THE URGENCY OF NOW

EXECUTIVE SUMMARY

AIDS AT A CROSSROADS

2024 GLOBAL AIDS UPDATE

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2024 GLOBAL AIDS UPDATE

FOREWORD

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UNAIDS Executive Director

This report shows that world leaders can fulfil their promise to end AIDS as a public health threat by 2030, and in so doing prevent millions of AIDS-related deaths, prevent millions of new HIV infections, and ensure the almost 40 million people living with HIV have healthy, full lives. Through powerful case studies and new data, the report shows how some countries are already on the right path—and how all countries can get on it.

The report also shows that, right now, the world is not on track to succeed, and the inequalities that drive the HIV pandemic are not being addressed sufficiently. It shows that due to the lack of progress on prevention, global numbers of new HIV infections are not declining fast enough, and in three regions of the world numbers of HIV infections are rising. It shows that almost a quarter of people living with HIV are not receiving lifesaving treatment, and consequently a person dies from AIDS-related causes every minute.

We know what enables success. Progress against HIV has been strongest in the countries that have invested as required in their responses and reformed their policies to enable people to access the services they need. To accelerate the end of AIDS as a public health threat, and to ensure services and systems are in place to meet the needs of the millions of

people living with HIV for decades to come, resourcing needs to be both sufficient and sustainable. Building a legal environment that facilitates access to effective, equitable and person-centred HIV services—including removing harmful criminalizing laws and tackling discrimination—is key to advancing and sustaining progress on prevention and treatment.

We know, too, what obstructs success. Progress is imperilled by the fraying of solidarity between and within countries. When political commitment to full financing and human rights is put at risk, progress in the HIV response is put at risk too.

A widening funding gap is holding back the HIV response in low- and middle-income countries, with fiscal space being tightened even further by the debt crisis. The recent surge in the promotion of anti-rights, anti-gender and anti-democracy policies is generating justified fear among people from marginalized communities who most need HIV prevention, testing, treatment and care services, and among the heroic frontline workers who provide them.

Advances in technology, in particular in the development of long-acting treatment and prevention options, can protect the health of everyone living with or at risk of HIV—but only if these technologies are shared with all low- and middle- income countries, and are produced by multiple manufacturers across the world at scale. Currently, patent-holders are not opening up access broadly enough to enable this breakthrough.

The HIV response is at a crossroads. Whether the world ends AIDS depends on the path that leaders take. The path that ends AIDS is not a mystery. It is a political and financial choice.

Some are reluctant to provide the scale of resourcing needed for ending AIDS. But, as the report demonstrates, the costs of not ending AIDS would be exponentially higher.

Some might like to walk away from the HIV response because the end is now in reach. But, as this report sets out, we cannot partly end a pandemic. Leaders can end AIDS as a public health threat only by overcoming it everywhere, for everyone.

Some imply that investments and reforms to end AIDS would detract from addressing other challenges. But, as the report illustrates, the actions needed to end AIDS will help advance the achievement of all the Sustainable Development Goals, ensure countries are prepared to overcome the pandemics of the future, and help secure a safer, fairer world for everyone.

I am sometimes asked whether I am an optimist about the HIV response, because the progress we have made shows the path that ends AIDS—or whether I am a pessimist, because restrictions on resourcing and rights are putting progress in danger. The answer is that I am neither an optimist nor a pessimist—I am an activist, because success depends on rising to the moment, on recognizing the urgency of now.

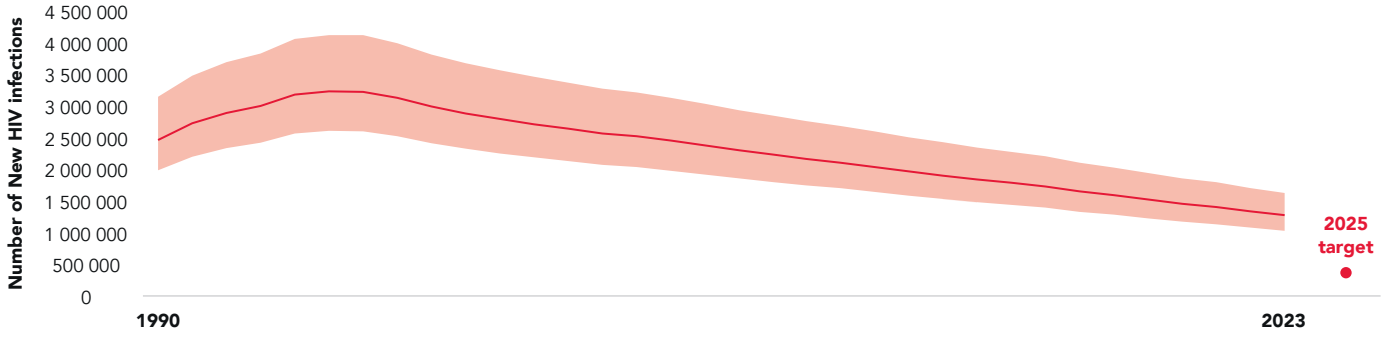
We can end AIDS, but only if leaders choose the right path now. We the people will ensure they do.

EXECUTIVE SUMMARY

Midway to the 2025 milestone set at the United Nations General Assembly in June 2021 *(1)*, the global HIV response has moved closer to the goal of ending AIDS as a public health threat by 2030, a commitment enshrined in the Sustainable Development Goals.

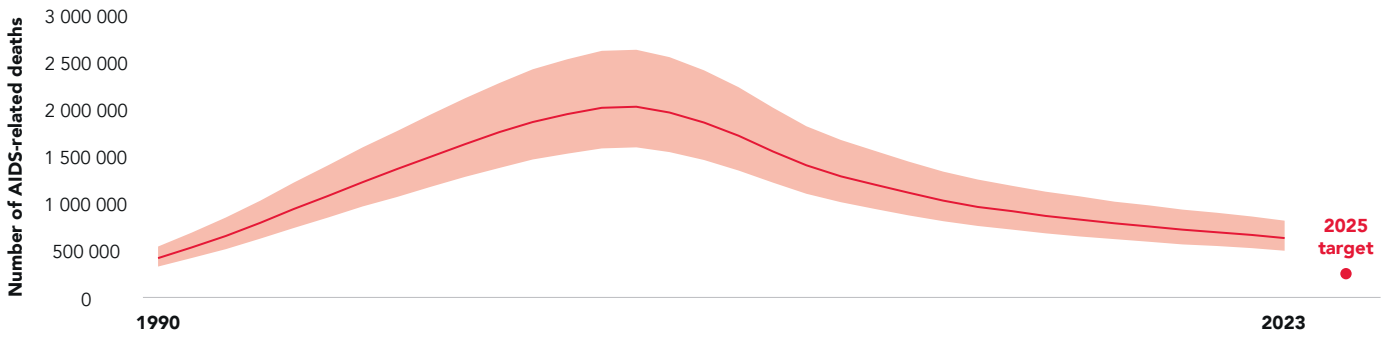
Fewer people acquired HIV in 2023 than at any point since the late 1980s. Almost 31 million people were receiving lifesaving antiretroviral therapy in 2023, a public health success that has reduced the numbers of AIDS-related deaths to their lowest level since the peak in 2004 (Figures 0.1 & 0.2)[1]. In sub-Saharan Africa, these successes have led to a rebound in average life expectancy from 56.3 years in 2010 to 61.1 years in 2023 *(2)*.

Figure 0.1 Number of new HIV infections, global, 1990–2023, and 2025 target



Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org/).

Figure 0.2 Number of AIDS-related deaths, global, 1990–2023, and 2025 target



Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org/).

1 For more information on UNAIDS data in this report see Annex 2 on Methods.

The progress is highly uneven, however. The global HIV response is moving at two speeds: relatively swiftly in sub-Saharan Africa, but hesitantly across the rest of the world. The numbers of people acquiring HIV are rising in at least 28 countries, some of which already have substantial epidemics. Many HIV programmes still neglect people from key populations,[2] exposing them to high risks of acquiring HIV. Programmes are also missing 9.3 million [7.4 million–10.8 million] people who need lifesaving treatment, with children and adolescents living with HIV especially affected. AIDS is not over—a great deal of unfinished work lies ahead.

The global AIDS response is at a crossroads: success or failure will be determined by which path leaders take today. *The Urgency of Now, AIDS at a Crossroads*, shows that the decisions leaders make this year will determine whether (or not) countries can achieve the 2030 target of ending AIDS as a public health threat and ensure progress beyond 2030.

While progress has been made in providing HIV treatment to over 30 million people, much more effort and urgency is required to accelerate prevention and break down the barriers that keep people, especially marginalized people, from both HIV prevention and treatment services.

Leaders, community members, and programme managers must work together to close the significant gaps that remain in access to HIV services. Progress on HIV prevention lags far behind what is required. HIV services will only reach people if human rights are upheld if unfair and harmful laws are removed, and if discrimination and violence are tackled. Equitable access to medicines and innovations, including long-acting technologies, is critical.

Now is the time to invest in ensuring that the 2025 targets are met and a sustainable response is built for the decades to come. The HIV response needs to adjust to become a sustainable, integrated pillar of health and social services with communities and human rights at the centre.

This report provides a summary of progress against the 2025 targets that were developed with the Global AIDS Strategy 2021–2026. The chapters describe progress against each target and Annex 1 provides a summary overview.

The HIV pandemic today

Globally, about 39% fewer people acquired HIV in 2023 compared with 2010, with sub-Saharan Africa achieving the steepest reduction (−56%). Nonetheless, an estimated 1.3 million [1.0 million–1.7 million] people acquired HIV in 2023—over three times more than the target of 370 000 or fewer new infections in 2025. Three regions are experiencing rising numbers of new HIV infections: eastern Europe and central Asia, Latin America, and the Middle East and North Africa.

2 People from key populations include sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and people in prisons and other closed settings

For the first time in the history of the HIV pandemic, more new infections are occurring outside sub-Saharan Africa than in sub-Saharan Africa. This reflects both the prevention achievements in much of sub-Saharan Africa and the lack of comparable progress in the rest of the world, where people from key populations and their sex partners continue to be neglected in most HIV programmes.

There is inadequate political will to fund and provide prevention programmes for people from key populations, and hostile legal and social conditions further limit their access to lifesaving services. Persistent stigma and discrimination related to HIV status, gender, behaviours or sexuality also stand in the way. The HIV-related needs of people from key populations are being served often by nongovernmental organizations, including community-led organizations, whose work tends to go unrecognized and underfunded.

Although decreasing, the incidence of HIV among adolescent girls and young women aged 15–24 years is extraordinarily high in parts of sub-Saharan Africa. Prevention programmes and efforts to reduce gender inequalities, violence against women and harmful gender norms are not having a big enough impact.

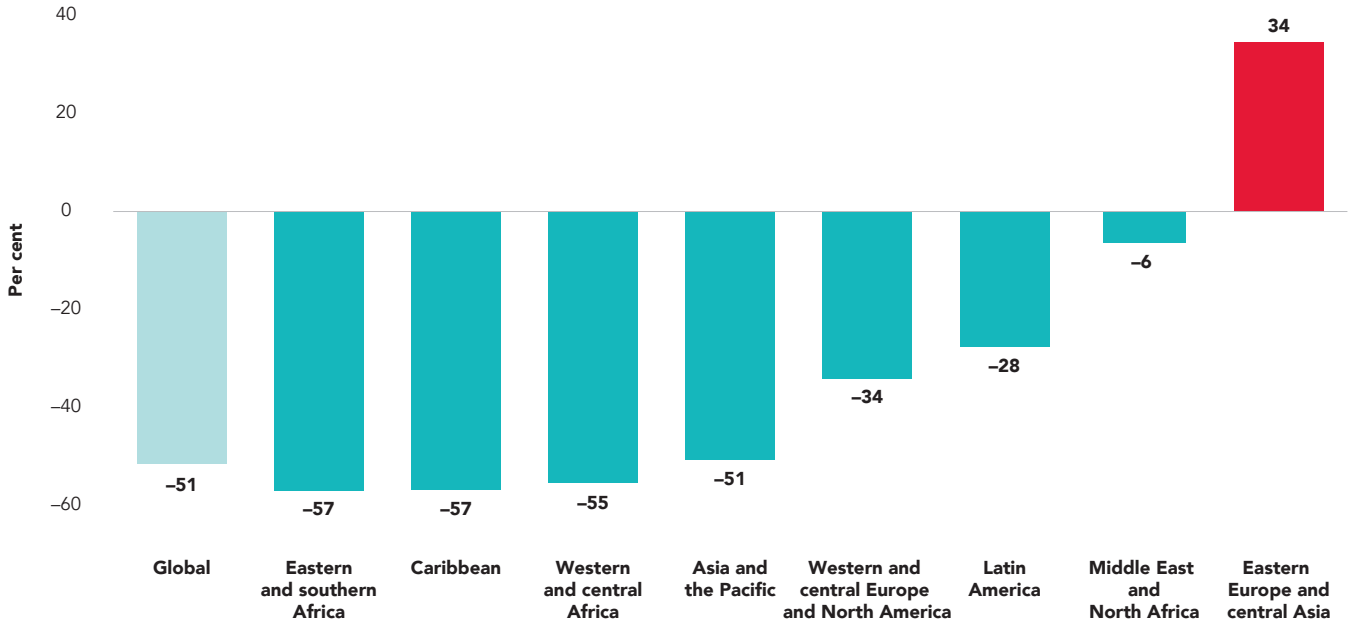
Far fewer children aged 0–14 years are acquiring HIV, a trend that is due largely to successes in eastern and southern Africa, where the annual number of new HIV infections in children fell by 73% between 2010 and 2023. The overall decline in vertical HIV infections,[3] however, has slowed markedly in recent years, particularly in western and central Africa. An estimated 120 000 [83 000–170 000] children acquired HIV in 2023, bringing the total number of children living with HIV globally to 1.4 million [1.1 million–1.7 million], 86% of whom are in sub-Saharan Africa.

Widening access to antiretroviral therapy—much of it provided free of charge and through the public health sector—has more than halved the annual number of AIDS-related deaths, from 1.3 million [1.0 million–1.7 million] in 2010 to 630 000 [500 000–820 000] in 2023. Treatment programmes are also driving down the numbers of new HIV infections.

An estimated 30.7 million [27.0 million–31.9 million] people were receiving HIV treatment in 2023. The world can reduce the number of AIDS-related deaths to fewer than the 2025 target of 250 000 if it achieves further rapid increases in diagnosing and providing HIV treatment to people living with HIV (Figure 0.3).

3 Vertical transmission of HIV occurs during the pregnancy and breastfeeding period.

Figure 0.3 Percentage change in annual number of AIDS-related deaths between 2010 and 2023, global and by region



Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org/).

The scale of the HIV pandemic is so large, however, that even these accomplishments still left about 9.3 million [7.4 million–10.8 million] people living with HIV without treatment in 2023, almost half (4.7 million [3.8 million–5.4 million]) of whom were in sub-Saharan Africa. Treatment coverage continued to be lower among men and among people from key populations especially in sub-Saharan Africa *(3)*, and it was especially low among children. Approximately 630 000 [500 000–820 000] people around the world lost their lives to AIDS in 2023, including 76 000 [53 000–110 000] children aged 0–14 years—one in eight people who died due to AIDS in 2023 was a child.

Mixed progress in serving people's prevention needs

Globally, the 2025 prevention target (95% of people at risk of HIV infection have access to and use effective combination prevention options) are not within reach. The global HIV prevention response is proceeding at an encouraging pace in sub-Saharan Africa, but it has stalled in other regions. Persistent and, in some countries, widening gaps in basic HIV prevention must be resolved urgently.

At least half of all people from key populations are not being reached with prevention services, according to data reported to UNAIDS. Men and women who inject drugs, gay men and other men who have sex with men, and transgender people are particularly neglected. In addition, more than half of the areas with high or moderately high HIV incidence[4] in sub-Saharan Africa are not being served by prevention programmes tailored for adolescent girls and young women.

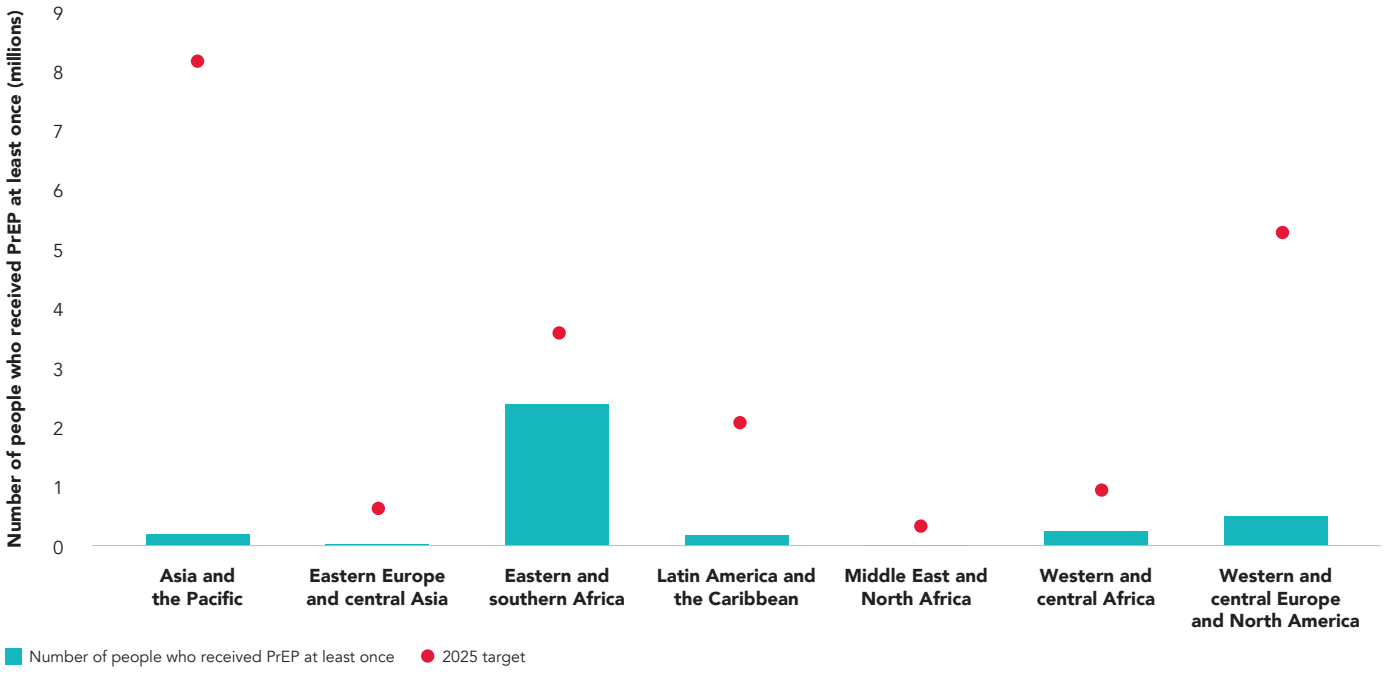
4 High HIV incidence denotes one or more new infections per 100 person-years. Moderately high incidence denotes 0.3–0.99 new infections per 100 person-years.

Condom use remains the most effective low-cost HIV prevention method (4, 5), but condom programmes have been defunded and social marketing schemes cut back in many countries *(6)*. Household survey data suggest condom use has declined in recent years, including among young people aged 15–24 years, and it is highly infrequent during sex with non-regular partners. About 36% of adults in eastern and southern Africa and 25% in western and central Africa used a condom at last sex.

Sex workers in some countries report high levels of condom use with clients, but their access to potent prevention tools such as pre-exposure prophylaxis (PrEP)[5] is minimal. The same is true for gay men and other men who have sex with men and for transgender people, except in a few high-income countries. Access to harm reduction services for people who inject drugs is extremely low in all but a few countries.

Rapid, wider access to PrEP could massively reduce the numbers of new HIV infections, especially among people from key populations and among women in areas where HIV incidence is currently high. The total number of people using oral PrEP rose from a little over 200 000 in 2017 to about 3.5 million in 2023 but is far short of the global 2025 target of 21.2 million people. Only the two regions in sub-Saharan Africa are making progress to reaching the 2025 PrEP targets (Figure 0.4). A six-month long-acting injectable PrEP product, lenacapavir, has shown extremely high efficacy in preventing HIV among adolescent girls and women in Africa. If this PrEP option is made available rapidly and affordably to potential users, it could herald a breakthrough for HIV prevention *(7)*.

Figure 0.4 Number of people who used pre-exposure prophylaxis (PrEP) at least once in 2023, by region, and 2025 target



Source: Global AIDS Monitoring, 2024 (https://aidsinfo.unaids.org/).

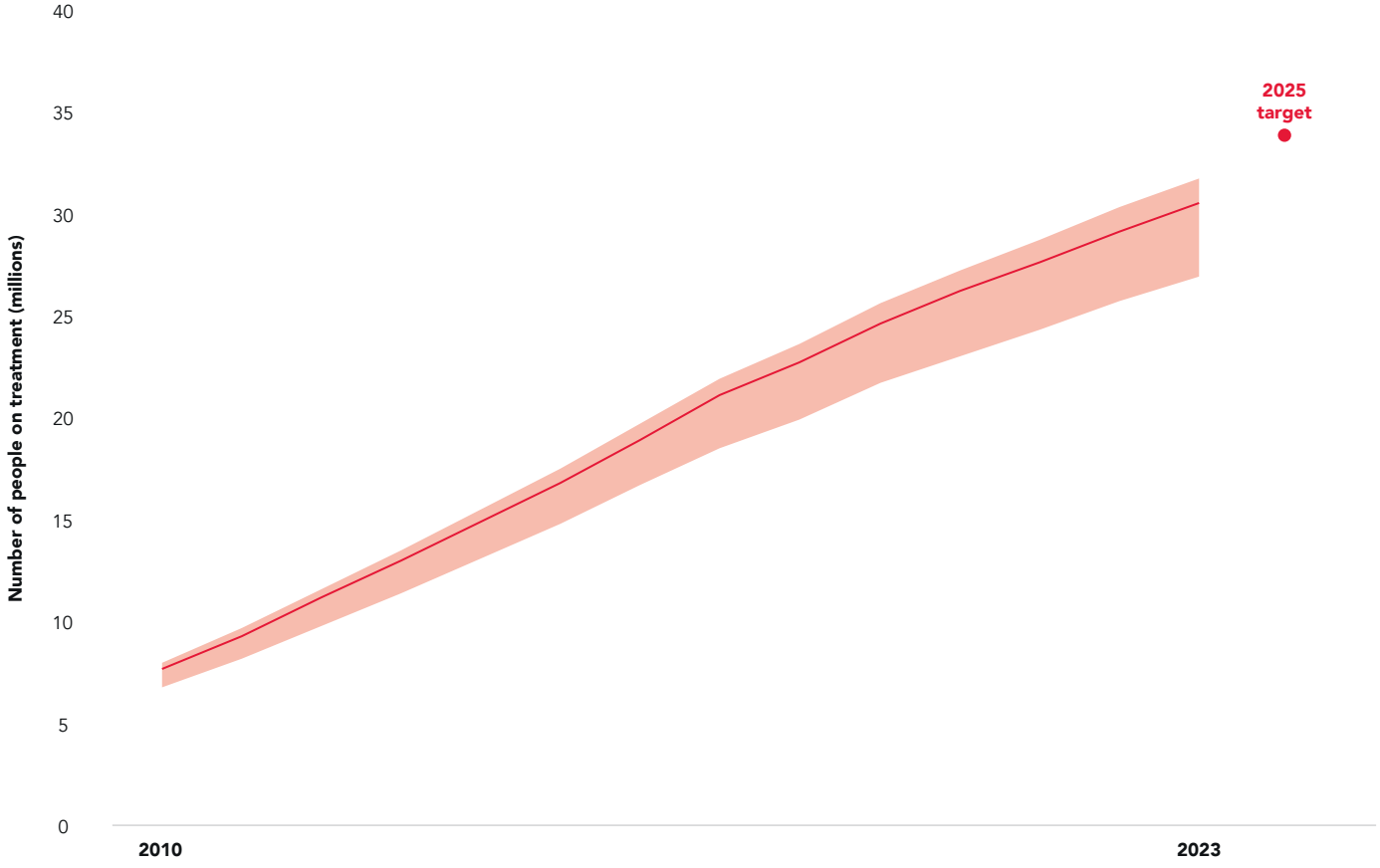
5 PrEP entails taking antiretroviral medicines to prevent the acquisition of HIV.

There are opportunities for voluntary medical male circumcision (VMMC) programmes to make a bigger impact *(8)*. The 35 million circumcisions conducted between 2008 and 2022 in 15 priority countries in eastern and southern Africa averted an estimated 670 000 HIV infections *(9)*. Most of these countries have scope to increase VMMC uptake further if they can overcome funding shortages and expand the services to older age groups.

Access to HIV treatment continues to expand

Approximately 30.7 million [27.0 million–31.9 million] of the estimated 39.9 million [36.1 million–44.6 million] people living with HIV globally were receiving antiretroviral therapy in 2023 (Figure 0.5). This is a landmark public health achievement. As recently as 2015, global treatment coverage was only 47% [38–55%]—but in 2023, it stood at 77% [61–89%].

Figure 0.5 Number of people receiving antiretroviral therapy, 2010–2023, global, and 2025 target



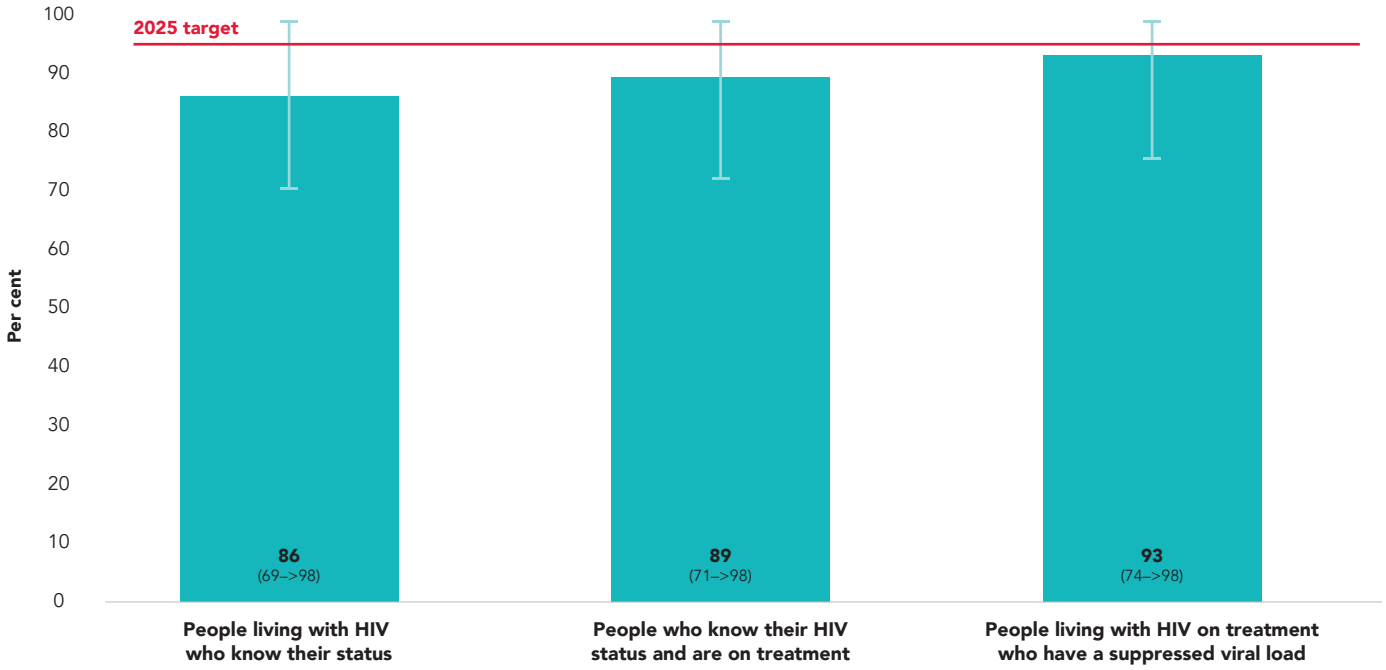
Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids).

Supporting people living with HIV to start and stay on antiretroviral therapy has enormous personal and public health benefits. People with an undetectable viral load have zero risk of transmitting HIV to their sexual partners, and people with a suppressed viral load have a near-zero risk of doing so *(10, 11)*.[6] This has given rise to the campaign Undetectable = Untransmittable, or U=U. The successful treatment of HIV is crucially important for preventing new HIV infections *(12)*. In 2023, almost three in four adults (73% [66–81%]) living with HIV globally had a suppressed viral load, a big improvement compared with the 40% [36–45%] in 2015.

The 95–95–95 targets set for 2025 are within reach.[7] Approximately 86% [69–>98%] of people living with HIV worldwide knew their HIV status in 2023. Among them, approximately 89% [71–>98%] of people were receiving antiretroviral therapy and 93% [74–>98%] of people on treatment had a suppressed viral load (Figure 0.6). Some of the biggest gains have occurred in sub-Saharan Africa, often in unfavourable conditions.

Health and community systems have become better at offering HIV tests to people who may have been exposed to HIV, and at linking them to reliable treatment and care services. More tolerable and effective treatment regimens are making it easier for people to keep taking their antiretroviral medicines and have suppressed viral loads.

Figure 0.6 Percentage of people living with HIV who know their HIV status, of people who know their HIV status and are receiving antiretroviral therapy, and of people on HIV treatment who have suppressed viral load, global, 2023

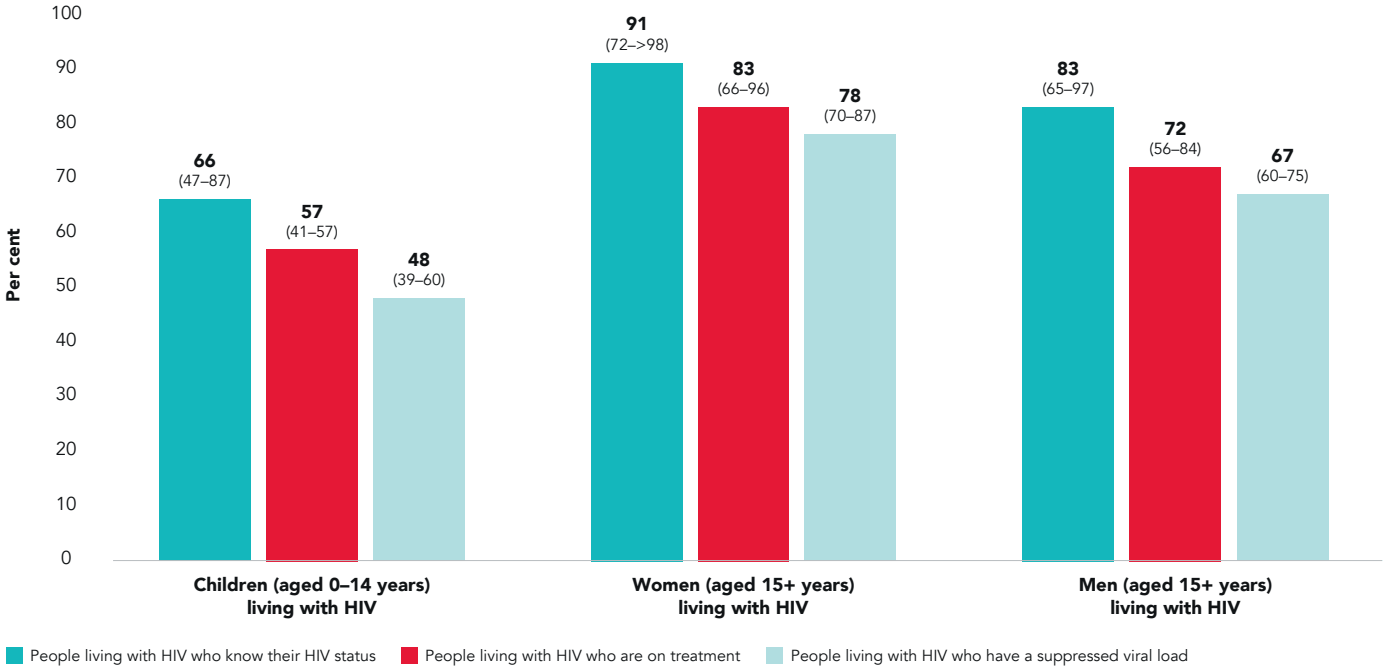


Source: Further analysis of UNAIDS epidemiological estimates, 2024.

6 A 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 below 1000 copies/mL.

7 95% of people living with HIV know their HIV status; 95% of people who know they are living with HIV receive antiretroviral therapy; and 95% of people receiving antiretroviral therapy have suppressed viral loads.

Figure 0.7 Testing and treatment cascade among children, women and men, global, 2023



Source: Further analysis of UNAIDS epidemiological estimates, 2024.

Disparities in access to HIV testing and treatment, however, continue to undercut the overall impact of these accomplishments (Figure 0.7). Children (aged 0–14 years) living with HIV remain considerably less likely than adults to be diagnosed and receive antiretroviral therapy: about 43% [31–57%] of the global total of 1.4 million [1.1 million–1.7 million] children living with HIV were not receiving treatment in 2023. Children accounted for 12% of all AIDS-related deaths, even though they constitute only 3% of people living with HIV. More than one third (36%), or 370 000 [250 000–470 000], of older adolescents (aged 15–19 years) living with HIV were not receiving antiretroviral therapy in 2023.

Across much of the world, adult men (aged 15+ years) living with HIV are less likely than their female counterparts to know their HIV status and receive HIV treatment; their treatment outcomes also tend to be poorer. Antiretroviral therapy coverage among some key populations may have increased in recent years *(13)*, but people from key populations living with HIV still have lower antiretroviral therapy coverage and worse treatment outcomes than other people living with HIV, particularly in sub-Saharan Africa *(3)*.

Consequently, one quarter (23% [19–27%]) of all people living with HIV were not receiving antiretroviral therapy in 2023. Access to treatment was especially low in eastern Europe and central Asia and the Middle East and North Africa, where only about half of the 2.1 million [1.9 million–2.3 million] and 210 000 [170 000–280 000] people living with HIV, respectively, were receiving antiretroviral therapy.

There are other challenges too. It is estimated that about 12.2 million [11 million–13.6 million] people have advanced HIV disease (AIDS). AIDS used to be seen mainly as a problem of late diagnosis and treatment of HIV infection. These concerns remain, but AIDS is now most common among people who have received antiretroviral therapy and stopped HIV treatment *(14, 15)*. This puts their health at risk, increases the risk of HIV transmission, and adds to the burden on health systems *(16, 17)*. There is an urgent need for effective interventions and support so people can stay on HIV treatment and those who have interrupted their treatment can be re-engaged in care.

The success of HIV treatment has led to a rise in the average age of people living with HIV. As people living with HIV grow older, they are likely to encounter a growing range of comorbidities, including noncommunicable diseases such as hypertension and diabetes, that require care. Closer integration of HIV and other health services, equipment and supply chains, and upgraded training for health workers, will be needed to deal with these changes.

Slow progress in reducing stigma, discrimination, social inequalities and violence

The 10–10–10 and the 30–80–60 targets set for 2025 are not within reach. Stigma, discrimination, social inequalities and gender-based violence make it hard for people to stay free of HIV and protect their health *(18)*. People from key populations are especially vulnerable *(19)*. Recognition of these hindrances has increased, but it is not yet sufficiently reflected in laws, policies and practices. Rising authoritarianism and attacks on human and civil rights are making it even more difficult to remove these barriers *(20)*.

HIV-related stigma and discrimination have declined in some countries but remain unnervingly common in many others. Gender-based inequalities continue to be pervasive, to varying degrees depending on the country. Punitive laws targeting people living with HIV and people from key populations are still on the statute books in almost all countries. Gender-based violence, including against women and girls, remains a menace everywhere.

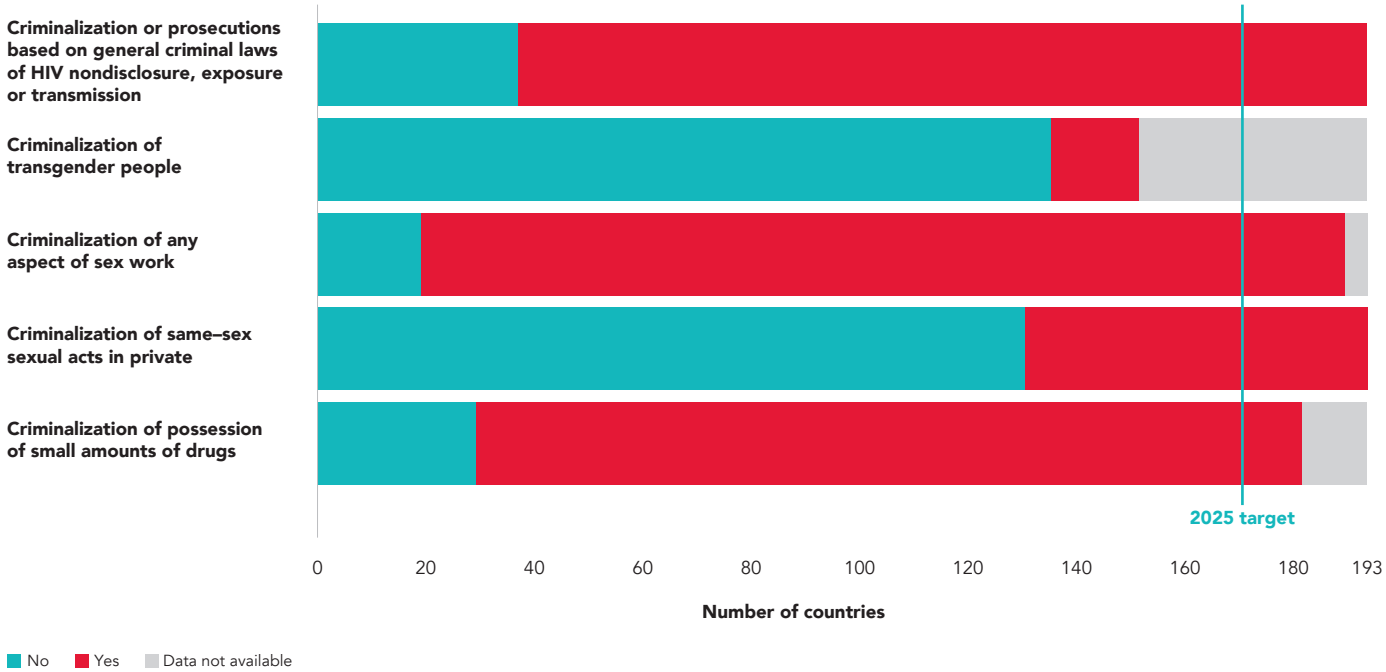
Across 42 countries with recent survey data, in median almost half (47%) of people harboured discriminatory attitudes towards people living with HIV *(21)*. These attitudes are found even at health facilities. Almost one quarter of people living with HIV reported experiencing stigma when seeking non-HIV-related health-care services in the previous year, according to an analysis of Stigma Index surveys conducted in 25 countries *(22)*.

These prejudices are reversible, but very few countries are close to achieving the 2025 target of reducing to less than 10% the percentage of people living with HIV and people from key populations experiencing stigma and discrimination.

Prompted by the activism of affected communities, a few countries have abandoned or reformed laws that target people living with HIV and people from key populations. Overall, however, only four[8] of 193 countries did not have any laws that criminalize sex work, same-sex sexual relations, possession of small amounts of drugs, transgender people, or HIV nondisclosure, exposure or transmission (Figure 0.8).

Gender-based violence harms hundreds of millions of people, and intimate partner violence is a painfully common ordeal and a human rights violation against women and adolescent girls especially.[9] Although the prevalence of physical or sexual violence by an intimate partner in the previous 12 months was below 10% in a little over half *(82)* of the 156 countries with available estimates, the prospect of experiencing physical or sexual violence remains unacceptably high even in these countries *(23)*. National health policies increasingly recognize the need to curb such violence, and there is strong evidence supporting the integration of violence prevention in health-care settings *(24–26)*. Implementation is often held back, however, by a lack of training and support for health-care workers and by scarce referral systems for survivors of violence *(27)*.

Figure 0.8 Number of countries with discriminatory and punitive HIV-related laws, global, 2024



Source: National commitments and policy instrument 2017–2024, supplemented by additional sources; 2024 (see references in regional factsheets and http://lawsandpolicies.unaids.org/).
Note: This figure does not capture where key populations may be de facto criminalized through other laws, such as vagrancy or public morality laws, or the use of the above laws for different populations.

8 Colombia, the Netherlands, Uruguay, Bolivarian Republic of Venezuela.
9 Intimate partner violence is behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Nongovernmental organizations, including community-led organizations, help provide services and support to people, especially people from key populations, whose HIV and other health-care needs tend to be neglected by public and private health providers *(28)*. These organizations need civic space, legal and regulatory environments that permit them to receive funding and operate, and functional links with public health systems. These conditions are lacking in many countries. Well over two thirds (71%) of the world's population lives in 78 countries where civic space is now either entirely closed or heavily controlled *(29)*—threatening people's most basic human rights, including the right to universal health.

Integration of HIV and other services is making an impact

When integrated, HIV and other health services can improve health outcomes, strengthen health systems, and support progress towards universal health coverage *(30)*. Integration across sectors has also been a feature of HIV responses, with the advancement of gender equality and women's empowerment, workplace interventions, humanitarian programmes, and social protection schemes being linked progressively with HIV-related interventions.

There has been a marked shift towards the integration of HIV and other health-care services in recent years. Although still in a minority, an increasing number of countries have national strategic HIV plans that are integrated with other health issues or diseases, and with broader health strategies or plans. Thirty-nine of the 151 reporting countries have national health strategies or policies that integrate the HIV response (seven more than in 2022). Of the 60 countries that have adopted universal health coverage schemes, 38 include antiretroviral therapy and 21 include pre-exposure prophylaxis (PrEP) in their health benefit and financing packages *(31)*.

These changes are making a mark. Often, both HIV and other health outcomes are better within integrated services than in separated services and the uptake of non-HIV services also tends to rise *(30)*. Linked or integrated tuberculosis (TB) and HIV treatment for people living with both HIV and TB, for example, averted an estimated 6.4 million [5.5 million–7.3 million] deaths between 2010 and 2022 *(32)*. Interventions that prevent and treat HIV, sexually transmitted infections and viral hepatitis can be both cost-effective and cost-saving, especially when combined *(33)*. Recent rapid emergence of mpox has reiterated the importance of integrated care, which has proved successful in some settings in North America and western Europe.

There is great scope for judiciously extending integration. Integrated services for HIV and sexual and reproductive health are not yet widespread *(34)*, and neither are functioning examples of integrated HIV and noncommunicable diseases services, especially in sub-Saharan Africa *(35)*. The rise in conflict-related and climate change-induced humanitarian emergencies underscores the need for integrated emergency responses that address people's health, nutrition and safety needs.

Integration is not without challenges or costs, however. The benefits are context-specific, and they require a range of enabling changes, including adequate staffing levels, efficiently functioning health systems, and decisive actions to prevent stigma and discrimination *(30, 36, 37)*. Moreover, it is vital that integration is pursued in ways that strengthen rather than weaken the person-centred and equity-based principles that define successful HIV programmes *(34)*.

A growing funding shortfall is holding back quicker progress

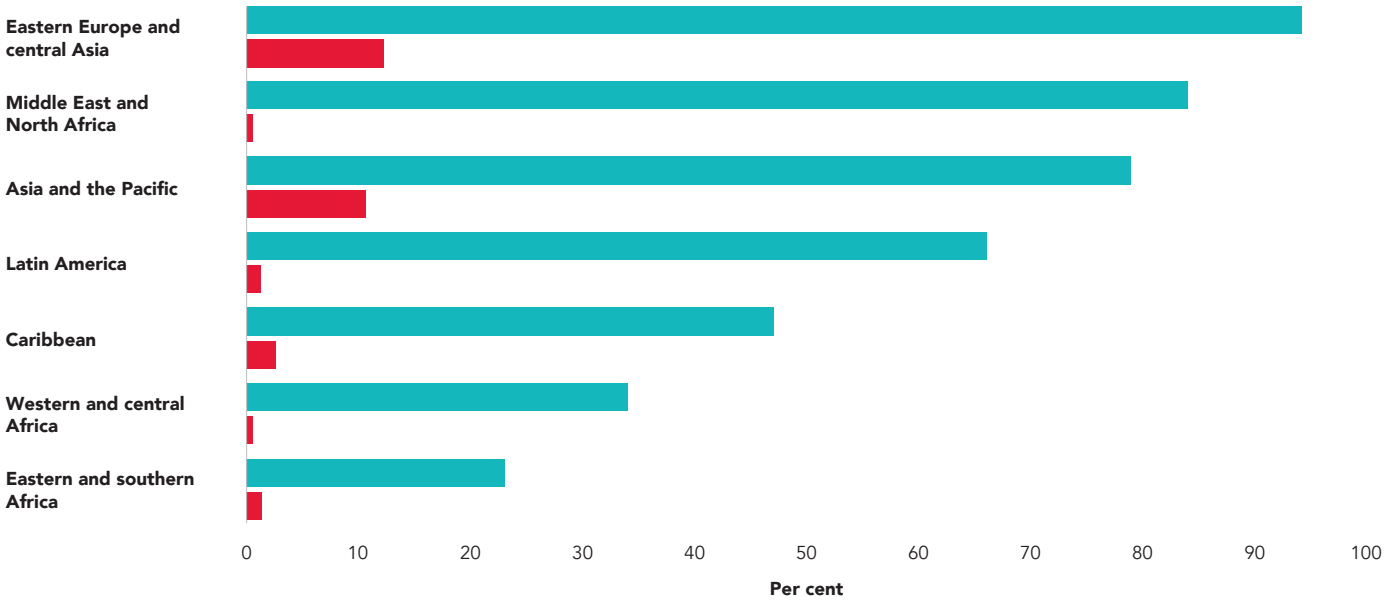
A widening funding gap is holding back the HIV response. Approximately US$ 19.8 billion (2019 United States dollars) was available in 2023 for HIV programmes in low- and middle-income countries—almost US$ 9.5 billion short of the amount needed in 2025. Total resources available for HIV, adjusted for inflation, are at their lowest level in over a decade. The regions with the biggest funding gaps—eastern Europe and central Asia and the Middle East and North Africa—are making the least headway against their HIV epidemics.

Most funding for HIV comes from domestic resources (about 59%), but both international and domestic HIV funding are under stress. Adjusted for inflation, domestic HIV funding declined in 2023 for the fourth year in a row, and international resources were almost 20% lower than at their peak in 2013. Financing support from bilateral donors has dwindled dramatically. The overall reductions in external HIV resources would be much steeper were it not for sustained and high levels of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Government. Development assistance for HIV will continue to be crucial.

The continued underfunding of HIV prevention, societal enabler programmes and community-led activities does not bode well for the HIV response. Interventions for people from key populations are especially neglected, even in regions where the vast majority of new HIV infections occur in people from these populations (Figure 0.9).

An estimated US$ 1.8 billion–2.4 billion was available for primary prevention programmes in low- and middle-income countries in 2023, compared with the US$ 9.5 billion that will be needed in 2025. Spending on societal enabler programmes amounted to US$ 0.9 billion–1.1 billion, far short of the US$ 3.0 billion needed in 2025.

Figure 0.9 Percentage of total HIV resources spent on programmes for people from key populations and percentage of new HIV infections occurring among members of key populations and their sex partners, by region, 2023



Source: Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multisources estimation. J Acquir Immune Defic Syndr. 2024;95(1S):e34–e45. doi:10.1097/QAI.0000000000003340.; UNAIDS financial estimates, July 2024 (http://hivfinancial.unaids.org/hivfinancialdashboards.html).

The prices of vital HIV products are a major factor in countries' abilities to sustainably finance their HIV programmes with domestic resources. Although the prices of many antiretroviral medicines have continued to decline in recent years, low- and middle-income countries spent approximately US$ 3 billion on antiretroviral medicines in 2020–2022. These procurement prices still vary drastically across regions and country income groups.

Looking beyond the crossroads

If HIV programmes remain on their current course, UNAIDS projections show that about 46 million people will be living with HIV in 2050. Even if the world achieves the 2025 targets and sustains these gains, there will be almost 30 million people living with HIV in 2050. Each of them will need lifelong treatment and support for HIV. In the absence of an effective and universally accessible vaccine or cure, there will also continue to be new HIV infections. Neither of these scenarios amounts to "the end of AIDS"—the world will still be contending with a major public health challenge.

The primary objective is to swiftly reduce numbers of new infections and AIDS-related deaths to levels that approach or achieve disease control—and to do so in ways that prevent a future resurgence of the epidemic *(38)*. This requires a resilient and durable HIV response.

Countries that are struggling to control their epidemics can achieve steeper declines in HIV incidence by rapidly increasing treatment coverage and adherence *(39, 40)*, and by intensifying their most effective primary prevention interventions. Projections show that high-burden countries that reach the 95–95–95 treatment targets could continue reducing new HIV infections by 20% every five years if they invest simultaneously in effective HIV primary prevention programmes *(41)*.

But a constantly evolving AIDS pandemic calls for other changes too. As the population living with HIV ages, the risk of acquiring HIV will shift towards older age groups, and prevention strategies will have to adjust to this. HIV programmes will need to make common cause with broader health programmes by responding to the growing impact of noncommunicable diseases, including among people living with HIV, and the ongoing toll exacted by other infectious diseases *(34, 42)*.

As HIV programmes are integrated further into broader health systems, there will also be ample room for mutual learning. HIV responses have fortified health and community systems, boosted the roles of affected communities, singled out the societal and structural factors fuelling the epidemic, and made human rights and equity central priorities. More extensive integration with other health programmes can share these attributes more widely, but it should not dilute the distinctive features that make HIV responses successful *(34, 43)*. This is especially urgent when serving populations who may be targeted with stigma, discrimination or worse.

All of this must be achieved in a context shaped by persistent inequalities within and between countries, a burgeoning threat of repressive governance, and ongoing discrimination against people who are inordinately exposed to HIV and other health threats. The fiscal constraints imposed by debt distress and low economic growth, especially in Africa, are also reducing low- and middle-income countries' abilities to invest more in their HIV responses, while some donors have diverted their assistance to other priorities.

An evolving pandemic and shifting context have brought the HIV response to a crossroads. The decisions and actions taken now will have a lasting impact on the world's effort to end the AIDS epidemic as a public health threat.

Mixed results at the halfway mark to the 2025 targets

Table Summary of progress against the 2025 targets

COMBINATION HIV PREVENTION FOR ALL	TARGET	2023 STATUS
Reduce new HIV infections to under 370 000	370 000	1 300 000
Reduce new HIV infections among adolescent girls and young women to below 50 000	50 000	210 000
95% of people at risk of HIV access effective combination prevention	95%	50%/40%/39%/39% (medians) (SW/MSM/PWID/TG)
Pre-exposure prophylaxis (PrEP) for 10 million people at substantial risk of HIV (or 21.2 million who used PrEP at least once during the year)	21.2 million	3.5 million
50% opioid agonist therapy coverage among people who are opioid-dependent	50%	0 of 8 regions
90% sterile injecting equipment at last injection	90%	11 of 27 countries
90% of 15+ men in 15 priority countries have access to voluntary medical male circumcision	90%	67%
95–95–95 FOR HIV TESTING AND TREATMENT	**TARGET**	**2023 STATUS**
Reduce annual AIDS-related deaths to under 250 000	250 000	630 000
34 million people are on HIV treatment by 2025	34 million	30.7 million
95–95–95 testing, treatment and viral suppression targets	95–95–95	All ages: 86–89–93 Women (15+ years): 91–91–94 Men (15+ years): 83–86–94 Children (0–14 years): 66–86–84 Key populations: unknown
90% of people living with HIV receive preventive treatment for tuberculosis (TB) by 2025	90%	17 million people living with HIV initiated on TPT between 2005 and 2022
Reduce numbers of TB-related deaths among PLHIV by 80%	80%	71%
PEDIATRIC HIV	**TARGET**	**2023 STATUS**
75% of children living with HIV have suppressed viral loads by 2023	75%	48%
100% of pregnant and breastfeeding women with HIV receive ART and 95% achieving viral suppression	100%	84%
GENDER EQUALITY AND EMPOWERMENT OF WOMEN AND GIRLS	**TARGET**	**2023 STATUS**
<10% of women and girls experienced physical or sexual violence from a male intimate partner in the past 12 months	<10%	13% [10%–16%]
<10% of key populations experience physical and/or sexual violence in the past 12 months	<10%	21%/8%/28%/24% (medians) SW/MSM/PWID/TG
< 10% people support inequitable gender norms by 2025	<10%	24.2% (median)
95% of women and girls 15-49 get sexual and reproductive health-care service needs met	95%	Median of 50.8% of women currently married or in union make their own decisions regarding sexual relations, contraceptive use and their own health care (data from 16 countries)
REALIZE HUMAN RIGHTS AND ELIMINATE STIGMA AND DISCRIMINATION	**TARGET**	**2023 STATUS**
<10% of countries criminalize - Sex work - Possession of small amounts of drugs - Same-sex sexual behaviour - HIV transmission, exposure or non-disclosure		170 countries 152 countries 63 countries 156 countries
< 10% of countries lack mechanisms for people living with HIV and for key populations to report abuse and discrimination and seek redress	<10%	52% of countries have mechanisms established by the government), 66% of countries have mechanisms established by communities
< 10% of people living with HIV and key populations lack access to legal services	<10%	39% of countries
>90% of people living with HIV who experienced rights abuses have sought redress	90%	31% of people sought redress
< 10% of general population reports discriminatory attitudes towards people living with HIV	<10%	47% (median)
< 10% of PLHIV report internalized stigma	<10%	38%
<10% of key populations report experiencing stigma and discrimination	<10%	26%/16%/40%/49% (medians) SW/MSM/PWID/TG
<10% of PLHIV experiencing stigma and discrimination in health-care and community settings	<10%	13% (HIV care) 25% (non-HIV care) 24% (community)
COMMUNITY LEADERSHIP	**TARGET**	**2023 STATUS**
CLOs deliver 30% of testing and treatment services	30%	
CLOs deliver 80% of HIV prevention services for populations at high risk of HIV infection and women	80%	
CLOs deliver 60% of programmes to support societal enablers	60%	
UNIVERSAL HEALTH COVERAGE AND INTEGRATION	**TARGET**	**2023 STATUS**
Systems for health and social protection that provide 90% of people living with, at risk of and affected by HIV with integrated HIV services	90%	
90% of people in humanitarian settings access integrated HIV services.	90%	
45% of people living with, at risk of and affected by HIV and AIDS have access to social protection benefits.	90%	
INVESTMENTS AND RESOURCES	**TARGET**	**2023 STATUS**
Fully fund the HIV response by increasing annual HIV investments in low- and middle income countries to US$ 29 billion	$29.3 billion	$19.8 billion

Progress is off track Moderate progress 2025 are within reach No data is available

Note: **SW** Sex workers - **MSM** Gay men and other men who have sex with men - **PWID** People who inject drugs - **TG** Transgender persons

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