2030 HIV Targets

Global Task Team for developing 2030 HIV targets

Summary report on meeting to propose targets

Glion, Switzerland, 29–31 October 2024

UNAIDS 2025

Background

The Global Task Team (GTT) for developing 2030 HIV Targets convened in Glion, Switzerland on 29–31 October 2024 to review proposals for 2030 HIV targets and to make recommendations to UNAIDS about a set of targets that would move countries toward the global goal of ending AIDS as a public health threat by 2030. These targets are intended to focus countries and all stakeholders on the most important aspects of the HIV response. The targets will provide the basis for the 2026–2031 global AIDS strategy and for the negotiation of the United Nations Political Declaration on HIV that countries will commit to at the next United Nations High-level Meeting on AIDS in 2026.

The GTT was composed of individuals that were chosen based on their expertise in the HIV response while also representing four distinct stakeholders in the response (see Annex 1 for membership). The GTT members represented: national governments, multilateral and donor organisations, civil society, and academic and public health experts.

The three-day meeting built on a series of earlier GTT meetings (March–September 2024) and on the work of GTT subgroups in five thematic areas: (1) HIV prevention, (2) HIV treatment, (3) societal enablers and communities, (4) integration, and (5) financing. The meeting was organized to facilitate discussion and decision-making about targets in each respective thematic area, with attention also given to how the targets and thematic areas fit together into a coherent and comprehensive framework.

This summary of the meeting synthesizes findings and outcomes from across different meeting sessions, addressing the five thematic areas as well as other key topics of discussion.

Key considerations of the Global Task Team on targets

The GTT sought to propose targets that were balanced in terms of attention given to major aspects of the HIV response (prevention, treatment, stigma and discrimination etc.), could be used to demonstrate impact, and were evidence-informed, easy to communicate, human rights-based, promoting gender equality, realistic, measurable, inclusive and person-centered. Important cross-cutting considerations included key populations, inequalities and multisectoral collaboration.

Decisions at the meeting were based in part on breakout sessions and reporting back from those sessions. The meeting co-chairs and session chairs structured the discussions to ensure that the perspectives of all four stakeholder groups were considered by the full GTT. The meeting also included updates on the status of two modeling exercises to inform the selection of targets. One exercise was to assess the impact of achieving the 2030 targets. The other exercise was to estimate resource requirements for achieving the targets.

In reflecting on 2030 targets, the GTT discussed the current context of the HIV response and concerns about declining resources, failure to meet 2025 HIV prevention targets, inequalities and inattention to societal enablers driving worse outcomes for key and vulnerable populations, communities not sufficiently empowered or supported to help lead national responses. In addition, the group recognized the large population needing to be sustained on ART for decades into the future and the risk of global resurgence of HIV if prevention and treatment efforts were not maintained or expanded.

The GTT recalled that global targets serve to galvanize and mobilize the international community around common goals. This common commitment is part of what has made the HIV response a success story of multilateralism. The targets are central to define our 2030 goals (the WHAT) and the next Global AIDS Strategy will outline HOW we get there (operationalizing the targets);.

The 2030 targets aim to:

- Generate country commitment and action. They have been intentionally selected so they can be applicable in every country;
- Show continuity with the existing Global AIDS Strategy 2021-2026 where evidence remains relevant and 2025 targets have not been achieved;
- Improve prioritization and simplify accountability by reducing the number of targets as compared with the 2025 set of targets;
- Demonstrate a commitment to integration and link with existing country commitments and strategies – e.g. ante-natal care, sexual and reproductive health, cervical cancer, TB, education.

Deliberations about the new targets reflected GTT members' shared recognition that fundamental changes are required to achieve top-line HIV prevention and treatment goals by 2030 and to maintain progress against HIV in the decades that follow. Across the five thematic areas, the following issues particularly stood out as "game-changers," i.e., opportunities to redefine the global HIV response in ways that will close prevention and treatment gaps, reduce inequalities, and ensure sustainability.

1. Achieve viral load suppression by ensuring access to rights-based, barrier-free, **HIV treatment services**
2. **Scale up HIV prevention choices** taking advantage of new HIV prevention technologies (e.g. long-acting PrEP);
3. **Integrate** HIV services in relevant health interventions (ANC, SRH, TB, etc.) and in other sectors of development (e.g. education, justice);
4. **Empower communities to lead** in the HIV response including in their role to ensure access to quality services;
5. Lay the foundation for **sustainable financing** of the HIV response including through progressive increases in domestic financing and preventing a rise in out-of-pocket expenses.

During the meeting there was discussion about prioritizing the targets. However that work only took place after the Glion meeting. See the final summary of the 2030 HIV targets for this prioritization and the list of topline and second tier targets:
recommended_2030_HIV_targets_livedocument_en.pdf

Outcomes by thematic area

HIV prevention

The GTT's discussion of HIV prevention targets resulted in a set of fifteen targets being recommended for inclusion in the 2030 targets. Five of the targets were existing 2025 targets to be extended to 2030, four are targets with minor modifications and five were new. The GTT further recommended an enhancement to the overall outcome target of reducing new HIV infections by 90% between 2010 and 2030, with the target being expanded to also call for a continued reduction in new HIV infections of 5% per year after 2030.

The following were among the considerations that informed decision-making about the recommended set of targets:

- Interest was expressed in how to formulate a target that would drive wider uptake of new HIV prevention technologies including PrEP interventions. There was discussion about the merits and drawbacks of focusing a target on PrEP initiation rather than PrEP adherence. It was recognized that potential demand for PrEP may vary greatly across countries and at-risk populations in the coming years.
- An approach of PrEP targets being directly linked to setting-specific and population-specific HIV incidence without thresholds but a more continuous relationship was considered, but it was perceived that this approach was overly complex to be elaborated as a global target. It was decided that the detailed algorithms for establishing country and population-specific PrEP targets should be defined as part of global and country needs estimation.
- The GTT's final recommendation for a target on the issue calls for 50% of people at very high risk of acquiring HIV, including key populations, to use effective PrEP and PEP options, with "target levels in line with epidemiology and people's choices".
- Concern was expressed about a proposed target on condom use relying on data that are collected through household surveys at five-year intervals, and it was suggested that countries need more recent data to guide programming. Attention was called to the utility of condom distribution data as a proxy measure for condom use, and to the ready availability of condom distribution data.
- The GTT addressed this concern by recommending the addition of a new target, "95% of the estimated need for condoms is available and distributed". The GTT also recommended similar new targets for distribution of PrEP, PEP and sterile syringes.
- There was discussion about the rationale for having a proposed 50% target for uptake of opioid agonist therapy (OAT) among people who inject opioids, since 50% was markedly lower than other prevention targets. After considering GTT members' input about contextual factors including OAT availability and community preferences, the GTT chose to recommend keeping the target at 50%.
- Regarding a target on "condom use at last sex with a non-regular partner," questions were raised about the term "non-regular partner" lacking precision and being stigmatizing. In response, it was noted that the source of data to measure performance on this target is a Demographic and Health Survey question that has long been in use and clearly defines "non-regular partner" as a partner that is not a marital nor co-habiting partner.
- The GTT recommended that a current 2025 target known as one of three "community leadership targets" be kept and be grouped with prevention targets in the 2030 targets framework. The target calls for 80% of HIV prevention services for key populations to be delivered by community-led organizations, noting that this includes the role of

communities around support for service delivery, awareness-raising and should be still relevant even in the context of delivering injectable PREP.

HIV treatment and care

The GTT's discussion of HIV treatment and care targets resulted in a set of eleven targets being recommended for inclusion in the 2030 targets. Nine of the targets were existing 2025 targets proposed to be extended to 2030, some of which underwent modifications. Two targets were new, one recommended screening for advanced HIV disease the other including existing WHO target addressing preventive therapy for tuberculosis for people living with HIV. Targets for HIV testing, treatment and viral suppression called for disaggregation for different key populations given significant heterogeneity within and between populations, core age groups, and pregnant and breastfeeding women.

The GTT's recommendations about this set of targets took into consideration the following issues:

- Interest was expressed by some GTT members in recasting the "95-95-95" HIV testing and treatment targets by shifting from the current conditional denominators for treatment coverage and viral suppression to the denominator of all people living with HIV. With the proposed denominator, the target of "95% of people living with HIV who know their HIV status are receiving antiretroviral therapy" would change to "90% of people living with HIV are receiving antiretroviral therapy". The target of "95% of people on antiretroviral therapy have a suppressed viral load" would change to "86% of people living with HIV have a suppressed viral load". Higher target levels were also considered.

- Potential benefits and drawbacks of changing the denominator and changing the target levels were identified. It was suggested that asking countries to report treatment coverage and viral load suppression in terms of all people living with HIV denominator would provide a clearer picture of their overall program performance. It was also suggested that using that denominator could present an opportunity for communicating the urgency of maintaining a strong HIV response, whereas retaining the widely known "95-95-95" targets and associated messaging might encourage the misconception that sufficient progress is being made against HIV. However, concern was expressed that shifting the denominator could be disruptive and confusing for many stakeholders who are accustomed to reporting on and tracking progress on the 95-95-95 targets, and that it could undermine political momentum to support the HIV response. Using the conditional denominator also can lead to more accurate measures of the 2nd and 3rd 95.
- The GTT recommended retaining the 95-95-95 targets while deciding to also recommend the following new target: "90% of all people living with HIV are virally suppressed by 2030, increasing to 95% by 2040". This target stimulates additional ambition for countries that have already reached the 95-95-95 targets to maintain the success of the treatment programme and continue increasing the population that is virally suppressed. The percentage of all people living with HIV that are virally suppressed is an important marker of the success of programmes in optimizing the benefit of treatment to prevent new HIV infections. The push to go beyond 2030 should contribute to building the long-term sustainability of the HIV response.
- The GTT recommended that a current 2025 target calling for "all pregnant and breastfeeding women living with HIV [to receive] lifelong antiretroviral therapy" be incorporated into the 95-95-95 targets in the interest of reducing and simplifying targets,

with the result that new numerical targets for pregnant and breastfeeding women were less than the 100% treatment coverage target for 2025. A current 2025 target on antiretroviral therapy for children was likewise proposed to be incorporated into the 95-95-95 targets.

- The GTT considered different options for developing 2030 targets that would drive progress in reducing AIDS-related deaths. It was agreed that a target on retention in care was not needed, since high retention in care is a prerequisite for achieving the third 95 target on viral suppression. A target was considered on time from seroconversion to diagnosis but was dropped when it was decided that measuring performance on a target on advanced HIV disease (AHD) would be more straightforward. Concern was expressed that a focus on screening for AHD at the time HIV is diagnosed would not be sufficient in consideration of high incidence of AHD following discontinuation of antiretroviral therapy. The GTT's final recommendation for an AHD target was: "95% of people newly diagnosed with HIV and people reinitiating antiretroviral therapy are screened for AHD as measured by CD4 count (or WHO staging when CD4 is not available)". The addition of the WHO staging criteria was included to ensure that the lack of a CD4 test would not inhibit medical professionals from starting people living with HIV on treatment.
- The GTT recommended grouping the existing 2025 target that calls for 30% of HIV testing, treatment and care services to be delivered by community-led organizations with HIV treatment and care targets in the 2030 targets framework. This target also was slightly reworded to clarify that the role of community-led organizations is to provide supportive services related to care and treatment rather than clinical services.

Societal enablers and communities

The GTT's discussion of societal enablers and communities targets focused primarily on a limited number of proposed new targets, as there was agreement about recommending that twenty one societal enablers targets and five community-related targets of which three are from the 2025 targets be extended to 2030. The GTT's recommendations about new targets reflected the following concerns:

- Interest was expressed in introducing a 2030 target on the proportions of members of key populations who experienced arrests relating to their key population identity or behavior. The rationale for this target was the availability of strong evidence linking arrests to poor HIV outcomes among members of key populations. Questions were raised about whether the proposed target should be broadened to address other types of violations in addition to arrests, such as administrative detention (i.e., compulsory treatment for people who use drugs). The final recommended wording of the new target was: "<10% of key populations experience harassment, arrest, detention or incarceration in the past year at an individual level". It was recognized that other types of violations such as physical and emotional violence were already suitably addressed in proposed stigma and discrimination targets.
- The GTT recommended moving forward with a proposed new target on coercion, mistreatment and abuse of women living with HIV in sexual and reproductive health services.
- Following discussions about how to safeguard the functioning of HIV related community-led organizations in problematic legal and regulatory environments, the GTT recommended the following target: "90% of countries remove regulatory barriers for community-led organizations (registration, eligibility, etc.)".

- GTT members expressed agreement with suggestions to introduce a 2030 target on community-led monitoring. The diversity of potential applications of community-led monitoring across different countries was recognized as a challenge in establishing a globally relevant target. The GTT's final recommendation for a community-led monitoring target was: "90% of countries incorporate community-led monitoring into national decision-making processes to strengthen accountability in HIV and tuberculosis programs".

Integration

The discussion of the GTT on integration for an improved people-centred and more sustainable HIV response resulted in a final set of nine targets being recommended for inclusion in the 2030 targets. The GTT subgroup that developed proposals for integration targets worked with the purpose of identifying targets that would "support the key outcomes of reducing HIV-related and non-HIV-related morbidity and mortality". The subgroup also reflected on the compelling new evidence of the need to integrate HIV-specific and non-HIV-specific health services to enhance both HIV and other health outcomes among people living with and at risk of HIV.

Three of the targets were existing 2025 targets. Six were new, of which three are aligned with WHO's existing global HIV and other relevant disease strategies. The recommended targets focused on HIV coinfections with viral hepatitis, HIV comorbidities with non-communicable diseases (NCDs) and cervical cancer, as well as sexual and reproductive health (including sexually transmitted infections), and mental health conditions. One of the targets was designed around the prevention of vertical transmission of HIV, hepatitis B virus (HBV) and syphilis. The following points informed decision-making:

- Depression was prioritized over other mental health conditions, including anxiety, as a well-documented highly prevalent condition among people living with HIV across the life-course that also often constitutes a barrier to accessing HIV services. An initial proposal for a mental health target focused on "screening and treatment services and psychosocial support" for depression, however, over the course of the detailed discussions, the focus geared towards only screening as a more measurable option and an essential "entry" point for further mental health treatment and/or psychosocial support for people living with HIV.
- The subgroup deemed it necessary to align with the WHO's global health sector strategies for HIV, STIs and viral hepatitis and the respective 2030 global viral hepatitis B and C targets focused on people living with HIV - "Percentage of people living with HIV tested for/and cured from hepatitis C – 90%/80%", and "Percentage of people living with HIV diagnosed/and treated for hepatitis B – 90%/80%", but with a specific focus on testing for HBV and HCV.
- The subgroup discussed some of the GTT members' initial proposal to focus one of the integration targets on older people living with HIV with the view of the increasing proportion of the ageing population of people living with HIV globally and the increasingly acute need to address their unique health needs, including managing NCDs and specific mental health conditions. Since the two new integration targets – for addressing NCDs and depression among people living with HIV were inclusive of older people living with HIV, the GTT no longer deemed it necessary to have a separate target for this age group.

The GTT agreed that the need, level, modalities and other dimensions of integration of systems for health for strengthening people-centered and sustainability of HIV response in countries are

local context-specific and thus, would be difficult to express numerically or measure as a global integration target. Hence, it was recommended that systems integration as an approach should be further detailed within the next Global AIDS Strategy rather than in the targets per se.

Financing

The GTT's discussion of financing targets resulted in a final set of seven targets being recommended for inclusion in the 2030 targets. Four of the targets were global targets rather than country targets. One, an existing 2025 target, addressed the total financial investment in HIV in low- and middle-income countries by 2030. The second, also an existing 2025 target, addressed financial resources for societal enabler interventions. The third recommended global target was an existing World Health Organization target addressing equitable pricing for diagnostics and therapeutics. The fourth recommended global target addressed financial resources for HIV prevention. Other recommended targets respectively addressed domestic funding for national HIV responses, resources for societal enablers, community-led activities including community-led monitoring, and out-of-pocket expenditures.

Decision-making about this set of targets took into consideration the following information and views shared at the meeting:

- Concern was expressed about the need for countries to invest more domestic resources in their HIV responses to offset declining external funding, and a target was proposed to address this issue. Because of the great variation in funding contexts, it was thought to be problematic to set a target asking all countries to aspire to providing the same proportion of domestic funding for national HIV budgets. Instead, the recommended target called for low-income countries, lower-middle-income countries and upper-middle income countries to provide different levels of domestic HIV funding.
- When the GTT considered how to establish a target that would encourage countries to fund the work of community-led organizations, it was recognized that a specific numerical target would not be equally suitable across all countries. The GTT instead recommended a target calling on countries to "commit to monitoring and reporting on resources allocated to community-led and other civil society organizations" to carry out HIV-related work including community-led monitoring and other activities.
- It was noted that National AIDS Spending Assessments (NASA) are expected to soon have new components that address funding for community-led activities, and that within two to three years it may be feasible to use NASA data to guide more informed decision-making about suitable levels of country funding for community-led organizations.
- It was agreed resource constraints in the future might result in an increase in our of pocket expenses and including a target to limit these would be useful. The sub-group on financing was invited to define such a target in line with existing UHC language.

Modeling the impact of proposed targets

John Stover (Avenir Health) shared preliminary results of a modeling exercise to simulate the impact of achieving the proposed GTT 2030 targets. The modeling team used the Goals HIV simulation model, which was previously used to simulate the impact of the 2025 targets. The model used risk categories from the model developed for the 2025 targets to generate

preliminary results, assuming a linear scale-up of intervention coverage from 2023 levels to 2030 target levels. The model assumed a PrEP method mix of 90% lenacapavir and 10% oral/ring PrEP.

Model results indicated that if proposed 2030 targets are met, new HIV infections will be reduced from the 2010 baseline of approximately 2.1 million to less than 500,000 in 2030. This would represent an 88% decline, almost in line with the 2030 impact target of achieving a 90% reduction in new infections from 2010. Meeting the targets was projected to reduce AIDS-related deaths 76% from the 2010 baseline, bringing AIDS-related deaths to under 400,000 annually. The model showed the number of annual new HIV infections dropping below the number of total deaths to the HIV population (the incidence mortality ratio for epidemic control) in 2025.

The anticipated volume of services required to achieve the results of the model was presented with disaggregation for various groups of service recipients. While the required volume of services for adults on antiretroviral therapy was projected to increase slightly, and decreases were projected for children on antiretroviral therapy and women receiving vertical transmission services, large increases were required in other populations. The required volume of services for sex workers and for men who have sex with men would need to increase by almost 50% and almost 40%, respectively. A threefold increase would be required in the volume of PrEP services used and continued over the course of a year.

Stover noted that a series of updates will be made to the model in accordance with ongoing research and country reviews before it is used to make projections based on the recommended 2030 targets.

It was also noted that estimates of the impact of achieving the current societal enabler targets show that 2.5 million more HIV infections could be prevented compared to a scenario in which no progress is made on societal enabler targets. Likewise, achieving the current societal enabler targets would result in the prevention of 1.7 million more AIDS-related deaths in comparison to the “no progress” scenario.

Estimating resource needs for implementation

Deepak Mattur (UNAIDS) reported on the status of ongoing work to estimate the “global price tag” for achieving the 2030 targets. Mattur shared a costing projection from the previous iteration of Price Tag to achieve 2025 targets showing resource needs through 2030, with the total cost in 2020, the baseline year, estimated to be US$ 21.6 billion. The total cost is projected to peak at US$ 29.3 billion in 2025, then decline slightly to US$ 28.2 billion in 2030. In 2025, approximately one-third of projected costs are for HIV testing and treatment, and another one-third are for primary prevention. Key population interventions account for almost half of all estimated primary prevention resource needs in 2025.

Mattur also shared cost comparisons from 2019, 2027, 2028 and 2029 across five categories of interventions: HIV testing and treatment, prevention of vertical transmission of HIV, primary prevention, program management and societal enablers. The model anticipates a steep increase in required resources for primary prevention, from approximately US$ 5 billion in 2019 to more than US$ 9 billion per year in 2027–2029, indicating that a large primary prevention funding gap will need to be closed. There is also a large anticipated funding gap for societal enablers, which are projected to require almost US$ 4 billion in 2029.

Mattur noted that UNAIDS has convened a group of global experts who participated in a September 2024 consultation on the evolving prices of health commodities. Work on costing the 2030 targets will continue in the first quarter of 2025 and costing findings will inform the target-development and strategy development processes.

Next steps after Glion

Regarding the communication of target-development results, peer-reviewed articles will be developed for submission in early 2025. Results also will be communicated in webinars and on the UNAIDS website. It was proposed that a narrative explaining why specific targets were included or changed would be beneficial for helping stakeholders understand the GTT's decision-making.

A few additional meetings will be held by the integration group and the finances group to agree on some final adjustments to the targets. Two additional consultations will present the draft targets to the HIV Multisectoral Leadership Forum and a group of broader development experts. Finally, the draft targets and the narrative will be shared with the GTT members for their final review.

After this meeting an additional virtual meeting was held to propose and agree on a set of prioritized targets. See the Summary targets report for more on the topline and second tier targets.

Annex 1. Global task team members

Co-chairs

Chewe Luo, consultant, former Director HIV, UNICEF
Michel Kazatchkine, consultant, former Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria

Members

Allan Maleche, Kenya Legal and Ethical Issues Network on HIV and AIDS
Andrew Spieldenner, MPact Global Action for Gay Men's Health and Rights
Anne Stangl, US Centers for Disease Control and Prevention
Annette Sohn, TreatAsia and amfAR
Anurita Bains, UNICEF
Binod Mahanty, Federal Ministry of Health, Germany
Chinmoyi Das, National AIDS Control Organization, India
Chris Beyrer, Duke Global Health Institute
David Serwadda, Makerere University
Draurio Barreira, Ministry of Health, Brazil
Eric Fleutelot, Expertise France
Erika Castellanos, Global Action for Trans Equality
Florence Riako Anam, Global Network of People Living with HIV
Judy Chang, International Network of People who Use Drugs
Jules Kim, Network of Sex Work Projects, Co-Chair Human Rights Reference Group
Linda-Gail Bekker, University of Cape Town Center
Maximina Jokonya, Y+ Global
Meg Doherty, WHO
Mohammed Abdulaziz, Africa CDC
Nduku Kilonzo, Yemaya Health Advisory, Kenya
Otar Chokoshvili, Infectious Disease, AIDS and Clinical Immunology Center, Georgia
Peter Vickerman, University of Bristol
Rebecca Bunnell/Jasmine Buttolph, PEPFAR
Robert Selato, National AIDS and Health Promotion Agency, Botswana
Siobhan Crowley, Global Fund to fight AIDS, TB and Malaria
Solange Baptiste, International Treatment Preparedness Coalition
Wafaa El-Sadr, International Center for AIDS Care and Treatment Program
Yewande Olaifa, National Agency for the Control of AIDS, Nigeria
Yogan Pillay / Neeta Bhandari, Gates Foundation

Modelling/guidance

Jeff Imai-Eaton, Harvard University
John Stover, Avenir Health
Kelsey Case, Imperial College London
Kennedy Kipkoech Mutai, University of Bristol

Laura Porter, US Centers for Disease Control and Prevention
Mehran Hosseini, Global Fund to Fight AIDS, Tuberculosis and Malaria
Stefan Baral, Johns Hopkins University
Tim Brown, Avenir Health