United Nations

A/80/724

General Assembly

Distr.: General
28 April 2026

Original: English

Eightieth session
Agenda item 10
Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS

United to end AIDS

Report of the Secretary-General*

Summary

As mandated in the 2021 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, this report reviews progress towards realizing the commitments set out in the 2021 Political Declaration and outlines the strategic directions for the world to achieve its goal of ending AIDS as a public health threat by 2030, with the opportunity of the new Global AIDS Strategy for 2026–2031: United Towards Ending AIDS and the 2026 political declaration.

The global HIV response is at a critical juncture. Progress is real and measurable, but it is increasingly vulnerable to converging crises, including declines in external financing, the high debt burden in the countries most affected by HIV, a growing number of humanitarian crises and a regression in human rights. At the same time, renewed country leadership, improved sustainability and significant innovations – including long-acting HIV prevention and treatment tools – offer new opportunities to accelerate progress.

The 2021 Political Declaration galvanized action to address the inequalities that fuel the global HIV epidemic. Over 31.6 million of the 40.8 million people living with HIV were receiving life-saving antiretroviral therapy in 2024, reducing numbers of AIDS-related deaths to their lowest level since the early 1990s. Significant gains have been made in sub-Saharan Africa, underscoring the power of national leadership, multilateral partnerships and multisectoral coordinated interventions.

* The present document was submitted to the conference services for processing after the deadline for technical reasons beyond the control of the submitting office.

26-06191 (E) 070526

Please recycle

But AIDS is not over. We are far from achieving the 2025 targets set out in the 2021 Political Declaration. At the end of 2024, 9.2 million people could not access HIV treatment; there were 630,000 AIDS-related deaths (two times the 2025 target); and 1.3 million people acquired HIV (3.5 times the 2025 target).[a] A pathway to end AIDS as a public health threat by 2030 exists and remains open, but this pathway requires HIV responses to adapt to the new context, confront the structural inequities that undermine access, close funding gaps and accelerate the expansion of HIV services in sustainable ways.

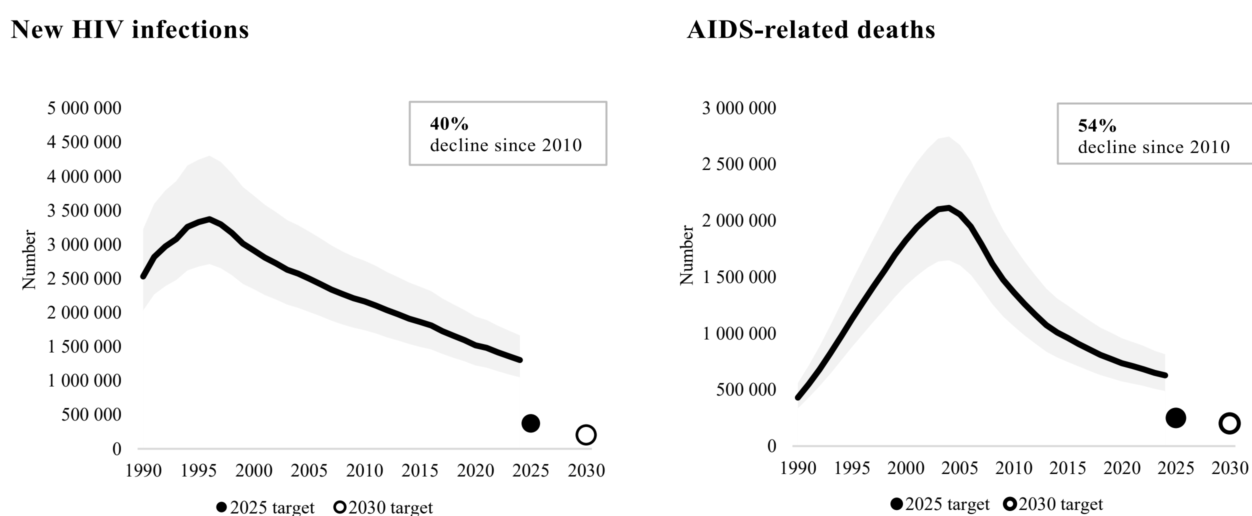
The Global AIDS Strategy for 2026–2031, developed through robust multi-stakeholder engagement to guide countries to reach the 2030 targets, was adopted at the Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board meeting in December 2025. It is a strategy for the world that presents a framework and actions serving the needs of people living with, at risk of or affected by HIV, based on country ownership, people-centred services and community leadership. The 2026 high-level meeting on HIV/AIDS is the opportunity for the international community to collaborate and renew its commitment to ending AIDS as a public health threat. No community or country can end AIDS alone: we must stand together.

[a] Joint United Nations Programme on HIV/AIDS (UNAIDS), *AIDS, Crisis and the Power to Transform: Global AIDS Update 2025* (Geneva, 2025).

I. Introduction

1. The global goal set by the United Nations to end AIDS as a public health threat by 2030 has led to remarkable progress globally.[1] The goal is defined as achieving a 90% reduction in numbers of new HIV infections and AIDS-related deaths from a 2010 baseline.[2] At the end of 2024, the world was closer than in the past two decades to reaching this goal. At that point, 31.6 million of the 40.8 million [37 million–45.6 million][3] people living with HIV (77%) were on life-saving treatment.[4] HIV prevention, testing, treatment and care services and measures to address the societal barriers that put people at heightened risk of HIV led to a 40% decrease in new infections and a 54% decrease in AIDS-related deaths between 2010 and 2024 (see figure I).[5]

Figure I
Numbers of new HIV infections and AIDS-related deaths, global, 1990–2024, and 2025 and 2030 targets



Source: UNAIDS epidemiological estimates, 2025 (https://aidsinfo.unaids.org/).

2. Decades of sustained work and unprecedented multilateral and multisectoral solidarity have reduced the annual numbers of people acquiring HIV and dying from AIDS-related causes to their lowest levels in more than 30 years. Examples of country successes were multiplying, and national Governments were assuming greater responsibility for their HIV responses. Since 2000, driven by shared responsibility, total HIV resources in low- and middle-income countries had risen from $5.1 billion to $18.7 billion in 2024, with domestic financing more than doubling and international financing significantly supporting countries with a high disease burden (see figure II).

[1] UNAIDS, *AIDS, Crisis and the Power to Transform: Global AIDS Update 2025* (Geneva, 2025).
[2] UNAIDS, *Fast-Track: Ending the AIDS Epidemic by 2030* (Geneva, 2014).
[3] Uncertainty bounds are calculated for each estimate. The bounds define the range within which the true value lies. Narrow bounds indicate that an estimate is precise, while wide bounds indicate greater uncertainty regarding the estimate.
[4] Unless otherwise indicated, all data cited in this report are available at https://aidsinfo.unaids.org, including monthly service delivery data under the “Service Continuation” tab.
[5] Estimates for the end of 2025 will be available in early June 2026.

3. There has been a shift, however, in political commitment to the response to HIV, with competing priorities and declines in foreign assistance. International aid for health from several major donors has been projected to drop by up to 40% in 2025 compared with 2023.[6] Resources for HIV prevention and community-led organizations are especially at risk. This comes amid uneven progress in HIV prevention and treatment services across regions and populations. HIV treatment coverage among people living with HIV was 84% in Eastern and Southern Africa and 48% in the Middle East and North Africa in 2024. In Eastern and Southern Africa, adolescent girls and young women (aged 15–24 years) are 3–4 times more likely to acquire HIV than their male counterparts in the same age group. This also comes with a regression in human rights affecting key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings, and all people living with HIV. For example, the number of countries criminalizing same-sex relationships has been increasing, with four new countries introducing criminalization in 2025.[7]

4. Communities and civil society organizations have rallied to support each other and the HIV response. Many Governments have stepped up in leadership and taken action to improve the sustainability of their HIV responses and increase domestic funding for health and HIV. For example, 26 countries have reported plans to increase their domestic budgets.[8] This has enabled some countries to maintain or even increase the number of people receiving HIV treatment.

5. UNAIDS, with the mandate from countries, works with countries and partners to develop evidence-based global HIV targets in five-year increments and provide a global monitoring and accountability framework. In 2011, at the high-level meeting of the General Assembly on HIV/AIDS, the world set a target to reach 15 million people living with HIV with treatment by 2015[9] and then met that target in 2015.[10] A good example of the success of the HIV targets is the global HIV 95–95–95 testing and treatment targets set by the General Assembly at its high-level meeting in 2021[11] to be reached by 2025, whereby 95% of people living with HIV know their HIV status, 95% of people who know their HIV-positive status are on antiretroviral therapy, and 95% of people on antiretroviral therapy have a suppressed viral load. There has been widespread adoption of the 95–95–95 targets by countries, communities, donors and stakeholders. Seven countries in Eastern and Southern Africa,[12] all with large HIV epidemics, achieved all three "95" targets in 2024, although not necessarily across all subpopulations at highest risk or across all ages. Some countries[13] have also been in reach of the prevention target of a 90% reduction in the number of new HIV infections by 2030 since 2010.[14]

6. A key strength of the global HIV response are the five-year global AIDS strategies, which include results-focused accountability frameworks endorsed by countries, led by communities and supported by the United Nations to align partners around shared goals. Since the 2001 Declaration of Commitment on HIV/AIDS, these

[6] Pascal Zurn and others, "Official development assistance for health: an expected 40% reduction", P4H Network, 23 April 2025.

[7] UNAIDS, *Global AIDS Update 2025*.

[8] UNAIDS, *World AIDS Day Report 2025: Overcoming Disruption – Transforming the AIDS Response* (Geneva, 2025).

[9] See General Assembly resolution 65/277.

[10] UNAIDS, "'15 by 15': a global target achieved", 2015.

[11] See General Assembly resolution 75/284.

[12] Botswana, Eswatini, Lesotho, Namibia, Rwanda, Zambia and Zimbabwe.

[13] Lesotho, Malawi, Nepal, Rwanda and Zimbabwe.

[14] UNAIDS, *Global AIDS Update 2025*.

frameworks have linked global targets to strategies that are adapted into national strategic plans based on local realities.

7. The General Assembly has played a central role by galvanizing political commitment, agreeing time-bound targets, providing a platform for accountability and annual reporting, and reviewing and setting new targets every five years.

8. Through multilateral action, in particular by UNAIDS, countries are supported to develop national strategic plans and to generate, analyse and use data to track results, identify gaps and accelerate action where needed. Communities and civil society have been critical to this accountability cycle, driving progress by holding Governments and institutions to account for the commitments they have made. Each year, UNAIDS collects data on the status of country epidemics and responses from over 150 countries, and these data are made accessible transparently to support all countries, communities, donors and stakeholders in monitoring, planning and guiding their investments in their HIV responses.

9. This report recommends that the forthcoming high-level meeting adopt new HIV targets for 2030, building on the 2025 targets, which will drive the world towards ending AIDS as a public health threat and, importantly, sustaining the response after 2030. The 2030 targets (see figure VI) were developed by taking into account the need for countries to sustain their HIV responses. The targets aim to ensure that people living with HIV have long and healthy lives, while moving countries towards a sustainable HIV response.

II. Where are we now? Transforming the HIV response

10. An estimated 1.3 million [1.0 million–1.7 million] people acquired HIV in 2024 globally – 40% fewer than in 2010. An even steeper 56% decline in the number of new infections was achieved in sub-Saharan Africa, which is home to half of all people who acquired HIV in 2024. Countries reduced the annual number of children acquiring HIV through vertical transmission to 120,000 [82,000–170,000], a 62% drop since 2010 and the lowest number since the 1980s. Overall, programmes to prevent vertical transmission of HIV averted nearly 3.8 million HIV acquisitions in children between 2010 and 2024.

11. In 2024, remarkable progress towards reaching the 95–95–95 testing and treatment targets had been achieved. Globally, an estimated 87% [69–>98%] of all people living with HIV knew their HIV status, 89% [71–>98%] of people who knew their HIV-positive status were on antiretroviral therapy, and 94% [75–>98%] of people on antiretroviral therapy had a suppressed viral load. Globally, in 2024, about three quarters of the 40.8 million [37.0 million–45.6 million] people living with HIV were receiving antiretroviral therapy (77% [62–90%]), and 73% [66–82%] had a suppressed viral load – a huge public health achievement. In sub-Saharan Africa, home to more than 60% of all people living with HIV, the provision of antiretroviral therapy, among other advances, led to a rebound in life expectancy from 56.5 years in 2010 to 62.3 years in 2024.[15]

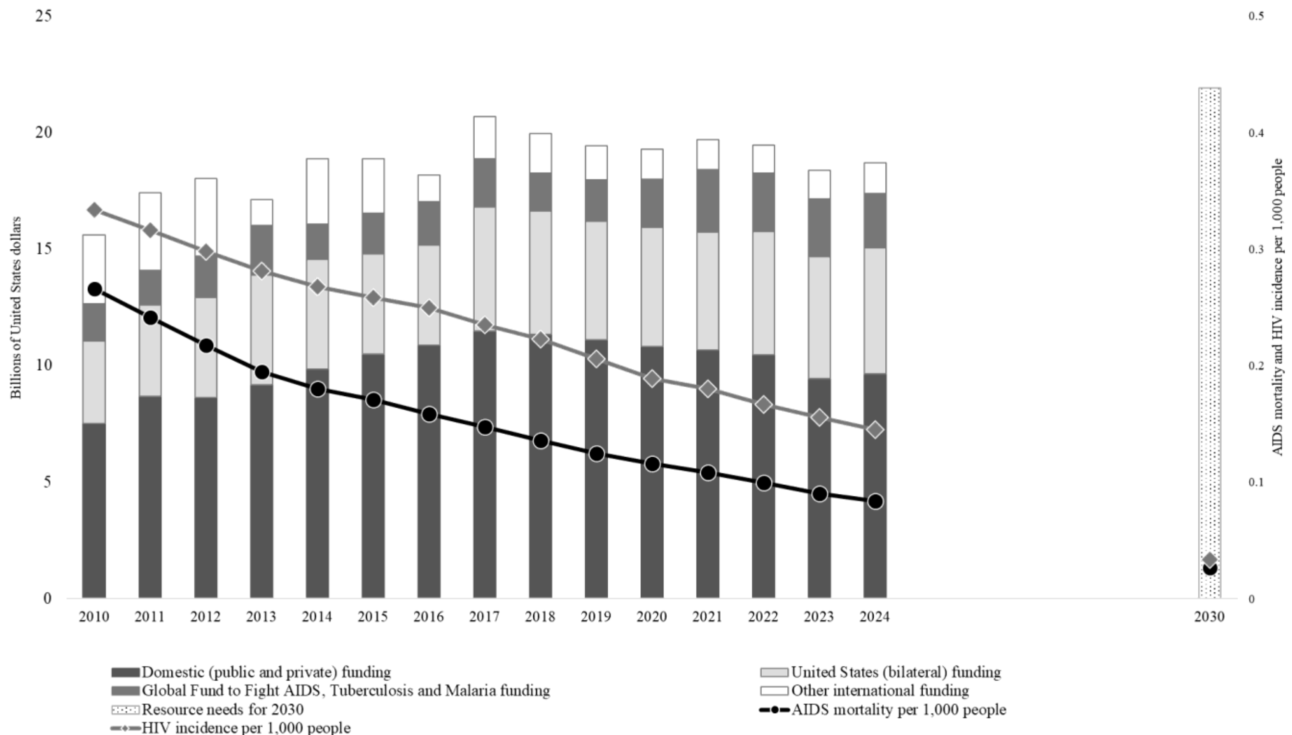
12. The number of global AIDS-related deaths – 630,000 [490,000–820,000] in 2024 – was still unacceptably high, but was 54% lower than in 2010, an achievement made possible by the large-scale provision of HIV testing and treatment services. The number of AIDS-related deaths among children was reduced from 240,000 [160,000–340,000] in 2010 to 75,000 [50,000–110,000] in 2024.

---

[15] United Nations, Population Division, Data Portal. Available at https://population.un.org/dataportal/.

13. This progress was underpinned by a financing landscape that, although still not reaching the levels needed to end AIDS, had shown global commitment from international donors and countries affected by HIV. Between 2010 and 2024, domestic HIV financing increased by 28% and international financing increased by 12% (see figure II).

Figure II
Distribution of HIV resources in low- and middle-income countries, and trends in HIV incidence and AIDS-related mortality, 2010–2024



Source: UNAIDS financial and epidemiological estimates, 2025.

Inroads in the response to HIV have been impressive but uneven

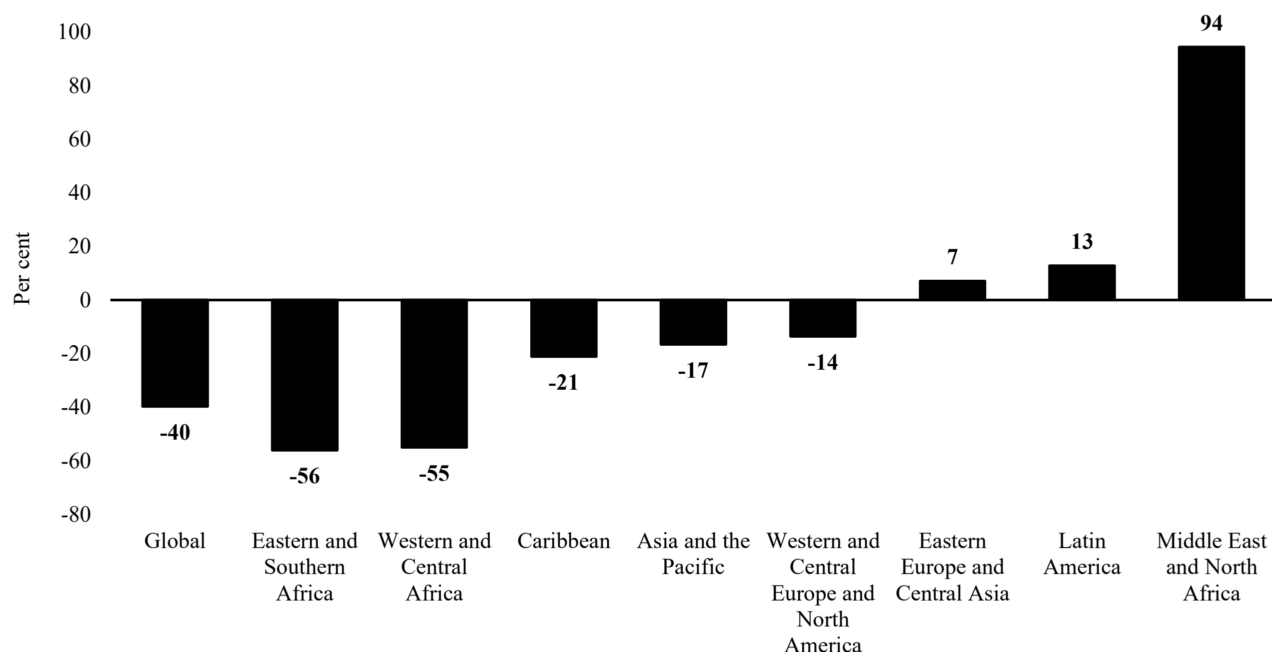
14. Despite this progress, the gains against HIV were spread unevenly across regions and populations. HIV testing and treatment coverage and viral suppression levels among people living with HIV improved across all regions in 2024, but they still lagged considerably in Eastern Europe and Central Asia, the Middle East and North Africa, and some countries in Asia and the Pacific.

15. Sub-Saharan Africa was home to half of the 9.2 million people globally in 2024 who needed but were not receiving HIV treatment. A further quarter of the total unmet need was in Asia and the Pacific. More than 620,000 of the estimated 1.4 million [1.1 million–1.8 million] children living with HIV were not receiving antiretroviral therapy in 2024. Globally, about 12% of all AIDS-related deaths in 2024 were among children, even though children accounted for only 3% of all people living with HIV. Men living with HIV, people from key populations, and vulnerable people, such as refugees and migrants, were less likely to be receiving treatment in many countries.[16]

[16] UNAIDS, *Global AIDS Update 2025*.

16. The number of new HIV infections decreased between 2010 and 2024 by 56% in sub-Saharan Africa, 21% in the Caribbean and 17% in Asia and the Pacific, but increased by 94% in the Middle East and North Africa, 13% in Latin America and 7% in Eastern Europe and Central Asia (see figure III).

Figure III
Percentage change in annual numbers of new HIV infections between 2010 and 2024, global and by region



Source: UNAIDS epidemiological estimates, 2025 (https://aidsinfo.unaids.org/).

17. Service gaps and deficiencies in HIV programmes and health and community systems contributed to an estimated 120,000 [82,000–170,000] children (aged 0–14 years) acquiring HIV in 2024, the majority of whom were in sub-Saharan Africa (83%). Greater access to antenatal care and integration of HIV testing and treatment with antenatal care are needed to improve health outcomes for mothers and children.

18. In 2024, 4,000 adolescent girls and young women (aged 15–24 years) acquired HIV every week, including 3,300 a week in sub-Saharan Africa. This is the result of structural inequalities that heighten women's and girls' vulnerability to HIV and restrict their ability to protect their own health.[17]

19. HIV prevention has fallen dangerously behind, and preventable infections continue to occur. HIV programmes are failing to reach people from key populations and their sexual partners, who account for an estimated 74% of new HIV infections outside sub-Saharan Africa and about 26% in sub-Saharan Africa.[18] Globally, the share of HIV acquisitions among people from key populations and their partners rose from 44% in 2010 to 49% in 2024.[19] Prevention services that did exist for people from

[17] Sanyukta Mathur and others, "HIV vulnerability among adolescent girls and young women: a multi-country latent class analysis approach", *International Journal of Public Health*, vol. 65, No. 4 (May 2020).
[18] UNAIDS, *World AIDS Day Report 2025*.
[19] Ibid.

key populations and for women and girls relied heavily on external assistance, but much of this support was halted in early 2025.[20]

20. Many of the barriers and inequalities that undermine progress against HIV persist. Stigma, discrimination, punitive laws, gender inequality and violence continue to limit people's ability to stay HIV-free or to live safe and healthy lives in dignity if they acquire HIV.[21] The 10–10–10 societal enabler targets set for 2025 by the 2021 Political Declaration on HIV and AIDS aimed to address these barriers. These targets, however, are not within reach. In many countries, limited political will constrains the scale and reach of multisectoral and integrated HIV-related services and protections for communities of people from key populations and other vulnerable populations.[22]

Gains are fragile and need to be protected

21. The progress achieved to date needs to be protected. Outside sub-Saharan Africa, antiretroviral therapy programmes are largely financed domestically. In Western and Central Africa, where donors provided 90% of treatment-related funding (including 53% from the Global Fund to Fight AIDS, Tuberculosis and Malaria), and in Eastern and Southern Africa, where international support accounted for 38% of funding in 2024,[23] such programmes are especially vulnerable to donor reductions.[24]

22. HIV prevention is especially at risk, particularly as external funding contributed almost 80% of HIV prevention in sub-Saharan Africa, 66% in the Caribbean and 60% in the Middle East and North Africa in 2024.[25] As changes to the funding landscape continue, we must ensure that all people living with, at risk of or affected by HIV have access to the HIV services they need, with safe spaces, peer support groups, legal literacy programmes and treatment networks.

23. For more than 40 years, community-led organizations and civil society, including the faith sector, have shaped and powered HIV programmes across the world. Community-led organizations, particularly those leading the delivery of peer-supported services, have been shown to increase testing uptake, improve adherence to antiretroviral therapy, strengthen retention in care, achieve higher levels of viral load suppression and reduce vertical transmission in multiple settings and countries.[26] Progress on the 30–80–60 targets set out in the 2021 Political Declaration regarding community service delivery has been difficult to measure, slow and insufficient due to chronic underfunding of community-led responses and shrinking civic space in many countries.[27] Recent funding shifts have caused many community-led organizations to reduce or cease their HIV activities, underscoring the urgency of accelerating sustainability measures to protect proven life-saving community-led responses.

---

[20] UNAIDS, "Impact of US funding cuts on HIV programmes in East and Southern Africa: 15 March–1 April", 31 March 2025.

[21] Carla M. Doyle and others, "The impact of HIV stigma and discrimination on HIV testing, antiretroviral treatment, and viral suppression in Africa: a pooled analysis of population-based surveys", *The Lancet HIV*, vol. 13, No. 4 (April 2026).

[22] UNAIDS, *Global AIDS Update 2025*.

[23] Global monitoring of UNAIDS-supported national AIDS spending assessments for 2019–2024 (see https://aidsinfo.unaids.org/).

[24] Judith Sherman and Hein Marais, "The future is on the line: the cost of inaction on HIV for children", UNAIDS and United Nations Children's Fund, 26 November 2025.

[25] Doyle and others, "The impact of HIV stigma".

[26] George Ayala and others, "Peer- and community-led responses to HIV: a scoping review", *PLoS One* (2021).

[27] Civicus, "Global findings 2025", Civicus Monitor database. Available at https://monitor.civicus.org/globalfindings_2025/.

Countries, communities and regional institutions are stepping up to take the lead

24. As international resources decline, transitions to national self-reliance have started and HIV responses are becoming more sustainable and country-owned. These transitions involve accelerated integration of the response into health, social and financial systems as they strengthen, while incorporating community leadership, growing domestic revenue mobilization and investments for health and HIV.

25. In several countries, strong national leadership is growing to sustain or even increase domestic funding for HIV responses while external funding shifts. Countries reporting to UNAIDS up to and including 2025, such as Burundi, Ethiopia, Mozambique and Ukraine,[28] have relatively steady numbers or even an increase in new antiretroviral therapy initiations. Despite considerable limitations on fiscal space, many low- and middle-income countries moved swiftly in 2025 to preserve HIV services and strengthen national responses. Although these increases in domestic investments do not compensate fully for reductions in international assistance, they have helped to mitigate some of the impacts of funding cuts.

26. In 2024, UNAIDS and partners began developing a new approach with countries to plan sustainably for the HIV response. This approach, reflected in the development of national HIV response sustainability road maps, relies on inclusive, participatory, country-driven and country-owned processes that integrate community leadership, gender and human rights. More than 30 countries, with support from UNAIDS and partners, have developed clear, actionable road maps to end AIDS as a public health threat, increase domestic financing and secure HIV-related gains across future years.

27. Across the world, communities of people living with, at risk of or affected by HIV have rallied to support each other and protect progress in the HIV response. NEPHAK, a national network of people living with or at risk of HIV in Kenya, is actively advocating for integration of HIV into general medical care and inclusion of HIV treatment in the package of services covered by the national health insurance programme.[29] In Viet Nam, the key population-led Lighthouse has piloted tiered co-payment models for pre-exposure prophylaxis (PrEP) to mitigate the effects of donor cuts and provided financial support to community members affected by service cutbacks.[30] Through its Fighter, Intelligent, Empowered, Resilient, Courageous and Excelling (FIERCE) campaign, the International Community of Women Living with HIV Eastern Africa has positioned young women at the forefront of advocacy for HIV prevention in their communities and countries.

28. Regional leadership, in particular the African Union, stepped up actions throughout 2025 with the African Union Road Map to 2030 and Beyond: Sustaining the AIDS Response, Ensuring Systems Strengthening and Health Security for the Development of Africa, which pledged to ensure diversified and sustainable financing for HIV and other health programmes;[31] a new African Epidemics Fund established to support countries in preparing for and responding to future health emergencies;[32] and the launch of the "Accra reset", where African leaders, convened by the President

[28] Monthly country-reported data through Global AIDS Monitoring platform.
[29] See personal communication, FR Anam, Global Network of People Living with HIV, 27 October 2025, in UNAIDS, *World AIDS Day Report 2025*.
[30] See personal communication, T Doan, Lighthouse, Viet Nam, 27 October 2025, in UNAIDS, *World AIDS Day Report 2025*.
[31] African Union, *African Union (AU) Roadmap to 2030 and Beyond: Sustaining the AIDS Response, Ensuring Systems Strengthening and Health Security for the Development of Africa* (Addis Ababa, 2025).
[32] Africa Centres for Disease Control and Prevention, "Africa's health financing in a new era", April 2025.

of Ghana, John Dramani Mahama, called for the creation of new governance and financing models for regional health and development.[33]

Critical importance of continuing international support for efforts to end AIDS

29. Although many countries are advancing greater ownership and financing of their HIV responses, continued international support remains essential to enable a sound and equitable transition, particularly for low-income countries and for preserving and further strengthening community-led responses.

30. Positive developments in the second half of 2025 with respect to the two primary international funders of global HIV programmes – the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Government of the United States of America – point to opportunities to accelerate progress against HIV with a drive towards self-reliance and sovereignty. Continued bilateral engagement, notably with the America First Global Health Strategy and significant renewed commitment in the global HIV response,[34] together with strong multilateral commitment reflected in pledges of $12.64 billion to the eighth replenishment of the Global Fund,[35] provides important momentum for countries to invest in high-impact HIV programmes to reach the people who need services the most.

Harnessing innovation to amplify impact and optimize efficiency

31. Maximizing HIV viral load suppression through timely HIV diagnosis, linkage to care and strong treatment adherence are cornerstones of the response, improving health outcomes for people living with HIV and eliminating the risk of transmission when viral load suppression is achieved. People with an undetectable viral load have zero risk of transmitting HIV to their sex partners, and people with a suppressed viral load have a near-zero risk of doing so.[36,37] With appropriate prevention measures, transmission to infants can also be prevented. The “U=U” (undetectable = untransmissible) message is critical and relevant across the HIV response.

32. Effective use of the combination of HIV prevention and treatment is essential to reduce the number of new HIV infections and accelerate progress. Innovations have the potential to make finite resources go further and maximize the public health impact of HIV investments. Mathematical modelling commissioned by UNAIDS underscores the critical importance of further programmatic scale-up and maintenance of very high service coverage levels.[38] This modelling, however, also demonstrates that HIV treatment, although essential, will not end AIDS on its own. Scaled-up HIV treatment must be complemented by an equally robust commitment to bring HIV prevention services to everyone who needs them.

33. In recent years, the development of long-acting injectable PrEP regimens as a complement to daily oral PrEP has brought new urgency and reinvigorated partnerships for HIV prevention. UNAIDS set bold HIV prevention targets and mobilized partners in multiple sectors, and the World Health Organization rapidly updated technical guidelines with recommendations for lenacapavir to increase

---

[33] Sara Jerving, “The ‘Accra reset’: time’s up for the legacy aid system”, Devex, 1 October 2025.

[34] United States of America, Department of State, “America First Global Health Strategy”, September 2025.

[35] Global Fund, “Global Fund board welcomes final eighth replenishment outcome of US$ 12.64 billion, backs strategic shifts to advance countries’ path to self-reliance”, 18 February 2026.

[36] A person’s viral load is undetectable when it is so low that a polymerase chain reaction test cannot measure it. A suppressed viral load is defined as equal to or less than 1,000 copies/mL.

[37] World Health Organization (WHO), *The Role of HIV Viral Suppression in Improving Individual Health and Reducing Transmission: Policy Brief* (Geneva, 2023).

[38] UNAIDS, *World AIDS Day Report 2025*.

adoption of and access to this prevention option.[39] In September 2025, the Government of the United States announced that it would support efforts by the Global Fund to provide long-acting PrEP to up to 2 million people in high-HIV-burden countries.[40] The Gates Foundation announced a partnership with Hetero Labs in India[41] and the Clinton Health Access Initiative and Unitaid entered into a similar partnership with Dr. Reddy's Laboratories[42] to manufacture generic versions of long-acting PrEP at a cost of $40 per person per year, with the aim of making the intervention affordable to national health systems. Equitable access to medicines and particularly to innovations at affordable prices is essential.

34. Communities play a critical role at the forefront of the HIV response, organizing, advocating and demanding access to services and the latest scientific advances.[43] When new technologies such as long-acting PrEP are developed, community-led organizations work to build demand and deliver services in acceptable and accessible ways,[44] ensuring that they reach the people who need them most.

III. Ending AIDS as a public health threat by 2030

35. The Global AIDS Strategy for 2026–2031,[45] adopted at the UNAIDS Programme Coordinating Board meeting in December 2025, provides the foundation for the recommendations set out in this report. It considers the impact of rapid changes in the HIV, global health and development ecosystem, and sets out a path for collective action over the next five years and beyond. The Strategy aims that, by 2030, 40 million people living with HIV are on HIV treatment and have a suppressed viral load; 20 million people are accessing HIV prevention, including antiretroviral-based HIV prevention options; and all people can access discrimination-free HIV-related services.

Renewed commitments and country-focused targets

36. Sixteen top-line targets are proposed that structure the global response into distinct, manageable sections and serve to simplify accountability while addressing evolving challenges (see figure VI).[46] Some targets are maintained from the 2021 Political Declaration because they have not yet been achieved by all countries and remain crucial. A new focus of the targets is on sustainability and integration.

37. Achievement of the 16 targets is expected to avert 3.3 million new HIV infections and 1.4 million AIDS-related deaths between 2025 and 2030, effectively meeting the 2030 goal of ending AIDS, with a 90% reduction in numbers of new HIV

[39] WHO, *Guidelines on Lenacapavir for HIV Prevention and Testing Strategies for Long-Acting Injectable Preexposure Prophylaxis* (Geneva, 2025).

[40] United States, Department of State, "PEPFAR commits to distributing breakthrough HIV drug lenacapavir demonstrating American excellence in science and American leadership in HIV prevention", 4 September 2025.

[41] Gates Foundation, "Gates Foundation partners with Indian manufacturer to drive down cost of, accelerate access to groundbreaking HIV prevention tool", 24 September 2025.

[42] Unitaid, "Unitaid, CHAI, and Witts RHI enter into landmark agreement with Dr. Reddy's to make HIV prevention tool lenacapavir affordable in LMICs", 24 September 2025.

[43] Ayala and others, "Peer- and community-led responses to HIV".

[44] Wawira Nyagah and others, "How might we motivate uptake of the dual prevention pill? Findings from human-centered design research with potential end users, male partners, and healthcare providers", *Frontiers in Reproductive Health* (2023).

[45] UNAIDS, *The Global AIDS Strategy for 2026–2031: United Towards Ending AIDS* (Geneva, 2026).

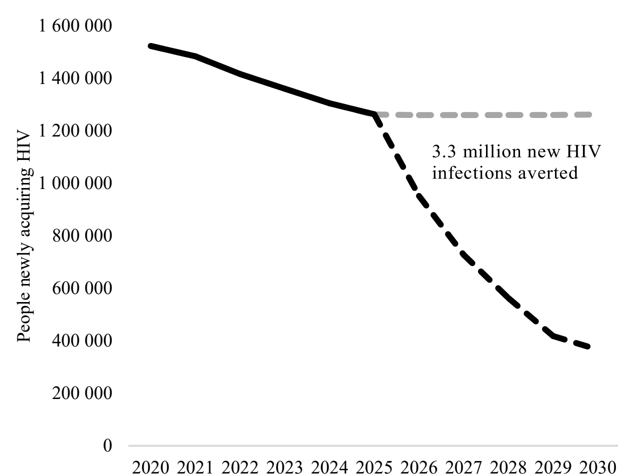
[46] UNAIDS, "Recommended 2030 targets for HIV" (see https://www.unaids.org/en/recommended-2030-targets-for-hivUNAIDS).

infections and AIDS-related deaths compared with 2010 (see figure IV). A further 5% reduction in numbers of new infections per year after 2030 would ensure the sustainability of longer-term progress in countries and communities after 2030.[47]

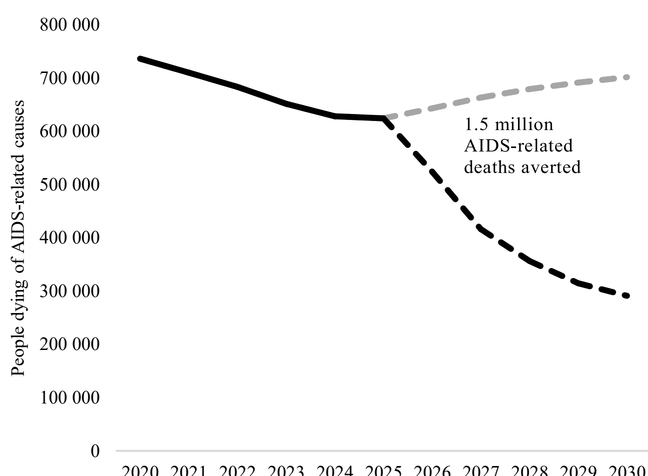
38. The goal can be achieved if people are able to consistently access HIV treatment to live healthy lives and reduce onward transmission; if they can access other effective prevention options; if stigma and discrimination are reduced; and if policies, laws and structural barriers that prevent people from accessing services are removed.

Figure IV
Potential new HIV infections and AIDS-related deaths averted if 2030 HIV targets are met, global 2020–2024 estimates and 2025–2030 projections

New HIV infections



AIDS-related deaths



Meeting 2030 targets   Constant 2024 coverage

Source: UNAIDS epidemiological estimates, 2025, and projections by the HIV Modelling Consortium "Goals" model.

New estimates of resource needs

39. UNAIDS projections indicate that achieving the Global AIDS Strategy targets will require annual resources of $21.9 billion in low- and middle-income countries by 2030 – about 0.2% of global health spending. This is lower than the previous estimate of $29.3 billion, due to price reductions and other savings achieved in recent years.[48]

40. Most annual resource needs for HIV in 2030 will be in upper-middle-income countries (46%), with the remainder in lower-middle-income countries (34%) and low-income countries (20%).[49] In 2024, HIV funding globally amounted to $18.7 billion, with domestic funding accounting for 52% of this. Based on differentiated domestic financing targets, it is envisaged that low-income countries would fund about a third, lower-middle-income countries about two thirds and upper-middle-income countries almost the entirety of their HIV responses with domestic resources, consistent with fiscal capacity space. Achieving these targets would

[47] Ibid.

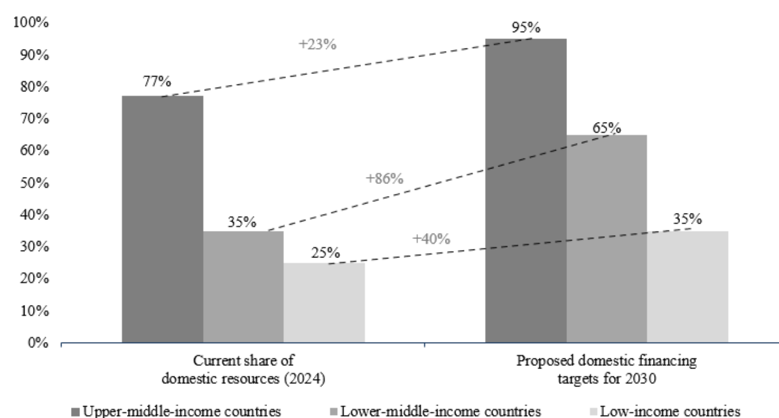
[48] John Stover and others, "The impact and cost of reaching the UNAIDS global HIV targets", medRxiv. 2 July 2025.

[49] The new estimates exclude upper-middle-income countries, which the World Bank reclassified as high-income countries in 2024.

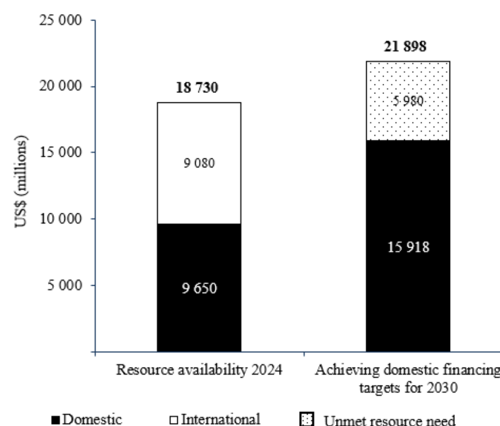
increase the overall domestic share across low- and middle-income countries to roughly two thirds of total needs by 2030. Sustained international support will remain crucially important in some countries, including those affected by conflict (see figure V).

Figure V
Estimated HIV resources available in low- and middle-income countries in 2024, estimated resource needs in 2030, and scenario in which domestic HIV financing targets are met

Current share of domestic resources and proposed domestic financing targets for 2030 in low-, lower-middle-income and upper-middle-income countries



Estimated HIV resources available in low- and middle-income countries in 2024 and estimated needs for 2030



Source: UNAIDS financial estimates, July 2025.
Note: the domestic financing targets reflect the average share of domestic resources across different income groups by 2030. Within each group – particularly among lower-middle-income and low-income countries – there is significant variation in disease burden and fiscal capacity across countries. These targets aim to encourage greater domestic ownership at the national level for a collective increase across each of the income groups.

Three priorities to end AIDS as a public health threat by 2030

41. The Global AIDS Strategy for 2026–2031 reinforces a shift towards people-centred approaches, while deepening expectations that national HIV responses be led by countries, communities and civil society within a framework of shared responsibility. In doing so, the Strategy consolidates and accelerates an ongoing transition in the HIV response, from an emergency-oriented, externally financed model towards a sustainable, nationally led, rights-based, gender-transformative and integrated approach embedded in resilient systems. It emphasizes long-term domestic financing; integration of HIV within universal health coverage, primary healthcare and other platforms; and the formalization of mechanisms to support community-led responses.

42. Within the Strategy, three core priorities and eight results areas have been identified, along with measurable targets that countries can monitor (see figure VI):

(a) Priority 1 emphasizes domestic leadership, diversified financing and integration of HIV into universal health coverage systems. It calls for fiscal innovation, multisectoral collaboration, integration into primary healthcare and strengthened country data systems, including governance grounded in equity and privacy;

(b) Priority 2 focuses on integrated, differentiated and people-centred HIV services that ensure access to HIV prevention, testing, treatment and care for people

living with, at risk of or affected by HIV by combining biomedical tools, structural interventions and societal and behavioural change and by pursuing equitable access to medicines and other health products;

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

43. Taken together, the priorities constitute a costed, measurable and focused agenda for ending AIDS by 2030 and sustaining multisectoral, inclusive national HIV responses into the future. The priorities lay out an ambitious but attainable path towards an historic public health achievement: ending AIDS as a public health threat by 2030.

Sustaining gains and building durable HIV responses

44. Sustainability requires robust, forward-looking planning and transformative approaches. Countries will need service delivery systems for healthcare that provide accessible, high-quality services to people living with, at risk of or affected by HIV, while minimizing out-of-pocket expenditure amid financial pressures. This requires supporting communities to provide prompt and adequate support and addressing structural barriers to access to services.

45. Sustainability calls for strategic investments in national and local capacities, including flexible and diversified financing arrangements that combine public revenues, additional domestic sources through health insurance schemes or health taxes, continued grants and financing instruments, ensuring responsible transitions by donors as countries strengthen their own public systems and get ready for self-reliance.

46. The HIV response has been a global pioneer in integrated, people-centred health service models.[50] Among the 152 countries with available data, about a quarter have integrated their HIV responses with broader health strategies. Integration of systems has the potential to boost efficiencies, generate cost savings and improve the overall functioning of health systems, including in humanitarian settings. In the context of rapidly integrating responses, it is important to ensure that integrated services can be provided without stigma and discrimination, preserve people-centred approaches and protect human rights and gender equality.[51]

[50] Caroline A. Bulstra and others, "Integrating HIV services and other health services: a systematic review and meta-analysis", *PLoS Medicine* (2021).

[51] Global Network of People living with HIV, "People Living with HIV Stigma Index 2.0: global report 2023 – hear us out: community measuring HIV-related stigma and discrimination", 2023.

Figure VI
Summary of the Global AIDS Strategy for 2026–2031

Abbreviations: NSP, needle and syringe programmes; OAT, opioid agonist therapy; PEP, post-exposure prophylaxis; SRH, sexual and reproductive health; STI, sexually transmitted infection.

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

47. AIDS cannot be overcome in isolation. HIV responses must be integrated within broader public health and development systems and agendas. Such integration strengthens impact, improves efficiency and sustainability and ensures that HIV responses contribute to and benefit from resilient, people-centred systems that address the full range of needs of people living with, at risk of or affected by HIV.

48. In many countries, health and other key services are managed and provided at local levels, allowing for productive partnerships to be developed between communities, local authorities, service providers, philanthropy, faith-based organizations, the private sector and other actors.

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

50. Multilateral action remains essential to generate and sustain political commitment, align partners including countries, communities, civil society, the private sector, local authorities, faith-based organizations, foundations, international organizations and other stakeholders behind shared goals and targets, advance normative guidance on international standards and strengthen accountability for results. A multilateral and multisectoral response has been one of the hallmarks of success of the HIV response, bringing together partners and stakeholders across sectors and society around a common goal with clear complementary efforts. It secures sustained, coordinated multilateral financing, as well as collaboration across different institutions and disciplines.

51. Through its convening power, the United Nations plays a central role in supporting countries to translate global commitments into coordinated, country-led action, and is working to ensure its support for the HIV response to remain fit for the future. In this context, the Secretary-General proposed, as part of the UN80 Initiative, to initiate a sunset process for UNAIDS in 2026 and mainstream its capacities and expertise into the relevant entities of the United Nations development system. The ultimate goal would be to ensure a smooth transition process to the co-sponsors that protect the Organization's ability to support the Global AIDS Strategy across all functions currently performed by UNAIDS. Accordingly, the UNAIDS Programme Coordinating Board decided at its fifty-seventh session to establish a working group on the further transition and integration of UNAIDS into the United Nations system and beyond. The working group was mandated with providing an interim report by June 2026 and a finalized plan by October 2026, in coherence with the UN80 Initiative, for subsequent transmission to the Economic and Social Council.[52] The working group is examining, inter alia, options to ensure continuity of critical functions – leadership and advocacy, convening and coordination, accountability through data, targets and strategy, and community leadership and engagement – including considerations for partially or integrally transitioning the functions of the UNAIDS secretariat into a hub hosted by a multilateral entity. It is also considering future funding and governance arrangements to ensure continued global stewardship of the Global AIDS Strategy, and a United Nations-mandated governance model that preserves the role of civil society and communities in decision-making.

[52] UNAIDS, "Terms of reference: PCB working group on the further transition and integration of UNAIDS into the UN system and beyond", 24 February 2026.

United to end AIDS

52. Collectively, the world has the means to end AIDS. Success depends on sustained political commitment, effective people-centred programmes, enabling policies, resilient health and community systems and sustainable financing. The leadership and experience of communities of people living with, at risk of or affected by HIV remain central to driving progress. A clear path to ending AIDS as a public health threat by 2030 exists and, united, we can arrive there.

IV. Recommendations

53. Member States are urged to adopt the following recommendations, advancing the three priorities of the Global AIDS Strategy for 2026–2031 and its top-line targets to end AIDS as a public health threat and build a sustainable, people-centred response. Together, these actions aim to reduce by 2030 the number of new HIV infections by 90% compared with 2010 levels, with a continued 5% decline per year after 2030, and to reduce the number of AIDS-related deaths by 90% compared with 2010 levels.

Recommendation 1
Build sustainable, multisectoral, rights-based and country-owned responses to HIV

54. Member States are urged:

(a) To ensure adequate, predictable and sustainable financing for people-centred HIV responses, including achieving the target of $21.9 billion mobilized annually for HIV investments in low- and middle-income countries, increasing the share of domestic financing for HIV, and reducing out-of-pocket expenditure for HIV in line with universal health coverage objectives so that cost is not a barrier to accessing HIV prevention, treatment, care and support;

(b) To integrate HIV services and HIV-related health and community systems with primary healthcare, broader health systems and key non-health sectors (including labour, education, justice, gender and humanitarian) to reach the targets of ensuring that 95% of people who are receiving HIV prevention or treatment services also receive sexual and reproductive health services (including for sexually transmitted infections) and 95% of pregnant women living with HIV and their newborns receive maternal and newborn care that integrates or links to comprehensive HIV services, including for the prevention of HIV and hepatitis B and the treatment of syphilis;

(c) To invest in integrated country-owned, surveillance, information and data collection systems, with the engagement of multiple sectors and communities, to ensure effective prevention, timely diagnosis, treatment and care of HIV and comorbidities. These should be linked to high-quality resource-tracking systems, which are critical for accelerating progress towards the targets.

Recommendation 2
Deliver people-focused services to guarantee equity, dignity and access to HIV services for people who need them most

55. Member States are urged:

(a) To scale up combination HIV prevention that brings together biomedical, behavioural, structural and community-led interventions to reach the target of 90% of people in need of prevention use effective prevention options, including PrEP, post-exposure prophylaxis, male and female condoms, needle–syringe programmes and opioid agonist maintenance therapy;

(b) To ensure equitable access to available, accessible, acceptable and high-quality HIV testing, treatment and care, and reach the 95–95–95 targets whereby 95% of people living with HIV know their HIV status, 95% of people who know their HIV-positive status are on antiretroviral therapy, and 95% of people on antiretroviral therapy have a suppressed viral load, among women, men, young people, children, people from key populations, and people from other vulnerable groups at higher risk of HIV acquisition, including refugees, migrants and Indigenous people;

(c) To end HIV-related stigma and discrimination and uphold human rights and gender equality in the HIV response, including through accelerated legal and policy reform to remove barriers that undermine access, sustainability and integration of HIV services and responses, and renew efforts to reach the 10–10–10 targets: <10% of people living with HIV and key populations experience stigma and discrimination; <10% of women, girls, people living with HIV and people from key populations experience gender inequality and violence; and <10% of countries have punitive legal and policy environments that deny or limit access to services;

(d) To ensure equitable and timely access to scientific, medical and technological innovations in HIV testing, prevention, treatment and care, including new and long-acting technologies, so that advances in science translate into real-world benefits for all people in need, everywhere, by promoting balanced legal frameworks that enhance country capacity to manage intellectual property rights through a public health lens.

Recommendation 3
Ensure community leadership

56. Member States are urged:

(a) In line with the Greater Involvement of People Living with HIV/AIDS principle, and recognizing their essential contributions to the sustainability of the response, to ensure that communities of people living with, at risk of or affected by HIV continue to lead the way in the HIV response by shaping policies, delivering services, providing quality assurance and driving accountability for the commitments that Governments have made;

(b) To strengthen community leadership and renew efforts to reach the 30–80–60 targets so that 30% of HIV testing and supportive services related to care and treatment are delivered by community-led organizations, including key population-led and women-led organizations, 80% of people-centred HIV prevention programmes for key populations are delivered by community-led organizations, and 60% of programmes that support achievement of the societal enablers are delivered by community-led organizations, including key population-led and women-led organizations.

Recommendation 4
Renew and affirm multilateral leadership and accountability through the United Nations to sustain collective ambition and action to end AIDS as a public health threat

57. Member States are urged:

(a) To annually report progress on national HIV epidemics and responses using global indicators and robust monitoring systems disaggregated by age and sex and identifying the gaps in services coverage and HIV response outcomes. These reports should continue to inform, inter alia, the General Assembly, the Economic and Social Council and the high-level political forum on sustainable development,

enabling evidence-based review, mutual accountability and timely course correction in a changing global health and development context;

(b) To consider convening a high-level meeting on HIV and AIDS in 2031 to review progress on the commitments made in 2026 towards the goal of ending AIDS as a public health threat by 2030 and sustaining it into the future, to consolidate a safe and durable transition of the global HIV response, while also taking stock of interim progress at the 2027 and 2030 General Assembly summits on the global goals.