not subjected to coerced sterilization or abortion. Programmes also need to become better at supporting all pregnant and breastfeeding women who do not know their HIV status to access testing and, if positive, to quickly initiate treatment. Those living with HIV who have dropped out of treatment need to be supported to restart treatment.

20. Gaps in the testing of infants and children exposed to HIV have left more than two fifths of children living with HIV undiagnosed. Almost half (46 per cent) of the world's 1.7 million children living with HIV in 2020 were not benefiting from antiretroviral therapy (see figure III), and the number of children on treatment globally has declined since 2019.

21. Nearly two thirds of these children are aged 5 to 14 years: children who are often unaware of their HIV-positive status until their immune systems weaken and they become ill. The single biggest paediatric treatment challenge is finding and linking to care the children who were not diagnosed at birth or during breastfeeding. Scale-up of rights-based index, family and household testing and self-testing, and integration of HIV screening with other child health services, can help close this gap.

Figure III
HIV testing and treatment cascade, in children and adults, globally, 2020



C. Combination HIV prevention

22. Combinations of evidence-informed HIV prevention options tailored to the needs of populations at higher risk of infection have been proven effective in a variety of epidemic and cultural settings. Countries with diverse epidemics and resources, including Burkina Faso, Eswatini, Nepal, the Netherlands, Thailand, Viet Nam and Zimbabwe, are succeeding in markedly reducing new HIV infections. Too many

countries, however, are not following this approach at sufficient scale or intensity. Societal barriers, such as punitive laws, gender inequality and human rights violations, are more common in countries where rates of HIV infection are stable or continue to rise.

23. HIV prevention services for key populations are unevenly accessible or entirely absent. Harm reduction services for people who inject drugs, for example, are seldom provided on a meaningful scale or adequately tailored for the specific groups they are designed to serve. Similarly, coverage of prevention programmes for transgender people and gay men and other men who have sex with men is still uniformly low, including within many high-income countries.

24. In East and Southern Africa, coverage of prevention programmes among sex workers is still low, and condom use at last higher-risk sex is below the levels required to drastically reduce HIV transmission during paid sex. Levels of condom use by sex workers during paid sex are much higher in all of the other regions, except for the Middle East and North Africa. People in prisons and other closed settings are often not provided HIV services despite their elevated risk of HIV and other communicable diseases.

25. Male and female condoms and lubricants offer very high protection against HIV, sexually transmitted infections and unintended pregnancy. An estimated 117 million HIV infections have been averted by condom use since 1990.

26. Consistent condom use during risky sex, however, has proved difficult to achieve among all populations. Patriarchal views of women's sexuality restrict access by women to condoms and other sexual and reproductive health services. Women in many countries need greater agency and support to negotiate consistent condom use. Punitive laws targeting sex work can affect the ability of sex workers to carry condoms and negotiate condom use.

27. Antiretroviral drugs play a major role in HIV prevention. Providing antiretroviral therapy for all people living with HIV and implementing a strategic combination of pre-exposure prophylaxis and post-exposure prophylaxis with other prevention interventions is highly effective. The use of treatment regimens recommended by the World Health Organization, viral load monitoring and services that support retention in care help individuals achieve undetectable viral loads that prevent onward sexual transmission.

28. Pre-exposure prophylaxis is a valuable additional HIV prevention option for people who are at high risk of acquiring HIV. Its global uptake has continued to expand slowly in recent years, despite the challenges created by the COVID-19 pandemic. Country data show that approximately 845,000 people in at least 54 countries received it in 2020, a 43 per cent increase since 2019 and a 182 per cent increase since 2018. The trend reflects strong demand for this HIV prevention option, fuelling optimism that new long-acting pre-exposure prophylaxis formulations and vaginal rings will be highly acceptable and more convenient for many people.

29. Nevertheless, much of the scale-up of pre-exposure prophylaxis is still highly concentrated in a small number of countries. The total number of people using this prevention option in 2020 was just 8 per cent of the 2025 target of 10 million people at substantial risk of infection. More countries must mobilize their health systems to provide information and ensure access to pre-exposure prophylaxis when people choose it as a prevention method. In addition to clinic settings, it is important to provide such services outside of health facilities, including by using virtual options for client initiations, refills and check-ins, and by decentralizing the dispensing of pre-exposure prophylaxis through community delivery and multimonth dispensing as much as possible.

30. In areas with high HIV prevalence and low rates of male circumcision, voluntary medical male circumcision can greatly contribute to HIV prevention. Despite this, there was a steep drop in the number of people taking up this option in the 15 priority countries in 2020, due mainly to service disruptions caused by the COVID-19 pandemic. Approximately 2.8 million boys and men underwent voluntary male circumcision in 2020, compared with 4.1 million in 2019.

31. A re-energizing of voluntary medical male circumcision programmes is needed to reach the target of 90 per cent of adolescent boys and men in the 15 priority countries undergoing the elective procedure by 2025. In areas of low prevalence of circumcision and high HIV burden, the focus of such services should be on sexually active adolescents 15 years and older and adult men at higher risk of HIV infection. In areas where the prevalence of circumcision among sexually active men is already high, a focus on sustaining and expanding services for adolescent boys over 15 years of age is needed to maintain high coverage levels.

32. The General Assembly has committed to ensuring that 95 per cent of women and girls of reproductive age have their HIV and sexual and reproductive health service needs met by 2025, but very few low- and middle-income countries are currently within reach of that target.

33. Family planning services are an important component of sexual and reproductive health and rights, but the availability of these services varies widely. Across 32 countries with available data between 2015 and 2020, the percentage of women aged 15 to 49 years who had their demand for family planning satisfied by modern methods ranged from 6 per cent to 87 per cent. Women were more likely to have their demand for family planning satisfied using modern methods if they were living in urban areas than in rural areas (in 19 of 32 countries) or if they had secondary or higher education than if they had no formal or only primary education (in 21 of 32 countries). That percentage also tended to be higher for older women than for younger women, and for women in the highest wealth quintile than for their peers in the lowest quintile.

D. Comprehensive sexuality education

34. Young people, including young people within key populations, accounted for 27 per cent of HIV infections in 2020 while making up only 16 per cent of the global population. Young people in many countries have insufficient access to quality and age-appropriate comprehensive sexuality education, leaving them vulnerable to myths and misinformation about sex and sexuality.

35. Gender-transformative, age-appropriate and culturally relevant comprehensive sexuality education is a key component of prevention of HIV and sexually transmitted infections for adolescents and young people. Comprehensive sexuality education plays a vital role in promoting health, well-being and critical thinking skills among young people and in strengthening responsible citizenship. It also plays a role in preventing gender-based violence, increasing the use of contraception, decreasing the number of sexual partners and delaying the initiation of sexual intercourse. Those in or outside of formal education who receive comprehensive sexuality education are empowered to take responsibility for their own decisions and behaviours, and for the ways in which their actions may affect others.

36. According to the latest analysis led by the United Nations Educational, Scientific and Cultural Organization (UNESCO) of country data from multiple sources, 132 of 155 countries (85 per cent) surveyed have supporting policies or laws relating to sexuality education, with considerably more countries reporting policies

to mandate delivery at the secondary education level than at the primary level.⁴ However, the existence of policy and legal frameworks does not always equate to evidence-based and comprehensive content or strong implementation. Deeper analysis suggests that comprehensive sexuality education curricula often lack the breadth of topics needed to make sexuality education effective and relevant. Surveys show that students frequently feel that they received information too late and would have preferred sexuality education to have started earlier in their schooling.

E. Integration

37. In the 2021 Political Declaration, Governments committed to speeding up the integration of HIV services with services for tuberculosis, viral hepatitis, sexually transmitted infections, non-communicable diseases and mental health conditions. They also committed to ensuring that HIV services for people living with, at risk of and affected by HIV are included within service packages for universal health coverage, and to including HIV responses within strong and resilient social protection systems.

38. Equity, quality and affordability are among the building blocks of universal health coverage. Key health system functions, especially at the primary care level, should be strengthened to support the effective delivery of HIV services, including access to quality medicines and other health commodities, technologies and innovations.

39. Integration is progressing well in some areas. For example, linkages between HIV treatment and tuberculosis screening, diagnosis, treatment and prevention have been strengthened.

40. At the first-ever high-level meeting of the General Assembly on the fight against tuberculosis, held in New York on 26 September 2018, Member States committed to providing tuberculosis preventive treatment to at least 30 million people by 2022, including 6 million people living with HIV. Substantial progress was made in 2018–2019, building upon a decade of expansion in services and declines in tuberculosis deaths among people living with HIV. However, COVID-19-related service disruptions in 2020 coincided with an increase in tuberculosis-related deaths compared with 2019. Tuberculosis remains the leading cause of death among people living with HIV.

41. Cervical cancer is a common cancer among women living with HIV. It is often caused by infection with human papillomavirus, a preventable infection that people with compromised immune systems struggle to clear. A high risk of persistent infection with human papillomavirus among women living with HIV puts them at a sixfold higher risk of developing invasive cervical cancer. Vaccination against human papillomavirus and cervical cancer screening, followed by adequate management of precancerous lesions, are highly cost-effective measures. As of June 2020, just 41 per cent of low- and middle-income countries provided such vaccination, either nationwide or in parts of the country.⁵

42. The COVID-19 pandemic has highlighted the vital importance of robust social protection systems to mitigate the impact of pandemics. HIV-sensitive social protection increases the use of HIV prevention, treatment and care services by reducing financial burdens and other hindrances. The 2021 Political Declaration requires that, by 2025, 45 per cent of people living with, at risk of and affected by

⁴ United Nations Educational, Scientific and Cultural Organization (UNESCO) and others, *The Journey towards Comprehensive Sexuality Education: Global Status Report* (Paris, 2021).

⁵ Laia Bruni and others, “HPV vaccination introduction worldwide and WHO and UNICEF estimates of national HPV immunization coverage 2010–2019”, *Preventive Medicine*, vol. 144 (March 2021).

HIV have access to social protection benefits. However, few countries are currently ensuring ready access to that social protection.

F. Sustainable financing

43. Underinvestment in the HIV responses of low- and middle-income countries was a major reason why global targets for 2020 were missed. Trends in resource allocation data show that both domestic and international funding streams have dangerously plateaued (see figure IV), and current forecasts of health investment capacity are pessimistic. The General Assembly has called for annual investments in the AIDS responses of low- and middle-income countries to reach \$29 billion to by 2025. In 2021, only \$21.5 billion (in 2019 dollars) was available.

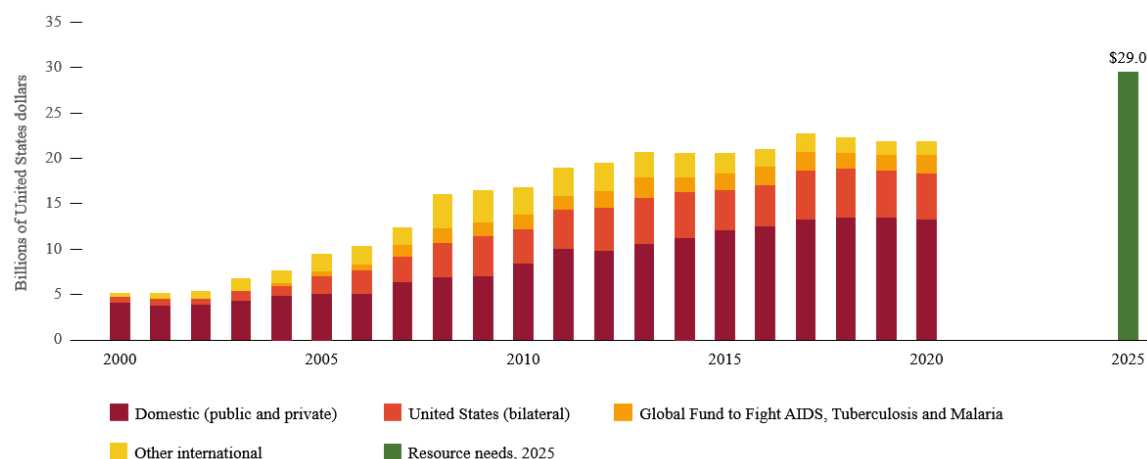
44. Resource allocations varied by region. Gaps were particularly large in Eastern Europe and Central Asia, the Middle East and North Africa and Asia and the Pacific. By contrast, HIV resources available in 2020 in East and Southern Africa and Latin America matched or even surpassed the total resource needs of those regions. The impact of those investments varied because a considerable proportion was not allocated to the programme areas or populations facing the biggest gaps.

45. A common resource gap across nearly all regions is funding for HIV prevention among key populations at higher risk of HIV infection. The 2021 Political Declaration also includes a commitment to greater investments in societal enablers, including removing restrictive and discriminatory laws and policies, eliminating stigma and discrimination, providing access to justice and ensuring gender equality. These investments must increase to \$3.1 billion in low- and middle-income countries by 2025.

Figure IV

Resource availability for HIV in low- and middle-income countries, 2000–2020, and 2025 target

(Billions of United States dollars)



Source: Joint United Nations Programme on HIV/AIDS financial estimates and projections for 2021. Available from <https://hivfinancial.unaids.org/hivfinancialdashboards.html>.

Note: The resource estimates are presented in constant 2019 United States dollars. The countries included are those that were classified by the World Bank in 2020 as being low- and middle-income countries.

46. The Global Fund to Fight AIDS, Tuberculosis and Malaria has invested more than \$53 billion in the HIV, tuberculosis and malaria responses of low- and middle-income countries over the past 20 years, greatly contributing to steep reductions in the combined death rate from these three diseases. Through the President's Emergency Plan for AIDS Relief, the United States has invested nearly \$100 billion in the global

AIDS response, accelerating progress towards controlling epidemics in more than 50 countries.

47. Disbursements from other international donors have decreased by about half since 2010. In 2022, the Global Fund is entering a critical seventh replenishment cycle, when at least \$18 billion in resources must be committed for the 2023–2025 period.

48. Ending AIDS will not be possible without increased domestic investments and international donor commitments. Additional financial resources for HIV, pandemic responses, the health sector and efforts to achieve the wider Sustainable Development Goals could be mobilized by tackling tax evasion, enacting progressive tax reforms, cancelling debt and reallocating special drawing rights.

III. Coronavirus disease and HIV

A. Impacts related to the coronavirus disease

49. Efforts to end the AIDS pandemic by 2030 were already moving too slowly when the COVID-19 pandemic struck. Measures to slow the spread of the COVID-19 virus and the additional strain placed on health systems disrupted HIV prevention, testing and treatment services, schooling, violence-prevention programmes and other efforts to address the inequalities that drive disparate health outcomes. The slow roll-out of COVID-19 vaccination in sub-Saharan Africa has prolonged the economic impacts of the pandemic in the region, increasing sovereign debt, widening economic gaps and having a negative impact on current and future capacity to invest in health and AIDS responses.

50. The damage being done to HIV programmes by the COVID-19 pandemic varies across countries. Available evidence shows that in 2020 HIV diagnoses decreased and fewer people living with HIV initiated treatment in 40 of the 50 countries that reported such data to UNAIDS. The biggest disruptions occurred in the first half of 2020, when many countries were in their first lockdowns. The number of people globally living with HIV receiving antiretroviral therapy increased by just 1.9 per cent between January and June 2020, compared with 6.3 per cent between January and June 2019.

51. Harm reduction services for people who use drugs were disrupted in nearly two thirds (65 per cent) of 130 countries surveyed in 2020.⁶ Many of the 15 priority countries for voluntary medical male circumcision suspended the procedures altogether.

52. The COVID-19 pandemic has reversed years of progress in providing essential tuberculosis and HIV services and reducing the tuberculosis disease burden. Lockdowns coincided with a large global drop in the number of people newly diagnosed with tuberculosis and reported to national Governments, which fell from 7.1 million in 2019 to 5.8 million in 2020. Reduced access to tuberculosis diagnosis and treatment resulted in an increase in tuberculosis deaths among people living with HIV, from 209,000 in 2019 to 214,000 in 2020.⁷

53. Lockdowns and COVID-19-related supply chain disruptions have also affected the manufacturing and distribution of sexual and reproductive health supplies, including male and female condoms, oral and injectable contraceptives and reproductive health kits.⁸

⁶ World Health Organization (WHO), *The Impact of COVID-19 on Mental, Neurological and Substance Use Services: Results of a Rapid Assessment* (Geneva, 2020).

⁷ WHO, *Global Tuberculosis Report 2021* (Geneva, 2021).

⁸ United Nations Population Fund, "Supply alert: navigating continuous supply chain disruptions", 19 May 2021.

54. Pre-exposure prophylaxis programmes were heavily affected during the first months of the COVID-19 pandemic. However, they rebounded quickly and on average expanded in low- and middle-income countries during the 2020 calendar year, and then continued to experience rapid growth in 2021, especially in sub-Saharan Africa and Asia.⁹

55. The COVID-19 pandemic has also aggravated inequalities that have been shown to limit access to HIV services. For example, the pandemic is eroding gains towards gender equality. Job and income losses during the pandemic have been higher among women, and their unpaid care burdens have increased. Rapid gender assessment surveys on the socioeconomic impacts of the COVID-19 pandemic conducted by the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) in 58 countries found that violence against women has increased since the beginning of the COVID-19 pandemic, with one in four respondents reporting that household conflicts have become more frequent and 7 in 10 reporting that verbal or physical abuse by a partner has become more common.¹⁰

56. Schooling also has been interrupted at some point for most children in the world. Prolonged school closures have deepened existing disparities in education, with poorer countries tending to have had longer school closures, and with girls, younger students and socioeconomically disadvantaged students experiencing greater learning losses.¹¹ An additional 100 million children were estimated to be living in multidimensional poverty by the end of 2021 compared with prior to the pandemic.¹²

57. As incomes plummet and food prices rise, food insecurity is increasing, which has a negative impact on the health outcomes of people living with HIV and has been linked with higher HIV risk behaviours among women. Social protection was temporarily expanded in many countries as entire employment sectors were shut down, but the assistance missed many of the poorest and most vulnerable people. Networks of sex workers, transgender people and gay men and other men who have sex with men reported difficulties in accessing these social protection services.

58. Studies show that people living with HIV are at elevated risk of COVID-19-related morbidity and mortality. There is also evidence that people living with HIV and others with compromised immune systems struggle to clear COVID-19 from their bodies if they are not vaccinated and not receiving the treatment they need for their medical conditions.

B. Rising to the challenges of the coronavirus disease

59. In many places, the upheaval caused by the COVID-19 pandemic has summoned the inventiveness and resilience that have become hallmarks of the HIV response. Programmes that are well resourced, willing to adapt and anchored in strong community involvement have tended to cope the best.

60. COVID-19-related movement restrictions necessitated an acceleration of multimonth dispensing of antiretroviral medicines for people living with HIV and

⁹ Data from the President's Emergency Plan for Aids Relief panorama spotlight website (<https://data.pepfar.gov>).

¹⁰ Ramya Emandi and others, *Measuring the Shadow Pandemic: Violence against Women during COVID-19* (United Nations Entity for Gender Equality and the Empowerment of Women, 2021).

¹¹ United Nations Children's Fund (UNICEF), UNESCO and World Bank, *Where Are We on Education Recovery?* (UNICEF, 2022).

¹² UNICEF and Save the Children, "Impact of COVID-19 on children living in poverty: a technical note", December 2021.

substitution therapy for people with opioid dependence. The approach enabled people to continue taking their medications despite service disruptions.

61. HIV treatment and other critical services were preserved by differentiating service delivery, most notably community-led services. Community pickup schemes and sites were set up, home delivery services were arranged and treatment support was shifted to telehealth and virtual platforms. By the end of 2020, most HIV testing and treatment programmes had rebounded from COVID-19 disruptions.

62. A large-scale example comes from Botswana, Eswatini, Namibia, Rwanda, Uganda, Zambia and Zimbabwe, where national AIDS programmes, with the support of the President's Emergency Plan for AIDS Relief, made key shifts in services. After COVID-19 restrictions were put in place, sites serving over 1.8 million people started provided antiretroviral medicine refills at community facilities and dispensed greater amounts of the drugs to cover longer periods of treatment (typically six months). In six of the seven countries, these adjustments reduced the percentage of patients who experienced treatment interruptions compared with pre-pandemic levels.¹³

IV. Ending inequalities through societal enablers, equitable financing and access, community leadership and people-centred data

A. Inequalities at the heart of uneven progress

63. The highest performing AIDS responses have demonstrated how extremely high coverage of HIV prevention, testing and treatment services greatly reduces HIV infections and AIDS-related morbidity and mortality. Conversely, gaps in service coverage perpetuate the pandemic. These gaps are largest within populations that routinely face stigma, discrimination, gender inequality, violence, criminalization and injustice. Depending on the place and context, these populations include women and girls, gay men and other men who have sex with men, transgender people, sex workers, people who use drugs, prisoners, migrants, refugees and other displaced persons.

64. The urgent need to address social and structural barriers to HIV services is expressed through the three 10-10-10 societal enabler targets of the 2021 Political Declaration. The first two societal enabler targets commit countries (a) to reduce to no more than 10 per cent the number of women, girls, people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence; and (b) to ensure that less than 10 per cent of people living with, at risk of and affected by HIV experience stigma and discrimination.

65. The third target is that less than 10 per cent of countries have restrictive legal and policy frameworks that unfairly target people living with, at risk of and affected by HIV, including age of consent laws and laws related to HIV non-disclosure, exposure and transmission and those that impose HIV-related travel restrictions and mandatory testing, and lead to the denial or limitation of access to services. That equates to 20 or fewer of the 193 countries that are States Members of the United Nations. Far more countries than that currently criminalize same-sex sexual relations, sex work, drug possession and use, and HIV-exposure, non-disclosure and transmission (see figure V).

¹³ Neha Mehta and others, "Impact of COVID-19 on HIV treatment interruption in seven PEPFAR countries, April–June 2020", abstract 2641 of the presentation during the International AIDS Society Conference, 18–21 July 2021.

B. Enabling legal and policy frameworks for HIV service delivery

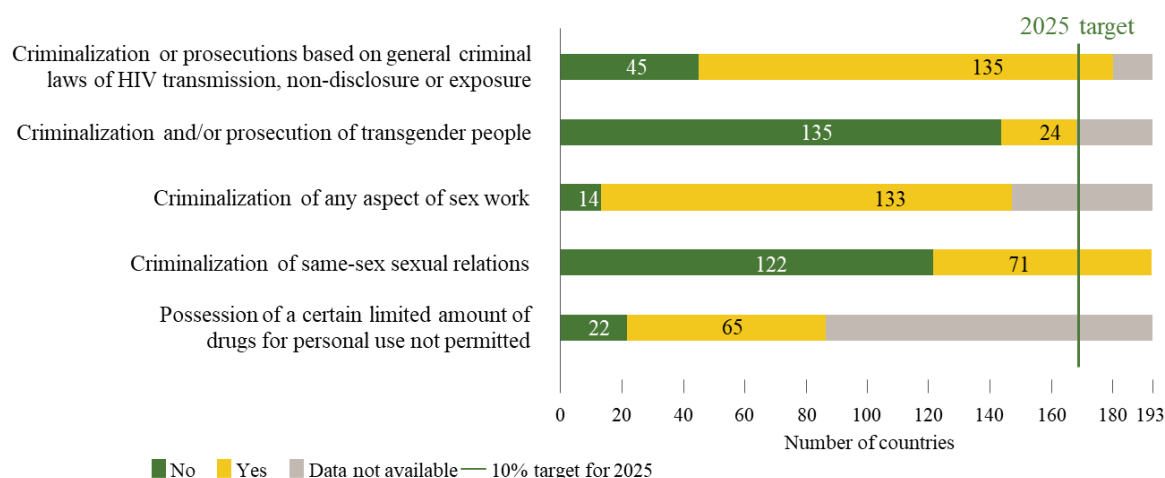
66. The criminalization of key populations has been linked to poorer progress towards HIV targets. Where same-sex sexual relationships, sex work and drug use were criminalized, levels of HIV status knowledge and viral suppression among people living with HIV were significantly lower than in countries that opted not to criminalize them. Conversely, there was a positive correlation between the adoption of laws that advance non-discrimination, the existence of human rights institutions and responses to gender-based violence and those same HIV outcomes.¹⁴

67. The findings lend further support to the recommendation of the Global Commission on HIV and the Law for countries to apply public health and human rights principles and remove or reform laws and policies that stop people from accessing and using the HIV and health services they need.

68. The removal of laws that require parental permission to access services for sexual and reproductive health and HIV prevention, testing and treatment has been shown to improve health-seeking behaviours of adolescents and young people.¹⁵ Forty countries reported to UNAIDS in 2021 that they had laws requiring parental or guardian consent for adolescents to access hormonal or long-lasting contraceptives, and 108 reported that such consent was required for an HIV test, 43 for HIV self-testing, 92 for HIV treatment and 22 for pre-exposure prophylaxis.

Figure V

Countries with discriminatory and punitive laws, 2021



Source: Joint United Nations Programme on HIV/AIDS National Commitments and Policy Instrument, 2017–2021.

C. Gender equality

69. Gender inequality and discrimination deny women and girls their fundamental human rights, including the rights to education and health, and increase their risk of HIV infection while hampering their ability to mitigate the impact of HIV.

¹⁴ Matthew M. Kavanagh and others, “Law, criminalization and HIV in the world: have countries that criminalize achieved more or less successful pandemic response?”, *BMJ Global Health*, vol. 6, No. 8 (2021).

¹⁵ Britt McKinnon and Ashley Vandermorris, “National age-of-consent laws and adolescent HIV testing in sub-Saharan Africa: a propensity-score matched study”, *Bulletin of the World Health Organization*, vol. 97, No. 1 (2019).

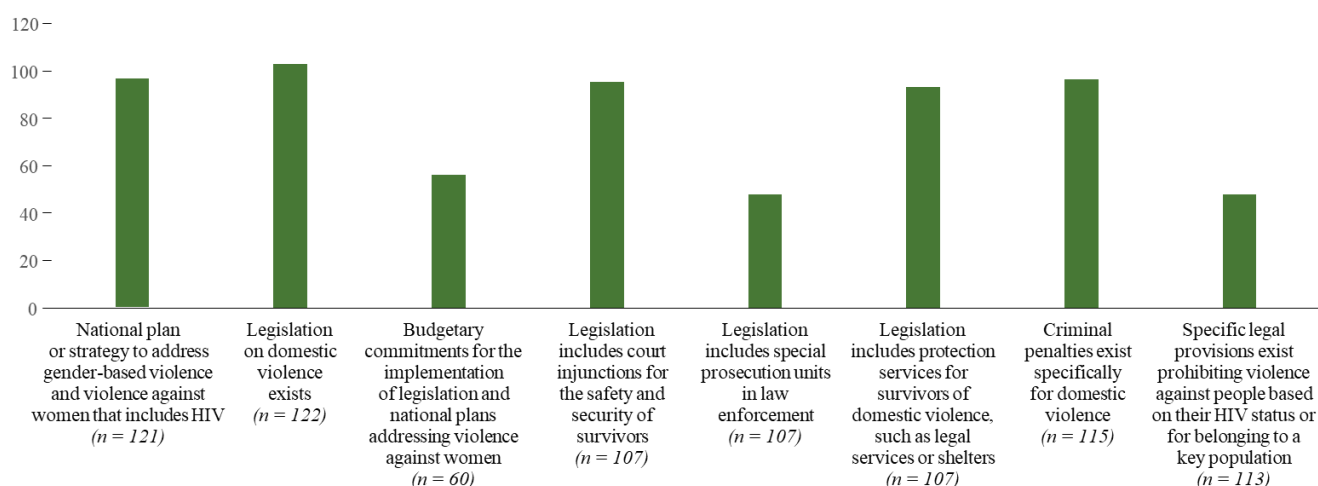
70. Across their lifetime, one in three women are subjected to physical or sexual violence by an intimate partner or sexual violence from a non-partner.¹⁶ Globally, more than 1 in 10 (13 per cent) of ever married or partnered women (aged 15 to 49 years) have experienced physical and/or sexual violence by an intimate partner in the previous 12 months. Only 7 of 43 countries with data available between 2015 and 2020 met the 2025 target of less than 10 per cent.

71. The 2021 Political Declaration includes a commitment by countries to adopt and enforce laws and policies that protect women and girls against violence. These protections should also ensure that survivors of violence receive adequate and suitable services and support, and that they can achieve legal redress against perpetrators of violence.

72. Among countries that reported information to UNAIDS, 103 indicated that they had domestic violence legislation, with the vast majority also reporting that such legislation included criminal penalties for perpetrators, and court injunctions and protection services for survivors. Ninety-six countries reported that they had a national plan or strategy to address gender-based violence and violence against women that included HIV, and 47 countries reported having special legal provisions that prohibited violence against people based on their HIV status or their identity as a member of a key population (see figure VI). The quality and implementation of these legal and policy protections vary.

73. The 2021 Political Declaration commits Member States to fulfilling the right to education of all girls and young women, and to economically empowering women by providing them with job skills, employment opportunities, financial literacy and access to financial services. UNESCO estimates that 129 million girls globally are out of school, including 32 million of primary school age, 30 million of lower secondary school age and 67 million of upper secondary school age. Only 49 per cent of countries have achieved gender parity in primary education, 42 per cent have done so in lower secondary education and 24 per cent have achieved it in upper secondary education.¹⁷

Figure VI
Number of countries with provisions related to violence, 2017–2021



Source: Joint United Nations Programme on HIV/AIDS National Commitments and Policy Instrument, 2017–2021.

¹⁶ WHO and others, *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, WHO, 2021).

¹⁷ See www.unicef.org/education/girls-education.

D. HIV-related stigma and discrimination

74. The prevalence of discriminatory attitudes towards people living with HIV varies widely. Across nearly all regions, there are countries where a large proportion of adults continue to hold discriminatory attitudes towards people living with HIV. In 52 of 58 countries with recent population-based survey data, more than 25 per cent of people aged 15 to 49 years reported holding these attitudes; in 36 of 58 countries, more than 50 per cent of the entire population held such attitudes. According to an International Labour Organization-Gallup report based on a survey in 50 countries in 2021, four out of six people were not comfortable working with a person living with HIV.¹⁸

75. In many countries, people living with HIV and key populations report through special surveys that they experience stigma and discrimination within health-care settings. These abuses take many forms, from judgmental or biased attitudes to breaches of confidentiality, poor support and delay or denial of treatment. Such abuses discourage people from seeking health care when they need it, degrade the quality of care that people receive and undercut both trust in health services and adherence to medical advice and treatment, resulting in poor physical and mental health outcomes.

76. In 2021, 95 of 131 reporting countries stated that government-established formal mechanisms were in place through which people living with HIV and key populations could report abuse and discrimination and seek redress. Monitoring by civil society plays a critical role in ensuring accountability and redress. In 53 countries, civil society organizations reported that communities and/or non-governmental organizations had established mechanisms to record and address individual complaints. Overall, 116 countries (60 per cent) reported that a formal and/or informal mechanism existed to address cases or individual complaints of HIV-related discrimination.

77. Twenty-nine countries have joined the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination. The Partnership has increased coordinated technical assistance and leveraged synergies of action to support country efforts to end stigma and discrimination across six settings: health care, justice, education, workplace, humanitarian and community settings.

E. Equitable access to health technologies

78. Pandemic responses fail when health technologies are available to some but are denied to others. It took the HIV response many years and millions of avoidable infections and deaths to learn that lesson. Determined advocacy from civil society, clinicians and Governments of low- and middle-income countries led to the establishment of mechanisms that help make HIV medicines and diagnostics affordable and available worldwide.

79. These mechanisms are under threat, however. New technologies for diagnosing, preventing and treating HIV, COVID-19 and other diseases are hitting the market, accompanied by intellectual property barriers, restricted sharing and technology transfer, limited locations of pharmaceutical production, weak regulatory capacities and prohibitive pricing.

80. Some middle-income countries are struggling to access affordable generic HIV drugs. Pre-exposure prophylaxis remains expensive in many countries due to monopolies on sale and distribution and limitations in local production. The development of child-friendly paediatric treatments, which are not seen as profitable investments, has been very slow. New technologies that can help address HIV inequalities, such as new HIV

¹⁸ International Labour Organization (ILO), *The ILO Global HIV Discrimination in the World of Work Survey* (Geneva, 2021).

treatment formulations for children and adults, long-acting formulations of pre-exposure prophylaxis and vaginal rings for HIV prevention and contraception, are in danger of being priced outside the reach of most who need them. More could also be done to promote highly effective low-technology solutions such as condoms.

81. The levying of user fees at clinics and hospitals in some countries still deprives many people, especially those with low incomes or who are excluded from household financial decisions, of the benefits of HIV and other health services and medicines.

82. Access to diagnostics remains uneven in many low- and middle-income countries, with impoverished and rural communities worst affected. Medical laboratories are also unequally distributed across countries. The United States of America, for example, has 260,000 accredited medical laboratories, while India, with four times as many inhabitants, has 1,150 such laboratories.¹⁹

83. Continuing inequity in the availability and distribution of COVID-19 vaccines, diagnostics and treatments underscores the urgent need for global measures to ensure equitable access to essential health technologies, especially during health crises. Without such measures, people in low- and middle-income countries will continue to be denied their fundamental right to health, and the world will remain unprepared for the pandemics of today and tomorrow.

84. A wider distribution of manufacturing of medical supplies, pharmaceuticals and other health technologies should be prioritized. Localizing manufacturing would reduce the vulnerability of health systems to supply chain disruptions and the hoarding of essential medical products during crises. This could be done by establishing regional value chains, developing subregional hubs in which manufacturers work together in clusters and harmonizing regulatory arrangements to facilitate and capitalize on cross-border collaboration. The recent creation of the African Medicines Agency is an important step towards establishing a continental platform for regulatory decisions.

F. Community leadership

85. An enduring legacy of the AIDS response is the central role of the people most affected in convincing governments to mount an adequate response to the pandemic. Over time, a patchwork of community organizations has matured into a community-led infrastructure essential to every aspect of the pandemic response, from the local to the global level.

86. Civil society and community-based organizations, especially those led by people living with HIV, women, young people and key populations, complement the pandemic responses of traditional health systems in three key roles: providing services; bringing community insights to planning and decisions; and supporting accountability and monitoring.

87. Since the early months of the COVID-19 pandemic, community-led organizations have been serving as bridges to marginalized communities, keeping HIV services running through COVID-19 lockdowns and other COVID-19-related disruptions. They have also been taking COVID-19 screening, testing and contact tracing into underserved areas in ways that respect people's different realities and concerns, and link communities to formal health services.

88. To get the AIDS response on track, full engagement of this community-led infrastructure must become universal. The 2021 Political Declaration includes a commitment by Member States to increase inclusion in decision-making and the

¹⁹ Kenneth A. Fleming and others, "The Lancet Commission on diagnostics: transforming access to diagnostics", *The Lancet*, vol. 398, No. 10315 (2021).

proportion of HIV services delivered by communities, strengthen the community health workforce and support the collection of community-generated data to protect rights and meet the needs of people living with, at risk of and affected by HIV.

89. There are also specific targets in the Declaration for countries to ensure that, by 2025, community-led organizations deliver (a) 30 per cent of testing and treatment services, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy; (b) 80 per cent of HIV prevention services for populations at high risk of HIV infection, including for women within those populations; and (c) 60 per cent of programmes to support the achievement of societal enablers. Developing specific methods to measure progress towards these new targets will be critical to their implementation.

G. People-centred data systems

90. The global HIV response has helped build some of the most comprehensive data systems in global health and development, and dozens of countries are using those systems against COVID-19 and other health challenges. Deepening and broadening the collection and use of granular data is critical to guiding efforts by health, education and social protection systems to close inequalities in service access and health outcomes.

91. Countries are also increasingly using granular data to fine-tune their HIV responses. In the 2021 round of the HIV epidemiological estimates supported by UNAIDS, 38 countries collected geolocated programme data and used the Naomi modelling tool to generate subnational HIV estimates and respond to variations in the data.

92. The HIV response is also in the vanguard of community leadership and engagement in data collection and use. Community-led monitoring is increasingly being used as an accountability mechanism that empowers networks of key populations, other affected groups or other community entities to systematically and routinely collect and analyse qualitative and quantitative data on the accessibility, appropriateness, affordability and acceptability of HIV services, and on rights violations and stigma and discrimination by service providers. Community-led monitoring informs HIV programme managers, health decision-makers, donors and other key stakeholders about what works well, what is not working and what needs to be improved. It also helps ensure that data are collected and used in a safe and rights-based manner, in particular in countries where key populations are criminalized.

93. Data gaps are standing in the way of reaching key populations. For example, many countries appear to underestimate the size of their key populations, and in some cases data on such populations are not even collected. As a result, their HIV programmes may be unbalanced, with potentially profound gaps in services for those in greatest need.

94. Underestimated population sizes are magnified by other data shortcomings for key populations. Biobehavioural surveys focused on such populations provide critical data on populations that are difficult to reach through standard means. However, funding constraints and other decisions are causing a reduction in the number of these surveys conducted.

95. Digital health technologies have the potential to support people living with HIV to reliably make more informed decisions with less stigma, and to take control of their health care. The adoption of these new technologies must be accompanied by legal protections that safeguard the privacy and confidentiality of users, ensuring that online health-care records, electronic medical records and communications with health-care providers are protected.

H. Joint United Nations support

96. In the 2021 Political Declaration, Member States requested UNAIDS to continue to support Member States in addressing the social, economic, political and structural drivers of the AIDS epidemic. Through its multi-agency joint United Nations teams and country offices, UNAIDS supports countries in developing and implementing national AIDS responses that reflect the strategic priorities of the Declaration and the latest normative and technical guidance. During the COVID-19 pandemic, UNAIDS helped to simplify and adapt HIV services in ways that better serve the needs of people living with HIV and reduce unnecessary burdens on the health system.

97. Since the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002, UNAIDS has supported more than 100 countries in attracting, implementing and leveraging more than \$18 billion in Global Fund investments.

98. UNAIDS also plays a leadership role in the convening of strategic partnerships on critical issues, such as Education Plus initiative, the Global HIV Prevention Coalition and the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination, and it mobilizes resources for the AIDS response.

99. However, like the broader global AIDS response, UNAIDS has experienced severe shortfalls in funding in recent years. For 2020 and 2021, UNAIDS had an approved annual budget of \$242 million. In 2020, it raised just \$194 million, and in 2021 only \$170 million.

V. Recommendations

100. Efforts to end the AIDS pandemic by 2030 remain off track. Member States are urged to take immediate action against the challenges that are slowing progress towards the 2025 targets contained in the 2021 Political Declaration. Fulfilling all of the commitments in the Declaration will also contribute to broader efforts to close inequalities, prepare for future pandemics, achieve universal health coverage and reach the Sustainable Development Goals.

Recommendation 1

Greater action on inequalities, HIV prevention and societal enablers

101. Member States are urged to:

(a) Urgently review their AIDS responses through an inequalities lens, and to assess progress towards HIV prevention and societal enabler targets in the 2021 Political Declaration through processes that generate national understanding of legal, policy and social barriers faced by people living with, at risk of and affected by HIV;

(b) Ensure that specific steps for achieving the 10-10-10 targets by 2025 and providing tailored packages of HIV prevention options to populations at high risk of HIV infection are included in the strategic plans for their national responses to HIV and receive sufficient funding for full implementation;

(c) If they have not already, join the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination.

Recommendation 2

Community-led responses

102. Member States are urged to build on the historic strengths of the AIDS response and the recent adaptations made during the COVID-19 pandemic by fully engaging and funding communities of people living with HIV, women, young people and key

populations for their meaningful participation in decision-making, service delivery and progress monitoring for the AIDS response and efforts to achieve universal health coverage, in line with global targets.

Recommendation 3

Equitable access to medicines and health technologies

103. Member States are urged to make full use of the Agreement on Trade-Related Aspects of Intellectual Property Rights, the Medicines Patent Pool and other mechanisms to ensure that the latest medicines and health technologies for HIV prevention, testing and treatment, including a future HIV vaccine, are rapidly made available and affordable for all low- and middle-income countries.

Recommendation 4

Sustainable financing for the AIDS response and wider pandemic prevention, preparedness and response

104. Member States are urged to increase domestic and international donor allocations to the AIDS responses of low- and middle-income countries to reach \$29 billion annually by 2025, including greater investments in HIV prevention and societal enablers, as agreed in the 2021 Political Declaration.

105. Fighting current pandemics and preventing future ones must happen simultaneously to be effective. As Member States work to establish mechanisms for pandemic prevention, preparedness and response, they are urged to ensure that greater actions to end the AIDS pandemic and key learning from the AIDS response are part of that work.

106. New mechanisms for pandemics come at a critical time of severe economic and fiscal stress. Member States are urged to create additional fiscal space by curbing tax evasion and using debt cancellation and special drawing right reallocations, and to mobilize the financial resources required for all countries to concurrently end AIDS within the next decade, swiftly defeat COVID-19 and proactively confront the pandemics of tomorrow.

Recommendation 5

People-centred data systems

107. Member States are urged to strengthen rights-based, people-centred, ethical and confidential national patient monitoring and case surveillance systems, including through the use of periodic anonymous surveys of key populations and other subpopulations at elevated risk of HIV; to collaborate with affected communities and strengthen their capacity to conduct complementary community-led monitoring; to track national progress towards the 10-10-10 societal enabler targets; and to use disaggregated data to identify and close location- and population-based gaps in services.

Recommendation 6

Strengthening global partnerships

108. Member States are urged to:

- (a) Ensure that the UNAIDS 2022–2023 Workplan²⁰ is fully funded;
- (b) Strengthen the global monitoring role of UNAIDS by annually reporting granular AIDS response data to the UNAIDS Global AIDS Monitoring system, in line with the 2025 targets and inequalities focus of the 2021 Political Declaration.

²⁰ UNAIDS, document UNAIDS/PCB (49)/21.27.