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THEMATIC SEGMENT BACKGROUND NOTE

Sustaining the gains of the global HIV response to 2030 and beyond

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Executive summary

1. The thematic segment of the 54th PCB meeting focuses on "Sustaining the gains of the global HIV response to 2030 and beyond". It builds on the thematic segment from the 43rd PCB meeting in 2018, *"Shared responsibility and global solidarity for an effective, equitable and sustainable HIV response for the post-2015 agenda".*

2. Accelerated progress is needed to meet the globally agreed 2025 targets of reducing the annual number of new HIV infections to fewer than 370 000 and AIDS-related deaths to fewer than 250 000, increasing the number of people living with HIV who receive treatment by another 4.2 million and enabling them to achieve viral suppression are vital steps toward reaching those targets.

3. In 2022, an estimated 86% of people living with HIV were aware of their HIV status, 76% were on treatment, and 71% were virally suppressed. Fewer men in comparison to women and a little over half of all children living with HIV were accessing treatment. While 21 countries were on track to meet the 95–95–95 targets by 2025 (including four that have achieved the targets already), a majority of countries were not on track. This has negative implications for the health and well-being of people living with HIV for averting new HIV infections and for preventing resurgent HIV epidemics.

4. People living with HIV require lifelong treatment and care. As people with HIV age, they also become more susceptible to a range of non-communicable diseases and health conditions. Preventing and managing the additional health challenges faced by people ageing with HIV will be a major priority towards and beyond 2030.

5. While research into an HIV cure and vaccine is ongoing, and promising advances have been made, the timeframe for achieving these remains uncertain.[i] [ii] A viable tuberculosis (TB) vaccine may, however, be available in a relatively shorter timeframe.[iii]

6. The geographic distribution of the HIV pandemic is shifting, with an increasing proportion of new HIV infections occurring outside sub-Saharan Africa, where most HIV acquisition is among people who belong to key populations. Annual new HIV infections have declined globally since 2010. This is largely due to the progress achieved by many countries in sub-Saharan Africa. Outside that region, progress has been uneven, with decreases in new HIV infections in some countries and increases in others, including steep rises in new infections in some instances. Intensified HIV prevention remains a priority for all countries.

7. Most countries still lack adequate HIV programmes for key populations, and many maintain laws and policies that make it exceedingly difficult for these populations to access HIV and other vital services. Many countries are yet to deploy people-centred, precision prevention approaches that can reduce the risks and vulnerabilities associated with acquiring HIV.[iv]

8. Economic and other inequalities, along with stigma and discrimination, continue to fuel the pandemic and undermine HIV treatment and care. Sustained inroads against the pandemic require reaching the 10–10–10 targets that set out to remove the social and legal barriers to an effective HIV response, including ending criminalization affecting key populations.

9. Civil society organizations, networks, and communities have led HIV responses in many countries throughout the pandemic but are not always able to operate freely. Countries must continue to prioritize meeting the 30-80-60 targets that set out to

ensure that people and communities affected by HIV, including key populations, are meaningfully involved in leading HIV responses.

10. Levels of financing for the HIV response have stagnated in recent years, leading to a widening funding gap, particularly in low- and middle-income countries. The US$ 20.8 billion available globally for HIV in 2022 is considerably lower than the US$ 29.3 billion needed for the HIV response in 2025.

11. Domestic funding for HIV has risen, but many countries also face formidable competing priorities in the context of slow economic growth, fiscal constraints, and high indebtedness. The evidence from low- and middle-income countries shows that investing in the HIV response yields long-term health, social and economic gains that far outstrip the initial investments.

12. The global HIV response is heading in the right direction, but too slowly and too unevenly, to achieve and sustain epidemic control in ways that leave no one behind. Nonetheless, the current environment also offers opportunities to address the challenges, meet the 2030 goal, and lay the foundation for the long-term sustainability of the HIV response.

13. Sustainability includes processes of continuous improvement that require immediate, medium-term, and long-term actions, including meeting the 2025 targets, maintaining progress through 2030, and ensuring momentum for a sustainable post-2030 response.

14. The elements necessary for a sustained HIV response to end AIDS as a public health threat by 2030 and beyond include: 1) the ability to ensure people-centred systems within a human rights and gender equality framework for health and equity; 2) a sufficient enabling environment that allows for multilevel responses and resources; and 3) upholding the right to health for all people.

15. Sound and effective HIV responses have evolved over the past four decades, providing vital insights into the processes necessary to intensify, accelerate, and advance progress to meet targets. Gaps, barriers, and vulnerabilities are known, and clear guidance is provided on how to address these.

16. Some countries are ‘building out’ from their HIV response to integrate HIV and non-HIV services to provide holistic care—a process that contributes to comprehensive healthcare access, following a whole-of-society approach towards achieving Universal Health Coverage (UHC).

17. While biomedical approaches for HIV prevention, treatment, and care, have increasingly been emphasized in the HIV response, it is acknowledged that the drivers of HIV include complex socioeconomic and cultural conditions that require integrated responses and solutions.[v] Reinvigorating the synergies between biomedical and social sciences is critical for ensuring an effective, holistic, and sustainable HIV response.

18. Countries must be positioned to restructure debt, ensure financial stability and growth in their fiscal space to sustain health gains and achieve a sound footing for post-2030 scenarios.

19. In the context of changing social, political, and environmental circumstances globally, including the potential for new or emerging epidemics, pandemics, and overlapping crises (polycrises), preparedness planning and actions are necessary to avoid a reversal of HIV gains.

20. Dialogue on sustainability is needed at all levels. Sustainability roadmaps are vital for planning the way forward for resilient country HIV responses that leave no one behind. Countries have an opportunity to leverage multisectoral collaboration and resources within their borders and build on regional and global partnerships to act now to chart the path towards a sustainable HIV response.

21. UNAIDS has a critical role in catalysing and leading the next steps toward HIV sustainability, including spearheading a coordinated multisectoral HIV response and accelerating progress toward HIV targets and the 2030 goal.

Key messages

22. The global AIDS pandemic is at a critical juncture. Immediate actions are needed to accelerate and broaden the progress achieved by the HIV response and to sustain all gains towards and beyond 2030.

23. To achieve sustainability, we need to bring down new infections, AIDS-related deaths, and stigma and discrimination, and ensure that all people living with HIV have access to treatment and care on a lifelong basis.

24. Ensuring that every aspect of the HIV response is on track requires political, financial, and programmatic sustainability.

25. Political sustainability entails strong leadership and commitment to supporting innovations, policies, and investments that can drive the HIV response forward at global, regional, and national levels. Crucially, this must occur in partnership with communities and organizations of people at risk of, affected by, and living with HIV. Political sustainability implies shared responsibility, participatory and accountable governance, enabling laws and policies, and achieving an equitable HIV response.

26. Programmatic sustainability involves applying the rich lessons from over four decades of HIV response, including multidisciplinary research and evidence that draws together the social and biomedical sciences to achieve high-impact outcomes; multisectoral strategies that harness all relevant resources; meaningful involvement of people and communities affected by HIV; and robust and well-resourced health systems that lead towards universal health coverage.

27. Financial sustainability means ensuring adequate, sustainable, and equitable domestic and external funding to boost and sustain the impact of the HIV response. That includes deploying country-tailored financing solutions alongside necessary global solidarity and support to meet diverse needs, confident in the knowledge that investing in HIV leads to substantial health, social, and economic gains for all people.

Introduction

28. The Programme Coordinating Board (PCB), at its 53rd session in December 2023, agreed that the focus of the thematic segment at the 54th meeting would be "Sustaining the gains of the global HIV response to 2030 and beyond". This note provides background information for the thematic discussion.

29. Goal 3 of the Sustainable Development Goals (SDGs) is to ensure healthy lives and promote well-being for people of all ages. Target 3.3 includes ending the epidemics of AIDS, TB, and malaria.

30. On 8 June 2016, the Political Declaration on HIV and AIDS adopted by the United Nations (UN) General Assembly committed countries to accelerate and scale up the fight against HIV and to end AIDS by 2030 by seizing "the new opportunities provided by the 2030 Agenda for Sustainable Development to accelerate action and to recast our approach to AIDS" by intensifying efforts towards comprehensive prevention, treatment, care, and support.

31. The follow-on Political Declaration on HIV and AIDS of 8 June 2021 committed countries to end inequalities and engaging stakeholders to end AIDS by 2030 by effectively implementing established approaches to HIV prevention and treatment, ensuring gender equality and empowerment, realizing human rights and eliminating HIV-related stigma and discrimination; increasing investments and resources for the HIV response; accelerating integration of HIV services into UHC and enhancing the use of data, science and innovation. The Declaration reaffirmed the Greater Involvement of People Living HIV (GIPA) principle which is aimed at empowering communities of people living with, at risk of, and affected by HIV to play critical leadership roles in the HIV response.

32. The Global AIDS Strategy 2021–2026[vi] seeks to reduce the inequalities underpinning HIV and emphasizes that "putting people at the centre" and "getting the world on track" to end AIDS as a public health threat by 2030 requires achieving three strategic priorities: (1) maximizing equitable and equal access to HIV services and solutions; (2) breaking down barriers to achieving HIV outcomes; and (3) fully resourcing and sustaining efficient HIV responses and integrating them into systems for health, social protection, humanitarian settings and pandemic responses.

33. Ending AIDS by 2030 requires achieving the 2025 targets, including the 95–95–95 targets (near-universal awareness of HIV status, uptake of HIV treatment, and viral load suppression), the 10–10–10 targets[1] (removing social and legal impediments to the HIV response), and the 30–80–60 targets[2] (ensuring investments in community- and key population-led HIV organizations and responses).

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[1] By 2025, less than 10% of countries have punitive legal and policy environments that deny or limit access to services; less than 10% of people living with HIV and key populations experience stigma and discrimination; and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.

[2] By 2025, 30% of testing and treatment services are delivered by community-led organizations; 80% of HIV prevention services for people from populations at high risk of HIV infection, including for women in those populations, are delivered by community-led organizations; 80% services for women, are delivered by community-led organizations that are women-led; 60% of the programmes to support the achievement of societal enablers are delivered by community-led organizations.

Figure 1. The UNAIDS 2025 targets[vii]

34. In 2022, there were an estimated 1.3 million new HIV infections (far higher than the 2025 target of fewer than 370 000), 630 000 AIDS-related deaths (compared with the 2025 target of fewer than 250 000), and 29.8 million people living with HIV receiving antiretroviral therapy (4.2 million fewer than the 2025 target of at least 34 million people on treatment). [3]

35. Other HIV targets include: 95% of women access sexual and reproductive health (SRH) services; 95% coverage of services for triple elimination of HIV, syphilis and viral hepatitis; 95% of children exposed to HIV are tested for HIV; 90% of people living with HIV receive preventive treatment for TB; and linking 90% of people living with HIV to other integrated health services.

36. As the United Nations' only cosponsored Joint Programme, UNAIDS supports the global HIV response and targets by leveraging the multisectoral expertise, implementation capacity, and in-country presence of its 11 UN Cosponsors to drive results and work on the ground in 85 countries. UNAIDS provides critical programmatic, epidemiological, and financial data for impact and resource allocation—including informing sustainability of the AIDS response; strongly endorses and enhances community-led HIV responses; advocates for legal and policy reform to protect rights, address inequalities, and tackle barriers to ending AIDS; and acts as an accountability mechanism for global HIV commitments.

[3] Unless otherwise referenced, all data reported is derived from the 2023 Global AIDS update: The path that ends AIDS. Geneva: UNAIDS; 2023 (https://thepath.unaids.org/wp-content/themes/unaids2023/assets/files/2023_report.pdf).

37. Sound and effective approaches for addressing HIV have evolved including political, strategic, and human rights leadership; policies, strategies, and advocacy; systems, programmes, multisectoral, and community responses; financial systems and investments; and research, monitoring, and evaluation. Gaps, barriers, and vulnerabilities have also been identified and are steadily being addressed. There is also growing recognition that preparedness is vital for meeting threats and crises that may disrupt the HIV response.

38. In the context of these efforts and the 2030 goal, the sustainability of the HIV response can be understood as a process of *continuous* improvement that includes immediate, medium-term and long-term actions to achieve sustained health outcomes and reduce health inequities.

39. A consultation convened by UNAIDS in July 2023 to describe the "end of AIDS as a public health threat" in eastern and southern Africa observed that if high levels of HIV treatment and viral suppression coverage targets are met, HIV incidence and AIDS-related mortality will be lower after 2030, with new HIV infections continuing to fall after that.[viii] Achieving that trajectory would require high levels of antiretroviral therapy coverage (95%); addressing chronic conditions among older people living with HIV; using differentiated service delivery models; and focusing on primary HIV prevention in conjunction with reducing societal barriers.[ix]

40. The pandemic is far from over. Projections show that, even by 2050, tens of millions of people will be living with HIV and will need services and systems in place to enable them to live healthy lives. Disease elimination exists along a continuum from disease control through elimination to eradication.[x] Globally, HIV has not yet reached the disease control phase, and only once new infections are below 1 per 10,000 in all countries and populations will we be within reach of ending AIDS as a public health threat.

The dimensions of sustainability

41. In 2018, the 43rd Programme Coordinating Board meeting considered the way forward for achieving sustainable HIV results, including outlining a sustainability framework comprising four components:[xi]

- Unwavering political commitment to shared responsibility—including increasing domestic and donor funding and resourcing services to ensure no one is left behind.
- Investing for impact and robust national strategies—including effective decision-making, improving programme and system efficiencies and adopting a UHC lens.
- Delivery for sustained results—including accelerating the quality implementation of fully funded HIV programmes incorporating human rights and gender considerations and delivery through strengthened health and community systems.
- Engaging now for long-term sustainability—including pursuing UHC, multisectoral financing of HIV, human rights, societal enablers, and health activities, and integrating donor financing within government-led fiduciary systems to build the foundation for sustainability and preparing for country transitions.

42. In September 2023, representatives from 55 PEPFAR partner countries, civil society, UNAIDS, the Global Fund, Africa Centres for Disease Control, AUDA-NEPAD, the United States Government, and other key stakeholders conducted an inception meeting on the sustainability of the HIV response. It was clarified at the meeting that the sustainability agenda is not a donor exit strategy. Pathways identified for

expanding country-led HIV responses to ensure that progress is made and sustained beyond 2030 included political, programmatic, and financial elements:

- Ensuring country leadership in the sustainability response by following a multisectoral, whole-of-government, and whole-of-society approach that includes government ministries, departments and agencies, civil society sectors, stakeholders, civil society organizations and communities, and establishing a permanent representative steering committee to oversee sustainability dialogues.
- Adopting new ways of working within countries, including programmatic transformations (such as HIV integration), support for health systems (including public health systems and policy reform), and flexibility and openness to diverse solutions.
- Planning now, including by developing guidance through Sustainability Roadmaps and ensuring that planning, monitoring and programmatic transformation includes people living with HIV, vulnerable populations and affected communities.
- Recognizing that greater attention and support are needed for civil society organizations and community involvement in advocacy, planning, and service delivery.
- Mobilizing domestic and other resources for sustainability and linking sustainability-focused finance initiatives to UHC and other convergences.

43. Following the meeting, it was agreed that the participation of multiple actors including Co-sponsors, community organizations and civil society, regional bodies, and global institutions, will ensure an integrated effort, abandoning the multiple fragmented efforts undertaken previously. Leveraging existing tools and efforts is considered essential, as is learning the lessons to ensure that dialogues and roadmaps lead to country-owned and country-led integrated approaches.[xii]

44. Sustaining the impact of the global HIV response requires political, programmatic and financial sustainability.[xiii] Measurable elements include: the status of laws, policies and practices (political sustainability);[xiv] the status of capacities and capabilities (programmatic sustainability);[xv] and the status of co-financing (financial sustainability)[xvi], with potential for tracking over the 2024–2030 period and beyond.

45. Sustainability has been defined in various ways.[xvii] [xviii] [xix] [xx] [xxi] In support of a new approach for planning and implementing sustainable national HIV responses, UNAIDS proposes the following definition of sustainability: "A country's ability to have and use, in an enabling environment, people-centred, human rights- and gender equality-based systems for health and equity; empowered and capable institutions and community-led organizations; and adequate, equitably distributed resources to reach and sustain the end of AIDS as a public health threat by 2030 and beyond, upholding the right to health for all." [xxii]

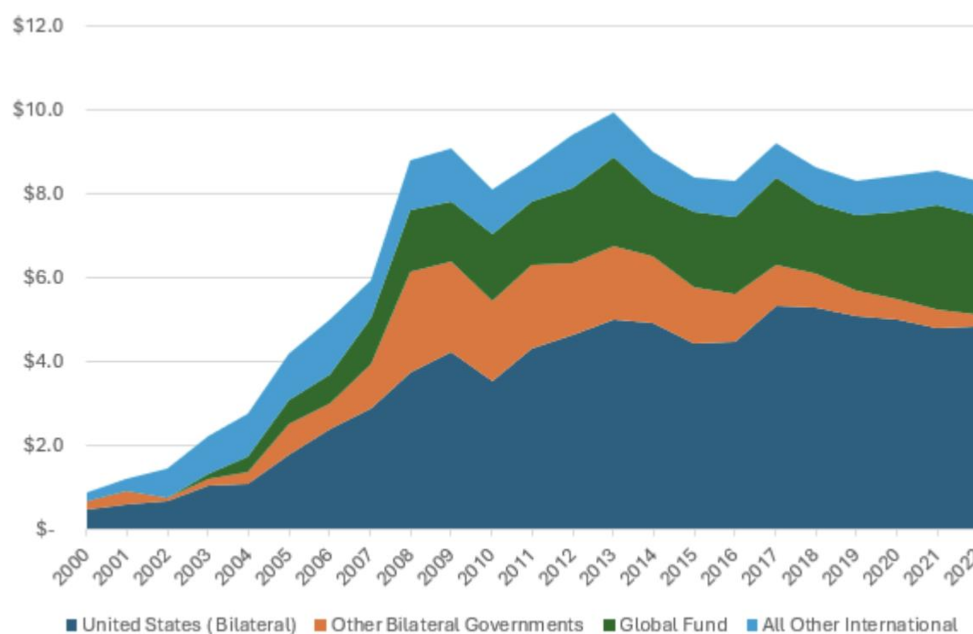
46. In line with this definition, country pathways for achieving the 2030 goals to end AIDS as a public health threat and protecting the impact of the HIV response, include ensuring the quality of life of people living with HIV beyond 2030 through addressing political, financial, and programmatic sustainability.

Investing in the HIV response

47. Priorities for HIV funding are guided by the strategic directions set out in the Global AIDS Strategy (2021–2026) and aligned strategies, including: national strategic plans; global health sector strategies on HIV, hepatitis B and C and sexually transmitted infections (STIs) (2022–2030); and the strategies of the Global Fund and PEPFAR.

48. In 2022, bilateral funding from the US Government constituted 58% of all external assistance for HIV, while disbursements from the Global Fund accounted for about 29%. Other international donors contributed the remainder, but that share has diminished considerably, from approximately US$ 3 billion in 2010 to US$ 1.2 billion in 2022, a 61% decrease.[xxiii]

Figure 2. UNAIDS estimates of HIV funding by source, 2000–2022[xxiv]



49. Trends in HIV financing show a widening funding gap. In 2022, US$ 20.8 billion (in constant 2019 US$) was available for HIV programmes in low- and middle-income countries—2.6% less than in 2021, and well short of the US$ 29.3 billion needed by 2025.

50. HIV prevention is significantly underfunded and is not well-prioritized in domestic funding streams. It is estimated that annual HIV prevention expenditure needs to reach US$ 9.5 billion in 2025, nearly double the investment of US$ 5.3 billion in 2019.[xxv]

51. A report of the 15th meeting of the HIV Multisector Leadership Forum[4] in 2023 recommended intensifying HIV prevention responses through the strengthening of financing and systems. This could achieved by: advancing HIV prevention stewardship and institutionalizing HIV prevention costs within national HIV response systems; strengthening cross-border and bilateral collaboration; developing guidance on multisectoral approaches and accountability for HIV prevention; standardizing HIV treatment guidelines and medications; and enhancing accountability.[xxvi]

52. A recent analysis by The Economist highlighted that investing in the HIV response in sub-Saharan Africa would yield a "triple dividend" of health, social and economic gains. Using South Africa as an example, estimates suggested that every dollar invested in the HIV response between 2022 and 2030 could result in seven-fold gains in gross

[4] This forum of the Global HIV Prevention Coalition provides a community of practice for directors of national AIDS coordinating agencies to support their leadership, coordination and advocacy for a multisectoral approach to HIV prevention in Coalition focus countries (HIV Multisector Leadership Forum | GPC (unaids.org)).

domestic product. The analysis further indicated that increased investment in the HIV response is a crucial component of economic recovery in lower and middle-income countries with high HIV burdens.[xxvii]

53. Lower- and middle-income countries HIV responses include transitions towards domestic funding due to changes in the investment environment shaped by policies of external partners. These processes have been slowed due to economic shifts following the COVID-19 pandemic and other consecutive crises.[xxviii] [xxix] Domestic health spending in low- and upper-middle-income countries spending is declining as inflation and unsustainable debt service costs have imposed additional budgetary challenges, and this impacts HIV spending. Around 3.3 billion people, including more than half of Africa's population, live in countries which spend more on debt interest payments than health and education.[xxx] Revised timelines and principles guided by international solidarity and shared responsibility with robust international and domestic investments are recommended.

54. Donor funding priorities may entrench practices that do not match local conditions and fully serve local needs. Consequently, country and global priorities may sometimes be misaligned. According to a review of external assistance conducted in high HIV prevalence countries in eastern and southern Africa,[xxxi] for example, among the factors constraining the sustainability of the HIV response was an emphasis in external assistance on HIV treatment over prevention; reluctance to pursue service integration; structural barriers that limit support for key populations; and limited capacity among organizations that are well-positioned to serve community needs. Recommendations included developing a primary prevention agenda, supporting processes that facilitate integration; investing in local capacity development, and advocating for stronger political will among diverse stakeholders.

55. Domestic financing can be supported by focusing on the efficiency of investments in HIV—for example, allocating (or reallocating) resources to the most epidemiologically effective interventions; reducing the unit costs of resources or services through improved targeting, improved procurement, and management practices; using community-based approaches linked to the most affected groups; and implementing cost-effective interventions.[xxxii]

56. Donor exits jeopardize HIV control, and there are risks of HIV resurgences among key populations. Where there is national government resistance to supporting key populations, opportunities can be explored for working sub-nationally, such as working with municipalities.[xxxiii] Removing legal and policy barriers to human rights, meaningfully involving civil society and communities at all levels, and providing resources and financing for community-led HIV responses are vital elements for a sustainable HIV response. Donors can support each of those processes.

57. A few countries have introduced innovative financing instruments to augment domestic HIV financing—for example, Zimbabwe's AIDS Trust Fund (involving taxes and levies): Botswana's National HIV/AIDS Prevention Support International Bank for Reconstruction and Development Buy-Down; and Côte d'Ivoire's Debt2Health Debt Swap Agreement (both are debt conversion instruments). The United States Agency for International Development (USAID) has implemented a Sustainable Financing Initiative for the HIV response which emphasizes three areas of engagement: public financial management, private-sector engagement, and financial protection, each of which is linked to three cross-cutting themes (efficiency, commodity security and evidence for advocacy).[xxxiv]

58. Private sector engagement and investment have the potential to bolster the sustainability of the HIV response. Approaches include workplace HIV initiatives; increasing access to private health facilities and laboratories; supporting capacity building; mobilizing strategic partnerships (for example, for pharmaceutical research, logistics support or utilization of technologies); and various financing options.

Progress and gaps in the HIV response

Progress towards the 2025 targets

59. New HIV infections have decreased significantly in sub-Saharan Africa, but there has been hardly any change in the annual number of infections outside that region since 2010, even though there has been progress in some countries. Several countries, including some in sub-Saharan Africa, are experiencing growing HIV epidemics. Global HIV estimates show that a large proportion of new HIV infections occurs among key populations and their sex partners, yet many countries lack comprehensive data on the sizes and HIV trends among their key populations—data that are needed for effective HIV prevention, treatment and care programmes.[xxxv] [xxxvi] [xxxvii] Other gaps and inequalities also characterize the global HIV response, including comparatively lower HIV treatment coverage among men and children living with HIV (Table 1).

Table 1: Progress towards 95–95–95 by 2022

Target	Progress by 2022
95–95–95 (Global)	▪ 86%–76%–71% ▪ Fewer men in comparison to women, and only 57% of children accessing treatment. ▪ HIV and other health services for people from key populations are often scarce, inaccessible or entirely absent in many countries.
95–95–95 (Countries and regions)	▪ 95–95–95 achieved by Botswana, Eswatini, Rwanda and Zimbabwe ▪ 17 countries (nine in sub-Saharan Africa) were on track to reach the targets by 2025. ▪ Viral suppression was lower among children living with HIV (43%) and among men living with HIV (67%) compared to women living with HIV (76%). ▪ In the Middle East and North Africa, and eastern Europe and central Asia, about half of people living with HIV were on antiretroviral therapy. Coverage in Asia and the Pacific was below the global average, and there has been limited improvement in coverage in Latin America.

60. Inequalities, criminalization, and stigma and discrimination underpin higher levels of HIV transmission, lower access to HIV treatment, and limited access to HIV and other services globally.[xxxviii]

61. In 2022, every country in the world either partially or fully criminalized one or more of the following: sex work, possessing of small amounts of drugs, same-sex sexual intercourse and HIV transmission, exposure or nondisclosure.[xxxix] Few countries have laws that protect transgender people from discrimination and violence.[xl] Some countries are introducing or expanding discriminatory laws that affect people who belong to key populations, including introducing laws that carry severe penalties.[xli]

However, other countries have repealed or reformed such discriminatory laws. The UNAIDS Reference Group on HIV and Human Rights has outlined steps for decriminalizing key populations.[xlii]

62. Population-based surveys in 54 countries show that approximately 59% of people report discriminatory attitudes—nearly six times higher than the 2025 target.[xliii] Some 77% of countries have laws and policies that are at odds with protecting people against stigma and discrimination, and 21% of countries lack laws and policies to protect women and girls, people living with HIV, and key populations against gender inequality and violence.[xliv] Sexual and reproductive health and rights (SRHR) services and comprehensive sexuality education are under-resourced.[xlv] There is also a dearth of investment in stigma reduction programmes (including research to inform effective programming).

63. Shifts away from decentralized funding approaches, have contributed to declining resources for community-based or -led organizations.[xlvi] In many countries, community-led organizations continue to face funding shortages, policy and regulatory barriers, capacity constraints, and other obstacles.[xlvii] The 30–80–60 targets are aimed at harnessing potential of community-led HIV responses. However, current monitoring systems do not adequately capture data to measure progress towards those targets, and UNAIDS is exploring options for appropriate metrics or proxy measures.

64. There has been underinvestment in poverty alleviation, despite strong evidence that social protection and related programmes can help HIV-vulnerable populations meet some of their essential needs, as well as benefit people living with, at risk of or affected by HIV.[xlviii]

Ensuring sustained the health of people living with HIV

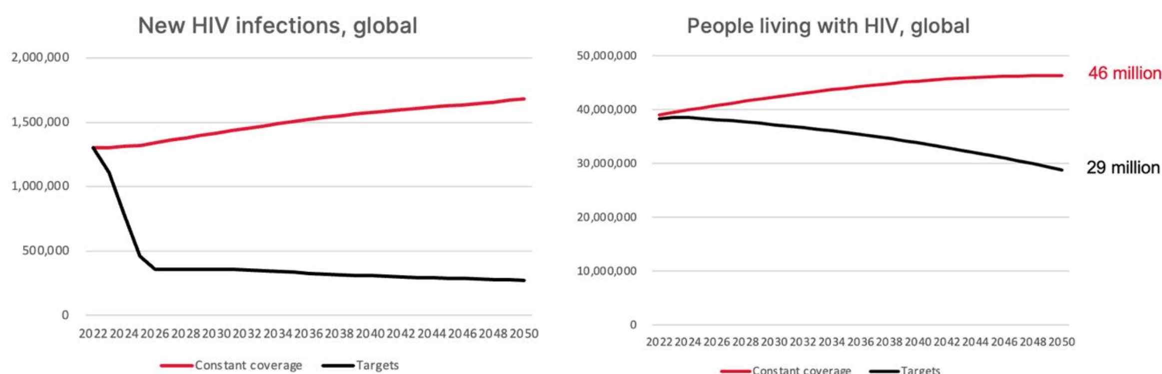
65. Approximately 24% of people living with HIV globally were aged 50 years and older in 2022. In regions such as western and central Europe and North America, almost half of people living with HIV are at least 50-years-old and similar trends are underway in other regions.[xlix] Older people living with HIV tend to have increasing health complications, some of which are exacerbated by HIV or further complicate the treatment and management of HIV. Those health conditions include hypertension, cardiovascular disease, various cancers, diabetes, osteopenia and osteoporosis, liver disease, renal disease, and neurocognitive decline.[l] Women with HIV are six times more likely to develop cervical cancer than women without HIV. Vaccination against the Human Papilloma Virus (HPV, the virus that causes cervical cancer) and cervical cancer screening and treatment are highly effective interventions, but they are very unevenly available to women.[li] Tuberculosis and cryptococcal meningitis commonly affect people living with HIV, and prompt diagnosis and treatment can avert serious morbidity and mortality risks.[lii]

66. Up to 10% of people living with HIV may have resistance to first-line antiretroviral therapy, some of whom are drug-resistant due to previous exposure to antiretroviral medicines.[liii] In addition, about one in three people in low- and middle-income countries who start or return to HIV care have advanced HIV disease (AHD).[liv] People with AHD are at high risk of death, even after starting antiretroviral therapy. Improved and scaled-up diagnostics, treatment, and care are needed.[lv]

67. Modelling data highlights the need for transformative approaches to reach key AIDS targets and sustain those achievements. In the absence of comprehensive and more effective HIV responses that meet the global targets, new HIV infections will increase in the coming decades (Figure 3). Projections show that if the 2025 targets are met,

there will be some 29 million people living with HIV in 2050; if the targets are not met and the HIV response continues on its current trajectory, there will be about 46 million people living with HIV, all of whom will require lifelong antiretroviral therapy.

Figure 3. Constant coverage versus meeting the HIV targets[lvi]



68. For countries currently achieving the 95–95–95 targets, modelling shows that a further 20% reduction in new HIV infections every five years is an ambitious but attainable target. In countries where progress is slower, rapid increases in treatment coverage will lead to steeper declines in HIV incidence.[lvii]

69. To achieve resilient epidemic control in eastern and southern African countries (defined as concerted actions towards integrated long-term services for millions of people living with HIV, minimizing new HIV infections, and confronting HIV stigma and discrimination), the Post-2030 HIV Response Working Group has identified four priorities for sustainability:
    - effective and uninterrupted HIV treatment provision, including ensuring viral load suppression to support Undetectable=Untransmittable (U=U);
    - ensuring timely diagnosis, including through frequent testing and self-testing;
    - adapting HIV prevention responses to evolving needs, including through strategies that engage large populations who are at moderate risk for HIV infection and smaller populations who are high risk; and
    - providing comprehensive HIV programmes and services for key populations.[lviii]

Ecuador: Antiretroviral treatment transition to improve viral suppression

WHO recommends that people living with HIV initiate HIV treatment with an antiretroviral regimen of tenofovir diproxil fumarate, lamivudine and dolutegravir (TLD), and that people who are or have been on treatment also transition to this regimen. Evidence based on programme data, is limited, especially in the Americas. A study in Ecuador found that this approach represents a significant advance in the treatment of HIV infection, due to its potency, high barrier to resistance and favourable drug-drug interaction profile. It also offers a safe and effective option for people with comorbidities, including TB. Research is continuing to inform approaches in settings with limited access to drug resistance testing and patient monitoring, to improve equitable access across countries.[lix]

70. Data on antiretroviral therapy coverage among key populations are only available for some countries. Available data shows that an average of about 44% of transgender people living with HIV were on treatment, as were 65% of sex workers, 69% of people who inject drugs, and 78% of gay men and other men who have sex with men—compared to 76% globally in the overall population in 2022.[lx] People in prisons are more than seven times more likely to be living with HIV than adults in the general population, yet prisons and other closed settings are often neglected in HIV responses, including treatment programmes.[lxi]

71. The integration of HIV and TB treatment has contributed to a 67% reduction in TB-related deaths among people living with HIV since 2010. However, only 46% of people living with HIV who developed TB in 2021 were on antiretroviral therapy, and the initiation of TB preventive treatment by people living with HIV is substantially below the 90% target for 2025. Further improvements in HIV-TB integration are therefore needed.

Accelerating HIV prevention

72. Patterns of new HIV infections are shifting, and for the first time in the history of the pandemic, there are roughly equal numbers of new HIV infections occurring within and beyond sub-Saharan Africa. An estimated 55% of new HIV infections globally now occur among people in key populations and their sexual partners. In sub-Saharan Africa, new HIV infections among key populations represented 25% of the total new infections in 2022. In the rest of the world, key populations represented 80% of all new infections. [lxii]

73. While steep reductions in new HIV infections among key populations and their sex partners are needed to achieve the 2025 targets, most countries do not have adequate programmes in place for key populations.[lxiii] In 2022, only approximately 49% of sex workers, 29% of gay men and other men who have sex with men, and 36% of people who inject drugs accessed two or more HIV prevention services in the previous three months—against a target of 90%. Harm reduction approaches are not widely available for people who inject drugs, and there is a limited focus on addressing the HIV-related vulnerabilities of non-injecting drug users.[lxiv] Data and programming for transgender people and people in prisons are inadequate.

74. In sub-Saharan Africa, adolescent girls and women account for a majority of new HIV infections. Adolescent girls and young women (aged 15–24 years) accounted for more than 77% of new infections among young people in that region. Gaps continue to exist in combination prevention programmes and in supportive programmes that promote biomedical, behavioural and structural interventions for adolescent girls and young women.[lxv] HIV infection risks are especially high for adolescent girls aged 10-19 years and are aggravated by biological susceptibility to HIV and age-disparate sexual relationships.[lxvi]

Jakarta, Indonesia: Optimizing resources for transformation

Despite ample local government and external resources allocated to the HIV response, service delivery in Jakarta, Indonesia, has proved to be complex. To address this challenge a STOP Strategy was implemented in 2018 to map all available resources and programmes linked to achieving the 95–95–95 targets. This comprehensive city-based approach led to an organized map of health service

delivery and fostered collaborations across diverse fields beyond the planned activities.

The approach helped address gaps in antiretroviral drug supplies during the COVID-19 pandemic. It also enabled the tailoring of ongoing HIV programmes to include HIV and other services provided by key population-led organizations. Coverage of testing and treatment and levels of viral suppression increased from 50–35–0 in 2018 to 79–48–59 by 2023. Innovative funding approaches continue to be explored. While there is potential for similar approaches in other cities, legal frameworks and system constraints must be considered.[lxvii]

75. The Global HIV Prevention Coalition (GPC) includes 40 focus countries, accounting for 76% of all new infections globally.[lxviii] There have been steeper declines in new HIV infections in these countries in the rest of the world. Those declines are attributed to high levels of HIV testing and treatment coverage, behavioural changes (including delayed sexual debut, fewer risky sexual encounters), moderate levels of condom use, and increased uptake of voluntary medical male circumcision.

76. Resource flows to well-established HIV prevention approaches such as condom use and voluntary medical male circumcision (VMMC) are declining in some of the largest epidemics in the world. [lxix] Condoms remain important for HIV prevention and offer additional benefits of preventing other STIs and pregnancy. In addition, many low- and middle-income countries outside eastern and southern Africa are not yet providing access to PrEP on a significant scale.[lxx] Widescale PrEP access in low- and middle-income countries may require additional investments.[lxxi]

77. Factors contributing to increases in new HIV infections or slow progress in the Coalition focus countries include a lack of political commitment, insufficient financing, lack of implementation of programmes at scale, neglect of proven interventions, and the persistence of legal and other obstacles (including criminalization, stigma, discrimination and social exclusion). The least progress against HIV is occurring in countries where HIV incidence is high among people belonging to key populations and their sex partners. [lxxii]

78. Wide coverage of vertical transmission programmes has reduced the number of children (aged 0–14 years) acquiring HIV.[lxxiii] The 2030 goal for the triple elimination HIV, syphilis and hepatitis B further supports improvements in maternal and child health.[lxxiv] Barriers to triple elimination in sub-Saharan Africa include policy, strategy, community engagement and resource gaps.[lxxv]

Zambia: Improving efficiencies for diagnosing young children with HIV

The elimination of paediatric AIDS is key for achieving epidemic control. It requires, among other elements, following HIV-exposed infants to ensure timely diagnosis of HIV. An intensive community-based campaign, including awareness raising, community engagement and involving mentor mothers, was conducted in Zambia to trace and test HIV-exposed infants, with 82% of infants reached. Additionally, HIV retesting was provided to 94% of breastfeeding mothers to identify those who acquired HIV during the pregnancy and breastfeeding periods. All mothers and infants who were diagnosed with HIV were enrolled on antiretroviral therapy. The approach highlighted gaps in tracking processes and informed ways to scale up the tracking of mothers and infants to eliminate vertical transmission and end paediatric AIDS.[lxxvi]

The potential for a viable HIV cure or vaccine

79. An HIV vaccine would be a potentially cost-effective solution to limit new HIV infections, and a cure will overcome challenges and costs of lifelong treatment. The search for an HIV cure includes the development of a “sterilizing cure”, which would eliminate the possibility of viral replication, and a “functional cure”, which would control HIV replication without treatment.[lxxvii] Near absolute efficacy is necessary for a cure to ensure non-remission.[lxxviii] The pathway to an HIV cure is complex due to the persistence of HIV in cellular reservoirs.[lxxix] For children whose HIV status is confirmed at an early age, there is the potential for the early-life immune system to be harnessed in developing a functional cure, and pathways are being investigated.[lxxx lxxxi lxxxii]

80. Although there is now a strong foundation for advancing vaccine science, only the R V144 Thai trial has shown modest efficacy.[lxxxiii] Studies on generating neutralizing antibodies show promise and the possibility of developing mRNA vaccines is being explored. However, the timeframes for achieving an HIV cure[lxxxiv] or a viable vaccine[lxxxv] remain uncertain.

81. Given that HIV infection increases the risk of progression to active TB and that TB is a leading cause of death in people with HIV, a TB vaccine would also have important implications for the sustainability of the HIV response.[lxxxvi] Multiple candidate TB vaccines for adults are in late-stage development and show promise.[lxxxvii] The BCG vaccine is protective for TB in children, and antiretroviral therapy is protective against TB for children living with HIV.[lxxxviii]

Threats to the HIV response

82. Emerging or intensifying humanitarian emergencies, epidemics and pandemics, armed conflict, sociopolitical factors, and climate change (many of which intersect and overlap as polycrises) pose a threat to current and future HIV response efforts and have implications for sustainability.

83. Pandemic preparedness and response processes have attracted increased attention and resources since the COVID-19 pandemic. Preparedness planning is needed, not only for future pandemics, but also to address a wider range of contingencies and threats that have the potential to limit or reverse HIV gains.

Humanitarian emergencies

84. Humanitarian emergencies typically involve multilayered health, social, political, economic and environmental factors, often including conflict and violence, which contribute to human suffering, compromise people’s health and increase societal fragility.[lxxxix]

85. Humanitarian emergencies disrupt the systems and structures that are necessary for health care, including HIV prevention, treatment and care. Meeting the needs of people living with HIV becomes more difficult during humanitarian emergencies, especially when continuity of access to commodities, resources and services is threatened. Key and vulnerable populations are likely to be more severely affected.[xc]

Emerging epidemics and pandemics

86. The COVID-19 pandemic severely impacted people's health and well-being and increased economic and social fragility across the world. During 2020–2021, HIV in-person health care and follow-up for HIV prevention and treatment were severely disrupted.[xci]

87. Innovations, including telemedicine, multi-month dispensing, the reorganization of health care workforces, procurement and supply chain adaptations, and community-led interventions (including by people living with HIV and other key populations), mitigated the impact of COVID-19, increased resilience, and improved the HIV response in many respects. Subsequent use of those innovations has, however, been uneven.[xcii] [xciii]

88. Several novel and re-emerging pathogens with epidemic and pandemic potential may constrain the HIV response, including evolving respiratory viruses and the Ebola virus, among others.[xciv] Emerging fungal infections pose risks for people with compromised immunity and are associated with high morbidity and mortality for people living with HIV.[xcv]

89. The development of a Pandemic Preparedness and Response Accord is underway, following agreement by member states of the WHO in the context of the International Health Regulations. Agreement was reached on key amendments in June 2024.[xcvi] There are opportunities to leverage HIV-related infrastructure and principles to strengthen pandemic preparedness, including for disease surveillance, supply chains, health-care workforce management and leveraging community responses.[xcvii]

Sociopolitical factors

90. Counterproductive or inadequate leadership related to the HIV response undermines the potential for sustainability. Examples include HIV denialism, support for fake cures, ongoing criminalization and harassment of key populations,[xcviii] the limiting of civic space, harmful practices, and other failures to uphold human rights.[xcix]

91. Governance and implementation challenges that undermine effective and sustainable HIV responses include insufficient investment in HIV programmes, over-reliance on donors, inadequate reporting to donors, mismanagement of funds, poor relationships with stakeholders, unsustainable programming, inadequate implementation, or unsatisfactory performance. Changing political conditions in donor or recipient countries may also result in countries being excluded as recipients of donor funds.[c]

Armed conflict

92. Armed conflicts contribute to the collapse of health and governance systems; damage and destroy vital health, water and sanitation infrastructure; cause increased environmental degradation; lead to reduced access to education; generate large-scale migration and displacement; and have long-lasting physical and mental health impacts. These factors can all contribute to HIV risk, disrupt HIV-related health services, and undermine HIV treatment and care.[ci] Key populations are likely to be especially affected.[cii]

Climate change

93. According to the WHO and the World Bank, climate change is projected to cause an additional five million deaths between 2030 and 2050—mainly from malnutrition,

malaria and diarrheal diseases—and lead to extreme poverty for a further 100 million people.[ciii] [civ] Community and public health infrastructure may also deteriorate or be permanently damaged. Changes due to climate change are ongoing and far-reaching and amplify inequalities.

94. Climate change can affect HIV incidence and health outcomes in a number of ways including: by increasing food and water insecurity, deprivation and poverty, as well as the prevalence of other diseases, and human migration and displacement. Food insecurity is linked to sexual risk-taking.[cv] The distribution of health commodities and access to HIV prevention, treatment and other services are affected by floods and other climate-related disasters, with knock-on effects on the continuity of access to medications and HIV prevention, treatment, and care resources and services. Stigma and discrimination affecting people displaced and vulnerable people, people living with HIV, and key populations may also be amplified.[cvi]

Country HIV responses and sustainability

Country ownership, leadership, and governance

95. The Global AIDS Strategy 2021–2026 emphasizes country ownership as a "sustainable driver of change in the HIV response through diversified funding, service integration and by matching the response to national, subnational and community needs."[cvii] This includes ensuring that national strategies are focused on reducing inequalities and incorporating decentralized and community ownership to maximize positive health outcomes.

96. The HIV Leadership Forum, a community of practice of National AIDS Coordinating Authorities (NACAs) Director Generals of GPC member states, has reviewed concerns relating to the extent of access to care and other crucial services, the lack of impetus for transforming vertical programmes into integrated models, and the ongoing need for enabling legal and policy environments to expedite the progress of the HIV response.[cviii] It has proposed that NACAs make use of opportunities offered through ongoing transitions to determine relevant country-led sustainability approaches including HIV service models that leverage and integrate with wider national, health, social, and economic systems.

97. Criteria for effective HIV governance include strong political leadership and commitment; linking HIV to broader social and economic concerns; implementing a multisectoral response; decentralizing authority and resources; and ensuring the genuine participation of civil society and communities.[cix] [cx] The latter aspect includes support and services for key populations and people living with HIV; the use of rights-based approaches; and their involvement in budgeting and monitoring in order to strengthen transparency and accountability. Also important are commitments to improve gender equality and uphold human rights (including removing or reforming punitive HIV-related laws); achieve adequate domestic spending on HIV and health; ensure financial accountability (including acting against anti-corruption); achieve adequate capacities for relevant state institutions; and ensure effective delivery of primary health care and essential social services. Preparing for multiple, overlapping threats and crises is also necessary.

Kenya: Leadership, multisectoral, decentralized and community-led responses for sustainability

Kenya is on track to meet the 95–95–95 targets as a result of strong political commitment and by applying targeted and decentralized approaches. These efforts have relied on considerable external funding and the Government is moving forward to address resource needs in the context of declining international development assistance. To strengthen the HIV response in line with UHC and other health reforms, a Sustainability Roadmap—which is envisaged as a living document—is being developed with national and county governments.

Laws were recently passed to support UHC, including Acts related to digital health, facility improvement financing and the establishment of a Social Health Authority to manage a Primary Healthcare Fund, Social Health Insurance Fund and an Emergency, Chronic and Critical Illness Fund. This approach promises to strengthen primary health care access and referral, as well as contribute to viable models for HIV service delivery integration.

External donor support has been provided to strengthen the implementation of related activities and programmes, including support to national and county budget allocations for health and strategic programmes through the medium-term expenditure framework. Countries will be able to draw on several models to determine the best fit for primary health care integration and meeting the 2025 targets. The approach includes community health promotion and outreach to support access to prevention services, continuity of treatment and care, and health system strengthening.[cxi]

Multisectoral responses

98. Multisectoral collaborations and partnerships can bring together government ministries, agencies, institutions, civil society organizations, and diverse sectors of society at all levels in the HIV response. Related actions include influencing and aligning policy, unifying leadership, integrating sectoral and health priorities, sharing resources, mitigating epidemic spread and impacts, engaging with stakeholders and communities, and contributing to sustainability. The approach requires political will, leadership and coordination to sustain partnerships and strengthen sectoral capacities.[cxii]

99. The Global AIDS Strategy 2021–2026 places particular emphasis on resourcing and supporting women-led responses, which remain marginalized within the HIV response and underfunded at all levels. The strategy has set specific targets to ensure that 80% of services for women, including prevention services, are women-led.[cxiii]

Community-led HIV responses

100. The UNAIDS Multistakeholder Task Team used the following definition of community-led HIV responses in its deliberations: “actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups, and networks that represent them.”[cxiv]

101. As noted by UNAIDS, community-led organizations are “held back by funding shortages, policy and regulatory hurdles, capacity constraints and [by] crackdowns on

civil society and the human rights of marginalized communities."[cxv] Those barriers must be removed to realize the full potential for community leadership and involvement in the HIV response. Furthermore, community leadership must be integrated into HIV plans and programmes and incorporated into funding decisions, given that "communities understand what is most needed, what works, and what needs to change".

102. The 2021 Political Declaration on HIV and AIDS reiterates the 2016 commitment to ensure that at least 30% of all HIV service delivery is community-led and by adding further targets for community-led HIV responses. Those include ensuring that communities affected by HIV and the networks and organizations that represent them are included in decision-making bodies and systems. Reaching the targets can help ensure that HIV responses serve community needs, resources are well-spent, and gaps and barriers are identified and addressed.[cxvi]

103. PEPFAR refers to "local civil society organizations helping PEPFAR programs and health institutions diagnose, pinpoint persistent problems, challenges and barriers related to HIV service uptake and retention at community and facility level."[cxvii] The Global Fund includes support for capacity building of community-led and community-based organizations, networks and groups.[cxviii]

104. Many of the earliest responses to HIV involved societal communication in combination with people-centred, community-driven interventions. These approaches, which primarily involved people subsequently defined as key populations and people living with and affected by HIV, showed that HIV incidence could be reduced, and care and support (including stigma reduction) could be provided with modest resources through community-led mobilization efforts. Examples include:

- Early responses to HIV in the United States in the 1980s, where networks of gay men partnered with allied organizations and health services and used rights-based activism, support groups, and resource mobilization to reduce HIV incidence and provide non-stigmatizing care and support to people living with HIV.[cxix] [cxx]
- Uganda's multisectoral, decentralized approach in the 1980s and early 1990s drew on government leadership and civil society partnerships and open discussion of HIV, which was linked to notions of "patriotic duty" and shared priorities. This enabled community-led HIV responses (including stigma reduction) to flourish. Actions included the establishment of clubs, support groups, networks and responsive community-based organizations.[cxxi] [cxxii]
- Interventions involving sex workers in India, including emphasis on condom use and health service access, have led to declines in HIV in multiple settings. [cxxiii] [cxxiv]
- Approaches adopted in Zimbabwe in the late 1990s and early 2000s, where HIV incidence declined due to reductions in multiple sexual partnerships, were linked to exposure to HIV communication through mass and community media and faith-based, workplace-based and interpersonal dialogues in the context of high levels of AIDS mortality and economic deterioration.[cxxv]
- In many high HIV-prevalence countries in eastern and southern Africa, civil society organizations were established or reoriented to respond to HIV, with support from diverse funding sources during the 1990s and early 2000s. These organizations contributed to community and social mobilization for HIV prevention and care. Shifts towards centralized multilateral and government funding occurred without ensuring sustained support for organizations, forcing many to close their doors. A survey of 439 organizations and case studies in eight countries in the region identified unique localized contributions from these organizations, noting that

relevant and sustainable civil society economies were undermined in the context of funding transitions and centralized high-budget funding regimes.[cxxvi]

Integration: HIV services, Primary Health Care, Universal Health Coverage and other convergences

105. HIV responses have leveraged broader health benefits. Several countries are “building out” from their HIV response to integrate HIV and non-HIV services to provide holistic care. The integration of HIV and non-HIV-specific services has increased access to comprehensive health services and improved health outcomes. HIV care has also inspired models for other diseases, such as chronic disease care. Health system components built through HIV investments, including strategic information systems, have also improved capacity and are contributing to better health outcomes.[cxxvii]

106. The HIV response includes addressing multiple levels of response and convergences related to PHC and UHC through social enablers—notably by protecting human rights through addressing legal environments and access to justice; achieving gender-equal societies; overcoming stigma and discrimination; and promoting “co-action across development sectors to reduce exclusion and poverty”.[cxxviii] Those actions occur across the education, labour, housing, transportation and health sector. Convergences in human rights, gender equality, elimination of stigma and discrimination, and development outcomes contribute to people-centred programmes and services that incorporate the principles of inclusion and participation.

107. The integration of HIV services, including related SRH services, into broader health care expands access to HIV prevention, treatment and care. Integration also improves health and health system outcomes and is a valuable strategy to boost the sustainability of the HIV response.[cxxix] Related benefits include reducing financial hardships in accessing health care, reducing inequalities, and enabling better protection from health emergencies.[cxxx]

108. PHC follows a whole-of-society approach to health to maximize health and well-being and is a cost-efficient approach for achieving UHC. Countries are adopting different paths towards UHC, based on their populations' health needs and the available resources.[cxxxi] Investing in PHC ensures that those needs are identified, prioritized and addressed in an integrated way; that there is a robust health system and workforce; and that all sectors of society contribute to confronting the environmental and socioeconomic factors that affect health and well-being.

109. The Lusaka Agenda, which involves an action plan for a shared long-term vision of nationally funded health care emerging from high-level multistakeholder dialogues, outlines fundamental shifts for strengthening global health initiatives to achieve UHC and other goals, including strengthening contributions to PHC, playing a catalytic role in sustainable domestic financing, strengthening joint approaches for achieving equity in health outcomes, achieving strategic and operational coherence, and coordinating research and development.[cxxxii]

110. Many of the same strategic and operational levers for PHC and UHC are relevant to HIV, SRH, and the sustainability of the HIV response. Those include strong political commitment and leadership; sound governance and policy frameworks; adequate resources and strategic funding allocations; engagement with communities and other stakeholders; diverse health systems components; and solid research, monitoring, and evaluation. These components present opportunities for convergent actions.

Synergizing biomedical and social science

111. Over the past decade, there has been a marked shift towards resourcing and implementing biomedical approaches for HIV prevention, treatment, and care. Yet the HIV pandemic and response is fundamentally shaped by socioeconomic and structural dynamics that require integrated, multidimensional solutions which address diverse populations and circumstances.[cxxxiii]

112. Concerns have been raised that biomedical approaches on their own do little to address or resolve underlying factors that fuel the pandemic.[cxxxiv] [cxxxv] Behavioural aspects are not adequately addressed through a biomedical lens, and the psychosocial aspects of HIV, including mental health and quality of life, tend to be underprioritized.[cxxxvi] [cxxxvii] [cxxxviii]

113. Multifaceted behavioural, social, economic and other circumstantial factors underpin testing, treatment uptake, and staying on treatment. An analysis of HIV adherence in 25 countries, mainly outside sub-Saharan Africa, found that 24% of people living with HIV were not adhering to treatment, with mental health challenges (depression, feeling overwhelmed), fears of HIV disclosure, and side effects being influential factors.[cxxxix] A review of 66 studies on adolescent HIV treatment adherence in sub-Saharan Africa found an adherence rate of 65% and a viral suppression rate of 55%, despite focused interventions—with socioeconomic challenges, health system factors, lack of social support, and stigma contributing to non-adherence.[cxl]

Uganda: Reducing self-stigma through psychosocial therapy

Self-stigma undermines psychological health and limits many aspects of living with HIV, including access to antiretroviral therapy. In Uganda, girls and young women living in impoverished areas are highly susceptible to self-stigma due their living conditions and the challenges of motherhood. Cognitive-behavioural therapy involves dialogue to address negative thought and behaviour patterns, improving problem-solving and self-confidence. While the approach is recognized as effective, it is under-utilized in low-resource settings where psychological support services are lacking. To address this gap, a peer-led psychosocial therapy model was introduced, including expert clients through health facilities in slum areas linked to prevention of vertical transmission services. Self-stigma was reduced, and self-care increased, and the approach has the potential to be scaled up in low-resource settings.[cxli]

Botswana: Improving outcomes for adolescents living with HIV

Adolescents living with HIV in Botswana face significant challenges related to socioeconomic inequalities, gender-based violence and mental health. Botswana, through a multisectoral partnership, conceptualized and implemented differentiated models of care to address the HIV treatment gap among adolescents living with HIV. The model includes training health-care workers and guardians, the creation of teen clubs at treatment sites to promote adherence and positive living and supporting the creation of a national network of young people living with HIV.

An evaluation of the clinical, psychosocial and behavioral outcomes among adolescents and young people living with HIV on antiretroviral therapy found increases in viral suppression and consistent adherence of greater than 10%. In addition, there was a major decline in the numbers of adolescents with partners five or more years older than themselves, as well as a 10% increase in condom use at last sex. The interventions are being scaled up to additional sites, including by

transforming teen clubs into empowerment clubs that provide peer support for mental health, and skills training to overcome socioeconomic inequalities.[cxlii]

114. HIV transmission results from practices and behaviours situated with social, economic, and other structural conditions.[cxliii] An analysis of biomedical approaches to HIV prevention found that they do not adequately address the understanding that “all prevention interventions must engage with the everyday lives of people and be integrated into their social relations and social practices.”[cxliv] For example, biomedical technologies for HIV prevention do not address or resolve the underlying gender power and other inequalities that perpetuate vulnerability to HIV infection. In contrast, these can be directly addressed through social and behaviour change approaches that consider social norms in relation to behaviours.

115. Social science research is necessary for developing theories of change and understanding the effectiveness of HIV programmes (via implementation science, for example). It is also valuable for exploring the shifting landscape of HIV, including emerging issues such as the needs of ageing people living with HIV, and for providing insights into neglected concerns such as mental health and unresolved issues such as stigma and discrimination.[cxlv] Such research also offers opportunities to deepen understandings of how communities and sectors meaningfully lead aspects of the HIV response and how they can be comprehensively integrated in that HIV response in ways that reflect their perspectives, realities and needs.[cxlvi] [cxlvii]

116. Reinvigorating and ensuring complementarity between the biomedical and social sciences are critical steps towards achieving effective, efficient, equitable, scalable, holistic and sustainable approaches.[cxlviii] Doing so requires institutionalizing and resourcing such collaboration, linkages and practices, especially multidisciplinary research.

The way forward

117. While the targets for 2025 provide a framework for defining progress toward epidemic control, sustainability hinges on multiple layers of the HIV response, including bringing about changes to policies, programmes and systems, ensuring responsive leadership toward universal human rights, and ending inequalities in the future.

118. Advocacy to address sustainability is necessary to increase attention to integrating sustainability planning in all aspects of the HIV response, including committing resources to sustainability planning and financing.

119. People of all ages who are living with or vulnerable to HIV, and countries responding to HIV, must be reassured that the sustainability of an equitable HIV response is being prioritized. Achieving the 2025 targets and 2030 goal—and then sustaining those accomplishments—requires intensified efforts by all stakeholders and sectors, including civil society and affected communities.

120. Sustainability requires a continuum of immediate, medium- and long-term initiatives that are informed by a framework of action, including convergent actions related to PHC, UHC,[cxlix] pandemic preparedness and other priorities.

121. An intensive, accelerated and focused response is needed to ensure that all countries are on track to achieve an equitable and sustainable HIV response. That includes equitable financing in conjunction with nuanced, simplified, person-centred and affordable, country-specific responses that fast-track HIV prevention and treatment,

strengthen societal enablers, address human rights and gender impediments, safeguard key and vulnerable populations, and engage in social contracting mechanisms to fast-track and reinforce community-led HIV responses—in conjunction with undertaking immediate sustainability planning processes.

122. Multisectoral dialogue, planning, coordination and accountability processes (including with civil society, community and key population-led organizations and networks, people living with HIV, women's organizations, key and vulnerable populations, and communities) are necessary. This will ensure timely shifts to achieving the 2025 targets and sustaining efforts to meet the 2030 goal, including establishing a foundation that meets the needs of the post-2030 response. It includes ensuring that resources are sufficient to meet the needs of millions of people living with HIV into the future.

123. Investments are needed for research to inform and scale-up effective, efficient and sustainable approaches, ensuring that epidemiological priorities are understood and addressed, and that monitoring and evaluation inform programmatic adaptations. Funding must be directed towards HIV response sustainability planning and implementation must be accepted as integral components of HIV response efforts moving forward. Flexibility is needed to adapt to changing local, international, and global circumstances.

124. Immediate transformative actions are necessary to reconfigure and rationalize the HIV response to ensure durability and resilience. Every step forward should contribute to maximizing gains, ensuring equity and leading to impacts that are sustained and sustainable (including taking into account crises that can disrupt the HIV response).

Focal areas for sustainability response

125. Most countries will likely not meet the 2025 HIV targets. This poses challenges for reaching the 2030 goal, including assumptions about funding transitions and the resources and capacities necessary to manage HIV epidemics at country levels and globally. It includes giving equal weight to meeting all targets and urgently addressing gaps in metrics for understanding and tracking progress. It is also necessary to look beyond 2030.

126. Several plausible definitions of HIV sustainability have been put forward, and they all recognize that efficient, effective responses are needed in the first instance and that any shifts away from intensive high-budget donor-funded programmes must cater for more simplified, person-centred services; must address short- and long-term affordability; and must prioritize and expand multisectoral and decentralized approaches that are informed by people and communities directly affected by HIV.

127. The UNAIDS working definition of sustainability highlights enabling environments, equity, rights and people-centred approaches, including institutional and community-led HIV responses. The definitions used by the Global Fund and PEPFAR also emphasize transitions in funding towards greater reliance on domestic resources, with responsive health and community systems necessary to achieve disease control.

128. There is sound evidence to support the epidemiological and health benefits of achieving 95–95–95 including ensuring that people living with HIV remain healthy and reducing the potential for HIV transmission. However, high and sustained levels of access to treatment are necessary, and may not be available in all settings, nor across all key and vulnerable populations to achieve the 2025 targets. There is a need to ensure that complementary HIV prevention initiatives and programmes in place—

especially in settings and contexts where the trajectory towards achieving 95-95-95 may take longer.

129. Lessons can be drawn from HIV responses that have embraced key population programming, GIPA, community and civil society ownership and leadership. Those approaches enable greater impact, often at lower cost, and facilitate greater investment in knowledge and capacities of people whose lives are directly impacted by HIV, including people living with HIV, key and vulnerable populations and women. There is a need to shift focus from community engagement and leadership towards ensuring community representation and meaningful participation in national and global sustainability processes across relevant decision-making structures, research, planning and programming.

130. Clear commitments to reach the targets for community leadership are key to ensuring this vision of sustainability, as are significantly increased investments in community-led organizations and networks, including support for strengthening operational and internal systems. Civil society organizations must be recognized and included, and they should be able to operate in hospitable legal and regulatory environments.

131. The under-resourcing and diminished utilization of social science and multidisciplinary research in the HIV response must be reversed to help clarify the repertoire of approaches, actions and programmes that can get the HIV response back on track.

132. There is an urgent need to reinvigorate and prioritize approaches for reducing the persistent high HIV incidence among adolescent girls, high and increasing HIV incidence among key populations and overcoming the response-limiting effects of stigma, discrimination and criminalization.

133. As humanitarian crises continue to emerge, it is important to absorb lessons from the COVID-19 pandemic, which showed health and community systems are more resilient when they are both strengthened. Investment in sustainability would benefit from a focus on identifying and strengthening the elements that underpin resilience to inform response in the context of crises, as well as in relation to PHC and UHC.

134. The strengthening and integrating health systems is underway as part of the focus on PHC and UHC. There is also a shift away from disease-specific, “exceptionalist” approaches.[cl] This entails reconfiguring response systems and using the potential of PHC and UHC to accelerate the achievement of HIV and TB control and of “triple elimination” in line with the SDGs.

135. There is wide recognition that shifts in HIV financing must emphasize scaling up cost-effective HIV prevention and treatment approaches. At the same time, countries must be able to restructure their debt obligations, achieve fiscal stability and pursue economic growth if they are to sustain their HIV and related health gains towards and beyond 2030.

Sustainability Roadmaps

136. While progress is lagging across the SDGs, there are immediate opportunities to shape an accelerated response through collaboration between all stakeholders—particularly affected communities—and by building on research and lessons learned to make HIV responses effective, equitable, efficient and impactful.

137. Commitment and actions for sustainability require dialogues between stakeholders at all levels to consider and decide on the priorities for building sustainability, the core elements of which can be framed in three categories:
   - Political sustainability: Including unwavering political commitment to sustainability, including shared responsibility and leadership, effective participatory governance, enabling laws and policies, and an equitable HIV response.
   - Programme sustainability: This includes: (i) multidisciplinary research-driven, effective, and high-impact programmes focused on HIV prevention, treatment, and underlying enablers, following multisectoral approaches and incorporating civil society and community involvement at all levels; and (ii) moving away from siloed approaches towards integration in line with PHC and UHC objectives and goals.
   - Financial sustainability, including investing in the sustainability response and ensuring: (i) adequate, sustainable and equitable domestic and external funding, with a focus on achieving the 2025 targets and sustaining those gains through 2030 and beyond; and (ii) country-tailored, transformative financing solutions for long-term sustainability that meet the needs of all people living with and vulnerable to HIV.

138. A Sustainability Framework or Roadmap supports dialogues and guides governments, research bodies and researchers, sectors, organizations, communities, development partners, UNAIDS Cosponsors, and other partners towards ensuring a balanced, effective, efficient (including cost-efficient) and resilient country HIV response that leaves no one behind, as the foundation for sustainability. That includes ensuring that sustainability planning is integrated in all aspects of the HIV response.

139. Sustainability is not achievable unless a holistic HIV response is prioritized. This includes developing responsive metrics for the social dimensions of HIV, including informing progress towards achieving the 10–10–10, the 30–80–60 and the HIV prevention targets, as well as sustainability assessment tools that inform the various dimensions of sustainability and monitor progress.

140. UNAIDS has a vital role in catalysing and leading the sustainability of the HIV response, while spearheading a coordinated multisectoral HIV response and accelerating HIV prevention, treatment and reducing HIV-related mortality.

141. UNAIDS is working with countries to develop a holistic, country-owned HIV Sustainability Roadmaps that are based on solid assessments of relevant sustainability factors. Details are outlined in an HIV Response Sustainability Primer and Companion Guide which describe a process that includes:[cli] [clii]
   - country leadership and governance of HIV response sustainability, including a working group on HIV response sustainability, dialogue and consultations.
   - an HIV Response Sustainability Roadmap, including assessment, goal setting, transformation planning, implementation guidance, and monitoring and evaluation; and
   - implementation of the transformation plan, including processes of learning and adaptation.

142. There are opportunities for countries to invigorate and leverage multisectoral partnerships and resources nationally, while building on regional partnerships that reflect the interdependencies and shared accountabilities for addressing HIV regionally. This includes consensus-building and accountability to ensure that human rights and gender equality are prioritized.

143. Commitment to sustainability can be supported by global, regional or country sustainability declarations and multicountry or regional frameworks. The African Leaders' Meeting Declaration includes promising pathways for mobilizing sustainable financing for health care in the region. The Association of Southeast Asian Nations has also committed to ensure the of their HIV responses through a declaration that emphasizes ending inequalities, prioritizing community leadership, securing financing for sustainability.[cliii] [cliv]

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