



# General Assembly

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## Seventy-third session

Agenda item 11

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

## Galvanizing global ambition to end the AIDS epidemic after a decade of progress

### Report of the Secretary-General

#### *Summary*

A world without AIDS was almost unimaginable when the General Assembly held its first special session on the epidemic 18 years ago. Since then, the global determination to defeat one of history's greatest health crises has produced remarkable progress. Over the past decade, the number of people living with HIV on treatment has increased 5.5 times, behaviour change communications and condom distribution programmes have successfully reduced the incidence of HIV infection in a variety of settings and a growing number of countries have eliminated mother-to-child transmission of HIV. Globally, deaths from AIDS-related illnesses among people of all ages and HIV infections among children have been cut nearly in half, and new infections among adults have declined by 19 per cent.

Strong gains against the epidemic inspired a commitment within the 2030 Agenda for Sustainable Development to end the AIDS epidemic by 2030. The General Assembly agreed in 2016 that achieving this target required rapid expansion of HIV prevention, testing and treatment services.

There are many challenges, including stigma and discrimination faced by people living with HIV and harmful gender norms. Laws and policies in many countries prevent young people, women, key populations (people who inject drugs, sex workers, transgender people, prisoners, and gay men and other men who have sex with men), indigenous peoples, migrants and refugees from accessing health and HIV services. Funding for HIV responses in low- and middle-income countries globally has also been flat for most of the past five years.



However, there is a window of opportunity for more countries, across all regions and income levels, to get on track to meet the 2020 targets agreed by the General Assembly. The United Nations system, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), is enhancing its support to countries through the United Nations reform initiative.

An important opportunity is the growing movement to achieve universal health coverage. A core principle of universal health coverage is to leave no one behind. Within the context of HIV, leaving no one behind requires a health benefit package that includes a comprehensive set of health facility-based HIV services, additional public health and social protection services provided through dedicated government funding streams and structural changes to ensure that vulnerable and marginalized people can access the services they need.

Member States are urged to adopt the following recommendations to galvanize political will, accelerate action and build the momentum necessary to reach 2020 targets: (a) reinvigorate primary HIV prevention; (b) diversify HIV testing and differentiate the delivery of health care to reach the 90–90–90 targets; (c) establish enabling legal and policy environments in order to reach marginalized and vulnerable populations; (d) mobilize additional resources and allocate them where they are most needed; (e) support communities to enable them to play their critical roles; and (f) incorporate a comprehensive HIV response into universal health coverage.

## **I. Progress towards the commitments made in the Political Declaration on HIV and AIDS of 2016**

1. The response to AIDS – the single largest collective global action against a deadly communicable disease – has been a transformational journey. In the early days of the epidemic, much of the world turned its back on people living with HIV. Such neglect allowed HIV infections and AIDS-related deaths to climb to crisis levels. Civil society activism changed the global mindset. Unprecedented amounts of resources have been mobilized, and results once derided as impossible in low-income settings have been broadly achieved.

2. The General Assembly has played a central role in this transformation by periodically forging ambitious global commitments and monitoring progress. Following the achievement of the Millennium Development Goal to halt and reverse the epidemic by 2015, the Assembly included within the targets of the 2030 Agenda on Sustainable Development a commitment to end AIDS as a public health threat. In 2016, the Assembly put in place a “fast-track” strategy to reach that target. The strategy calls for a rapid scale-up of evidence-based HIV prevention, testing and treatment services by 2020 in order to reduce new HIV infections and AIDS-related deaths by 90 per cent by 2030.<sup>1</sup>

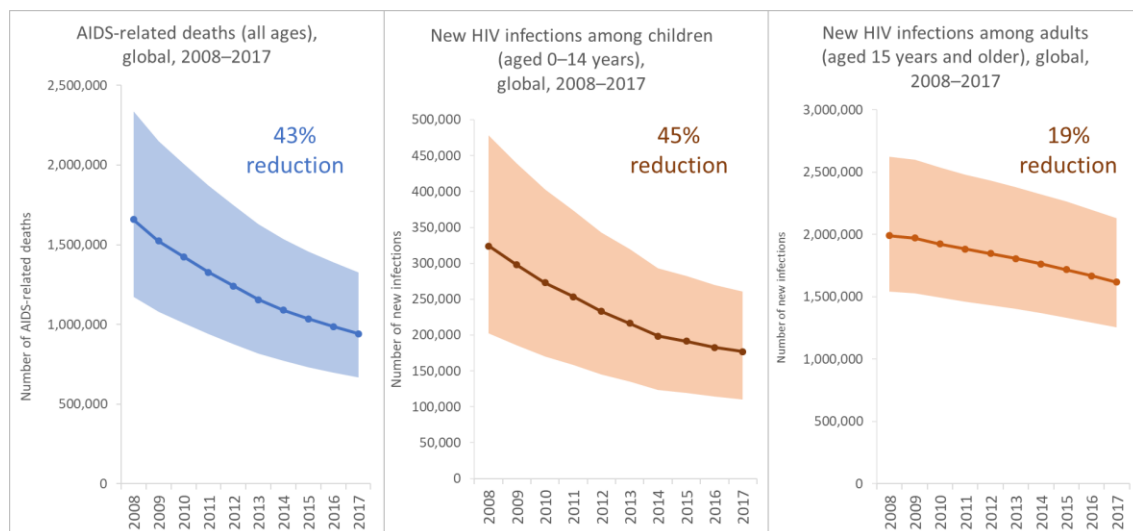
3. Three years after the fast-track approach was agreed, country progress reports submitted to the Joint United Nations Programme on HIV/AIDS (UNAIDS) show that it is an effective strategy. In East and Southern Africa, the region most affected by AIDS, steady increases in both domestic and international funding have supported a massive expansion of evidence-informed and human rights-based programmes. Over the past decade (2008–2017), AIDS-related mortality in the region has declined by 53 per cent and the annual number of new HIV infections has declined by 36 per cent. An epidemic that once killed more than a million people in the region per year now claims fewer than 400,000 lives per year.

4. In other regions of the world, including Latin America, the Caribbean, West and Central Africa, Asia and the Pacific, Western and Central Europe and North America, increases in the coverage of HIV testing and treatment services have achieved significant reductions in AIDS-related deaths over the past decade. Most of these regions have also experienced declines in new HIV infections.

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<sup>1</sup> These 90 per cent reductions in new HIV infections and AIDS-related deaths are compared with the 2010 baseline.

**Figure I**  
**Decade of progress against AIDS-related deaths and HIV infections**



Source: UNAIDS 2018 estimates.

5. Globally over the past decade, deaths from AIDS-related illnesses (all ages) and HIV infections among children (aged 0–14 years) have both nearly halved. Progress in preventing new HIV infections among adults (aged 15 years and older) has been more modest, with new infections declining 19 per cent globally between 2008 and 2017 (see figure I).

6. These gains have been guided by the collection and analysis of data from health-care facilities, research programmes, household surveys, special studies of key populations and other sources. Such data are used to focus resources on the locations and populations in greatest need of HIV services. In Nigeria, for example, a recent national household survey showed that the prevalence of HIV among adults (aged 15–49 years) was 1.4 per cent in 2018, considerably lower than previous estimates, and that women are disproportionately affected by HIV. HIV prevalence among adult women in Nigeria was 1.9 per cent, while among men it was 0.9 per cent.

7. Scientific research is also improving HIV service delivery. For example, a large-scale HIV prevention trial conducted in South Africa and Zambia between 2013 and 2018 showed that door-to-door delivery of comprehensive health and HIV services through community care providers achieved a population-wide 20 per cent reduction in new HIV infections compared with the basic standard of care offered by the control arm of the trial.

8. The search for an HIV vaccine and a cure continues unabated. Two vaccine candidates are currently being tested in large phase 3 trials in Africa, the first large trials since the vaccine study conducted in Thailand a decade ago. The confirmation in 2019 of long-term remission in a second person living with HIV who received a bone marrow transplant gives new hope that a cure is possible. However, the difficult and dangerous procedure is not readily scalable, and experimental “kick-and-kill” techniques to eliminate reservoirs of HIV in the human body have so far not been successful. Gene-editing techniques are proving promising in animal models.

9. More practical advances in HIV treatment include the ongoing development of long-lasting injectable forms of antiretroviral medicines and the introduction of dolutegravir into first-line treatment regimens. Dolutegravir-based regimens are better tolerated, less likely to lead to treatment disruption and associated with more

rapid viral suppression and a higher genetic resistance barrier. Reports of possible serious side-effects in the fetuses of women when dolutegravir is used around the time of conception are being addressed by additional research. In the meantime, the World Health Organization (WHO) has advised health-care providers to provide women information regarding the risks and benefits of dolutegravir, to improve access to modern contraceptive choices and to offer other treatment regimens to women planning to become pregnant.

### **90–90–90 testing and treatment targets**

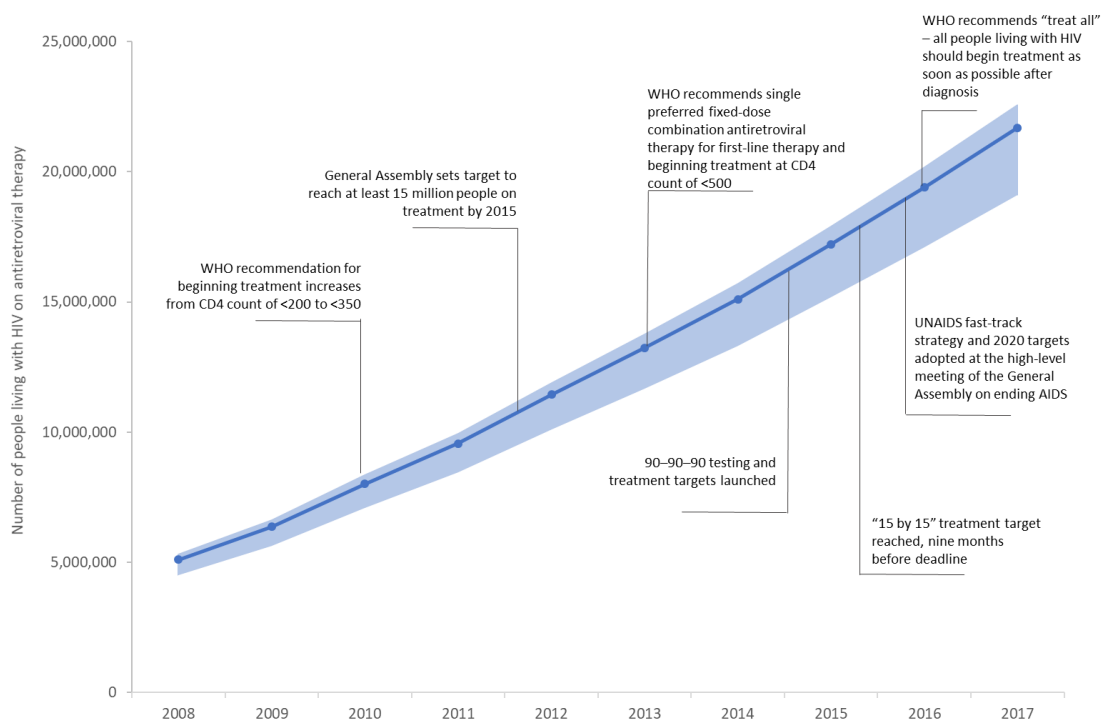
10. An estimated 21.7 million [19.1–22.6 million] people globally were receiving antiretroviral therapy at the end of 2017, 5.5 times more than just a decade ago. Strong and steady progress in HIV treatment has been driven by the active voice of communities of affected populations, a clear global ambition and vision, shared investment among countries at all income levels and the consistent development of new technologies and improved ways of reaching the people living with HIV with testing and treatment services (see figure II).

11. The scale-up of HIV testing and treatment in recent years has been guided by the ambitious 90–90–90 targets: 90 per cent of people living with HIV knowing their HIV status, 90 per cent of people living with HIV who know their status accessing antiretroviral therapy and 90 per cent of people on treatment having suppressed viral loads by 2020. These targets emphasize the importance of diagnosing HIV as soon as possible after infection, immediate enrolment in treatment, retention in care and routine monitoring of viral load. This approach maximizes viral suppression, which protects people living with HIV from AIDS-related illness and greatly lowers the risk of transmitting the virus to others.

12. At the end of 2017, an estimated three quarters [55–92 per cent] of people living with HIV globally knew their HIV status. Among them, 79 per cent [59– >95 per cent] were accessing antiretroviral therapy, and 81 per cent [60– >95 per cent] of people accessing treatment had suppressed viral loads. These global averages conceal large differences among regions and countries.

13. Several middle-income countries, Botswana, Cambodia, Eswatini, Lesotho and Namibia, have reached or nearly reached the 90–90–90 targets. Western and Central Europe and North America, East and Southern Africa and Latin America appear to be on track towards achieving the targets. Asia and the Pacific and the Caribbean have made important progress but will need to accelerate their testing and treatment programmes to reach the targets by 2020. Treatment coverage in Eastern Europe and Central Asia, the Middle East and North Africa and West and Central Africa are alarmingly low.

**Figure II**  
**Milestones during the increase in people living with HIV (all ages) accessing antiretroviral therapy, 2008–2017**



Source: UNAIDS 2018 estimates.

14. The gap in knowledge of HIV status is being closed by advances in HIV testing. Community-based testing reaches people who live far away from a health facility, provides services at times that suit people at high risk of HIV infection and mitigates stigma and discrimination. Engaging adolescents and key populations through peer outreach workers is also proving successful. The increasing availability of HIV self-test kits is improving HIV testing among young people, men and key populations. Concerns about linkages to confirmatory diagnosis and treatment initiation following a reactive self-test are being addressed through peer-assisted self-testing. Index testing – when people newly diagnosed with HIV are assisted to bring their sexual partners, family members and other persons in their household to be tested – has been shown to be an especially effective way to reach people who are less likely to seek voluntary counselling and testing, such as men and children.

15. Viral load testing among people on treatment is the recommended approach for checking that treatment is working and determining whether viral suppression has been achieved and is sustained, and for diagnosing and confirming treatment failure. Viral load testing gives clients greater understanding, control and motivation to adhere to treatment. For health-care providers, it is a critical tool for tailoring care to enable those with suppressed viral loads to visit health facilities less frequently, and greater attention is focused on patients with unsuppressed viral loads. Coverage of viral load testing is increasing. In some high-prevalence countries, the pace of scale-up has been extraordinary. In Uganda, for example, the number of districts with 90 per cent or greater coverage of viral load testing increased from 29 to 70 in a single year

and the number of districts with less than 80 per cent coverage decreased from 53 to 22.<sup>2</sup>

### **Eliminating mother-to-child transmission of HIV**

16. The ongoing decline in the number of children acquiring HIV is a major public health triumph. Globally, 1.6 million [1.0 million–2.4 million] new child infections were averted between 2008 and 2017 (see figure III) – an achievement that stems from a steep increase in the percentage of pregnant women living with HIV who receive antiretroviral medicines to prevent mother-to-child transmission of HIV or as lifelong therapy, from 25 per cent [19–31 per cent] in 2008 to 80 per cent [61–>95 per cent] in 2017.<sup>3</sup> The increase in the number of pregnant women screened for syphilis and HIV and improved access to adequate treatment have also seen the incidence of congenital syphilis fall from an estimated 752,000 cases globally in 2012 to approximately 683,000 in 2016. An increasing number of low-disease-burden countries have validated the elimination of mother-to-child transmission of HIV and/or syphilis. Among countries with high HIV prevalence, Eswatini, Malawi, Namibia and Zimbabwe have achieved major reductions in mother-to-child transmission. Such progress shows the potential to bring about the end of paediatric AIDS in the near future.

17. For infants exposed to HIV, point-of-care virological testing technologies provide faster results for infant diagnosis, resulting in lower loss to follow-up, more consistent initiation of treatment before the immune systems of infected infants weaken and fewer AIDS-related deaths. In Mozambique, for example, antiretroviral therapy was initiated within 60 days of sample collection for 89.7 per cent of infants living with HIV who were diagnosed through point-of-care assays, compared with 12.8 per cent of children who received standard early infant diagnosis.<sup>4</sup>

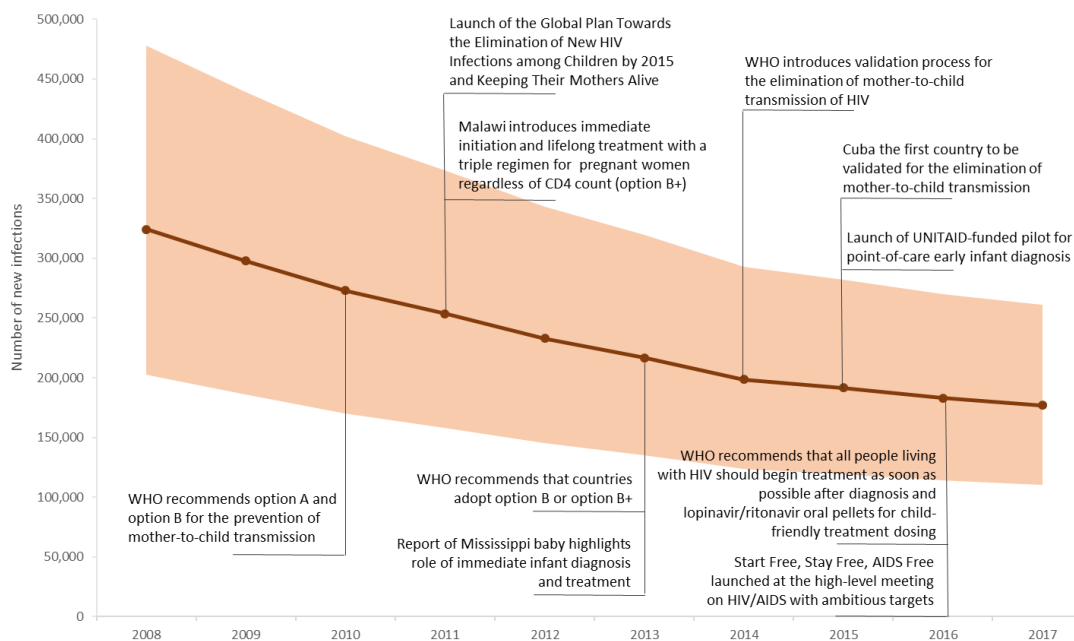
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<sup>2</sup> Uganda, Ministry of Health, Viral Load Dashboard. Available at the website of the Central Public Health Laboratories: <http://cphl.go.ug>.

<sup>3</sup> The coverage estimate for 2008 excludes single-dose nevirapine, which was widely available at the time but is no longer recommended by the World Health Organization (WHO) because of its limited effectiveness.

<sup>4</sup> Ilesh V. Jani and others, “Effect of point-of-care early infant diagnosis on antiretroviral therapy initiation and retention of patients”, *AIDS*, vol. 32, No. 11 (July 2018).

**Figure III**  
**Milestones as new HIV infections among children (aged 0–14 years) reduce towards the elimination of mother-to-child transmission, 2008–2017**



Source: UNAIDS 2018 estimates.

Abbreviations: UNIAID, International Drug Purchase Facility.

### Primary HIV prevention

18. Primary HIV prevention has been a central component of the AIDS response since the earliest days of the epidemic and remains the bedrock of efforts to reach the 2020 and 2030 targets for infection reduction. Behaviour change communications and condom distribution programmes have successfully reduced the incidence of HIV infection in numerous countries. A recent systematic review of 29 studies demonstrated that the distribution of condoms in schools often leads to greater condom use and reductions in sexually transmitted infections among young people, while also not leading to earlier sexual debut or an increase in sexual activity or the number of sexual partners.<sup>5</sup>

19. Comprehensive sexuality education plays a central role in the preparation of adolescents and young people for a safe, productive and fulfilling life and is an important component of the HIV prevention package for young people. Curriculum-based sexuality education programmes have been shown to contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, a decreased number of sexual partners, reduced risk-taking, increased use of condoms and increased use of contraception among young people. Evidence also demonstrates

<sup>5</sup> Eda Algur and others, “A systematic global review of condom availability programs in high schools”, *Journal of Adolescent Health*, vol. 64, No. 3 (March 2019).



that comprehensive sexuality education contributes to other critical outcomes, including gender-equitable attitudes, confidence and self-identity.<sup>6</sup>

20. Harm reduction – including the provision of sterile injecting equipment, opioid substitution therapy, naloxone and other evidence-based elements of the comprehensive package of services recommended by UNAIDS, the United Nations Office on Drugs and Crime and WHO – has greatly reduced HIV infections and fatal overdoses in countries that ensure that these services are easily accessible for people who inject drugs.

21. The roll-out of newer, biomedical prevention interventions, including voluntary medical male circumcision and pre-exposure prophylaxis (PrEP), has accelerated in recent years. In 2017, 4 million voluntary medical male circumcisions were performed in 14 countries that have high levels of HIV prevalence in East and Southern Africa. PrEP is widely available in several cities in North America, Western Europe and Australia, where it is contributing to declines in new HIV diagnoses among gay men and other men who have sex with men. Access to PrEP is increasing in several countries in sub-Saharan Africa and Asia, as well as in Brazil.

### **Moving towards zero stigma, discrimination and marginalization**

22. In the early days of the HIV epidemic, pervasive stigma and discrimination against people at high risk of HIV infection and people living with HIV nearly paralysed the AIDS response. Although the impacts of those early failures are still being felt, efforts to dispel the stigma and discrimination surrounding the epidemic have had a measurable positive effect. Declines in HIV-related stigma have been observed in countries where multiple surveys have been conducted. In East and Southern Africa, for example, the percentage of people who would not buy vegetables from a shopkeeper living with HIV declined from 50.7 per cent in 2000–2008 to 29.5 per cent in 2009–2016.

23. A country's adherence to the rule of law has been shown to be a foundational determinant of health.<sup>7</sup> The Global Commission on HIV and the Law has documented the enormous potential of law to improve the lives of people living with HIV, as well as the harm that is done when legal systems fail to protect people from discrimination and other rights violations. Since the Commission released its report in 2012, more than 89 countries have taken action to repeal or reform laws. Some have repealed laws criminalizing HIV, same-sex relations and drug possession, and others have enacted laws advancing reproductive rights, sex education and the human rights of people living with or at risk of HIV.

24. Since the General Assembly committed to eliminating HIV-related restrictions on entry, stay and residence in 2011, 29 countries have either repealed such restrictions or officially clarified that they do not discriminate on the basis of HIV status. Just 20 countries reported the existence of such restrictions in 2017.

<sup>6</sup> United Nations Educational, Scientific and Cultural Organization, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, United Nations Entity for Gender Equality and the Empowerment of Women and WHO, *International Technical Guidance on Sexuality Education: An Evidence-informed Approach*, revised ed. (Paris, 2018).

<sup>7</sup> Angela Maria Pinzon-Rondon and others, "Association of rule of law and health outcomes: an ecological study", *BMJ Open*, vol. 5, No. 10 (October 2015).

## II. Critical gaps in services

25. Where comprehensive, evidence-based programmes have been scaled up and an enabling environment established for the provision of services to the people and locations in greatest need, strong progress has been achieved. However, the determination to make ending AIDS a reality by 2030 is not sufficiently widespread. Entire regions are off track, and, in dozens of countries, the epidemic is worsening.

26. In Eastern Europe and Central Asia, for example, the annual number of new HIV infections has risen by 30 per cent since 2010, and, in the Middle East and North Africa, deaths from AIDS-related illnesses have increased by 11 per cent over the same period. Services focused on key populations within these regions are few and far between, and harsh punishments for same-sex relationships, drug use and sex work in these regions and elsewhere are formidable barriers to the few services that are available.

27. In West and Central Africa, insufficient domestic funding, weak health systems, formal and informal user fees for health care, humanitarian situations and high levels of stigma and discrimination have undermined efforts to scale up HIV testing and treatment. As a result, there are huge gaps along the continuum of HIV testing, treatment and care. Among all people living with HIV in the region in 2017, less than half (48 per cent) knew their HIV status, just two in five (40 per cent) were accessing antiretroviral therapy and less than one third (29 per cent) had suppressed viral loads. In all regions, combinations of primary HIV prevention services tailored to meet the needs of people at highest risk of infection are rarely provided on an adequate scale and with sufficient intensity.

28. Where HIV services are difficult to access – such as where people must travel long distances to a clinic, where clinic hours are not suited to individuals or groups or where clinic staff discriminate against people living with and key populations at risk of HIV – the uptake of these services tends to decrease. Policy and structural barriers and a failure to systematically implement proven prevention programmes at scale have denied HIV prevention services to adolescent girls, young women, key populations at high risk of infection and marginalized populations. Food insecurity, costs associated with HIV and viral load testing, other health-care costs, transport costs, lost income and opportunity costs contribute to later treatment initiation, lower treatment adherence and higher rates of AIDS-related mortality.

29. Gaps across the cascade of HIV testing and treatment services have left more than half of all people living with HIV globally with unsuppressed viral loads, making them vulnerable to AIDS-related illnesses and mortality and also increasing their chance of transmitting the virus to others. Knowledge of HIV status, treatment coverage and viral suppression rates are consistently lower among children, young people and men, and the majority of evidence points to lower treatment adherence and lower viral suppression among female sex workers, people who inject drugs, transgender persons, prisoners and gay men and other men who have sex with men.

### Key populations

30. Key populations are largely ignored by public health policymakers in many countries, even though data show that nearly half (47 per cent) of new HIV infections globally in 2017 were among key populations and their sexual partners. Harm reduction services, for example, are provided at scale in only a handful of countries. Criminal laws and aggressive law enforcement give license to discrimination, harassment and violence, push key populations to the margins of society and deny them access to basic health and social services. Laws and policies that criminalize same-sex sexual relationships still exist in more than 68 countries, and at least

17 countries criminalize transgender persons. Sex work is criminalized in more than 116 countries, and people who commit drug-related crimes still face the death penalty in 33 countries. Stigma and discrimination against key populations within health-care settings has been identified as a major barrier to HIV testing and treatment services, leading to late diagnosis and treatment initiation, treatment interruption and an increased risk of AIDS-related morbidity and mortality.

31. Stigma and discrimination faced by people living with HIV remains unacceptably high. In 22 countries with recent surveys, a median of 50.4 per cent (range of 17.6–76.0 per cent) of men and women aged 15–49 years held discriminatory attitudes towards people living with HIV, and a median of 31.2 per cent (range of 7.3–58.8 per cent) of men and women aged 15–49 years said that children living with HIV should not be able to attend school with children who are not infected with HIV, despite the near-zero risk of HIV transmission among children in school settings. Overly broad criminalization of HIV non-disclosure, exposure and transmission fuels stigmatizing attitudes and discriminatory behaviour in many countries. In a review in 2018, UNAIDS found that 69 countries had laws that criminalized HIV transmission, non-disclosure or exposure. A further 19 countries reported that, while they did not have such specific laws in their statute books, prosecutions did occur on the basis of other criminal laws.

### **Young people, including adolescent girls and young women**

32. In sub-Saharan Africa, declines in child mortality combined with ongoing high fertility rates have resulted in children and young adults comprising a large part of the overall population. This “youth bulge” is not being consistently reached by HIV prevention efforts. Knowledge about HIV prevention among young people has remained stagnant over the past 20 years. Nationally representative surveys conducted between 2012 and 2017 revealed that only 34 per cent of young men and 28 per cent of young women (aged 15–24 years) in sub-Saharan Africa had a basic knowledge of how to protect themselves from HIV. Of the countries reporting to UNAIDS, 19 per cent still do not have a policy of providing comprehensive sexuality education in secondary schools and 95 countries have laws requiring parental consent for adolescents to access HIV testing. Declines in domestic and donor financing of condom social marketing programmes – part of an overall decline in the percentage of funding allocated to primary prevention – is having an impact on access to condoms in high-prevalence countries.

33. High rates of HIV infection continue among adolescent girls and young women across sub-Saharan Africa, many of whom become mothers. Adolescent girls and young women (aged 15–24 years) accounted for one in four HIV infections in the region in 2017, despite making up just 10 per cent of the population, and AIDS-related illnesses were a leading cause of death among women and girls of reproductive age (aged 15–49 years). One in five pregnant women living with HIV is not diagnosed or does not access treatment, and retention on HIV treatment for pregnant and breastfeeding women is too low, with 20 per cent of women in sub-Saharan Africa who began treatment dropping out of care before delivering their babies. In addition, a substantial number of women acquire HIV while pregnant or breastfeeding and are not diagnosed in time to prevent vertical transmission.

### **Gender inequality**

34. Gender inequalities and harmful gender norms increase the risk of HIV infection among women, especially young women in sub-Saharan Africa. Limited access to education, a lack of economic autonomy and unequal power dynamics in the home and wider society deny women control over their lives, restricting their access to HIV prevention and sexual and reproductive health services and exposing them to intimate

partner and sexual violence, as well as a heightened risk of HIV, other sexually transmitted infections, unwanted pregnancies and maternal mortality.<sup>8</sup> Women who experience intimate partner violence are 50 per cent more likely to acquire HIV than those who do not.<sup>9</sup> Country reporting shows that daughters and sons do not have equal inheritance rights in 39 countries globally. In a review in 2018, UNAIDS found that women require the consent of a spouse or partner to access sexual and reproductive health services in four countries, and World Bank data show that only 78 countries explicitly criminalize marital rape.

### **Marginalized populations**

35. The marginalization of indigenous peoples, migrants and refugees exposes them to poorer health outcomes, including higher rates of AIDS-related morbidity and mortality. Indigenous groups in Brazil, Canada, Indonesia and Venezuela (Bolivarian Republic of) have been shown to have poorer access to health care and a higher risk of HIV infection and AIDS-related illnesses.<sup>10, 11, 12, 13</sup>

36. Migration can place people in situations that increase their risk of acquiring HIV. Poverty, exploitative working conditions, denial of entitlements or a high background prevalence of infection at the origin or destination (or along the transit route) are among the factors that influence the risk of HIV, tuberculosis and other infections among migrants. A host of factors also hinder migrant workers from accessing the health-care services they need, including irregular immigration status, language and cultural barriers, user fees, a lack of migrant-inclusive health policies and inaccessible services.<sup>14</sup> This vulnerability can be exacerbated in countries with travel restrictions on people living with HIV because such restrictions discourage migrants from accessing HIV testing and treatment services.

37. Refugees and displaced people may face similar barriers to accessing health care and other social services. Those without the means to support themselves are at higher risk of sexual violence and exploitation or of being forced into situations that leave them vulnerable and marginalized – all of which may seriously affect their health and well-being. Refugees and migrants may also be subject to mandatory HIV testing and restrictions on freedom of movement or other rights violations for those testing positive. People living with HIV who are forced to flee their homes are also in extreme danger of treatment disruption and AIDS-related morbidity and mortality. Food

<sup>8</sup> Kristin L. Dunkle and Michelle R. Decker, “Gender-based violence and HIV: reviewing the evidence for links and causal pathways in the general population and high-risk groups”, *American Journal of Reproductive Immunology*, vol. 69, No. s1 (February 2013); and Frank Chirowa, Stephen Atwood and Marc Van der Putten, “Gender inequality, health expenditure and maternal mortality in sub-Saharan Africa: a secondary data analysis”, *African Journal of Primary Health Care and Family Medicine*, vol. 5, No. 1 (2013).

<sup>9</sup> Lori Heise and Elizabeth McGrory, eds., “Greentree II: violence against women and girls, and HIV”, project report, STRIVE research consortium, August 2016.

<sup>10</sup> Adele Schwartz Benzaken and others, “HIV and syphilis in the context of community vulnerability among indigenous people in the Brazilian Amazon”, *International Journal for Equity in Health*, vol. 16, No. 92 (2017).

<sup>11</sup> A.C. Bourgeois and others, “HIV in Canada – surveillance report, 2016”, *Canada Communicable Disease Report*, vol. 43, No. 12 (December 2017).

<sup>12</sup> Leslie Butt, “‘Living in HIV-land’: mobility and seropositivity among highlands Papuan men”, in *From “Stone-Age” to “Real-Time”: Exploring Papuan Temporalities, Mobilities and Religiosities*, Martin Slama and Jerry Munro, eds. (Canberra, ANU Press, 2015).

<sup>13</sup> Julian A. Villalba and others, “HIV-1 epidemic in Warao Amerindians from Venezuela: spatial phylodynamics and epidemiological patterns”, *AIDS*, vol. 27, No. 11 (July 2013).

<sup>14</sup> WHO, Regional Office for Europe, “Migration and health: key issues – Migrant health in the European region”, 2016.

insecurity during emergencies can also affect treatment adherence and result in HIV-related risk behaviour, such as transactional sex.

38. The number of affected people living with HIV may be increasing as the frequency and magnitude of humanitarian emergencies increase. The Office of the United Nations High Commissioner for Refugees, through modelling undertaken with support from the World Food Programme, estimated that there were 479 million people affected by emergencies in 2016, up from 314 million in 2013, and the number of people living with HIV affected by humanitarian emergencies increased from 1.71 million to 2.57 million.

### **Poverty and vulnerability**

39. The right to health is enshrined in the Universal Declaration of Human Rights of 1948. Seventy years later, in nations of all income levels, that minimum standard of health is often denied to the poorest and most vulnerable. Being poor increases a person's chances of ill health, and the cost of health care is more likely to push that person deeper into poverty. Impoverished individuals must spend much larger proportions of their income on health care than the wealthy and are less likely to have the health insurance needed to avoid catastrophic health costs.

40. The links between poverty and HIV infection are complex. Impoverished individuals may not necessarily be at higher risk of acquiring HIV, but they are differentially affected by its health, economic and social consequences.<sup>15</sup> For example, income level appears to be an important variable in HIV treatment outcomes. In South Africa, persons living with HIV with a low socioeconomic status (based on income, assets or employment status) had a more than 50 per cent higher risk of dying from HIV-related causes than their counterparts with a high socioeconomic status.<sup>16</sup>

41. User fees and other out-of-pocket expenses limit access to health-care services for people living with HIV.<sup>17</sup> Even if antiretroviral medicines are available free of charge, fees for diagnostic tests, consultations and medicines for opportunistic infection have a huge impact on lower-income individuals. User fees have also been shown to reduce access to health services more broadly among the more vulnerable within society.<sup>18</sup> Out-of-pocket payments make up substantial proportions of total health expenditure in all regions (see figure IV), and in some low- and middle-income countries private out-of-pocket spending is estimated to account for more than 60 per cent of total health expenditure.<sup>19</sup>

<sup>15</sup> Stuart Gillespie, Suneetha Kadiyala and Robert Greener, "Is poverty or wealth driving HIV transmission?", *AIDS*, vol. 21, supplement 7 (November 2007).

<sup>16</sup> Charlotte Probst, Charles D. H. Parry and Jürgen Rehm, "Socio-economic differences in HIV/AIDS mortality in South Africa", *Tropical Medicine and International Health*, vol. 21, No. 7 (July 2016).

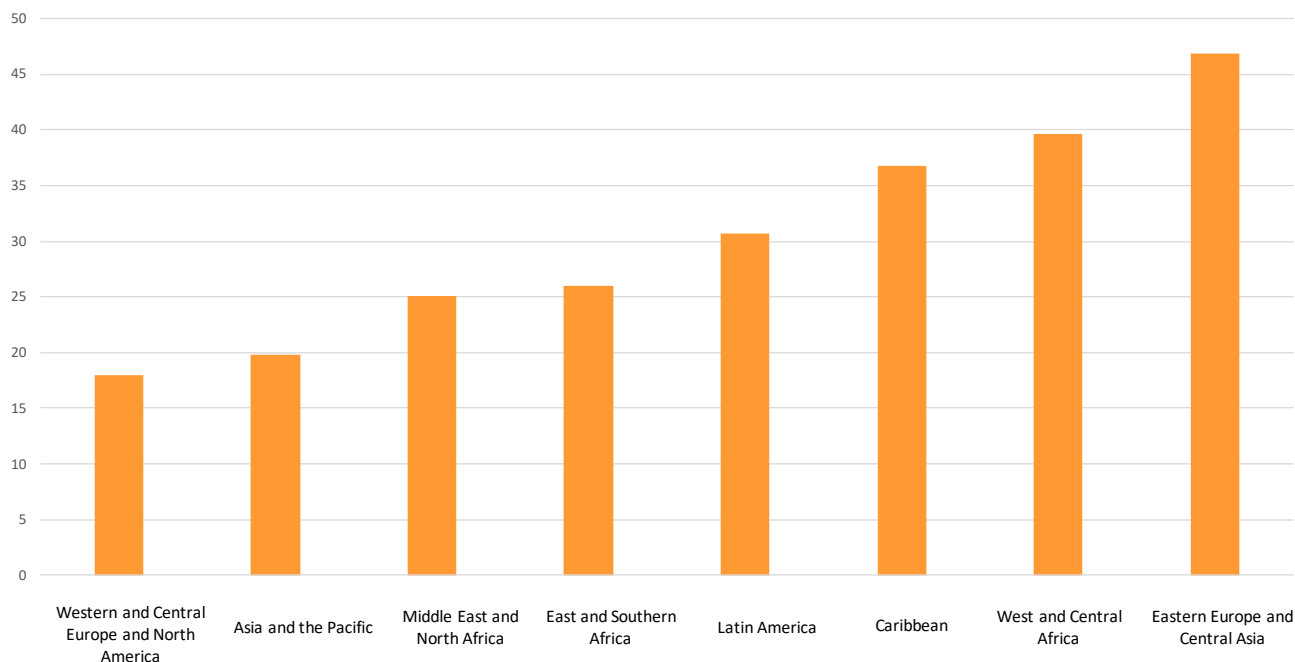
<sup>17</sup> Shabnam Asghari and others, "Challenges with access to healthcare from the perspective of patients living with HIV: a scoping review and framework synthesis", *AIDS Care*, vol. 30, No. 8 (2018).

<sup>18</sup> Chris D. James and others, "To retain or remove user fees? Reflections on the current debate in low- and middle-income countries", *Applied Health Economics and Health Policy*, vol. 5, No. 3 (September 2006); and Mylene Lagarde and Natasha Palmer, "Evidence from systematic reviews to inform decision making regarding financing mechanisms that improve access to health services for poor people", policy brief prepared for the international dialogue on evidence-informed action to achieve health goals in developing countries, Khon Kaen, Thailand, December 2006.

<sup>19</sup> Organization for Economic Cooperation and Development, "Universal health coverage: facts and figures", December 2018.

Figure IV  
**Out-of-pocket payments by households as a percentage of total health expenditure, regional average, 2015**

(Percentage)



Source: WHO, Global Health Expenditure Database. Available at <http://apps.who.int/nha/database/Select/Indicators/en> (accessed on 1 June 2018).

#### **Insufficient availability of recent innovations**

42. In most regions, newer testing technologies are still not widely available. Among countries that reported information on available HIV testing modalities to UNAIDS in 2018, just 32 countries allowed lay providers to perform HIV testing, 14 offered HIV self-testing and 18 offered home-based HIV testing. Assisted partner notification was more common, with 54 out of 140 reporting countries reporting that trained providers may be provided to assist newly diagnosed individuals in disclosing their HIV status to partners and then offer HIV testing (see figure V).

43. Viral load testing coverage remains low in many parts of the world. Among the 79 countries that reported data to UNAIDS in 2017, one quarter indicated that less than half of people on treatment received an annual viral load test.

44. Progress towards the global target of 3 million people on PrEP worldwide by 2020 has been slow. The estimated number of people who have ever started PrEP was about 350,000 by mid-2018, with two thirds of these in the United States of America.

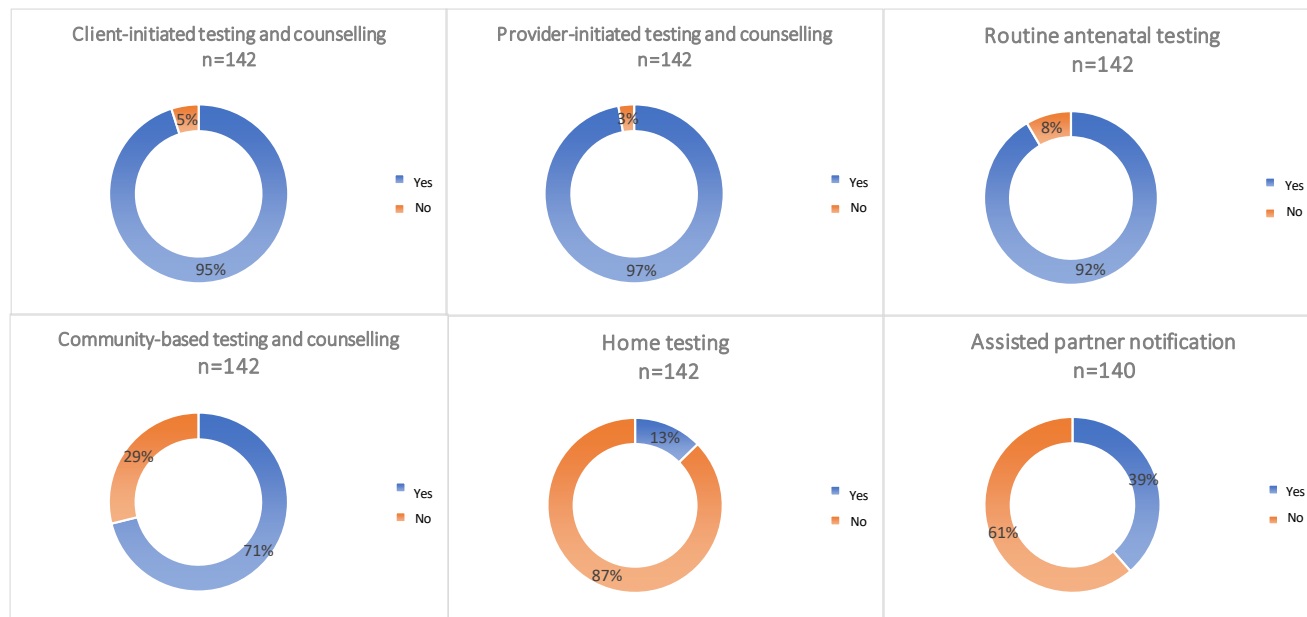
#### **Insufficient investment**

45. More than a decade of growth in funding for HIV responses in low- and middle-income countries stalled in 2009 amid global economic turmoil. As financial markets stabilized and concern mounted that momentum against one of the world's greatest health threats could be lost, the General Assembly agreed to the expansion of investments in low- and middle-income countries over five years, to \$26 billion by 2020 – an amount in line with the estimated costs for these countries to achieve the fast-track programmatic targets in the 2016 Political Declaration on HIV and AIDS:

On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.

Figure V

**Percentage of countries reporting the presence of HIV testing approaches, global, 2018**



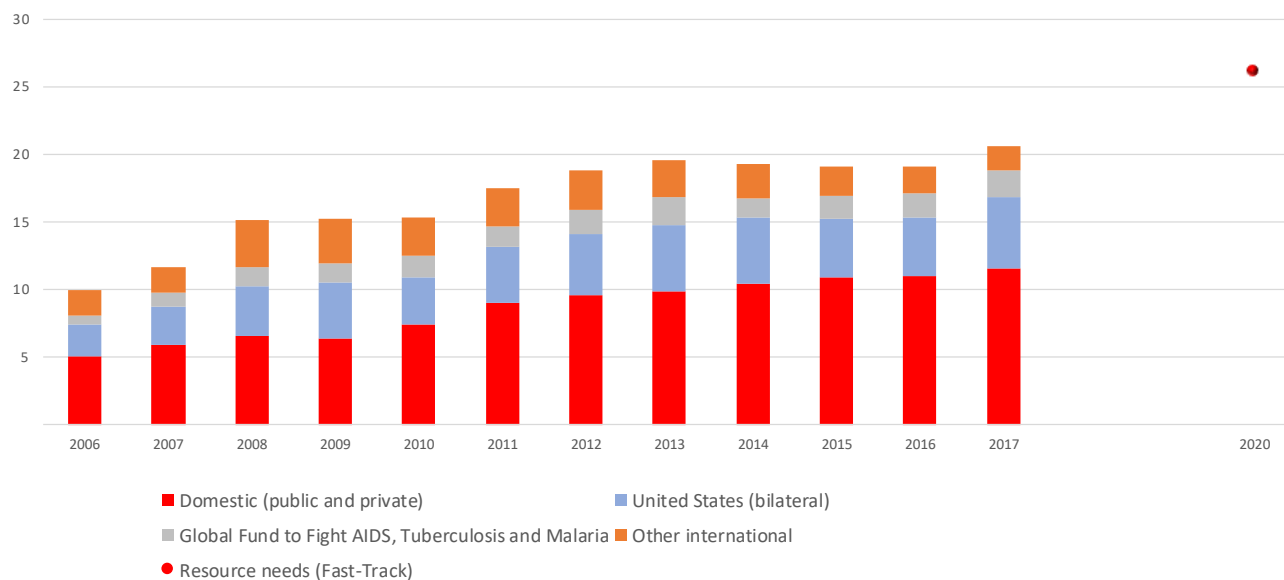
Source: WHO, 2018.

Abbreviation: n, number of countries that reported data.

46. Total funding for HIV responses in low- and middle-income countries was flat between 2012 and 2016. Within that overall trend, steady increases in domestic investments have been offset by reductions in donor funding. In 2017, increased donor disbursements and continued increases in domestic investments combined to increase spending to \$20.6 billion (in constant 2016 United States dollars) – about 80 per cent of the 2020 target for low- and middle-income countries (see figure VI). The recent extension of the United States President’s Emergency Plan for AIDS Relief is a welcome new commitment from the single largest provider of international support for the global AIDS response. However, additional donor and domestic commitments are needed to reach the 2020 investment target. The sixth replenishment conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria, to be held in October 2019, is critical to securing additional donor commitments for 2020–2022 and spurring additional domestic investment.

Figure VI  
**HIV resource availability in low- and middle-income countries, in constant United States dollars, by source of funding, 2000–2017 and 2020 target**

(Billions of United States dollars)



Source: UNAIDS resource availability and needs estimates, 2018.

Note: Estimates for low- and middle-income countries as per 2015 World Bank income level classification. All figures are expressed in constant 2016 United States dollars.

### Taking AIDS out of isolation

47. The response to AIDS does not exist in isolation. The nature of HIV – both the way it is transmitted and how it attacks the immune system – requires a people-centred, holistic effort across multiple sectors to reduce risk from multiple health and social issues and to address multiple medical conditions faced by people living with HIV. For example, human papillomavirus puts women living with HIV at a four- to fivefold greater risk of invasive cervical cancer than women who are not infected with HIV.<sup>20</sup> Tuberculosis is the leading preventable cause of death among people living with HIV, with some 300,000 [270,000–340,000] people dying from HIV-associated tuberculosis in 2017.<sup>21</sup> In 2016, more than half of people who inject drugs were living with hepatitis C and one in eight were living with HIV. Among HIV-positive people who inject drugs, four out of five had serological evidence of past or present hepatitis C infection and 7 per cent had hepatitis B.<sup>22</sup>

48. Despite the clear advantages of integrating tuberculosis and HIV services, this approach is far from universal. Of the 117 countries that reported data to UNAIDS at the end of 2017, about half had integrated HIV counselling and testing with tuberculosis services and just over a third had fully integrated HIV and tuberculosis treatment (see figure VII). WHO has estimated that half of people living with HIV and tuberculosis in 2017 were unaware of their tuberculosis infection and therefore not receiving tuberculosis treatment. Where diagnosis is delayed, there is increased

<sup>20</sup> Sheri A. Denslow and others, “Incidence and progression of cervical lesions in women with HIV: a systematic global review”, *International Journal of STD and AIDS*, vol. 25, No. 3 (March 2014).

<sup>21</sup> WHO, “HIV-associated tuberculosis”, fact sheet, 2018.

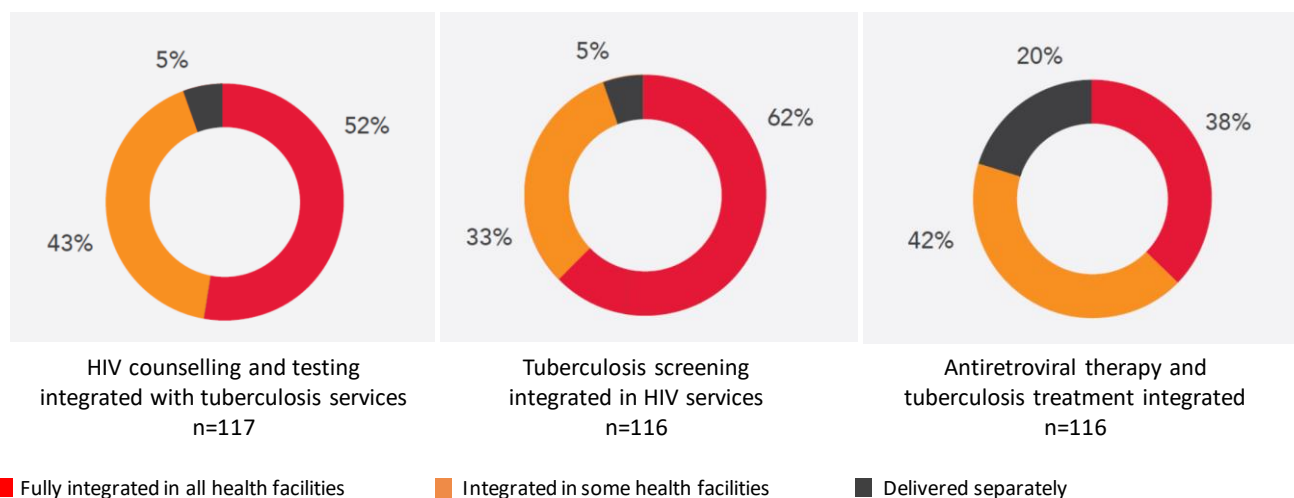
<sup>22</sup> WHO, *Global Hepatitis Report*, 2017 (Geneva, 2017).



risk of mortality, especially from multidrug-resistant and extensively drug-resistant tuberculosis.

49. Developments in molecular technologies mean that it is increasingly possible to diagnose different diseases rapidly using single platforms. These platforms offer technical and financial efficiencies for national health systems, while expanding access to care and saving lives.<sup>23</sup> Services for multiple diseases can also encourage routine HIV testing as just another part of a health check-up and help to overcome stigma and discrimination, because visiting an integrated service facility may make it harder for others to guess an individual's HIV status.<sup>24</sup>

Figure VII  
**Percentage of countries reporting the delivery of integrated HIV and tuberculosis services, global, 2017**



Source: UNAIDS, 2017 National Commitments and Policy Instrument.

Abbreviation: n, number of countries that reported data.

### III. Leaving no one behind as countries adopt universal health coverage

50. Efforts to end AIDS as a public health threat, to achieve the other health commitments within the Sustainable Development Goals and to deliver on the 71-year-old declaration of a global, inalienable right to health all rely heavily on progress towards one specific goal: universal health coverage.

51. The growing movement for universal health coverage aims to ensure that all people can access the high-quality health services they need, to safeguard all people from public health risks and to protect all people from impoverishment due to illness, whether from out-of-pocket payments for health care or loss of income when a household member falls

<sup>23</sup> WHO, "WHO advises on the use of multidisease testing devices for TB, HIV and hepatitis", 22 June 2017; and WHO, Global TB Programme and Department of HIV/AIDS, "Considerations for adoption and use of multidisease testing devices in integrated laboratory networks", information note, June 2017.

<sup>24</sup> Baotran N. Vo and others, "Patient satisfaction with integrated HIV and antenatal care services in rural Kenya", *AIDS Care*, vol. 24, No. 11 (2012); and Population Council, "Assessing the benefits of integrated HIV and reproductive health services: the Integra Initiative".

sick. Ensuring universal access to affordable, high-quality health services will also be an important contribution to ending extreme poverty by 2030.

52. The core principle of universal health coverage is to leave no one behind. This has been a mantra of the HIV response for more than a decade. The inequities behind these calls are deeply intertwined. HIV is the fourth leading cause of death in low-income countries and the second leading cause of death in sub-Saharan Africa.<sup>25</sup> Leaving no one behind requires a health benefit package that includes a comprehensive set of HIV services, additional public health and social protection services provided through dedicated government funding streams and structural changes to ensure that vulnerable and marginalized people can access the services they need.

53. The health benefit packages at the centre of universal health coverage should include facility-based HIV services, such as adult and child HIV testing and treatment, the prevention of mother-to-child transmission, PrEP and voluntary medical male circumcision. Universal health coverage platforms can also facilitate ongoing efforts to integrate HIV services with maternal and child health services, sexual and reproductive health services, the prevention and treatment of tuberculosis, hepatitis, sexually transmitted infections and non-communicable diseases, human papillomavirus vaccination and harm reduction services.

54. In addition, universal health coverage should include dedicated public health or social protection funding streams for other critical services delivered by a range of sectors, such as condom promotion, behaviour change interventions, comprehensive sexuality education, human rights programming, stigma and discrimination reduction and outreach services for key populations.

55. In low- and middle-income countries with a high burden of HIV, where HIV services account for a large percentage of total health expenditure, it may not be possible for domestic resources to pay for a comprehensive set of services in the medium term. Even in low- and middle-income countries with low-level epidemics, the cost of lifelong HIV treatment can put a strain on national health financing schemes. Donor support will be required as countries transition to universal health coverage systems. Countries receiving such support will need to strengthen underlying systems, such as health information and financial management systems, to build both public and donor confidence in national health financing schemes.

#### **IV. Greater political will needed to achieve global goals**

56. The challenges to ending AIDS are myriad and vary from country to country (and even within countries), reflecting the global diversity of laws, policies, customs and practices. Such challenges can sometimes seem insurmountable as countries grapple with competing priorities and limited resources. However, the evidence is clear: enabling environments have been established and fast-track targets reached in a variety of epidemic and income settings. When these targets are reached, the result is steady declines in HIV infections and AIDS-related deaths.

57. Finding the political will to meet these challenges and reach the 2020 targets in a much larger number of countries, across all regions and income levels, is required to get the world on track to ending AIDS as a public health threat by 2030. By contrast, complacency with the status quo will at best prolong the epidemic and at worst result in a rebound to crisis. Continuing high rates of new HIV infections among adults translate to ever-growing populations of people living with HIV who require

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<sup>25</sup> WHO, "Global health estimates 2016: estimated deaths by cause and region, 2000 and 2016".

lifelong antiretroviral therapy. The burden of care placed upon health systems grows each year.

58. Multiple initiatives are under way to assist countries in meeting their commitments, especially in the areas of the HIV response that have been lagging behind. These initiatives are being undertaken within the larger context of United Nations reform, which is guiding more effective use of resources and improving the ability of the United Nations system to deliver against its mandates and to support countries in implementing the 2030 Agenda. UNAIDS, a joint programme of 11 United Nations entities, has been refining its unique model in line with broader United Nations reform.

59. The Global HIV Prevention Coalition, composed of Member States, donors, civil society organizations and implementers, is addressing slow progress in the reduction of HIV infections among adults. A public-private partnership initiative of the United Nations Population Fund is aiming to expand for-profit promotion and distribution of condoms in sub-Saharan Africa, including by calling greater attention to the barriers faced by the private sector, such as high taxes, tariffs and confusing regulatory pathways.

60. Through a call to action for the linking of sexual and reproductive health and rights and HIV interventions, a broad coalition of United Nations agencies and international non-governmental organizations is promoting 10 key strategies for upholding sexual and reproductive health and rights and meeting HIV service needs. In East and Southern Africa, the “2gether4SRHR” (together for sexual and reproductive health and rights) programme is working to increase integrated service delivery in 10 high-prevalence countries.

61. The need to empower young people with accurate information on HIV prevention, sexuality and sexual and reproductive health, especially in high-prevalence settings, was addressed by the issuance in 2018 of a revised version of the International Technical Guidance on Sexuality Education that stresses the importance of comprehensive sexuality education in schools.

62. A new global partnership for action to eliminate all forms of HIV-related stigma and discrimination was launched in 2018, with a number of countries already pledging to take action on stigma and discrimination. The Start Free, Stay Free, AIDS Free initiative is promoting a set of human rights-based interventions to end AIDS as a public health threat among children, focusing on 23 countries with high numbers of children, adolescents and young women living with HIV.<sup>26</sup>

63. More than 300 cities globally have joined the Fast-Track Cities initiative, which focuses the efforts of these urban areas to achieve the 90-90-90 targets, increase the utilization of combination HIV prevention services and reduce to zero the negative impact of stigma and discrimination. Five years after the launch of the initiative, the first international Fast-Track Cities conference will be held in September 2019 in London to address cross-cutting challenges and share best practices.

## V. Recommendations

64. Remarkable progress against the HIV epidemic has been achieved, but this progress is uneven. Dozens of countries and entire regions are in danger of missing the targets for 2020 that were agreed within the Political Declaration on HIV and

<sup>26</sup> Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

AIDS of 2016. Member States are urged to adopt the following recommendations to maintain political will, galvanize action and build the momentum necessary to reach the 2020 targets set by the General Assembly and put the world on track to end AIDS as a public health threat by 2030.

**Recommendation 1: reinvigorate primary HIV prevention**

65. The Global HIV Prevention Coalition has developed the HIV prevention 2020 road map,<sup>27</sup> a common agenda that requires countries to set national and subnational prevention targets and to strengthen HIV primary prevention programming. Since the coalition was formed in 2017, new national prevention coalitions have been established and national prevention strategies have been revamped in many countries with a high HIV burden. These national strategies need to be urgently translated into national action.

**Recommendation 2: diversify HIV testing and differentiate the delivery of health care to reach the 90-90-90 targets**

66. The experience of countries that have achieved the 90-90-90 targets shows that diverse approaches to HIV testing – including provider-initiated testing, community-based testing, peer outreach, index testing and self-testing – are needed to reach the target of 90 per cent of people living with HIV knowing their HIV status. After an HIV diagnosis, immediate initiation of antiretroviral therapy, adherence support mechanisms and periodic viral load testing are needed to reach 90 per cent coverage of treatment among people diagnosed with HIV and 90 per cent of people on treatment having suppressed viral loads. Differentiated health-care service delivery, including shifting tasks from doctors to nurses and from nurses to community health workers, has been shown to achieve high coverage of services in settings with low levels of human resources for health.

**Recommendation 3: establish enabling legal and policy environments in order to reach marginalized and vulnerable populations**

67. Specific efforts are required to ensure that marginalized and vulnerable groups, including key populations at high risk of HIV acquisition, have their health and HIV needs met. The Global Commission on HIV and the Law has spelled out in detail the measures that should be undertaken to ensure effective, sustainable health responses consistent with universal human rights obligations.<sup>28</sup>

**Recommendation 4: mobilize additional resources and allocate them where they are most needed**

68. At least \$14 billion is being sought for Global Fund grants for HIV, tuberculosis and malaria for 2020–2022. Fully meeting that target is critical but still not enough to get the world on track to ending AIDS as a public health threat by 2030. Continued increases in donor and domestic resource allocation are needed to reach the high levels of service coverage called for in the 2016 Political Declaration. Efficiency gains are also needed. Domestic and donor resources should be spent on evidence-informed services that focus on the people and places in greatest need, using a location-population approach informed by granular data collection.

<sup>27</sup> Available at [www.unaids.org/sites/default/files/media\\_asset/hiv-prevention-2020-road-map\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf).

<sup>28</sup> All 30 recommendations made by the Global Commission on HIV and the Law can be found in its 2018 supplement, *Risks, Rights and Health*.

**Recommendation 5: support communities to enable them to play their critical roles**

69. Exceptional civil society advocacy has driven an exceptional global response to HIV, and civil society participation in the delivery of key services is needed to reach high levels of coverage. Community groups of people living with HIV, key populations, women, adolescents and young people should be included in the design, implementation and monitoring of health and social programmes, including efforts to establish systems to achieve universal health coverage. Involving women in leadership and decision-making positions is key. National and local systems for social contracting are needed to ensure that community-based organizations receive public funding for service provision.

**Recommendation 6: incorporate a comprehensive HIV response into universal health coverage**

70. The high-level meeting of the General Assembly on universal health coverage, to be held in September 2019, is an opportunity to incorporate a comprehensive HIV response into universal health coverage. Evidence-based HIV interventions should be included in comprehensive health benefit packages, public health campaigns, public education systems and the delivery of social protection. Robust and transparent public financial management systems are needed to ensure the efficient use of domestic and donor resources.

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